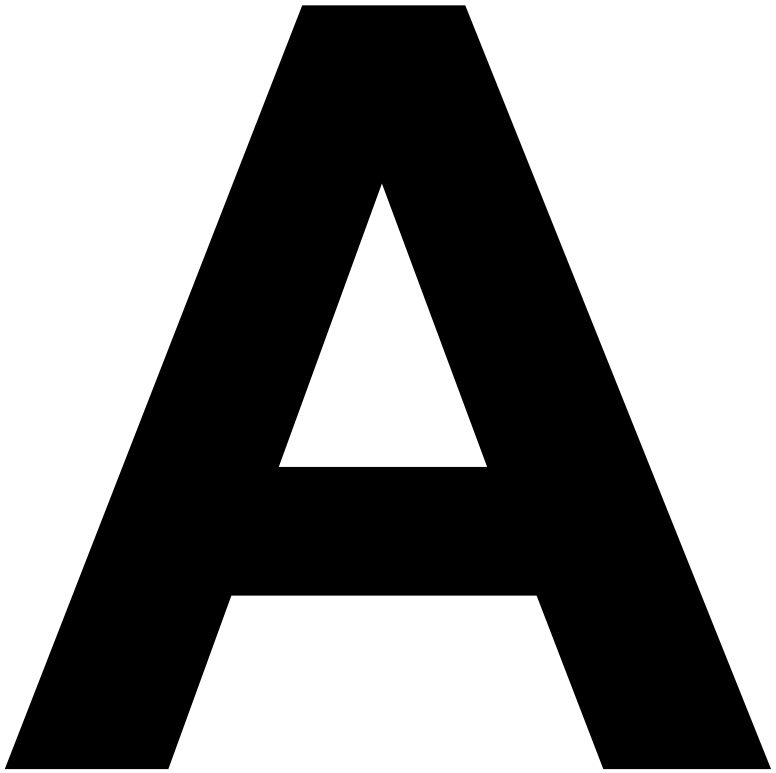
Meeting Title	**Leicester, Leicestershire and Rutland (LLR) Integrated Care Board meeting** (meeting held in public)	**Date**	**Thursday, 13 April 2023**
Meeting no.	**7**	**Time**	**Meeting in public: 9:00am – 11:15am** **Confidential meeting: 11:20am – 11:30am**
Chair	**David Sissling** **Independent Chair, ICB**	**Venue / Location**	**Via MS Teams**

REF	AGENDA ITEM	ACTION	PRESENTER	PAPER	TIMING
ICB/23/26	Welcome and Introductions	To receive	David Sissling	**Verbal**	9:00am
ICB/23/27	Apologies for Absence: • Mark Andrews • Simone Jordan	To receive	David Sissling	**Verbal**	9:00am
ICB/23/28	Notification of Any Other Business	To receive	David Sissling	**Verbal**	9:00am
ICB/23/29	Declarations of Interest	To receive	David Sissling	**Verbal**	9:00am
ICB/23/30	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/23/31	Minutes of the meeting held on 9 February 2023	To approve	David Sissling	**A**	9:15am
ICB/23/32	Matters arising and actions for the meeting held on 9 February 2023	To receive	David Sissling	**B**	
ICB/23/33	Update from the Chair	To receive	David Sissling	**Verbal**	9:20am
ICB/23/34	Update from ICB, Acute Sector and Mental Health and Community Sector	To receive	Andy Williams / Richard Mitchell / Angela Hillery	**Verbal**	9:25am
SHARING CASE STUDIES AND PATIENT STORIES					
ICB/23/35	Children and Young People patient story	To receive	Dr Nil Sanganee	**C** **presentation**	9:35am
STRATEGY AND SYSTEM PLANNING					
ICB/23/36	Primary Care Strategy 2022-2025	To approve	Rachna Vyas	**D**	9:55am
ICB/23/37	Update on the Development of the LLR ICB 5 Year Joint Forward Plan	To receive	Sarah Prema	**E**	10:10am
ICB/23/38	LLR ICB Board Assurance Framework 2022/23 and 2023/24	To approve	Caroline Gregory	**F**	10:15am
ICB/23/39	Equality, Diversity and Inclusion Annual report	To approve	Alice McGee	**G**	10:30am
OPERATIONAL					

REF	AGENDA ITEM	ACTION	PRESENTER	PAPER	TIMING
ICB/23/40	Emergency Preparedness, Resilience and Response (EPRR) Annual Update	To approve	Rachna Vyas	**H**	10:40am
ICB/23/41	LLR System Finance monthly report (month 11)	To receive	Caroline Gregory	**I**	10:50am
ASSURANCE					
ICB/23/42	Assurance report from the Finance Committee and approval of the terms of reference	To approve	Cathy Ellis	**J**	11:00am
ICB/23/43	Assurance report from the System Executive Committee and approval of the Strategic Commissioning Group terms of reference	To approve	Andy Williams	**K**	
ICB/23/44	Assurance report from the Remuneration Committee and approval of terms of reference	To approve	David Sissling	**L**	
ICB/23/45	Assurance report from the Quality and Safety Committee	To receive	Pauline Tagg	**M**	
ICB/23/46	Assurance report from the Audit Committee	To receive	Darren Hickman	**N**	
ICB/23/47	Assurance report from the Health Equity Committee	To receive	Prof Azhar Farooqi	**O**	
GOVERNANCE					
ICB/23/48	ICB Register of Interests and Register of Gifts and Hospitality 2022/23	To approve	Caroline Gregory	**P**	11:10am
ICB/23/49	Forward Planner 2023/24	To approve	Caroline Gregory	**Q**	
FOR INFORMATION					
ICB/23/50	Update on delivery of a safe Winter through 2022/23	To receive	Rachna Vyas	**R**	**For information**
ICB/23/51	Delegation of Primary Pharmacy, Optometry & Primary and Secondary Dental Services (PODs) from NHSE to NHS Leicester, Leicestershire and Rutland Integrated Care Board	To receive	Sarah Prema	**S**	
ANY OTHER BUSINESS					
ICB/23/52	Items of any other business and review of meeting	To receive	David Sissling	**Verbal**	11:15am

The next meeting of the LLR Integrated Care Board meeting will take place on **Thursday 8 June 2023**, 9:00am to 11:30am, meeting to be held in public via MSTeams.

Where applicable - 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")
Held in Public, Thursday 9 February 2023
9:00am – 11:30am, 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
Dr Caroline Trevithick	Chief Nursing Officer, NHS LLR ICB
Ms Caroline Gregory	Interim Chief Finance Officer, NHS LLR ICB
Ms Sarah Prema	Chief Strategy Officer, NHS LLR ICB
Dr Nil Sanganee	Chief Medical Officer, NHS LLR ICB
Professor Azhar Farooqi	Non-Executive Member, NHS LLR ICB
Mr Darren Hickman	Non-Executive Member, NHS LLR ICB
Ms Simone Jordan	Non-Executive Member, NHS LLR ICB
Mr Richard Mitchell	Partner Member - acute sector representative (Chief Operating Officer, University Hospitals of Leicester NHS Trust)
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)
Dr Nainesh Chotai	Primary Care Sector representative
Professor Mayur Lakhani	Clinical Executive Lead, NHS LLR ICB

Participants:

Ms Alice McGee	Chief People Officer, NHS LLR ICB
Ms Harsha Kotecha	Chair, Healthwatch Leicester and Leicestershire
Ms Cathy Ellis	Chair of Leicestershire Partnership NHS Trust
Cllr Sam Harvey	Chair, Rutland County Council Health and Wellbeing Board
Cllr Louise Richardson	Chair of Leicestershire Health and Wellbeing Board

In attendance:

Mrs Daljit Bains	Head of Corporate Governance, NHS LLR ICB
Ms Charlotte Gormley	Corporate Governance Officer, NHS LLR ICB (note taker)
Dr Leslie Borrill	Charnwood GP federation *(for item ICB/23/10 only)*
Dr Bharathy Kumaravel	Consultant Public Health (Leicestershire County Council) *(for item ICB/23/10)*
Ms Karen Tomlinson	Trust Chair, EMAS *(for item ICB/23/12)*
Will Legge	Director of Strategy and Transformation, EMAS *(for item ICB/23/12)*
Ms Yasmin Sidyot	Deputy Chief Operating Officer, NHS LLR ICB

Seven members of the public joined to observe the meeting.

ITEM		LEAD RESPONSIBLE
ICB/23/1	**Welcome and Introductions** The ICB Independent Chair welcomed colleagues and members of the public to the meeting. The meeting was held in public and was quorate. No confidential meeting was being held today.	
ICB/23/2	**Apologies for absence from Members and Participants:** • Pauline Tagg, Non-Executive Member • Martin Samuels, Partner Member - local authority sectoral representative (Strategic Director, Partner Social Care and Education, Leicester City Council) • Dr Janet Underwood, Chair, Healthwatch Rutland	

ITEM		LEAD RESPONSIBLE
	• Mr Mark Andrews, Partner Member – local authority sectoral representative (Chief Executive, Rutland County Council) • Rachna Vyas, Chief Operating Officer • Councillor Vi Dempster, Chair, Leicester City Council Health and Wellbeing Board	
ICB/23/3	**Notification of Any Other Business** No additional items of business had been notified.	
ICB/23/4	**Declarations of Interest on Agenda Items** The register of interests was published on the ICB website and would continue to be reviewed and updated. It was highlighted that the Chief People Officer had a direct conflict of interest in Paper H (Strategic Leadership Collaborations). It was agreed that although the Chief People Officer would remain present for the item she would not participate in the discussion. **It was RESOLVED to:** • **NOTE and AGREE** the approach to managing the conflicts identified.	
ICB/23/5	**Consider written questions received in advance from the Public in relation to items on the agenda** Mr Sissling thanked members of the public for submitting questions in advance of the meeting. He emphasised that the ICB was keen to respond to queries, and he advised that members of the public were also welcome to contact the ICB outside the formal cycle of Board meetings. The questions received, and the responses provided by the LLR ICB were as follows: <u>Questions received from Giuliana Foster</u> *1. "With reference to paper G 6f, Draft Primary Care Strategy. Care Closer to Home – transforming community services and improving discharge , including the implementation of the 'virtual wards' – supported by Primary Care.* *Whilst I applaud this concept and acknowledge that this change in delivery of care is in line with NHSE Long Term Plan, I have great concerns that due to the national healthcare staff shortage crisis, these plans are going to be almost impossible to implement with the necessary support that patients will require to be safe, stable and continuity of care will not always be possible. I fear that in some cases this may well result in patients being re-admitted to hospital and thus being trapped in the 'cog' of the system again.* *The ICB state that there are 3 fundamental areas to achieve in line with the Primary Care Strategy: recruitment/retention, parity and connectivity with the wider systems and moving away from traditional models.* *Does the ICB have detailed plans in place to mitigate the staff shortages that are required to deliver the correct level of care in the 'Care Closer to Home' programme? And if so, what are they?"* In response to Ms Foster's question, Mr Andy Williams advised that the ICB is working with other system partners to modify its recruitment strategy in partnership with main providers. This includes changing and developing roles,	

ITEM		LEAD RESPONSIBLE
	holding recruitment events and working to be a more attractive employer. Work is also taking place with educational partners and other professional training bodies. At this time, it is not possible to guarantee the workforce that will be in place, however it is possible to evidence the positive and proactive approach. Questions from Zuffar Haq *1. What extra measures are in place for winter pressure in comparison with the previous year?* *2. How many patients waiting more than 4 hours in an Ambulance outside LRI for September, October and November 2022?* *3. How many cancelled operations at UHL in December 2021, January 2022 and February 2022?* *4. Do the board think the numbers will be higher or lower this December, January and February?* In response to the first question, Mr Williams advised that the LLR winter plan covers a range of interventions including a targeted flu and vaccination programme, a GP acute pathway to support admission avoidance, additional bedded capacity within LPT, additional pathway 1 and 2 capacity to support earlier discharge, an unscheduled care hub to support ambulance conveyance and additional MIAMI capacity to support non-urgent patients. In response to the second question, Mr Williams advised that patients waiting over four hours for an ambulance numbered 231 in September 2022, 311 in October 2022, and 333 in November 2022 for a total of 875 patients. In response to the third question, Mr Williams advised that the number of cancelled operations within UHL during December 2021 totalled 167 in comparison to 177 in December 2022, and 220 in January 2022 in comparison to 98 cancelled operations in January 2023. Data for February 2022 and 2023 is not yet available. In response to the fourth question, Mr Williams advised that much of the capacity created through the winter plan will be mainstreamed, enabling the system to be better prepared for winter 2023/24. The system is working in partnership for clarity on its approach to urgent and emergency care. Questions from Jennifer Fenelon *1. Does the ICB agree that it would make sense nationally to synchronise ICS Strategy and 5 Year plan Implementation and will the ICB ask for delay of submission of the LLR 5 year plan to synchronise with completion of the ICS Strategy now scheduled for the Autumn?* In response to Ms Fenelon's question, Mr Williams advised that the development of the Five Year Forward View is required to be completed by the end of June 2023, as per timescales set out in the guidance issued in December 2022. The plan will take into account the current draft Integrated Care Partnership Strategy which is going through Health and Wellbeing Boards before being issued for engagement and finalisation by the Autumn of 2023. Given that the Five Year Forward Plan has to be updated annually there will be opportunities in the future to ensure it continues to align to the Integrated Care Strategy.	

ITEM		LEAD RESPONSIBLE
	Questions from Andrew Nebel *1.Please can we learn what specific operational changes are planned within the Joint Forward Plan to increase the opportunity for Rutland patients to receive care closer to home within the county and reduce the need to travel across the border to neighbouring healthcare facilities?* *2. And where cross-border travel is necessary, are there plans to collaborate with NWAFT on use of the Stamford & Rutland Hospital given its clinical strategy aims to provide more day-case services including cancer treatments, expanded diagnostics, ophthalmology, pain management and consideration of how to move its MIU to an UTC in line with National Guidance?* *3. How will the 7 high level objectives agreed last Summer for Rutland be operationalised* In response to the first question, Mr Williams advised actions relating to the steps set out in the Rutland Health Plan, which forms part of the Rutland Health and Wellbeing Strategy, can be found at the following link: https://rutlandcounty.moderngov.co.uk/documents/s23598/LLR%20ICB%20Healthcare%20Plan%20RHWB%20120722%20Slide%20Deck%20v.6%20New%20Org%20Template.pdf Key actions in relation to care closer to home include expanded diagnostics and outpatients. In response to the second question, Mr Williams advised that the ICB continue to work with NWAFT given the number of patients from Rutland that attend hospitals in the NWAFT area. Plans for Rutland Hospital are set out in the Rutland Health plan as per above answer. In response to the third question, Mr Williams advised that the Rutland Health and Wellbeing Strategy contains seven priority areas; the strategy is supported by a Delivery Plan that sets out how the actions identified in the strategy will be operationalised. A copy of the Health and Wellbeing Strategy can be found at the following link: https://www.rutland.gov.uk/health-wellbeing/health-plans-policies-reports/health-wellbeing-strategy Questions from Ramsay Ross *1. Does the ICB consider that it is in breach of its duty to prepare an implementation plan for Rutland, aligned with the objectives set by the Rutland HWB?* *2. Is the ICB satisfied with the level of development of a deliverable Health Plan for Rutland at this time (February 2023)?* *3. Is the Financial Director of the ICB satisfied at this point in time, that the information available in the Health Plan provides a sufficient basis for the allocation of funds within the budgetary process for FY 23/24?* *4. When will a Health Plan for Rutland, with sufficient detail to form a basis for both public consultation and the allocation of financial funds for the county be produced?* In response to the first question, Mr Williams advised that a Health Plan for Rutland has been developed which sets out actions Health will take to develop services locally. This forms part of the Delivery Plan for the Health and Wellbeing Strategy. The link to this plan is as follows: https://rutlandcounty.moderngov.co.uk/documents/s23598/LLR%20ICB%20H	

ITEM		LEAD RESPONSIBLE
	ealthcare%20Plan%20RHWB%20120722%20Slide%20Deck%20v.6%20New%20Org%20Template.pdf In response to the second question, Mr Williams advised that a Rutland Health Plan has been developed and work is now ongoing to implement the individual elements of this plan. Regular updates are planned to be provided to the Rutland Health and Wellbeing Board. In response to the third and final question, Mr Williams advised that work is currently underway to assess the level of capital funding required to make any necessary changes to the Rutland Memorial Hospital to provide increased diagnostics and outpatient activity. At this moment in time there are no proposals in the Rutland Health Plan that will require consultation and funding is based on that currently allocated to services.	
ICB/23/6	**Minutes of the meeting held on 8 December 2022 (Papers A)** The minutes were confirmed as an accurate record. **It was RESOLVED to:** • **APPROVE** the minutes of the ICB Board meeting held on 8 December 2022.	
ICB/23/7	**Matters Arising and actions for the meeting held on 8 December 2022 (Paper B)** Progress made against specified actions were described in the report. With regard to Minute 22/87 of 8 December 2022, the ICB Independent Chair confirmed that the confidential meeting had taken place and that the position of a modest surplus had been agreed for the LLR ICB itself, with a forecast system deficit of £20m. This position was in line with the control total agreed with NHS England. **It was RESOLVED to:** • **RECEIVE** the update and progress made in relation to the actions.	
ICB/23/8	**Update from ICB Chair** Mr Sissling noted his intention to review the ICB agendas with colleagues, to assess whether the current operational/strategic split was appropriate. He also highlighted good progress on a number of partnership and collaborative working issues, including: • a positive meeting with local government colleagues to develop relationships further; • an inspirational visit to Inclusion Healthcare Leicester, and • the ongoing development of partnership working and collaborative relationships between the 5 East Midlands ICBs. **It was RESOLVED to:** • **RECEIVE** the update.	

ITEM		LEAD RESPONSIBLE
ICB/23/9	**Update from ICB, Acute Sector, Mental Health and Community Sector** Mr Williams advised that he would welcome any feedback on the information he had circulated to colleagues with respect to the first five months of the LLR ICB's existence. He also thanked system colleagues, staff, volunteers, and members of the public for their support during the ongoing industrial action, noting the significant work undertaken to maintain services. Mr Richard Mitchell highlighted four issues: (a) work to improve outcomes, including the ongoing system focus on ambulance handovers. Since the 24 December 2022 peak pressure point, ambulance handovers had continued to significantly improve, with UHL now accounting for 0.4% of delays nationally compared to 5% previously. An escalation hub had opened at the Leicester Royal Infirmary site, and a permanent facility was being reviewed. An urgent and emergency care plan was scheduled to be developed for 31 March 2023. (b) There was continued focus on improving performance in respect of patient waits for cancer services. He acknowledged that there was still work to do, although UHL's position had improved significantly. Noting his recent work with UHL's cancer services, Mr Williams praised the dedication and responsiveness of UHL's 2-week wait clinical team in particular, and he commented on the benefit of primary and secondary care colleagues gaining a greater understanding of each other's roles. (c) Significant ongoing work with respect to health inequalities, with 30 workstreams in train aiming to improve equity of access. (d) Continued engagement with wider partners in respect of social care, including a visit to the Shama Women's Centre. Mr Mitchell also noted the good response to recent recruitment drives by the Trust, for Estates and Admin posts. Mr Mitchell was thanks for the positive update. Mr Sissling advised that ICB Non-Executive Members would welcome an update on the reconfiguration programme and New Hospitals Programme investment at a future development session. In the temporary absence of Ms Angela Hillery, an update on the mental health and community sector was provided later in the meeting (detailed here for ease of reference). Ms Hillery advised of an increase in funding for mental health crisis cafes and noted a continued focus on quality standards for community provision. AHSN funding had been secured for East Midlands Alliance work on patient safety in mental health, which was welcomed and evidenced good partnership working. **It was RESOLVED to:** • **RECEIVE** the verbal reports.	**Richard Mitchell**
ICB/23/10	**Population Health Management Approach to Tackle Health Inequalities in Charnwood (presentation)** In introducing the presentation, the Dr Sanganee particularly welcomed this collaborative approach to building primary care into community interaction and outreach, and queried how the project could be rolled out more widely.	

ITEM		LEAD RESPONSIBLE
	Dr B Kumaravel Consultant Public Health (Leicestershire County Council), and Dr L Borrill Charnwood GP Federation, attended to present recommendations from their work to explore a population health management approach to tackle health inequalities in Charnwood. The 3 recommendations focused on [i] building trust and rapport; [ii] improving access to healthcare, and [iii] improving knowledge and awareness, and the presentation detailed the actions proposed on each of those recommendations. The presenters drew the Board's attention to an increased uptake of bowel cancer and cervical cancer screening as a result of the actions taken to date. The presentation also set out the methodology used for the project. LLR ICB members welcomed this report. Acknowledging that tailored approaches were needed, Professor A Farooqi advised that the proposed interventions were well-recognised as being effective. He strongly supported their roll-out elsewhere and queried the time and resourcing implications required to do that. These comments were echoed by Mr Hickman, who highlighted the ICB's role in encouraging collaborative working for patient benefit, and suggested that the next step was also to link in to the 30 health inequality workstreams currently being progressed by UHL NHS Trust. Dr B Kumaravel confirmed that she had already made contact with UHL's Director of Health Equality and Inclusion regarding appropriate collaboration, and was also meeting with the ICB Chief Operating Officer to discuss roll-out of the project across key areas e.g. cancer, cardiology, respiratory. Dr B Kumaravel acknowledged the additional resource requirements, but considered that the approach was easily replicable. Noting interest from some other Primary Care Networks already, Dr L Borrill considered that, with appropriate local leadership, the project could be rolled out more widely, and he welcomed the ICB's funding of some outreach communications. In terms of rolling out the approach, Professor Farooqi suggested focusing on those PCNs where there was a known health inequality issue. Mr Sandys also voiced his support for the project, noting the need to appropriately resource both its delivery and the related learning. Members echoed these comments, and emphasised the need to share the learning and innovation, and translate this into appropriate service redesign. Mr Sissling supported these comments, and suggested that an 'innovate, learn, and adopt' theme would be useful to reflect in the LLR ICB 5-year Joint Forward Plan. **It was RESOLVED to:** • **RECEIVE** the presentation.	
ICB/23/11	**Update on the development of the LLR ICB 5 Year Joint Forward Plan and Operational Plan 2023/24 (Paper D)** Ms Prema updated the Board on the development of the LLR ICB's 5-year Joint Forward Plan (5YJFP) and the LLR Operational Plan 2023/24 submission. The key areas to be covered, and the timelines for consideration of the 5-year Joint Forward Plan by the ICB and partner organisations were detailed in the report, the next draft version would be available in late March 2023 and the final submission due to NHSE on 30 June 2023. As required, views on the 5YJFP would also be sought from the respective Health and Wellbeing Boards. The final LLR Operational Plan 2023/24 would be presented to an extraordinary of the Board at the end of March 2023, ahead of the 30 March 2023 NHSE	**CSO** **CSO**

ITEM		LEAD RESPONSIBLE
	submission deadline. Ms Prema commented on a challenging year in terms of planning. Ms Hillery welcomed the report's clarity on the process and timelines, and emphasised the need for the plans to be appropriately discussed and commented on prior to submission. This point was reiterated by Mr Sissling. With regard to the Operational Plan 2023/24, Mr Hickman sought assurance regarding the process for managing business case submission, including the number submitted to date and how expectations were being managed. Ms Prema advised that circa 140 business cases had been submitted – decisions on the level of investment available would be made after 10 March 2023, informed by an appropriate prioritisation process. An appropriate clinical risk assessment/clinical quality impact assessment would be applied to business cases which were not approved, and Dr Sanganee advised that a filter had already been applied to the process. Given the likely funding constraints, Professor Farooqi also sought assurance that health inequalities would be taken into account when considering business cases, and that a review would be undertaken to ensure that the current prioritisation process remained fit for purpose. Board members also commented on the benefits of having a longer-term 5-year plan. **It was RESOLVED to:** • **RECEIVE and NOTE** an update on the development of the Leicester, Leicestershire and Rutland Integrated Care Board 5 Year Joint Forward Plan and Operational Planning 2023/24 Submission.	
ICB/23/12	**East Midlands Ambulance Service (EMAS) Strategy (Paper E)** EMAS colleagues attended to present the refreshed EMAS Strategy, setting out the national and local context for the refresh, the key headline principles, and the methodology used to develop the strategy. The presentation particularly focused on the draft 5 key ambitions within the strategy. The presentation contents and co-production approach were welcomed by the LLR ICB and prompted a number of questions/comments, including: (a) how EMAS would reflect local ways of working and community knowledge; (b) how EMAS could help the LLR system in learn from other areas of good practice across the wider EMAS patch; (c) how the draft 5 ambitions would link to the EMAS strapline statement of "Respond-Develop-Collaborate", and how the ambitions (which currently focused on quality aspects) would address the responsiveness challenges facing the service. The LLR ICB also suggested a need to make the ambitions more memorable; (d) how EMAS would anticipate service needs/demand. The LLR ICB also commented on the need to look at changing mindsets in terms of reducing service demand where appropriate, including working on alternative provision initiatives with Primary Care Networks and 111; (e) whether the EMAS strategy was envisaging separate additional input from GPs, and if so, what discussion had taken place with GPs on that issue; (f) whether cross-sector working was being considered, and the benefits of aligning clinical models and strategies across partners. The need for all partners to work together to improve healthcare provision and attract appropriate staff was also highlighted; (g) whether international best practice was also being reflected, and	

ITEM		LEAD RESPONSIBLE
	(h) the need to ensure that partner organisations' various strategies were appropriately aligned/signposted to avoid duplication and improve communication. In the interests of time, EMAS representatives provided some responses and agreed provide further clarification outside of the meeting where required. **It was RESOLVED to:** • **RECEIVE** the presentation.	
ICB/23/13	**Responding to the Developing Role of the Integrated Care Board (Paper F)** Mr Williams described the evolving role of the LLR ICB, noting that paper G below would be seeking approval for the delegation of specified NHSE functions to ICBs. Mr Williams considered that the process of ongoing ICB development was a positive one. Members took assurance from the report, and the Prof Lakhani suggested that integration with social care and integration of clinical services within LLR were key areas which would benefit from a partnership approach. Mr Hickman commented that each delegation request would need to be considered on its own merits, with full understanding of the implications and resourcing requirements. **It was RESOLVED to:** • **RECEIVE** the report for assurance.	
ICB/23/14	**Delegation of NHS England Functions to ICBs (Paper G)** The paper set out the proposed delegation to ICBs from NHSE/I of [i] Primary Pharmacy, Optometry, and Primary and Secondary Dental Services (PODS) on 1 April 2023, and [ii] specified Specialised Services (acute and pharmacy) on 1 April 2024, and requested delegated approval of the related governance arrangements. Delegation of these services was national policy, and accountability would remain with NHSE/I. The PODS involved circa £87.4m across 548 individual contracts, and it was proposed that these services would continue to be managed on an East Midlands and West Midlands basis. Specialised Services would be on a Midlands basis. The proposed hosting arrangements, Distributed Leadership Model, and governance arrangements were as detailed in paper G. In response to a query from Mr Sandys, Ms Prema advised that where service issues could be shaped locally, there would continue to be scope to do so. Mr Sandys suggested that an appropriate explanatory narrative be included in any public communications on these delegations of NHSE functions. Commenting on the apparent complexity of the proposed governance arrangements, Mr Sissling noted the need also to understand the commissioning plans and strategy for the services being delegated. Ms Prema agreed to provide a further update on this at a future Board meeting once the hosting arrangements had appropriately embedded. Following due consideration, the LLR ICB approved the recommendations in paper G. **It was RESOLVED to:** • **APPROVE** the workforce hosting arrangements. • **APPROVE** the Distributed Leadership arrangements.	**Sarah Prema**

ITEM		LEAD RESPONSIBLE
	• **APPROVE** delegated authority to the Chair and Chief Executive to consider and approve the Tier 1 governance arrangements including the Joint Working Agreement, Joint Committee Terms of Reference and Scheme of Reservation and Delegation. • **APPROVE** delegated authority to the Chair, Chief Executive and Audit Committee Chair to approve any changes necessary to the LLR ICB governance arrangements to reflect delegation to the Joint Committee.	
ICB/23/15	**Strategic Leadership Collaborations (Paper H)** The Board noted Ms McGee's interest in this item, as declared earlier in the meeting. The report briefed the Board on the approach being explored to enable sharing of professional and strategic leadership across the LLR and Northamptonshire ICBs in respect of the People agenda. The approach was proposed to be piloted for a minimum of 6 months, split 1.5 days per week at Northants and 3.5 days per week at LLR. If supported, the approach would then also be discussed further with the Remuneration Committee, including the intention to consider any further opportunities for such sharing in other services. The outcome of the pilot would be reported to the LLRI ICB. Mr M Sandys Partner Member queried what actions were being put in place to [i] mitigate the impact on LLR ICB of sharing its Chief People Officer, and [ii] ensure that appropriate support was being provided to Ms McGee herself in taking on this broader role. In response, Mr Williams provided assurance that an appropriate professional development process was in place for the Chief People Officer's team, and he noted that one of the aims of the pilot was to assess the practicality of such shared arrangements. Mr Mitchell noted his support for this approach of closer working, noting that it was happening elsewhere. Ms Hillery also voiced her support for the proposed talent management measures, and advised that she would be happy to discuss LPT's experience of shared roles. Following due consideration, the Members supported the proposal as presented. **It was RESOLVED to:** • **RECEIVE and NOTE** the approach being explored and tested to enable sharing of professional and strategic leadership across Leicester, Leicestershire and Rutland and Northamptonshire ICBs for the People agenda. • **NOTE** that the approach will be discussed further with the Remuneration Committee, including the intention to consider any future opportunities for sharing expertise and capacity for future roles if appropriate. • **NOTE** that the board will evaluate the outcome of the trial period before any substantive changes are made.	
ICB/23/16	**LLR System People and Workforce Report (Paper I)** The Board considered the first such LLR ICB people and workforce report, setting out the approach to working and highlighting the data used to inform people and workforce decisions. It was not yet in the form of a strategic dashboard, and Ms McGee sought views on the content and format of the report. Although welcoming the report, Ms Hillery and Mr Mitchell both suggested that it would also be useful to include more detail on the strategic workforce shifts being made, in addition to the existing granular detail provided. Mr Mitchell also queried progress on the following strategic aim of the LLR ICS	

ITEM		LEAD RESPONSIBLE
	People and Culture Board: "Build a One team, One People Culture" – in response Ms McGee advised that this was currently at a strategic principle level, with a further session scheduled for March 2023 to explore delivery. Ms Sissling advised that he was assured by the arrangements outlined to progress and monitor people and workforce information. He stated his preference for a dashboard of indicators also to be included in future reports, to enable the Board to monitor progress on strategic aspects. **It was RESOLVED to:** • **RECEIVE** the People and Workforce report, noting the headline figures and how this information drives forward our priorities set at the LLR People and Culture Board**.** • **FOR ASSURANCE** note the governance and assurance processes for the People risks and programmes of work.	
ICB/23/17	**Performance and Delivery (Paper J)** The report from the Ms Sidyot presented a revised oversight framework for delivery of ICB's objectives, and provided assurance against delivery of the immediate priority of a safe winter. Although ambulance handover delays had reduced, other winter pressures also remained challenging. The position regarding 104 week waits and 78-week waits was still also challenged. Mr Williams advised that since producing paper J, further national guidance had been issued in relation to Tier 1 operation, and he was therefore reviewing the proposed assurance processes to assess the most appropriate way forward. Mr Sissling provided a brief explanation of the term 'Tier 1', noting that UHL NHS Trust was currently included in that Tier (and likely to remain so for the near future, as now advised by Mr Mitchell). He noted the proposal in the report to establish a System Delivery Group, and emphasised his view that this group must complement rather than duplicate or add to existing governance processes. **It was RESOLVED to:** • **NOTE** the development of the LLR System Delivery Group to oversee the delivery of performance and transformation across the ICB • **RECEIVE for assurance** the briefing against delivery of the LLR winter plan and continued work to strengthen this • **NOTE** the impact of the delivery of the LLR winter plan, on both the ambulance handover and the 104-week trajectories	
ICB/23/18	**LLR System Finance Monthly Report (Month 9) (Paper K)** Ms Gregory advised that a revised £20m deficit control total had been agreed with NHSE. She advised that the LLR ICB was on target to deliver that control total, noting the month 9 deficit position of £15.7m. Although acknowledging a number of red RAG-rated indicators in the report, the cash position was now green, which was welcomed. Ms Gregory was confident that the capital programme would deliver to break even at year end (currently below plan by £7.5m). Agency spend was a continued concern, fuelled by winter pressures and capacity demands – Ms Sissling commented on the significant overspend on agency, but recognised the drivers for that overspend. In discussion, Mr Mitchell noted the need to avoid the inference that UHL's financial position was having to be countered by the system more widely, and Mr Sissling agreed that was not the case.	

ITEM		LEAD RESPONSIBLE
	It was RESOLVED to: • **RECEIVE and NOTE** the financial position as at month 9 and the forecast performance. • **RECEIVE** for assurance.	
ICB/23/19	**Assurance Report from the Finance Committee (Paper L)** The Chair of the LLR ICB Finance Committee presented the discussions from the December 2022 and January 2023 meetings of that Committee. She noted the year-to-date overall deficit position of £15.7m (comprising a UHL deficit of £11.3m, an LPT deficit of £2.5m, and an LLR ICB deficit of £1.9m), which was £10.3m adverse to plan. A £20m year-end deficit was forecast. The revenue position was amber RAG-rated for month 9. Run rates were stable for months 8 and 9. Ms Cathy Ellis considered that it was crucial to deliver the agreed control total in terms of System financial credibility, and advised that assurances had been received that the UHL NHS Trust financial position risks were being managed. Work continued on the 2023/24 System financial plan, noting the need to bridge the underlying deficit gap to reach a break-even position. The transformation indicator was red RAG-rated, and the ICB Independent Chair requested an in-depth briefing on transformation – it was suggested that this would be most-appropriately delivered at a LLR ICB development session. **It was RESOLVED to:** • **RECEIVE** the report for assurance.	
ICB/23/20	**Assurance Report from the System Executive Committee (paper M)** Mr Williams presented the discussions from the December 2022 and January 2023 System Executive Committee, noting both challenges and positive developments. Mr Sissling particularly welcomed the pages reflecting 'improvements in LLR' appended to the report. **It was RESOLVED to:** • **RECEIVE** the report for assurance.	
ICB/23/21	**Assurance Report from the Quality and Safety Committee (Paper N)** In the absence of the Committee Chair, Dr Nil Sanganee presented the discussions from the January 2023 LLR ICB Quality and Safety Committee, noting that it had now moved to bi-monthly meetings incorporating a deep-dive session. The most recent deep-dive had related to children and young people, and had identified a series of actions. Oakham Medical Practice had now moved to a CQC rating of 'good' which was welcomed. Discussion on the primary care assurance report had identified a number of actions, including enhancing patient and public involvement. **It was RESOLVED to:** • **RECEIVE** the report for assurance.	
ICB/23/22	**Assurance Report from the Audit Committee (Paper O)** Mr Hickman presented the discussions from the December 2022 meeting of that Committee, which had taken assurance on cyber-security arrangements	

ITEM		LEAD RESPONSIBLE
	and levels of protection. Following an Board development session in January 2023, work continued to progress to support further evolving the LLR ICB BAF, with a view to producing an updated version for the April 2023 Board meeting. **It was RESOLVED to:** • **RECEIVE** the report for assurance.	
ICB/23/23	**Assurance Report from the Health Equity Committee and terms of reference (Paper P)** Prof Farooqi presented the discussions from the December 2022 meeting of that Committee. He welcomed the discussions held at today's Board meeting on health inequalities and equity of access, and the good interventions described to the ICB in the various presentations received today. He provided assurance that resources had now been identified for a health and equality support unit, which he hoped would launch in the near future. The Health Equity Committee was developing a dashboard as a key assurance tool for the LLR ICB, and would particularly look at cancer and at core 20+5 vaccination and prevention work. The update was welcomed. **It was RESOLVED to:** • **RECEIVE** the report for assurance.	
ICB/23/24	**Assurance Report from the (Inaugural) Equality, Diversity and Inclusion Committee (Paper Q)** This advisory group had held its inaugural meeting in November 2022, and would meet quarterly. Mr Sissling emphasised the need for this group to have an appropriately-high profile with a wide cross-sector membership, given the importance of the issues being discussed. **It was RESOLVED to:** • **RECEIVE** the report for assurance.	
ICB/23/25	**Items of any other business and review of the meeting** There were no further items of business. In comments during the meeting, the ICB Independent Chair welcomed the strong focus on partnership working and health equality issues. The meeting closed at 11:35am.	
Date and Time of next meeting: The next meeting of the NHS LLR Integrated Care Board will take place on **Thursday 13 April 2023** 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 April 2023	Status
ICB/22/41	11 August 2022	Primary Care update	Dr Nil Sanganee	Final version of the Primary Care Strategy to be presented for approval in February / March 2022.	~~February /~~ April 2023	Report on the agenda for the April 2023 Board meeting. **Action complete**	**Green**
ICB/22/85	8 December 2022	Ockenden review – progress and update	Dr Caroline Trevithick	A further update to be provided on this item in May / June 2023.	May 2023	Report on the forward planner for June 2023 meeting. **Request that action be closed.**	**Amber**
ICB/23/9	9 February 2023	Update from ICB, Acute Sector, Mental Health and Community Sector	Mr Richard Mitchell	That an update on the reconfiguration programme be provided at a future Board development session.	July 2023 (tbc)	Item included within the Board forward planner, timescales to be confirmed. **Request for action to be closed.**	**Amber**
ICB/23/14	9 February 2023	Delegation of NHS England functions to ICBs	Ms Sarah Prema	A report be presented to a future LLR ICB meeting on the commissioning plans and strategy for the services being delegated (once hosting arrangements had embedded).	TBC	Item added to the forward planner under joint commissioning arrangements.	**Amber**
ICB/23/16	9 February 2023	LLR System People and Workforce Report	Ms Alice McGee	That the LLR system people and workforce report be reviewed periodically at the Board, including a dashboard of indicators to monitor strategic progress.	tbc	Item added to the forward planner. **Request for action to be closed.**	**Amber**

D

Name of meeting:	**Leicester, Leicestershire and Rutland ICB Board meeting**		
Date:	**13 April 2023**	**Paper:**	**D**
Report title:	**LLR Primary Care Strategy 2022-2025**		
Presented by:	Rachna Vyas, Chief Operating Officer, LLR ICB		
Report author:	Mayur Patel, Head of Transformation, LLR ICB		
Executive Sponsor:	Rachna Vyas, Chief Operating Officer, LLR ICB Dr Nilesh Sanganee, Chief Medical 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:

- **Approve** the attached LLR primary care strategy.

Purpose and summary of the report:

1. The purpose of this briefing paper is to provide assurance to the Integrated Care Board that our primary care strategy has had the appropriate level of input from our key leads within the ICB, system partners, patients and voluntary organisations.

2. The Integrated Care Board are asked to approve the attached primary care strategy, appreciating this is a living/agile piece of work which will be updated at regular intervals.

3. The Integrated Care Board are asked to authorise future work to the strategy which include;

   a. Developing a revised primary care strategy towards the end of 2023 which will allow us to review how we are working with our PODs.
   b. Produce an online interactive primary care strategy, adapted to suit different audiences i.e. public facing.
   c. Develop a series of supporting documents, such as theme summaries, toolkits and easy reads.

Appendices:	• Appendix A –LLR 'One' Primary Care Strategy 2022-25 V1.09 • Appendix B- Stakeholder Engagement
Report history (date and committee / group the content has been discussed / reviewed prior to presenting to this meeting):	• Primary Care Transformation Board (PCTB) • LLR PPG Forums • LLR Clinical Directors (CDs) forum • Protected Learning Times (PLTs) • ISOC, JICB, IDGs • Public Health • Healthwatch LLR

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	Clinical Lead is also a practicing GP
☐	Conflict noted, conflicted party can participate in discussion but not in decision	
☐	Conflict noted, conflicted party can remain in meeting but not participate in discussion or decision.	
☐	Conflict noted, conflicted party to be excluded from the meeting.	

Implications:	
a) Does the report provide assurance against a corporate risk(s) e.g. risk aligned to the Board Assurance Framework, risk register etc? *If so, state which risk and also detail if any new risks are identified.*	Yes, the development of Primary Care Strategy is aligned to the risks within the BAF.
b) Does the report highlight any resource and financial implications? If so, provide which page / paragraph this can be found within the report.	No
c) Does the report highlight quality and patient safety implications? If so, provide which page / paragraph this is outlined in within the report.	N/A
d) Does the report demonstrate patient and public involvement? If so, provide which page / paragraph this is outlined in within the report.	Yes
e) Has due regard been given to the Public Sector Equality Duty? If so, how and what the outcome was, provide which page / paragraph this is outlined in within the report.	Yes

DRAFT PRIMARY CARE STRATEGY 2022-2025

Context

1. The Leicester, Leicestershire and Rutland (LLR) Integrated Care Board (ICB) recognises that Primary Care is the foundation of the NHS and the wider health and social care system, particularly as we develop working as Integrated Care Systems.

2. Primary Care is the fulcrum and first point of entry for the prevention and treatment of illness and poor health. Developing an LLR Primary Care Strategy that outlines the need for Primary Care providers to work together collaboratively with a shared aim of keeping people healthy and independent, and to ensure that those requiring care will be treated in the most appropriate place by the appropriate healthcare professional.

3. Like all other health and social care organisations, the pressures of Covid-19 have been felt significantly in Primary Care. Since the start of the pandemic in March 2020, Primary Care has continued to deliver services to our population and has quickly embedded new ways of working.

4. Therefore, is it imperative that we recognise the value of Primary Care and design our Primary Care Strategy so that it will work towards building resilient, sustainable, and thriving Primary Care Services which will be at the heart of an integrated health and social care system; setting a clear vision to improve the overall health and wellbeing across our population of LLR.

5. The LLR Primary Care Strategy sets out the commitments that the LLR ICB will make in the next three years which are:
    a. Working collaboratively with our system partners across System, Place and Neighbourhood to deliver on the key health and wellbeing challenges our people face.
    b. Implementing Population Health Management and personalised care approaches to improve health outcomes and address health inequalities (Core20Plus5 in particular).
    c. Tackle variation, restoring and improving the parity of access to Primary Care services – ensuring this meets the needs of patients at place and neighbourhood.
    d. Supporting the health and wellbeing of Primary Care workforce, in line with the Workforce Strategy, which includes promoting recruitment, retention, supervision, mentoring and coaching opportunities as well as training and development.
    e. The NHS Long Term Plan includes priority commitments to support people keeping healthier for longer. We are working with partners both within the NHS and outside to help people make healthier lifestyle choices and treat avoidable illness early on. Therefore, focusing on the Prevention agenda by taking full advantage of the opportunities to transform the delivery of service, including key preventive areas such as cancer services, mental health, etc.
    f. Care closer to home: Transforming community services and improving discharge, including implementation and delivery of Virtual Wards supported by primary care, which allows patients to get the care they need at home safely and conveniently, rather than being in hospital.
    g. Partnership working with other primary care providers such as Community Pharmacies, Opticians and Dental practices to deliver care through a personalised approach.

6. The Primary Care Strategy would need to be aligned to the vision, values and objectives of the LLR Integrated Care Board.

Primary Care Strategy Overview

7. The original Primary Care Strategy was published in 2019 as part of a collaborative integrated working approach through achievements with the Better Care Fund.
8. The strategy builds on this and our existing local health and wellbeing strategies and place led plans across LLR, solidifying our commitment and shared aspirations.
9. We share our view of our primary care priorities and propose these are used as a starting point for collaborative delivery of our vision.
10. Alongside these priorities we then recommend next steps for collaborative work aimed at all the organisations representing primary care in LLR, the ICS and ICB and for primary care professionals themselves.
11. We describe why it matters and what it might mean for our patients, colleagues, and partners.
12. We conclude by emphasising our commitment to giving everyone within LLR both a voice and stake in being able to create a community which provides the very best health and social care service.

Why we needed to do this work

13. We needed to refresh our primary care strategy and reset our vision for primary care to ensure that our ambitions are reframed and refocused as we join forces and unite as one team. Working with a shared purpose, common goals, and a system-wide commitment to collaborate and act together to address:
    a. National changes, contract reforms and the changing structures of the health and care system affecting primary care.
    b. Key system challenges: many of which are also felt in primary care.
    c. New models of care driven by changing public expectations, patient need and a focus on improving population health.

How we developed the strategy

14. Fuller Stock-take Steering Group acted as a Primary Care Strategy Task and Finish Group and supported with the development and delivery of the strategy.
15. We started developing the strategy by properly understanding the strategic shift affecting primary care, agreeing on a framework and methodology to approach our development; as summarised in section 3 of the strategy.
16. We utilised a range of data and insights from both local and national engagement exercises. These include:
    a. The National Patient Survey 2022 with over 14’000 responses.
    b. Local survey with over 5000 responses.
    c. The Enhanced Access Report with over 44’000 responses.
    d. Listening sessions with each of the 26 LLR PCNs
    e. The Summary of findings from these surveys can be found within appendix 2 of the strategy
17. Used secondary data collected including for the Building Better Hospitals Report of Findings (May 2021) and the, Step up to Great Mental Health Report of Findings (October 2021). All this robust data contributes to our Behaviour, Insights and Marketing Hub.
18. Used intelligence from our monthly meetings with the GP practice Patient Participation Group Network and via our online eCitizens’ panel comprising of 1,300 local people who actively feedback their experiences and insights of local services.

19. Adopted the set of ICS guiding principles, hanging our work of the wider ICS principles and priorities. i.e. Equitable Access
20. Triangulating with our wider LLR ICS/ICB ambitions and priorities, the NHS LTP, LLR place led plans, and district level plans. As well as linking back to our ICB 5 year plan and the ICB clinical model as both these strategies represent the 'clinical thinking' and 'priority actions' for health and care across LLR.
21. Ensuring our primary care priorities are applicable at all three levels. (Neighbourhood, Place, System), as they offer flexibility for places to balance and apply them varyingly, depending on local need.

Stakeholder engagement

22. The following people, groups or organisations for have been involved informing, contributing, and developing our Primary Care Strategy:

- Our LLR Patient Participation Groups
- Public and Patient Involvement Assurance Group
- General practice and PCNs across LLR
- Voluntary, Community and Social Enterprise Alliance
- LLR Professionals Committee: LMC (Leicester Medical Committee), LOC (LLR Local Optometric Committee), LDC (LLR Dental Committee), LPC (LLR Pharmacy Committee)
- Local Authorities and District Councils
- The patients and public of Leicester, Leicestershire and Rutland
- Our LLR ICB colleagues from all directorates
- The LLR ICB PCTB (Primary Care Transformation Board)
- Our LLR ICS and ICB Governance, Delivery, Assurance, Design Groups, ISOC, JICB, IDG, Health and wellbeing Boards
- Our LLR ICB Clinical leads, SME's and PCN Clinical Directors
- Public Health, Health Education England, NHS Colleagues, from Leicester City, Leicestershire & Rutland
- Healthwatch Leicester, Leicestershire & Rutland
- Our Strategic Partners: UHL, LPT, EMAS, DHU
- All our system partners

23. A full list of stakeholder engagement can be found in appendix 2.

Key considerations

24. Our current commissioning arrangements and responsibilities are heavily general practice focussed which is evident within this strategy. However, this is changing, which will help us reset our legacy view of primary care; appreciating primary care is wider than general practice, and also includes urgent care, pharmacy, dentistry, and optometry services.
25. We acknowledge that as with other health and social care systems, our local strategic commissioning arrangements, place planning, provider alliances and Primary Care Networks are still evolving with much of the detailed changes yet to emerge, including the direct commissioning of wider primary care services such as pharmacy, dentistry and optometry.
26. The Primary Care Strategy will continually be reviewed as the local and national picture for health and social care changes. This will include engagement within the ICB, with our system partners and offer public engagement opportunities to enhance the strategy going forward. i.e. Further POD involvement

Next steps

- Development of the delivery plan to support the delivery of the strategy.
- Primary care in LLR is on a journey. This strategy acts as starting point for collaborative primary care action, providing us with a snapshot of some of the priorities and an approach to delivering them, we will add to this strategy in the near future as we look at doing the following;
    a. A revised primary care strategy towards the end of 2023 which will allow us to review how we are working with our PODs.
    b. An online interactive primary care strategy, adapted to suit different audiences i.e. public facing.
    c. A series of supporting documents, such as theme summaries, toolkits and easy reads.
- Between now and then the recommendation from the steering group is to use the LLR Primary Care Transformation Board to oversee the development of the delivery plan and additional work, with oversight from the LLR System Executive and LLR Strategic Commissioning Board for feedback, comment and assurance.
- Continued engagement and consultation with key stakeholders for the co-production of the delivery plan and supporting documents.

Recommendation

- **APPROVE** The Primary Care Strategy

.

Appendix A

A VISION FOR PRIMARY CARE TRANSFORMATION IN LLR

‘ONE LLR’ OUR PRIMARY CARE STRATEGY 2022-2025

PROFESSIONAL & CLINICIAN VERSION

PENDING ICB BOARD APPROVAL
NOT FOR WIDER CIRCULATION

Governance:	**Pending Approval From LLR ICB Board** .			
Title:	**'ONE LLR' OUR PRIMARY CARE STRATEGY 2022-2025**			
Executive Sponsor:	Rachna Vyas (COO) LLR ICB Dr Nilesh Sanganee (CMIO) LLR ICB			
Clinical Leads:	Dr Nilesh Sanganee (CMIO) LLR ICB Dr Sulaxni Nainani (CMIO) LLR ICB			
SRO:	Yasmin Sidyot (Deputy COO I&T) LLR ICB			
Lead Author: **Supported By:**	Mayur Patel (Head of I&T) LLR ICB Muhammad Kharodia (I&T Manger) LLR ICB			
Version Control:	1.1-1.7	24/12/2022: Working first draft Updates	MK	Not Approved
	1.8	30/03/2023: Clinical lead revisions	NS/SN	
	1.9	03/04/2023: Final draft for board	MP	
Notes:	1. Document needs to be branded in ICB branding as per spec			

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2. **Why we need a new strategy?** ..... **Page 8**
3. **How we developed the strategy** ..... **Page 9**
4. **A vision for primary care** ..... **Page 11**
5. **How our primary care vision will be enabled** ... **Page 20**
6. **Next Steps** ..... **Page 27**
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Acknowledgments

The ‘One LLR: Primary Care Strategy is presented by the LLR ICB. It has been developed by the LLR ICB Integration & Transformation directorate with the involvement of key stakeholders.

Our key contributors as well at the associated governance boards are listed in section 7 (acknowledgments). We thank everyone who has contributed to drafting, testing, and refining our strategy; as without these generous contributions the development of our strategy would not have been possible.

Foreword

Welcome to our ‘One LLR Primary Care Strategy’, written in collaboration with our patients, staff, partners and wider communities. It sets the broad remit for our primary care ambitions across LLR as a whole- recognising that only with the joining up of our efforts will we truly be able to shape the future of our primary care services; ultimately improving the health and wellbeing of our people and creating a sustainable, resilient health and social care system that is fit for future generations to come.

Exec Summary

The Leicester, Leicestershire and Rutland (LLR) primary care strategy forms an integral part of the core work of the LLR Integrated Care System (ICS). The LLR ICS will enable the further integration of primary care teams (General Practice, Urgent Care, Pharmacy, Dentistry, and Optometry) with the wider health and care system at scale, and in a way previously unachieved, resulting in improved access to care for our patients.

Healthcare services are becoming more complex as they attempt to navigate the changing primary care landscape, increased demand for services, in an environment that is stretched and under pressure.

Whilst there are continued and new challenges in every part of the health and care system, the pandemic has resulted in a healthcare system under even greater pressure across the nation. Many feel they are at 'breaking point' and struggle to cope with the current levels of demand, with staff and patients being pushed to the brink. These challenges alone are significant but set against the backdrop of significant increases in the cost of living, a widening health inequalities gap and a pressing need to improve health outcomes, there is a "perfect storm".

These challenges will require time to address, but they are certainly ones which are best tackled collectively, with integration at the heart of our efforts. The task for our primary care leaders is to learn from the recent lessons and make lasting changes to policy and practice to create an environment that can allow primary care to continue to flourish; enabling the very 'bedrock' of care to continue to deliver a personalised, high quality, sustainable, cost-effective health offer.

We already have place-based partnerships up and running in different forms. This early mobilisation has proved invaluable, allowing us to move at pace and enabling early adopters to trial new ways of working. Our clinical leadership's experience, innovation and commitment to making tangible differences for patient care is exemplary. Our staff remain motivated and enthusiastic to deliver change despite sometimes working in ambiguity. Our new relationships across all organisations are going from strength to strength and we are on the road to successfully improve the health and wellbeing of our population. However, we believe that this is just the beginning of this exciting evolution of primary care.

To truly evolve we need to release the potential of our primary care and wider health and social care workforce, who we consider are our greatest strength and most important asset. Good health and wellbeing starts with people, our connections with family, friends and colleagues, the behaviour, care and compassion we show one another and the environment we create to live together and the unity and spirit we share to rise to the challenges in our communities.

The pandemic has tested our community, but; much was learnt through the experiences of working more collaboratively across organisations and working with our primary care stakeholders in new ways helped us to rise to the challenge that was presented to us. We will continue to build on this learning to meet the new challenges ahead.

Understanding how to make this change happen well is vital. Our strategy sets out a vision for a primary care, building on our existing local health and wellbeing strategies and place

led plans across LLR, solidifying our commitment and shared aspirations.

We share our view of our primary care priorities, and these are used as a starting point for collaborative delivery of our vision. Alongside these priorities there are recommendations for next steps for collaborative work aimed at all the organisations representing primary care in LLR as well as our partners in the Integrated Care System.

We describe why it matters and what it might mean for our patients, colleagues, and partners. We conclude by emphasising our commitment to giving everyone within LLR both a voice and stake in being able to create a community which provides the very best health outcomes.

Delivery of this vision is not going to be easy. We will need to push our boundaries, challenge our abilities, and support each other with the needed cultural shift. There are two essential components that we must harness collectively, regardless of the position that each of us hold – that of leadership (in its widest context) and that of bravery, with the will to succeed.

This strategy is only the start. The implementation requires the continued input and effort of our ICS colleagues, the ICB and LLR Health and Wellbeing Partnership chairs and primary care leaders, as well as the support of our system partners.

We hope you find this strategy useful and invite everyone to play an active part in helping us achieve our ambitions, embarking on this bold journey with us as 'One LLR Primary Care' team.

Rachna Vyas (Chief Operating Officer) LLR ICB

Dr Nilesh Sanganee (Chief Medical Officer) LLR ICB

This strategy will guide and inform the response of our primary care transformation and should be read in conjunction with documents as per Appendix 1A.

1. Introduction

1. 1 Developing Primary Care In LLR

Our population's health and care needs are changing, and primary care must evolve to meet them. Patients seek better care continuity, easy access to local services, and support to maintain independence. However, there is a significant gap between these expectations and what we can currently provide. To bridge this gap, we must transform how we view and approach primary care, recognising that it includes urgent care, pharmacy, dentistry, and optometry services, not just general practice. We aim to integrate a range of primary and community services and collaborate with various stakeholders to create patient-centred care. This strategy translates our vision into action and assures national requirements' delivery while allowing for more localised adaptation through our place-based and PCN plans.

We will focus on achieving both nationally mandated deliverables and local primary care delivery priorities for LLR. This approach ensures our priorities align with the strategy and remain responsive to emerging needs at the local level. We believe this balances our forward-looking ambitions with the reality of change in the primary care and wider health and social care environment today.

1. 2 Our Primary Care Ambitions

Our goal is to create effective primary care services by:

- Removing barriers between health and social care.
- Prioritizing patient needs and addressing health inequalities.
- Collaborating with patients, staff, partners, and communities to shape and deliver care.
- Developing an integrated, multi-disciplinary model of care focused on prevention, self-care, and shared health outcomes.
- Providing timely access to anticipatory and urgent care, including safe alternatives to A&E for non-hospital care needs.
- Integrating mental health and wellbeing services into primary care.
- Implementing new care models for vulnerable and long-term conditions patients.
- Building services tailored to local neighbourhoods.
- Improving communication and engagement to encourage people to seek help when needed.
- Empowering people to manage their own health and support prevention and self-care.
- Supporting a diverse and valued primary care workforce.
- Providing care in appropriate locations, at the right time, and in the right way.
- Offering local primary care facilities with integrated teams and a range of services.
- Investing in and resourcing primary care for sustainability and integrated care outside of hospitals.

1. 3 The Leicester, Leicestershire & Rutland Context

The LLR ICB came together as one statutory organisation in July 2022, replacing the Leicester City, East Leicestershire and Rutland and West Leicestershire CCG's. The LLR ICB is one of 42 national ICS's; a new local partnership of organisations that come together to plan and deliver joined up health and care services to improve the lives of their population.

Our primary care strategy covers our full ICS patient footprint made up of our Leicester, Leicestershire & Ruland (LLR) population of 1.2m. The ICS operates at three levels; Neighbourhood, Place and System to provide the right care. Our partnership also brings together three local authorities and seven district councils served by our dedicated and passionate health and social care ICS workforce of 76'000 individuals. Our primary care community is made up of over 132 General Practises across 26 PCNS, 227 Community Pharmacies, 164 Dentists and 176

Opticians. We have one provider for acute care: University Hospitals of Leicester NHS Trust (UHL) and one for community, mental health and learning disability services: Leicestershire Partnership Trust NHS Trust (LPT). Our other partners also include; East Midlands Ambulance Service (EMAS) who provide emergency services, Derbyshire Health United (DHU) who provides a range of urgent care and general practice services across the system, many out of area provides, hundreds of voluntary, community and social enterprise sector organisations and our regulators NHS England and NHSI.

Our health system is extremely busy. During 2021-2022 across LLR we saw 11k births, 193k emergency department attendances, 6.4m GP appointments, 101k emergency admissions, 137k elective planned operations, over 1.1m outpatient appointments,

The combined investment in local health provision for our ICS is in excess £19bn. However, as a local health system we collectively face a recurring annual in-year financial deficit of over £104m. We currently invest £219m in primary medical care which represents 16% of the total ICS budget. We will soon inherit commissioning responsibility for be optometry, dentistry and pharmacy which represents a further investment of £91m, giving us a total primary care budget of around £310m. This is expected to increase by £51m in the next 5 years.

1. 4 Our ICS Wide Vision

Our goal is to create a health and care system in Leicester, Leicestershire and Rutland that addresses health inequalities and improve the health and wellbeing of local people while delivering value for money. To achieve this, we will prioritise investment in primary care, ensuring it is resilient and transformative in line with the ambitions of the NHS Long Term Plan. Our strategy focuses on strategic priorities (Fig 1) aligned with local plans and the health and wellbeing strategies, consolidated under several themes to maximise impact on health outcomes.

Figure 1: ICS strategic priorities

1. 5 Our Population Health Snapshot

Across LLR our population health and wellbeing picture looks very different due to a diverse range of social, economic and environmental factors which impact on people's health such as housing, employment and education. These wider determinants of health vary massively across our three places, presenting our communities with different challenges. Let's have a quick look at some of these differences.

Leicester City

Leicester is the 10th largest city in England and one of the most populous in the East Midlands. It is ethnically diverse, with over 65% of its 400k population belonging to an ethic minority group. Leicester is ranked as the 32nd most deprived local authority area in the country (out of 317). Just over 35% of the population live in an area classified as being in the most deprived 20% nationally. This deprivation presents Leicester with significant health challenges. These include; 1 in 10 children and around 38k adults with mental health problems, 50% of adults who are overweight or obese, over 45k people living with more than one long term condition, over 35% of 65s+ have 2 or more long term conditions, and 1

in 10 have 8 or more. Behaviours such as smoking, excessive drinking, drug use, poor diet and inactivity are greater in many parts of our city than they should be. Leading to a poorer quality of life and a shorter life expectancy (a seven-year difference in life expectancy between men living in the most and least deprived areas of the city).

- Primary care provisions: 11 PCNS, 56 General Practises, 98 Pharmacies, 71 Opticians, 66 Dental Practices. (Source: DHSC: Shape tool)

Leicestershire

Leicestershire is a predominantly rural County and comprises of seven local authority districts, each with its own distinctive character. The total population is approximately 720,000, 10% of which belong to an ethic minority. Leicestershire has an aging population with over 26% aged 60 and over. This is expected to grow by 20% by 2043. Leicestershire is a relatively affluent county; however, some pockets of significant deprived areas fall into the 10% most deprived neighbourhoods in England. There is an eight-year difference in life expectancy at birth between males in the most deprived decile and least deprived decile of the population. The county also underperforms compared to national averages in areas such as immunisations, A&E attendances for children under 18, dementia diagnosis, and fractures in those over 65. Additionally, Leicestershire has a significant population living with chronic and complex conditions, with over 52,000 people having five or more long-term conditions and 16,000 people having eight or more.
Primary care provisions: 14 PCNS, 71 General Practices, 127 Pharmacies, 99 Opticians, 88 Dental Practices. (Source: DHSC: Shape tool)

Rutland

Rutland is England's smallest historic county, with a population of around 40,000 living in a rural area with two market towns - Oakham and Uppingham. The county has an older population, with almost 24% being over 65. Although life expectancy at birth for males and females is generally better than the national average, Rutland faces challenges in accessing care services, limited health infrastructure, and community health services. Some groups, such as low-income families children with special educational needs and disabilities, the Armed Forces community, the prison population, carers, people living with learning disabilities, and certain farming communities, have poorer outcomes than the wider population in Rutland.

- Primary care provisions: 1 PCN, 5 General Practices, 6 Pharmacies, 6 Opticians, 10 Dental Practises. (Source: DHSC: Shape tool)

At a system, place (LLR) and at neighbourhood (locally) we are already transforming our delivery approaches to further ensure the right care is available in the right places, and that people are getting the support they need, when they need it. We and our patients can see improvements from the work we have been doing, although recognise there remains more to do in an ever-changing landscape.

2. Why we need a new strategy?

Recent and still evolving commissioning landscape changes alongside our existing strong track record for responding to change in Primary Care provides an excellent opportunity in taking our next steps together in planning for how we want Primary Care to look in the future in LLR. To really harness the opportunities going forward we must refresh our primary care strategy; starting by resetting our vision for primary care to ensure that our ambitions are reframed and refocused as we join forces and unite as one team. Working with a shared purpose, common goals, and a system-wide commitment to collaborate and act together to address:

- National changes, contract reforms and the changing structures of the health and care system affecting primary care.
- Key system challenges: many of which are also felt in primary care.

- New models of care driven by changing public expectations, patient need and a focus on improving population health. National changes, contract reforms and the changing structures of the health and care system affecting primary care.

2.1 National context and reform

The NHS is undergoing structural and operational changes that are interconnected and aimed at creating a new model of healthcare delivery and transforming primary care. These changes and reforms are happening at a national level and include:

- The **NHS LTP** published by NHSE in January 2019, building on the FV and GPFV.
- **White Paper Integration and innovation** published by DHSC in 2021.
- **Health and Social Care Act 2022** for Integrated care systems (ICSs).
- **The Fuller Stocktake Report** 2022.
- Changes to the **GP network contract** 2023 and **Directed Enhanced Services** 2019.
- Delegated commissioning for **POD's** 2023.

(A summary of the national changes affecting primary care is included in Appendix 1b)

These changes have the potential to allow primary care to work together across the system and to enable true integration of primary care services with the wider health and care system at scale and pace previously unachieved.

2.2 Key System Challenges

Many challenges in primary care are also present in the broader healthcare system, such as increased demand and limited access to care, secondary and community care pressures, delayed hospital discharges, waiting lists, poor communication between care providers, prioritising illness over wellness, unwarranted variation in healthcare, staff shortages leading to burnout, poor patient experience, underinvestment in primary care funding, short-term commissioning with limited value, limited use of digital technology and infrastructure, and inadequate investment in healthcare facilities.

2.3 Changing Models of Care

Primary care has undergone significant changes, including working together at neighbourhood level to improve outcomes for specific patient groups, providing evening and weekend access to care, access to pharmacies through the Community Pharmacy Consultation Scheme and redesigning Urgent care pathways. New services, such as Acute Respiratory Infection hubs, were established to address urgent primary care needs during 22/23. Healthcare professionals are also delivering home-based care through virtual wards. Similar transformations will continue in primary care and the community over the coming years.

3. How we developed the strategy

We have developed our primary care strategy and the priorities by triangulating with our wider LLR ICS/ICB ambitions and priorities, the NHS Long term plan, LLR place led plans, and district level plans. As well as linking back to our ICB 5-year plan and the ICB clinical model as both these strategies represent the 'clinical thinking' and 'priority actions' for health and care across LLR. By doing this cross pollination we were able to develop a well aligned set of primary care themes and priorities introduced in Chapter 4. Accepting that our primary care strategy is one of the many vehicles driving forward primary care and wider health and social care transformation in LLR.

Over the next few years primary care teams will transform the way they currently provide care to their communities. We have a great opportunity to continue to work together across our professions, with our communities and wider health and social care teams in deciding how primary care services are shaped, designed and delivered.

We started developing the strategy by properly understanding the strategic shift affecting

primary care, agreeing on a framework and methodology to approach our development; as summarised in the figures 2-4 below.

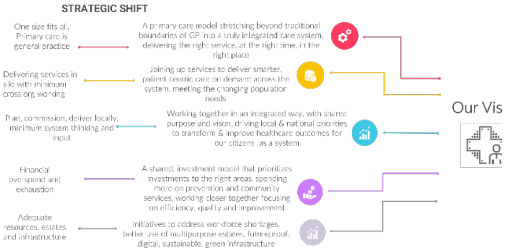

Figure 2: Overview of the strategic shift for primary care

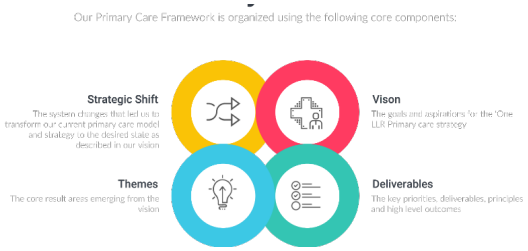

Figure 3: Framework for strategy development

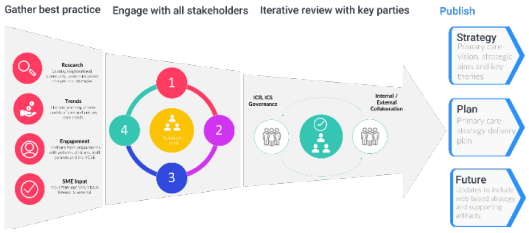

Figure 4: Strategy development methodology

3.1 Engagement with patients, staff, communities and partners

Our patients, staff and partners are at the heart of 'the why, 'the how, 'the when', 'the where' and 'the what', of everything we do. This is reflected in our chosen approach of engagement. Over the course of the last few years, we have gathered intelligence and furthered our insight on the issues and challenges we face. We recognise that we won't be able to solve them all overnight, and we still have a lot to do to get it right. We understand there will need to be differences in approach between neighbourhoods. This will require active listening to guide our learning from those at the "coal face" of primary care. We will need to engage our patients, carers, staff, partners and the wider community in continuing to better shape primary care. We have utilised a range of data and insights from both local and national engagement exercises. These include:

- The National Patient Survey 2022 with over 14'000 responses.
- Local survey with over 5000 responses.
- The Enhanced Access Report with over 44'000 responses.
- The Summary of findings from these surveys can be found within appendix 2.

In addition to using these qualitative and quantitative insights to inform this strategy we have also used secondary data collected including for the Building Better Hospitals Report of Findings (May 2021) and the, Step up to Great Mental Health Report of Findings (October 2021). All this robust data contributes to our Behaviour, Insights and Marketing Hub, which is valuable tool for bringing together insights and data from people which the system should use to enhance services and improve the health and wellbeing of people locally. The hub is a central point for market research and inequality data. Data and insights from patients, carers and staff which helps us to understand needs will support us to develop services to fit these needs. We have also involved our people in decisions about health care via monthly meetings with of the GP practice Patient Participation Group Network and via our online eCitizens' panel comprising of 1,300 local people who actively feedback their experiences and insights of local services. To ensure that we hear from all our socio-demographic groups we also:

- Work with the voluntary, community and social enterprise sector through an LLR VSCE Alliance.
- Work closely with our local Healthwatch organisations and Public Health.

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- Engage at practice level to do local work including engaging with their patient population via high profile campaigns for example our 'get in the know campaign'.
- We undertake hyperlocal work within individual communities bringing people together with their practice and the voluntary sector to empower people to increase the control they have of their own lives including their health.

3.2 Guiding Principles

We recognise various principles within primary care, and to maximise our impact, we've developed a set of priorities based on shared principles.

- Equitable Access: Provide equally high-quality care to all, without exception.
- Personalisation: Encourage patients to actively participate in their own health, informed of available services.
- Sustainability: Pool resources to support primary care resilience, provide value for money, and benefit the local economy.
- Joint up: Partner with citizens to integrate and deliver effective services improving local outcomes.
- Multi-disciplinary: Develop population-specific care, focusing on prevention, self-care, shared health outcomes, and suitable facilities.
- Clinical-based design: Apply clinical principles to primary care service and model design.

3.3 Relevance at all levels

Our primary care priorities apply at all levels (Neighbourhood, Place, System) and can be tailored to meet local needs and health inequities. Examples at place include reducing infant mortality in Leicester, implementing targeted interventions for those experiencing poorer outcomes in Leicestershire, and focusing on specific deprived groups in Rutland. Neighbourhood-level priorities may involve building multi-agency teams for personalized care, while system-level priorities may include urgent care hubs and workforce planning.

4.A vision for primary care

In Leicester, Leicestershire & Rutland, we are committed to putting primary care at the centre of our integrated care system. We recognise the benefits of strong primary care, including better population health, improved patient outcomes, increased lifespan, and lower overall care costs. By prioritising primary care, we can accelerate the development of new care models that go beyond traditional general practice and focus on patient needs.

To achieve this, primary care needs to evolve beyond its current form and involve wider primary care services, such as urgent care, pharmacy, dentistry, and optometry. As a primary care collective, we need to collaborate with colleagues from secondary care, community care, social care, government, partners, and the voluntary sector to ensure that care is provided at the right time, by the right person, and in the right place.

Our Primary Care Vision

"We want to build a new primary care system together, for everyone in LLR. Nurturing a safe, healthy, and caring community. Giving all our people the best start in life, supporting them to stay healthy and live longer, happier more fulfilling lives. We will use our collective capabilities and strong partnership working to provide high quality, sustainable, joint up care; ensuring greatest overall impact on health and wellbeing outcomes"

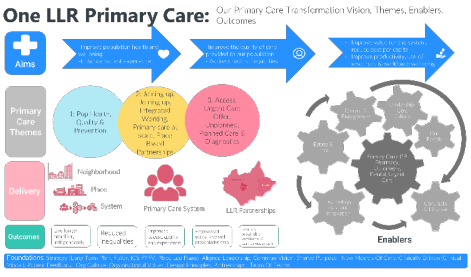

Figure 5: Primary care vision overview

Our Themes

Our vision is based around **three person-centred themes**. To support the needed transformation and to provide a focus for action several **priorities** have been developed for each of these themes. Each priority is fully detailed within the delivery plan appendix 3.

We will interact with these 'transformational' themes individually and at different stages in life; recognising that naturally these will evolve, develop and change in time. Therefore, we commit to continuously reassess these themes-working with our patients and partners across LLR to ensure that they are always appropriate, suitable, realistic and deliverable.

Our transformation will require coordinated and sustained effort across the healthcare system, linking to other workstreams and system enablers both within and outside the NHS. The vision therefore also has **six enabling themes**.

Figure 6: Primary care themes overview

4.1 Theme 1 Population Health Quality, Prevention

Improve health and care outcomes and quality of care for all our local communities by minimising avoidable, unfair differences in care. Levelling up by providing equal opportunities for all our people to lead healthy lives and flourish

Focus Areas: Health inequalities, Quality, Prevention, Self-care, Personalized care, LTC Management, Mental Health, Women's and CYP.

Our aim

Based on factors outside of their direct control, our people experience systematic, unfair and avoidable differences in their health, the care they receive and the opportunities they have to lead healthy lives. Health inequalities have a huge impact on people's lives. In the worst examples, people are dying significantly earlier than the general population because of health inequalities. In LLR, a boy born today in our most deprived area could be expected to die up to nearly nine years earlier than a boy born in the least deprived area. Inequalities can be seen as being present from birth, through someone's early years and into later life. This can be shown in a tale of two babies in figure 7 below.

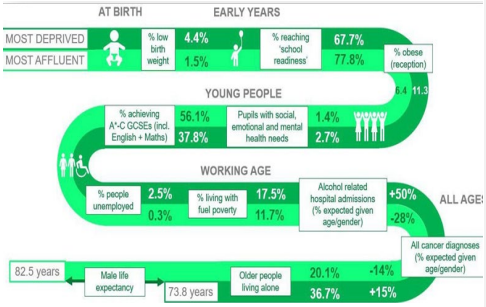

Figure 7: A tale of two babies in LLR, PHE Fingertips

The recent pandemic has served to highlight the impact of health inequalities. Coronavirus has not only replicated existing health inequalities, but in some cases, has increased them, through its disproportionate impact on certain population groups. The cost-of-living crisis will

likely worsen those inequalities that already exist. A 2022 survey commissioned by the Royal College of Physicians found that of those who reported their health getting worse, 84% said it was due to increased heating costs, over three quarters (78%) a result of the rising cost of food and almost half (46%) down to transport costs rising. Health inequalities are not inevitable, and the gaps are not fixed. Evidence shows that a comprehensive, multifaceted approach to tackling them can make a difference. These inequalities cannot be addressed by the health and care system alone. Nationally, integrated care systems will need to work in partnership across the NHS, local government and voluntary sector organisations to slowly start to reverse the current trend.

In LLR we are committed to the 'national mission to tackling inequality'. We aim to advance a business-as-usual PHM approach helping us to improve population health, mental and physical, whilst reducing health inequalities within and across a defined population, through data driven planning and delivery of proactive care to achieve maximum impact. We will embed a standardised universal service across LLR, but with equitable variation between groups helping us to level up.

We will also enhance the quality of care by coming together with our providers and partners; making shared decisions, redesigning services based on population health needs and optimising use of scarce resources to achieve improved health outcomes for our local population. We will become better at predicting and preventing ill health; helping all people to stay well for longer. We also want to ensure that those cohorts with the worst health outcomes or biggest inequalities get the support they need. For example, women, children and young people, our LGBTQ+ community, ethnic minority groups, the elderly, and the armed forces community.

National NHS commitment

- Realising the left shift concept; moving from costly secondary care towards preventative, supported, self-managed, facilitated care.
- Targeting the most deprived populations, suffering from the most significant health issues, core20plus5 (adult and CYP).
- Increasing the focus on population health and population health management. (All three of our place led, joint health and wellbeing strategies include reducing health inequalities as a priority area). ICS commitment to delivering on the LLR health inequalities framework and tackling the wider determinants of health i.e. housing, environment, employment.
- Focusing of specific groups i.e. learning disabilities, the homeless, LGBTQ+.

When we asked our patients and staff what we must do to improve they said

- Patients, service users' and carers' perceptions of the quality of the healthcare they receive is highly dependent on the quality of their interactions with their healthcare professional and team.
- A better understanding of culture and language is needed whether on the telephone, face-to-face, in leaflets or online.
- The use of understandable and consistent terminology, without jargon, and accessible resources including translation and interpreter services.
- People feel that clinicians and health professionals should be encouraged to empower patients and carers to take control of their own health, with information, explanation and an understanding of the range of choices such as social prescribing.
- People feel it is important to have confidence that professionals listen to them and decision making around healthcare is a joint exercise, particularly those with long-term conditions, as they feel this can prevent an appointment to an urgent care.
- Patients would prefer to stay in their own home for as long as possible, but their level of confidence is dependent on support from

health professionals, family and external agencies which they felt can vary.

- A significant proportion of patients do not consider themselves to have any real medical knowledge or confidence to go looking for self-care advice or support. People need an initial consultation to identify their medical issue and to have a treatment pathway and provide advice about their condition, which they see as the gateway to them being able to look after their own health more effectively.
- People want messages from a trusted source and receive information either directly or linked to an up-to-date website.

Our Ambitions

Starting well:

- Best start – Prioritise the first 1,001 critical days, developing a model where every baby and family is able to fulfil their full potential.
- Better births – More personalised care because every woman, pregnancy, baby and family are different.
- Preparing for life – Look beyond just early primary care and plan for the future. Support our partners in education, housing, social care, etc., to create an ecosystem in which we can help our young people transition seamlessly from childhood to adulthood, acquiring the emotional and physical skills to navigate and thrive in society.
- Joining up – Offer a joined-up community service for children and young people, improving their mental and physical health outcomes, with a focus on disadvantaged families, vulnerable individuals, and those with special educational needs and disabilities (SEND).

Staying healthy & well:

- Identify the risk factors affecting the health of our communities, providing the right information and support to prevent illness.
- Actively identify people at risk of becoming ill and support them to stay well.
- Increase early identification of a range of early diagnosis and treatment- vaccines, screening, cancer etc.
- Improve wellbeing in communities and work together to address the wider determinants.
- Encourage better lifestyle choices i.e. reduce smoking, alcohol consumption, better diet.
- Promotion in physical activity.
- Reduce the variation in quality and accessibility of our services i.e. LGBTQ+
- Reduce cases of and improve health outcomes for major mental and physical health conditions, and those with a LTC.

Living and aging well:

- Provide joined-up care to support older people and reduce social isolation.
- Support people to live independently and avoid unnecessary hospital admissions

Ending well:

- Understand and meet the holistic needs of people in their final phase, supporting them to plan and manage their care and respecting their choice of place of death.
- Provide consistent and continuous care for those with long-term conditions, supporting them to transition to end-of-life care and make informed decisions.
- Support carers and families with end-of-life care plans, respect plans, and bereavement support.

Key priorities to deliver the aim

1. **Tacking Health Inequalities at 3 levels**

Focussing on: System, Place, and Community or Neighbourhood level inequalities.

2. **Implementing CORE20PLUS5 / CORE20PLUS5 CYP**

Focussing on: Prioritizing health inequalities in primary care and focusing on women's health priorities as outlined in DHSC women's health strategy.

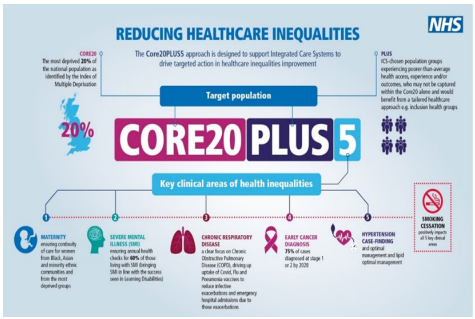

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Figure 8: NHS Core20Plus5 Approach (Adults & CYP)

3. **Use of Health Inequalities best practice, frameworks, data and capabilities**

Focussing on: LLR health inequalities framework, tackle "causes of the causes" of local inequalities, leverage our LLR wide data tools, dashboards and intelligence capabilities, resource allocation decisions based on the principle of "proportionate universalism", focussed approach to populations facing greatest inequality in outcomes.

4. **Population Health Management Approach**

Focussing on: Achieving five domains of the NHSE quintuple aims of PHM, developing our PHM capabilities, leverage our LLR wide PHM model to improve segmentation, risk stratify and personalise care.

5. **More PCN involvement: PCN Maturity**

Focussing on: Community and local partnership approach to population health, PCN maturity, use of ARRS, development of action set.

6. **High quality of care**

Focussing on: Making quality and safety everyone business, continued investment in improving quality and driving up standards, intelligence and evidence-based initiatives, quality culture, learning from mistakes, sharing excellence, embed research in all primary care, achieve high quality ratings across all of primary care i.e. CQC, PQS etc, fulfil national & statutory metrics and targets i.e. QOF, IIF, CPCS.

7. **Resilience & Sustainability**

Focussing on: Enhance communication and engagement between ICB/ICS and primary care, at-scale sustainability solutions, rethink spending distribution across primary care to support left shift initiatives, design of a primary care operating model that supports the sustainability of primary care collectively.

8. **Proactive & Preventative Care**

Focussing on: Whole-system approach to self-care, proactive, preventative clinical based model of care, early detection and diagnosis i.e. in pharmacy, primary care liaison service.

9. **Making Every Contact Count (MECC)**

10. **Mental Health, Learning disability & Autism**

Focussing on: Promotion of MH services, improving access to MH, offering MH services closer to home, dementia diagnosis, digital innovation, annual health checks (AHCs) and targeting i.e. LD cancer screening, CYP Keyworker Programme, Primary Care fulfilment of the 3 key requirements of the NHS Confederation's "No Wrong Door: a vision for mental health, autism and learning disability services in 2032"

11. **Personalized care & Empowerment**

Focussing on: Personalised care 'business as usual' in all primary, develop a whole system ,all age approach by default (maternity to EOL).

12. **Chronic Disease Management and Complex Care**

Focussing on: Self-care with support from community MDT model, supporting high risk patients, use of community assets to ensure early intervention i.e. Pharmacy led hypertension case finding, patient education, digital resources, and support networks.

13. **Medicine Optimisation**

Focussing on: A person-centred approach to safe and effective medicine use, reducing medicine-related problems.

14. **Enhancing the involvement of people and communities**

Focussing on: Primary care engagement framework, empower people & communities,

15. **Pharmacy, Optometry and Dentistry Priorities**

Focussing on: New commissioning PODs when these come into effect.

What will success look like

A Higher proportion of people self-reporting good mental and physical wellbeing whilst experiencing less health inequality

- A shared and agreed view and approach to tackling health inequalities.
- Make health inequalities business as usual for primary care and wider care.
- Shift resources towards preventative measures and addressing root causes of inequality.
- Collaboration, investing in relationships.
- Increased healthy life expectancy.
- More people living well independently.
- Provide high-quality care and outcomes
- Integrate mental health and learning disabilities and autism services.

Theme Summary & Delivery Plan

See appendix 3 and 4.

4.2 Theme 2 Joining Up

Well led, collaborative, joined up care built with and for our local communities.

Focus Areas: Joining up, Integrated working, Primary care at scale, Place based partnerships.

Our aim

We want to improve care by connecting health and care teams in our communities, addressing unique challenges and involving local input to tailor care. We aim to lead primary care teams with shared funding and decision-making to innovate and deliver services effectively.

National NHS commitment

- Collaborate better with our primary care colleagues in community pharmacy, optometry, and dentistry to deliver high quality services to our communities.
- Integrated neighbourhood 'team of teams' need to evolve from PCNS, a collaborative, cross-sector, multi-organisational and sector team working in neighbourhoods.
- Enhancing rapid community response teams, to prevent unnecessary emergency hospital admissions, speed up discharges.
- Giving people more control over their own health and the sharing of information between health and social care, delivering more person-centred care.
- Enhanced support in care homes.

When we asked our patients and staff what we must do to improve they said

- IT systems should be joined up and improved between organisations with improved access to records; technology acting as a better tool to support integrated working; and information availability.
- Transfers between services/handovers are stressful times for both GPs and other staff and patients and family carers, in particular older and vulnerable people.
- Family carers want to be recognised as carers and need services which are reliable and appropriate to their situation and allow them to support their loved one.
- Patients and carers need a more efficient and effective link between GP surgeries and hospitals; between professionals working in health and those working in social care and more obvious use of technology using digitised notes and shared computer systems, so they don't have to tell their story a number of times.
- People want primary Care professionals to inform them of local support services and have a better understanding of how to support them and their whole family, particularly on how to live with long term conditions.
- People need more recognised involvement of the voluntary and community sector in a formal capacity, rather than a voluntary one.
- People felt that a more joined up approach to services supporting good physical and mental health would prevent more people from having an emotional breakdown, particularly those people who are coping with a long-term physical condition.

Our Ambitions

Starting well:

- Children and families thriving and supported in our communities.
- Joint up children's and young people's primary care services.
- Embed children and young people's physical and mental health services into our offer.
- Identification and support for vulnerable young people, educating parents on matters such as breastfeeding, immunisations and management of minor ailments.

Staying healthy & well:

- Continuing to improve our joined up and place-based approach to care.
- Prevention is always better than cure. We will actively identify people at risk of becoming ill and support them to stay well.
- Develop primary care mental health services

Living and aging well:

- Joined up, person-centred and seamless services that support people out of hospital in our communities.
- Develop strong networks and partnerships with specialist centres.
- Provide joined up care to be responsive for frail, vulnerable and elderly patients.
- Avoid unnecessary hospital admissions.
- Personalised, multi-agency care at home.

Ending well:

- Fewer organisational barriers for staff, patients and communities to support the people in their own homes.
- When people develop ill health, provide timely and well-coordinated support to ensure it does not dominate their lives and to allow people to stay independent.
- Support and care for our population during their last phase, allowing them to die in a place of their choice.

Key priorities to deliver the aim

1. **Creating the right environment for change**

Focusing on: Fuller stocktake recommendations, back-office support, management support functions, primary care excellence initiatives, clinical leadership/support, clinical culture.

2. **Truly Joining Up Primary Care**

Focussing on: Joint up care models, vertical integration, freedom to innovate, adoption of a 'one place, one budget' 'one population' ethos.

3. **Integration with wider system**

Focussing on: Extending the remit of our PODs, Primary care service offer, ARRS, primary care professional's networks, communities of interest.

4. **Integrated Neighbourhood Teams**

Focusing on: PCN maturity, multi-professional 'team of teams', neighbourhood model of care.

5. **Place Based Partnerships & the VCSE**

Focussing on: Place based partnerships, VCSE, new provider collaboratives, primary care provider support and leadership.

6. **Population Wellbeing, Everyone's Business**

Focussing on: Whole and all system approach, collaboration with Public Health England, development as an 'anchor organisation', Promotion of physical activity (Everyone active).

7. **Devolution**

Focussing on: Pooled budgets, place-based governance, leadership and budgets.

8. **Knowing LLR to give best care**

Focussing on: Operating at Neighbourhood, Place, System level, developing a 'needs based' primary care offer. i.e. Armed forces community.

9. **Maintain continuity of care where possible**

Focussing on: Maintain clinician, holistic person-centred care, across organisational care

10. **Effective Leadership & decision making**

Focussing on: Alignment, right mindset, collaborative decision making, clinical leadership and oversight, leader development.

11. **System Alignment: The bigger picture**

Focussing on: Shared purpose, wider determinants of health, primary care forums and networks.

12. **System wide investment decisions**

Focussing on: Joint investment and decision making, shift of investment (prevention and community), redistributing investment to areas with greater inequality gaps/variations.

13. **Infrastructure First**

Focussing on: Physical space and technology for our 'Team of Teams', PCN clinical and estate strategies, champion a 'One' estate ethos.

14. **Research & Innovation**

Focussing on: Embedding research into all care, build a research and innovation workforce.

15. Focus on patient outcomes, not output.
16. **Change the way we do things to help improve clinical and patient experiences.**

Focussing on: Shared administration from secondary care to primary care, public communication, patient activation and engagement, staff training, patient experience.

17. **Women's Health, Maternity & Children**

What will success look like

Improve health and care outcomes and reduce avoidable illness.

experience and quality of care.

- Increased capacity in primary, secondary and community care to enable more care to be delivered at home and in the community.
- Shared purpose with primary and community care staff, working together to deliver preventative, out of hospital, care for LLR patient population.
- Reduced the pressure on emergency services and hospitals.
- Increase the number of people able to stay at home, freeing up beds for most needed.
- Continue to ensure the sustainability and resilience of our individual GP practices, creating capacity by better managing demand and co-ordinating care.
- The aggregation of our PCNs at 'Place' level – to remove silos of provision, incentivising providers over health outcomes not levels of activity, working together in an integrated delivery model.
- Better patient experience, patients able to access appropriate care in the right place.
- Digital technology such as cloud-based telephony and additional integrated System1 functions will allow us to manage the stack better, predicting, identifying, planning and responding to varying demand.

Theme Summary & Delivery Plan

See appendix 3 and 4.

4.3 Theme 3

Access to care closer to home

Provide consistent, efficient, accessible, responsive, sustainable primary care services across LLR.

Focus Areas: Access, Urgent Care Offer, Unplanned, Planned Care & Diagnostics

Our aim

To meet the changing needs of our communities, we must find innovative ways to develop, access, and deliver quality care more sustainably. Our goal is for everyone in LLR to have easy access to high-quality primary and urgent care services seven days a week. Currently, patients with urgent care needs are unsure which service to contact, adding pressure to general practice. Our urgent care system is under constant pressure, resulting in patients seeking care through inappropriate means. We aim to improve same-day care, urgent care, and diagnostics by testing new approaches and working closely with our partners to provide the right care the first time. Without tackling this together, we won't be able to ease the constant pressures we face.

When we asked our patients and staff what we must do to improve they said:

- People need a better experience of getting through on the telephone easily, being treated respectfully, and accessing GP services, as well as improved confidence and satisfaction with the type of appointment they are offered.
- When asked what makes a good primary care appointment people wanted to be seen in a timely manner, with no long waits, to be listened to by the GP or health professional, to feel they had enough time and not rushed and to leave with a diagnosis/advice/support/referral.
- There is an obvious preference for 'traditional' face-to-face appointments, but

some people say they are happy to have an initial telephone consultation and others are comfortable with an online consultation. Remote consultations are currently viewed as more acceptable for 'non-emergency' medical issues.
- The setting and location of care is important, and people want it to be fair and equitable.
- New services and ways of working need to be shared with/promoted to both staff and patients, but it is important to people that messages are delivered by a known and trusted source.
- Many people are comfortable with digital consultations. However, many are either not digitally enabled or digitally confident, or feel that a digital appointment is not appropriate to their medical problem.
- Many people say they would like to feel more confident in the support they receive in a crisis and to keep mobile and active.

National NHS commitment

- Improve access to primary care services, increasing the number of appointments.
- Boosting out of hospital care, increasing investment in primary and community health services.
- Expand community multidisciplinary teams, with integrated neighbourhood teams becoming the norm.
- An urgent care model made up of primary care, community pharmacists, ambulance and other community-based services who provide a locally accessible and convenient alternative to A&E.
- Commitment to planned care and quicker diagnostics.

Our Ambitions

Access

- We want patients in LLR to continue to have equitable access to high quality primary care services when they need to, getting the right care, in the right place at the right time.
- We need to support patients better and earlier in their pathway, reducing avoidable demand by educating them about services, empowering them to self-care, and better engage with the prevention agenda.

Streamlined and integrated urgent care

- Further develop our out of hospital offer and urgent care offer to reduce acute hospital admissions or assessments.
- Provide a fit for purpose urgent care offer with a single point of access.

Planned Care, Therapy & Diagnostics

- Improved planned care pathways with easy self-access referrals.
- Implements the Proactive care model for better LTC management.
- Access to more diagnostics and testing services closer to home.
- Seamless transfer of care from hospital to home.

Key priorities to deliver the vision

Primary Care Access

1. **Primary care front door 7-day access**

Focusing on: A 7-day primary care offer, same day and pre-bookable availability, standardised front door for access, care navigation, CPCS.

2. **Stabilise Demand in primary care**

Focusing on: Demand and capacity management, stack management, new delivery models, reducing staff burden.

3. **Redesign care pathways**

Focusing on: Inclusive access mechanisms, negate '8am' model, active signposting 'talk before you walk', Urgent Treatment Centre model across LLR, CPCS.

4. **Multichannel primary care access**

Focusing on: Multichannel 24/7 access to primary care, system wide approach to assessment, triage, and streaming. Delivery model focusing of worst outcomes e.g. homeless, people with Learning Disability etc

5. **'Digital First approach'**

Focusing on: Digital by default, patient and staff education, digital inclusion.

6. **Retaining continuity of care as the core strength of primary care**

Focusing on: The separation of cases (urgent same day access and long-term conditions) to offer continuity of care.

Streamlined and integrated urgent care

1. **Single door for all urgent care**

Focusing on: A single place based integrated urgent care offer, single point of access, effective triage and streaming of cases. Delivery model focusing of worst outcomes e.g. homeless, people with LD etc

2. **Responsive Pre-Hospital model**

Focusing on: Extensive range of services locally, UTC, healthcare hubs (increase tier 2/3 activity, reduce tier 4 LRI ED activity).

3. **Direct access and self-referral pathways**

Focusing on: Patient access and self-referrals.

4. **Urgent care response service**

Focusing on: 27/7 365 multidisciplinary urgent response offer across LLR.

5. **Equitable fallers offer across LLR**

Focusing on: Early identification and proactive management, equitable falls crisis response.

6. Making frailty everyone business

Focusing on: Early identification and effective management of frailty in all settings.

7. **Enhanced health in care homes**

Focusing on: Multidisciplinary approach to the management of care in care home.

8. **Home First**

Focusing on: A mature out of hospital community home first model, extension to CYP, virtual wards.

Planned Care, Therapy & Diagnostics:

9. **Pro-active care**

Focusing on: A Proactive care model, to support primary care staff to optimise clinical care and self-management for people with CVD risk factors via structured and holistic care planning.

10. **Community based diagnostics**

Focusing on: Place based models for diagnostics, enhanced diagnostic offer.

11. **Integrated Therapy & Specialist outpatient services**

Focusing on: 7-day therapy and speciality services, utilisation of shared resources.

12. **Seamless discharge and transfer of care**

Focusing on: Timely discharge and seamless transfer of care, integrated neighbourhood teams, LLR Integrated Discharge Hub, DMS.

13. Palliative & EOL care and support

Focusing on: Integrated support offer i.e. community pharmacy support with EOL meds, normalising EOL, supporting patient choice.

What will success look like

Easy and equitable access to primary care services for all patients across LLR.

- Easy access to primary care close to home.
- Right care, right time, right place.
- Moving focus to meeting need and not demand.
- Reduced demand and distribution of cases.
- Increased use of urgent care services, reducing avoidable hospital attendances.
- More patients able to manage their health and illness at home, with appropriate support from a range of services.
- A range of pharmacy services and support.
- Patients with complex needs, LTC's and vulnerabilities better supported in the community.
- Redistribution of finances to support primary care and OOH models of care.
- Increased number of diagnostics conducted in primary care settings.
- Better care for patients with palliative care needs and those in care home.

Theme Summary & Delivery Plan

See appendix 3 and 4.

4.4 Cross Cutting Themes

- Supporting good mental health
- Covid 19 recovery

5.How our primary care vision will be enabled

Alongside our three-person centred themes six enabling themes have been identified as essential in supporting with our primary care transformation. Some enablers are specific to primary care and the organisations that support it both within the NHS and outside. Others require the support of different parts of the healthcare system, and need primary care to be included in wider system strategies and subsequent developments. As with the first three themes, a set of implementation goals have been developed and are included within each theme.

5.1 Enabler 1 Our People & Workforce

Our Aim

The performance of any health and care system ultimately depends on its people. We must work together to make this a rewarding environment. Delivering our vision requires a confident, capable and motivated workforce. We need to attract and retain skilled people to work here. Workforce is one of the greatest challenges facing general practice, broader primary care services, support services and the NHS. In LLR we are committed to addressing workforce shortages, through retaining our existing workforce whilst supporting and optimising new roles. It is our ambition to make LLR a great place to work, and we will do this by working together to drive our ambitions. We will:

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

National Commitment

Through better recruitment and retention, the NHS is nationally committed to ensuring there are enough people working in the NHS to support patients, and that they get the support they need to continue delivering the best possible care. NHSE are also committed to strengthening NHS leadership, while improving the working environment for frontline staff – from support to manage their own health and wellbeing, to investing in the digital technology that can help them do their jobs more easily.

How we see workforce in 5 years

We will work to:

- Ensure we have enough people, with the right skills and experience, so that staff have the time they need to care for patients well.
- Ensure our people have rewarding jobs, work in a positive culture, with opportunities to develop their skills and use state of the art equipment and have support to manage the complex and often stressful nature of delivering healthcare.
- Strengthen, support good, compassionate and diverse leadership at all levels – managerial and clinical – to meet the complex practical, financial and cultural challenges a successful workforce plan, Long-Term Plan and the 5 Year Joint Forward Plan demands,

Implementation Goals- A focus for activity

We are developing a Primary Care Workforce Strategy which will span across the next 5 years. It will seek to address the challenges and optimise the opportunities to enable workforce growth by examining and confirming the direction of travel for workforce recruitment, retention, attraction, and supply, whilst striving to balance the day-to-day workforce challenges and possible solutions.
Our Place Led Delivery plans will describe workforce priorities for each of our PCNs and for

each Place and how we co-design and co-develop workforce strategies to get to our 5-year projections in terms of the type and quantity of Primary Care Workforce required. The implementation of these strategies will be supported by the following principles:

- Local jobs for local people.
- Connective recruitment between graduates and local vacancies.
- Data informed, evidence-based decisions
- Attractive and supportive staff packages.
- Sustainable workforce solutions.
- Learning and training to be at the heart of developing our people.
- Partnership working with all.

It is recognised that some of the drivers to achieve the above will be organisational culture, development, and leadership within Primary Care. This is multifaceted and an evolution over time. This will be supported, developed, and enhanced through a range of strategies. Whilst there are workforce gaps and issues there are also areas for workforce transformation such as the Additional Roles Reimbursement Scheme and developing closer working with our Pharmacy, Optometry and Dentistry workforce.

What will success look like

- Closing the gap on national shortages for primary care professionals and open posts.
- Attract more staff, improve recruitment processes and workplace initiatives.
- A happier workforce, working in rewarding jobs and with a more supportive culture.
- New NHS roles and careers will be shaped to reflect the future needs and priorities.
- Improved development opportunities and staff having more control over their working lives.

Finding our more

- Louise Young, People & Workforce, LLR ICB.

5.2 Enabler 2

Estates & Infrastructure

Our Aim

A robust estate of safe, secure, high-quality buildings, capable of supporting current and future service needs across primary, secondary and acute care.
Collaboration is essential, with acute and secondary care estate sitting with our trust partners and, to a great extent, the primary care estate being held privately. Understanding these constraints, whilst openly exploring how the estate can adapt to enable the delivery of clinical models, with the needs of the patient foremost.
To further increase flexibility and create opportunities for health and care integration, we will work closely with our local authority and voluntary sector partners to explore co-location and successfully manage the estate implications of bringing health and care teams together.

Implementation Goals- A focus for activity

Supporting the development plans of the practices identified in the Primary Care Estates Strategy, addressing sufficiency, suitability, and the impacts of housing growth. Development of Primary Care Network strategies which will see PCN's consider how their clinical objectives can be met by their existing estate.

Extending practices where possible, alongside making best use of LiftCo and NHS properties, buildings owned by the health trusts, as well as exploring use of local authority and voluntary sector partner properties will be key to ensuring the primary care estate is sufficient for delivery of services.

In conjunction with our partners, we will develop an **LLR ICS Estates Strategy** by March 2024 that will ensure alignment of trust partner's

strategies, and detail how estates will enable the delivery of ICS objectives.

What will success look like

Close working with our local authority planning partners to understand and put in place plans to mitigate the effects of the location, scale, and timescale of housing growth, predicting impact at neighbourhood level and thereby forecasting health infrastructure need.
Whilst working differently, using new technology and reconfiguring spaces are valid tools for consideration, the identification of areas of estate shortfall through robust analysis will be used to support business cases for future capital investment strategies for NHS England and the ICS.

How it is already happening

Sustainability is a key priority for the NHS and the ICS, both of whom have developed and published their green plans. A Greener General Practice network has been established to promote ideas, share experience and enable GP practices to work to reduce their impact on the environment and climate change.

We work to secure developer contributions which are used to expand health care provision to meet the needs of the increased population.

We actively collaborate with estate partners to share experience, estate opportunities and discuss organisational need through;

- LLR ICS Estates Forum.
- One Public Estate Leicester Partnership.
- ICS/Region green delivery boards.

Finding our more

- Lorna Simpson, Head of Strategic Estates.

5.3 Enabler 3 Technology, Data, Innovation and research

Our Aim

LLR have an agreed Digital Strategy in place which focuses on the direction of travel for the next three years. Within this strategy we have set out the vision for improving data and information sharing. Throughout the Digital Strategy there are initiatives which will support working across primary care.

National Commitment

- Enabling information to flow between care providers within and beyond organisational boundaries, and between care providers.
- GP IT systems sit at the heart of primary care technology, offer patients access to online GP services.
- Supporting practices to develop IT functionality which responds to the evolving needs of patients and underpins integration across care pathways.
- Digital transformation of health and social care is a top priority for NHS England (NHSE). The system's long-term sustainability depends on it.

How we see digital in 5 years

- Person-centred care along care pathways rather than being organisation specific.
- Allow people to remain in their home when it is safe and appropriate to do so.
- Digitally support models of care which provide a seamless patient experience along multi-organisation care pathways.

All of which will improve patient experience, the efficiency of scarce, high-cost inpatient resources and upstream and downstream communication.

Implementation Goals- A focus for activity

Currently;

- There is limited integration between organisational systems.
- Our systems don't easily support multi-organisational pathways.
- Transfers of care can require significant manual effort and communication.

Meaning that;

- Models of care are aligned to individual organisations or locations.
- Conventional referral mechanisms between organisations can be slow, resource intensive, and disjointed.
- Patient discharge from an inpatient stay can be slower than it should be.

Leading to:

- A fragmented patient experience as the retell their story when they are referred between organisations.
- High-cost resources such as ward beds are used when alternative options are available.

How it is already happening

- Roll out of virtual wards and remote monitoring.
- Digital primary care solutions. i.e. video and online consultations, cloud based telephony.
- Digital referral management solution
- LLR Shared Care record within primary, secondary, acute and emergency care
- Patient access: Use of the national NHS App to access a range of NHS services digitally, locally patients have the opportunity to use supplementary apps and portals, integrated with the NHS App, to provide targeted information and healthcare management.

What will success look like

- More patients participating in their health planning and accessing digital services.
- Joined up infrastructure at scale; supporting mobile working and integrated teams.
- Wider information sharing across all settings.
- Improve digital maturity across primary care.

Finding our more

- Sharon Rose. Senior Digital Enablement Manager. LLR ICB.

5.4 Enabler 4

Governance, Measurement & Leadership

Our Overarching Governance Model

To achieve our vision for primary care in LLR, it is crucial to have appropriate governance structures in place. We plan to use the LLR ICS and ICB governance structures to ensure that primary care transformation aligns with other LLR transformation programs. This strategy is just one enabler of the larger vision that the overarching governance structures are responsible for delivering. By utilizing these governance models, we can have a more comprehensive view of other transformation programs. Our approach emphasizes that transformation must be delivered from the bottom up and our engagement with staff, partners, patients, and the public will support us in transforming the planning, shaping, and delivery of primary care services. More information on our governance can be found in appendix 5

The Role Of The (PCTB)

Beneath the ICS/ICB governance structure the Primary Care Strategy's governance will be through the PCTB which was established to oversee and ensure the successful delivery of Primary Care Transformation. Specifically, the PCTB leads on developing the strategy with a focus on design, delivery and quality. A key role of the PCTB is to interpret, disseminate and implement national policy relating to primary care recognising the interdependencies across health and care partners. Specifically, The PCTB will work with reference to key national policies to maximise outcomes for patients. The PCTB reports into the Strategic Commissioning Group which itself reports into System Executive. The PCTB has established five workstreams to ensure efficiency in carrying out its functions. In the first instance these workstreams include:

1. Access 2. Resilience and Sustainability
3. Service delivery 4. Workforce / Leadership

5. PCN Development

Measurement

There are currently many ways by which we will measure the performance of primary care. These include data dashboards, proactive care tools, patient experience and satisfaction, CQC, QOF, IIF etc. However, with the move towards joint working through our ICS and developments within primary care we will need to adapt these methods. Our ICB PMO will help us to track progress and provide us with a view of progress against this strategy with SMART performance measures (Specific, Measurable, Achievable, Realistic, and anchored in a Time frame) and provide regular performance reports and progress updates to the appropriate boards. We will also share our progress with you and celebrate our successes by publishing updates and reports; promoting them through our partnership and community events.

Clinical Leadership

Primary Care has significant clinical leadership across LLR. The Medical Directorate provides direct leadership to the PCTB as well as to the wider ICS. In addition, our 5 Place Based Clinical Primary Care Leaders provide leadership at Place and, through their connections with the Clinical Directors of our 26 Primary Care Networks, at neighbourhood too.

Our ICS Clinical Leadership also has a large number of leaders from a Primary Care background providing enabling clinical leadership (Workforce, Business Intelligence, Population Health and Health Inequality, Digital and Finance and Contracting) as well as transformational clinical leadership, for instance, for Children and Young People, Medicines Management, Elective Care as well as specific Clinical leadership for Primary Care Quality.

On the ICB Board itself, we also have a Primary Care Partner and we work closely with clinical leaders on our Local Medical Committee too.

Finding our more

- Dalijit Bains. Head of Corporate Governance. LLR ICB.

5.5 Enabler 5

Communications & Engagement

Our Aim

Our aim is to work closely with people communities, partner and the VCSE in line with our public involvement legal duties that require us to have arrangements to ensure that people are 'involved'.

National Commitment

Nationally the NHS has committed through the ICS design framework to set the expectation that partners across the ICS should agree how to listen consistently to, and collectively act on, the experience and aspirations of local people and communities. This includes supporting people to sustain and improve their health and wellbeing, as well as involving people and communities in developing plans and priorities, and continually improving services.

How we see things in 5 years

Through our support of our ICB People and Communities Strategy we would achieve:

- A deep understanding of people and communities.
- Insights and diverse thinking of people and communities helping us to tackle health inequalities and the other challenges faced by primary care.
- Fresh opportunities for strengthening our work, continually expanding relationships, networks and activities.
- Well informed, empowered people and communities, reduced health inequalities, better outcomes, experience and access.

Implementation Goals- A focus for activity

- Effective co-produced communications and engagement strategy.
- Implement the co-designed ICB People and Communities Strategy.
- Effective co-produced voluntary and community strategy.

We will achieve our implementation goals by starting with people:

Figure 9: Our communication and engagement approach

What will success look like

- Improved engagement and patient experience at practice, PCN and system levels.
- Empower communities to provide ongoing and iterative insights and work with system to implement change.
- System is using the insights to design and improve services.
- Focus on what matters to communities and the priorities of those who experience the worst health inequalities.
- Showcase how people's involvement leads to improvement and better outcomes.
- Approaches to better work with specific people and communities.

How it is already happening

- Implementing our People and Communities Strategy, and our Primary Care Engagement Framework.
- Reinvigoration Patient Participation Group.
- Launched the VCSE alliance.

Finding our more

- Sue Venables, Head of Engagement and Insights. LLR ICB.
- Dave Rowson, Head of Communications and Marketing. LLR ICB.

5.6 Enabler 6

Finance & Contracting

Our Aim

We want LLR health and care organisations to work together to ensure that we live within our means. It is vital that we make the right investments in the right areas that will sustain and improve the quality of health and care services within the resources we have. This will involve; innovative ways of working, shifting some of our spending to prevention and community settings, working closer together and a robust focus on efficiency and quality improvement. All of which will support our aim to ensure there is efficient use of our resources and move towards underlying financial balance. Meeting the challenge of increasing demand for services and stretched resources will require a considerable programme of work to; manage demand, invest wisely and make efficiencies to reduce waste whilst maintaining quality.

National Commitment

- Ringfenced funding for primary care.
- Investment in ARRS and enhanced access.
- Financial incentives: i.e. IIF which rewards PCN's for delivering set objectives.
- System development and GPIT funding.
- Use of NHS combined buying power.
- Deliver better value on medicines.
- Make better use of capital investment.

How we see primary care funding in 5 years

The Integrated Care System are experiencing significant financial pressures in 2022/23 with similar pressures being identified for future years. Primary Care investment accounts for just over 16% of the £1.9bn budget for the Leicester, Leicestershire and Rutland Integrate Care System and so will need to be included in any efficiency programme designed to bring the system back to a balanced position in the next few years. There is currently an underlying deficit across the system of £104m and this is set to

increase each year as the allocation for growth and inflation will not be enough to close the gap between income and expenditure. If the system does not take action to address the deficit by becoming more efficient and productive for every pound spent, the underlying deficit is estimated to increase to £272m in 2027/28.

Primary Care Funding Allocations

Table 1 below projects the primary care allocations through to 27/28 based on the latest guidance. It is assumed that the allocations for the Pharmacy, Optometrists and Dental (PODs) increases at the same rate as that for the GP Co Commissioning budget and that the Primary Care budget increases in the same proportion as the ICBs programme allocation.

TABLE 1. Primary Care Allocation Summary					
	23/24	24/25	25/26	26/27	27/28
Primary Care	23,268	23,902	24,746	25,618	26,522
Primary Care Co-Commissioning	195,134	203,138	211,470	220,143	229,173
Delegated Pharmacy, Optometrist and Dental allocations	91,475	93,619	97,459	101,456	105,617
Estimated Primary Allocations	**309,877**	**320,659**	**333,674**	**347,218**	**361,312**
System Programme and Co Comm projected combined allocations	**1,931,255**	**1,986,545**	**2,057,786**	**2,131,588**	**2,208,043**
Proportion allocated to Primary Care	**16%**	**16%**	**16%**	**16%**	**16%**

Figure 10: Projected LLR primary care allocations 23-28

As can been seen in the table above, the budget for 2023/24 for primary care, including the element for delegated budgets for primary medical care and the PODs, is in the region of £310m for the ICB. This is expected to increase by £51m in the next 5 years. The ICBs commitment is to continue to invest in the innovative Primary Care Funding Model where practices are paid for the services that they provide and that there is consistent provision for patients irrespective of where they are registered. Access to Capital Resource – In addition to the access to centrally held capital resource for the funding of practice IT refresh programme, the ICB has earmarked an element of this capital funding to support small practice improvements. Depending on access to central capital resource, it is hoped that this arrangement will continue for the next few years, giving practices some vital support in getting some of the smaller schemes implemented and so improving capacity and the patient experience.

Finding our more

- Andrew Roberts, Finance Partner, LLR ICB.

6. Next Steps

6.1 The role of the Primary Care Transformation Board (PCTB)

We have set out in this strategy, our vision, values and strategic primary care priorities for the next few years. We must now ensure we work collaboratively to deliver our plans. The governance responsibility of which sits with the PCTB, reporting into established ICS and health and wellbeing boards to ensure all key decision makers across LLR, our health and social care teams and system partners support its successful delivery.

During delivery of this strategy the PCTB will:

- Provide appropriate governance and assurance at all levels.
- Through our PMO track progress, outcomes, and financial spend, regularly and transparently sharing progress updates.
- Communicate the strategy across primary care, LLR boards, national, regional and local partners.
- Regularly review the strategy against national and local developments and feedback from our people, communities and partners.

6.2 Delivery Plan

Our delivery plan provides an extensive view of our priorities and our plan for delivery. It is far reaching and comprehensive. We recognise that several key priorities are being delivered by other parts of the system due to similarities in our programmes of work or ongoing collaborations and system wide initiatives. We also recognise that the majority of our primary care priorities will apply at neighbourhood and place level, However, some priorities will be delivered at a system level. (See appendix 3 for the detailed delivery plan).

6.3 Future developments to the strategy

Primary care in LLR is on a journey. This strategy acts as starting point for collaborative primary care action, providing us with a snapshot of some of the priorities and an approach to delivering them, we will add to this strategy in the near future as we look at doing the following;

- A revised primary care strategy towards the end of 2023 which will allow us to review how we are working with our PODs.
- An online interactive primary care strategy, adapted to suit different audiences i.e. public facing.
- A series of supporting documents, such as theme summaries, toolkits and easy reads.

6.4 Closing remarks / conclusion

We acknowledge that we have a lot of work ahead of us to achieve our vision. We have witnessed first-hand the enthusiasm and dedication of our people who have come together to articulate our vision. We appreciate the valuable contributions and inspiring voices that have played an active role in shaping our approach.

Our strategy provides us with a set of shared priorities acting as a starting point for collaborative action. Delivering these will come with further collaboration from all the organisations that lead, support, educate, commission, provide and regulate primary care in LLR. Building on our progress to date by creating a 'learn not blame' culture; supporting each other every step of the way.

This work starts now with us developing a deeper understanding of the 'breadth of primary care'. Ranging from a small surgery to a large multi practice PCN, from the small independent pharmacy on the high street, to a chain of optometrists, to a village dentist inherited from generations of the same family to a multi-million pound urgent care centre.

We will overcome silo working and make deeper more meaningful connections between our organisations, programmes and places. Working together as one system; one shared purpose, one ethos; collectively shaping, influencing and delivering for our people.

We need to embrace our vision at a local and neighbourhood level, with all primary care professionals and their representative organisations, as well as the wider health and social care systems. At a system level, our ICB and ICS, including local authorities, need to apply a 'one system view' to connect primary care teams with each other and with the wider multidisciplinary teams in community and secondary care.

Our success will be measured not just in the traditional dashboards of inputs and outcomes; but also, by looking at reported experiences our people. We know we have succeeded when people who need access to health and care on the same day receive it; those who need care within a hospital setting receive it in an effective and efficient manner; those living with one or more long term conditions or frailty are supported in their place of choice; the integration with community teams working together to form a cocoon of services around our population need; acute and emergency services will be provided to the most in need patient; every service provided will see a measurable impact against inequity and seek to further address this; people who need a diagnosis receive it in a timely manner; and those who deliver care can do so without moral injury.

We are extremely grateful for the passionate contributions toward this work- from our fantastic primary care professionals who care passionately about our patients, from our united and resistant people and communities, from our committed and hardworking partners through to our vibrant VCSE, all of whom will look to us to make good on the delivery of this strategy.

“The secret of change is to focus all your energy not on fighting the old, but on building the new”

Socrates

7. Acknowledgments

We would like to thank the following people, groups or organisations for their input and support in informing, contributing, and developing our Primary Care Strategy:

- Our LLR ICB colleagues from all directorates
- The LLR ICB PCTB (Primary Care Transformation Board)
- Our LLR ICS and ICB Governance, Delivery, Assurance, Design Groups, ISOC, JICB, IDG, Health and wellbeing Boards
- Our LLR ICB Clinical leads, SME's and PCN Clinical Directors
- Public Health, Health Education England, NHS Colleagues, from Leicester City, Leicestershire & Rutland
- Healthwatch Leicester, Leicestershire & Rutland
- LLR Professionals Committee: LMC (Leicester Medical Committee), LOC (LLR Local Optometric Committee), LDC (LLR Dental Committee), LPC (LLR Pharmacy Committee)
- Local Authorities and District Councils
- Our Strategic Partners: UHL, LPT, EMAS, DHU
- All our system partners
- Our LLR Patient Participation Groups
- Public and Patient Involvement Assurance Group
- Voluntary, Community and Social Enterprise Alliance
- The patients and public of Leicester, Leicestershire and Rutland

8. References

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9. Appendix

Appendix 1a: Associated Strategies

(Note please check that these strategies are the latest versions as the links will not direct you to any updated documents)

- Leicester health, care and wellbeing strategy 22-27
- Leicestershire joint health and wellbeing strategy 22-32
- Rutland joint health and wellbeing strategy: The Rutland place-based plan 22-27
- LLR primary care strategy 19-22
- LLR Health & Wellbeing Partnership Integrated Care Strategy 22
- LLR ICB quality and improvement strategy
- LLR ICB digital strategy 22-25
- LLR clinical model strategy
- LLR primary care estates strategy
- LLR ICB people plan
- Looking After Our People Priorities
- LLR ICB people and community's strategy 22-24
- LLR operational plan
- LLR ICB health inequalities and inclusion strategy and framework 21-25
- Embedding Research into Practice Strategy
- Green Plan 2022 - 2025
- Better care for all
- Future in Mind Transformation plan
- Better Mental Health For All LPT
- Leicester, Leicestershire and Rutland Living Well with Dementia Strategy 2019-2022
- CYP Future In Mind strategy
- Fuller stocktake report
- NHS Long Term Plan

Appendix 1b: Summary of the national changes affecting primary care

NHS Long Term Plan- Realizing we needed to build on the FV and GPFV in January 2019 NHSe published the LTP, a blueprint for NHS for the next 10 years with focus on prevention, improving services for patients and finally abolishing the divide between primary and community services. A key output of the LTP was the birth of our Integrated Care Systems (ICS), giving us a platform for further partnership working and integration.

GP Contracts- Changes to the GP network contract and Directed Enhanced Services (DES) specifications were published also published in 2019 and translated the commitments in the NHS LTP into a five-year framework for the GP services contract. This solidified the direction of travel for primary care. With joined up commissioning our PCN's are making a real difference to patient health and wellbeing. Example

DHSC White Paper- In 2021 the DHSC published the White Paper Integration and innovation: working together to improve health and social care for all, which set out legislative proposals for a health and care bill. Bringing together proposals that build on the integrating care by collectively looking at the needs of the population at the various partnership levels i.e. System, Place and Neighbourhood.

Health and Social Care Act 2022- Shortly after the proposals in the white paper were passes as cart of the Health and Social Care Act 2022. Integrated care systems (ICS) bring together providers and commissioners of NHS services with local authorities and other local partners in 42 areas across England. A key opportunity offered by ICS is to improve the health of the population at local level through genuine partnership working between the NHS, local government, the voluntary and community and local communities.

Financial initiative schemes- At around the same time other national policies, financial initiatives and changes such as Integrated Urgent Care, Building better hospitals along with investment initiatives such as ARRs, IIF and ETFT have paved the way for 'system level' collaboratives and partnerships; bringing together people from primary, secondary, community, LA, partners and VCSE.

The Fuller Stocktake (Fuller 2022)- Sets out how we do this by introducing a new vision for integrating primary care at place, improving the access, experience and outcomes for our communities, which centred around three essential themes. Streamlining access to care and advice, providing more proactive, personalised care with support from a multidisciplinary team of professionals and helping people stay well for longer.

Delegated commissioning responsibilities for PODs (Pharmacy, Optometry and Dentistry) from April 2023- ICSs will have more ability to deliver services that meet the specific needs of their populations, including local commissioning for dentistry, optometry and community pharmacy from 2023. This additional responsibility gives us the chance to work across the broad set of services to identify how we can reshape improved delivery of care through deeper integrated working.

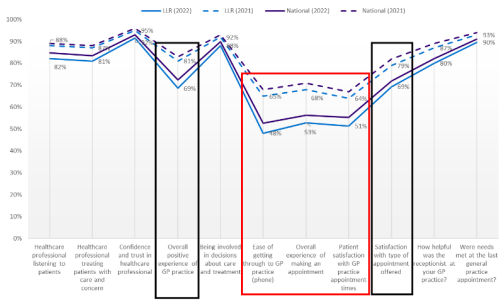
NHS Priorities and operational planning guidance 23/24- The 2023/24 priorities and operational planning guidance reconfirms the ongoing need to recover our core services and improve productivity, making progress in delivering the key NHS Long Term Plan ambitions and continuing to transform the NHS for the future.

Further Changes to Primary Care Contracts- The changes to the GP contract in 2023/24 set out the requirements of General Practice and PCNs with the goal of improving patient experience and satisfaction, recognising that this will require both time and support to assess, review and implement changes. These changes will be supported in several ways including freeing up workforce capacity through significant changes to the Impact and Investment Fund (IIF) and through the QOF Quality Improvement (QI) modules. One key change was the number of indicators in the IIF which will be reduced from 36 to 5.

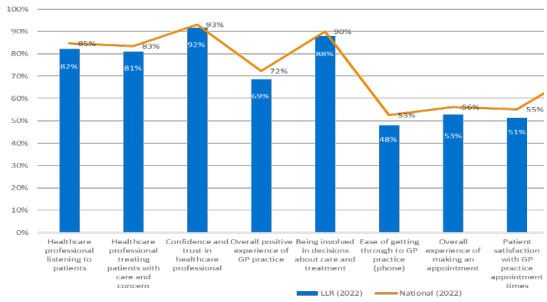
Appendix 2: Summary of findings from engagement with our communities

To help us better understand the patient and carer need we have utilised a range of data and insights from both local and national sources. This intelligence has helped us to shape our vision for the future.

The National GP Patient Survey provides use the trends across 2021 and 2022.



47,789 people were invited to take part in the 2022 survey. 14,426 people returned surveys in Leicester, Leicestershire and Rutland. This represents a 30% response rate. Locally we performed below the national average for 11 questions in both 2021 and 2022. The 2021 data was collected during the third lockdown and 2022 data was collected as the UK was transitioning to 'normal', which may have influenced the data. The data shows that the three worst scoring questions relate to access to GP services. Followed by overall experience of GP practice and satisfaction with the type of appointment on offer.



Although locally we were below the national average, the majority of respondents to the survey had positive perceptions of their care (92%) and felt their needs were met during their last GP appointment. In addition, confidence and trust in healthcare professionals is high among respondents and 90% of respondents felt their needs were met during their last GP appointment.

This survey aligns with a local survey undertaken which 5,483 people contributed to and the consolidated Enhanced Access Report where 44,400 people shared their insights into enhanced access services.

In addition to using these qualitative and quantitative surveys reviewed the information across secondary data collected across 74 reports including from large scale public consultation Report of

Findings including Building Better Hospitals Report of Findings (May 2021) and the, Step up to Great Mental Health Report of Findings (October 2021).

The themes

Outlined below are the key themes emerging from patients, family carers, staff and stakeholders from the consolidated insights. These have informed this strategy:

Health Quality and Prevention

- Patients, service users' and carers' perceptions of the quality of the healthcare they receive is highly dependent on the quality of their interactions with their healthcare professional and team.
- A better understanding of culture and language is needed whether on the telephone, face-to-face, in leaflets or online.
- The use of understandable and consistent terminology, without jargon, and accessible resources are important to the people. Vulnerable groups report the lack of availability of translation / interpreter services. They also report that healthcare staff do not have an awareness of the cultural differences common to these groups.
- People feel that clinicians and health professionals should be encouraged to empower patients and carers to take control of their own health, with information, explanation and an understanding of the range of choices such as social prescribing.
- People feel it is important to have confidence that professionals listen to them and decision making around healthcare is a joint exercise, particularly those with long-term conditions.
- Patients would prefer to stay in their own home for as long as possible, but their level of confidence is dependent on support from health professionals, family and external agencies which they felt can vary.
- A significant proportion of patients do not consider themselves to have any real medical knowledge or confidence to go looking for self-care advice or support. When patients do seek out support from their General Practice or Health Centre, they often find it difficult to even make contact with an appropriate person. Many patients express frustrations about not being able to make appointments in general. Often, they feel they need to have an initial consultation with a GP or other health professional to identify their medical issue and for the GP or health professional to devise a treatment pathway and provide advice about their condition – many patients see this as the gateway to them being able to look after their own health more effectively.
- People would like health professionals to directly support those patients in poor health with advice and support to help them manage their conditions, as they feel this can prevent an appointment to an urgent and emergency care.
- People want messages from a trusted source and receive information directly rather than seek it out.
- Patients feel that their General Practice website is either out-of-date or it is not easy to find things. People want information to include self-care help and advice in order to arm them with as much useful and reliable information as they need in this area.

Joining up care

- IT systems should be joined up and improved between organisations, improved access to records; technology acting as a better tool to support integrated working; and information availability.

- Transfers between services/handovers are stressful times for both GPs and other staff and patients and family carers, in particular, older and vulnerable people.
- Family carers need services which are reliable and appropriate to their situation and allow them to support their loved one. They report difficulties in being recognised as carers by their GP practice and getting the help they need and felt frustrated particularly when trying to get help at times of crisis or prevent a crisis.
- Patients and carers wanted a more efficient and effective link between GP surgeries and hospitals; between professionals working in health and those working in social care and more obvious use of technology using digitised notes and shared computer systems, so they don't have to tell their story a number of times.
- Primary Care professionals could better inform people of local support services and have a better understanding of how to support patient and their whole family, particularly how to live with long term conditions.
- People need more recognised involvement of the voluntary and community sector in a formal capacity, rather than a voluntary one.
- People felt that a more joined up approach to services supporting good physical and mental health would prevent more people from having an emotional breakdown, particularly those people who are coping with a long-term physical condition. People also saw social prescribing as a support service for patients and their family carers.

Access to care closer to home

- When asked what makes a good primary care appointment people wanted to be seen in a timely manner, with no long waits, to be listened to by the GP or health professional, to feel they had enough time and not rushed and to leave with a diagnosis/advice/support/ referral.
- Being able to get an appointment easily is important, as is being treated respectfully by members of staff at the Practice.
- The setting and location of care is important and needs to be fair and equitable. New services and ways of working need to be shared with/promoted to both staff and patients, but it is important that messages are delivered by a known and trusted source.
- Many people are comfortable with digital consultations, however many are either not digitally enabled or digitally confident, or feel that a digital appointment is not appropriate to their medical problem.
- Many people say they would like to feel more confident in the support they receive in a crisis and to keep mobile and active.
- People need a better experience of getting through on the telephone and accessing GP services, as well as improved confidence and satisfaction with the type of appointment they are offered.
- There is an obvious preference for 'traditional' face-to-face appointments but some people say they are happy to have an initial telephone consultation and other are comfortable with an online consultations. Remote consultations are viewed as more acceptable for 'non-emergency' medical issues.

Appendix 3: Delivery plan (Under development)

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Appendix 4: One page theme summaries - public facing (Under development)

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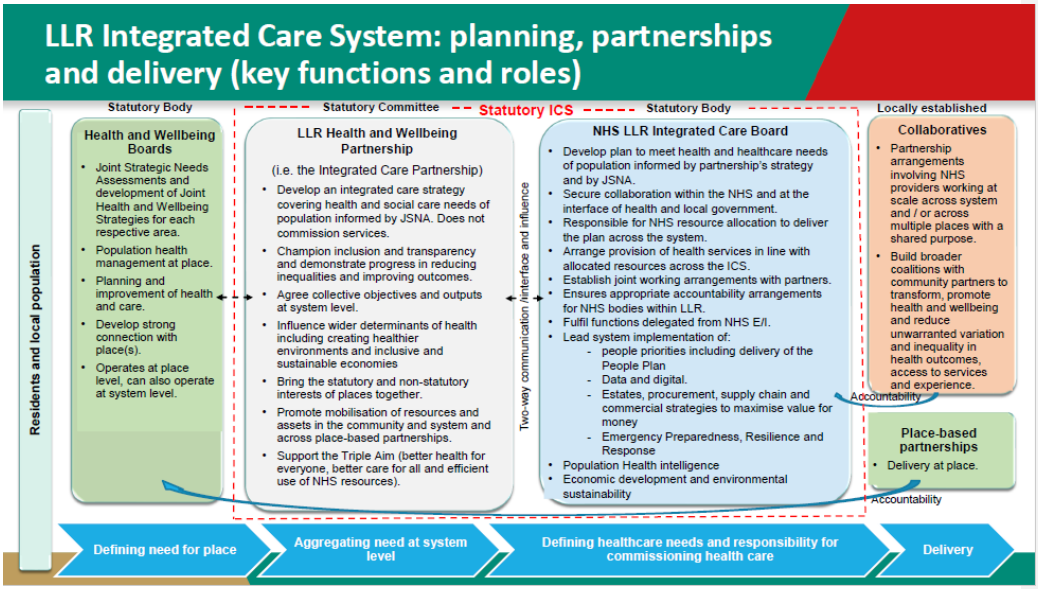
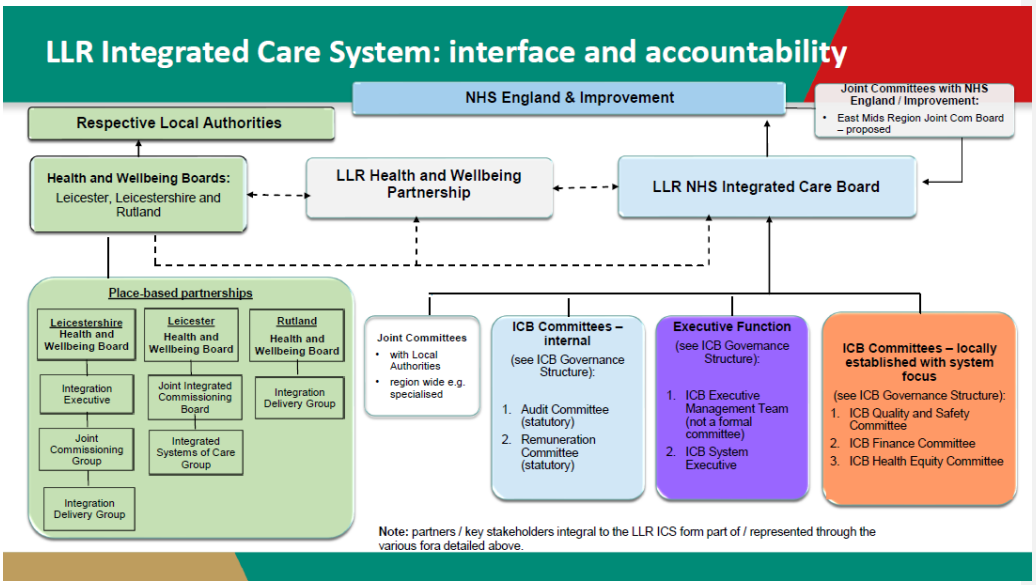
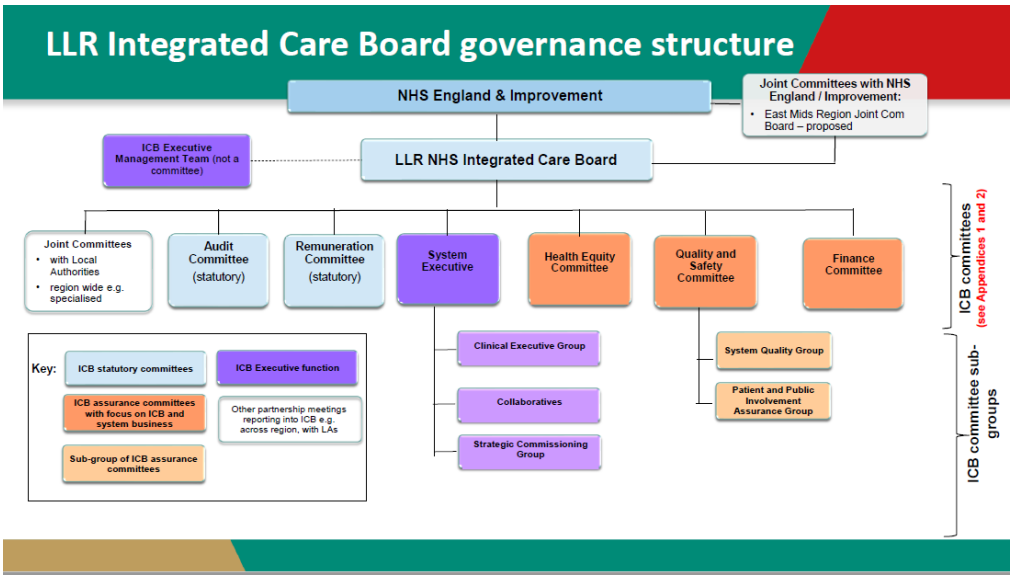
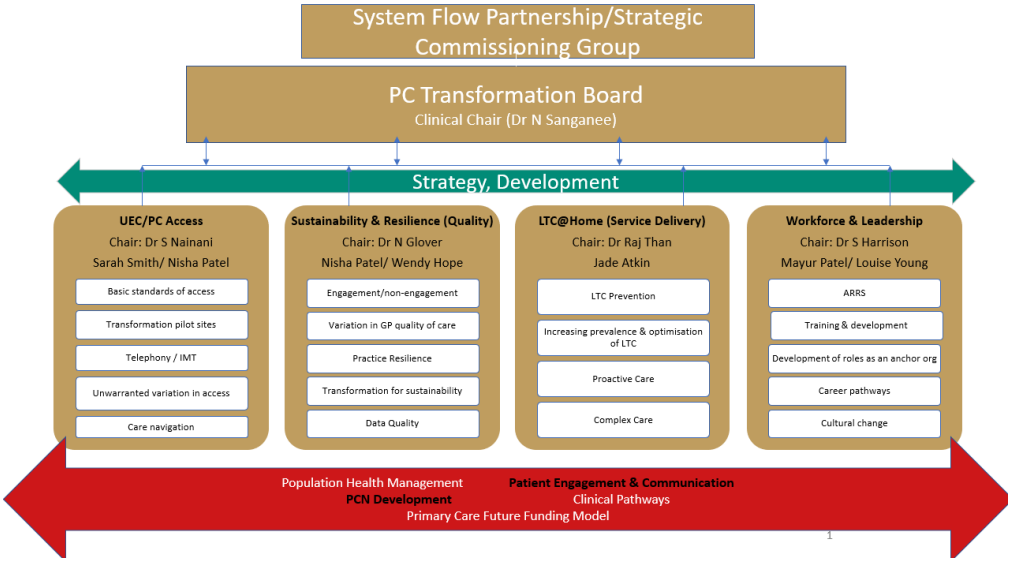
Appendix 5a: ICS/ICB Governance






LLR Integrated Care Board governance structure
NHS England & Improvement
Joint Committees with NHS England / Improvement:
East Mids Region Joint Com Board – proposed
ICB Executive Management Team (not a committee)
LLR NHS Integrated Care Board
Joint Committees
with Local Authorities
region wide e.g. specialised
Audit Committee (statutory)
Remuneration Committee (statutory)
System Executive
Health Equity Committee
Quality and Safety Committee
Finance Committee
Clinical Executive Group
Collaboratives
Strategic Commissioning Group
System Quality Group
Patient and Public Involvement Assurance Group
Key:
ICB statutory committees
ICB Executive function
ICB assurance committees with focus on ICB and system business
Other partnership meetings reporting into ICB e.g. across region, with LAs
Sub-group of ICB assurance committees
ICB committees (see Appendices 1 and 2)
ICB committee sub-groups


System Flow Partnership/Strategic Commissioning Group
PC Transformation Board
Clinical Chair (Dr N Sanganee)
Strategy, Development
UEC/PC Access
Chair: Dr S Nainani
Sarah Smith/ Nisha Patel
Basic standards of access
Transformation pilot sites
Telephony / IMT
Unwarranted variation in access
Care navigation
Sustainability & Resilience (Quality)
Chair: Dr N Glover
Nisha Patel/ Wendy Hope
Engagement/non-engagement
Variation in GP quality of care
Practice Resilience
Transformation for sustainability
Data Quality
LTC@Home (Service Delivery)
Chair: Dr Raj Than
Jade Atkin
LTC Prevention
Increasing prevalence & optimisation of LTC
Proactive Care
Complex Care
Workforce & Leadership
Chair: Dr S Harrison
Mayur Patel/ Louise Young
ARRS
Training & development
Development of roles as an anchor org
Career pathways
Cultural change
Population Health Management
PCN Development
Patient Engagement & Communication
Clinical Pathways
Primary Care Future Funding Model

Appendix 5b: PCTB (PRIMARY CARE TRANSFORMATION BOARD) Group Membership

Organisation	Directorate/Team	Name	Membership Role
Core Membership			
Leicester, Leicestershire & Rutland Integrated Commissioning Board (LLR ICB)	Integration & Transformation	Yasmin Sidyot	Deputy Chief Operating Officer
Leicester, Leicestershire & Rutland Integrated Commissioning Board (LLR ICB)	Integration & Transformation	Sabina Esat	I&T Support Officer (PCTB Administrator)
Leicester, Leicestershire & Rutland Integrated Commissioning Board (LLR ICB) **(CHAIR)**	Medical Directorate	Dr N Sanganee	Chief Medical Officer
Leicester, Leicestershire & Rutland Integrated Commissioning Board (LLR ICB) **(Deputy Chair)**	Medical Directorate	Dr S Nainani	Deputy Chief Medical Officer
Leicester, Leicestershire & Rutland Integrated Commissioning Board (LLR ICB) **(Deputy Chair)**	Medical Directorate	Dr Andy Ahyow	Deputy Chief Medical Officer
Leicester, Leicestershire & Rutland Integrated Commissioning Board (LLR ICB)	Primary Care - Integration & Transformation	Mayur Patel	Head of Integration & Transformation (Programme SRO)
Leicester, Leicestershire & Rutland Integrated Commissioning Board (LLR ICB)	Primary Care - Integration & Transformation	Nisha Patel	Head of Integration & Transformation (Programme SRO)
Leicester, Leicestershire & Rutland Integrated Commissioning Board (LLR ICB)	Strategy and Planning	Mark Pierce	Head of Population Health Management
Leicester, Leicestershire & Rutland Integrated Commissioning Board (LLR ICB)	Nursing and Quality	Wendy Hope	Head of Quality and Safety
Leicester, Leicestershire & Rutland Integrated Commissioning Board (LLR ICB)	People and Innovation	Louise Young	Deputy Chief Officer People and Workforce
Leicester, Leicestershire & Rutland Integrated Commissioning Board (LLR ICB)	People and Innovation Communications	Dave Rowson	Head of Communications & Marketing
Leicester, Leicestershire & Rutland Integrated Commissioning Board (LLR ICB)	People and Innovation Engagement	Susan Venables	Head of Engagement and Insights
Leicester, Leicestershire & Rutland Integrated Commissioning Board (LLR ICB)	Finance, Contracting and Corporate Governance	Andrew Roberts	Primary Care Finance Business Partner

Leicester, Leicestershire & Rutland Integrated Commissioning Board (LLR ICB)	Contracts	Jamie Barrett	Senior Contracts Manager
Leicester, Leicestershire & Rutland Integrated Commissioning Board (LLR ICB)	City	Fahad Rizvi	Place Based Lead
Leicester, Leicestershire & Rutland Integrated Commissioning Board (LLR ICB)	City	Dr Avi Prasad	Place Based Lead
Leicester, Leicestershire & Rutland Integrated Commissioning Board (LLR ICB)	County	Dr James Ogle	Place Based Lead
Leicester, Leicestershire & Rutland Integrated Commissioning Board (LLR ICB)	County	Dr Nikhil Mahatma	Place Based Lead
Leicester, Leicestershire & Rutland Integrated Commissioning Board (LLR ICB)	Rutland	Lynette Patino	Place Based Lead
Leicester, Leicestershire & Rutland Integrated Commissioning Board (LLR ICB)	Long-Term Conditions Care@Home (LTC)	Debra Mitchell	ICB Lead
Leicester, Leicestershire & Rutland Integrated Commissioning Board (LLR ICB)	Long-Term Conditions Care@Home (LTC)	Dr Raj Tun Than	Clinical Lead
Leicester, Leicestershire & Rutland Integrated Commissioning Board (LLR ICB)	PC/UEC Access	Sarah smith	ICB Lead
Leicester, Leicestershire & Rutland Integrated Commissioning Board (LLR ICB)	PC/UEC Access	Dr Girish Purohit	Clinical Lead
Leicester, Leicestershire & Rutland Integrated Commissioning Board (LLR ICB)	PC/UEC Access & Sustainability & Resilience (Quality)	Dr Nick Glover	Clinical Lead
Leicester, Leicestershire & Rutland Integrated Commissioning Board (LLR ICB)	Estates and Facilities	Lorna Simpson	Head of Strategic Estates
Leicester, Leicestershire and Rutland LMC	LMC	Dr Fahreen Dhanji	LMC representative
University Hospitals of Leicester (UHL)	UHL - Deputy Director of Organisational Transformation	Lucy Wall	UHL Representative
Leicestershire Partnership Trust (LPT)	LPT	Nikki Beacher	Deputy Director Community Health Services

Healthwatch Leicester and Leicestershire	Leicester and Leicestershire	Kash Bhayani	Healthwatch Leicester and Leicestershire representative
Healthwatch Rutland	Rutland	Tracey Allan-Jones	Healthwatch Rutland representative
Public Health (PH)	Head of Locality East and SRCT Social Care and Education	Sezer Domac	Leicester City Council
Leicestershire County Council	Health and Care Integration Project Manager	Lucy Hulls	Leicestershire County Council
Rutland County Council	Hospital and Clinical Integration Lead	Mat Wise	Rutland Council
In attendance			
Leicester, Leicestershire & Rutland Integrated Commissioning Board (LLR ICB)	Primary Care Access and Variation	David Muir	ICB Lead – Primary Care Access
Leicester, Leicestershire & Rutland Integrated Commissioning Board (LLR ICB)	Sustainability & Resilience (Quality)	James Hickman	ICB Lead – Primary Care Access
Leicester, Leicestershire & Rutland Integrated Commissioning Board (LLR ICB)	Workforce and Leadership	Rajesh Thanki	Senior workforce planning and BI Manager
Leicester, Leicestershire & Rutland Integrated Commissioning Board (LLR ICB)	Workforce and Leadership	Dr Stacey Harrison	Clinical Lead
Leicester, Leicestershire & Rutland Integrated Commissioning Board (LLR ICB)	Home First	Fay Bayliss	ICB Lead
Leicester, Leicestershire & Rutland Integrated Commissioning Board (LLR ICB)	Home First	Dr Rekash Inamdar	Clinical Lead
Leicester, Leicestershire & Rutland Integrated Commissioning Board (LLR ICB)	Long-Term Conditions Care@Home (LTC)	Jade Atkin	ICB Lead
Leicester, Leicestershire & Rutland Integrated Commissioning Board (LLR ICB)	LLR ICB Digital Innovation and Transformation Team	Saadia Shafeeq-Uddin	Senior Delivery Manager
University Hospitals of Leicester (UHL)	Chief Operating Officer - UHL	John Melbourne	UHL Representative
Leicestershire Partnership Trust (LPT)		Sam Leak	Executive Director for Community Health Services
Healthwatch Leicester and Leicestershire	Leicester and Leicestershire	Harsha Kotecha	Healthwatch Leicester and Leicestershire representative

Appendix 6: Table of figures (Full Visuals)

Figure 1: ICS strategic priorities

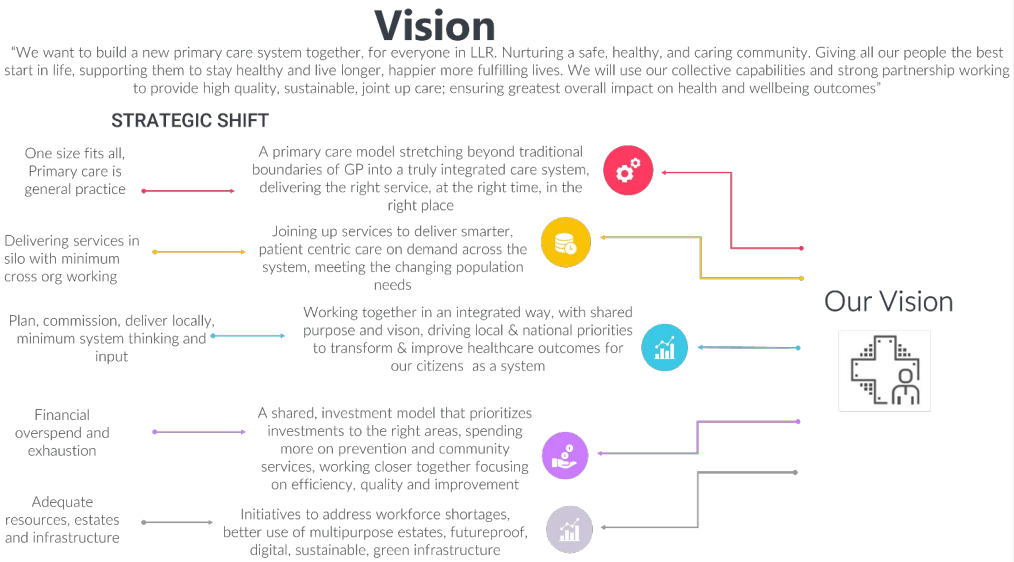


Figure 2: Overview of the strategic shift for primary care

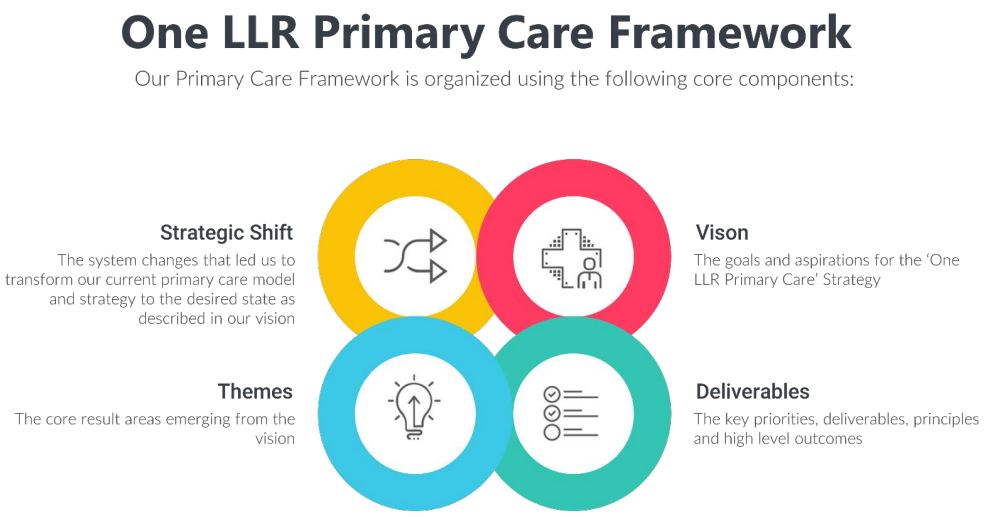


Figure 3: Framework for strategy development

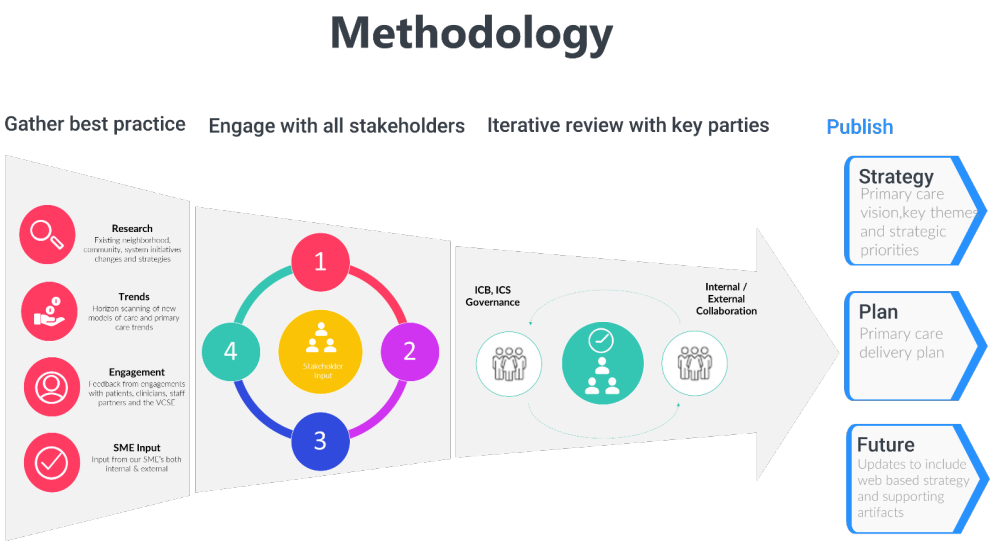


Figure 4: Strategy development methodology

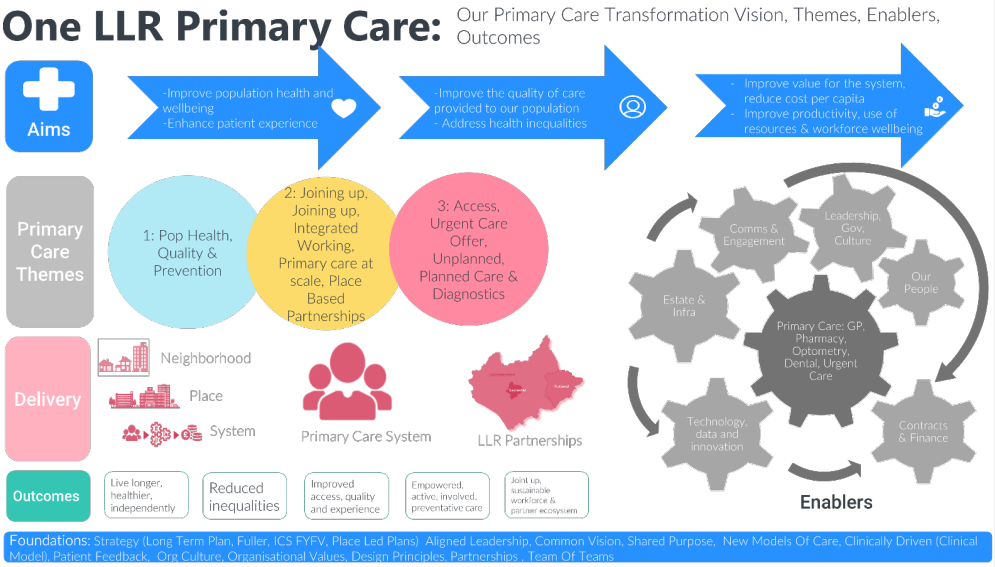


Figure 5: Primary care vision overview

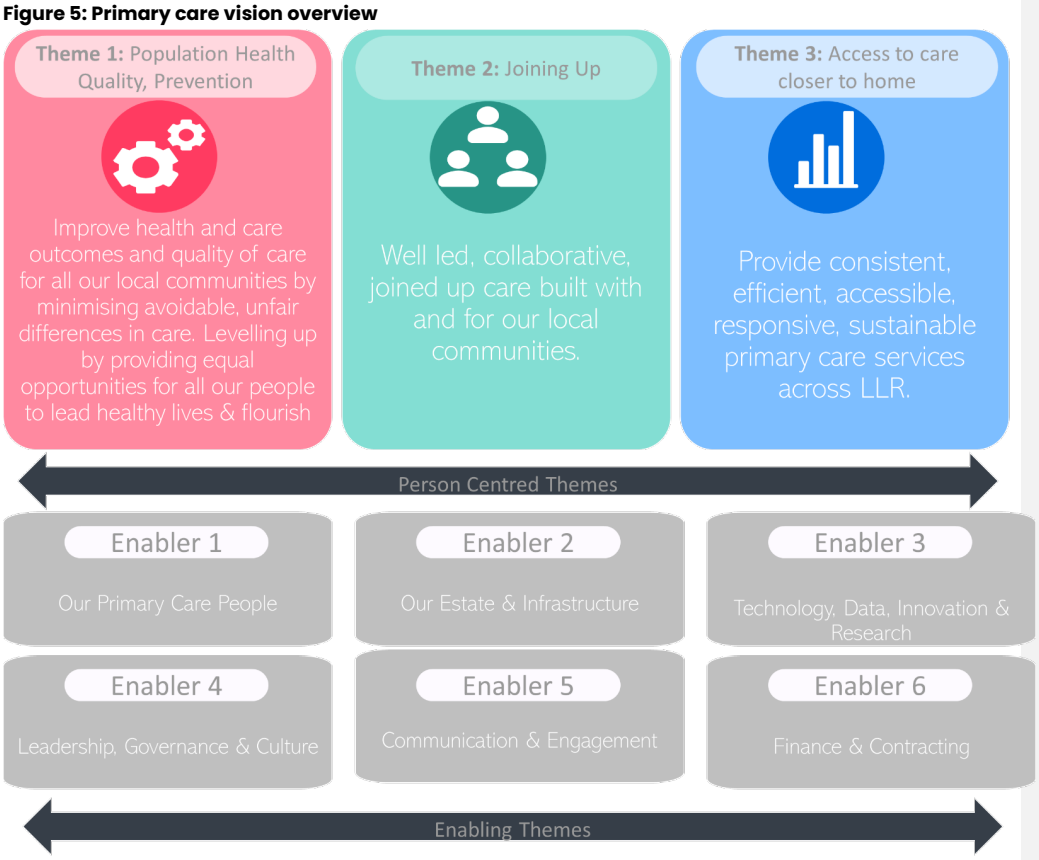


Figure 6: Primary care themes overview

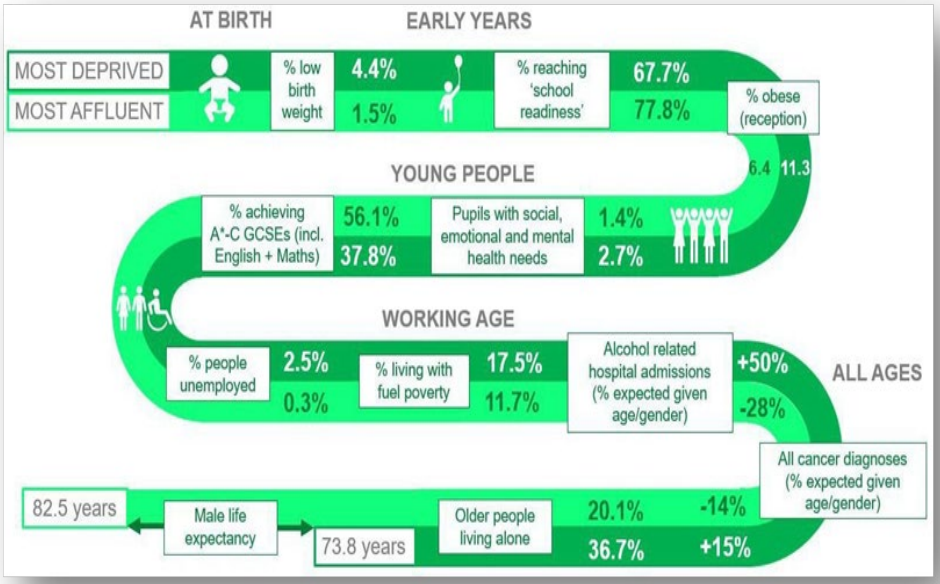
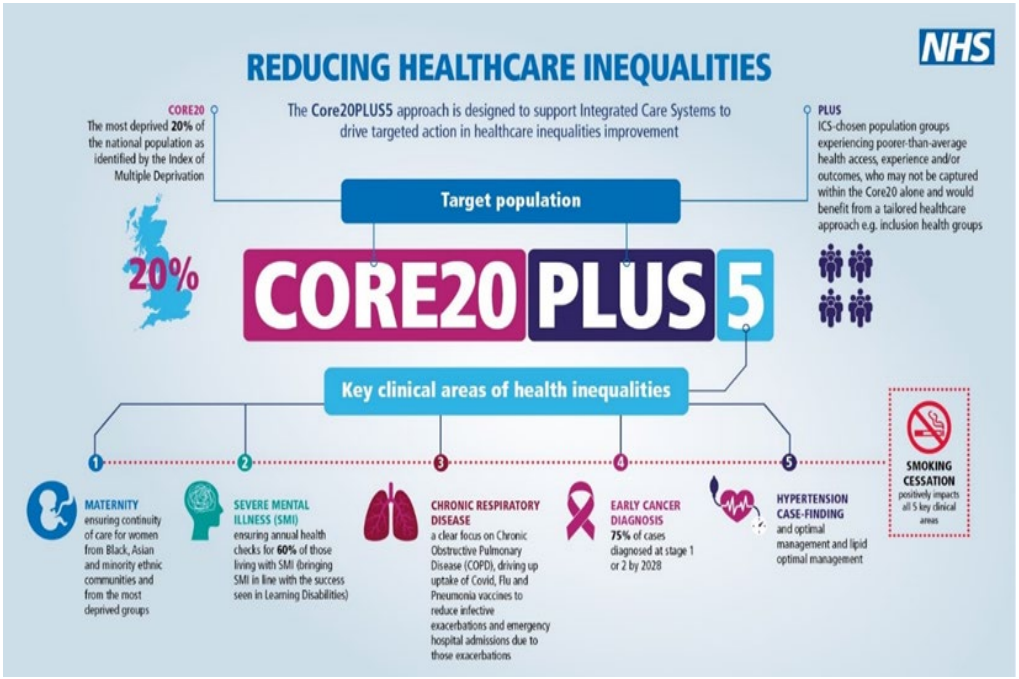


Figure 7: A Tale of Two babies - Difference in health indicators between the most and least deprived local areas of LLR. Source: PHE Fingertips



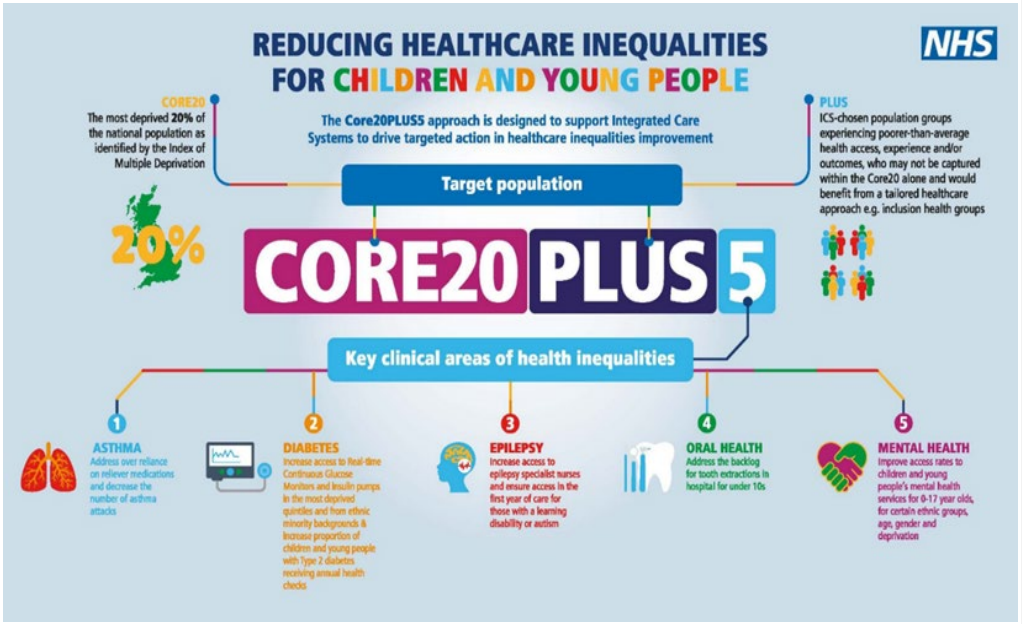


Figure 8: NHSe Core20Plus5 Approach (Adults & CYP)

Figure 9: Our communication and engagement approach

TABLE 1. Primary Care Allocation Summary					
	23/24	24/25	25/26	26/27	27/28
Primary Care	23,268	23,902	24,746	25,618	26,522
Primary Care Co-Commissioning	195,134	203,138	211,470	220,143	229,172
Delegated Pharmacy, Optometrist and Dental allocations	91,475	93,619	97,459	101,456	105,617
Estimated Primary Allocations	**309,877**	**320,659**	**333,674**	**347,218**	**361,312**
System Programme and Co Comm projected combined allocations	**1,931,205**	**1,986,545**	**2,057,786**	**2,131,588**	**2,208,043**
Proportion allocated to Primary Care	**16%**	**16%**	**16%**	**16%**	**16%**

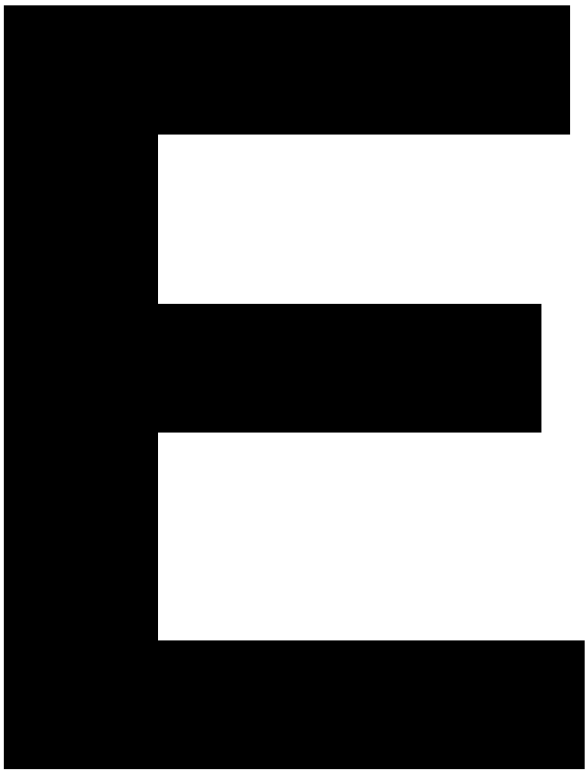
Figure 10: Projected LLR primary care allocations 23-28

10. Glossary Of Terms

A&E Accident and Emergency
APMS Alternative Provider Medical Services
ARRS Additional Roles Reimbursement Scheme
BAU Business as Usual
BCF Better Care Fund
CCG Clinical Commissioning Group
Core20PLUS5 NHS England and Improvement approach to reducing health inequalities
CPCS Community Pharmacy Consultation Scheme
DES Direct Enhanced Service
ED Emergency Department
ETTF Estates and Technology Transformation Fund
ETTF Estates Transformation Fund
GMS General Medical Services
GP General Practice
GPFV General Practice Forward View
GPIT General Practice Information Technology
HEE Health Education England
HWB Health and Wellbeing Board
ICB Integrated Care Board
ICP Integrated Care Partnership
ICS Integrated Care System
IIF Impact & Investment Fund
INT Integrated Neighbourhood Teams
ICS Integrated Care System
IT Information Technology
JHWS Joint Health and Wellbeing Strategy
LDC Local Dental Committee
LLR Leicester, Leicestershire, Rutland
LMC Local Medical Committee
LOC Local Optical Committee
LPC Local Pharmaceutical Committee
LTC Long Term Condition
LTP Long Term Plan
MDT Multi-Disciplinary Team
MECC+ Making Every Contact Count
MH Mental Health
NHS E&I National Health Service England and Improvement
NHS National Health Service
PCN Primary Care Network
PHM Population health management
PPG Patient Participation Group
QOF Quality Outcomes Framework
SEND Special Education Needs And Disability
STP Sustainability and Transformation Partnership
UEC Urgent and Emergency Care
UTC Urgent Treatment Centre
VCSE Voluntary Community Social Enterprise

Appendix B

Org	Contact	Role / JT	Status	Notes	Relevant link	RACI	Item Type	Path
LLR ICB	VYAS, Rachna (NHS LEICESTER, LEICESTERSHIRE AND RUTLAND ICB - 04C)	COO	3. Consulting & Collaborating	1. Individual updates MP 2. Constant engagement and feedback 3. Drafts for comment circulated in Nov 22 Jan 23 Feb 23 March 23		NA	Item	sites/msteams_df3bfe/Lists/Stakeholder Engagement
LLR ICB	SIDYOT, Yasmin (NHS LEICESTER, LEICESTERSHIRE AND RUTLAND ICB - 04V)	Deputy COO	3. Consulting & Collaborating	1. Individual updates via weekly meetings 2. Constant engagement and feedback 3. Drafts for comment circulated in Nov 22 Jan 23 Feb 23 March 23		NA	Item	sites/msteams_df3bfe/Lists/Stakeholder Engagement
LLR ICB	SANGANEE, Nilesh (CASTLE MEDICAL GROUP)	CMIO	3. Consulting & Collaborating	1. Individual updates via weekly meetings and monthly PCTB 2. Constant engagement and feedback 3. Drafts for comment circulated in Nov 22 Jan 23 Feb 23 March 23		NA	Item	sites/msteams_df3bfe/Lists/Stakeholder Engagement
LLR ICB	NAINANI, Sulaxni (NHS LEICESTER, LEICESTERSHIRE AND RUTLAND ICB - 04C)	CMIO	3. Consulting & Collaborating	1. Individual updates via weekly meetings and monthly PCTB 2. Constant engagement and feedback 3. Drafts for comment circulated in Nov 22 Jan 23 Feb 23 March 23		NA	Item	sites/msteams_df3bfe/Lists/Stakeholder Engagement
LLR ICB	RIZVI, Fahad (NHS LEICESTER, LEICESTERSHIRE AND RUTLAND ICB - 04V)	Place Lead	4. Action, Feedback, Follow up	1. 19/01/23 PCTB feedback session 2. 31/01/23 Follow up call with place leads 3. Constant engagement and feedback 4. Drafts for comment circulated in Nov 22 Jan 23 Feb 23 March 23		NA	Item	sites/msteams_df3bfe/Lists/Stakeholder Engagement
LLR ICB	PRASAD, Avi (WILLOWS HEALTH)	Place Lead	4. Action, Feedback, Follow up	1. 19/01/23 PCTB feedback session 2. 31/01/23 Follow up call with place leads 3. Constant engagement and feedback 4. Drafts for comment circulated in Nov 22 Jan 23 Feb 23 March 23		NA	Item	sites/msteams_df3bfe/Lists/Stakeholder Engagement
LLR ICB	OGLE, James (NHS LEICESTER, LEICESTERSHIRE AND RUTLAND ICB - 04V)	Place Lead	4. Action, Feedback, Follow up	1. 19/01/23 PCTB feedback session 2. 31/01/23 Follow up call with place leads 3. Constant engagement and feedback 4. Drafts for comment circulated in Nov 22 Jan 23 Feb 23 March 23		NA	Item	sites/msteams_df3bfe/Lists/Stakeholder Engagement
LLR ICB	BURDEN, James (THE UPPINGHAM SURGERY)	Place Lead	4. Action, Feedback, Follow up	1. 19/01/23 PCTB feedback session 2. 31/01/23 Follow up call with place leads 3. Constant engagement and feedback 4. Drafts for comment circulated in Nov 22 Jan 23 Feb 23 March 23		NA	Item	sites/msteams_df3bfe/Lists/Stakeholder Engagement
LLR ICB	PIERCE, Mark (NHS LEICESTER, LEICESTERSHIRE AND RUTLAND ICB - 04C)		3. Consulting & Collaborating	1. Individual updates 2. Constant engagement and feedback, Input for section 3. Drafts for comment circulated in Nov 22 Jan 23 Feb 23 March 23		NA	Item	sites/msteams_df3bfe/Lists/Stakeholder Engagement
LLR ICB	SHETH, Adhvait (NHS LEICESTER, LEICESTERSHIRE AND RUTLAND ICB - 03W)		3. Consulting & Collaborating	Several catch-up and feedback sessions		NA	Item	sites/msteams_df3bfe/Lists/Stakeholder Engagement
LLR ICB	VENABLES, Susan (NHS LEICESTER, LEICESTERSHIRE AND RUTLAND ICB - 04V)		3. Consulting & Collaborating	1. Individual updates 2. Constant engagement and feedback, Input for section 3. Drafts for comment circulated in Nov 22 Jan 23 Feb 23 March 23		NA	Item	sites/msteams_df3bfe/Lists/Stakeholder Engagement
LLR ICB	ROWSON, David (NHS LEICESTER, LEICESTERSHIRE AND RUTLAND ICB - 04C)		3. Consulting & Collaborating	1. Individual updates 2. Constant engagement and feedback, Input for section 3. Drafts for comment circulated in Nov 22 Jan 23 Feb 23 March 23		NA	Item	sites/msteams_df3bfe/Lists/Stakeholder Engagement
LLR ICB	ROSE, Sharon (NHS LEICESTER, LEICESTERSHIRE AND RUTLAND ICB - 03W)		3. Consulting & Collaborating	1. Individual updates 2. Constant engagement and feedback, Input for section 3. Drafts for comment circulated in Nov 22 Jan 23 Feb 23 March 23		NA	Item	sites/msteams_df3bfe/Lists/Stakeholder Engagement
LLR ICB	JOSHI, Miral (NHS LEICESTER, LEICESTERSHIRE AND RUTLAND ICB - 04V)		3. Consulting & Collaborating	1. Individual updates 2. Constant engagement and feedback, Input for section 3. Drafts for comment circulated in Nov 22 Jan 23 Feb 23 March 23		NA	Item	sites/msteams_df3bfe/Lists/Stakeholder Engagement
LLR ICB	YOUNG, Louise (NHS LEICESTER, LEICESTERSHIRE AND RUTLAND ICB - 04V)		3. Consulting & Collaborating	1. Individual updates 2. Constant engagement and feedback, Input for section 3. Drafts for comment circulated in Nov 22 Jan 23 Feb 23 March 23		NA	Item	sites/msteams_df3bfe/Lists/Stakeholder Engagement
LLR ICB	ROBERTS, Andrew (NHS LEICESTER, LEICESTERSHIRE AND RUTLAND ICB - 04V)		3. Consulting & Collaborating	1. Individual updates 2. Constant engagement and feedback, Input for section 3. Drafts for comment circulated in Nov 22 Jan 23 Feb 23 March 23		NA	Item	sites/msteams_df3bfe/Lists/Stakeholder Engagement
LLR ICB	BARRETT, Jamie (NHS LEICESTER, LEICESTERSHIRE AND RUTLAND ICB - 03W)		3. Consulting & Collaborating	1. Individual updates 2. Constant engagement and feedback, Input for section 3. Drafts for comment circulated in Nov 22 Jan 23 Feb 23 March 23		NA	Item	sites/msteams_df3bfe/Lists/Stakeholder Engagement
LLR ICB	HOPE, Wendy (NHS LEICESTER, LEICESTERSHIRE AND RUTLAND ICB - 04C)		3. Consulting & Collaborating	1. Individual updates 2. Constant engagement and feedback, Input for section 3. Drafts for comment circulated in Nov 22 Jan 23 Feb 23 March 23		NA	Item	sites/msteams_df3bfe/Lists/Stakeholder Engagement
LLR ICB	HUTCHINSON, Hannah (NHS LEICESTER, LEICESTERSHIRE AND RUTLAND ICB - 04C)		3. Consulting & Collaborating	1. Individual updates 2. Constant engagement and feedback, Input for section 3. Drafts for comment circulated in Nov 22 Jan 23 Feb 23 March 23		NA	Item	sites/msteams_df3bfe/Lists/Stakeholder Engagement
LLR ICB	BAINS, Daljitkaur (NHS LEICESTER, LEICESTERSHIRE AND RUTLAND ICB - 03W)		3. Consulting & Collaborating	1. Individual updates 2. Constant engagement and feedback, Input for section 3. Drafts for comment circulated in Nov 22 Jan 23 Feb 23 March 23		NA	Item	sites/msteams_df3bfe/Lists/Stakeholder Engagement
Healthwatch			3. Consulting & Collaborating	1. Engagement via Mayur 2. Development session feedback 3. MK shared strategy for comment		NA	Item	sites/msteams_df3bfe/Lists/Stakeholder Engagement
LMC			3. Consulting & Collaborating	1. Discussed on x2 calls 2. Feedback via development days and PLT		NA	Item	sites/msteams_df3bfe/Lists/Stakeholder Engagement
Place City Council ISOC/JICB			2. Initial Engagement Kickoff	Socialised for comment, shared for review		NA	Item	sites/msteams_df3bfe/Lists/Stakeholder Engagement
Place County Council IDG			2. Initial Engagement Kickoff	06//12/22 Socialised with IDG Shared for comment, shared for review		NA	Item	sites/msteams_df3bfe/Lists/Stakeholder Engagement
Place Rutland IDG			2. Initial Engagement Kickoff	06//12/22 Socialised with IDG Shared for comment, shared for review		NA	Item	sites/msteams_df3bfe/Lists/Stakeholder Engagement
System Design Groups			3. Consulting & Collaborating	As above		NA	Item	sites/msteams_df3bfe/Lists/Stakeholder Engagement
Primary Care Forums			2. Initial Engagement Kickoff	23/11/22 CD forum NII presented and shared ideas, feedback incorporated		NA	Item	sites/msteams_df3bfe/Lists/Stakeholder Engagement
LLR Patient Grouos / VCSE			2. Initial Enaaement Kickoff	Via Sue/David insights and data		NA	Item	sites/msteams_df3bfe/Lists/Stakeholder Enaaement
LPT			3. Consulting & Collaborating	Socialised strategy via place based governance groups		NA	Item	sites/msteams_df3bfe/Lists/Stakeholder Engagement
UHL			3. Consulting & Collaborating	Socialised strategy via place based governance groups		NA	Item	sites/msteams_df3bfe/Lists/Stakeholder Engagement
PCN Forums			3. Consulting & Collaborating	CD forums PCN forums		NA	Item	sites/msteams_df3bfe/Lists/Stakeholder Engagement
DHU			3. Consulting & Collaborating	Socialised strategy via place based governance groups		NA	Item	sites/msteams_df3bfe/Lists/Stakeholder Engagement
EMAS			3. Consulting & Collaborating	Socialised strategy via place based governance groups		NA	Item	sites/msteams_df3bfe/Lists/Stakeholder Enaaement
LLR LCB	SIMPSON, Lorna (NHS LEICESTER, LEICESTERSHIRE AND RUTLAND ICB - 03W)	Head of Estates	3. Consulting & Collaborating	1. Individual updates 2. Constant engagement and feedback, Input for section 3. Drafts for comment circulated in Nov 22 Jan 23 Feb 23 March 23		NA	Item	sites/msteams_df3bfe/Lists/Stakeholder Engagement
LLR LCB	THANKI, Rajesh (NHS LEICESTER, LEICESTERSHIRE AND RUTLAND ICB - 04V)		3. Consulting & Collaborating	1. Individual updates 2. Constant engagement and feedback, Input for section 3. Drafts for comment circulated in Nov 22 Jan 23 Feb 23 March 23		NA	Item	sites/msteams_df3bfe/Lists/Stakeholder Engagement
LLR LCB	THWAITES, Melanie (NHS LEICESTER, LEICESTERSHIRE AND RUTLAND ICB - 04C)	CYP Lead	3. Consulting & Collaborating	1. Individual updates 2. Constant engagement and feedback, Input for section 3. Drafts for comment circulated in Nov 22 Jan 23 Feb 23 March 23		NA	Item	sites/msteams_df3bfe/Lists/Stakeholder Engagement
LLR LCB	BHAVSAR, Mina (NHS LEICESTER, LEICESTERSHIRE AND RUTLAND ICB - 04C)	Women Lead	3. Consulting & Collaborating	1. Individual updates 2. Constant engagement and feedback, Input for section 3. Drafts for comment circulated in Nov 22 Jan 23 Feb 23 March 23		NA	Item	sites/msteams_df3bfe/Lists/Stakeholder Engagement
LLR LCB	HAMMOND, Justin (NHS LEICESTER, LEICESTERSHIRE AND RUTLAND ICB - 03W)	Head Of MH & LD	3. Consulting & Collaborating	1. Individual updates 2. Constant engagement and feedback, Input for section 3. Drafts for comment circulated in Nov 22 Jan 23 Feb 23 March 23		NA	Item	sites/msteams_df3bfe/Lists/Stakeholder Engagement
LLR IDG		IDG	2. Initial Engagement Kickoff	10/01/23 Socialised with IDG		NA	Item	sites/msteams_df3bfe/Lists/Stakeholder Engagement
LLR ICB	GRIZZELL, Jo (NHS LEICESTER, LEICESTERSHIRE AND RUTLAND ICB - 04C)		3. Consulting & Collaborating	On going engagement re pod changes, working on narrative 1. Individual updates 2. Constant engagement and feedback, Input for section 3. Drafts for comment circulated in Nov 22 Jan 23 Feb 23 March 23		NA	Item	sites/msteams_df3bfe/Lists/Stakeholder Engagement
LLR ICB	MAHATMA, Nikhil (KINGSWAY SURGERY)		3. Consulting & Collaborating	1. Individual updates 2. Constant engagement and feedback, Input for section 3. Drafts for comment circulated in Nov 22 Jan 23 Feb 23 March 23		NA	Item	sites/msteams_df3bfe/Lists/Stakeholder Engagement
NHSe	GREEN, Jane (NHS ENGLAND - X24)	Primary Care Programme Manager (PI	2. Initial Engagement Kickoff	Primary Care Programme Manager (Pharmacy, Optometry and Dental) – East Midlands NHS England - Midlands M: 07500 976141 Email: jane.green18@nhs.net		NA	Item	sites/msteams_df3bfe/Lists/Stakeholder Engagement
Upper tier local authorities						LLR LA	Item	sites/msteams_df3bfe/Lists/Stakeholder Engagement
LLR Local Optometric Committee		Chair	2. Initial Engagement Kickoff	1. Kick off 2. Shared for comment and review 3. Reviewed comments, shared	http://www.leic	NA	Item	sites/msteams_df3bfe/Lists/Stakeholder Engagement
LLR LDC (Leics Dental Committee)	MOTI, Hanif (HEALTH EDUCATION EAST MIDLANDS)	LDC Chair	2. Initial Engagement Kickoff	1. Kick off 2. Shared for comment and review 3. Reviewed comments, shared	https://leicester	NA	Item	sites/msteams_df3bfe/Lists/Stakeholder Engagement
LLR Pharmacy Committee		Chief Officer	2. Initial Engagement Kickoff	1. Kick off 2. Shared for comment and review 3. Reviewed comments, shared	https://leicester	NA	Item	sites/msteams_df3bfe/Lists/Stakeholder Engagement
Public Health England		Various	3. Consulting & Collaborating	Kajal Lad Strategic Lead – Healthcare Public Health Public Health Leicestershire County Council Mitch Harper (mitchell.harper@leics.gov.uk) who is the strategic lead for Rutland and also my colleague Sally Vallance Nazira Vania project manager for the Leicester Community Wellbeing Champions network Nazira.Vania@leicester.gov.uk Paul Miles (he/him) Programme Manager – Long Term Conditions Partnerships & Inequities Team | Division of Public Health Leicester City Council Shared strategy various times Feedback and input provided		NA	Item	sites/msteams_df3bfe/Lists/Stakeholder Engagement
Clinical Directors			3. Consulting & Collaborating	Nilesh presented at CD forum Strategy shared on forum Feb 23 Revised startegy our for comment 23/03/23 next CD forum		NA	Item	sites/msteams_df3bfe/Lists/Stakeholder Engagement
LLR ICB ;LEADS			3. Consulting & Collaborating	1. Individual updates 2. Constant engagement and feedback, Input for section 3. Drafts for comment circulated in Nov 22 Jan 23 Feb 23 March 23		NA	Item	sites/msteams_df3bfe/Lists/Stakeholder Engagement
LLR Patient Participation Groups			3. Consulting & Collaborating	Nov 22: PPG Presentation Feedback via MK Strategy informed via patient and community feedback		NA	Item	sites/msteams_df3bfe/Lists/Stakeholder Engagement
Place Led Plans : Leads			3. Consulting & Collaborating	Triangulation with place led plans and via Strategy team colleagues		NA	Item	sites/msteams_df3bfe/Lists/Stakeholder Engagement
(Various Stakeholders) Dedicated Team Development Days			3. Consulting & Collaborating	Nov 21 workshop June 22 workshop Jan 23 PCTB organised workshop, extensive round table discussion		NA	Item	sites/msteams_df3bfe/Lists/Stakeholder Engagement
VCSE Alliance			3. Consulting & Collaborating	22 Nov 22: VCSE Presentation Strategy informed by partner feedback, priorities aligned		NA	Item	sites/msteams_df3bfe/Lists/Stakeholder Engagement



Name of meeting:	**Leicester, Leicestershire and Rutland Integrated Care**		
Date:	**13 April 2023**	**Paper:**	**E**
Report title:	**Update on the development of the LLR ICB 5-Year Joint Forward Plan**		
Presented by:	Sarah Prema, Chief Strategy Officer, LLR ICB		
Report author:	Jo Grizzell, Senior Planning Manager, LLR ICB Sue Venables, Head of Engagement and Insights, LLR ICB		
Executive Sponsor:	Sarah Prema, Chief Strategy Officer, LLR ICB Alice McGee, Chief People 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:

- **NOTE** the update on the development of the Leicester, Leicestershire and Rutland Integrated Care Board 5-Year Joint Forward Plan.

Purpose and summary of the report:

1) Members will recall that the current position of the plan was discussed at the LLR ICB Board Development session held in March 2023.

2) Ongoing development of the plan has taken place since the Development Session and the latest version of the NHS LLR Integrated Care Board with the draft 5-Year Joint Forward Plan will be sent to members to enable them to provide feedback on the content.

3) Alongside the plan the draft communications and engagement plan will be sent to members for information.

4) An engagement activity log is in place following a stakeholder mapping exercise. Following the last LLR ICB Development Session there has been attendance at partner meetings including the Leicestershire Partnership Trust Board and UHL Trust Leadership Team Meeting. In addition, we have attended the Clinical Directors Forum, Clinical Leaders Development Session and the Patient Public Involvement Assurance Group and a meeting with the Local Medical Committee.

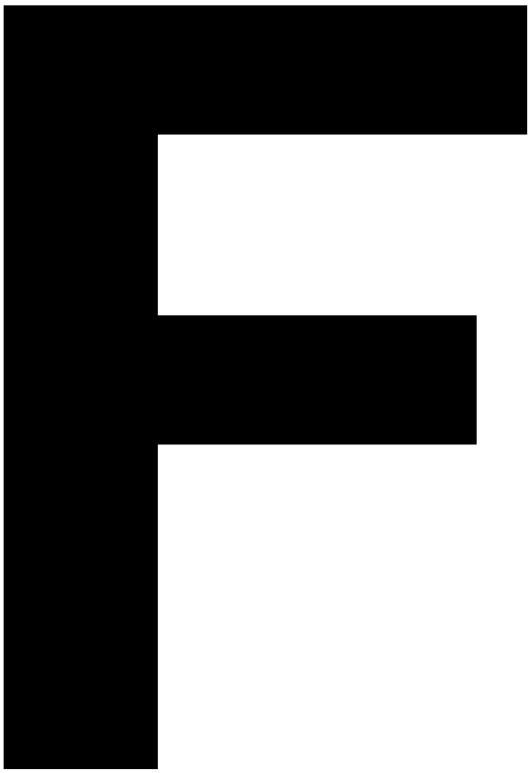
5) In addition a meeting took place with NHSE on Thursday 30th March 2023 where it was agreed that whilst the final 5-Year Joint Forward Plan will be ready for the deadline of 30th June 2023, given the need to receive a formal statement from the three Health and Wellbeing Boards and the timing of their meetings, that the final plan will be formally approved at the LLR Integrated Care Board meeting in July 2023.

Appendices:	
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 in the context of this paper
b) Does the report highlight any resource and financial implications? If so, provide which page / paragraph this can be found within the report.	Not in the context of this paper
c) Does the report highlight quality and patient safety implications? If so, provide which page / paragraph this is outlined in within the report.	Not in the context of this paper
d) Does the report demonstrate patient and public involvement? If so, provide which page / paragraph this is outlined in within the report.	The draft communications and engagement plan is appended for information.
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 at this stage. However, an overarching equality impact and risk assessment will be undertaken as the plan is further developed.



Name of meeting:	**Leicester, Leicestershire and Rutland ICB Board meeting**		
Date:	13 April 2023	**Paper:**	**F**
Report title:	**ICB Risk Management update and Board Assurance Framework 2022/23 and 2023/24**		
Presented by:	Caroline Gregory, Chief Finance Officer		
Report author:	Daljit K. Bains, Head of Corporate Governance		
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 Board is requested to:

- **RECEIVE the report.**
- **APPROVE** the closing position of the ICB Board Assurance Framework 2022/23 (as at Appendix 1).
- **APPROVE** the new ICB Board Assurance Framework 2023/24 (as at Appendix 2) which incorporates some of the existing risks from 2022/23 and others have been closed and / or replaced.

Purpose and summary of the report:

This report aims to provide an overview and assurance of the risk management arrangements in place across the ICB currently and outlines how these arrangements have development and evolved to ensure they continue to be fit for purpose. The risk profile of the ICB continues to change and therefore the Board Assurance Framework (BAF) remains a live document and it will continue to evolve. This report to the Board captures a snapshot of the risk profile of the ICB at a point in time.

The report covers the followings areas:

- National context
- An update on the actions following the Board development sessions in January 2023 and March 2023.
- LLR ICB Risk Management arrangements
- LLR ICB BAF 2022/23 end of year position and how the risks map over to the 2023/24 version.
- Proposed LLR ICB BAF strategic objectives and risks for 2023/24.

Appendices:	• Appendix 1 – LLR ICB BAF 2022/23 • Appendix 2 – LLR ICB BAF 2023/24
Report history (date and committee / group the content has been discussed / reviewed prior to presenting to this meeting):	• October 2022 – Executive Management Team (EMT) and Operational Delivery Group (ODG) meetings • 18 October 2022 – Audit Committee meeting • 12 December 2022 – Executive Management Team meeting • 21 February 2023 – Audit Committee meeting • 6 March 2023 – EMT considered proposal for ICB BAF 2023/24. • 23 March 2023 – proposal presented for consideration and discussion at the Board development session. • 3 April 2023 – EMT further considered the proposal for ICB BAF 2023/24.

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 governance arrangements.

ICB Risk Management update and
Board Assurance Framework 2022/23 and 2023/24

Introduction

1. This report aims to provide an overview and assurance of the risk management arrangements in place across the ICB and outlines how these arrangements have development and evolved to ensure they continue to be fit for purpose. The risk profile of the ICB continues to change and therefore the Board Assurance Framework (BAF) remains a live document and it will continue to evolve. This report to the Board captures a snapshot of the risk profile of the ICB at a point in time.

2. The report covers the followings areas:

    - National context
    - An update on the actions following the Board development sessions in January and March 2023
    - LLR ICB Risk Management arrangements
    - LLR ICB BAF 2022/23 end of year position and how the risks map over to the 2023/24 version.
    - Proposed LLR ICB BAF strategic objectives and risks for 2023/24

3. The Board approved the Risk Management Strategy and Policy on 1 July 2022 and adopted the Board Assurance Framework containing the strategic risk profile as transferred from the LLR CCGs.

4. The Board has the responsibility to ensure appropriate risk management systems and processes are in place.

5. 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, and therefore will ensure regular review of the BAF in its entirety.

6. The Board will seek assurance from the Audit Committee in relation to the effectiveness of these arrangements as part of the overall internal control arrangements of the ICB.

7. Each of the other Board assurance Committees will have oversight and management of strategic risk(s) within their scope of responsibility.

National context

8. The international standards (*ISO 31000:2009 Risk Management – Principles and Guidelines*) are recognised as good practice for risk management arrangements. The ICB has adopted a risk management strategy and policy which is aligned to ISO 31000:2009 risk management systems and processes.

9. In relation to risk management across the integrated care system (ICS), currently there is no national guidance outlining risk management principles or developing system level risk management arrangements. It is anticipated that NHS England may look to developing principles that could be used, however further information is awaited.

LLR ICB Risk Management arrangements

10. **The LLR ICB Risk Management Strategy and Policy (July 2022)** describes the overarching risk management arrangements for the ICB as a statutory body, the Strategy and Policy are

aligned to the *ISO 31000:2009 Risk Management – Principles and Guidelines* risk standard. The Strategy and Policy covers in detail the risk management principles including the process for risk evaluation, and process for escalation and de-escalation of risk that are used within the ICB in embedding risk management across the organisation and in the development of the reporting tools, including the BAF.

11. An overview of some of the key aspects from the ICB's Risk Management Strategy and Policy are captured below.

12. **"Risk"** is defined as the "effect of uncertainty on objectives" and is often expressed in terms of a combination of an event and the associated likelihood of occurrence. It is the chance / likelihood of something happening which could provide a positive opportunity / consequence or could threaten the achievement of the organisation's strategic objectives. Where a risk has materialised this is defined as an "**issue"** and actioned through existing mechanisms as opposed to through the BAF or a risk register.

13. The ICB uses the following methods to identify risks:

    - **External methods** e.g media, national reports, new legislation, reports from assessments/inspections by external bodies, reviews of partnership working and considering the political, economic, social and technological, legal, environment (PESTLE). This is also known as a ***'top-down'*** approach.

    - **Internal methods** e.g. complaints, claims, serious incident reporting and corporate incident reporting and identification of trends, audits, project/programme risks, staff surveys, risk assessments, whistle-blowing and contract quality monitoring of commissioned services. This is also known as a ***'bottom-up'*** approach.

14. Each strategic and operational risk is has three risk scores assigned to it, the risk score categories are as detailed in Table 1. Each risk score is assessed using the 5 x 5 risk matrix for the impact and likelihood.

Table 1

Risk score and definition	
Inherent risk score:	• the effect of something that might happen before taking account of controls in place to manage or mitigate it. • The higher the score the more attention the risk will require and more likely the Board would seek assurance as to how it is being managed.
Risk appetite score:	• This is the level of exposure to the risk the organisation is willing to accept. • This will be defined in terms of both tolerable impact if a risk is realised, and tolerable frequency of that impact using the 5 x 5 risk matrix. • Not Static. • The lower the risk appetite, the less the ICB is willing to accept in terms of risk and consequently the higher levels of controls that are put in place to manage the risk. • The higher the ICB's appetite for risk, the more the ICB is willing to accept in terms of risk and consequently the ICB will accept business as usual activity for established systems of internal control, and will not necessarily seek to strengthen those controls above all else.
Residual risk score:	• risk score after taking account of the controls in place to reduce the likelihood of it materialising, or to minimise its impact should this happen. • This evaluation of a risk compared with the risk appetite is useful as a guide for prioritising risks and determines the appropriate level of managerial supervision and action.

15. **Reporting and assurance tools -** the ICB currently has **two formal tiers of risk reporting tools** as aligned to the ICB's Risk Management Strategy and Policy, these are: the **Board Assurance Framework (strategic)** and **the risk registers (operational).** Table 2 details the differences between the two tools.

16. The **Board Assurance Framework (BAF)** serves as the key document to assure the Board that risk management is firmly embedded in the organisation. One of the primary purposes of the BAF is to identify gaps in control or assurance in relation to these principal risks. It also provides a structure for the evidence to support the Annual Governance Statement as part of the Annual Reporting requirements. The BAF simplifies Board reporting and the prioritisation of action plans which, in turn, allows for more effective performance management.

Table 2: illustrates difference between the tiers of reporting

	ICB Board Assurance Framework (strategic)	**Directorate / functional / project risk registers (operational)**
Content	Comprises strategic / principal risks defined by the ICB Board and aligned to the ICB's strategic objectives and thus preventing the ICB Board from fulfilling the objectives of the ICB. If these risks were to materialise they could potentially have an impact on the ICB achieving its strategic objectives.	Operational risks are mainly identified at operational level through the organisation from day-to-day activities. Operational risk registers are in place across all directorates / teams / functions and are also developed at project / programme level.
	Risks are organisation wide in their scope and impact.	Risks are usually focused on a directorate, function or cross-directorate / functions.
	Risks typically have a high current risk score (15+) by virtue of their strategic nature, however for a risk to escalate to the BAF this is not the only factor, it must be significant and have the potential to impact strategic objectives.	May have a current risk score of 15+ however may not only affect the operational aspects of the organisation.
	Usually contains no more than ten risks.	May have a number of operational risks.
Responsibilities	Risks are identified, defined and assessed by the Executive Team and / or by the ICB Board (top-down).	Risks are identified, defined and assessed by the Director, directorate, function, project level. The Executive Management Team will maintain oversight of risks escalated to the Executive Team whether they may impact across directorates / functions (bottom-up)
	Decision to include risks in the BAF, remove them, or adjust risk scores, is taken by the Board following recommendation by EMT / Committees.	
Reporting	Reported to the Board in full and discussed (six-monthly at present). Audit Committee to review in its entirety to provide assurance of effective risk management arrangements.	High level risks reported to EMT.
	Board assurance committees to review risks in detail relating to their remit and provide assurance to the Board.	

17. **Escalation and de-escalation** - the current risk escalation and de-escalation process is captured in Table 3 below. Table 3 illustrates how risks may be escalated through to the BAF and risk registers, and from the Board through the different levels.

Table 3: risk escalation and de-escalation aligned to the LLR ICB's Risk Management Strategy and Policy (July 2022)

Tool	Level responsible	Risk score and escalation / de-escalation	… seeks assurance
Board Assurance Framework (strategic)	**LLR ICB Board** - Approve BAF - Risk Management Strategy and policy	• Extreme risks (inherent risk score 15 – 25) that may impact achievement of strategic risks. • Escalation from: EMT or Committees and / or Audit Committee • De-escalation to: EMT, committee or directorate • May also close / archive strategic risks if mitigated or no longer a risk.	• **LLR ICB Board** seeks assurance that strategic risks are effectively managed.
Board Assurance Framework / corporate risks (strategic)	**Executive** - Implementation - Oversight of BAF and operational risks. - Ensure effective systems and processes **[Committees -** ensure oversight of specific risks on the BAF that fall within their remit.**]**	• Manage high risks (inherent risk score 8 – 12) and extreme risks (risk score 15 – 25). • Escalation to: Board via BAF – extreme risks, if residual risk score is ≥ 15, and where residual risk score is higher than risk appetite. • De-escalation from: Board • Escalation from: Directorates to Executive Team (for Committees, the escalation is through the BAF and assurance report from the Committee to the Board). • De-escalation to: from EMT to directorate	• **ICB Audit Committee:** • Seek assurance that effective risk management systems / processes and internal controls are in place. • Provide assurance to Board.
Directorate / team level risks (operational)	**Directorates** - Maintain local risk register - Manage / mitigate operational risks	• Manage low, moderate and high risks (inherent risk score up to 12). • Escalation to: EMT – if residual risk score is ≥ 12 and cannot be managed locally. • De-escalation from: EMT • Escalation from: programmes / project teams • De-escalation to: programmes / project teams	• **EMT:** • Ensure adequate controls are in place. • Oversight and assurance
Programme / Project risks (operational)	**Programme / project team** - Maintain project risk register - Manage / mitigate project risks	• Manage low and moderate risks (inherent risk score up to 12). • Escalation to: Directorate – if inherent risk score is ≥ 12 and cannot be managed locally. • De-escalation from: directorate	• **Directorate:** • Oversight and assurance.

Actions following the Board development sessions

18. The Board agreed a number of high-level actions to be taken forward following the development session on risk management held in January 2023, including consideration of the ICB BAF risks and what constitutes a system level risk, and whether these risks should be captured within a single BAF document or whether another mechanism is to be considered for visibility of provider-level strategic risks.

19. Whilst the *LLR 5 Year Joint Forward Plan* is being compiled and future strategic objectives still being agreed, the Board members considered and supported the proposal that the ICB BAF 2023/24 is refreshed using the core purposes of an integrated care board as the strategic objectives. It was also noted that the proposed strategic risks presented at the development session in March 2023 would be reviewed further by the Executive Management Team ahead of the Board receiving the BAF for approval in April 2023. The actions and comments have been considered and taken forward.

LLR ICB Board Assurance Framework 2022/23

20. The current ICB BAF 2022/23 was transitioned from the LLR CCGs and has been updated regularly, the current version is as at **Appendix 1.** The Board is requested to approve the closing position of the 2022/23 BAF. It is proposed that, where these risks remain applicable to the ICB, the risks be carried forward into 2023/24; a couple of risk descriptions have been amended to accurately reflect the current risk to the ICB; and it is proposed that one of the four risks are closed and replaced with a new risk in 2023/24 which is more broader in its scope reflecting the current risk profile.

21. Table 4 outlines the proposed transition of risks between the BAF 2022/23 and BAF 2023/24.

Table 4: Proposed BAF 2023/24 compared to BAF 2022/23

Risk Ref	BAF 2022/23 Risks (as in Appendix 1)	Exec Lead	Net /residual risk score (Mar 2023)	BAF 2023/24 (proposed risks as in Appendix 2)	
ICB BAF 1	**Risk Description: Emergency Preparedness, Resilience and Response (EPRR) arrangements** There is a lack of systematic and continuous processes in place for EPRR and as a result of the LLR ICB becoming category 1 responder, which means the ICB is less resilient to respond to an emergency and to provide safe patient care. This may result in financial loss and legal consequences if the ICB is unable to comply with national NHS EPRR Core Standards.	**RV**	16	Carried forward and amended to reflect current risk	6. Emergency preparedness, resilience and response (EPRR) – failure to be adequately prepared to respond to major and / or business continuity incidents.
ICB BAF 3	**Risk Description: Financial viability over next 5 years** There is risk that due to a lack of robust information and tested schemes, the financial viability of the local health economy (over the next 5 years) cannot be assured. As a result, this could impact on the ICB's organisational reputation, incur possible financial penalties and result in closer regulatory scrutiny.	**CG**	12	Carried forward and amended to reflect current risk.	4. There is risk that due to a lack of robust information and tested schemes, the financial viability of the local health economy (over the short, medium and long term) cannot be assured. As a result, this could impact on the organisational reputation, incur possible financial penalties and result in closer regulatory scrutiny.
ICB BAF 4	**Risk Description: Cyber Security** There is a risk that due to a significant rise in new and unknown cyber-attacks (locally or nationally) this could make access to IT services unavailable for extended periods of time. This may result in risks to the confidentiality of corporate or patient confidential data, disruption to organisational business continuity and to operational services.	**CG**	12	Carried forward.	7. There is a risk that due to a significant rise in new and unknown cyber-attacks (locally or nationally) this could make access to IT services unavailable for extended periods of time. This may result in risks to the confidentiality of corporate or patient confidential data, disruption to organisational business continuity and to operational services.
ICB BAF 7	**Risk Description:** There is a risk that the demand for general practice appointments continues to exceed availability of appointments. This is due to a variety of factors including increasing demand driven and exacerbated by late acute presentations, increased mental health presentations, tackling the backlog in long term condition / routine face to face appointments and continuing workforce challenges. This may result in the risk of patients being unable to access appointments and seeking alternatives placing pressure on other services.	**RV**	**12**	Closed and replaced	3. There is a high demand for urgent and emergency services which continues to exceed availability of commissioned services due to variety of factors. This could result in the risk of patients being unable to access services and seeking alternatives placing pressure on other services.
	N/A			New	1. The ICB is unable to develop and sustain a culture of

Risk Ref	BAF 2022/23 Risks (as in Appendix 1)	Exec Lead	Net /residual risk score (Mar 2023)	BAF 2023/24 (proposed risks as in Appendix 2)	
					collaboration and partnership working and thus unable to improve outcomes in population health and healthcare.
	N/A			New	2. Health inequalities and outcomes – failure to adequately address health inequalities and improve health equity and outcomes for the population of LLR.
	N/A			New	5. Quality improvement – failure to maintain and improve the quality of services and meet the core standards resulting in potential harm and poor quality outcomes for patients.
	N/A			New	8. Workforce recruitment and retention – the ability to recruit and retain staff may be affected by the pressures and reduction in running costs impacting on enhancing productivity and delivering the ICB's strategic objectives.

Proposed LLR ICB Board Assurance Framework 2023/24

22. The initial list of proposed strategic risks presented to the Board in March 2023 has been refined further in discussion with the Executive Management Team following the Board development sessions. Furthermore, the format has been simplified to enable alignment of the proposed strategic risks to one or more of the strategic objectives. The BAF remains a live document and aims to provide a snapshot at a point in time, therefore the risk profile will continue to evolve.

23. The proposed new **ICB BAF 2023/24 is presented at Appendix 2** and this continues to adhere to the ICB's Risk Management Strategy and Policy.

24. Review of system level risks will be given further consideration during 2023/24, initially it is proposed that the ICB BAF 2023/24 captures whether a risk solely relates to the ICB or whether there are implications for the ICB and other partner organisations within the system using the following principles:
    a. The ICB BAF to capture strategic risks that the ICB can influence and / or control relating specifically to the ICB (i.e. specific to the ICB as a statutory body) and
    b. That the ICB BAF captures strategic risks that the ICB can influence and / or control where they collectively impact the ICB objectives and system objectives (categorise these as "system" risks). An escalation and de-escalation process will need to be articulated to support escalation of system risks, however this will continue to evolve as processes mature and develop.

Recommendations

The LLR ICB Board is asked to:

- **RECEIVE** the report.
- **APPROVE** the closing position of the ICB Board Assurance Framework 2022/23 (as at Appendix 1.
- **APPROVE** the new ICB Board Assurance Framework 2023/24 (as at Appendix 2) which incorporates some of the existing risks from 2022/23 and others have been closed and / or replaced.

Appendix 1

Leicester, Leicestershire and Rutland Integrated Care Board

APPENDIX 1

Board Assurance Framework 2022/23

(Version 8 as at 20 March 2023)

To be read in conjunction with the LLR ICB Risk Management Strategy and Policy

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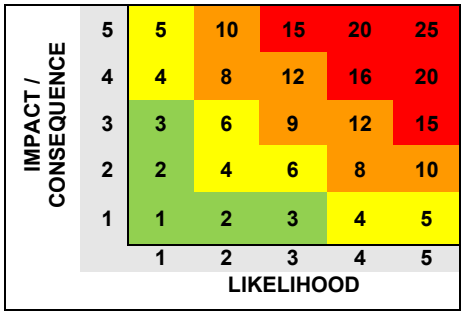
Definitions (as within the Risk Management Strategy and Policy, July 2022)

Areas	Definitions
Assurance	An evaluated opinion, based on evidence gained from review, on the organisation's governance, risk management and internal control framework. The more measurable, verifiable and objectives an assurance is the stronger the declaration and source of evidence it is. The assurance must also be up to date. Effective assurance needs to be at two levels, internal and external
Board Assurance Framework	The Board Assurance Framework provides evidence that the Board has systematically identified its objectives both strategically and operationally, and manages its risks to achieving them. The framework systematically provides a vehicle for the identification of assurances and controls to risks and their effectiveness.
Cause	The reason for the risk to potentially occur.
Consequence	The results should the risk materialise.
Control	A measure put in place to mitigate a risk from occurring i.e. to prevent. Different types of control can be preventative, detective, directive and corrective.
Description	The way of explaining risk to allow consistent understanding across the ICB in a single sentence where possible. Consider the 'x, y, z' approach as described in the Strategy and Policy ('x' could happen, because of 'y', resulting in 'z').
Gaps in controls/ assurances	Where the residual risk does not meet the risk appetite, gaps in the controls and the assurances must be identified in order to reduce the residual risk as close as possible to the risk appetite.
Gross / Inherent Risk	Inherent risk is the effect of something that might happen before taking account of controls in place to manage or mitigate it. The higher the score, the more attention the risk will require and the more likely the Board would seek assurance as to how it was being managed whether directly or via a committee of the Board.
Impact	A measurement of the effect the risk will have if it materialises.
Issue	Issue is something that has happened, as opposed to a risk which is something that could happen.
Likelihood	A measurement of the chance that a risk will materialise.
Mitigation Actions	These are the actions the risk owners take to reduce the risk or where this is not possible limit the impact of the risk.
Net risk	The measurement in terms of likelihood and impact on a risk after controls are considered to mitigate the risk. Also referred to as 'residual risk'.

Areas	Definitions
Objective	The context in which risks are assessed i.e. ICB Aims/Objectives
Operational risks	Operational risks are by-products of the day-to-day running of the ICB and includes a broad spectrum of risks including clinical, fraud, security, financial and legal risks arising from employment law of health and safety.
Owner	Either the owner of the risk (risk owner i.e. Director) or owner of an action (action owner i.e. the completer on the assigned action by the risk owner).
Principal risk	Principal risks are defined as those that threaten the achievement of the ICB's principal objectives.
Register	A tool to capture and report on the risks identified at project / programme level, Directorate level or Corporate level.
Residual Risk	Another term for net risk.
Risk	ISO 31000:2009 defines risk as the "effect of uncertainty on objectives" and states that "risk is often expressed in terms of a combination of the consequences of an event and associated likelihood of occurrence"
Risk Appetite	An expression of the nature and quantum of risk or uncertainty which the organisation is willing to take or accept to achieve its strategic objectives. Risk appetite score may be a different for different objectives and / or different risk categories.
Risk Management	Risk Management is the process by which an organisation identifies risks, assesses their relative importance, determines the appropriate control mechanisms and ensures that the agreed action is taken. Risk management may involve judgement as well as data.
Risk Management Process	The systematic application of management policies, procedures and practices to the tasks of establishing the context, identifying and analysing, evaluating, treating, monitoring and communicating risk.
Risk Matrix	The tool used to as accurately as possible identify the measurement of likelihood and impact of the risk identified.
Risk Tolerance	The threshold level of risk exposure which, when exceeded, will trigger an escalation.
Strategic risks	Strategic risks are those that represent major threats to achieving the ICB's strategic objectives or to its continued existence. Strategic risks will include key operational service failures, for example, failure to meet key targets or provision of poor-quality care would be very damaging to the ICB's reputation.

5 x 5 Risk Assessment Matrix (Risk Management Strategy and Policy)

IMPACT / CONSEQUENCE		LIKELIHOOD	
1	NEGLIGIBLE	1	RARE
2	MINOR	2	UNLIKELY
3	MODERATE	3	POSSIBLE
4	MAJOR	4	LIKELY
5	CATASTROPHIC	5	ALMOST CERTAIN



This will result in risks being rated in one of the following four categories

Risk score	Category
1 – 3	Low risk (green)
4 – 6	Moderate risk (yellow)
8 – 15	High risk (orange)
15 – 25	Extreme risk (red)

Key:
AW = Andy Williams, Chief Executive
CG = Caroline Gregory, Chief Finance Officer
AM = Alice McGee, Chief People Officer
SP = Sarah Prema, Chief Strategy and Planning Officer
CT = Caroline Trevithick, Chief Nursing Officer
RV = Rachna Vyas, Chief Operating Officer
NS = Dr Nil Sanganee, Chief Medical Officer

LLR ICB's Strategic Objectives (as approved by the Board on 1 July 2022)

A. Increase the health outcomes of the Leicester, Leicestershire and Rutland population.
B. Reduce health inequalities across the Leicester, Leicestershire and Rutland population.
C. Reduce the variation in health outcomes across the Leicester, Leicestershire and Rutland population.
D. Deliver a sustainable system financial plan – ensuring funding is distributed to where services are delivered.
E. Deliver NHS Constitutional requirements
F. Develop and deliver services with providers that are evidenced based and offer value for money
G. Deliver integrated health and social care.

Summary of the Board Assurance Framework (BAF) content (as at March 2023)

Risk Ref (strategic objectives)	**Risk theme**	**Exec Lead**	**Net /residual risk score (Dec 2022)**	**Trend**	**Net /residual risk score (March 2023)**	**Page**
ICB BAF 1 ***(previously LLR BAF 07)*** (A,B,C,F)	Emergency Preparedness, Resilience and Response (EPRR) arrangements	**RV**	16	⟺	16	8
ICB BAF 3 ***(previously LLR BAF 13)*** (D,E)	Failure to assure local health economy financial viability over the next 5 years	**CG**	12	⟺	12	11
ICB BAF 4 ***(previously LLR BAF 17)*** (A,B,C,D,E,F,G)	Cyber Security risk - the impact from new and previously unknown cyber threats is potentially significant across all LLR organisations.	**CG**	12	⟺	12	13
ICB BAF 7 **(previously LLR BAF 20)** (A,B,C,E)	There is high demand for GP appointments which continues to exceed availability of appointments due to variety of factors. This could result in the risk of patients being unable to access appointments and seeking alternatives placing pressure on other services.	**RV**	12	⟺	12	16

Risks that have been archived or removed from the LLR ICB BAF as they have materialised

Risk Ref (strategic objectives)	**Risk theme**	**Exec Lead**
ICB BAF 2 *(previously LLR BAF 11)* (A,B,C,E)	LLR ICB will fail to meet core standards in relation to the delivery of the cancer targets. (Removed in November 2022)	**RV**
ICB BAF 5 *(previously LLR BAF 18)* (E)	Ambulance Handover delays **-** concerning ambulance handover delays and cancellation of elective activity. (removed in November 2022)	**RV**
ICB BAF 6 *(previously LLR BAF 19)* (A,B,C,E)	The 104 week wait standard not being met primarily due to Covid-19, increased pressures in the system relating to workforce capacity, sickness absence and theatre capacity across providers resulting in poor patient experience and a potential deterioration in health of patients. (removed in November 2022)	**RV**

Risk Ref: **ICB BAF 1**	**Risk Description: Emergency Preparedness, Resilience and Response (EPRR) arrangements** There is a lack of systematic and continuous processes in place for EPRR and as a result of the LLR ICB becoming category 1 responder, which means the ICB is less resilient to respond to an emergency and to provide safe patient care. This may result in financial loss and legal consequences if the ICB is unable to comply with national NHS EPRR Core Standards.

Section A **A1. Strategic objective the risk is aligned to.**	**A3. Risk to be treated, confirm frequency of review by lead**		**Section B**		**Section C** **Risk rating (impact x likelihood = risk score)**						
Strategic Objectives E	*Monthly*	*Quarterly* ✓	**B1. Executive Lead (risk owner):**	**Rachna Vyas** **Risk Lead:** Rachel Dewar	**C1. Gross/inherent risk score**	**5**	**x**	**4**	**=**	**20**	**R**
A2. Date risk identified.	**A4. Risk Category**		**B2. Date last reviewed**	Dec 2022	**C2. Net/residual risk score**	**4**	**x**	**4**	**=**	**16**	**R**
					C3. Risk appetite score	**4**	**x**	**3**	**=**	**12**	**A**
Carried forward from CCG specific BAFs 2020.	**Clinical**	✓	**B3. Committee/Group with oversight for risk?**	Executive Management Team (EMT)	**C4. Risk Treatment:** *(Terminate, Treat, Transfer, or Tolerate)*	Treat					
	Organisational	✓									
	Financial				**C5. Date current/residual score assessed**	March 2023					
	Information										

Section D: Key Controls

- LLR On Call Pack documents, plans and policies updated including LLR Incident Response Plan.
- Creation of 2 new EPRR Groups – Health Emergency Planning Operational Group (HEPOG) to undertake and oversee actions from the LHRP meetings and a Health EPRR Risk Management Group to assess local health risks and priorities and establish a system risk register for EPRR.
- Testing of emergency planning takes place.
- Assessment against EPRR Core Standards.
- Structure to support the change to becoming Level 1 responder in place.
- Attendance at LHRP Executive continues with senior level staff in attendance at all meetings.

Section E: Rationale for current score

As an ICB the organisation is now cat 1 responders and therefore there is a potential training gap. On-call Director training continues.

The risk score remains the same following review of winter pressures.

	Section F: Current risk score trend

Section G: Internal and/or external assurances *Where can we gain evidence that our controls/systems on which we are placing our reliance are effective?*		
	Internal	**External**
External verification of level of compliance provided by NHS England on annual basis (October 2021) (positive assurance received).		✓
LHRP work plan and meetings with NHS England in place.		✓
ICB Checklist and evidence	✓	✓
Updated showdown ICB plans and policies in place	✓	

Section H: Actions being taken to address gaps in controls and/or assurance					
H1. Gaps in controls and/or assurance *Where are the gaps in our control/systems? Where are we failing to make them effective? Where is the CCG failing to gain evidence that the controls/systems are effective?*	**H2. Details the actions to be taken** *(including brief note on updates/progress where appropriate and confirm when action completed) What actions are required to bridge the gaps in controls and/or assurance?*	**H3. Action to be completed by (date)**	**H4. Will the action reduce impact of risk score or likelihood or both?**		
			Impact	**Likelihood**	**Both**
Table-top exercise yet to be arranged to test the Business Continuity Plans across LLR ICB.	Exercise to be arranged by the EPRR Team along with the Corporate Governance Team.	**February / March 2023**			✓
The regional NHSE/I EPRR Team is awaiting formal notification from the national team with regards to a refresh of the Civil Contingencies Act and whether the LLR CCGs will formally be upgraded to Cat 1 responders. We have now received the formal letter and ICB Readiness for EPRR checklist from the regional NHSEI EPRR Team. This states that ICBs will become Category 1 responder under Civil Contingencies Act 2004. The letter sets out the requirements for ICBs in fulfilling their legal duties from 1 July 2022.	Part B focuses on longer-term steps for delivery between October-December 2022, these are on track however currently will be RAG rated Amber as several actions are required from NHSEI before the ICB can put in place final plans and actions.	October 2022			✓

Risk Ref: **ICB BAF 3**	**Risk Description: Financial viability over next 5 years** There is risk that due to a lack of robust information and tested schemes, the financial viability of the local health economy (over the next 5 years) cannot be assured. As a result, this could impact on the ICB's organisational reputation, incur possible financial penalties and result in closer regulatory scrutiny.

Section A **A1. Strategic objective the risk is aligned to.**	**A3. Risk to be treated, confirm frequency of review by lead**		**Section B**		**Section C** **Risk rating (impact x likelihood = risk score)**						
Strategic Objectives D, E	*Monthly* ✓	*Quarterly*	**B1. Executive Lead (risk owner):**	**Caroline Gregory** **Risk Lead:** Spencer Gay, Gill Killbery	**C1. Gross/inherent risk score**	**5**	**x**	**4**	**=**	**20**	**R**
A2. Date risk identified.	**A4. Risk Category**		**B2. Date last reviewed**	December 2022	**C2. Net/residual risk score**	**4**	**x**	**3**	**=**	**12**	**A**
					C3. Risk appetite score	**4**	**x**	**2**	**=**	**8**	**A**
Carried forward from CCG specific BAFs 2020.	**Clinical**		**B3. Committee/Group with oversight for risk?**	LLR ICB Finance Committee	**C4. Risk Treatment:** *(Terminate, Treat, Transfer, or Tolerate)*	Treat					
	Organisational	✓			**C4. Date current/residual score assessed**	February 2023					
	Financial	✓									
	Information										

Section D: Key Controls	**Section E: Rationale for current score**
• Monthly triangulation meetings take place between contract teams. • System Financial Strategy Produced for 2021/22 – 2023/24 • System Finance Team monitor the system position and provide monthly reports to LLR ICB Finance Committee. This includes review of the LLR ICB's financial plans to ensure consistency. • Design Groups continually working with PMO to construct transformation plans which will support financial improvement	The biggest challenge to delivery and reducing this risk further will be the level of cost efficiencies built in over the time-period. The LLR ICB will need to start delivering significant savings and continue throughout the period. Current focus on the management of high levels of emergency activity and elective backlog are potentially impacting on the underlying position moving forward, while also delaying transformational projects. This is increasing the risk to the achievement of system breakeven and therefore the risk scores remained unchanged
	Section F: Current risk score trend

Section G: Internal and/or external assurances *Where can we gain evidence that our controls/systems on which we are placing our reliance are effective?*		
	Internal	**External**
External Financial performance reports are reviewed monthly as part of Board Reports		✓
Internal and External Auditor reports and findings are in place (integrity of the General Ledger and Financial Systems Report 2020/21 provided significant assurance).		✓
System operational group, NHS Strategic Executive, ICB Finance Committee and CFOs – overview of financial position and emerging plans	✓	

Section H: Actions being taken to address gaps in controls and/or assurance					
H1. Gaps in controls and/or assurance *Where are the gaps in our control/systems? Where are we failing to make them effective? Where is the CCG failing to gain evidence that the controls/systems are effective?*	**H2. Details the actions to be taken** *(including brief note on updates/progress where appropriate and confirm when action completed) What actions are required to bridge the gaps in controls and/or assurance?*	**H3. Action to be completed by (date)**	**H4. Will the action reduce impact of risk score or likelihood or both?**		
			Impact	**Likelihood**	**Both**
Review of medium-term plan.	Position against medium term plan will be reviewed once 2022/23 plan is finalised. Initial draft medium-term plan reviewed by the Board in December 2022. **ACTION COMPLETE**	~~**June 2022**~~ **Oct 2022**			✓

Risk Ref: **ICB BAF 4**	**Risk Description: Cyber Security** There is a risk that due to a significant rise in new and unknown cyber-attacks (locally or nationally) this could make access to IT services unavailable for extended periods of time. This may result in risks to the confidentiality of corporate or patient confidential data, disruption to organisational business continuity and to operational services.

Section A **A1. Strategic objective the risk is aligned to.**	**A3. Risk to be treated, confirm frequency of review by lead**		**Section B**		**Section C** **Risk rating (impact x likelihood = risk score)**						
Strategic Objectives A,B,C,D,E,F,G	*Monthly* ✓	*Quarterly*	**B1. Executive Lead (risk owner):**	**Caroline Gregory (as SIRO)** **Risk Lead:** Chris Biddle (LHIS)	**C1. Gross/inherent risk score**	**4**	**x**	**4**	**=**	**20**	**R**
A2. Date risk identified.	**A4. Risk Category**		**B2. Date last reviewed**	December 2022	**C2. Net/residual risk score**	**3**	**x**	**4**	**=**	**12**	**A**
					C3. Risk appetite score	**2**	**x**	**4**	**=**	**8**	**A**
October 2020	**Clinical**		**B3. Committee/Group with oversight for risk?**	Executive Management Team (EMT)	**C4. Risk Treatment:** *(Terminate, Treat, Transfer, or Tolerate)*	Treat					
	Organisational	✓									
	Financial	✓			**C5. Date current/residual score assessed**	February 2023					
	Information	✓									

Section D: Key Controls

- Network boundary protection (firewalls) using multi-tiered approach.
- Internal counter measures such as Advanced Threat Protection (ATP), Sophos Anti-Virus, Intercept-X anti-ransomware, 'honeypot' alerting system, etc.
- Change controls and policy/procedure framework for operation of security platforms.
- Alerting and intrusion detection systems in place.
- Routine and cyclical technical security testing of network boundaries.
- Independent assessment of security posture (e.g. Bitsight = top 10% of healthcare organisations).
- Assurances through cyber security governance frameworks (e.g. ISO27001, Data Security Protection Toolkit, SPT, etc).
- Established and tested incident response procedures
- Continuity and disaster recovery plans in place.
- Monitoring of security alerts and information published through credible routes (e.g. NHSDigital CareCERT, SANS).

Section E: Rationale for current score

- The risk continues to be monitored to reflect the pandemic response and an increased reliance on remote working technologies.
- A major national NHS systems outage in January 2021 highlighted the need for robust and tested local continuity plans to provide assurance that clinical services can continue to operate, especially in 'out of hours' scenarios.
- Geopolitical situation in Ukraine has heightened the threat profile of attack on UK's IT infrastructure. Although it is unlikely that healthcare will be directly targeted, adverse events affecting national infrastructure could have a collateral effect on NHS national systems.
- An established process is in operation for addressing and remediating vulnerability alerts from NHS Digital. No outstanding issues are present and feedback reporting through the NHS Digital portal provides assurance that all notified alerts have been considered.
- Recent cyber security attacks on NHS service providers highlights collateral impact on service provision.

As a result of the above the risk scoring remains unchanged however there is continuous monitoring of this risk.

• LHIS has subscribed to the Police Cyber Alarm platform which provides alerts to potentially malicious activity on our network boundary. • LHIS continues to conduct security testing of various estate-wide services. • Moved to NHS Mail • Subscribed to the NCSC Early Warning System which adds an additional layer of monitoring to our external network boundary. • Active directory audit being planned • Ransomware simulation being planned • NCSC desktop simulations underway	There are no updates to provide for this month as the risk is continued to be managed and actions continue to progress.
	Section F: Current risk score trend

Section G: Internal and/or external assurances

Where can we gain evidence that our controls/systems on which we are placing our reliance are effective?

	Internal	External
Routine technical security testing	✓	
External evaluation of security posture (e.g. Bitsight)		✓
Audit reviews of security and governance frameworks (e.g. ISO27001, DSPT) (Internal Audit Review on DSPT 2020/21 provided significant assurance).		✓
Incident response to threats/attacks (i.e. was the attack successful) (assurance provided indicates controls are effective).	✓	
External security testing of LLR networks		✓
LHIS has attained a Tiger scheme penetration testing accreditation (positive assurance).	✓	✓

Section H: Actions being taken to address gaps in controls and/or assurance

H1. Gaps in controls and/or assurance *Where are the gaps in our control/systems? Where are we failing to make them effective? Where is the CCG failing to gain evidence that the controls/systems are effective?*	**H2. Details the actions to be taken** *(including brief note on updates/progress where appropriate and confirm when action completed) What actions are required to bridge the gaps in controls and/or assurance?*	**H3. Action to be completed by (date)**	**H4. Will the action reduce impact of risk score or likelihood or both?**		
			Impact	**Likelihood**	**Both**
Efficacy of local continuity plans for service provision in the event of a successful cyber-attack, preventing access to IT systems (including VPN) for an extended period (e.g., days).	Acquire assurance, through testing, that local service continuity plans are established and are operating as expected (i.e., service provision is not affected by outage). **Action complete**	**End January 2022**			✓
Ability of LHIS to respond effectively to 'zero-day' and new threats that have not been previously identified.	Test incident response and disaster recovery procedures. This work has started but further work is being planned during Q2. Output to be reported.	**September 2023**			✓

New technical vulnerabilities and risks are identified without adequate remediation plans.	Additional external technical security testing has been commissioned which includes external attack surface review, ransomware simulation, registration with NCSC Web Check and Active Directory review.	**March 2023**			✓
Geopolitical situation in eastern Europe - The current conflict in Ukraine has heightened the likelihood of attack by Russian state actors. Although it is unlikely that UK healthcare will be specifically targeted, there is a significantly increased likelihood of attack on UK government infrastructure which could have a collateral impact on the NHS, specifically in relation to nationally hosted services	Additional controls have been deployed to strengthen our local security posture. Increased frequency of external security testing Reduction in timescales for inactive user accounts Backup/restore testing conducted Additional 'honeypot' platforms deployed Geo-blocking under review.	~~**September 2022**~~ **March 2023**			✓

Risk Ref: **ICB BAF 7**	**Risk Description:** There is a risk that the demand for general practice appointments continues to exceed availability of appointments. This is due to a variety of factors including increasing demand driven and exacerbated by late acute presentations, increased mental health presentations, tackling the backlog in long term condition / routine face to face appointments and continuing workforce challenges. This may result in the risk of patients being unable to access appointments and seeking alternatives placing pressure on other services.

Section A **A1. Strategic objective the risk is aligned to.**	**A3. Risk to be treated, confirm frequency of review by lead**		**Section B**		**Section C** **Risk rating (impact x likelihood = risk score)**						
Strategic Objectives A, B, C, D, F & G	*Monthly* ✓	*Quarterly*	**B1. Executive Lead (risk owner):**	**Rachna Vyas** **Risk Leads:** Yasmin Sidyot	**C1. Gross/inherent risk score**	**4**	**x**	**5**	**=**	**20**	**R**
A2. Date risk identified.	**A4. Risk Category**		**B2. Date last reviewed**	December 2022	**C2. Net/residual risk score**	**4**	**X**	**3**	**=**	**12**	**A**
					C3. Risk appetite score	**3**	**X**	**3**	**=**	**9**	**A**
April 2022	**Clinical**	✓	**B3. Committee/Group with oversight for risk?**	Primary Care Transformation Board	**C4. Risk Treatment:** *(Terminate, Treat, Transfer, or Tolerate)*	Treat					
	Organisational	✓			**C5. Date current/residual score assessed**	January 2023					
	Financial										
	Information										

Section D: Key Controls

- Benchmark of 75:1000 appointments set for all LLR practices
- Trajectory to return to 2019 levels of activity month on month
- Implementation of enhanced access from 1st October 2022
- Monthly review at Primary Care Transformation Board
- Monthly metrics discussed at Acute Care Collaborative
- Fortnightly review at PC/UEC Access Programme meetings
- Triangulation with the RCGP, OPEL and Accelerated Access Improvement Programme initiatives
- Quality Dashboard
- Additional workforce via ARRS to support service delivery

Section E: Rationale for current score

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General Practice continues to experience significant challenges owing to increasing demand driven by a range of factors including and exacerbated by late acute presentations, increased mental health presentations, tackling the backlog in long term condition / routine face to face appointments and continuing workforce challenges.

Demand continues to exceed capacity, compounded by the desire to be seen by GPs rather than accepting signposting to lower acuity services such as community pharmacies.

Risk is sustained as the number of practices needing support is not diminishing and we are seeing an increasing number of general practices on the risk log with significant and serious patient safety and quality issues.

Enhanced Access plans have been received from all 26 PCNs and are due to go live from the 1st October 2022.

	Section F: Current risk score trend

Section G: Internal and/or external assurances

Where can we gain evidence that our controls/systems on which we are placing our reliance are effective?

	Internal	External
Daily escalation calls	✓	✓
Fortnightly PC/UEC Access Programme meetings	✓	✓
Fortnightly Acute Care Collaborative	✓	✓
Monthly Primary Care Transformation Board	✓	✓

Section H: Actions being taken to address gaps in controls and/or assurance

H1. Gaps in controls and/or assurance *Where are the gaps in our control/systems? Where are we failing to make them effective? Where is the CCG failing to gain evidence that the controls/systems are effective?*	H2. Details the actions to be taken *(including brief note on updates/progress where appropriate and confirm when action completed) What actions are required to bridge the gaps in controls and/or assurance?*	H3. Action to be completed by (date)	H4. Will the action reduce impact of risk score or likelihood or both?		
			Impact	Likelihood	Both
Ability to articulate the variety in service delivery across the 134 GP practices We have an operational plan that will be overseen via Primary Care Transformation Board	Primary Care Transformation Board Dashboard which will articulate a range of performance metrics, reportable by GP practice, PCN or Place	Phased from June 2022 onwards.	✓		

Appendix 2

APPENDIX 2

Leicester, Leicestershire and Rutland Integrated Care Board

Board Assurance Framework 2023/24

(Version 1 as at 3 April 2023)

To be read in conjunction with the LLR ICB Risk Management Strategy and Policy

CONTENTS **PAGE**

Strategic Objectives

Summary of the Board Assurance Framework

Detailed version of the Board Assurance Framework

Definitions and risk matrix

LLR ICB Strategic Objectives

LLR ICB Strategic Objective (Note: 1 – 4 are the national core purposes of an ICB)
1. Improve outcomes in population health and healthcare
2. Tackle inequalities in outcomes, experience and access
3. Enhance productivity and value for money
4. Help the NHS support broader social and economic development
5. Deliver NHS Constitutional and legal requirements

Summary of the strategic risks contained within the LLR ICB Board Assurance Framework

Strategic risk	Exec Lead	Committee oversight	Risk aligned to the LLR ICB Strategic Objective(s)					Page
			1.	2.	3.	4.	5.	
1. The ICB is unable to develop and sustain a culture of collaboration and partnership working and thus unable to improve outcomes in population health and healthcare.	**AW**	System Executive Committee / EMT	✓	✓	✓	✓	✓	
2. Health inequalities and outcomes – failure to adequately address health inequalities and improve health equity and outcomes for the population of LLR.	**SP**	Health Equity Committee	✓	✓		✓	✓	
3. There is a high demand for urgent and emergency services which continues to exceed availability of commissioned services due to variety of factors. This could result in the risk of patients being unable to access services and seeking alternatives placing pressure on other services.	**RV**	System Executive Committee		✓			✓	
4. There is risk that due to a lack of robust information and tested schemes, the financial viability of the local health economy (over the short, medium and long term) cannot be assured. As a result, this could impact on the organisational reputation, incur possible financial penalties and result in closer regulatory scrutiny.	**CG**	Finance Committee			✓	✓	✓	
5. Quality improvement – failure to maintain and improve the quality of services and meet the core standards resulting in potential harm and poor quality outcomes for patients.	**CT / NS**	Quality and Safety Committee	✓	✓			✓	
6. Emergency preparedness, resilience and response (EPRR) – failure to be adequately prepared to respond to major and / or business continuity incidents.	**RV**	System Executive Committee / EMT	✓	✓			✓	
7. There is a risk that due to a significant rise in new and unknown cyber-attacks (locally or nationally) this could make access to IT services unavailable for extended periods of time. This may result in risks to the confidentiality of corporate or patient confidential data, disruption to organisational business continuity and to operational services.	**CG**	Executive Management Team	✓				✓	
8. Workforce recruitment and retention – the ability to recruit and retain staff may be affected by the pressures and reduction in running costs impacting on enhancing productivity and delivering the ICB's strategic objectives.	**AMcG**	Remuneration Committee / People Board	✓	✓			✓	

Principal / strategic risk:
1.The ICB is unable to improve outcomes in population health and healthcare as it is unable to develop and sustain a culture of collaboration and partnership working.

Date risk identified	ICB Executive lead (risk owner)	ICB Committee oversight	Risk category (✓ applicable category(ies))		ICB only or system risk (✓ one)		Risk rating (impact x likelihood = risk score)						Risk treatment *(i.e. state whether to terminate, treat, transfer, or tolerate the risk)*	If to be treated confirm frequency of review (e.g. monthly, quarterly)
					ICB	System								
March 2023	**Andy Williams**	EMT / System Executive Committee	Clinical		✓		**Gross/inherent risk score**	4	x	3	=	**12**	Treat	**Quarterly**
			Organisational	✓			**Risk appetite score**	4	x	2	=	**8**		
			Financial				**Net/residual/ current risk score**	4	x	3	=	**12**		
			Information				**Residual / current risk score trend since last report:**						⟷	
							Next review date:						July 2023	

Key controls in place and rationale for current / residual risk score	Internal and / or external assurances *Where can we gain evidence that our controls/systems on which we are placing our reliance are effective?*		Gaps in controls and/or assurance *Where are the gaps in our control/systems? Where are we failing to make them effective? Where is the ICB failing to gain evidence that the controls/systems are effective?*
	internal	**external**	
• ICB works with partners (i.e. LAs and NHS) to identify priority areas for joint working, development of joint strategies and plans, reviews progress and resources, risks, issues and mitigations. • Committees and forums in place include ICB Board, System Executive Committee, LLR Health and Wellbeing Partnership, Quality and Safety Committee, Health Equity Committee, and Finance Committee. • Attendance at and joint working with other partnership forums including: Health and Wellbeing Boards across all three places, District councils' Health Leaders meetings, Integrated Systems of Care (ISOC) meeting (Leicester), Joint Integrated Commissioning Board (Leicester) Staying Healthy Partnership meetings (Leics.) Community Safety Partnership meetings, ICB-VCS Alliance regular meetings, regular meetings with Healthwatch across all three places, Collaborative meetings, Patient Participation Forum meetings, LLR Research Strategy Board.	• Outcomes and progress following these meetings are reported through the ICB Board and respective ICB Committee. • Staff survey results • 360-degree evaluations of system, ICB, system maturity matrices • Complaints/disputes	• NHSE Quarterly System Review meetings • NHSE Regional Coordination Centre Daily calls • NHSE feedback on submissions such as Annual Operational plans, Joint Forward Plan, Integrated Care Plan, Better Care Fund Plans, Fuller Stocktake updates.	• There is room for more formal soliciting of partner evaluations of the state of our relationships and culture.

Actions being taken to address gaps in controls and/or assurance					
Detail the actions to be taken *(including brief note on updates/progress where appropriate and confirm when action completed)* *What actions are required to bridge the gaps in controls and/or assurance?*	**Action to be completed by (date)**	**Will the action reduce impact of risk score or likelihood or both?**			**Progress on action(s) as at ……**
		Impact	Likelihood	Impact and likelihood	
a) Look for formal tool to measure partners' assessment of Trust/collaboration to provide structured feedback to ICB on their perception of our performance. If a suitable one can be identified – request system partners to complete and evaluate response.	30 August 2023			✓	

Principal / strategic risk:
2. Health inequalities and outcomes – failure to adequately address health inequalities and improve health equity and outcomes for the population of LLR.

Date risk identified	ICB Executive lead (risk owner)	ICB Committee oversight	Risk category (✓ applicable category(ies))		ICB only or system risk (✓ one)		Risk rating (impact x likelihood = risk score)						Risk treatment *(i.e. state whether to terminate, treat, transfer, or tolerate the risk)*	If to be treated confirm frequency of review (e.g. monthly, quarterly)
					ICB	System								
20 March 2023	**Sarah Prema**	**EMT / System Executive Committee**	Clinical	✓		✓	**Gross/inherent risk score**	5	x	5	=	**25**	Treat	Monthly
			Organisational	✓			**Risk appetite score**	5	x	3	=	**15**		
			Financial	✓			**Net/residual/ current risk score**	5	x	4	=	**20**		
			Information				**Residual / current risk score trend since last report:**						⟷	
							Next risk review date:						May 2023	

Key controls in place and rationale for current / residual risk score	Internal and / or external assurances *Where can we gain evidence that our controls/systems on which we are placing our reliance are effective?*		Gaps in controls and/or assurance *Where are the gaps in our control/systems? Where are we failing to make them effective? Where is the ICB failing to gain evidence that the controls/systems are effective?*
	internal	**external**	
• Senior Leaders in Health Equity (including an Executive and Non-Executive ICB lead) have been appointed in each NHS organisation. • ICB Health Equity Committee in place and provides assurance to the Board regarding the effectiveness of programmes of improvement to reduce health inequity. • A Health Inequalities Framework has been developed. A delivery plan has been agreed. • System-wide training for aspirant clinical and managerial health inequality leaders is under way (35 people in Cohort 1which started in March 2023). • LLR Health Inequalities Support Unit (LLR HISU) has been established with dedicated analytical resource for the next 15 months. Workplan and strategic focus set by a Steering Group. Purpose is to support the Design Groups in undertaking intelligence-led improvement projects to reduce health inequity. • An innovative new model of primary care funding has been developed which has improving health equity as a core purpose. • The ICB is participating in Wave 2 of the NHSE Core20 Connectors programme – working with three VCS partners across Leicester and Leicestershire 2022-24 on cancer, respiratory and cardiovascular disease. • ICB has invested £1.6M in a three-year Health inequalities Improvement programme with public Health in Leicester 2022-25. • ICB has invested £1.1M (2022-24) in a fuel poverty and health programme in Leicester.	• Assurance reports from Health Equity Committee to the ICB Board. • Metrics on clinical performance in ICB Performance dashboard/ ICB Health Inequalities Dashboard. • LeDeR reviews. • Complaints/complements from patients and families • "Reducing Health Inequalities In Neighbourhoods" DES – activity reports. • LLR Workforce and Public Sector Equality Duty reports to the ICB Board.	• Feedback from NHSE at QSRMs and to HI Operational plan & HI Stocktake submissions. • Inequality data from the Elective waiting list. • LLR Maternity Services reports. • Joint Strategic Needs Assessments from Public Health - especially for PLUS groups	• Quality and completeness of ethnicity coding in primary care is still relatively poor. This must be addressed as a fundamental platform for equity improvement. • (Dependent on necessary improvements in ethnicity coding over time) More regularly analyse access, experience of care and outcomes data by ethnicity and postcode to identify health equity improvement opportunities.

• Maternity Equity Plan submitted to NHSE September 2022 – Delivery Group meets monthly to oversee action on plan.			

Actions being taken to address gaps in controls and/or assurance					
Detail the actions to be taken *(including brief note on updates/progress where appropriate and confirm when action completed)* *What actions are required to bridge the gaps in controls and/or assurance?*	**Action to be completed by (date)**	**Will the action reduce impact of risk score or likelihood or both?**			**Progress on action(s) as at ……**
		Impact	Likelihood	Impact and likelihood	
Undertake a review of the quality of ethnicity coding in primary care and develop an improvement plan	28 September 2023			✓	
Undertake more frequent profiling of access, experience, and outcomes data by Ethnicity and postcode to support Health equity initiatives across all clinical specialties	Ongoing			✓	
Develop the information governance and data processing framework to enable a more household- orientated approach to population health management.	March 2024			✓	

Principal / strategic risk:
3. There is a high demand for urgent and emergency services which continues to exceed availability of commissioned services due to variety of factors. This could result in the risk of patients being unable to access services and seeking alternatives placing pressure on other services.

Date risk identified	ICB Executive lead (risk owner)	ICB Committee oversight	Risk category (✓ applicable category(ies))		ICB only or system risk (✓ one)		Risk rating (impact x likelihood = risk score)					Risk treatment *(i.e. state whether to terminate, treat, transfer, or tolerate the risk)*	If to be treated confirm frequency of review (e.g. monthly, quarterly)
					ICB	System							
March 2023	Rachna Vyas (Chief Operating Officer)	System Executive (operational oversight: Primary Care Transformation Board)	Clinical	✓	✓		**Gross/inherent risk score**	4	x	5	= **20**	Treat	Quarterly
			Organisational	✓			**Risk appetite score**	3	x	3	= **9**		
			Financial	✓			**Net/residual/ current risk score**	4	x	3	= **12**		
			Information				**Residual / current risk score trend since last report:**					⟷	
							Next risk review date:					March 2023	

Key controls in place and rationale for current / residual risk score	Internal and / or external assurances *Where can we gain evidence that our controls/systems on which we are placing our reliance are effective?*		Gaps in controls and/or assurance *Where are the gaps in our control/systems? Where are we failing to make them effective? Where is the ICB failing to gain evidence that the controls/systems are effective?*
	internal	**external**	
Operational performance monitoring and review of metrics through various groups and Committees including the System Executive Committee, Clinical Executive Group, Strategic Commissioning Group, Winter Board, Quality and Safety Committee, People Board.	Assurance reports and mitigations plans reported to the ICB Board and relevant Committee.	NHS England Quarterly System Review meetings.	Development of a primary care transformation dashboard detailing a range of performance indicators.
Triangulation with the RCGP, OPEL and Accelerated Access Improvement Programme initiatives.	Daily escalation calls.		

Actions being taken to address gaps in controls and/or assurance					
Detail the actions to be taken *(including brief note on updates/progress where appropriate and confirm when action completed)* *What actions are required to bridge the gaps in controls and/or assurance?*	**Action to be completed by (date)**	**Will the action reduce impact of risk score or likelihood or both?**			**Progress on action(s)**
		Impact	Likelihood	Impact and likelihood	
Development of a primary care transformation dashboard detailing a range of performance indicators.	**June / July 2023**			✓	Work underway. (lead updating this risk currently).

Principal / strategic risk:

4. There is risk that due to a lack of robust information and tested schemes, the financial viability of the local health economy (over the short, medium and long term) cannot be assured. As a result, this could impact on the organisational reputation, incur possible financial penalties and result in closer regulatory scrutiny.

Date risk identified	ICB Executive lead (risk owner)	ICB Committee oversight	Risk category (✓ applicable category(ies))		ICB only or system risk (✓ one)		Risk rating (impact x likelihood = risk score)					Risk treatment *(i.e. state whether to terminate, treat, transfer, or tolerate the risk)*	If to be treated confirm frequency of review (e.g. monthly, quarterly)
					ICB	System							
Carried forward from 2022/23	**Caroline Gregory**	Finance Committee	Clinical			✓	**Gross/inherent risk score**	5	x	4	= **20**	Treat	**monthly**
			Organisational	✓			**Risk appetite score**	4	x	2	= **8**		
			Financial	✓			**Net/residual/ current risk score**	4	x	3	= **12**		
			Information				**Residual / current risk score trend since last report:**					⟷	
							Net risk review date:					May 2023	

Key controls in place and rationale for current / residual risk score	Internal and / or external assurances *Where can we gain evidence that our controls/systems on which we are placing our reliance are effective?*		Gaps in controls and/or assurance *Where are the gaps in our control/systems? Where are we failing to make them effective? Where is the ICB failing to gain evidence that the controls/systems are effective?*
	internal	**external**	
System Financial Strategy Produced for 2021/22 – 2023/24 and ICB Financial Plan aligned to the Operational Plan. Capital Plan in place.	Financial performance reports are reviewed monthly as part of Board Reports.	Internal and External Auditor reports and findings are in progress (integrity of the General Ledger and Financial Systems Report 2022/23).	Operational Plan, including the Capital Plan to be approved by the ICB Board.
System Finance Team monitor the system position and provide monthly reports to LLR ICB Finance Committee. This includes review of the LLR ICB's financial plans to ensure consistency.			Cost improvement plans to be established.
Internal and External Auditors conduct annual audits on financial systems to provide assurance that internal controls are effective.		Internal and external auditor reports and opinion.	Year end governance processes for 2022/23 underway (i.e. Annual Report and Accounts).

Actions being taken to address gaps in controls and/or assurance					
Detail the actions to be taken *(including brief note on updates/progress where appropriate and confirm when action completed)* *What actions are required to bridge the gaps in controls and/or assurance?*	**Action to be completed by (date)**	**Will the action reduce impact of risk score or likelihood or both?**			**Progress on action(s) as at April 2023**
		Impact	Likelihood	Impact and likelihood	
Operational Plan to be approved by the ICB Board.	**April 2023**	✓			On the Board agenda for April 2023 for approval.
Accounts to be produced for 2022/23 and to receive unqualified audit opinion and satisfactory value for money report.	**May 2023**			✓	Work underway to support end of year Annual Report and Accounts corporate and financial governance processes.
Three year capital plan to be updated to reflect 2023/24 planning guidance.	**April 2023**		✓		On the Board agenda for April 2023 for approval.
Cost Improvement Plans to be established with credible schemes to enable financial targets for 2023/24 to be achieved	**April 2023**		✓		Work underway.

Principal / strategic risk:
5. Quality improvement – failure to maintain and improve the quality of services and meet the core standards resulting in potential harm and poor quality outcomes for patients.

Date risk identified	ICB Executive lead (risk owner)	ICB Committee oversight	Risk category (✓ applicable category(ies))		ICB only or system risk (✓ one)		Risk rating (impact x likelihood = risk score)						Risk treatment *(i.e. state whether to terminate, treat, transfer, or tolerate the risk)*	If to be treated confirm frequency of review (e.g. monthly, quarterly)
					ICB	System								
March 2023	**Caroline Trevithick / Dr Nil Sanganee**	Quality and Safety Committee	Clinical	✓		✓	**Gross/inherent risk score**	4	x	5	=	**20**	Treat	Monthly
			Organisational	✓			**Risk appetite score**	4	x	3	=	**12**		
			Financial				**Net/residual/ current risk score**	4	x	4	=	**16**		
			Information				**Residual / current risk score trend since last report:**						⟷	
							Next risk review date:						May 2023	

Key controls in place and rationale for current / residual risk score	Internal and / or external assurances *Where can we gain evidence that our controls/systems on which we are placing our reliance are effective?*		Gaps in controls and/or assurance *Where are the gaps in our control/systems? Where are we failing to make them effective? Where is the ICB failing to gain evidence that the controls/systems are effective?*
	internal	**external**	
Monthly performance monitoring reports reviewed by the Quality and Safety Committee and the System Executive Committee.	Committee assurance reports presented to the ICB Board.	External scrutiny via NHS England Quality System Review Meetings.	None at present from ICB perspective, note working in partnership with provider organisations.
Winter Board established and reviews pressures across urgent and emergency services through the winter period.	Regular briefings and reports to the ICB Board.	External scrutiny via NHS England.	None at present from ICB perspective, note working in partnership with provider organisations.

Actions being taken to address gaps in controls and/or assurance					
Detail the actions to be taken *(including brief note on updates/progress where appropriate and confirm when action completed)* *What actions are required to bridge the gaps in controls and/or assurance?*	**Action to be completed by (date)**	**Will the action reduce impact of risk score or likelihood or both?**			**Progress on action(s) as at ……**
		Impact	Likelihood	Impact and likelihood	
None at present					

Principal / strategic risk:
6. Emergency preparedness, resilience and response (EPRR) – failure to be adequately prepared to respond to major and / or business continuity incidents.

Date risk identified	ICB Executive lead (risk owner)	ICB Committee oversight	Risk category (✓ applicable category(ies))		ICB only or system risk (✓ one)		Risk rating (impact x likelihood = risk score)						Risk treatment *(i.e. state whether to terminate, treat, transfer, or tolerate the risk)*	If to be treated confirm frequency of review (e.g. monthly, quarterly)
					ICB	System								
July 2022	**Rachna Vyas**	System Executive / EMT	Clinical			✓	**Gross/inherent risk score**	5	x	4	=	**20**	Treat	**Quarterly**
			Organisational	✓			**Risk appetite score**	4	x	3	=	**12**		
			Financial	✓			**Net/residual/ current risk score**	4	x	4	=	**16**		
			Information				**Residual / current risk score trend since last report:**						⟷	
							Next risk review date:						July 2023	

Key controls in place and rationale for current / residual risk score	Internal and / or external assurances *Where can we gain evidence that our controls/systems on which we are placing our reliance are effective?*		Gaps in controls and/or assurance *Where are the gaps in our control/systems? Where are we failing to make them effective? Where is the ICB failing to gain evidence that the controls/systems are effective?*
	internal	**external**	
LLR Incident Response Plan in place and Corporate Business Continuity Plan in place.	• ICB checklist and evidence review.	• Regular meetings with NHS England and LHRP. • NHS England reviews ICB's compliance with EPRR core standards.	Plans to be reviewed to align responsibilities to Level 1 responder.
Health Emergency Planning Operational Group (HEPOG) oversees actions from the LHRP meetings.			
Health EPRR Risk Management Group to assess local health risks and priorities and establish a system risk register for EPRR.			
Testing of emergency planning takes place.			Testing of business continuity plans to be undertaken.
Strategic Control Centre and Incident Command Centre arrangements in place.			

Actions being taken to address gaps in controls and/or assurance					
Detail the actions to be taken *(including brief note on updates/progress where appropriate and confirm when action completed)* *What actions are required to bridge the gaps in controls and/or assurance?*	**Action to be completed by (date)**	**Will the action reduce impact of risk score or likelihood or both?**			**Progress on action(s) as at ……**
		Impact	Likelihood	Impact and likelihood	
1. Table-top exercise yet to be arranged to test the Business Continuity Plans across LLR ICB. (Corporate Governance Team in conjunction with the EPRR team)	End April 2023			✓	• Directorate level risk registers in place across all directorates / functions. • Feedback from NHS England's review of the core standards to inform the review of the Corporate Business Continuity Plan prior to testing the plan. Following which the Corporate Business Continuity Policy and Plan.

Principal / strategic risk:
7. There is a risk that due to a significant rise in new and unknown cyber-attacks (locally or nationally) this could make access to IT services unavailable for extended periods of time. This may result in risks to the confidentiality of corporate or patient confidential data, disruption to organisational business continuity and to operational services.

Date risk identified	ICB Executive lead (risk owner)	ICB Committee oversight	Risk category (✓ applicable category(ies))		ICB only or system risk (✓ one)		Risk rating (impact x likelihood = risk score)						Risk treatment *(i.e. state whether to terminate, treat, transfer, or tolerate the risk)*	If to be treated confirm frequency of review (e.g. monthly, quarterly)
					ICB	System								
Carried forward from 2022/23	**Caroline Gregory (as SIRO)**	Executive Management Team	Clinical		✓		**Gross/inherent risk score**	4	x	4	=	**16**	Treat	**Quarterly**
			Organisational	✓			**Risk appetite score**	2	x	4	=	**8**		
			Financial	✓			**Net/residual/ current risk score**	3	x	4	=	**12**		
			Information				**Residual / current risk score trend since last report:**						⟷	
							Next risk review date:						July 2023	

Key controls in place and rationale for current / residual risk score	Internal and / or external assurances *Where can we gain evidence that our controls/systems on which we are placing our reliance are effective?*		Gaps in controls and/or assurance *Where are the gaps in our control/systems? Where are we failing to make them effective? Where is the ICB failing to gain evidence that the controls/systems are effective?*
	internal	**external**	
• Network boundary protection (firewalls) using multi-tiered approach. • Internal counter measures such as Advanced Threat Protection (ATP), Sophos Anti-Virus, Intercept-X anti-ransomware, 'honeypot' alerting system, etc. • Change controls and policy/procedure framework for operation of security platforms. • Alerting and intrusion detection systems in place. • Routine and cyclical technical security testing of network boundaries. • Independent assessment of security posture (e.g. Bitsight = top 10% of healthcare organisations). • Assurances through cyber security governance frameworks (e.g. ISO27001, Data Security Protection Toolkit, SPT, etc). • Established and tested incident response procedures • Continuity and disaster recovery plans in place. • Monitoring of security alerts and information published through credible routes (e.g. NHSDigital CareCERT, SANS). • LHIS has subscribed to the Police Cyber Alarm platform which provides alerts to potentially malicious activity on our network boundary. • Moved to NHS Mail • Subscribed to the NCSC Early Warning System which adds an additional layer of monitoring to our external network boundary.	• Active directory audit being planned • NCSC desktop simulations underway • Ransomware simulation being planned • LHIS continues to conduct security testing of various estate-wide services.	• External evaluation of security posture (e.g. Bitsight) • Audit reviews of security and governance frameworks (e.g. ISO27001, DSPT) (Internal Audit Review on DSPT 2022/23 underway). • Incident response to threats/attacks (i.e. was the attack successful) (assurance provided indicates controls are effective). • LHIS has attained a Tiger scheme penetration testing accreditation (positive assurance).	• Efficacy of local continuity plans for service provision in the event of a successful cyber-attack, preventing access to IT systems (including VPN) for an extended period (e.g., days).

Actions being taken to address gaps in controls and/or assurance					
Detail the actions to be taken *(including brief note on updates/progress where appropriate and confirm when action completed)* *What actions are required to bridge the gaps in controls and/or assurance?*	**Action to be completed by (date)**	**Will the action reduce impact of risk score or likelihood or both?**			**Progress on action(s) as at ……**
		Impact	Likelihood	Impact and likelihood	
Efficacy of local continuity plans for service provision in the event of a successful cyber-attack, preventing access to IT systems (including VPN) for an extended period (e.g., days).	October 2023			✓	• Acquire assurance, through testing, that local service continuity plans are established and are operating as expected (i.e., service provision is not affected by outage).

Principal / strategic risk: **8. Workforce recruitment and retention – the ability to recruit and retain staff may be affected by the pressures and reduction in running costs impacting on enhancing productivity and delivering the ICB's strategic objectives.**																										
Date risk identified	**ICB Executive lead (risk owner)**	**ICB Committee oversight**	**Risk category** (✓ applicable category(ies))		**ICB only or system risk** (✓ one)		**Risk rating (impact x likelihood = risk score)**																**Risk treatment** *(i.e. state whether to terminate, treat, transfer, or tolerate the risk)*	**If to be treated confirm frequency of review** (e.g. monthly, quarterly)
					ICB	**System**																				
March 2023	**Alice McGee**	Remuneration Committee / People Board	Clinical		✓		**Gross/inherent risk score**			x			=										Treat	**Quarterly**
			Organisational	✓			**Risk appetite score**			x			=												
			Financial				**Net/residual/ current risk score**			x			=												
			Information				**Residual / current risk score trend since last report:**																**N/A**			
							Next risk review date:																July 2023			

Key controls in place and rationale for current / residual risk score	Internal and / or external assurances *Where can we gain evidence that our controls/systems on which we are placing our reliance are effective?*		Gaps in controls and/or assurance *Where are the gaps in our control/systems? Where are we failing to make them effective? Where is the ICB failing to gain evidence that the controls/systems are effective?*
	internal	**external**	
Regular workforce dashboard reports presented to the Executive Management Team and the People Board meetings.	**Dashboard assurance report to be**		Workforce reports to be considered at the Remuneration Committee following amendment to remit of Committee.
Risk currently being assessed further.			

Actions being taken to address gaps in controls and/or assurance					
Detail the actions to be taken *(including brief note on updates/progress where appropriate and confirm when action completed)* *What actions are required to bridge the gaps in controls and/or assurance?*	**Action to be completed by (date)**	**Will the action reduce impact of risk score or likelihood or both?**			**Progress on action(s) as at ……**
		Impact	Likelihood	Impact and likelihood	
Remuneration Committee terms of reference amended to include assurance reports on ICB workforce and the people plan.	End April 2023				To be presented for approval to the ICB Board in April 2023.

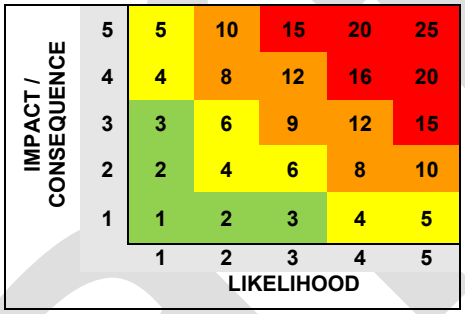
Appendix 1: Definitions and 5x5 Risk Matrix (as within the Risk Management Strategy and Policy, July 2022)

Areas	Definitions
Assurance	An evaluated opinion, based on evidence gained from review, on the organisation's governance, risk management and internal control framework. The more measurable, verifiable and objectives an assurance is the stronger the declaration and source of evidence it is. The assurance must also be up to date. Effective assurance needs to be at two levels, internal and external
Board Assurance Framework	The Board Assurance Framework provides evidence that the Board has systematically identified its objectives both strategically and operationally, and manages its risks to achieving them. The framework systematically provides a vehicle for the identification of assurances and controls to risks and their effectiveness.
Cause	The reason for the risk to potentially occur.
Consequence	The results should the risk materialise.
Control	A measure put in place to mitigate a risk from occurring i.e. to prevent. Different types of control can be preventative, detective, directive and corrective.
Description	The way of explaining risk to allow consistent understanding across the ICB in a single sentence where possible. Consider the 'x, y, z' approach as described in the Strategy and Policy ('x' could happen, because of 'y', resulting in 'z').
Gaps in controls/ assurances	Where the residual risk does not meet the risk appetite, gaps in the controls and the assurances must be identified in order to reduce the residual risk as close as possible to the risk appetite.
Gross / Inherent Risk	Inherent risk is the effect of something that might happen before taking account of controls in place to manage or mitigate it. The higher the score, the more attention the risk will require and the more likely the Board would seek assurance as to how it was being managed whether directly or via a committee of the Board.
Impact	A measurement of the effect the risk will have if it materialises.
Issue	Issue is something that has happened, as opposed to a risk which is something that could happen.
Likelihood	A measurement of the chance that a risk will materialise.
Mitigation Actions	These are the actions the risk owners take to reduce the risk or where this is not possible limit the impact of the risk.
Net risk	The measurement in terms of likelihood and impact on a risk after controls are considered to mitigate the risk. Also referred to as 'residual risk'.

Areas	Definitions
Objective	The context in which risks are assessed i.e. ICB Aims/Objectives
Operational risks	Operational risks are by-products of the day-to-day running of the ICB and includes a broad spectrum of risks including clinical, fraud, security, financial and legal risks arising from employment law of health and safety.
Owner	Either the owner of the risk (risk owner i.e. Director) or owner of an action (action owner i.e. the completer on the assigned action by the risk owner).
Principal risk	Principal risks are defined as those that threaten the achievement of the ICB's principal objectives.
Register	A tool to capture and report on the risks identified at project / programme level, Directorate level or Corporate level.
Residual Risk	Another term for net risk.
Risk	ISO 31000:2009 defines risk as the "effect of uncertainty on objectives" and states that "risk is often expressed in terms of a combination of the consequences of an event and associated likelihood of occurrence"
Risk Appetite	An expression of the nature and quantum of risk or uncertainty which the organisation is willing to take or accept to achieve its strategic objectives. Risk appetite score may be a different for different objectives and / or different risk categories.
Risk Management	Risk Management is the process by which an organisation identifies risks, assesses their relative importance, determines the appropriate control mechanisms and ensures that the agreed action is taken. Risk management may involve judgement as well as data.
Risk Management Process	The systematic application of management policies, procedures and practices to the tasks of establishing the context, identifying and analysing, evaluating, treating, monitoring and communicating risk.
Risk Matrix	The tool used to as accurately as possible identify the measurement of likelihood and impact of the risk identified.
Risk Tolerance	The threshold level of risk exposure which, when exceeded, will trigger an escalation.
Strategic risks	Strategic risks are those that represent major threats to achieving the ICB's strategic objectives or to its continued existence. Strategic risks will include key operational service failures, for example, failure to meet key targets or provision of poor-quality care would be very damaging to the ICB's reputation.

5 x 5 Risk Assessment Matrix (Risk Management Strategy and Policy)

IMPACT / CONSEQUENCE		LIKELIHOOD	
1	NEGLIGIBLE	1	RARE
2	MINOR	2	UNLIKELY
3	MODERATE	3	POSSIBLE
4	MAJOR	4	LIKELY
5	CATASTROPHIC	5	ALMOST CERTAIN



This will result in risks being rated in one of the following four categories

Risk score	Category
1 – 3	Low risk (green)
4 – 6	Moderate risk (yellow)
8 – 15	High risk (orange)
15 – 25	Extreme risk (red)

Key for Executive Directors:

AW = Andy Williams, Chief Executive
AM = Alice McGee, Chief People Officer
CG = Caroline Gregory, Chief Finance Officer
CT = Caroline Trevithick, Chief Nursing Officer
NS = Dr Nil Sanganee, Chief Medical Officer
RV = Rachna Vyas, Chief Operating Officer
SP = Sarah Prema, Chief Strategy and Planning Officer

Name of meeting:	**Leicester, Leicestershire and Rutland Integrated Care Board (LLR ICB)**		
Date:	**13 April 2023**	**Paper:**	**G**
Report title:	**Draft ICB Equality, Diversity and Inclusion (EDI) Annual Report 2022-23**		
Presented by:	Alice McGee, Chief People Officer		
Report author:	Shaun Cropper, Equality, Diversity & Inclusion Business Partner MLCSU		
Executive Sponsor:	Alice McGee, Chief People 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:

Leicester, Leicestershire and Rutland Integrated Care Board (LLR ICB) are asked to:

- **Approve** the LLR ICB Equality, Diversity and Inclusion Annual Report.

Purpose and summary of the report:

1. The purpose of the Equality, Diversity & Inclusion (EDI) Annual Report is to demonstrate how Leicester, Leicestershire & Rutland ICB is complying with the Equality Act 2010, the Public Sector Equality Duty (PSED) 2011 and NHS Mandated Standards.

2. The EDI Annual Report also includes a number of initiatives that the ICB has undertaken organisationally and with LLR system partners over the past nine months. The report demonstrates how we embed equalities and work to reduce health inequalities in everyday work with communities, staff and stakeholders.

3. In February, the Equality and Human Rights Commission (the national regulator for equality and human rights in England) wrote to all ICBs, emphasising our responsibilities under the PSED.

4. The statutory requirement is to publish data by 31st March 2023, the LLR EDI report has been published on the website in draft, subject to approval from the Board.

Appendices:	• APPENDIX A – Draft EDI Annual Report 2022-23
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.	None
☐	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.*	N/A
b) Does the report highlight any resource and financial implications? If so, provide which page / paragraph this can be found within the report.	No
c) Does the report highlight quality and patient safety implications? If so, provide which page / paragraph this is outlined in within the report.	No
d) Does the report demonstrate patient and public involvement? If so, provide which page / paragraph this is outlined in within the report.	No
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.	The Equality and Inclusion Annual report demonstrates due regard to the Public Sector Equality (specific) Duty which requires public bodies to publish relevant, proportionate information demonstrating their compliance with the Equality Duty.

Appendix A

NHS
Leicester, Leicestershire and Rutland
Integrated Care Board

Equality, Diversity & Inclusion (EDI)

Annual Report July 2022 – April 2023

DRAFT

A proud partner in the:

Leicester, Leicestershire and Rutland
Health and Wellbeing Partnership

Accessibility statement

If you would like information in another format, such as another language, Braille, audio or large print, please let us know by calling 07795 452827 or emailing LLRICB-LLR.beinvolved@nhs.net to discuss your requirements.

Or you can write to us at:
Freepost Plus RUEE–ZAUY–BXEG
LLR ICB, G30, Pen Lloyd Building,
Leicestershire County Council, Leicester Road
Glenfield, Leicester, LE3 8TB

अगर आपको इस दस्तावेज में शामिल जानकारी समझने में सहायता चाहिए तो कृपया 0116 295 2110 पर फ़ोन कीजिए।

ਜੇਕਰ ਤੁਹਾਨੂੰ ਇਸ ਦਸਤਾਵੇਜ਼ ਦਾ ਵਿਸ਼ਾ ਵਸਤੂ ਸਮੱਝਣ ਲਈ ਮਦੱਦ ਦੀ ਲੋੜ ਹੈ ਤਾਂ ਕ੍ਰਿਪਾ ਕਰਕੇ ਇਸ ਨੰਬਰ ਤੇ ਟੈਲੀਫੋਨ ਕਰੋ 0116 295 2110.

જો તમને આ દસ્તાવેજમાં આપેલ માહિતી સમજવા માટે મદદ જોઇતી હોય તો મહેરબાની કરીને 0116 295 2110 પર ફોન કરો.

এই ডকুমেন্ট'এর কোন বিষয় বুঝতে আপনার যদি সাহায্যের প্রয়োজন হয়, তাহলে অনুগ্রহ করে 0116 295 2110 নাম্বারে টেলিফোন করুন।

Hadii aad u baahantahay in lagaa caawiyo fahmida qoraalka ku qoran documintigaan fadlan nagala soo xiriir telefoonkaan 0116 295 2110.

Jeśli potrzebujesz pomocy w zrozumieniu treści tego dokumentu prosimy o telefon pod numer 0116 295 2110.

"اگر آپ کو اس دستاویز کے مشمولات کو سمجھنے میں مدد کی
ضرورت ہو تو براہ کرم ہمیں 0116 295 2110 پر فون کریں۔"

Caso pretenda ajuda para compreender o conteúdo deste documento, por favor ligue para o 0116 295 2110.

如果您在理解本文档的内容时需要任何帮助，请致电 0116 295 2110.

Jei norėtumėte, kad kas nors padėtų suprasti šį dokumentą, skambinkite tel. 0116 295 2110. Ja jums nepieciešama palīdzība, lai saprastu šī dokumenta saturu, lūdzam zvanīt uz 0116 295 2110.

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Welcome to our first Equality, Diversity and Inclusion Annual Report as an ICB

NHS Integrated Care Boards (ICBs) are statutory bodies established from 1 July 2022, replacing Clinical Commissioning Groups (CCGs). In Leicester, Leicestershire and Rutland (LLR) this means that the functions of Leicester City CCG, West Leicestershire CCG and East Leicestershire and Rutland CCG became the NHS Leicester, Leicestershire and Rutland Integrated Care Board.

This report sets out how we, as an ICB, fulfil our responsibilities arising from the Equality Act 2010 and other NHS mandated requirements. The Equality Act requires all ICBs to publish appropriate information which demonstrates how we are meeting the Public Sector Equality Duty 2011 (PSED, specific duties) and addressing any significant gaps which may adversely impact on local people who are protected by equalities law.

This Annual Report covers the period of July 2022 to April 2023. An addendum was added to the previous EDI Annual Report covering the period of April to July 2022 when we were still a Clinical Commissioning Group.

Foreword by Alice McGee, Chief People Officer

We are pleased to publish our first Integrated Care Board's, Equality, Diversity and Inclusion (EDI) Annual Report. As an organisation, we are dedicated to developing an organisational culture that promotes inclusion and embraces diversity, ensuring that the focus on EDI is maintained not only within the ICB but as part of the wider Integrated Care System.

Leicester Leicestershire & Rutland (LLR) has some of the most deprived and diverse communities in the UK which have been hit particularly hard by Covid-19, reflecting some of the underlying poor health and inequalities experienced by many of the communities we serve. The diversity of our population is mirrored in the diversity of our workforce. Across Health and Social care, we employ over 76,000 staff, of which current health workforce data suggests 42% are from a black and minority ethnic background, reflecting the diverse race profiles of our population.

Our Integrated Care System aims to deliver a health and care system in Leicester, Leicestershire and Rutland that tackles inequalities in health and improves the health, wellbeing and experiences of local people and provides value for money.

We have a clear purpose:

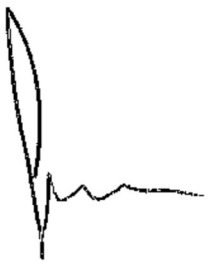
'To work together for everyone in Leicester, Leicestershire and Rutland to have healthy, fulfilling lives.'

We have four main priorities:

To achieve these priorities, we will ensure that success will be seen on the ground with quicker diagnosis, care closer to home in improved facilities, higher quality services, earlier intervention in long-term conditions, improved wellbeing, more digital healthcare options where

appropriate, and greater integration between healthcare providers so patients have seamless care between organisations.

By working with partners, we aim to reduce the unfair and avoidable health inequalities which exist in our community and improve health equity relative to need.



Alice McGee

Chief People Officer

Legal Duties for Equality, Diversity and Inclusion

The Equality Act 2010 protects people from unfavourable treatment, making it unlawful to discriminate, harass or victimise an individual due to a reason related to one of the following nine protected characteristics – see **Appendix A** for more information.

Other Vulnerable Groups (Inclusion Health Groups)

In addition to the nine protected characteristic groups, we also recognise that there are additional groups that experience health inequalities and face disadvantage in society. These include (but are not limited to):

Carers	Rural communities
Veterans and their families	Asylum Seekers and Refugees
People experiencing Homelessness	People experiencing Deprivation
Looked after children and young people	Gypsy, Roma and Traveller communities
People in contact with the justice system	People with poor literacy and/or health literacy
People affected by addiction and/or substance misuse	Sex workers

Public Sector Equality Duty (PSED) 2011

Section 149 of the Equality Act 2010 applies to public sector organisations and bodies delivering public services, and requires the LLR ICB to address the following duties:

1. Eliminate unlawful discrimination, harassment, victimisation, and other prohibited conduct.
2. Advance equality of opportunity between people who share a protected characteristic and those who do not.
3. Foster good relations between people who share a protected characteristic and those that do not.

The Equality Act explains that the second aim involves, in particular, having due regard to the need to:

- Remove or minimise disadvantages suffered by people due to their protected characteristics.
- Take steps to meet the needs of people with certain protected characteristics where these are different from the needs of others.
- Encourage people with certain protected characteristics to participate in public life or in other activities where their participation is disproportionately low.

LLR ICB Specific Duties Under the PSED

Leicester, Leicestershire and Rutland ICB has specific duties under the Public Sector Equality Duty (PSED) to:

- Publish information annually to demonstrate their compliance with the equality duties, including information relating to employees who share protected characteristics (for public bodies with 150+ employees), and information relating to people who are affected by the public body's policies and practices who share protected characteristics.
- Set equality objectives, at least every four years. (These can be found in our Equality Diversity and Inclusion Strategy). More on this can be found on page 18.

Our EDI Report is fulfilling the specific duty requirements.

Showing ‘Due Regard’ to the Public Sector Equality Duty

To commission high quality, and inclusive health services, we aim to ensure that protected groups have the same access, experiences, and outcomes as the general population, and where required, to focus on equity of service provision. This may mean that some of our protected groups have enhanced access to services.

We recognise that there are many things that influence this that we may not have complete control over, but we are committed to working with our communities and partners to ensure that our commitment to our equality duty is central to the work that we do and the decisions we make.

One of the ways that we demonstrate ‘due regard’ is though our Equality, Health Inequality Impact and Risk Assessment process. More on this can be found on page 13.

Human Rights Act 1998

The Human Rights Act 1998 sets out universal standards to ensure that an individual’s basic needs as a human being are recognised and met.

Public authorities have a mandated duty to ensure they have arrangements in place to comply with the Act.

It is unlawful for a healthcare organisations to act in any way that is incompatible with the Act. In practice, this means we must treat individuals with Fairness, Respect, Equality, Dignity and Autonomy known as the **FREDA** principles.

Modern Slavery Act 2015

The Modern Slavery Act 2015 applies to all organisations within the United Kingdom with a turnover of £36 million or above. A key element of the Act is the 'Transparency in Supply Chains' provision, which requires businesses above a certain threshold to produce a 'Slavery and Human Trafficking Statement' outlining what steps they have taken in their supply chain to ensure slavery and human trafficking is not taking place.

Slavery is a violation of a person's human rights. It can take the form of trafficking, forced labour, bonded labour, forced or servile marriage, descent-based slavery, and domestic slavery.

The ICB has a zero tolerance for modern day slavery and breaches of human rights, so we ensure that this protection is built into the processes and business practices that we, our partners and our providers use.

To view our Modern Slavery Act Statement on our website, please click on to the following link: Modern Slavery Act Statement - LLR ICB

The Health and Social Care Act 2022

The ICB has a legal duty under the Health and Social Care Act 2022, to reduce inequalities between people in regard to their ability to access health services, and to reduce inequalities between patients with respect to the outcomes achieved for them by the provision of health services.
The Act also places duties on the ICB to promote the NHS Constitution, to enable choice, and to promote patient, carer and public involvement in shaping health services.

To do this effectively, the ICB works with its partner organisations to reduce health inequalities, and embeds this requirement into its commissioning strategies and policies. The ICB is also required to demonstrate how it provides culturally sensitive services, and ensures all patients can exercise choice and be involved in decision making.

NHS England has a statutory duty under the Health and Social Care Act 2022, to conduct an annual assessment of ICBs. A single oversight framework called the NHS System Oversight Framework was introduced in 2019 for this purpose. This includes oversight metrics for reducing health inequalities and racial inequalities.

More information about the NHS System Oversight Framework for 2022/23 can be found at [NHS England » NHS Oversight Framework 2022/23]

The Care Act (2014)

This sets out carers' legal rights to assessment and support, and relates mostly to adult carers aged 18 and over who are caring for another adult. This is because young carers (aged 17 and under) and adults who care for disabled children can be assessed and supported under children's law.

The NHS Constitution

The NHS Constitution came into law as part of the Health Act in November 2009 and has recently been updated in January 2021. It contains seven principles that guide the NHS, as well as a number of pledges for patients and the public.

Several of these, demonstrate the commitment of the NHS to the requirements of the Equality Act 2010 and the Human Rights Act 1998. For example, the first principle requires that the NHS *"is available to all, irrespective of gender, race, disability, age, sexual orientation, religion and belief, gender reassignment status, pregnancy and maternity or marital or civil partnership status."*

Meeting our Statutory Duties, NHS Mandated Equality Standards and other Equality-related Initiatives

Equality and Health Inequalities Impact and Risk Assessments (EHIIRA)

The ICB use the Equality, Health Inequality Impact and Risk Assessment (EHIIRA) toolkit from the Equality and Inclusion Team at NHS Midlands and Lancashire Commissioning Support Unit (MLCSU). The EHIIRA toolkit provides a framework for undertaking EHIIRA assessments. The first part of this toolkit is a screening assessment tool which is located on an internet platform called UAssure. If a second stage assessment is required, the ICB use a more detailed word template.

The assessments combine equality risk, health inequalities and human rights considerations. The tool enables the ICB to show 'due regard' to the Public Sector Equality Duty and ensures that consideration is given prior to any policy or commissioning decision made by the Governing Bodies (or other committees) that may impact upon people with protected characteristics, equality and human rights.

In July 2022 we improved the accessibility of the EHIIRA stage 2 template which includes new interactive tools such as drop-down menus. Additionally, the health inequalities section has been strengthened to provide the opportunity for a more detailed analysis of inclusion health groups and reflect new requirements such as Core20PLUS5 - see Health Inequalities Section.

Most of our proposed services, polices and functions are subject to an EHIIRA. This also includes (but is not limited to) service and policy planning and review, projects and work programmes, performance management, commissioning and procurement, budget planning and allocation, employee performance, development and relations.

During early 2023, planning is taking place with ICS colleagues to develop a shared equality impact assessment template which we aim to align to the health equity assessment tool and underpin the inclusive decision-making framework noted below on page 15.

The ICB are also developing a joint ICB Quality Impact Assessment and Equality Impact Assessment Policy (EQIA) with links to relevant resources and templates. The current ICB EHIIRA template will be used until we have developed a system version noted in the paragraph above.

Analysis of EHIIRAs undertaken from July 2022 to April 2023

Name of EHIIRA	Stage 1 Screening	Stage 2 (full EHIIRA)
Individual Funding Request (IFR) Policy review	✓	
Children and Young People Pathway review of mental health services	✓	
Redesign of ICB office workspace	✓	
Work experience policy	✓	
LLR PCNs Enhanced access	✓	
Skin Analytics AI Powered Tele Dermatology	✓	
Rosemead Dive GP practice List Closure	✓	
Willows Health Limited – Proposed Practice Merger	✓	✓
Continuous Glucose Monitors	✓	
Employee volunteer policy	✓	
Leicester Place Delivery Plan	✓	
	Total 11	Total 1

Additional EHIIRA Training

Staff are able to access one-to-one training and support on how to complete Equality, Health Inequality Impact and Risk Assessments from the MLCSU Equality and Inclusion Business Partner upon request. During the reporting year two team training sessions were also provided.

Adoption of Inclusive Decision-Making Framework (IDMF)

In July 2020, a number of LLR System Equality, Diversity and Inclusion (EDI) priorities were identified by the Leicester, Leicestershire and Rutland (LLR) EDI Taskforce, including the creation and implementation of an Inclusive Decision-Making Framework.

The Inclusive Decision-Making Framework (IDMF) aims to enhance our decision-making processes and ensure they are not influenced by biases, and thoroughly consider the diverse needs of our patients, our service users, our workforce and the wider community.

Inclusive decision-making involves thorough consideration of equality, diversity, and inclusion when we are developing and implementing strategies, plans, programmes, projects, or commissioning or decommissioning and procuring services.

We have created the framework to support the embedding of equality, diversity and inclusion into our culture, so that it can enable transformation and innovation across the LLR System.

This means promoting inclusive and compassionate leadership so that we can create a diverse workforce which is able to deliver 21st Century care to all of the communities in Leicester, Leicestershire and Rutland. The successful application of this framework ensures that we can integrate equality analyses into our decision-making to reduce health inequalities and attract, retain and develop diverse talent.

The Framework takes into account our role as anchor institutions whose long-term sustainability is tied to the health and wellbeing of the local community we serve.

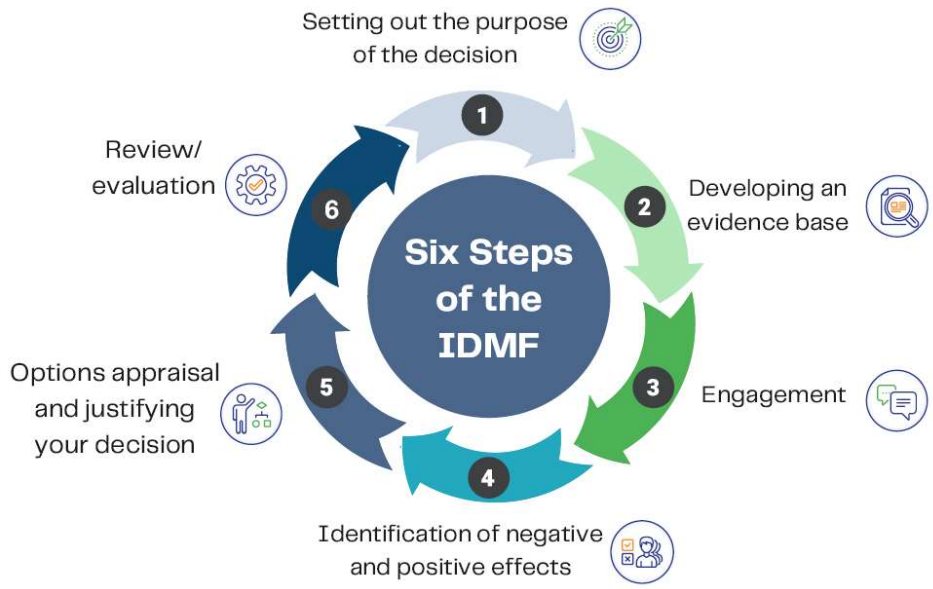
To facilitate effective implementation of the framework three key areas were identified to test the application of the framework in different contexts. These were:

- The Building Better Hospitals (Reconfiguration Programme)
- The implementation of the LLR Health Inequalities Framework
- LLR Clinical Design Group Planning

The Inclusive Decision-Making Framework - the 6 steps

The inclusive Decision-Making Framework consists of a 6-step process and a number of behavioural enablers which take into account the climate in which decision-making takes place and promote inclusivity in decision-making. Equally the Framework identifies the environmental barriers which can lead to sub-optimal biased decision-making. The IDMF recognises that equality is an expectation, diversity is a lived reality, and inclusion is a choice.

The figure below shows the six steps of the IDMF:



Step 1 Setting out the purpose of the decision

A robust assessment will set out the reasons for the change, how this change can impact on protected and inclusion health groups, as well as whom it is intended to benefit, and the intended outcome. Decision makers should also think about how individual proposals might relate to one another. This is because a series of changes to different services could have a severe impact on particular protected characteristics and inclusion health groups. Joint working with partners will also help us to consider thoroughly the impact of joint decisions on the people we collectively serve.

Step 2 Developing an evidence base

It is important to consider the information and research already available locally and nationally. The assessment of the effect of a change on equality and inclusion health groups should be underpinned by up-to-

date and reliable information about the different groups of people that the change is likely to have an impact on. For example, workforce dashboard data and Public Health England dashboards reporting on health inequalities. A lack of information would not be a sufficient reason to conclude that there is no impact.

Step 3 Engagement

Engagement is crucial to assessing the effect of a change on equality and inclusion health groups. There is an explicit requirement to engage people under the duty to reduce health inequalities, and beyond the legislative imperative it will help our teams to improve the equality, diversity and inclusion information that they use to understand the possible effect of a change or service improvement on diverse groups. No-one can give better insight into how proposed changes will have an impact than the people who would be affected by change.

Step 4 Identification of positive and negative effects

It is not sufficient to state simply that a change will impact on everyone equally. There should be a more in-depth consideration of available evidence to see if particular protected characteristic and inclusion health groups are more likely to be affected than others. Equal treatment does not always produce equal outcomes, and sometimes organisations will have to take particular steps for certain groups to address an existing disadvantage or to meet differing needs. This could be through the use of proportional universalism or positive action.

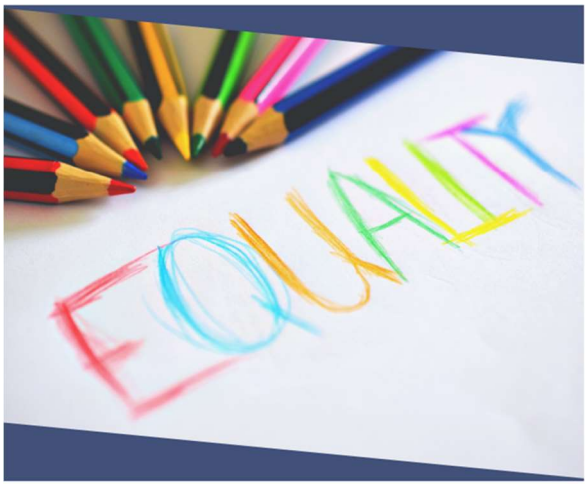
Step 5 Options appraisal and justifying your decision

The assessment should clearly identify the option(s) chosen, and their potential implications, and document the reasons for the decision(s).

Step 6 Review/Evaluation

Although assessments of the effect on of a change on equality and inclusion groups will help to anticipate the likely effect on different communities and groups, in reality the full impact of a decision will only be known once it is introduced. It is therefore important to set out arrangements for reviewing the actual impact of a change once it has been implemented.

LLR CCG/ICB Equality, Diversity and Inclusion Strategy 2021-2025



The Equality, Diversity and Inclusion strategy is designed to cover the initial period of transition of the LLR CCGs becoming the new LLR ICB.

Having the equality objectives in place fulfils our legal obligation until we reshape the strategy once we know what the new structures will look like. There are plans to revise this in the coming reporting year of 2023-24.

The current strategy was approved in May 2021 and sets out our strategic approach to delivering equality, diversity and inclusion for the benefit of the local population and staff in line with the aims and objectives of the Equality Act 2010, the Public Sector Equality Duty and NHS mandated duties.

To view the EDI strategy, please click on the following link:
https://leicesterleicestershireandrutland.icb.nhs.uk/equality-statement/

Equality Objectives 2023-2027

The ICB EDI strategy presents our current equality objectives for service delivery and employment practices aligned to the Equality Delivery System (EDS). The overarching equality objective is to reduce unacceptable differences in the health inequalities of all people who live within Leicester, Leicestershire and Rutland.

The ICB's current equality objectives are as follows:

1. (EDS Goal 1) Better health outcomes
2. (EDS Goal 2) Improved patient access and experience
3. (EDS Goal 3) A representative and supported workforce
4. (EDS Goal 4) Inclusive Leadership

The action plan at the end of the report provides an update of progress made on these equality objectives.

As noted, we have aligned our current equality objectives to the Equality Delivery System (EDS). Therefore, our equality objectives will change following the adoption of EDS 2022. The change is to reflect the new 'domains'. These domains (our equality objectives) and expected outcomes will form part of our Improvement/Action plan. The outcomes can be found on page 21 of the EDI Annual Report.

Our three new equality objectives from April 2023 to April 2027 will be:

Commissioned or provided services

Workforce health and well-being

Inclusive leadership

More information on the new domains/equality objectives and expected outcomes can be found in the following EDS section of the report.

LLR ICB Equality Delivery System EDS 2022

The EDS is the foundation of equality improvement within the NHS. It is an accountable improvement tool for NHS organisations in England - in active conversations with patients, public, staff, staff networks and trade unions - to review and develop their services, workforces, and leadership. It is driven by evidence and insight.

The third version of the EDS was commissioned by NHS England and NHS Improvement with, and on behalf of, the NHS, supported by the NHS Equality and Diversity Council (EDC). It is a simplified and easier-to-use version of EDS2.

To take account of the significant impact of COVID-19 on Black, Asian, and Minority Ethnic community groups, and those with underlying and long-term conditions such as diabetes, the EDS now supports the outcomes of the Workforce Race Equality Standard (WRES) and the Workforce Disability Equality Standard (WDES) by encouraging organisations to understand the connection between those outcomes and the health and wellbeing of staff members. The EDS provides a focus for organisations to assess the physical impact of discrimination, stress, and inequality, providing an opportunity for organisations to support a healthier and happier workforce, which will in turn increase the quality of care provided for patients and service users.

The EDS comprises eleven outcomes spread across three Domains, which are:

- Commissioned or provided services
- Workforce health and well-being
- Inclusive leadership.

The outcomes are evaluated, scored, and rated using available evidence and insight. It is these ratings that provide assurance or point to the need for improvement. The EDS is designed to encourage the collection and use of better evidence and insight across the range of people with protected characteristics described in the Equality Act 2010, and so to help NHS organisations meet the public sector equality duty (PSED) and to set their equality objectives.

During the reporting year relevant NHS organisations have been asked to test the new EDS with full implementation expected from April 2023.

The outcomes for each of the three EDS domains are as follows:

Domain 1: Commissioned or provided services

1A: Patients (service users) have required levels of access to the service *(simpler version of EDS2 2.1)*

1B: Individual patients (service user's) health needs are met *(simpler version of EDS2 1.2)*

1C: When patients (service users) use the service, they are free from harm *(like EDS2 1.4)*

1D: Patients (service users) report positive experiences of the service *(same as EDS2 2.3)*

Domain 2: Workforce health and well-being

2A: When at work, staff are provided with support to manage obesity, diabetes, asthma, COPD, and mental health conditions (response to COVID-19)

2B: When at work, staff are free from abuse, harassment, bullying and physical violence from any source *(like EDS2 3.4)*

2C: Staff have access to independent support and advice when suffering from stress, abuse, bullying, harassment, and physical violence from any source (response to Covid-19)

2D: Staff recommend the organisation as a place to work and receive treatment *(like EDS2 3.6)*

Domain 3: Inclusive leadership

3A: Board members, system leaders (Band 9 and VSM) and those with line management responsibilities routinely demonstrate their understanding of, and commitment to, equality and health inequalities (like *EDS* 4.1)

3B: Board/Committee papers (including minutes) identify equality and health inequalities related impacts and risks and how they will be mitigated and managed (like *EDS2* 4.2)

3C: Board members, system, and senior leaders (Band 9 and VSM) ensure levers are in place to manage performance and monitor progress with staff and patients (response to Covid-19)

The EDS is integral to core equality work and addressing health inequalities and applies to all the protected characteristic groups.

The use of EDS by single organisations should cease and be applied in partnership, in an integrated approach supported by People Leaders across ICB/UHL/LPT.

Update on progress made during 2022/23: A series of task and finish groups with appropriate experts has been convened to consider each of the domains. The framework and technical guidance provide advice around partner engagement, insights and data needed to collect and the included groups and characteristics to consider within each domain.

Update on Domain 1: System pathways have been accepted by the LLR ICB Health Equity Board and Executive Management Team in August reflecting the clinical priority (and Core20plus5 strategy) areas of:

- Maternity
- Respiratory
- Virtual Wards

Website Accessibility Standard

The Public Sector Bodies (Website and Mobile Applications No. 2) Accessibility Regulations 2018 builds on existing obligations to make 'reasonable adjustments' under the Equality Act, and public sector bodies must make their websites and apps more accessible by making them 'perceivable, operable, understandable and robust'. This regulation also includes internal websites such as intranets.

The LLR ICB (and providers) websites should contain clear accessibility statements to ensure that the population can access information, resources and documents from the ICB in a format that meets their needs, for example via easy read or large print formats. Where possible, information resources and publications hosted on the ICB website are presented in plain and easy to understand language.

For a copy of the ICB website accessibility statement please click on the following link: Accessibility Statement - LLR ICB

Accessible Information Standard (AIS) 2016

The aim of the Accessible Information Standard (AIS) is to make sure that people who have a disability, impairment or sensory loss receive information in the best format for them, and receive any communication support that they may require.

The AIS applies to service providers across the NHS and adult social care system, and effective implementation requires such organisations to make changes to policy, procedure, human behaviour and, where applicable, electronic systems.

Commissioners of NHS services and publicly funded adult social care must show due regard to this standard, to ensure that they enable and support compliance through their relationships with provider organisations. This standard is in all of the ICBs NHS Standard Contracts and is monitored by Quality and Performance Key Performance Indicators (KPIs).

A copy of LLR ICBs AIS statement can by clicking on the following link: https://leicesterleicestershireandrutland.icb.nhs.uk/equality-statement/

Provider Compliance Audit 2021-2022

NHS Midlands and Lancashire Commissioning Support Unit's Equality and Inclusion Team Business Partner conducts a desktop provider compliance check of commissioned service provider websites on the following equality-related legal duties and NHS Mandated Standards:

- Equality Objectives published on the provider's website (reviewed every 4 years)
- Published Equality information – e.g., Equality Compliance
- Equality Delivery System Grading and Report (on an annual basis)
- Workforce Race Equality Standard Report (on an annual basis)
- Workforce Disability Standard Report (on an annual basis)
- Up to date Modern Slavery Act 2015 Statement on website (for providers of £36 million and over – on an annual basis)
- Accessible Information Standard (AIS) and Website Accessibility Statement -– see above for more information on what these are.

The table below shows a summary of equality analyses carried out in October 2022. The following providers were reviewed:

- East Midlands Ambulance Service (EMAS)
- Leicestershire Partnership NHS Trust
- University Hospitals Leicester (UHL)

Key completed but not published at time of check

Commissioned Provider	Equality Objectives	Published # Equality Information	Published WRES report	Published WDES report	AIS	Website accessibility statement	Modern Slavery Act Statement
EMAS	✓	✓	✓	✓	✓	✓	✓
Leicestershire Partnership NHS Trust	✓		✓	✓	✓	✓	✓
UHL	✓	X			✓	✓	X

Our Workforce

As an employer we aim to build a great place to work. With a culture of inclusive and compassionate leadership, we strive to create a working environment where all our staff feel included, valued and can fulfil their potential.

The organisation has robust policies and procedures in place which ensure that all staff are treated fairly and with dignity and respect - some of which are included in the support for staff section. We are committed to promoting equality of opportunity for all current and potential employees.

People Plan

The NHS is made up of 1.3 million employees who care for the people of this country with skill, compassion, and dedication. People work in many different roles, in different settings, employed in different ways, and in a wide range of organisations.

The NHS People Plan was published in July 2020 and sets out actions to support transformation across the whole NHS now and in the future. It focuses on how we must all continue to look after each other and foster a culture of inclusion and belonging, as well as grow our workforce, train people, and work together differently to deliver patient care.

The NHS People Plan is set out in four broad themes:

- Belonging in the NHS
- New ways of working and delivering care
- Growing for the future
- Looking after our staff

The ICB is undertaking many initiatives both organisationally, and with system partners, to advance the above aims. Two such initiatives are detailed below, and others can be seen in the Working in Collaboration with LLR System Partners section.

The Lead, Connect, and Care Festival (looking after our staff)

In June 2022, we held a Lead, Connect and Care Festival. The event was organised by the system Health and Wellbeing Project Team with the support and input from the Looking After Our People workstream, including organisational health and wellbeing leads.

It covered three key themes integral to embedding a culture of health and wellbeing[1] across the LLR health and care system: Leadership, Quality Improvement, Equality, Diversity and Inclusion, and Health and Wellbeing Sessions. Activities throughout the festival week held these themes at the heart of their content, including:

- Eating well to feel well (the link between healthy eating and mental health)
- Alcohol awareness
- Trans health inequality
- Reproductive health and the menopause

There were 450 attendances at sessions across the week with the most well attended session being a masterclass on Compassionate and Inclusive Leadership with Professor Michael West.

The event ended with a family fun-day on 25th June, to celebrate the success of the festival and to give back to our workforce and their families. In attendance were approximately 60 local health and wellbeing activity providers and stallholders who provided valuable information and resources to 235 attendees consisting of staff and their families.

***Quote from family fun-day participant**: "Loved it! What an absolute treat especially after the past 2 years! My kids thought it was great that they could do all of the things for free and as a single mum that hugely helped my bank balance! Thank you!"*

[1] Due to timelines this event was not captured in the previous annual report for the combined LLR CCGs.

Primary Care Workforce - Health & Wellbeing Programme (looking after our staff)

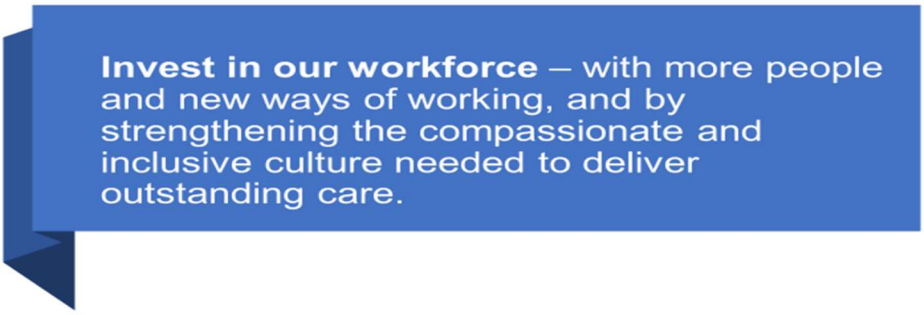
The Primary Care Health and Wellbeing in-reach model:

- Provides a health and wellbeing offer which is accessible to all Primary Care staff.
- Collects baseline information on staff health and well-being and general resilience.
- Provides staff tools for self-help use.
- Provides accessible support and will sign post to existing services where appropriate.

Wellbeing Wednesdays

The programme has been running every Wednesday throughout the Annual Report reporting period. It provides a short, bite size, virtual health and wellbeing led video. NHS staff are able to access the video whenever they want, at their own pace. The videos are no longer than 15 mins and are themed around movement, breathing and achievements.

The Health and Wellbeing programme forms part of the operational planning guidance for 2022/23 which was to:



The People Plan continued…

The People Plan sets out what NHS staff can expect from leaders and each other and includes a focus on fostering *a culture of inclusion and belonging*. Some of the relevant actions are found in our Workforce Race Equality Standard Action plan. The NHS People Plan includes a People Promise, which outlines the actions and behaviours staff should expect from their employers and colleagues, as part of improving the experience of working in the NHS for everyone.

The Inclusive People Promise

Equality, diversity, and inclusion run through the People Plan, changing the culture of NHS services to focus more on learning, belonging, recognition, work life balance, mental health and wellbeing and being the best place for people to work. Details of the inclusive people promise are shown below:

We are a team

- First and foremost, we are one huge, diverse and growing team, united by a desire to provide the very best we can.
- We learn from each other, support each other and take time to celebrate successes.

We work flexibly

- We do not have to sacrifice our family, our friends or our interests for work.
- We have predictable and flexible working patterns, and, if we do need to take time off, we are supported to do so.

We are always learning

- Opportunities to learn and develop are plentiful, and we are all supported to reach our potential.
- We have equal access to opportunities.
- We attract, develop and retain talented people from all backgrounds.

We are safe and healthy

- We look after ourselves and each other.
- Wellbeing is our business and our priority, and if we are unwell, we are supported to get the help we need.
- We have what we need to deliver the best possible care –from clean safe spaces to rest in, to the right technology.

We each have a voice that counts

- We all feel safe and confident to speak up.
- We take the time to really listen to understand the hopes and fears that lie behind the words.

We are recognised and rewarded

- A simple thank you for our day-to-day work, formal recognition for our dedication, and fair salary for our contribution.

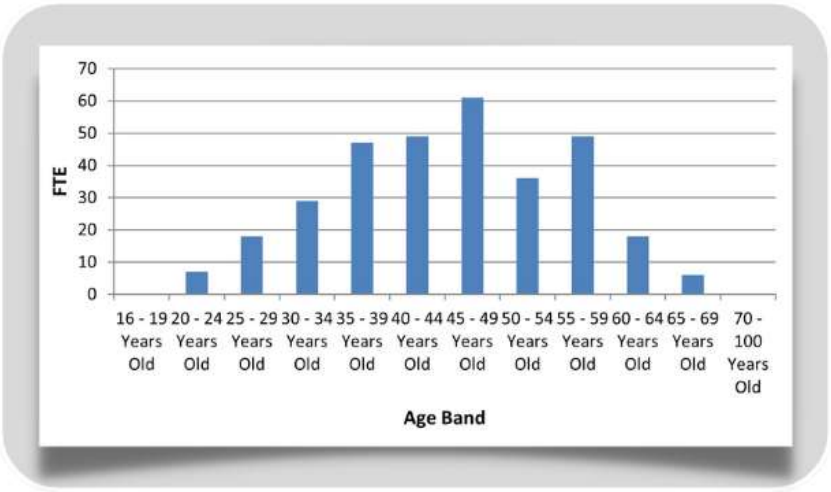
We are compassionate and inclusive

- We do not tolerate any form of discrimination, bullying or violence.
- We are open and inclusive.
- We make the NHS a place where we all feel we belong.

Workforce Profile

Our aim is to employ a diverse workforce that is representative of our local communities as we believe this will support our decision making in the development of health services.

This section illustrates the demographics of Leicester, Leicestershire and Rutland ICB workforce as of 30th September 2022, and compares the figures to Census 2021 local population data[2]. The ICB will use this data for future workforce planning.



Age

The age-band graph above shows that the largest proportions of the Leicester, Leicestershire and Rutland ICB workforce are between the ages of 45-49 (19%), 40-44 (15.3%), 55-59 (15.3%), and 35-39 (14.7%). Whilst at the other end of the scale, the lowest proportions of the LLR ICB workforce are between the ages of 65-69 (1.9%) and 20-24 (2.2%).

Census 2021 data from the Office of National Statistics (ONS[3]) details that 19% of the total resident population of Leicester, Leicestershire and Rutland local authority districts are between the ages of 35-49 so this does mirror the ICB workforce figures. However, Census 2021 data also details that 7.1% of the resident population of Leicester, Leicestershire and Rutland local authority districts are between the ages of 20-24, so this is perhaps one age group that is currently under-represented in the workforce demographic.

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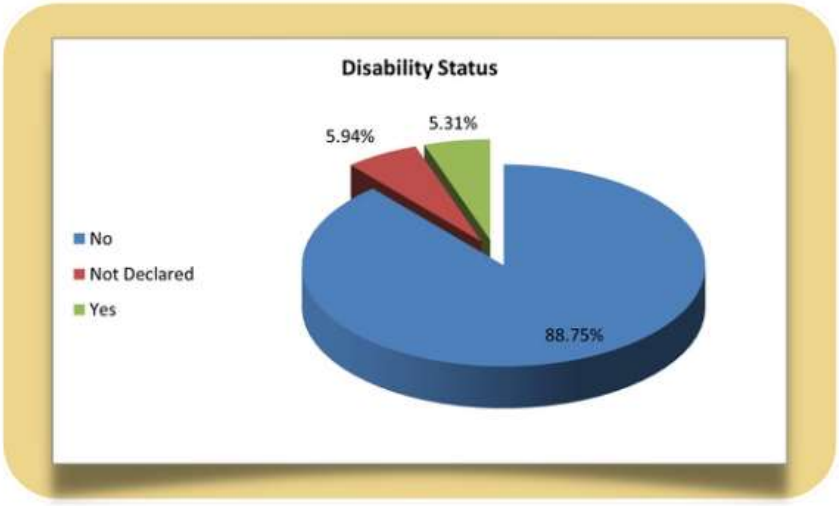
[2] Where percentages are low (under 5%) and can result in staff being identified as a result, we have not presented the data for that particular protected characteristic. However, where this occurs, we have still shown these smaller portions without figures being attributed. This is because it is important to demonstrate that we have people from diverse protected characteristic groups working at the ICB.

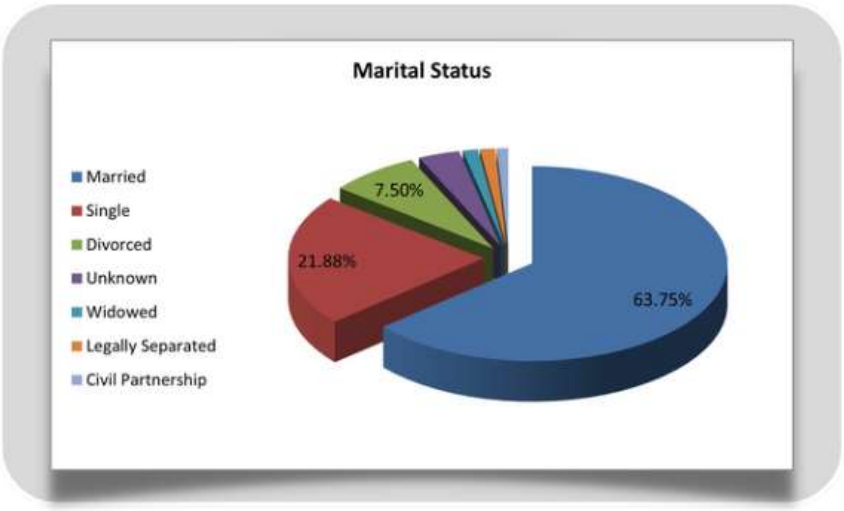
[3] https://www.nomisweb.co.uk/

Disability



The figures shown in the graph above illustrate that 88.7% of the Leicester, Leicestershire and Rutland ICB workforce identify themselves as having no disability, 5.3% declare that they have a disability, and 5.9% opted not to disclose their disability status.

Census 2021 data from the Office of National Statistics (ONS), confirms that 83.8% of the resident population of Leicester, Leicestershire and Rutland local authority districts view themselves as not being disabled under the Equality Act, whilst the local resident population figure for the disabled category was 16.2%. Therefore, the number of ICB workers with a disability is under-representative of the local population who declare a disability by 10.9%.



Marriage and Civil Partnership

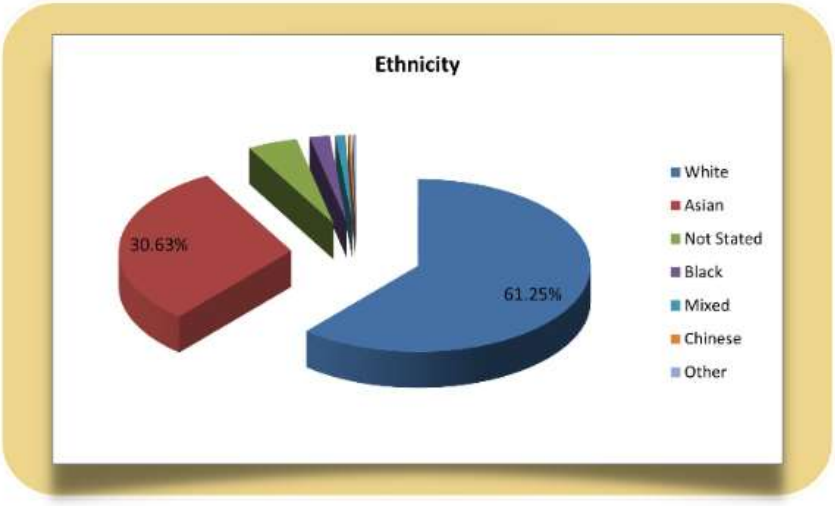
The marriage and civil partnership graph above illustrates that 63.7% of the Leicester, Leicestershire and Rutland ICB workforce identify themselves as being married. This is higher than the Census 2021 data for Leicester, Leicestershire and Rutland local authority districts, which

details that 47% of the total resident population aged 16 and above have listed themselves in the same category.

The proportion of the Leicester, Leicestershire and Rutland ICB workforce who declare themselves to be single is 21.8%. This is lower than the Census 2021 figure for the same category, for Leicester, Leicestershire and Rutland local authority district residents aged 16 and above, which is 36.5%.

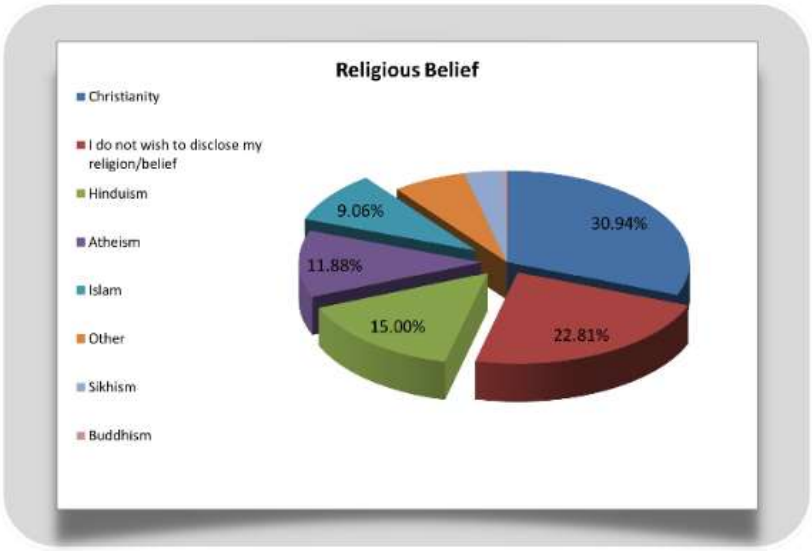
As is shown above, 7.5% of the LLR ICB workforce identify themselves as divorced. This proportion is similar to the Census 2021 figure for Leicester, Leicestershire and Rutland local authority districts for the same category, at 8.3%.

Race



The figures shown in the graph above illustrate that 61% of the Leicester, Leicestershire and Rutland ICB workforce identify themselves as White, and 30% identify as Asian. The total BAME population for the ICB workforce is 32.8%.

Census 2021 data from the Office of National Statistics (ONS), confirms results of 72.5% and 19.5% respectively, for the White and Asian ethnicity categories for the total resident population of Leicester, Leicestershire and Rutland local authority districts, and a total BAME population of 23.3%. Therefore, the BAME workforce is more than representative compared to the local population.

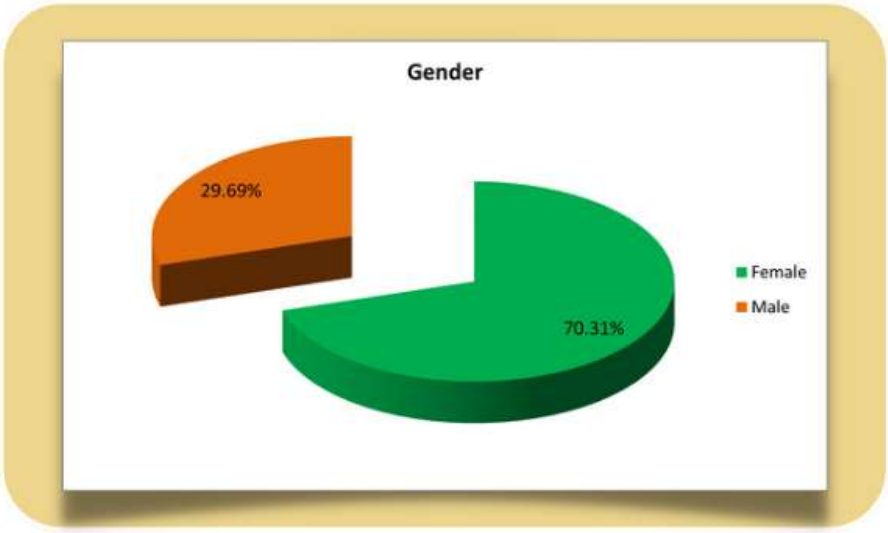


Religion and Belief

The graph above illustrates that 30.9% of the Leicester, Leicestershire and Rutland ICB workforce identify themselves as being Christian, 9% identify as Muslim, and 15% as Hindu. The Christian and Muslim figures mirror those of the 2021 Census, which gives results of 39.2% and 9.2% respectively, for the total resident population of Leicester, Leicestershire and Rutland local authority districts. The number of Hindu employees, is however, almost twice as high as the total number of local residents identifying themselves in that category, which is 8.2%.

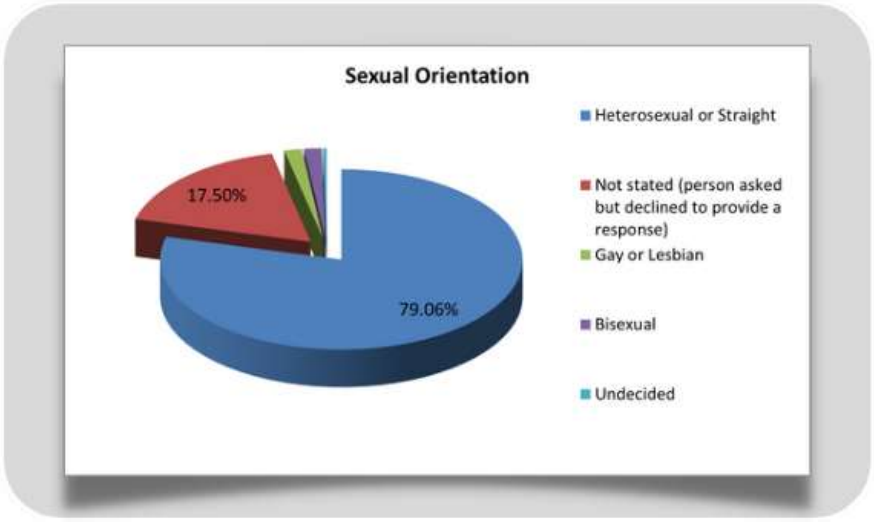
The proportion of the Leicester, Leicestershire and Rutland ICB workforce who chose not to declare their religion is 22.8%. This is almost four times higher than the Census 2021 figure for the same category, for Leicester, Leicestershire and Rutland local authority district residents, at 5.5%.

Sex



The graph above shows that two thirds of the Leicester, Leicestershire and Rutland ICB workforce are female. This reflects the latest available statistics from NHS Digital, which detail that 76.7% of the total NHS workforce are women[4].

In contrast, Census 2021 data from the Office of National Statistics (ONS) shows that 49.5% of residents in Leicester, Leicestershire and Rutland local authority districts are male, and 50.5% are female. This also mirrors the data for both the East Midlands region and England as a whole. Therefore, the number of females who work for the ICB is over representative compared to the local population.



Sexual Orientation

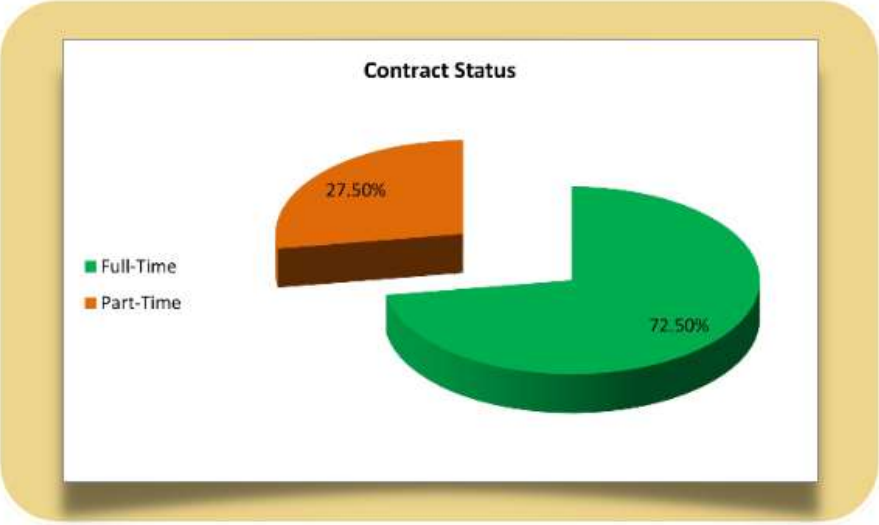
The sexual orientation graph above illustrates that 79% of the Leicester, Leicestershire and Rutland ICB workforce identify themselves as heterosexual or straight. This is slightly lower than the Census 2021 data for Leicester, Leicestershire and Rutland local authority districts, which details that 89.5% of the total resident population aged 16 and above have listed themselves in the same category.

As is shown above, 17.5% of the Leicester, Leicestershire and Rutland ICB workforce chose not to declare their sexual orientation status. This figure is almost ten percent higher than the Census 2021 data for Leicester, Leicestershire and Rutland local authority districts, which details that 7.8% of the total resident population over the age of 16 chose not to answer this question on their census form.

The total lesbian, gay or bisexual ICB workforce population is slightly higher than the equivalent population for England and Wales at 2.8%, as reported in the Census 2021 results.

[4] https://www.england.nhs.uk/2021/03/nhs-celebrates-the-vital-role-hundreds-of-thousands-of-women-have-played-in-the-pandemic/

Contract Status



The contract status figures shown in the graph above illustrate that just over two thirds of the total LLR ICB workforce are employed on a full-time basis. This mirrors the Census 2021 data from the Office of National Statistics (ONS), which details that 69.3% of the total population of Leicester, Leicestershire and Rutland local authority districts who are aged 16 and over and were in employment a week before the census, are contracted on a full-time basis also.

Workforce Race Equality Standard (WRES) 2022

The Leicester, Leicestershire and Rutland ICB is required to demonstrate “due regard” (consideration) to the Workforce Race Equality Standard (WRES), and in meeting our requirements of the ICB Assurance Framework, which means monitoring and supporting NHS and other large provider organisations with progression of the Standard.

We aim to fully understand the diversity of our workforce to ensure non-discriminatory practice, work with staff and staff representatives. The Standard helps identify and eliminate barriers and discrimination in line with the Public Sector Equality Duty (PSED), the Equality Act 2010 and Employment Statutory Code of Practice. Ultimately, it is about ensuring an inclusive approach with regards to recruitment, training and promotion.

Since its introduction in 2015, the WRES has required NHS trusts and clinical commissioning groups (now ICBs) to self-assess annually, on nine indicators of workforce race equality. These include indicators related to BAME (black, Asian, and minority ethnic) representation at senior and board level. The WRES requirement for ICBs was paused during the reporting year as we were newly established organisations.

Workforce Disability Equality Standard (WDES)

The Workforce Disability Equality Standard (WDES) was introduced in April 2019 as a mandated data collection for NHS provider trusts. The WDES is a collection of 10 metrics that aim to compare the workplace and career experiences of disabled and non-disabled staff. NHS Trusts and Foundation Trusts are required to report and publish data, on an annual basis, for each of these metrics.

At present, Integrated Care Boards (ICBs) are not required to undertake the WDES assessment. However, as part of our commitment to workforce equality and inclusion we included an action in our Equality, Diversity & Inclusion (EDI) Action Plan to voluntarily commence work on the WDES for the new Integrated Care Board (ICB). It is also important as the ICB plays an active role in the development of EDI across the system.

In October 2022 we presented a report of our first voluntary analysis to the Operational Delivery Group. We will be looking to run a development session with this group to discuss the results when we have next year's data for comparison. This report can be found in Appendix B.

The Gender Pay Gap Reporting

The specific duty regulations contain an obligation for public bodies with 250 or more staff to publish gender pay gap information each year. This duty to publish will apply to ICBs from 30 March 2024. However, the published data will cover our workforce profile on 31 March 2023, so will be collected and recorded. This is known as a snapshot.

Training and Development Opportunities

Welcome sessions

The aim of these sessions is to welcome new starters to the LLR ICB and to provide them an overview of who we are, the system that we are operating in, what they can expect from working for us as well as signposting to useful information. The welcome sessions include an EDI workshop exploring people's knowledge, and explaining the basic concepts, relevant legislation and organisational requirements.

EDI Mandatory training

LLR ICB staff are required to complete an on-line EDI training module every 3 years which is accessed via the Electronic Staff Record (ESR). The table below shows the level of compliance for all ICB staff including lay members as of September 2022:

Competency	All Workers	
	Match	No Match
NHS|CSTF Equality, Diversity and Human Rights - 3 Years	90.03%	9.97%

Details of other training and development can be found in the action plan at the end of this report, and in the Working in collaboration with LLR System Partners section.

Communication with Staff and the Wider Community

A range of communication options are regularly viewed by our staff via the following methods:

- LLR Connect – fortnightly newsletter
- Five on Friday – top 5 articles for our partners and stakeholders
- Social media (Facebook, Instagram and Twitter)
- Regular staff briefings (Virtual)
- Regular team meetings
- Pulse Survey
- Stakeholder bulletin – circulated every Thursday to external partners, MPs and stakeholders
- Annual Staff Survey

- Ad-hoc email communications to all staff
- MP briefings

Each month, we share equality awareness articles in our staff newsletters. The articles raise the profile of key equality related dates across the UK, and allows us to draw attention to local awareness and celebration events.

From July 2022 to February 2023, the ICB has promoted a range of events that promote awareness and celebration of protected characteristics and other groups including (but not limited to):

- Eid al-Adha
- South Asian Heritage Month (July-August 2022)
- World Alzheimer's Day (September 2022)
- Navratri
- Active bystander programme was mentioned at LLR ICB staff brief by Andy Williams CEO 06/09/22. Advertised in LLR connect October 28th, 2022
- Diwali promoted by Rachna Vyas Chief Operating Officer in a video clip
- International Day of Older people October 2022
- Black History Month October 2022
- World Mental Health Day: 10 October 2022
- Events for International Men's Day November 2022
- Women in Clinical leadership conference. Guest speakers included Alice Mc Gee Chief People Officer LLR ICB, Dr Nil Sanganee, Chief Medical Officer LLR ICB and Rebecca Carlin Senior OD and Workforce Manager LLR ICB November 2022.
- Anti-bullying week Nov 22
- Chinese or Lunar New Year - 'Gong Hei Fat Choy' (Happy New Year) message Jan 2023.
- Race Equality Week with an organisational anti-racist pledge made by Alice Mc Gee, Chief People Officer February 2023
- LGBTQ+ History Month with a pledge to the month made by Alice Mc Gee, Chief People Officer February 2023

Support for Staff

We have several policies in place to support staff when they have a concern about abuse, harassment, bullying or violence. Equality Impact Assessments were recently undertaken on the following policies:

- Grievance Policy
- Harassment and Bullying at Work Policy
- Health & Wellbeing policy
- Whistleblowing Policy

We will be piloting **Your Voice** in 2023, which is an online reporting tool for staff experiencing harassment, victimisation and discrimination (see the Working in collaboration with LLR System Partners section below for more information).

Working in Collaboration with LLR system partners

The national direction with regard to people development has provided LLR with an opportunity to collaborate and co-design people development practices that will enable our organisational and system workforces to be supported and developed with a cohesive and consistent approach. The cross-system development approach affords a valuable opportunity to share, design and deliver resource via the LLR Academy.

Working collaboratively, the LLR systemwide Equality, Diversity and Inclusion (EDI) Group recently identified a number of priority areas. A brief explanation and update on each area is provided below:

- **Reverse Mentoring** – seeks to pair a BAME, Disabled or LGBT+ member of staff with a senior NHS leader in a co-mentoring relationship. **Update:** Four pairs were matched from the ICB during this reporting period. There is also information about the celebratory event which took place in December where we shared feedback from the participants on page 45.
- **The Inclusive Decision-Making Framework** – is a new way of embedding Equality, Diversity and Inclusion into our culture and addressing bias in decision making. See page 15 of this report for more information.
- **Six High Impact Actions** - developed by the Midlands NHSE regional EDI Team. This forms the priority actions contained in the Midlands Workforce Race Equality Standard (WRES) and is

included in our WRES Action Plan as well as the updated action plan contained in this report. **Update:** These priority actions are now part of a wider system self-assessment tool to deliver the Workforce Strategy. The last collaborative system report was produced in December 2022.

- **Active Bystander Programme (ABP)** – a pro-active organisational approach to address harmful behaviours, promote an inclusive and compassionate culture, and role model our system values and expectations. **Update:** A pilot phase of the programme was successfully implemented across LLR, with 100 places offered across 5 groups between October 2022 and February 2023. Workshops are being followed up with monthly Action Learning Sets to embed learning, create a community of practice, and foster cultural change in 2023. Plans for a regional scale up of the ABP across Midlands ICS organisations is in the 'set up' phase and the national scale up offer is in the 'design' phase for summer 2023.

- **Your Voice** – an online tool for LLR NHS staff is (in its initial phase) for reporting experiences of harassment, victimisation and discrimination. Signposting to support available will be part of the tool. **Update:** An engagement exercise including workshops to establish and support the tool across LLR NHS organisations has been completed, and work on the design of the Your Voice platform pages for Leicester Partnership Trust and LLR Integrated Care Board is underway. This work has supported University Hospitals Leicester to explore and strengthen the support framework within the organisation.

- **LLR Staff Networks** – **Update:** The Staff Network Chairs forum has been set up with a schedule of quarterly meetings. Group members can also attend the new Equalities Advisory Committee – see below.

- **Equality, Diversity and Inclusion Advisory Committee** – a new LLR EDI Advisory Committee held its inaugural meeting in November 2022.The Committee has been set up to create a continued focus on the approach LLR takes to EDI both for its staff and our communities. The EDI advisory committee will be focussed on learning, developing and testing thinking around the equality, diversity and inclusion agenda.

  The delivery of the People Plan, of which EDI is a key component, remains the responsibility of the People and Culture Board. However, the Advisory Committee will be responsible for looking at our health

and social care priorities from a lens of our staff and our diverse population to ensure we are considering factors relating to diversity in our decision making.

The Advisory Committee is not a formal decision-making committee, but one whose format and purpose is to learn together in an open way, challenge issues in a respectful manner and collaborate to pool expertise to ensure progress is made.

The membership will have Non-Executive Directors, Directors, Staff Network representatives and EDI experts from across health, social care and the wider public sector.

The advisory committee meets quarterly to review progress and learn together. It is anticipated that the outputs of the advisory committee will form agenda items for both the NHS Integrated Care Board and the Health and Well Being Partnership.

- **Cultural Competency –** currently developing 'Cultural Enablers' which is a programme of work to support colleagues to be more culturally competent and to support enablers across the system.

Developing Diverse Leadership Programme (DDL)

LLR is focussed on creating and sustaining an inclusive culture for people working in, and people accessing our health and care system. To deliver great health and care across LLR, we know that it is important to encourage and support colleagues from diverse backgrounds to step into leadership roles. Whilst we have many success stories, our Workforce Race Equality Standard (WRES) data showed that there are differences around progression for nursing, Advanced Allied Professionals (AHP) and midwifery colleagues from BAME backgrounds compared to other ethnic groups.

The 'Developing Diverse Leaders (DDL)' tailor-made LLR pilot programme for aspiring black, Asian and minority ethnic leaders in the workplace, was designed and launched in October 2022, and was specifically aimed at Midwifery, Nursing and Allied Health Professionals AHP (Bands, 5-7) and their line managers.

The programme aims to support our leaders of the future, increase diversity at a leadership level - leading to better outcomes for colleagues

and the communities we serve - and to offer opportunity and access to development and career progression to BAME colleagues.

First Steps

In LLR we set out to embed diverse leadership differently – rather than just creating an isolated development programme for up to 40 BAME colleagues that want to move into leadership roles, we created a holistic programme that includes:

- An aligned development programme for the line managers of the participants
- Shared Action Learning Sets for participants and line managers to learn, grow and develop together
- Deep levels of organisational support via organisational leads
- Committed executive sponsorship and commitment to developing colleagues
- Informal networking and support opportunities for participants
- Further support via ‘drop-in’ sessions with executive leaders, organisational leads during the programme and access to coaching and/or mentoring via the LLR Leadership Academy
- Ongoing check-ins and career reporting to understand each participant’s career aspirations and career successes over the next two-years

This approach means that participants have access to ongoing support and development, outside of just attending a traditional training programme. We hope that by taking a systemic and long-term approach like this, we can enable participants to achieve their leadership aspirations.

Positive Change

The pilot programme has only been running for 4-months at the time of writing, but already feedback from participants and line managers has been incredibly positive. We are delighted to report that:

- relationships and trust have been developed within the groups, which appear to be consolidating into ongoing peer-to-peer support.
- participants have reported key ‘moments of impact’, such as personal branding, unconscious bias, intersectionality and privilege, and that their confidence levels have increased significantly.

- opportunities for reflective practice have been welcomed, and many participants are already sharing their new knowledge and understanding with other colleagues.

The project will be tracking the longer-term outcomes of this programme over the next 12-18 months, but this pilot programme is already demonstrating the power and impact that comes from BAME colleagues having the opportunity to focus on their own development. We are seeing our staff blossom with confidence and optimism to have the careers they want for themselves!

Time for Celebration

Success at the Midlands Inclusivity and Diversity Awards

There was success for the local NHS in Leicester, Leicestershire and Rutland (LLR), at the first MIDAS awards, with a hat trick of wins!

This year, NHS England – Midlands launched a new award scheme which recognises innovative and excellent ways of working by staff, managers, and leaders across the region, to make the Midlands a more inclusive place to work for all our NHS people.

The Midlands Inclusivity and Diversity Award Scheme - also known as 'MIDAS' – aims to celebrate and share good practice following the launch of the Midlands Workforce Race Equality and Inclusion Strategy (WREIS) last year.

The first MIDAS awards ceremony was held virtually on Friday 18 November 2022, with LLR winning three of the seven awards:

- **Inclusive Integrated Care System (ICS) of the Year Award** – awarded to Leicester, Leicestershire and Rutland ICS
- **Excellence in Executive Inclusive Leadership Award** – awarded to Angela Hillery, Chief Executive at Northamptonshire Healthcare NHS Foundation Trust and Leicestershire Partnership NHS Trust
- **EDI Champion of the Year Award** – awarded to Asha Day, Head of International Recruitment at Leicestershire Partnership NHS Trust

For a full list of winners and runners up, visit:
https://www.england.nhs.uk/midlands/wrei/midas-awards/

Rachna Vyas, Chief Operating Officer for the Leicester, Leicestershire and Rutland ICB, named as one of the 50 most influential Black, Asian and Minority Ethnic people in health

An article published by the Health Service Journal (HSJ) highlighted Rachna's work on the design and delivery of transformed models of care and the development of integrated services at place and neighbourhood level across Leicester, Leicestershire and Rutland.

Leicester is one of the country's most diverse cities and some of Rachna's work has focused on ensuring covid vaccination rates in the area are as high as possible.

Reverse Mentoring Celebration Event

ICB colleagues (including the CEO Andy Williams, Dave Sissling Independent Chair, and Alice McGee Chief People Officer) were part of the reverse mentoring celebration event which took place on the 9th December together with other system colleagues. The event celebrated all those who have been involved with the programme over the past 3 years.

Feedback from the event:

Mentees, mentors and attending leaders were asked to provide feedback on their reverse mentoring experiences, its impact and what changes they believed we can make going forward to go from good to excellent:

- As a mentor one has to have courage to empower others, make changes and take action.
- Reverse mentoring provided a safe space to have difficult conversations about differences, mutuality.
- It leads to better understanding about difficult subjects and mistakes made in the past.
- It brought forth emotions like being uncomfortable, awkward moments of silence, fearful of the unknown and its outcomes, sadness, shock, anger, trauma, assumptions, vulnerability, fear, guilt, anxiousness, ignorance, unconscious biases and personal traits. But it also brings forth experiences of excitement,

happiness, connectedness, positive intrigue, belief, acceptance, lifelong learning and lessons.

- Mentors put themselves forward to show vulnerabilities, fragilities and impact change.
- It raises awareness that we don't have all the answers.
- It helps people understand what it means to have white privilege.
- You need to have a willingness to understand and break down barriers.
- It gives you courage to empower others, make changes and take action.

The Impact of Reverse Mentoring:

- It helps you consider all perspectives, to look at equality and equity
- Reverse mentoring helps challenge thought processes and assumptions.
- As mentors and mentees, we learnt together about history, race, love, life, and health.
- We have personal growth, feel stronger and feel Reverse Mentoring has changed us forever.
- We can use the experience to impact wider change.
- We can question and challenge others.
- We have gratitude for the time taken to complete the programme.
- It builds relationships and trust beyond the programme

Health Inequalities

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

Those living in the most deprived areas often have poorer health, as do some ethnically diverse groups and vulnerable/socially excluded groups. These inequalities are due to many factors, such as income, education and the general conditions in which many people are living. In addition, the most disadvantaged groups are not only more likely to get ill, but less likely to access services when they are ill.

Health Inequalities have been made worse by the Coronavirus pandemic, which has hit hardest the groups who already did not have the best health. The rate of people dying from the virus has been higher in more economically deprived areas and among some ethnically diverse communities and amongst disabled people. People in crowded housing, on low wages, unstable or frontline work have also experienced a greater impact from Covid 19.

The NHS contributes to tackling inequalities in health in three distinct ways:

1. **Influencing multi-agency action to address social determinants of health -** The role of integrated care systems (ICSs) working with local authorities and local communities is particularly critical here.

2. **The NHS is a significant economic actor in its own right -** The choices we make as an employer, a purchaser and a local 'anchor institution' can help moderate inequalities.

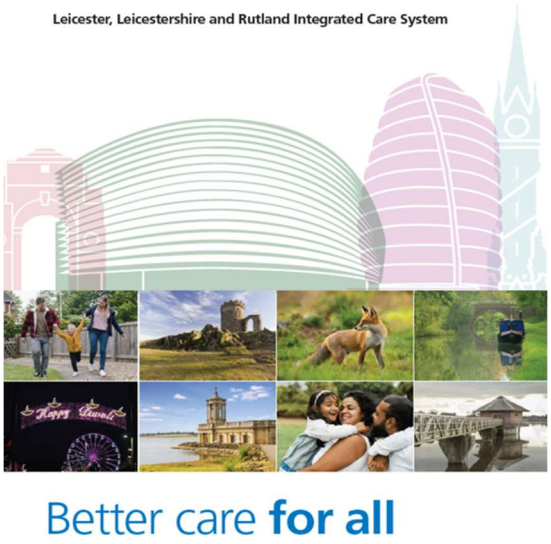
3. **Tackling inequalities in healthcare provision -** This is our direct responsibility and must be the prime focus of our action. The enduring mission of the NHS is high quality care for all. That means tackling the relative disparities in access to services, patient experience and healthcare outcomes.

Great work is happening across a number of organisations to address healthcare inequalities and we are committed to working with our partners to further enhance and accelerate this.

There is always going to be variation in health outcomes within a population, some variation is unavoidable, due to people's age or genetics, but many differences in health are avoidable, unjust and unfair.

It is because we are concerned about this that the LLR Health Inequalities Framework – Better care for all, has been developed.

The LLR Health Inequalities Framework



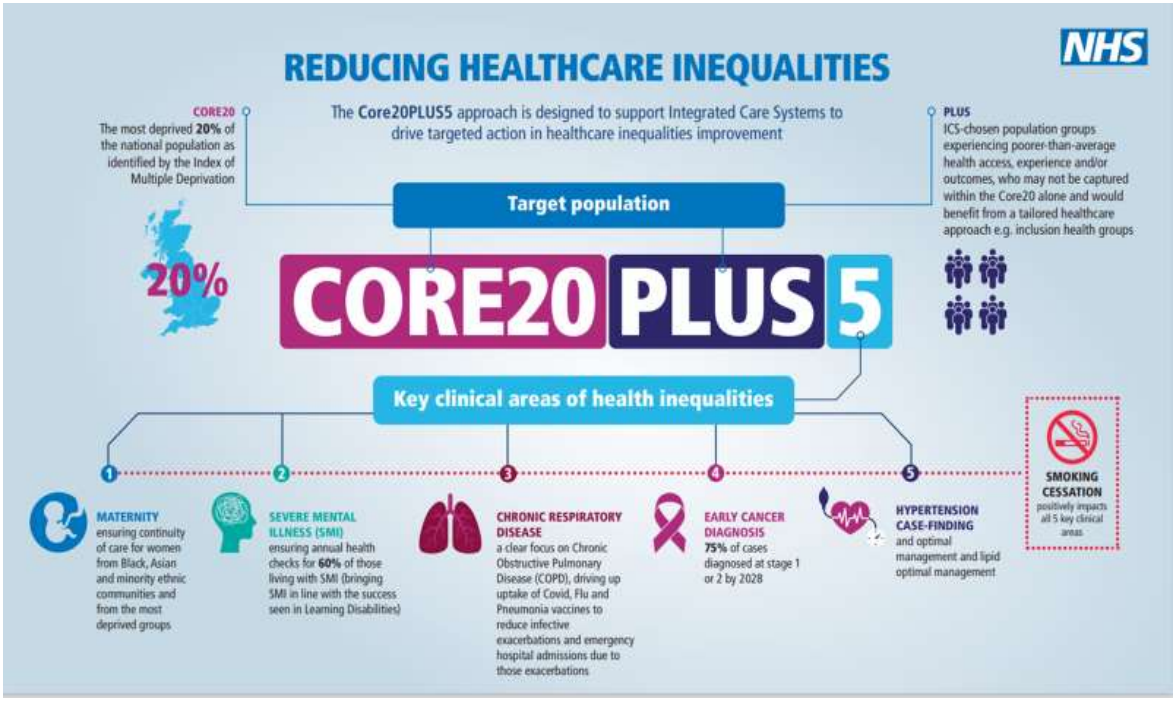
The LLR Health Inequalities Framework is the result of a collaboration of partners from across LLR, including the local NHS, Public Health, Health Watches and Local Authorities. It sets out our commitment to reducing health inequalities as a core purpose for the ICB, and for the future partnership which the Integrated Care System (ICS) represents.

The document sets out the principles we will work to, and the key actions we will take at system level to improve access to, experience of, and outcomes from local NHS services. This framework has been very positively received at regional and national levels.

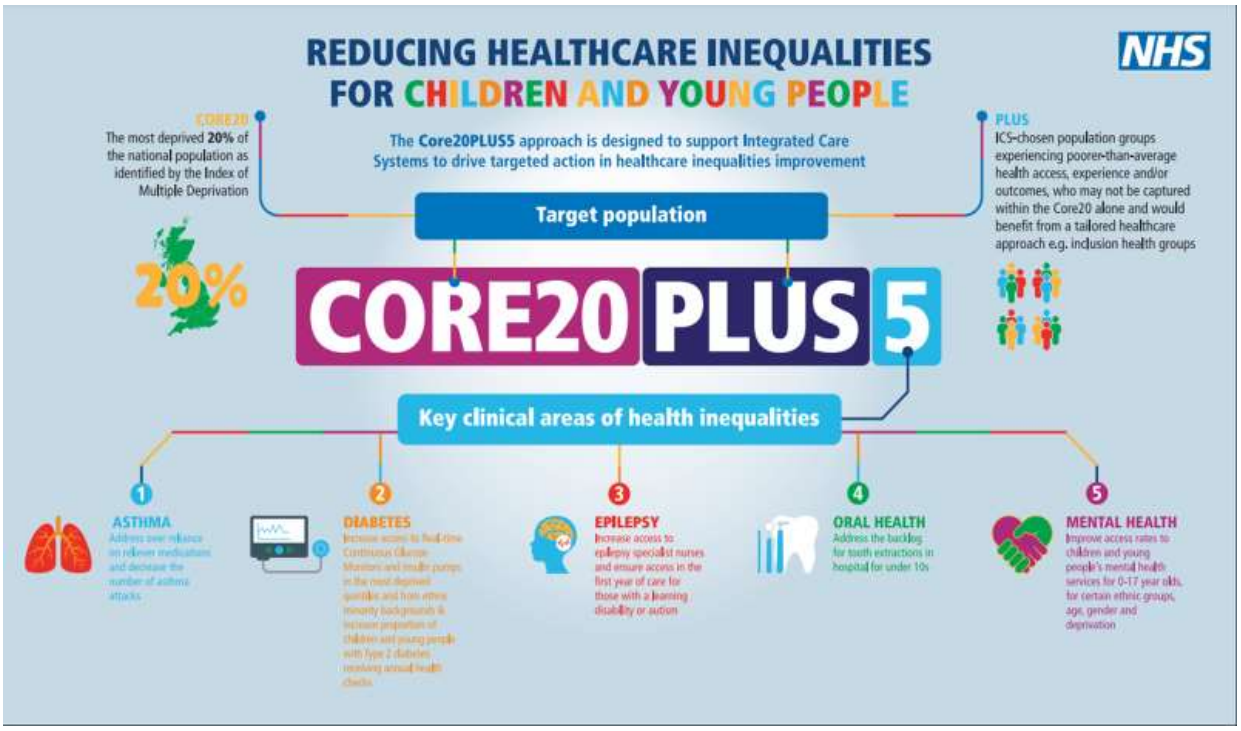
Core20PLUS5 Framework

The NHS focus on reducing healthcare inequalities is stronger each year. The LLR ICB will be working on this agenda using the CORE20Plus5 framework. The framework asks the NHS to have developed specific plans for how it will improve access, experience and outcomes for:

- people in the least affluent 20% of the population (**Core 20**)
- for locally identified additional vulnerable populations such as those who are homeless and those with a learning disability etc. (**Plus**)
- any of the following five key clinical areas of healthcare – cancer, severe mental illness, high blood pressure, pregnancy and birth, lung problems (**5**)



In November 2022, the Core20Plus5 framework was expanded to include children and young people in five different key clinical areas – asthma, diabetes, epilepsy, oral Health and mental Health:



These frameworks emphasise that the detailed plans to reduce health inequalities in each of the three “places” in LLR – Leicester City, Leicestershire, and Rutland – will be led by the local Health and Wellbeing Boards, based on their knowledge of their population’s needs. These plans will be published in each area as a refresh of their Health and Wellbeing Strategies.

Five National Key Priorities for Systems and Providers

There are also five national key priorities for systems and providers that we will focus on in Leicester, Leicestershire and Rutland and they are as follows:

Priority 1: Restoring NHS services inclusively

NHS performance reports should be broken down by patient ethnicity and Index of Multiple Deprivation (IMD) quintile, focusing on:

- Under-utilisation of services (e.g., proportions of cancelled appointments)
- Waiting lists
- Immunisation and screening
- Late cancer presentations

Priority 2: Mitigating against 'digital exclusion'

- Ensure providers offer face-to-face care to patients who cannot use remote services
- Ensure more complete data collection, to identify who is accessing face-to-face, telephone and/or video consultations (broken down by patient age, ethnicity, IMD quintile, disability status or condition)

Priority 3: Ensuring datasets are complete and timely

- Improve collection of data on ethnicity, across primary care, outpatients, A&E, mental health, community services and specialised commissioning.

Priority 4: Accelerating preventative programmes

- Flu and Covid vaccinations
- Annual health checks for people with severe mental illness (SMI) and learning disabilities
- Continuity of maternity carers
- Targeting long-term condition diagnosis and management

Priority 5: Strengthening leadership and accountability

- System and provider health inequalities leads to access Health Equity Partnership Programme training, as well as the wider support offer, including utilising a new Health Inequalities Leadership Framework (to be developed).

Fair Allocation of Resources for GP Practices

The model, created by one of our ICB primary care doctors was developed using local population health data. The new model aims to ensure that practices have a fair allocation of funding based on the needs of our resident population. Practices in areas where health outcomes are poor will need greater resources to help bring these outcomes up to the level of the healthiest places in LLR. This model will help achieve that over time. LLR is the first place in the country to do this and our work has received some very positive interest from NHS England as a possible model for other areas.

Equality Impact Assessments and Health Inequalities

The ICBs Equality, Health Inequalities, Impact and Risk Assessment template has a section specifically on health inequalities and protected characteristics which require project leads to assess for adverse impacts.

In July 2022 we improved the accessibility of the EHIIRA stage 2 template which includes new interactive tools such as drop-down menus. Additionally, the health inequalities section has been strengthened to provide the opportunity for a more detailed analysis of inclusion health groups and reflect new requirements such as Core20PLUS5.

During early 2023 planning is taking place with ICS colleagues to develop a shared equality impact assessment template which we aim to align to the health equity assessment tool and underpins the inclusive decision-making framework noted on page 15.

The ICB will consider the needs of, and impact on, populations in Leicester, Leicestershire and Rutland when undertaking its functions as a commissioner and employer by undertaking robust equality analysis on its decision making.

Engagement

LLR ICB People and Communities Strategy (2022-2024)

This past year we have focused on the development of the LLR ICB People and Communities Strategy (2022-2024). This collaborative strategy sets out how the ICB will work with people and communities. It has been developed by partners in the health system and after discussion with stakeholders.

The Strategy has been built on firm foundations of participation, involvement and engagement with people and communities over many years in LLR organisations - commissioners, providers and partners. We have recognised what has worked well and what can be done better, reflected on it and implemented improvements. We have identified many priorities through the strategy with the main objective of embedding public and patient engagement and involvement at all levels through the ICB.

Voluntary, Community and Social Enterprise (VCSE) Alliance

One of the first areas for implementation was the development and launch of a new Voluntary, Community and Social Enterprise (VCSE) Alliance, aimed to grow strong and mutually beneficial relationships with the voluntary and community sector, social enterprises and volunteers to tackle health inequalities and empower communities. Co-designed with VCSE organisations from across LLR, we have created a unique and successful way to share, collaborate and promote projects with the sector, and actively give it a voice through the ICB regardless of size, reach or experience.

With over 100 local organisations now VCSE Alliance members, we can reach into the most diverse communities and to those with whom we often seldom engage.

The VCSE Alliance plays an integral and central part of our decision making and through this model we can demonstrate we have the right methods and processes in place to reach people in the best way. This often is through collaboration, and by working with both our NHS partners and the VCSE, we can tailor our approaches to suit targeted audiences.

Through the VCSE Alliance, we remain committed to working with and commissioning organisations that can offer us specific and specialist engagement on our behalf when it is best to do so.

Specialist Engagement with Communities

In November 2022, we commissioned a local VCS organisation to coordinate rural engagement on the Hinckley hospital (which begins in January 2023), to undertake specific outreach with population cohorts to ensure that they were aware of the engagement and encourage people to take part and have their voices heard.

In January 2023, we invited VCS organisations to bid to reach out to people and communities who have used the A&E at Leicester Royal Infirmary but could have been more appropriately seen and treated elsewhere.

Through this funding opportunity, we are looking to reach those who live within a 1mile radius of Leicester Royal Infirmary and communities living in the Leicester City boundary on the main arterial roads into Leicester City, most specifically:

- Families with babies and young children under the age of 10
- People within the age group of 21-30 years (young professionals) and 31-40 years. These groups are also most likely to have children 10 years or under
- People experiencing homelessness
- Refugees and asylum seekers
- Eastern European and black, Asian, and minority ethnic communities
- Other groups with particular barriers to healthcare access.

The contract term will run from February 2023 to the end of April 2023 and will be managed through the new VCSE Alliance model.

Insights, Behaviour and Research Hub

As an Integrated Care Board (ICB) we are an organisation who are rich with data and insight. The current issue is there is no central point to access this insight, which can aid many of our collaboratives, design groups and workstreams. There is an opportunity with the implementation of a systematic and structured hub to help address this issue and make the ICB partners work more efficiently.

The objectives of the Insights, Behaviour and Research Hub are to:

- Provide information and aid in identifying gaps to help to promote understanding of what people need (including our most vulnerable groups) from local NHS services.
- Support the Integrated Care System (ICS) teams and delivery groups to interpret, utilise and identify gaps from the data in planning and decision-making processes.
- Provide the system Quality and Safety Committee with robust data that supports them to provide assurance to the ICB Board with regard to the safety and quality of care to the population we serve.
- Enable patterns of poor quality to be identified and reported to the Quality and Safety Committee and other appropriate committees.
- Tackle health inequalities by helping to ensure that we are involving a true representation of our population.
- Encourage collaboration with delivery groups to identify the impact of intelligence and articulate clearly, the difference it has made.
- Promote collaboration between initially the ICB, Leicestershire Partnership Trust (LPT) and University of Hospitals Leicester (UHL). In the longer term it will also support joint working with Healthwatch organisations, local authorities and other organisations with common interests for added value for organisations and patients.
- Provide and encourage data sharing securely across organisations which encourages financial savings by developing joint systems and processes that reduce duplication.
- Feedback to people and communities so that they can see how their voice has impacted services.
- Allow information provided by partners to be accessible in the hub.
- Ensure that the information is structured by place and communities that aligns with the ICB strategy.

We are currently in a 6-month pilot with a software company to develop the Hub, to ensure it can meet our needs and is effective to support the ICB and wider health system in the future.

Action Plan Update July 2022 – March 2023

Overarching Equality Objective: To reduce unacceptable differences in the health inequalities of all people who live within Leicester, Leicestershire & Rutland		
Equality Objective	**Linked to EDS Goal**	**Update**
1	EDS Goal 1: Better health outcomes 1.1: Services are commissioned, procured, designed and delivered to meet the health needs of local communities 1.2: Individual people's health needs are assessed and met in appropriate and effective ways	Last year's Equality Delivery System (EDS) analysis highlighted some of the key findings of the GP practice survey broken down by 8 protected characteristics. The survey and its findings related to EDS goals one and two. Following the initial response and recommendations the LLR CCG/ICB worked with the voluntary and the community sector (VCS) together with carers across Leicester, Leicestershire, and Rutland to explore their views and experiences of GP-led primary care services during the Covid-19 pandemic. As well as exploring any issues it was important to explore these because of the low response rates from certain equality groups. The follow up involved in-depth and group interviews with members of VCS and carers. These interviews were carried out via video calls and face-to-face. A number of new recommendations were developed to ensure they picked up the issues noted in the EDS analysis. The analysis was presented to Public and Patient Involvement Assurance Group (PPIAG) in February 2022 and the recommendations from this meeting has also be taken forward. The section below explores some of the work undertaken this year. A summary of the the EDS analysis was presented in the previous

		Annual Report. For a copy of the Annual Report 2021/22 or the EDS analysis please email: equality.inclusion@nhs.net.
2	EDS Goal 2: Improved patient access and experience 2.1: People, carers and communities can readily access hospital, community health or primary care services and should not be denied access on unreasonable grounds 2.2: People are informed and supported to be as involved as they wish to be in decisions about their care 2.3: People report positive experiences of the NHS 2.4: People's complaints about services are handled respectfully and efficiently	EDS primary care (access and experience): We continue to work closely with primary care colleagues, GP practices and practice managers on their improvement plans for patient access and experience. To assist, we have commissioned work with the voluntary and community sector (VCS) to share messages across communities, particularly promoting the new 'Get in the Know about local health services' campaign. We have chosen 10 GP practices to work with, offering additional support with website development, events and surveying. We continue to work with the Patient Public Involvement (PPI) Assurance Group to share developments, and with Patient Participation Groups (PPGs) to share best practice. We are supporting a digital access programme with Age UK which is trialling the training of patients on the use of computers to order prescriptions, make appointments and have online consultations.

3	EDS Goal 3: A representative and supported workforce 3.1: Fair NHS recruitment and selection processes lead to a more representative workforce at all levels 3.2: The NHS is committed to equal pay for work of equal value and expects employers to use equal pay audits to help fulfil their legal obligations 3.3: Training and development opportunities are taken up and positively evaluated by all staff 3.4: When at work, staff are free from abuse, harassment, bullying and violence from any source 3.5: Flexible working options are available to all staff consistent with the needs of the service and the way people lead their lives 3.6: Staff report positive experiences of their membership of the workforce	**3. & 3.1** Overview: In May 2021, the NHSE/I Midlands EDI team launched their Workforce Race Equality and Inclusion Strategy (WREI). Whilst primarily focussed on addressing inequality for BAME staff it is also aimed at all the protected characteristics. Initially, there were 6 actions identified as priorities. Most of these (which we are progressing on/working towards) are also found in the ICBs WRES Action Plan and are linked to our recruitment, selection and progression process. • Ensure ESMs own the agenda as part of cultural changes with improvements in BAME representation (and other underrepresented groups) e.g., targets linked to recruitment. • Diverse interview panels • Organise talent panels • Enhance EDI support available • Overhaul the interview process • Adopt resources guides and tools for productive conversations around race Subsequently the Midlands NHSE team developed an assessment tool containing the priorities above and a number of other actions to deliver all the requirements in the WREI strategy. This is updated on a regular basis and submitted to the Regional team. The last collective assessment was held on 6/12/2022.

		We have a number of workstreams taking place across the system to support a representative and supported workforce and more information on these can be found in the Working in collaboration with LLR system partners section. The ICB also voluntarily reported against the Workforce Disability Equality Standard (WDES) in October 2022. A copy of the analysis can be found in **APPENDIX B. The workforce Race Equality Standard (WRES) was suspended for the reporting year.** **3.3 – Training & Development** The ICB is actively involved in the system wide training and development initiatives taking place such as Active Bystander and the Cultural Competency enabler programme. For more information see Working in collaboration with LLR system partner's. **3.4** Free from abuse, harassment, bullying, violence at work **See 'Your Voice' and Active bystander programme in the working in collaboration with LLR partners section. This information is also captured in the WDES (attached at appendix B) and staff survey.** **3.5** – We have a new revised Flexible Working Policy. The policy outlines that the ICB is committed to offering flexible, modern employment practices which recognise that all our employees want to strike a sensible balance between their work and home life. LLR ICB recognises that different balances may be needed at different times during an employee's working life.

		The purpose of this policy is to highlight the options available for managers and employees to consider when trying to achieve the right work life balance for an employee. **3.6** The results of the staff survey will be incorporated into our staff survey action plan and is not available at the time of reporting.
4	EDS Goal 4: Inclusive Leadership 4.1: Boards and senior leaders routinely demonstrate their commitment to promoting equality within and beyond their organisations 4.2 Papers that come before the Board and other major Committees identify, equality-related impacts including risks, and say how these risks are managed	**4.1** In March 2021, a report on the external peer review of goal 4 for 2020/21 was approved at the Governing Board. One of the recommendations was: To include an EDI section in the staff newsletter and ensure that we have that dedicated focus on EDI including how the board are supporting this on a monthly basis. This could include the promotion of EDI awareness events throughout the year e.g., Diwali & Eid. A number of these events and others in the report have been promoted by senior leaders and are found in the main report and in the section called 'communication with our staff and wider community'. **4.2 The n**umber of EIAs undertaken July-February is **12** The ICB are also developing a joint ICB Quality Impact Assessment and Equality Impact Assessment Policy (EQIA) with links to relevant resources and templates. The current ICB EHIIRA template will be used until we have developed a system version.

		At the time of writing the ICB are also looking at a new governance structure for reviewing EIAs and Quality Impact Assessments.

Conclusion

The development of the ICS will allow a greater focus on preventing ill-health and managing long-term health conditions proactively to keep people well and out of hospital wherever possible.

We still face major operational challenges: tackling backlogs, meeting deferred demand, new care needs, changing public expectations, tackling longstanding health inequalities, enabling respite and recovery for those who have been at the frontline of our response, and re-adjusting to a post-pandemic financial regime. The intensity of the incident may have abated, but we are still managing exceptional pressure and uncertainty, with differential impacts across the country.

As we respond, Integrated Care Systems (ICSs) will play a critical role in aligning action between partners to achieve their shared purpose: to improve outcomes and tackle inequalities, to enhance productivity and make best use of resources and to strengthen local communities. To this end, system partners working on the equalities agenda have worked on many collaborative projects noted in this report and will continue to do so. The new Equality Delivery System is very much based on collaborative working.

The LLR ICB continues to demonstrate compliance to our legal and mandated equalities duties. We continue to embed equality considerations into decision making. This includes commissioning decisions that impact our communities and also internal workforce changes which directly or indirectly impact on our workforce.

END

This report was produced by Leicester, Leicestershire and Rutland ICB in conjunction with the Equality, Diversity and Inclusion Team at Midlands and Lancashire Commissioning Support Unit. If you have any feedback about the content of this report, please email equality.inclusion@nhs.net

Appendix A - Protected Characteristics

Age:

This can refer to people of a specific age (e.g. 50 years old) or belonging to a particular age range (e.g. 18 to 30 year olds or the general working age population). Age discrimination includes treating someone less favourably for reasons relating to their age (whether young or old).

Disability:

A person has a disability if they have a physical, mental impairment, learning disability or sensory impairment which has a substantial and long-term adverse effect on their ability to carry out normal day-to-day activities. People with a past disability which falls under the definition remain protected.

Certain medical conditions are protected under the characteristics of disability. These include cancer, HIV and multiple sclerosis. People with genetic conditions would also be protected under this characteristic if the effect of the condition has a substantial and long-term adverse effect.

Sensory impairments such as sight loss, hearing loss and communication difficulties are included under the definition of disability.

Most people will link this characteristic solely to people with visible disabilities such as limited mobility but disability also includes a wide range of invisible disabilities which may be physical or non-physical in their nature.

Invisible disabilities may include learning disabilities and conditions relating to mental health conditions and mental illness. Conditions such as dementia should also be included under this characteristic. Within in the Equality Act, there is no requirement that the mental illness is clinically recognised – the focus is on the impairment rather than the cause.

Autistic Spectrum Conditions (ASC) (sometimes termed as Autistic Spectrum Disorder or Autism) may fall within the definition of disability.

Conditions such as dyslexia and dyscalculia are generally terms as ‘learning difficulties’ and, depending on their impact on the individual, may fit the definition of ‘disability’ under the Equality Act.

In some circumstances, disfigurement may also fit the definition under the Equality Act.

Gender Reassignment:

This refers to a person proposing to undergo, who is undergoing (at any stage of the process), or has undergone the process of reassigning their sex by changing physiological or other attributes of sex. A person does not need to have undergone any specific clinical treatment or surgery to change from birth sex to preferred gender in order to be protected under this characteristic. The term ‘transgender’ is also protected under this characteristic.

Marriage and Civil Partnership:

Protection under this characteristic is given to people that are legally married or in a legal civil partnership. Marriage is defined as a union between a man and a woman, or between same-sex couples. This characteristic only recognises people in formally recognised unions and, therefore, does not include people that are not married, cohabiting couples, widows, divorcees and fiancées. Same-sex couples can also have their relationships recognised as civil partnerships. Civil partners must not be treated less favourably than married couples.

Under the Equality Act, legal protection of this group applies in an employment context only and does not extend to service provision.

Race:

Race includes skin colour, nationality, and/or ethnic or national origins. Nationality is determined by citizenship. This can include specific inclusion health groups such as Gypsy, Roma and Traveller communities, or Asylum Seekers and Refugees.

NHS organisations have adopted the term 'ethnically diverse' to describe groups that are not White British.

Religion and Belief:

The Equality Act does not provide a explicit definition of religion or belief. It includes the main world religions such as Christianity, Islam, Judaism, Hinduism, Sikhism, Humanism, Secularism and Paganism. The Equality Act protects any religion, religious or philosophical belief – this also includes a lack of religion / belief such as Atheism.

Sex:

Sex refers to individual male and female people, but also includes males and females as groups. Sex discrimination involves treating a male or female, or males and females, less favourably for reasons relating to their sex. People describing themselves as non-binary are not currently recognised within the Act.

Sexual Orientation:

A person's sexual attraction towards their own sex, the opposite sex or more than one sex. This include people who are lesbian, gay, bisexual, or heterosexual.

Pregnancy and Maternity:

The Equality Act protects people that are discriminated against due to their pregnancy or maternity status – which includes breastfeeding. This protection may relate to current or previous pregnancy. Maternity protection extends for 26 weeks from the date of the birth. Protection also includes where a baby was stillborn in cases where the pregnancy progressed for at least 24 weeks prior to birth.

Further information on the nine protected characteristics can be found at: https://www.equalityhumanrights.com/en/equality-act/protected-characteristics

Carers:

A carer is anyone, including children and adults, who looks after a family member, partner or friend who needs help because of their illness, frailty, disability, a mental health problem or an addiction and cannot cope without their support. The care that they give is unpaid.

Under the Equality Act, it is illegal to discriminate against a carer because of their responsibilities as a carer, or because of the individual(s) they care for.

Appendix B - NHS Workforce Disability Equality Standard (WDES) 2021-22

Analysis

Introduction

1. The aim of this analysis is to raise awareness of the work currently taking place on the NHS Workforce Disability Equality Standard for the ICB.
   The Workforce Disability Equality Standard (WDES) was introduced in April 2019 as a mandated data collection. The WDES consists of 10 metrics (see Appendix A) that aim to compare the workplace and career experiences of Disabled and non-disabled staff. NHS Trusts and NHS Foundation Trusts are required to report and publish data, on an annual basis, for each of these metrics.

2. At present, Integrated Care Boards (ICBs) are not required to undertake the WDES assessment. However, as part of our commitment to workforce equality and inclusion we included an action in our Equality, Diversity & Inclusion (EDI) Action Plan to voluntarily commence work on the WDES for the new Integrated Care Board (ICB). It is also important as the ICB plays an active role in the development of EDI across the system.

3. It is anticipated that ICBs will be required to undertake a WDES assessment possibly in the next reporting year. This analysis will provide baseline data for most of the metrics and will enable a better understanding where any inequalities for disabled colleagues exist.

4. It should be noted that the report is based on the combined LLR CCGs data for the reporting period 2021-2022.

National context

5. The national NHSE 2021 WDES data analysis highlights that Disabled job applicants are less likely to be appointed through shortlisting, whilst Disabled NHS staff are:

- more likely to go through performance management capability processes
- more likely to experience harassment, bullying or abuse
- less likely to feel that they have equal opportunities for career progress or promotion
- more likely to feel pressured to attend work
- less likely to feel valued for their contribution to the organisation, and less likely to feel engaged.

6. Disabled people also continue to be underrepresented in middle to senior pay bands and on Boards.

The importance of WDES

7. The WDES is deeply rooted in the fundamental values, pledges and responsibilities set out in the NHS People Plan and the NHS Constitution.

8. Section 149 of the Equality Act sets out the Public Sector Equality Duty (PSED), which offers protection in relation to employment, as well as access to goods and services. The PSED strengthens the duty on employers to eliminate discrimination and advance equality of opportunity for staff with protected characteristics, including disabled people. Implementing the WDES will assist the ICB to ensure that they are complying with the provisions of the Equality Act 2010, and the aims of the PSED.

9. As of December 2021, 8.4 million people of working age were identified as Disabled. This represents 20% of the working age population and is an increase of 327,000 from 2019. Across the UK, 52.3% of Disabled people were in employment, compared to 81.1% of non-disabled people. In relation to unemployment, the rate for Disabled people was 8.4% in October-December 2021, up from 6.9% a year previously. This compared to an unemployment rate of 4.6% for non-disabled people. (Ref: WDES guidance: House of Commons Library April 2021)

The WDES Metrics (Summary)

10. There are ten (10) WDES metrics.

    - Three (3) metrics focus on workforce data.
    - Five (5) are based on questions from the NHS Staff Survey.
    - One (1) metric focuses on disability representation on boards.
    - One (1) metric (metric 9b) focuses on the voices of Disabled staff. This asks for evidence to be provided within trusts' WDES annual reports.

11. The data on workforce profiles metrics 1,2 and 10 for 2012-22 was not available for the reporting period 2021-2022.

These are:

- Percentage of staff in AfC (Agenda for Change) pay bands or medical and dental subgroups and very senior managers (including Executive Board members) compared with the percentage of staff in the overall workforce.
- Relative likelihood of non-disabled staff compared to Disabled staff being appointed from shortlisting across all posts.
- Percentage difference between the organisation's Board voting membership and its organisation's overall workforce, disaggregated: • By voting membership of the board. • By Executive membership of the board.

Analysis of WDES (based on LLR CCG combined data for the reporting period April 2021 - March 2022)

12. The analysis is based on the LLR CCGs data mainly relating to the NHS staff survey. The staff survey offers a snapshot in time of how people experience their working lives. The analysis is to act as a baseline for the anticipated ICB mandatory reporting requirement.

13. Metrics 1 & 2 data not available as noted in paragraph 11.

14. Metric 3 - Relative likelihood of Disabled staff compared to non-disabled staff entering the formal capability process, as measured by entry into the formal capability procedure.

We cannot meaningfully report against this metric given the very small number of formal capability cases we have in the ICB (then CCG).

15. WDES Metrics 4-9a - LLR CCGs National NHS Staff Survey results 2020 & 2021 *LTC – Long term condition

	LLR CCGs National NHS Staff Survey results 2020 &2021: WDES indicators/Metrics 4-9a				
Metric No	**Staff survey question**	**Disabled people (%)**	**Disabled people (%)**	**Non Disabled people (%)**	**Non Disabled people (%)**
		2020	**2021**	**2020**	**2021**
4a.i	Percentage of staff experiencing harassment, bullying or abuse from patients, relatives, or the public in the last 12 months	3.4	4.7	4.3	3.6
		Median benchmark* 11.4	**Median benchmark*** 12.0	**Median benchmark*** 8.7	**Median benchmark*** 8.0
Number of respondents		**29/205**	**43/252**	**162/205**	**194/252**

Analysis: The percentage of disabled staff experiencing harassment, bullying or abuse from patients, relatives, or the public has risen slightly by **1.3% from 3.4 %** to **4.7%.** This is still substantially below the median of 12%.

In comparison the data shows that non-disabled staff experiencing harassment, bullying or abuse from patients, relatives or the public has decreased slightly by **0.7% to 3.6%** which is also below the median of 8.0%.

The survey results suggest that disabled staff were slightly more likely to experience harassment and bullying, from the public etc., than non-disabled staff **(4.7% compared to 3.6%).**

Metric No	**Staff survey question**	**Disabled people (%)**	**Disabled people (%)**	**Non Disabled people**	**Non Disabled people**

				(%)	(%)
		2020	**2021**	**2020**	**2021**
4a.ii	Percentage of staff experiencing harassment, bullying or abuse from managers in last 12 months	24.1	11.6	12.9	7.7
		Median benchmark* 16.9	**Median benchmark*** 12.7	**Median benchmark*** 8.7	**Median benchmark*** 7.2
Number of respondents		**29/205**	**43/252**	**163/205**	**194/252**
4a. iii	Percentage of staff experiencing harassment, bullying or abuse from other colleagues in the last 12 months	20.7	9.5	13.6	5.2
		Median benchmark* 18.0	**Median benchmark*** 15.6	**Median benchmark*** 9.1	**Median benchmark*** 8.1
Number of respondents		**29/205**	**42/252**	**162/205**	**194/252**

Analysis of 4a ii & iii - bullying and harassment from managers and colleagues Disabled staff experiencing harassment, bullying or abuse from managers has decreased significantly **from 24.1% to 11.6%.** There was also a **11.2%** decrease in harassment etc., from other colleagues from **20.7% to 9.5 %.** These figures are also under the median values.

Non-disabled staff experiencing bulling and harassment from managers has decreased from **12.9% to 7.7%** and from colleagues from **13.6% to 5.2%.**

There has been a decrease in harassment etc., for both metrics for disabled and non-disabled staff in the 2021 survey. However, the results suggest that disabled staff were more likely to experience harassment etc., from managers **(11.6% compared to 7.7%)** and other colleagues **(9.5% compared to 5.2%).**

Metric No	Staff survey question	Disabled people (%)	Disabled people (%)	Non Disabled people (%)	Non Disabled people (%)
		2020	**2021**	**2020**	**2021**
4.b	Percentage of staff saying that the last time they experienced harassment, bullying or abuse at work, they or a colleague reported it	-	-	33.3	25.0
		Median benchmark*	**Median benchmark***	**Median benchmark***	**Median benchmark***
		45.5	46.2	43.2	46.4
Number of respondents		**9/205**	**7/252**	**33/205**	**28/22**
Analysis: There were no disabled staff members (2020 &2021) who said that the last time they experienced harassment, bullying or abuse at work, they or a colleague formally reported it. The responses from non - disabled people decreased by **8.3% to 25.0%** and is significantly lower than the median of 46.4%. The number of staff responding to this question in the survey was low.					

Metric No	Staff survey question	Disabled people (%)	Disabled people (%)	Non Disabled people (%)	Non Disabled people (%)
		2020	**2021**	**2020**	**2021**
5.	Percentage of staff who believe that their organisation provides equal opportunities for career progression or promotion	48.1	63.0	63.9	65.8
		Median benchmark*	**Median benchmark***	**Median benchmark***	**Median benchmark***
		55.5	56.5	61.5	63.0
Number of respondents		**27/205**	**46/252**	**169/205**	**202/252**

Analysis: The percentage disabled respondents believing that the organisation provides equal opportunities for career progression or promotion has seen a significant increase of **14.9% to 63.0% from 48.1%.** This is above the median of 56.5%

Non-disabled staff believing that their organisation provides equal opportunities for career progression or promotion increased slightly from **63.9% to 65.8%** which is also above the median of 63.0%.

Metric No	Staff survey question	Disabled people (%)	Disabled people (%)	Non Disabled people (%)	Non Disabled people (%)
		2020	**2021**	**2020**	**2021**
6.	Percentage of staff who have felt pressure from their manager to come to work, despite not feeling well enough to perform their duties	11.8	12.5	14.5	15.4
		Median benchmark* 19.8	**Median benchmark*** 15.0	**Median benchmark*** 12.7	**Median benchmark*** 11.2
Number of respondents		**17/205**	**32/252**	**76/205**	**91/252**

Analysis: The data shows that both disabled and non-disabled staff who have felt pressure from their manager to come to work, has increased slightly, despite not feeling well enough to perform their duties; from **11.8% to 12.5%** for disabled staff and from **14.5% to 15.4%** for non-disabled staff.

The figure for disabled staff is below the median of 15.0%, while the figure for non-disabled staff is above the median of 11.2%.

The figures suggest that non-disabled people are more likely to feel pressure to come to work disabled people when feeling unwell.

Metric No	Staff survey question	Disabled people (%)	Disabled people (%)	Non Disabled people (%)	Non Disabled people (%)
		2020	**2021**	**2020**	**2021**
7.	Percentage of staff satisfied with the extent to which their organisation values their work	20.7	50.0	45.9	55.9
		Median benchmark* 49.4	**Median benchmark*** 51.1	**Median benchmark*** 59.8	**Median benchmark*** 58.9
Number of respondents		**29/205**	**46/252**	**170/205**	**202/252**
Analysis: The percentage of staff satisfied with the extent to which their organisation values their work has increased on the previous year by **29.3% to 50%** for disabled staff and by **10% to 55.9%** for non-disabled staff					

Metric No	Staff survey question	Disabled people (%)	Disabled people (%)	Non Disabled people (%)	Non Disabled people (%)
		2020	**2021**	**2020**	**2021**
8.	Percentage of staff with a long lasting health condition or illness saying their employer has made adequate adjustment(s) to enable them to carry out their work	87.5	81.8	-	-
		Median benchmark* 85.8	**Median benchmark*** 81.3	**Median benchmark*** -	**Median benchmark*** -
Number of respondents		**16/205**	**22/252**	**-**	**-**
Analysis: Although in line with the national average, there has been a decrease of **5.7%, from 87.5% to 81.8** of disabled staff saying that reasonable adjustments have been made. It suggests that **18.2%** of disabled staff had not received their adjustment at the time of reporting.					

Metric No	Staff survey question	Disabled people (%)	Disabled people (%)	Non Disabled people (%)	Non Disabled people (%)
		2020	**2021**	**2020**	**2021**
9.a	*Staff engagement score (0-10)	6.4	6.6	7.0	7.1
		Median benchmark*	**Median benchmark***	**Median benchmark***	**Median benchmark***
		6.9	6.9	7.3	7.2
Number of respondents		**29/205**	**46/252**	**170/205**	**202/252**
*The staff engagement score is a composite score calculated using the responses to nine individual questions There has been a slight improvement in engagement score for disabled staff and non-disabled staff.					

***Table includes the 2017, 2018, 2019 and 2020, 2021 CCG and benchmarking group median results.

16. **Metric 9.b Has your Trust taken action to facilitate the voices of Disabled staff in your organisation to be heard?** (Yes) e.gs include, initial stage of developing a system staff network and the development of 'your voice' – see initiatives below.

17. **Metric 10**

Percentage difference between the organisation's Board voting membership and its organisation's overall workforce, disaggregated:

- By voting membership of the Board.
- By Executive membership of the Board.

18. We do not have the data for the reporting year as a CCG. However, by using the current 2022 ICB Board membership the data shows that there were no members who declared a disability.

19. **Some initiatives currently happening for disabled people within the ICB and in collaboration with system partners:**

- The ICB have committed to signing up to 'Disability Confident'.
- The Reverse Mentoring scheme has continued to be rolled out and is open to disabled members of staff. The scheme helps increase confidence and hopefully representation in the workforce.
- We are currently developing a System Staff network(s) which will act as a group where staff can connect with colleagues with a shared characteristic, experience, or interest. Networks give development opportunities to staff who face inequality in the workplace, as well as producing events and insight for the organisation which all staff can learn and benefit from.
- The development of 'Your Voice' an online reporting tool will help to report bullying and harassment and will be piloted in the ICB 2023.
- The development of the systemwide 'Active Bystander' programme will help to address harmful behaviours, promote an inclusive and compassionate culture, and role model our system values and expectations.

Other proposals

- Re-publicise the bullying and harassment policy.
- Launch a campaign to encourage more people to complete the equality monitoring on ESR and declare their disability if they have one.
- To run a development session with the Operational Delivery Group following year two results.

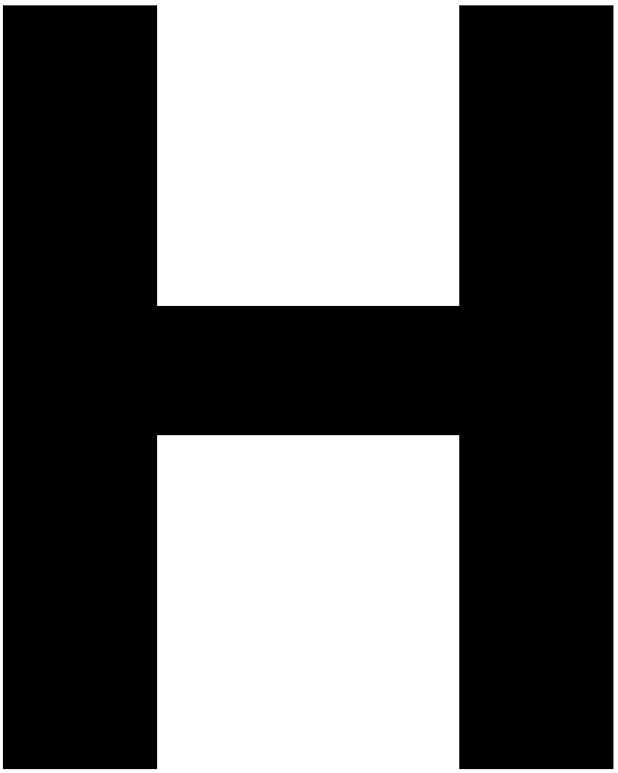
Workforce Metrics

For the following three workforce metrics, compare the data for both Disabled and nondisabled staff.

Metric 1	**Percentage of staff in AfC pay-bands or medical and dental subgroups and very senior managers (including Executive Board members) compared with the percentage of staff in the overall workforce**. Organisations should undertake this calculation separately for nonclinical and for clinical staff. Cluster 1: AfC Band 1, 2, 3 and 4 Cluster 2: AfC Band 5, 6 and 7 Cluster 3: AfC Band 8a and 8b Cluster 4: AfC Band 8c, 8d, 9 and VSM (including Executive Board members) Cluster 5: Medical and Dental staff, Consultants Cluster 6: Medical and Dental staff, Non-consultant career grade Cluster 7: Medical and Dental staff, Medical and dental trainee grades **Note:** Definitions for these categories are based on Electronic Staff Record occupation codes with the exception of medical and dental staff, which are based upon grade codes.
Metric 2	**Relative likelihood of non-disabled staff compared to Disabled staff being appointed from shortlisting across all posts.** **Note:** i) This refers to both external and internal posts ii) If your trust implements a guaranteed interview scheme, the data may not be comparable with organisations that do not operate such a scheme. This information will be collected on via the narrative WDES data return to ensure comparability between organisations.
Metric 3	**Relative likelihood of Disabled staff compared to non-disabled staff entering the formal capability process, as measured by entry into the formal capability procedure.** **Note:** i) This metric will be based on data from a two-year rolling average of the current year and the previous year ii) This metric applies to capability on the **grounds of performance and not ill health**.

National NHS Staff Survey Metrics For each of the following four Staff Survey Metrics, compare the responses for both Disabled and non-disabled staff	
Metric 4 Staff Survey Q13a-d	**a) Percentage of Disabled staff compared to non-disabled staff experiencing harassment, bullying or abuse from:** i) Patients/Service users, their relatives or other members of the public ii) Managers iii) Other colleagues **b) Percentage of Disabled staff compared to non-disabled staff saying that the last time they experienced harassment, bullying or abuse at work, they or a colleague reported it**
WDES Metrics **Metric 5** **Staff Survey Q14**	Percentage of Disabled staff compared to non-disabled staff believing that the Trust provides equal opportunities for career progression or promotion.
Metric 6 **Staff Survey** **Q11e**	Percentage of Disabled staff compared to non-disabled staff saying that they have felt pressure from their manager to come to work, despite not feeling well enough to perform their duties.
Metric 7 **Staff Survey Q5f**	Percentage of Disabled staff compared to non-disabled staff saying that they are satisfied with the extent to which their organisation values their work.
The following NHS Staff Survey metric only includes the responses of Disabled staff	
Metric 8 Staff Survey Q26b	**Percentage of Disabled staff saying that their employer has made adequate adjustment(s) to enable them to carry out their work.**
NHS Staff Survey and the engagement of Disabled staff For part a) of the following metric, compare the staff engagement scores for Disabled and non-disabled staff For part b) add evidence to the Trust's WDES Annual Report	

Metric 9	**a) The staff engagement score for Disabled staff, compared to non-disabled staff.** **b) Has your Trust taken action to facilitate the voices of Disabled staff in your organisation to be heard? (Yes) or (No)** **Note: For your Trust's response to b)** **If yes,** please provide at least one practical example of current action being taken in the relevant section of your WDES annual report. **If no**, please include what action is planned to address this gap in your WDES annual report. Examples are listed in the national WDES 2019 Annual Report.
Board representation metric For this Metric, compare the difference for Disabled and non-disabled staff.	
Metric 10	Percentage difference between the organisation's Board voting membership and its organisation's overall workforce, disaggregated: • By voting membership of the Board. • By Executive membership of the Board.



Name of meeting:	**Leicester, Leicestershire and Rutland Integrated Care Board**		
Date:	13 April 2023	**Paper:**	**H**
Report title:	**Emergency Preparedness, Resilience and Response (EPRR) Annual Update**		
Presented by:	Rachna Vyas, Chief Operating Officer		
Report author:	Amita Chudasama, Acting Head of EPRR		
Executive Sponsor:	Rachna Vyas, Chief Operating Officer		

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

Recommendations:

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

- **RECEIVE for assurance t**he LLR ICB overall EPRR annual update and the key ICB priorities for the next 12 months relating to EPRR
- **APPROVE** the EPRR plan for 23/24

Purpose and summary of the report:

1. The EPRR workstream supports the ICB to meet our responsibilities as Category 1 responders under the Civil Contingencies Act (2004) (CAA) and NHS England's Core Standards for EPRR which are audited on an annual basis.

2. This report provides the ICB with the mandatory annual update against the ICB EPRR arrangements for 2022/23 to help ensure the ICB is well prepared to respond to any disruptive challenge or emergency and serve LLR patients and communities irrespective of any adverse circumstances the ICB/ICS face.

Appendices:	• Appendix 1 – Core Standards Action Plan • Appendix 2 – ICB and ICS Work Plan – available to download from the LLR ICB website https://leicesterleicestershireandrutland.icb.nhs.uk/ • Appendix 3 – ICB Lessons Learned Log – available to download from the LLR ICB website https://leicesterleicestershireandrutland.icb.nhs.uk/
Report history (date and committee / group the content has been discussed / reviewed prior to presenting to this meeting):	• LLR ICB Executive Management Team meeting 13th March 2023

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.*	This report provides assurance of mitigations in place to support risks relating to EPRR and business continuity and risks are escalated accordingly in line with the risk management processes.
b) Does the report highlight any resource and financial implications? If so, provide which page / paragraph this can be found within the report.	No specific resource implications identified as this is a report providing assurance.
c) Does the report highlight quality and patient safety implications? If so, provide which page / paragraph this is outlined in within the report.	No specific quality and patient safety implications identified as this is a report providing assurance.
d) Does the report demonstrate patient and public involvement? If so, provide which page / paragraph this is outlined in within the report.	Not required 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 required in relation to the production of this report.

LLR ICB EPRR ANNUAL UPDATE

13th April 2023

Introduction

1. The purpose of this report is to assure the ICB Board on the progress made in the ICB EPRR arrangements. This report provide an annual update on the following:

    - EPRR governance arrangements;
    - Compliance with NHS England Core Standards for EPRR;
    - EPRR work programme;
    - EPRR policies and plans;
    - EPRR training, testing and exercising;
    - Summary of any business continuity, critical and major incidents experienced by the organisation.
    - Lessons identified and learning undertaken from incidents and exercises.
    - Collaborative working
    - Summary of work completed to date.
    - EPRR Priorities for 2023/24

EPRR Governance Arrangements

2. To support the statutory and non-statutory requirements for EPRR, the ICB has an Accountable Emergency Officer (AEO), Andy Williams. This role has strategic responsibility for EPRR provides assurance to the Board that LLR ICB is meeting its requirements. The AEO has delegated operational responsibility to the ICB Chief Operating Officer, Rachna Vyas.

3. The EPRR governance structure is via the ICB Executive Management Team, chaired by Andy Williams and includes Executive representation from all ICB directorates.

4. The EPRR Team consists of a full-time Acting Head of EPRR (Amita Chudasama), 1 full time EPRR Senior Officer (Sara Watson), and 1 fixed-term SPOC Administrator (Priyanka Jadav). 2 x full time Band 4 administrator vacancies need to be recruited to and these roles will cover EPRR, UEC and DoS administration.

5. The ICB works closely with EPRR teams across the ICS footprint to ensure joined up working and alignment of emergency plans across LLR. The ICB takes the lead for health representation at LRF meetings, and the team are supported by the UHL and LPT EPRR teams. As part of the LRF Executive restructure the ICB will take strategic leadership of the LRF People and Communities Group with Andy Williams appointed as the Executive Lead.

Compliance with NHS England Core Standards for EPRR

6. The NHS Core Standards for EPRR are the minimum standards which all NHS organisations and providers must meet to comply with the requirements of the Core Standards Framework, the NHS Contract, and the Civil Contingencies Act 2002.

7. The ICB EPRR team undertook a self-assessment against the relevant individual core standards and self-assessed against the compliance rating. In total there were 47 standards that were applicable to the ICB. The ICB submitted an overall Partial Compliance to NHSE in September 2022.

8. Following a confirm and challenge exercise by NHSE the ICB revised this to non-compliance and resubmitted in November 2022. This was largely as a result of the timing of requirements as the ICB was formed. A detailed action plan has been created to address the standards that were non-compliant and monthly assurance meetings have been scheduled with NHSE to monitor progress, with no issues raised thus far.

9. The action plan is attached as Appendix 1 to this paper. Progress against the action plan continues:
    a. the EPRR and Corporate Team have met with NHSE to review the 10 business continuity standards in detail to enable a better understanding of the requirements to meet full compliance.
    b. The EPRR Team are liaising with UKHSA with regards to High Consequence Infectious Disease to enable the updating of action cards within the ICB Major Incident Plan and work continues with UHL and LPT with regards to testing the Mass Countermeasures Plan and the Evacuation and Shelter Plans. This may not be achieved before the next round of Core Standards due to the complexities of planning such large exercises.
    c. With regards to the training and exercising standards work continues with LRF colleagues to align training needs and courses, further information for this is shown below in the collaborative working section.

EPRR Work Programme

10. The EPRR team have updated the ICB work programme for EPRR and created a ICS wide EPRR work programme. The ICB programme includes:

- Updates to ICB and LRF plans and policies,
- Maintenance of on call packs and on call documentation.
- Updates to contact directories both local and regional.
- ICB training and exercising.
- Training needs analysis.
- Wider exercising within the ICS and regional exercise
- Management of HEPOG and LHRP
- Business Continuity Planning

The working draft of both the ICB and ICS work programme is attached as Appendix 2 which details all the work streams (2 separate tabs on excel worksheet).

EPRR Policies and Plans

10. Updating EPRR policies and plans contributes to a significant proportion of the EPRR work programme with most plans and policies requiring an annual update. The following plans and policies have been updated in the last year:

- EPRR Policy
- Major Incident Plan
- ICB On Call Handbook
- LLR OPEL Surge & Escalation Plan
- Hot and Cold Weather Plans
- Mass Casualties Framework
- Pandemic Influenza Concept of Operations

EPRR Training, testing and exercise

11. In the past year the ICB have added 13 new staff who have all had the local training for ICB on call processes.

12. 49 members of staff including the EPRR team, on call staff and the Executive Management Team have attended the NHSE Principles of Health Command training and 5 more staff are due to attend once new dates are released.

13. The EPRR Team have held several MS Teams learning sessions for on call staff. Topics have ranged from dealing with a major incident, on call process, Operation London Bridge, ambulance handover delays and general escalation processes. Going forward the EPRR team will be scheduling quarterly on call sessions with topics being agreed as per system demands or escalations.

14. ICB on call staff have attended a number of internal and external exercises over the last year as detailed below:

- Exercise VANYA – this was a series of immersive LRF Strategic Coordinating Group (SCG) and Tactical Coordinating Group (TCG) in person exercises held at Shepshed Fire Station. The exercises gave ICB on call staff the experience of attending a multi-agency LRF SCG or TCG meeting to coordinate a response to a major incident (2022/23)
- Exercise Albus – ICB major incident training exercise (June 2023)
- Exercise Toucan I and II – online/telephone exercise run by NHSE testing in and out of hours communication and cascade mechanisms. (July and Oct 2022)
- Exercise Lemur – LRF power outage exercise (Nov 2022)
- Floodex – LRF led flooding immersive TCG and SCG exercise (Nov 2022)
- Exercise Arctic Willow – workbook and tabletop exercise carried out via MS Teams testing the health response to multiple, concurrent operational and winter pressures. (Dec 2022).

16. Planning is underway for future exercises including:
    - Exercise Mighty Oak a national Power Outage Exercises in March 2023 and
    - Exercise Volturnus which will replace Exercise VANYA and be run across dates in 2023/24.
    - The EPRR team are also working closely with the Corporate team to carry out a Business Continuity exercise in April
    - Working with the ICB Communications Team to test the ICB EPRR Communications Plan.
    - Wider ICS exercises are also being planned with UHL and LPT to test Mass Countermeasures Plan.

Summary of any business continuity, critical and major incidents experienced by the organisation

17. The EPRR Team have been involved in co-ordinating and managing a number of ICS wide incidents including:

    i. Cyber Incident (Advance System outage) Aug 2022
    ii. Operation London Bridge (Queen's Death) Sept 2022
    iii. Church Gate building collapse Sept 2022
    iv. East Leicester Disorder Sept 2022
    v. Blood Stock shortages Oct 2022

vi. Gravel Street Nightclub Fire Oct 2022
vii. UHL Critical Incident (increasing pressure in ED and ambulance handover) Dec 2022
viii. UHL Power Outage Incident March 2023.

Lessons identified and learning undertaken from incidents and exercises

18. NHSE share quarterly learning from incidents, exercises and events which occur across the Midlands to enable good practice to be embedded across organisations. The ICB have a process in place to review the lessons identified, extract those that apply to the ICB and ensure corrective action is taken. The ICB then provides a quarterly update at the HEPOG meetings. As at February 2023 51 learning points were applicable to the ICB and 27 of these had been addressed. Appendix 3 to this document provides the ICB Lessons Learned Log and action plan to address the outstanding learning points.

Collaborative Working

19. In order to maximise the use of available resources and maximise performance to achieve mutual objectives it has been imperative that ICS and LRF partners work together to achieve our mutual objectives and ensure value for money. To this end, the 3 EPRR Leads from the ICB, UHL and LPT collaborate on EPRR planning and policies ensuring we share resources where possible, have joint exercising which enables the testing of individual organisation plans and policies in a joint forum and ensure that any new plans or policies are mutually developed utilising the same framework which can then be adapted to individual organisational needs and requirements.

20. We share templates where possible and have already started to create joint evidence for this year's core standards submission which will mean the process is less burdensome on all 3 organisations and demonstrates partnership working. Closer working links with the LRF have meant that we have been able to utilise the LRF training budget to send staff on Multi-Agency and JESIP Commander courses which can range in price from £3000 upwards.

21. We will also have training places on loggist training and other tactical and strategic courses. The LRF have also adopted the Health Minimum Occupational Standards for Civil Contingencies which will provide the framework for future training and exercising which will assist health organisations to demonstrate how they meet the training and exercising Core Standards and other LRF organisations to meet the National Resilience Standards and avoids duplication of work across the ICS footprint.

22. The ICB will also have access to an online training and learning platform to enable the EPRR team to keep track of training requirements, course completion and competency assessment which will also be paid for from the LRF Training budget.

23. This partnership working has enabled the ICB to be part of a wider working group that shares a single purpose, brings together complementary skills, improves productivity, and has enabled more agile and flexible working to manage the demands of the extensive EPRR portfolio.

Summary of work completed to date

24. The ICB EPRR Team have undertaken a significant workload in the last 12 months to continue to deliver against work described in the CCG 2022 work programme. In addition to the normal day to day delivery of EPRR functions the team have also overseen a number of additional responsibilities:

- Transition to becoming an ICB and the relevant assurance processes required by NHS England (NHSE) to ensure the ICB could meet its obligations as a Category 1 responder under the CAA 2004.
- Devolvement of the Health Emergency Planners Operational Group (HEPOG) and the Local Health Resilience Partnership (LHRP) meetings to the ICB to Chair and lead on including the development of the ICS EPRR Work Programme and EPRR Risk Register.
- The setting up of the Single Point of Access (SPOC) mailboxes for both Incidents and EPRR business as usual. All NHSE correspondence is via the SPOC with the ICB responsible of distributing to providers and workstream leads and ensuring coordinating and return of any information. NHSE asked all ICBs to put in place governance processes to ensure all information is logged and tracked (this is shown in Fig 1 below).

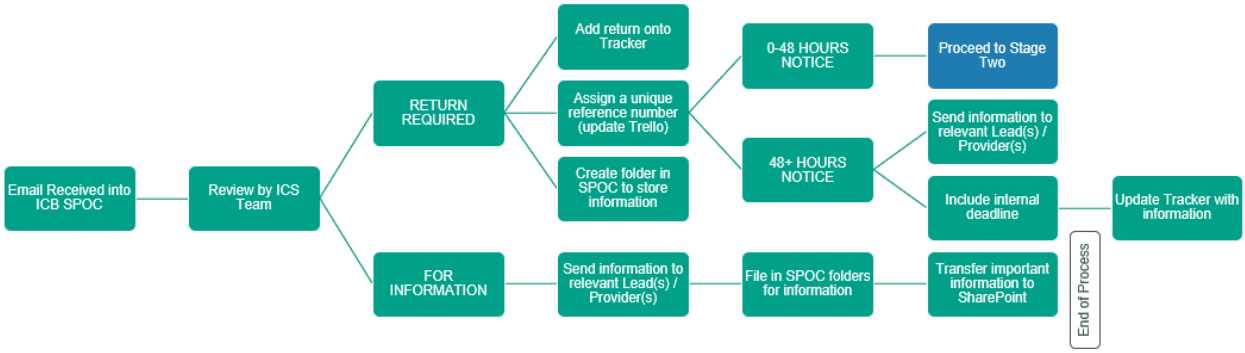


Figure 1 – SPOC process

- Setting up the System Control Centre (SCC) that operates 7 days a week, 365 days a year with 0800-2000 staffing cover. SCCs proactively lead the system response and manage proactive planning as well as lead on the day-to-day management of system performance as well as manage times of surge or critical incidents aligned to existing EPRR arrangements. The ICB SCC is located at Room G31 in County Hall. The room is now fully set up with live data feeds from UHL Nervecentre and the National Ambulance Coordination Centre (NACC) which will enable the SCC Leads to monitor performance and be responsive to any system pressures and escalate as appropriate.

- 360 Assurance review to provide assurance in respect of the ICBs business continuity and EPRR arrangements to assess that ICB policies cover all necessary regulation, including statutory responsibility and action plan in place to monitor compliance with the EPRR Core Standards. The audit is ongoing with a final reported expected in April 2023.

- Lead health organisation ownership for the Local Resilience Forum (LRF). The ICB is now responsible for co-ordinating health services between individual health organisations and at a multi-agency and LRF level and ensure coordination across the ICS footprint. This was previously the role of NHSE.

- Overseen the mobilisation of the response to Monkeypox and the actions to be followed to swab and treat patients if necessary.

- Coordinate the plan to deliver single dose Diphtheria vaccination and appropriate course of antibiotics to and eligible contacts arriving in LLR as asylum seekers/refugees from the Manston Centre in Kent.

- Coordinating the response to the world-wide shortage of Becton Dickinson's Blood Tubes in conjunction with UHL.

- Providing information to the COVID-19 Public Inquiry.

- Planning and coordination for all Industrial Action dates.

EPRR ICB Priorities

25. The EPRR workload continues to grow substantially, and the team strives to maintain the balance of delivery against core EPRR workstreams and the ongoing demands of the SCC and SPOC as well as supporting the wider ICS with planning for Industrial Action and managing incidents.

26. The key priorities of the EPRR team will focus on:

    a. 2023/24 Core Standards assessment process with a view to improving on the current non-compliant rating to achieve a substantially compliant position over the next 12 months.
    b. Achievement of the ICB and ICS EPRR work plan.
    c. Continued system working with ICS partners to achieve streamlined EPRR processes.

Recommendations:

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

- **RECEIVE for assurance t**he LLR ICB overall EPRR annual update and the key ICB priorities for the next 12 months relating to EPRR
- **APPROVE** the EPRR plan for 2023/24

Appendix 1

Ref	Domain	Standard name	Standard Detail	Self assessment RAG Red (not compliant) = Not compliant with the core standard. The organisation's work programme shows compliance will not be reached within the next 12 months. Amber (partially compliant) = Not compliant with core standard. However, the organisation's work programme demonstrates sufficient evidence of progress and an action plan to achieve full compliance within the next 12 months. Green (fully compliant) = Fully compliant with core standard.	Action to be taken	Lead	Timescale	Comments	Updates/Comment	RAG
Domain 1 - Governance										
4	**Governance**	**EPRR work programme**	The organisation has an annual EPRR work programme, informed by: • current guidance and good practice • lessons identified from incidents and exercises • identified risks • outcomes of any assurance and audit processes The work programme should be regularly reported upon and shared with partners where appropriate.	Fully compliant	The work programme needs to be further refined and dates and leads added to some of the workstreams	Amita Chudasama	Oct-22	Reassessed during confirm and challenge mtg 07.11.22 can remain fully compliant	Work programme updated as per HEPOG Feb 2023 - ICS programme will go to LHRP in Feb for sign off. ICB Programme will got to EMT in Feb for sign off	
6	**Governance**	**Continuous improvement**	The organisation has clearly defined processes for capturing learning from incidents and exercises to inform the review and embed into EPRR arrangements.	Fully compliant	Policy update needs to include the regional lessons process	Amita Chudasama	May-23		Next review date is May 2023	
Domain 2 - Duty to risk assess										
7	**Duty to risk assess**	**Risk assessment**	The organisation has a process in place to regularly assess the risks to the population it serves. This process should consider all relevant risk registers including community and national risk registers.	Fully compliant	To be approved by HEPOG Risk Group - updated with NRR and further detail.	Amita Chudasama	Nov-22	Reassessed during confirm and challenge mtg 07.11.22 can remain fully complaint	Risk Register approved at Feb 2023 HEPOG - going to LHRP in March 2023 for final sign off	
Domain 3 - Duty to maintain Plans										
9	**Duty to maintain plans**	**Collaborative planning**	Plans and arrangements have been developed in collaboration with relevant stakeholders to ensure the whole patient pathway is considered.	Fully compliant	Multiagency consultation process needs to be formalised - document/table to be created	Amita Chudasama	Jan-23		No actions commenced as yet	Not Started
10	**Duty to maintain plans**	**Incident Response**	In line with current guidance and legislation, the organisation has effective arrangements in place to define and respond to Critical and Major incidents as defined within the EPRR Framework.	Fully compliant	Remove NHS Improvement in next reiteration. Check formatting (numbers) Section 2.3 to be updated to include alerting NHSE OOH	Amita Chudasama	Apr-23		Next review due June 2023, however formatting etc will be done by end April 2023	

11	Duty to maintain plans	Adverse Weather	In line with current guidance and legislation, the organisation has effective arrangements in place for adverse weather events.	Fully compliant	Overarching severe weather plan to be produced in conjunction with the LRF. Severe weather triggers and response to be included in ICB On Call Handbook.	Sara Watson/Andrew Murr	Nov-22	Reassessed during confirm and challenge mtg 07.11.22 can remain fully compliant.	Awaiting LRF to draft overarching Severe Weather Conops - ICB Hot and Cold weather plans already updated and will form annexe to LRF CONOPS	
12	Duty to maintain plans	Infectious disease	In line with current guidance and legislation, the organisation has arrangements in place to respond to an infectious disease outbreak within the organisation or the community it serves, covering a range of diseases including High Consequence Infectious Diseases.	Partially compliant	Detailed Health process (plan) for HCID with action card in Major Incident Plan for ICB roles to be created.	Amita Chudasama	Mar-23	Reassessed during confirm and challenge mtg 07.11.22 downgraded to partial	Requested updated process from UKSHA (Susanne Howes) - once received the ICB process icluding action card will be produced	
13	Duty to maintain plans	New and emerging pandemics	In line with current guidance and legislation and reflecting recent lessons identified, the organisation has arrangements in place to respond to a new and emerging pandemic	Fully compliant	When plan is updated include social distancing, virtual working etc	Amita Chudasama	Mar-23	Changed to observational following confirm and challenge mtg 07.11.22 can remain fully compliant	Next update of Flu Plan due March 2023 - work already commenced to review and updates have been requested from UKSHA - response from Susanne was CRC colleagues are planning updates soon (no timeframe).	
14	Duty to maintain plans	Countermeasures	In line with current guidance and legislation, the organisation has arrangements in place to support an incident requiring countermeasures or a mass countermeasure deployment	Partially compliant	Revised plan to be tested	Jonathan Broadbridge UHL	Aug-23		Awaiting UHL exercise - no actions commenced from ICB as yet	Not Started
15	Duty to maintain plans	Mass Casualty	In line with current guidance and legislation, the organisation has effective arrangements in place to respond to incidents with mass casualties.	Fully compliant	LRF Plan has been updated reference to be made in Major Incident Plan. Awaiting LRF consultation process. UHL and LPT plans to include details from the LRF plan.	Amita Chudasama/Mo Patel/Mike Ryan	Nov-23	Changed to observational following confirm and challenge mtg 07.11.22 can remain fully compliant	Mass Casualties Framework updated Jan 2023 - roles and responsibilities to be updated/added to ICB Major Incident Plan. Awaiting UHL Mass Cas exercise Aug 2023	

16	Duty to maintain plans	Evacuation and shelter	In line with current guidance and legislation, the organisation has arrangements in place to evacuate and shelter patients, staff and visitors.	Partially compliant	Evacuation and Shelter Plans to be added to the ICS exercising schedule	UHL/LPT with support from Amita Chudasama	Jul-23		This has been added to the ICS work programme - system agreement on date for exercise required.	
Domain 4 - Command and control										
20	Command and control	On-call mechanism	The organisation has resilient and dedicated mechanisms and structures to enable 24/7 receipt and action of incident notifications, internal or external. This should provide the facility to respond to or escalate notifications to an executive level.	Fully compliant	Update NHSE&I to NHSE in next iteration of the on call handbook				LLR ICB On-Call Handbook updated in December 2022. All NHSEI references have now been changed to NHSE	
21	Command and control	Trained on-call staff	Trained and up to date staff are available 24/7 to manage escalations, make decisions and identify key actions	Partially compliant	Training needs analysis to be carried out. Personal training records and exercising portfolio's to be developed for key on call staff members	Amita Chudasama	Nov-23	Reassessed during confirm and challenge mtg 07.11.22 downgraded to partial	Training Records created for all DoC's, TNA remains to be carried out, currently reviewing software (MYRUS) in conjunction with the LRF which will enable us to record all training in a central location, identify further training requirements and monitor compliance.	
Domain 5 - Training and exercising										
22	Training and exercising	EPRR Training	The organisation carries out training in line with a training needs analysis to ensure staff are current in their response role.	Partially compliant	Training needs analysis to be carried out. Personal training records and exercising portfolio's to be developed for key on call staff members	Amita Chudasama	Nov-23		Training Records created for all DoC's, TNA remains to be carried out, currently reviewing software (MYRUS) in conjunction with the LRF which will enable us to record all training in a central location, identify further training requirements and monitor compliance.	
23	Training and exercising	EPRR exercising and testing programme	In accordance with the minimum requirements, in line with current guidance, the organisation has an exercising and testing programme to safely* test incident response arrangements, (*no undue risk to exercise players or participants, or those patients in your care)	Partially compliant	ICB Exercise Programme to be developed. Business Continuity Exercise to take place in 2023	Daljit Kaur Bains supported by EPRR Team	Apr-23		Exercise Programme started but not completed - Mighty Oak, Business Continuity, communications and ICC identified as areas to be tested. Further work required to set dates	

24	**Training and exercising**	**Responder training**	The organisation has the ability to maintain training records and exercise attendance of all staff with key roles for response in accordance with the Minimum Occupational Standards. Individual responders and key decision makers should be supported to maintain a continuous personal development portfolio including involvement in exercising and incident response as well as any training undertaken to fulfil their role	Partially compliant	Training records to be cross reference against the Minimum Occupational Standards. Personal training records and exercising portfolios to be developed for key on call staff members	Amita Chudasama	Nov-23	A LRF document detailing the MOS has been created and will be presented to the LRF Exec Board on 1st March (currently draft is under consultation). Once approved the ICB will adopt this document to cross reference against the training records	
25	**Training and exercising**	**Staff Awareness & Training**	There are mechanisms in place to ensure staff are aware of their role in an incident and where to find plans relevant to their area of work or department.	Partially compliant	To ensure training and exercising updates are provided as part of the EPRR update to the Board.	Amita Chudasama	Mar-23	EPRR update going to System Exec Board in March and ICB Board in April 2023 - training and exercising will be covered as part of the update	
Domain 6 - Response									
26	**Response**	**Incident Co-ordination Centre (ICC)**	The organisation has in place suitable and sufficient arrangements to effectively coordinate the response to an incident in line with national guidance. ICC arrangements need to be flexible and scalable to cope with a range of incidents and hours of operation required. An ICC must have dedicated business continuity arrangements in place and must be resilient to loss of utilities, including telecommunications, and to external hazards. ICC equipment should be tested in line with national guidance or after a major infrastructure change to ensure functionality and in a state of organisational readiness. Arrangements should be supported with access to documentation for its activation and operation.	Partially compliant	ICC Plan to be tested. Training and testing schedule to be established.	Amita Chudasama	May-23	ICC Plan finalised - awaiting sign off. Training and testing schedule not yet completed.	
27	**Response**	**Access to planning arrangements**	Version controlled current response documents are available to relevant staff at all times. Staff should be aware of where they are stored and should be easily accessible.	Fully compliant	Offline plans saved on individual laptops	Amita Chudasama	Jan-23	All DoC's have been sent instructions to save on call documents and plans on hard drive. Paper copies are also available in the ICB SCC at County Hall.	
29	**Response**	**Decision Logging**	To ensure decisions are recorded during business continuity, critical and major incidents, the organisation must ensure: 1. Key response staff are aware of the need for creating their own personal records and decision logs to the required standards and storing them in accordance with the organisations' records management policy. 2. has 24 hour access to a trained loggist(s) to ensure support to the decision maker	Partially compliant	Loggist refresher training	Amita Chudasama	May-23	Currently sourcing loggist training - looking at carrying out joint training with LRF partners a number of providers have been identified awaiting details of training and costings.	

30	Response	Situation Reports	The organisation has processes in place for receiving, completing, authorising and submitting situation reports (SitReps) and briefings during the response to incidents including bespoke or incident dependent formats.	Fully compliant	For next iteration include in the arrangements the need to establish situation rhythm, the person who may sign off the report and who in the incident structure has responsibilities for the completion of the report.	Amita Chudasama	Jun-23	Next iteration will be June 2023 when the sitrep arrangements will be refreshed and strengthened.	Not started
Domain 7 - Warning and informing									
33	Warning and informing	Warning and informing	The organisation aligns communications planning and activity with the organisation's EPRR planning and activity.	Fully compliant	Next iteration to include trolling. Remove CCG and NHSEI and replace with ICB and NHSE	Dave Rowson	Mar-23	With the comms team and update expected by 31st March 23	
34	Warning and informing	Incident Communication Plan	The organisation has a plan in place for communicating during an incident which can be enacted.	Partially compliant	Major Incident Comms Plan to be tested in and out of hours and as part of an ICB major incident exercise	Amita Chudasama/ Dave Rowson	Jun-23	Included in exercising schedule and will be tested as part of Major Incident Plan exercise.	Not started
Domain 8 - Cooperation									
39	Cooperation	Mutual aid arrangements	The organisation has agreed mutual aid arrangements in place outlining the process for requesting, coordinating and maintaining mutual aid resources. These arrangements may include staff, equipment, services and supplies. In line with current NHS guidance, these arrangements may be formal and should include the process for requesting Military Aid to Civil Authorities (MACA) via NHS England.	Fully compliant	Change MACA request to NHSE National to Regional team in Major Incident Plan	Amita Chudasama	Jun-23	Check with NHSE - is this referring to Regional Mutual Aid Guidance document?	Not Started
40	Cooperation	Arrangements for multi area response	The organisation has arrangements in place to prepare for and respond to incidents which affect two or more Local Health Resilience Partnership (LHRP) areas or Local Resilience Forum (LRF) areas.	Partially compliant	Multi area response agreement to be drawn up with neighbouring LHRPs	Amita Chudasama	Nov-22	Not started this work - would like guidance from Regional Team on how best to proceed	Not started

43	Cooperation	Information sharing	The organisation has an agreed protocol(s) for sharing appropriate information pertinent to the response with stakeholders and partners, during incidents.	Partially compliant	LRF agreement to be updated and include ICB	Amita Chudasama/ Andrew Murr	Dec-23		LRF to draft and seek approval at LRF Exec in March
Domain 9 - Business Continuity									
44	Business Continuity	BC policy statement	The organisation has in place a policy which includes a statement of intent to undertake business continuity. This includes the commitment to a Business Continuity Management System (BCMS) that aligns to the ISO standard 22301.	Fully compliant	Policy to outline the roles of service managers of the EPRR team in BC management. Although document is marked up as plan its a BCMS, lacks some detail required in the standard. Commitment to ISO noted.	Daljit Kaur Bains	TBC	Changed to observational following confirm and challenge mtg 07.11.22 can remain fully compliant	ICB EPRR and Corporate Team have met with James and seeked clarification on what further action is required. ICB Corporate Team working on recommendations as part of the Business Continuity Plan review and updates.
45	Business Continuity	Business Continuity Management Systems (BCMS) scope and objectives	The organisation has established the scope and objectives of the BCMS in relation to the organisation, specifying the risk management process and how this will be documented. A definition of the scope of the programme ensures a clear understanding of which areas of the organisation are in and out of scope of the BC programme.	Fully compliant	In the self-assessment document states CS 45 the BC policy will be reviewed on 2023, in the actual BC policy states review date 2024. Specific roles within the BCMS don't cover all roles within BC. NHSEI mentioned on the Internal Audit plan, remove on the next itineration. BCMS needs to be more explicit in processes to be followed. No mention of resource commitment to carry out, no KPI have been set for the monitoring of the system	Daljit Kaur Bains	TBC	Changed to observational following confirm and challenge mtg 07.11.22 can remain fully compliant	
46	Business Continuity	Business Impact Analysis/Assessment (BIA)	The organisation annually assesses and documents the impact of disruption to its services through Business Impact Analysis(es).	Fully compliant	BIA is combined into the BCP but the Policy doesn't state these are combined or how to use them together, or where they will be held. Need to look at how this is described in the BCMS	Daljit Kaur Bains	TBC	Changed to observational following confirm and challenge mtg 07.11.22 can remain fully compliant	

47	Business Continuity	Business Continuity Plans (BCP)	The organisation has business continuity plans for the management of incidents. Detailing how it will respond, recover and manage its services during disruptions to: • people • information and data • premises • suppliers and contractors • IT and infrastructure	Partially compliant	More process detail needs to be in the BCMS/policy about the plans, unclear how the exercising and activations are being monitored and who has responsibility for this.	Daljit Kaur Bains	TBC	Reassessed during confirm and challenge mtg 07.11.22 downgraded to partial
48	Business Continuity	Testing and Exercising	The organisation has in place a procedure whereby testing and exercising of Business Continuity plans is undertaken on a yearly basis as a minimum, following organisational change or as a result of learning from other business continuity incidents.	Partially compliant	Policy mentions that BC plan must be trained at least once per year. Demonstrate some records of previous tests.	Daljit Kaur Bains	TBC	Reassessed during confirm and challenge mtg 07.11.22 downgraded to partial
50	Business Continuity	BCMS monitoring and evaluation	The organisation's BCMS is monitored, measured and evaluated against established Key Performance Indicators. Reports on these and the outcome of any exercises, and status of any corrective action are annually reported to the board.	Partially compliant	Needs to establish the KPI for monitoring compliance such as the number of plans completed or in place etc	Daljit Kaur Bains	TBC	Reassessed during confirm and challenge mtg 07.11.22 downgraded to partial
51	Business Continuity	BC audit	The organisation has a process for internal audit, and outcomes are included in the report to the board. The organisation has conducted audits at planned intervals to confirm they are conforming with its own business continuity programme.	Partially compliant	Plans to be updated to reflect - auditing of the system, no cross reference to the audit arrangements in the audit plan. Need to ensure the policy/bcms describes this process	Daljit Kaur Bains	TBC	Reassessed during confirm and challenge mtg 07.11.22 downgraded to partial
52	Business Continuity	BCMS continuous improvement process	There is a process in place to assess the effectiveness of the BCMS and take corrective action to ensure continual improvement to the BCMS.	Fully compliant	Plans to be updated to reflect - How are these recorded and who's responsibility is this to monitor is not clear in the arrangements, where changes are made to the system how are these followed up upon	Daljit Kaur Bains	TBC	Changed to observational following confirm and challenge mtg 07.11.22 can remain fully compliant

53	**Business Continuity**	**Assurance of commissioned providers / suppliers BCPs**	The organisation has in place a system to assess the business continuity plans of commissioned providers or suppliers; and are assured that these providers business continuity arrangements align and are interoperable with their own.	Partially compliant	Plans to be updated to reflect - the process being followed in the policy/bcms or who has responsibility for this as it is not documented.	Daljit Kaur Bains	TBC	Reassessed during confirm and challenge mtg 07.11.22 downgraded to partial

Name of meeting:	**Leicester, Leicestershire, and Rutland Integrated Care Board**		
Date:	**13 April 2023**	**Paper:**	**I**
Report title:	**Finance Report Month 11 2022/23**		
Presented by:	Caroline Gregory, Chief Finance Officer		
Report author:	Spencer Gay, Deputy Director of Finance (System)		
Executive Sponsor:	Caroline Gregory, Chief Finance Officer		

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

Recommendations:

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

- **RECEIVE and NOTE** the financial position as at month 11 and the forecast performance.
- **RECEIVE for assurance.**

Purpose and summary of the report:

The overall year-to-date (YTD) system position is a deficit of £19.1m.

UHL have reported a YTD deficit of £16.6m, LPT have reported a YTD deficit of £2.8m, whilst the ICB have reported a £0.2m YTD surplus.

The system has declared a deficit forecast of £14.9m (UHL £12.6m deficit, LPT £2.9m deficit and ICB £0.6m surplus), an improvement of £5.1m following additional funding being received by the system from NHSE.

Appendices:	• Appendix 1
Report history (date and committee / group the content has been discussed / reviewed prior to presenting to this meeting):	• CFO • Finance Committee • System Execs

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.*	This aligns to the financial sustainability risk
b) Does the report highlight any resource and financial implications? If so, provide which page / paragraph this can be found within the report.	Yes as the report focuses on the financial position
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.	

Finance Report Month 11 2022/23

13 April 2023

Month 11 System Financial Position

1. Dashboard:
   The system dashboard is shown below:

System	YTD £'000			M1-12 £'000		
	Target	Actual	Rating	Target	FOT	Rating
System Delivery of planned surplus/(deficit)	355	(19,141)		-	(14,897)	
System Revenue expenditure not to exceed income	2,443,853	2,462,994		2,678,093	2,692,990	
System Capital expenditure not to exceed allocations	65,638	69,204		116,211	116,211	
System Operates within Cash Reserves	90,681	103,342		105,344	128,597	
ICB Running Costs Allocation not to be exceeded *(included within system position)*	19,428	17,284		20,518	18,844	
ICB Primary Care Co-Commissioning Allocation not to be exceeded *(included within system position)*	173,433	174,568		190,537	191,673	
System CIP delivery	61,501	61,331		70,730	67,673	
System Better Payment Practice code % NHS invoices paid within target (£)	95%	94%		95%	94%	
System Better Payment Practice code % NHS invoices paid within target (number)	95%	90%		95%	90%	
System COVID Year on Year Comparison	12,972	3,810		19,962	4,330	
System Agency spend within ceiling				43,500	61,574	
ICB MHIS spend requirement to meet target				172,694	172,888	
ICB Performance against ERF Allocation	36,792	35,414		39,983	39,744	

Revenue

2. **The system is reporting a year-to-date deficit of £19.1m which is £19.5m worse than plan**, (UHL £17.2m adverse variance, LPT £2.5m adverse variance, ICB £0.2m variance against plan). The position reflects pressures relating to emergency care, sustained high MH acuity, agency costs, Out of Area activity and growth in CHC packages.

3. **The system is forecasting a £14.9m deficit year end position**, UHL reporting £12.6m deficit (reduction of £5.1m due to additional funds allocated by NHSE in M10), LPT £2.9m deficit and ICB 0.6m surplus. The system is on track to deliver the revised control total of £14.9m deficit year-end position.

4. The system has planned **efficiencies** of £70.7m of which we are currently forecasting £67.7m delivery (£61.3m achieved year to date). System-wide cost avoidance and income generation plans totalling £26.4m were identified at the planning stage but were not included in organisational plans as efficiencies (rather they were included as expenditure reductions); we have only identified limited savings of £4.1m against these to date.

Capital

5. Capital spend is currently above plan by £3.6m with a year to date actual spend of £69.2m. The system is forecasting break even spend against its operational capital of £58.7m, and against the additional £57.6m capital funding received from national programmes.

Other Indicators of note

6. **Agency spend** remains above target. The position has been impacted by the use of a surge ward at LPT staffed predominantly by agency.

7. **Better Payments Policy** expectation across all public sector organisations is to pay creditors in a timely manner. LPT and ICB are achieving the cumulative standard of 95% of invoices (both in value and volume) paid within 30 days, UHL is cumulatively at 70% in relation to the numbers of NHS invoices paid within 30 days (non NHS at 93%).

8. NHS partners within LLR are expected to manage their **cash** position proactively in line with plans and cash draw down limits. The current financial deficit position will impact on cash usage across all partners. There is no system for transferring cash between partners without the raising of invoices. UHL and LPT are currently holding above plan cash balances, balances have reduced in year and expected to continue reducing through 23/24. The ICB is maintaining a minimal end of month cash balance as required.

9. The ICB receives funding for specific elements of spend within its allocation. Better Care Fund, Primary Care Co-Commissioning, Mental Health Investment and running costs are examples of these. The ICB has committed funds in line with allocations in all these areas and is forecasting to spend more in relation to Primary Care Co-commissioning and Mental Health Investment and underspend against running costs

10. **Primary Care Co-Commissioning** is forecasting an overspend of £1.1m against the allocation for 22/23.

Conclusion

11. As a system at month 11, we have reported an in-year deficit of £19.1m against revenue budgets and forecast a £15m year end deficit.

12. Capital spend is currently above plan and forecasting a breakeven position.

13. The ICB are declaring achievement of the Mental Health Investment Standard, Better Payment Practice Code and Running Costs targets.

14. Cash position remains positive across the system.

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

- **RECEIVE and NOTE** the financial position as at month 10 and the forecast performance.

- **RECEIVE for assurance.**

J

Name of meeting:	**Leicester, Leicestershire and Rutland Integrated Care Board meeting**		
Date:	13 April 2023	**Paper:**	**J**
Report title:	**Summary Report from the ICB Finance Committee**		
Presented by:	Cathy Ellis – Chair of ICB Finance Committee		
Report author:	Cathy Ellis – Chair of ICB Finance Committee Imran Asif – Corporate Governance Officer		
Sponsor:	Caroline Gregory – Interim 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 Integrated Care Board is asked to:

- **RECEIVE** the report for assurance.
- **APPROVE** the terms of reference (as at Appendix 1) noting that there are no amendments.

Purpose and summary of the report:

1. This report provides a summary of the key areas of discussion and outcomes following the meeting of the ICB Finance Committee meeting held on 22 February and 29 March 2023. 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 below.

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

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

Conflicts of interest screening		Summary of conflicts *(detail to be discussed with the Corporate Governance Team)*
☒	No conflict identified.	
☐	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 projected financial delivery for 2022/23 and for the 2023/24 financial plan. There are risks associated with both forecasts.
b) Does the report highlight any resource and financial implications? If so, provide which page / paragraph this can be found within the report.		There are risks to delivering a statutory break even in 2022/23. A revised control total of £14.9m deficit has been agreed for the system.
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.

Assurance Report from the ICB Finance Committee

1.0 Introduction

1.1 This report provides a summary of the key areas of discussion and outcomes from the ICB Finance Committee held on 22 February and 29 March 2023. The report also covers items for escalation and consideration by the Board ensuring that it is alerted to emerging risks or issues.

2.0 Terms of Reference

2.1 The ICB Finance Committee members reviewed the Terms of Reference in line with the Committee work programme and noted there were no amendments required. The Board is asked to support and approved the current version of the terms of reference as at Appendix 1.

3.0 Committee Forward Planner

3.1 The ICB Finance Committee forward planner was reviewed and it was noted that the committee effectiveness review has been moved to April 2023. The ICB Finance Committee members approved the forward planner for the first 4 months of 2023/2024. The pattern of reporting has been established and the full plan for 2023/24 will be part of the April review.

4.0 M11 System Financial Position

4.1 The overall year to date (YTD) system position at M11 is a deficit of £19.1m.

4.2 The system has agreed a revised year end forecast deficit position of £14.9m with NHSE; UHL £12.6m deficit, LPT £2.9m deficit and ICB £0.6m surplus.

5.0 Detailed Capital Report

5.1 The LLR system reported it is currently forecasting to fully utilise its capital allocations for 2022/2023. Further national scheme funding of £32m was allocated in M10 to UHL.

5.2 UHL and LPT provided assurance that capital expenditure is being tracked and monitored to ensure full utilisation by end of year.

6.0 Transformation and Efficiency Schemes

6.1 At M11, the LLR system reported there is an underachievement of £25.3m against the annual efficiency target of £97.1m.

6.2 The System PMO is supporting 118 active schemes (+1 scheme since M10) 69 of which (58.5%) are in the delivery phase. An increase of 12 additional schemes in delivery were reported since M10.

6.3 ICB Finance Committee members discussed if more value could be added by the System PMO if it shifts its focus from collaboratives to system wide efficiency schemes. This approach will enable the System PMO to work with all stakeholders to drive efficiency savings which can reduce the financial deficit. It was noted that significant benefits are

forecast for delivery for the Medicines Optimisation (£9.7m) and Personalisation of care (£7.6m) schemes in 2022/23.

7.0 Effectiveness of the Winter 2022/23 schemes

7.1 The LLR system provided detailed analysis of how the £11.5m of discharge and demand and capacity funding received in 2022/2023 had been used.

7.2 The committee asked about the impact of the schemes. It was noted that the Unscheduled Care Hub (scheme 10); support services to reduce flow into ED (scheme 15); and pre-transfer unit (scheme 5) were positive examples of initiatives which had made a significant difference.

7.3 The Winter Board will be reviewing the impact and learnings to understand the risk of stopping the schemes after the Winter peak and to assist in the 2023/2024 Winter planning.

8.0 Financial Plan 2023-2024

8.1 The papers reviewed at the meeting proposed a 2023/24 plan submission of £50m. Post-meeting it has been confirmed that the LLR system will submit a financial plan of £49.2m deficit on 30 March 2023 (UHL £32.5m, LPT £5.4m and ICB £11.3m)

Following discussions with the regional and national NHSE colleagues and the LLR Quarterly System Review Meeting, the LLR system is expected to meet its statutory duty to submit a break-even plan. The LLR ICB have identified five workstreams to close the deficit gap to reach break-even:-

1. Improvement across emergency care pathway;
2. Management of planned care (Patient Initiated Follow Up and Outpatient follow-ups);
3. Access to Care thresholds;
4. Workforce growth constraints; and
5. ICB internal opportunities (including running costs).

8.2 LPT advised that their Board had reviewed a break even and £5.4m deficit financial plan scenario. It was agreed that for the 30 March submission LPT would submit a £5.4m deficit financial plan for 2023/2024 due to the level of risk and currently unidentified measures to close the gap. There was a commitment that further work would be undertaken to enable movement towards a break-even plan.

8.3 UHL informed that their Board discussions focused on the approval of £56m CIP and the commitment to achieve operational delivery targets for bed occupancy, four hour waits, improvements on 62day cancer targets and reduction on elective pathways to 65 weeks. The UHL board had approved a deficit plan of £32.5m.

8.4 The LLR system detailed significant risks within the £49.2m deficit financial plan: -

1. Ability to deliver CIP programme (additional £50m);
2. Inflation contained in the plan in line with national assumptions and not reflecting local variation (£40m);
3. Ability to achieve additional level of income through Independent Sector activity exceeding plan or claw back on NHSE providers where we do not deliver to target (£12m); and
4. Containing workforce growth within ‘capped’ levels (£12m).

9.0 Medium Term Financial Planning

9.1 ICB Finance Committee members were informed that the medium-term plan is being refreshed to align with the financial plan for 2023/2024. Work is currently being undertaken to determine the following: -

1. Assess the scale of the financial challenge being faced by the system over the next five years; and
2. Identify opportunities for financial improvements – establish areas of focus such as transformation/productivity and prevention.

9.2 In May 2023 the ICB Finance Committee will receive the 5 Year Joint Forward Plan along with the financial strategy document which will incorporate the financial model.

10.0 Finance Report on the Delegation of NHSE directly commissioned services for 2023/2024

10.1 An update was provided that the Pharmacy, Optometry and Dentistry (POD) delegated budgets will be allocated to the LLR system in April 2023 by NHSE.

10.2 It was noted in February's meeting that an overspend of £2.9m for M9 was reported for the LLR services. LLR are an outlier on Pharmacy expenditure and therefore have a significant overspend of £3.7m which is offset by an underspend of £1.1m on Dentistry. Further work is being undertaken to understand the implications for the 2023/24 budgets, noting that Dental spend will be ring-fenced.

11.0 UHL exit from Recovery Support Programme

11.1 UHL reported progress against the road map to exit the Recovery Support Programme.

11.2 The 2021/2022 accounts are being audited by KPMG and is expected to be completed with an opinion at the end of February 2023, with the aim to take to the UHL Board in April 2023.

11.3 UHL is planning to submit a case to exit to the regulator in Q1 of 2023/24 with a view to exiting the Recovery Support Programme in Q2. This is subject to the UHL Medium Term Financial plan meeting exit requirements.

12.0 M11 system risk register

12.1 Risks 3, 10 and 14 (2022/2023 financial risks) have now had their scores reduced to 6 as the LLR system has forecast to achieve the deficit control total.

12.2 It was noted that the mitigations/actions and comments section will require further narrative to capture actions for all risks. Updates will be included when the risk register is reviewed following the submission of the 2023/2024 financial plan.

13.0 Summary of assurance from the Committee

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

Key area	Level of assurance	Rationale for level of assurance	Risk(s) to escalate where required
1. Terms of Reference	**Green**	Terms of Reference were approved with no amendments noted.	
2. Committee Forward Planner	**Green**	Committee forward planner was reviewed and ICB Finance Committee members agreed the current schedule of business.	
3. M11 System Financial Position	**Green**	A £19.1m deficit was reported for YTD at M11. The LLR system has agreed a deficit of £14.9m.	Risk that £14.9m deficit could be exceeded due to risks arising from the junior doctors strike.
4. Detailed Capital Report	**Amber**	54% of operational capital has been spent in M10.	Expenditure is back-weighted to M11 and M12.
5. Transformation and Efficiency Schemes	**Red**	There is a significant gap in the delivery of transformation savings. Plans for 2023/24 are under review.	A new approach to system transformation is required to close the gap.
6. Effectiveness of Winter schemes	**Green**	Clear and accountable data has been provided on the use of national winter funding. The impact of each scheme has been analysed and further work is ongoing to enhance this insight.	There is a risk that Winter schemes increase the recurrent expenditure for the system into 2023/24.
7. Draft Financial Plan 2023-2024	**Red**	£49.2m deficit will be submitted in the draft financial plan for 2023/2024. Further work is to take place to achieve break-even, ICB will provide focus on five areas to assist in closure of the financial gap and review the CIP programme.	There is a risk that the LLR system will not achieve statutory break even.
8. Medium Term Financial Plan	**Red**	Work is being undertaken to refresh the medium term plan in line with the 2023/2024 financial plan.	
9. Finance Report on the Delegation of NHSE directly commissioned services for 2023/2024	**Red**	The 2022/23 LLR system "shadow" budget allocation reported a £2.9m overspend at Month 9. Indicative allocations have been given for 2023/24 and 2024/25.	Risk share agreements are yet to be agreed for the East Midlands Hub.
10. UHL exit from recovery support programme	**Amber**	UHL is planning to exit the Recovery Support Programme in Q2 of 2023/24.	UHL medium term financial plan could impact the exit from the Recovery Support Programme.
11. M11 system risk register	**N/A not rated**	M11 risk register has been updated and a revised score of 6 has been allocated for 2022/2023 financial risks 3,10 and 14.	Further risks will be created for 2023/24

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.
Blue	Not considered at the meeting as item not due.

Recommendations

The LLR Integrated Care Board is asked to:

- **RECEIVE** the report for assurance.

Appendix 1

NHS Leicester, Leicestershire and Rutland Integrated Care Board

Finance Committee
Terms of Reference (v2, October 2022)

1. CONSTITUTION

The Finance Committee (the Committee) is established by the NHS Leicester, Leicestershire and Rutland Integrated Care Board (the Board or ICB) as a Committee of the Board in accordance with its Constitution.

These terms of reference set out the membership, the remit, responsibilities and reporting arrangements of the Committee and may only be changed with the approval of the Board.

The Committee will be chaired by a Non-Executive Director from either the ICB or from a NHS partner organisation, it is a committee of the Board and its members are bound by the Standing Orders and other policies of the ICB.

2. PURPOSE OF THE COMMITTEE

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

The Committee will provide regular assurance updates to the ICB in relation to activities and items within its remit.

3. DELEGATED AUTHORITY

The Committee is a formal committee of the ICB. The Board has delegated authority to the Committee as set out in the Scheme of Reservation and Delegation and may be amended from time to time.

The Committee holds only those powers as delegated in these Terms of Reference as determined by the ICB Board.

4. MEMBERSHIP AND ATTENDANCE

Membership

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

The Board will appoint no fewer than four members of the Committee including two who are Non-Executive Members (one of whom will be from the ICB). Other attendees of the Committee need not be members of the Board, but they may be.

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

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

Members

- Non-Executive Director (from NHS partner organisation) – Non-Executive Director from Leicestershire Partnership Trust (Chair)
- Non-Executive Director – Remuneration and People (ICB) (vice Chair)
- Chief Finance Officer (ICB) or nominated deputy
- Chief Nursing Officer or the Chief Medical Officer or their respective deputies (ICB)
- Non-Executive Director from University Hospitals of Leicester NHS Trust (UHL)
- Chief Finance Officer from University Hospitals of Leicester NHS Trust (UHL) or nominated deputy
- Non-Executive Director from Leicestershire Partnership NHS Trust (LPT)
- Chief Finance Officer from Leicestershire Partnership NHS Trust (LPT) or nominated deputy

Only members of the Committee have the right to attend committee meetings. Other individuals may be invited to attend all or part of any meeting as and when appropriate. The following individuals may be asked to attend on a regular basis, however they would not form part of the membership and therefore do not have voting rights:

- Deputy Director of Finance (for system) (ICB)
- Non-Executive Member – Audit (ICB)
- Representative from East Midlands Ambulance Service
- NHS England / Improvement representative

Chair and vice chair

In accordance with the Constitution, the Committee will be chaired by a Non-Executive Member of the Board and the second Non-Executive Member will be the vice Chair of the Committee.

The Committee shall satisfy itself that the ICB's policy, systems and processes for the management of conflicts, (including gifts and hospitality and bribery) are effective including receiving reports relating to non-compliance with the ICB policy and procedures relating to conflicts of interest.

If the Committee Chair has a conflict of interest then the vice chair or, if necessary, another member of the Committee will be responsible for deciding the appropriate course of action.

5. MEETING QUORACY AND DECISIONS

The Finance Committee shall meet on a monthly basis. Additional meetings may be convened on an exceptional basis at the discretion of the Committee Chair.

Quoracy

For a meeting to be quorate a minimum of four members will be required with either the Chair or the vice Chair present, plus the Chief Finance Officer (ICB) plus a member from UHL and a member from LPT.

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

Where members are unable to attend they should ensure that a named and briefed deputy is in attendance who is able to participate on their behalf.

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

Decision making and voting

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

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

Where there is a split vote, with no clear majority, the Chair of the Committee will hold the casting vote. The result of the vote will be recorded in the minutes.

If a decision is needed which cannot wait for the next scheduled meeting, the Chair may conduct business on a 'virtual' basis through the use of telephone, email or other electronic communication.

6. RESPONSIBILITIES OF THE COMMITTEE

The responsibilities of the Committee will be authorised by the ICB Board. It is expected that the Committee will:

- Gain assurance from the executive functions and provide assurance to the Board that there are robust processes in place for the effective management of:
    - financial strategy;
    - financial planning and management;

  - financial performance, activity and control;
  - capital expenditure and schemes; and
  - financial risk management.

- Oversee and monitor delivery of the ICB key statutory requirements.

- Ensure that suitable policies and procedures are in place to comply with relevant regulatory, legal and code of conduct requirements.

- Have oversight of the Terms of Reference and work programmes for the groups reporting into the Finance Committee.

Financial Strategy

- Provide oversight of the financial strategy
- Receive and evaluate recommendations from the Executive Finance officers for the key financial priorities that are included within the ICB strategy/ annual plan, including priorities to address variation/ inequalities in care
- Oversight of payment policy reform and impact of commissioning reforms such as place based allocations
- Oversight of provider collaboration and impact on finance.

Financial planning

- Oversight of the development of system financial management information systems and processes, forming recommendations to the Board on the model of financial planning to be adopted and the contractual frameworks to be operated within the system.
- Provide assurance on the development and delivery of the continuous improvement and efficiency agenda

Financial performance and controls

- Have oversight of the monthly financial performance of the system and provide the Board with an accurate understanding of the system's current and forecast financial position and the development and oversight of the system's financial strategy/ recovery plans to address any underlying challenge.
- To review exception reports on any material in-year overspends against delegated budgets, including adequacy of any proposed remedial action plans
- Receive assurance that appropriate arrangements are in place to ensure robust system financial control.
- Consider proposals for the system financial architecture and financial controls required to ensure the system is able to meet the value for money criteria and ensure financial sustainability.

Capital

- Oversight of the system capital plans including robust in year monitoring and forecasting to provide the Board with an accurate understanding of the system's current and forecast position.

- Ensure capital plans are aligned to LLR strategic, clinical, operational and innovation priorities.

Financial risk management

- To have oversight of strategic financial risks on the Board Assurance Framework and high-risk operational risks and oversight of associated mitigations. Ensure the ICB is kept informed of significant risks and mitigation plans, in a timely manner

7. ACCOUNTABILITY and REPORTING ARRANGEMENTS

The Finance Committee is directly accountable to the ICB. The minutes of meetings shall be formally recorded. The Chair of the Committee shall report to the Board (public session) after each meeting and provide a report on assurances received, escalating any concerns where necessary.

The Committee will advise the Audit Committee on the adequacy of assurances available and contribute to the Annual Governance Statement

The Committee will receive scheduled assurance report from its delegated groups. Any delegated groups would need to be agreed by the ICB Board.

8. BEHAVIOURS AND CONDUCT

ICB values

Members will be expected to conduct business in line with the ICB values and objectives. Members of, and those attending, the Committee shall behave in accordance with the ICB's Constitution, Standing Orders, and Standards of Business Conduct / Conflicts of Interest Policy.

Equality and diversity

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

9. DECLARATIONS OF INTEREST

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

10. SECRETARIAT AND ADMINISTRATION

The Committee shall be supported by the Corporate Governance Team this will include ensuring that:

- The agenda and papers are prepared and distributed in accordance with the Standing Orders having been agreed by the Chair with the support of the relevant executive lead;
- Attendance of those invited to each meeting is monitored and highlighting to the Chair those that do not meet the minimum requirements;
- Records of members' appointments and renewal dates and the Board is prompted to renew membership and identify new members where necessary;
- Good quality minutes are taken in accordance with the standing orders and agreed with the chair and that a record of matters arising, action points and issues to be carried forward are kept;
- The Chair is supported to prepare and deliver reports to the Board;
- The Committee is updated on pertinent issues/ areas of interest/ policy developments;
- Action points are taken forward between meetings and progress against those actions is monitored.

11. REVIEW

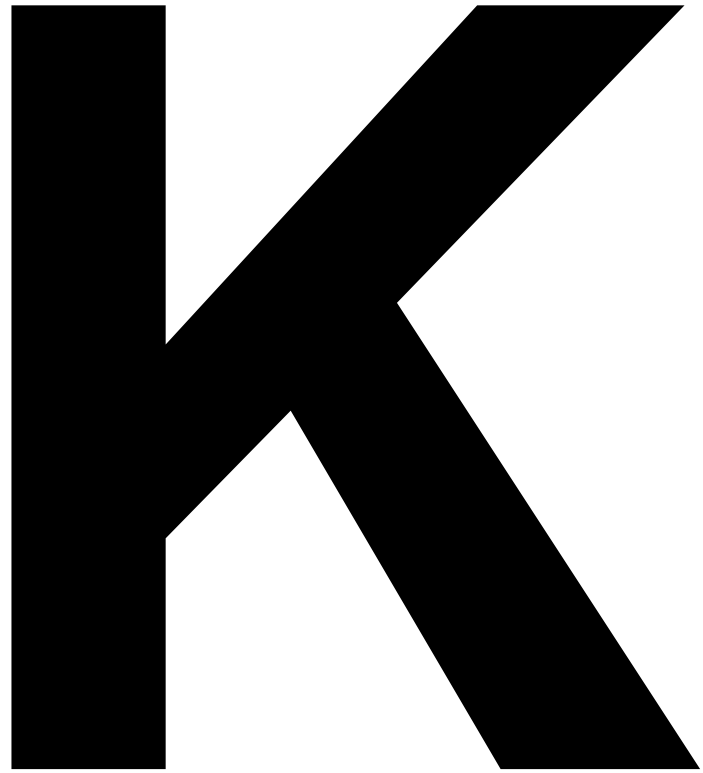
The Committee will review its effectiveness at least annually and complete an annual report submitted to the Board.

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

The Committee will utilise a continuous improvement approach in its delegation and all members will be encouraged to review the effectiveness of the meeting at each sitting.

Date of approval: 1 July 2022 by the Board of the LLR ICB (minor amendments made by Committee in October 2022 to ensure current role titles and details were accurate)

Date of review: July 2023



Name of meeting:	**Leicester, Leicestershire and Rutland Integrated Care Board**		
Date:	13 April 2023	**Paper:**	**K**
Report title:	**Assurance Report from the System Executive**		
Presented by:	Andy Williams, Chief Executive LLR ICB and Chair of the System Executive		
Report author:	Daljit K. Bains, Head of Corporate Governance		
Sponsor:	Andy Williams, Chief Executive LLR ICB and Chair of the System 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.
- **APPROVE** the updated terms of reference of the Strategic Commissioning Group (as at Appendix 2) noting specifically the request to include further delegated authority from the ICB Board aligned to the new delegated commissioning functions from NHS England.

Purpose and summary of the report:

1. This report provides a summary of the key areas of discussion and outcomes following the meetings of the System Executive Committee held on 24 February 2023 and 24 March 2023. The report also covers items for escalation and consideration by the Board ensuring that the Board is alerted to emerging risks and issues.

2. One of the key areas to draw to the Board's attention is the request to approve the proposed amendments to the Strategic Commissioning Group's terms of reference. The changes are summarised in the report at paragraphs 17 and 18 and within Appendix 2.

3. A summary of the level of assurance provided by the Committee is detailed in paragraph 19.

Appendices:	• Appendix 1 – System performance assurance report as presented to the System Executive • Appendix 2 – Proposed amendments to the Strategic Commissioning Group terms of reference
Report history (date and committee / group the content has been discussed / reviewed prior to presenting to this meeting):	• N/A

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

Conflicts of interest screening		**Summary of conflicts** *(detail to be discussed with the Corporate Governance Team)*
☒	No conflict identified.	
☐	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 mitigating strategic risks as identified in the BAF and to identify and evaluate risks on an ongoing basis.
b) Does the report highlight any resource and financial implications? If so, provide which page / paragraph this can be found within the report.	Assurances received in relation to the financial plan.
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 due regard is considered within reports presented to the Committee.

Assurance Report from the System Executive

Introduction

1. This report aims to provide assurance to the Board and a summary of the key updates, decisions, and outcomes, aligned to the Committee's delegated authority, following the meetings of the System Executive Committee held on 24 February 2023 and 24 March 2023. The report also covers items for escalation and consideration by the Board ensuring that it is alerted to emerging risks or issues.

Strategy and Planning

2. Draft content for the **LLR ICB 5-Year Joint Forward Plan** was presented to the Committee for consideration and comment. There was no requirement to submit an initial draft of the Plan to NHS England by the end of March 2023. Assurances would be provided to NHS England regarding the development of the plan. The final plan will be submitted for the consideration of the Board in June 2023.

3. No engagement will be permitted during the pre-election period. Indicative dates for input from the Trust Boards and Health and Wellbeing Boards have been factored in for May and June 2023.

4. **Update on the Operational Planning 2023/24 Submission –** As agreed by the Board on 23 March 2023, the ICB deficit is to be reduced within the plan prior to the draft submission on 30 March 2023, subject to assurance checks. A steer was provided by the Board for the system deficit to be reduced and Trust Boards will meet to discuss the position. Actions are to be taken through the Chief Finance Officers and Executive Teams.

5. Five workstreams have been devised to move the planning forward, each of which has a suggested SRO. The System Executive Committee will review the process and agree the Terms of Reference for each workstream over the coming weeks. The ICB Executive Management Team will also meet to discuss internal efficiencies. A proposal is to be presented to the Board in May 2023 as to how the reduction in the deficit is to be achieved.

Operational performance assurance

6. An **update on the ICB 2022/23 Financial Position at month 10 (January 2023)** identified that the system year to date (YTD) deficit had deteriorated by £2.9m since that reported at month 9. Financial analysis carried out prior to finalisation of the draft plan for 2023/24 identified a system deficit of £159m.

7. The Committee held a detailed discussion regarding the key areas of safer staffing, emergency/winter pressures, prescribing, cost pressures and investments. A set of principles to inform operational planning were considered and agreed. Work would be carried out to identify all potential risks.

8. A further **update on the ICB 2022/23 Financial Position at month 11 (February 2023)** identified movement due to additional anticipated resources of £5.1m allocated to UHL from regional NHSE. The system year to date (YTD) deficit at month 11 had therefore improved by £0.7m since that reported at month 10, to become a deficit of £18.4m. The system is now declaring a deficit forecast of £14.9m at year end.

9. **The LLR system performance report** is considered as a standing item at every meeting. The report in March covered a selection of key performance indicators as follows with benchmarking intelligence and local actions outlined:

- Urgent Care including 6 winter plan metrics and ambulance handovers
- Primary Care
- Elective Long Waiters
- Cancer
- Learning Disabilities and Autism
- Maternity

10. The Committee specifically drew out the data relating to elective care and CDIF, noting that work is ongoing with NHS England to achieve the given targets. Webinars and training courses are also taking place.

11. Improvements have been recorded in ambulance handover times and 104 week-waits, which are on track to reach 0 patients by the end of March 2023. Annual health checks for patients with learning disabilities and autism are also on target to reach 75%.

12. The detailed system performance report for March 2023, as provided to the Committee, is appended for information at **Appendix 1.** The content aligns with the requirements as set out in NHS England's Oversight Framework.

13. Submission of the **Leicester, Leicestershire and Rutland System Provider Segmentation Scores** became the responsibility of the LLR ICB in September 2022. The recommended scores remain the same as last quarter and were agreed as follows:
    a. **LPT: 2 -** for trusts in segments 1 and 2, overall support needs will be formally reviewed on a quarterly basis by the relevant regional team (in the case of individual organisations this will happen in partnership with the integrated care board).
    b. **UHL: 4 -** those in segment 4 enter the Recovery Support Programme (RSP). The RSP replaces the previous financial and quality special measures programmes and will provide a collaborative, ICB-focused approach for supporting those trusts and ICBs with the toughest challenges.

14. **National Collaborative Innovator Programme –** LPT and NHFT placed a successful bid to be one of the 9 Provider Collaborative Innovators in England. This is to be fulfilled with ICB and NHS England regional support. The key contributors from each organisation are to be identified and input is encouraged from a wide range of colleagues.

Other decisions including business cases, procurements and contracts

15. Committee members considered and supported a number of decisions as follows all of which fall within the delegated authority of the Committee:

    a. Addendum to the 2022-2023 Better Care Fund policy framework and planning requirements: Adult Social Care Discharge Fund – ICB funding allocations were retrospectively approved.

    b. VCS Getting Help in Neighbourhoods Mental Health Grant Scheme – Re-issue of Round 1 Grant Awards for 2023/24 – the request to re-issue grants to VCS organisations for a further 12 months was approved. The cost of the grant awards total £765,778.66 in 2023/24.

    c. The proposed **Discretionary Grants to Voluntary Sector Organisations (VSOs) 2023/2024** were approved. A strategic review of Voluntary Sector Organisations, which aims to develop a future strategy for working with the voluntary sector**,** is currently underway.

d. **Voluntary Sector Organisation (VSO) Crisis Cafes – Re-issue of Round 1 Grant Awards for 23/24 –** the re-issue of grants to the 11 organisations in receipt of grants as part of Round 1 of the scheme was approved. This is at a cost of £187,181.45 and is accounted for within the Mental Health Investment Standard (MHIS) which was approved as part of the Mental Health Commissioning Plan in 22/2023.

e. **Children and Young People (C&YP) Mental Health Services Pathway Review 2022-23 Update and Next Steps –** A number of key services were included within the review including the Post Sexual Abuse Service, Community Early Intervention Service, Community Chill Out Zone, and the First Steps Eating Disorder Service. The recommendation for a direct award was approved. The length of the contract is 2 years with an extension option of 25 months.

f. **Contracting for Elective Care Services from Leicester Nuffield and Spire Independent Sector (IS) for 2023/24 –** The implementation of a 1-year extension option from April 2023 through the current contracts for both Nuffield and Spire was approved. The two current contracts would therefore be extended to 31 March 2024. This would reduce the elective care backlog and ease some of the pressures facing UHL.

16. Regular assurance reports are received from the Strategic Commissioning Group (group with delegated authority from the Board for primary care commissioning and sub-group of the System Executive Committee) and the Clinical Executive Group.

17. **The Strategic Commissioning Group** has reviewed its terms of reference over the last couple of months to consider the remit of the Group and to further enhance its remit to support the new delegated functions from NHS England including Pharmacy, Optometry and Dental services, and specialised commissioning. The review also considered further support that the Strategic Commissioning Group can offer the System Executive Committee.

18. Table 1 below summarises the changes proposed and the terms of reference highlighting the amendments as at **Appendix 2.**

Table 1: proposed changes to the Strategic Commissioning Group terms of reference

Functions	Current ToR	Proposed changes as at 28 March 2023
Commissioning / de-commissioning, investment / dis-investments decisions	• Aligned with delegation of primary medical care commissioning (except individual GP performance management). • Assurances in preparation for PODs delegation.	• Broaden remit to include wider primary medical care commissioning in addition to primary medical care co-commissioning. • Broaden remit to include delegated primary care commissioning and contracting of PODs including broader aspects e.g. acute dental, specialised commissioning. • Include commissioning / de-commissioning, investment / disinvestment of healthcare commissioning more broadly to support System Executive including continuing healthcare. • Note decisions relating to the Commissioning Support Unit (healthcare and non-healthcare services) to remain with the Executive Management Team.
Decisions relating to business cases, procurement, preferred bidder / contract award and contract variations.	• Limited to the primary medical care and limited to co-commissioning budget.	• Expand remit to include all primary care commissioning budgets in addition to co-commissioning budget. Note the proposed financial delegation of primary care co-commissioning budgets includes primary medical care, pharmacy, optometry and dental services. In addition to this, proposal is for an additional financial delegation of up to £10m as stated to be requested from the Board. • Propose approval of up to **£10m total value of contract** for healthcare commissioning decisions in addition to primary medical care co-commissioning. • The Collaboratives will continue to report directly to the System Executive Committee and commissioning decisions via the Collaboratives will be the responsibility of the System Executive or the Board if above Committee delegation.
Sub-groups	• None	• Primary Care Transformation Board to report to SCG. • Additional sub-groups proposed: High Risk and Complex Care Panel and the Childrens' Continuing Care Panel.
Membership	• ICB Executive Team and Clinical Adviser	• Retain current membership at present and invite other officers and experts to attend as and when required.

Summary of assurance from the Committee

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

Key area	Level of assurance	Rationale for level of assurance	Risk(s) to escalate where required
1. Strategy and planning	**Amber**	• Draft content has been produced for the 5 Year Joint Forward Plan. A draft submission was not required to NHSE in March 2023. NHSE will continue to receive assurances as to the development of the plan. • The draft Operational Plan 2023/24 was to be further revised prior to submission on 30 March 2023, with a reduction in the system deficit from £100m to £50m.	There is a risk of interventions and restrictions being placed on the ICB if national requirements for the Operational Plan 2023/24 are not met.
2. Operational performance assurance	**Amber**	• A set of principles were considered and agreed to inform operational planning. • Work would take place to understand the potential risks. • The System performance report – challenges remain in the areas of ambulance handovers, elective care and CDIF.	N/A
3. Other decisions including business cases, procurements and contracts	**Green**	• No specific issues identified.	N/A

4. Information only	**Amber**	• Assurance reports from sub-groups are regularly received, and issues and risks identified along with mitigations.	N/A

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.
Blue	Not considered at the meeting as item not due.

Recommendations

The LLR Integrated Care Board is asked to:

- **RECEIVE** the report for assurance.
- **APPROVE** the updated terms of reference of the Strategic Commissioning Group (Appendix 2) noting specifically the request to include further delegated authority from the ICB Board aligned to the new delegated commissioning functions from NHS England.

Appendix 1

LLR ICS SYSTEM EXECUTIVE COMMITTEE

NHS
Leicester, Leicestershire and Rutland

Performance Overview

NHS
Midlands and Lancashire
Commissioning Support Unit

24th Mar 2023

Hannah Hutchinson– Assistant Director of Performance & Quality Improvement, LLR ICB

PERFORMANCE OVERVIEW

Key metrics for the LLR system

The aim of this PowerPoint is to provide a high-level overview and focuses on:

- Ambulance Handovers,
- Six Winter Plan Urgent Care Metrics,
- Discharges,
- Primary Care,
- Elective Long Waiters,
- Cancer,
- Learning Disabilities & Autism
- Maternity and
- LLR performance of the System Oversight Framework 22/23.

Report Summary – Improvement

Areas of Improvement :

Primary Care : Number of GP appointments & face-to-face appointments

- *ICB ranks 5/42 for number of GP appointments per 10,000 weighted patients however 36/42 for a "good" experience of making an appointment.*

Elective: Long waiters (104+ weeks)

- *ICB ranks 41/42 for the number of patients currently waiting for care. However, there has been a reduction of the number of patients waiting over 104 weeks and the ICB has committed to being at zero 104 week waits by 31/3/23.*

Cancer: Improvement in performance for 2WW breast symptom

- *National target of 93% met for Jan 23 (100%)*

Ambulance Handovers over 60 mins

- *LLR has moved from the 2nd highest 60 minute ambulance handover rates in the Midlands with 38% of all waits taking over 60 mins to this now being 6% for February 23.*

System Performance Commitments 23/24

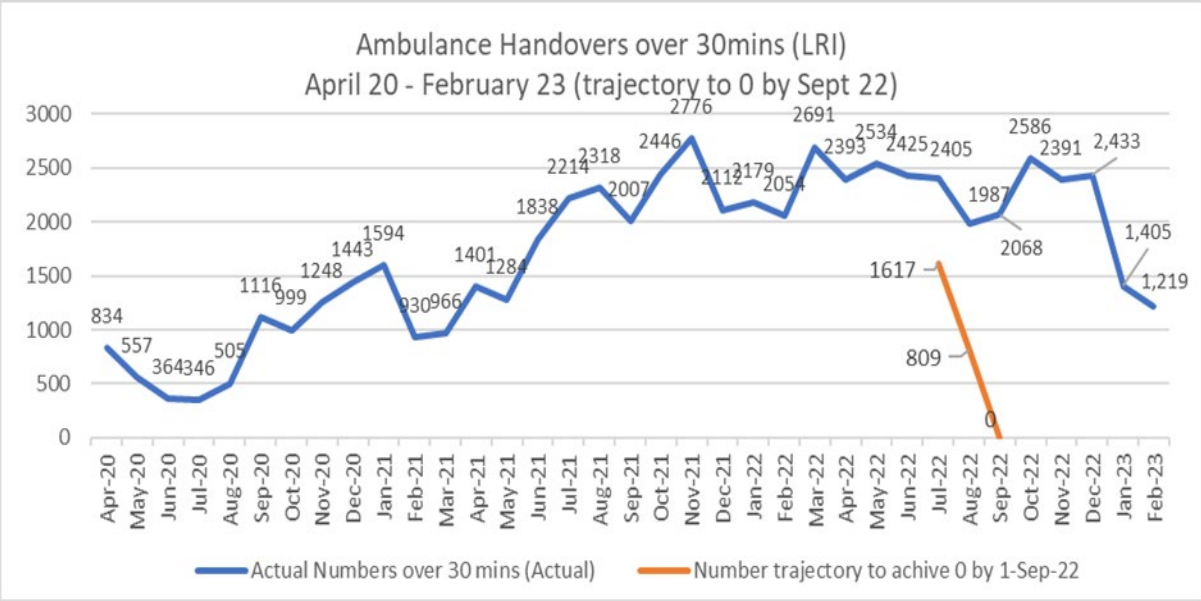
There are 27 ICB Performance and Mental Health indicators listed in the 23/24 planning templates. 19 indicators are on track to meet the targets specified in the planning guidance – including **Cancer 62 day waits; 4 hour A&E performance; 104 and 65 week waits for elective care.**

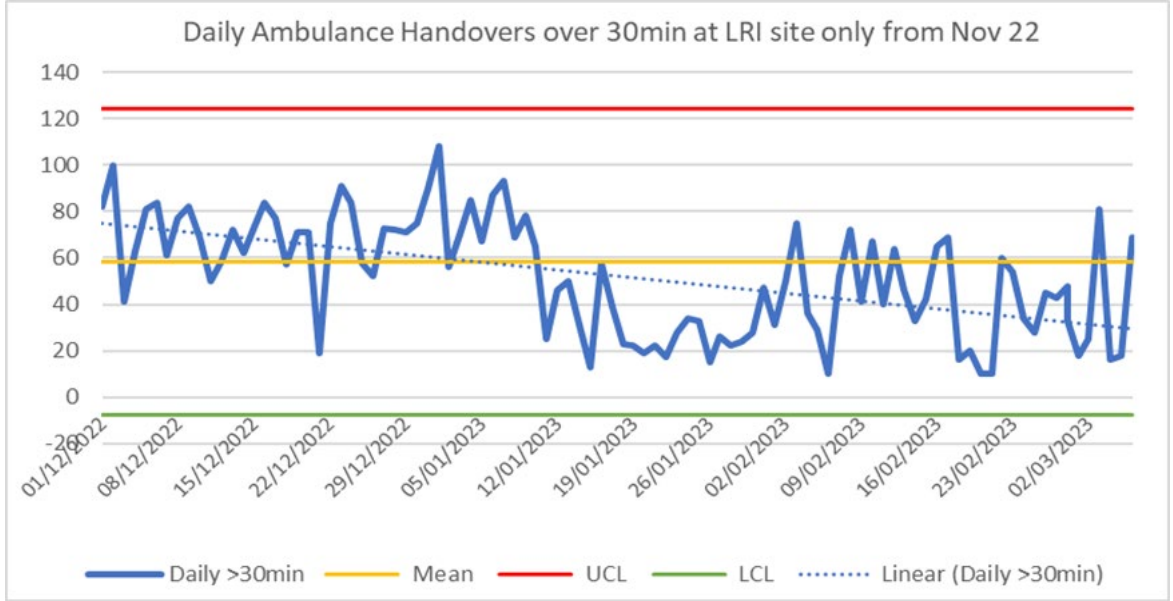
Listed in the tables below are details of 8 planning metrics:

- There are 2 indicators within the LLR system that do not have trajectories to meet the national requirement. 1 of the 2 metrics showing as not achieving is based on NHSE's model.
- 5 of the 7 Diagnostic Test Waiting Times metrics have a target to be met by March 2025 (the other 2 tests set to achieve by March 24)

Metric	National Target	National Target to be achieved in 23/24	Latest Position	Rationale
Community services waiting list (Paediatrics services)	Agree a plan for reduction of lists / expectations for each quarter of 2023/24	x Increase in Paediatric Community Services Waiting List	Paediatrics currently increasing each month, due to an increase in neurodevelopmental referrals, this is approximately 2% increase. This is being offset by other community services who are expected to reduce their waiting list size, therefore a 1% increase overall. Adults has the same reduction as last year	
Total access to IAPT services	33,826	x 27,416 by end Mar 24	19,180 (12mth rolling to Sept 22)	Recovery Action Plan in place with IAPT provider (VITA). NHSE are fully aware that the target will not be met. Original contract had incorrect target numbers and was picked up some months after the service was mobilised, so taking time to recover to the correct target.
NEW Cancer - number of people referred onto a non-specific symptoms pathway	NHSE model for referrals (LLR: 3,198 in 23/24)	Local trajectory: 840 in 23/24	New service at UHL from Jan 23, therefore no activity data available yet	Local trajectory based on UHLs trajectory for 23/24 + 10% (-non LLR pts at UHL + LLR pts attending Out of County providers)
Diagnostic test waiting list - Magnetic Resonance Imaging	Test within six weeks in line with the **March 2025** ambition of 95%	91% in March 24	63% waiting <6wks (ytd Dec 22)	Waiting list and % trajectories based on UHL trajectory for 23/24
Diagnostic test waiting list - Non-Obstetric Ultrasound		70% in March 24	45% waiting <6wks (ytd Dec 22)	
Diagnostic test waiting list - Colonoscopy		89% in March 24	44% waiting <6wks (ytd Dec 22)	
Diagnostic test waiting list - Flexi Sigmoidoscopy		89% in March 24	64% waiting <6wks (ytd Dec 22)	
Diagnostic test waiting list - Gastroscopy		89% in March 24	38% waiting <6wks (ytd Dec 22)	

Ambulance Handovers over 30mins at LRI site





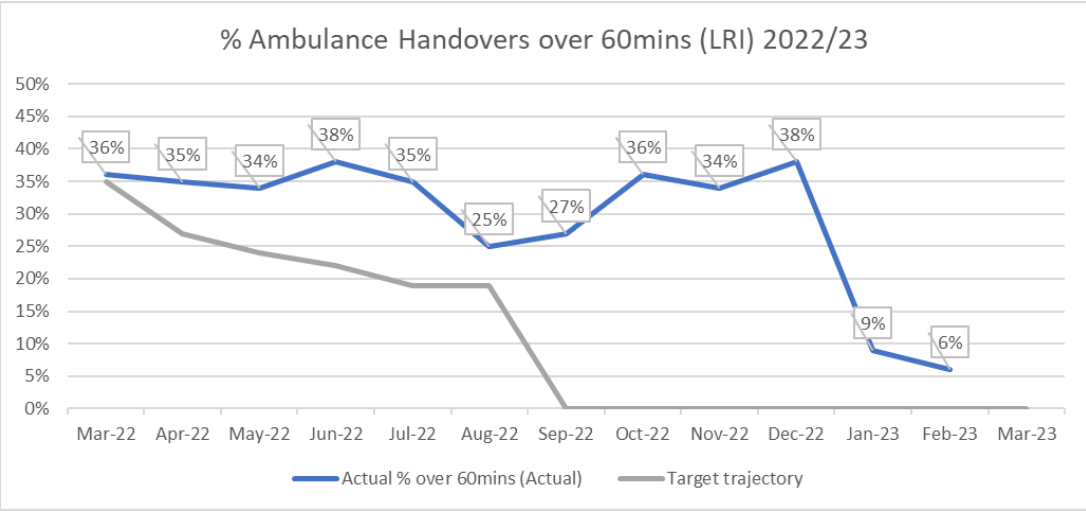
The graph above shows the monthly number of ambulance handovers waiting over 30mins at the LRI site only, against the trajectory of achieving 0 (zero) by 01-Sept-22

At the end of each reporting month, the number of >30min handovers is refreshed and therefore is likely to increase (by c.125 each month) compared with 'live' daily data.

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

The above graph shows a natural variation for the handovers over 30 mins; within the upper and lower limits.

Ambulance Handovers over 60mins at LRI site



Data source: EMAS Portal

	Actual % over 60mins (Actual)	Actual Numbers over 60 mins (Actual)
Mar-22	36.0%	1760
Apr-22	35.5%	1532
May-22	33.9%	1573
Jun-22	37.9%	1658
Jul-22	35.0%	1449
Aug-22	25.0%	1061
Sep-22	27.2%	1237
Oct-22	36.4%	1658
Nov-22	33.9%	1562
Dec-22	38.3%	1564
Jan-23	9.3%	404
Feb-23	6.2%	250

The graph shows the monthly % of ambulance handovers waiting over 60mins at the LRI site only, against the trajectory of achieving 0 (zero) by end of March 23.

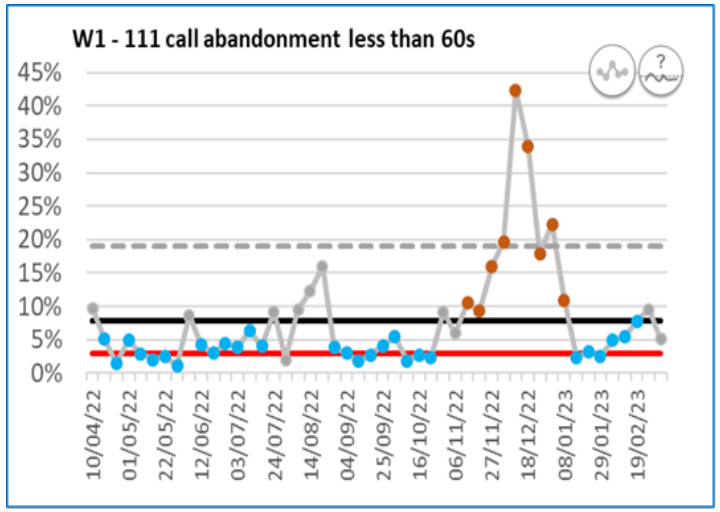
For February 2023, 6% of ambulance waits took over 60mins, an improvement in performance when compared to 38% in December 22.

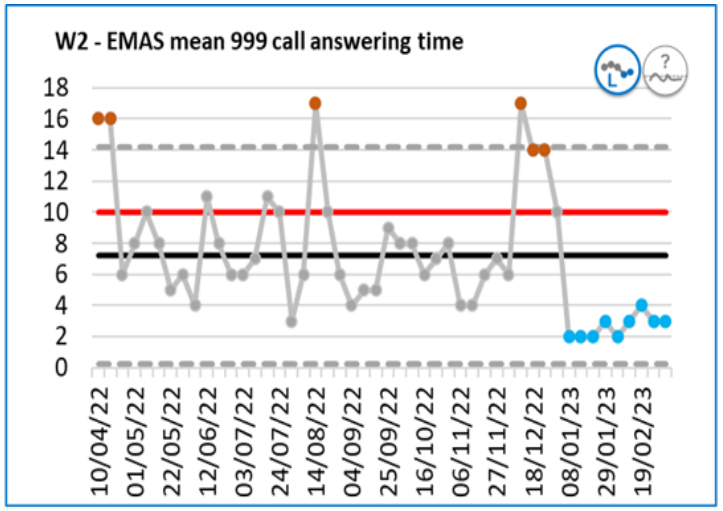
The table shows % and actual numbers over 60 mins, a steady improvement in performance from Mar 22 – Feb-23.

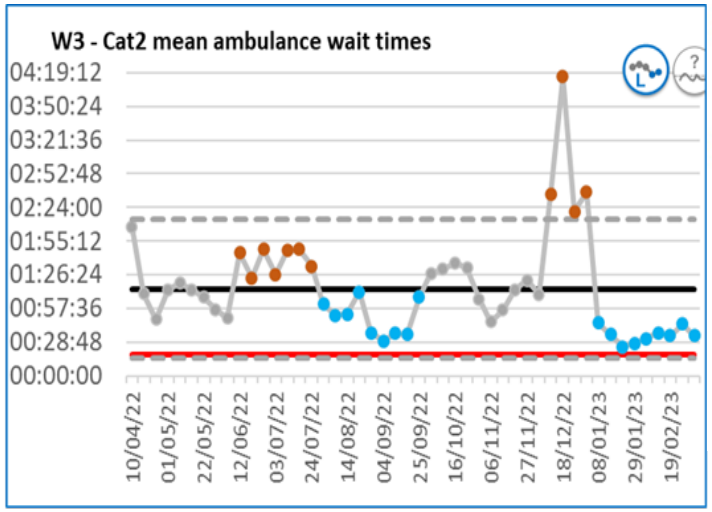
Six Winter Plan Urgent Care Metrics

NHSE/I require 6 Urgent Care metrics be reported locally and also form part of the monthly Winter Plan Assurance Framework. These 6 metrics are now being reported weekly, using the Making Data Count approach. National & local targets have been applied.

Improvements across all call and ambulance related metrics.







= special cause variation of particular **concern** and needing action

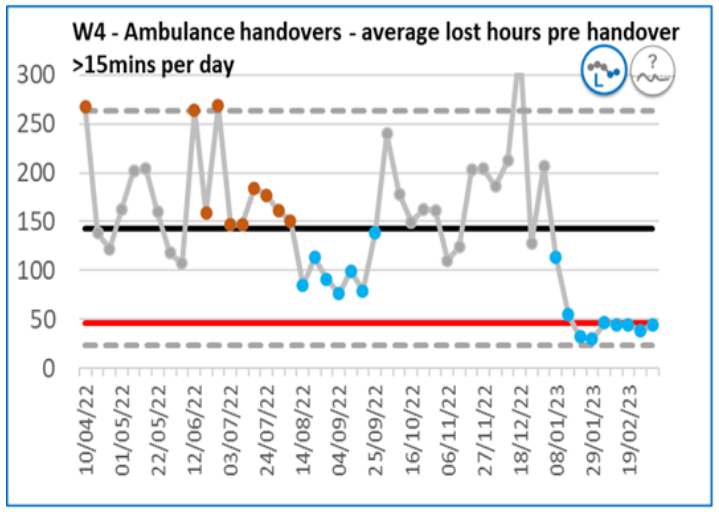
= special cause variation indicating **improvement**

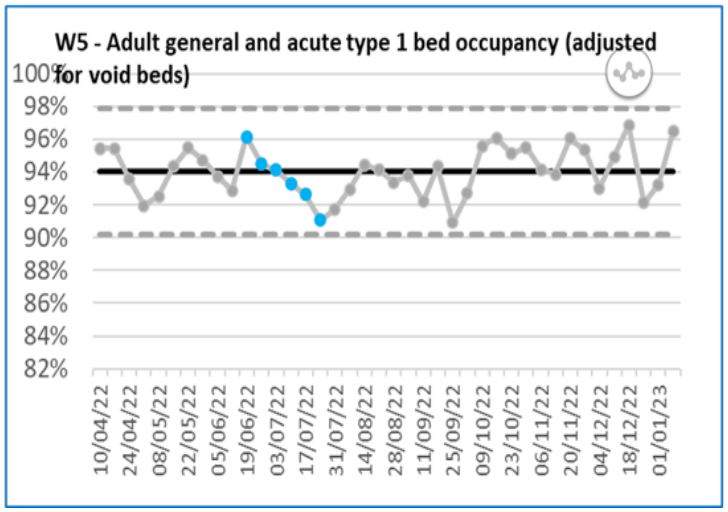
=no significant change (common cause variation)

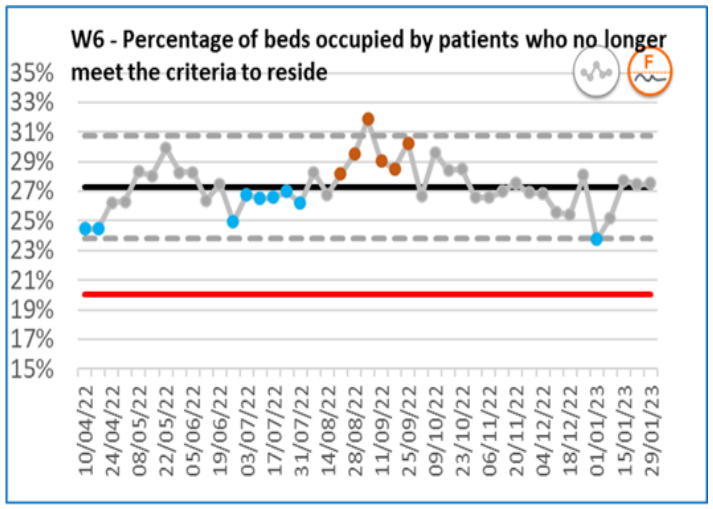
= target

= mean

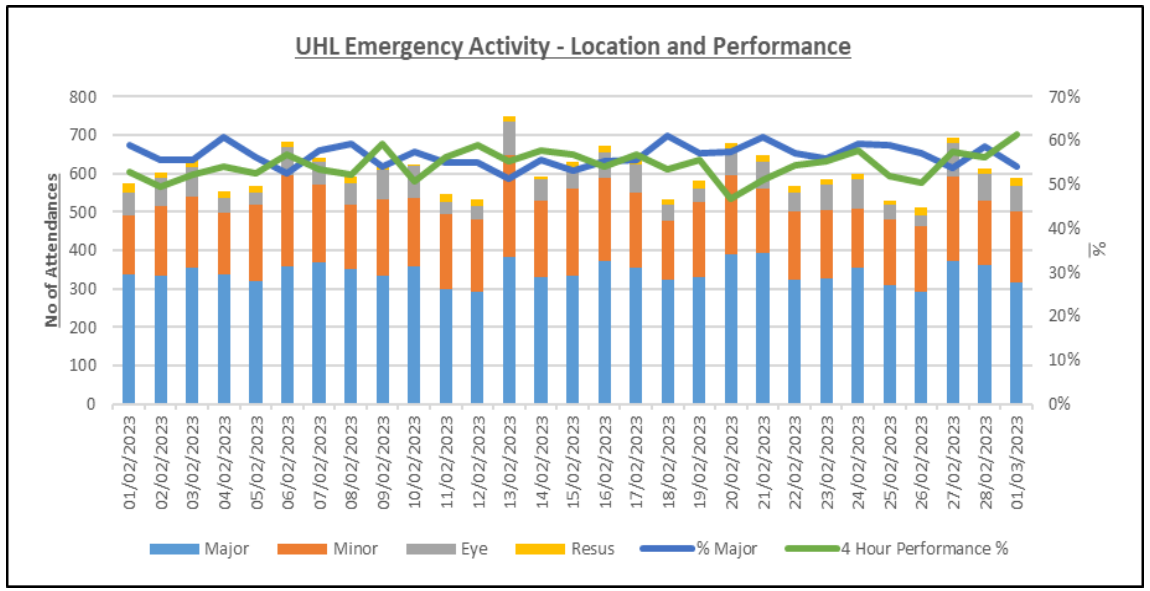
= upper and lower control limits

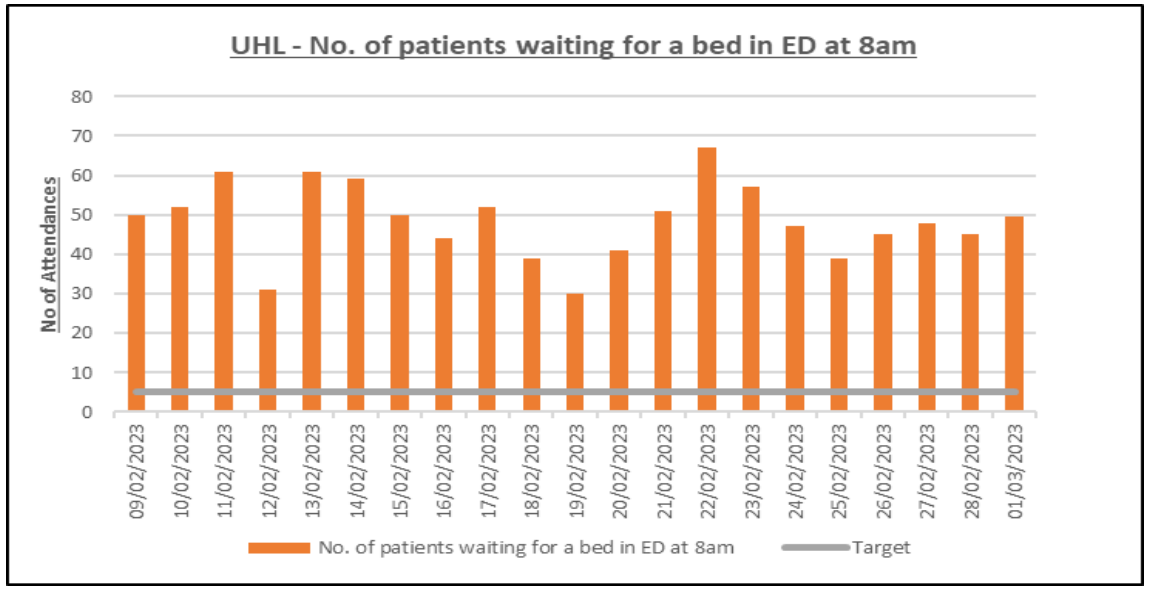






Emergency Department





UHL Emergency Activity - Location and Performance

The graph shows the ED attendances by area, % that are Majors and overall 4hr wait performance, over the past 3 weeks, which includes MIaMI activity.

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

UHL ED Activity - Age Group			
Period	**Total ED activity**	**Adults**	**Children**
Latest Month (1st Feb-28th Feb)	16,979	12,307	4,672
Previous Month (1st Jan-31st Jan)	17,393	12,854	4,539
Variance	**-414**	**-547**	**133**
% Variance	**-2.4%**	**-4.3%**	**2.9%**

The above shows there has been a reduction in ED activity (🡻 2.4%) from January to February.

For the same period overall adults attending ED has reduced (🡻 4.3%) and children's has increased (🡹 2.9%).

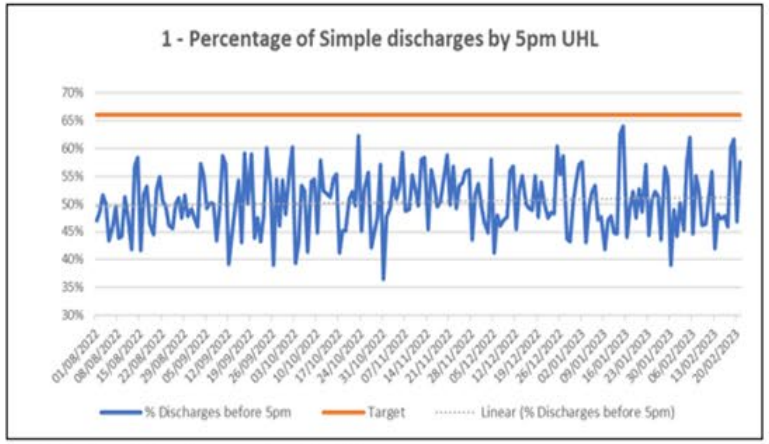
Numbers of patients awaiting beds in ED at 8am each morning at UHL

The number of patients waiting for a bed in ED at 8am has increased over the past 7 days (🡹 2.1%), however it decreased when compared from January to February (🡻 1.0%).

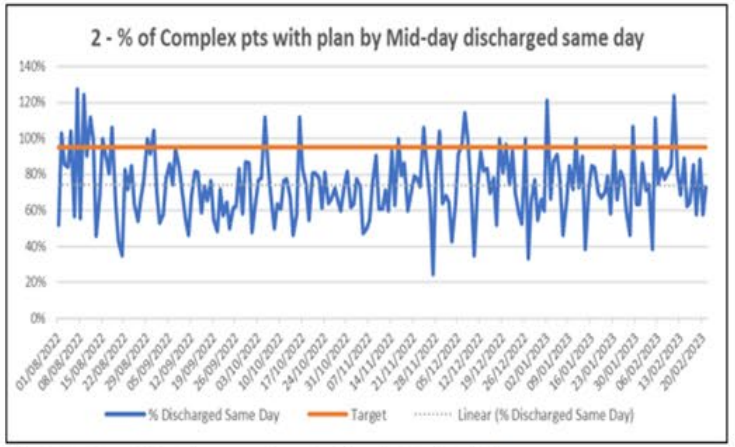
Discharges

WINTER PLAN KEY DELIVERABLE 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)

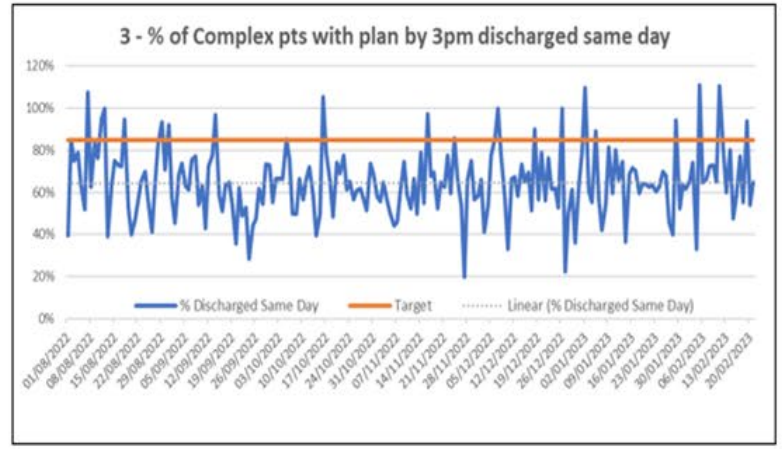
1 - Simple discharges by 5pm UHL



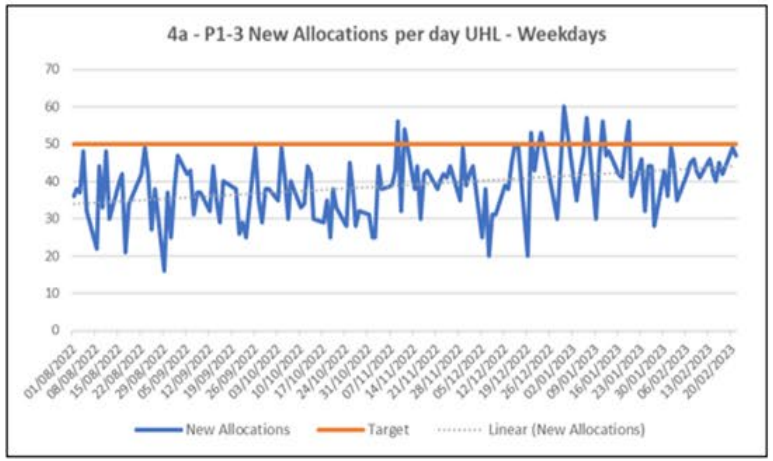
2 - Complex pts with plan by Mid-day discharged same day



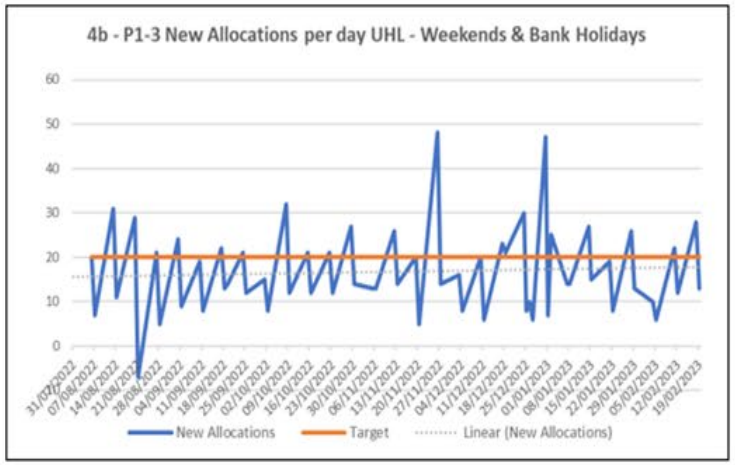
3 - Complex pts with plan by 3pm discharged same day



4a - P1-3 New Allocations per day - Weekday

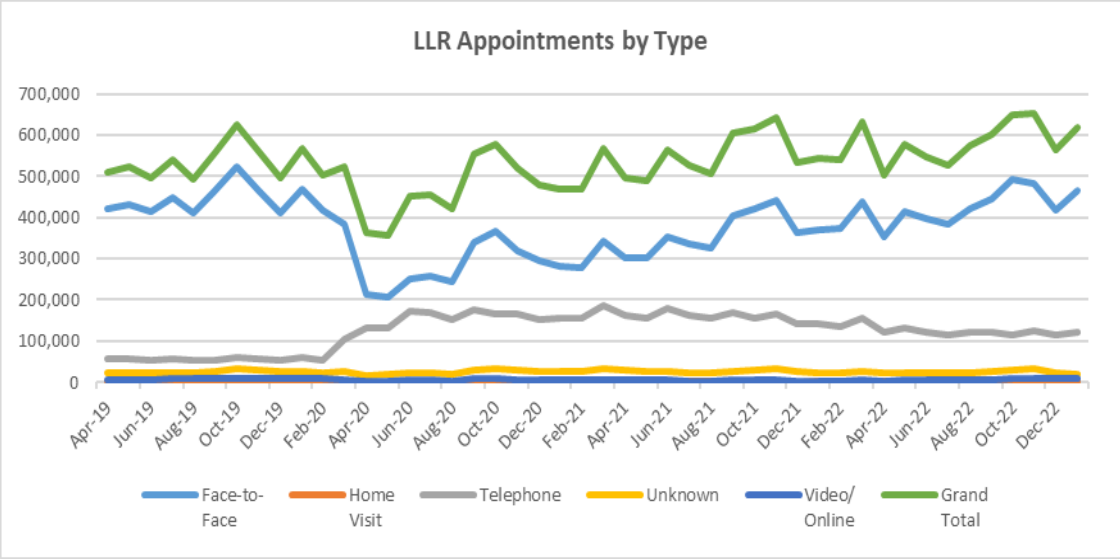


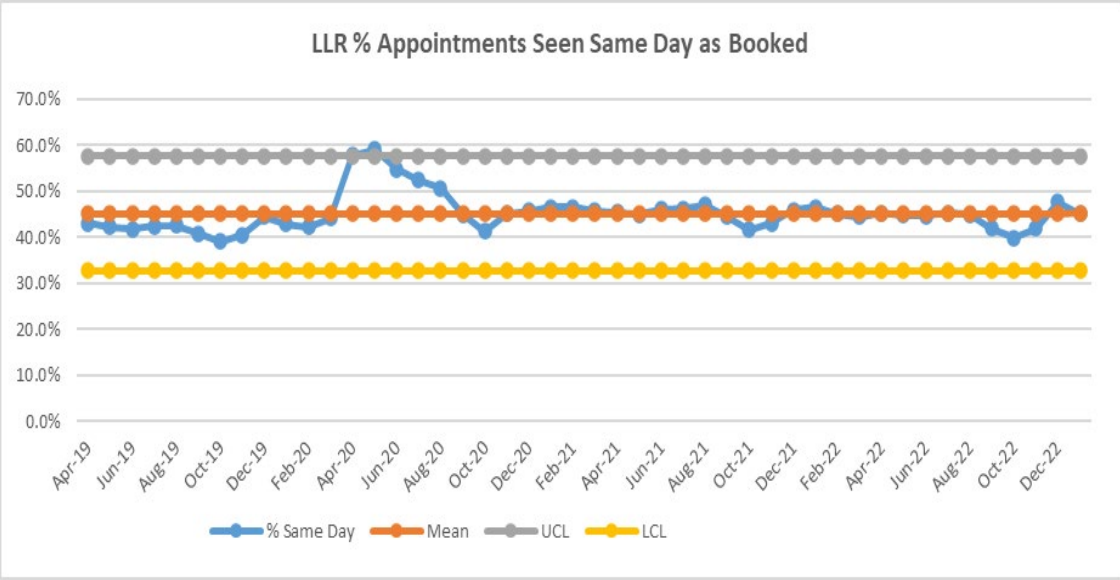
4b - P1-3 New Allocations per day - Weekend & Bank Holidays



- **Chart 1** shows the percentage of Simple (PO) discharges each day that were discharged by 5pm. The target is 66% per day which we are currently not meeting.
- **Chart 2** shows the percentage of Complex (P1-P3) patients that had a plan to be discharged by Mid-day each day that were actually discharged on that day. The target is 95%. This is not routinely being met.
- **Chart 3** shows the percentage of Complex (P1-P3) patients that had a plan to be discharged by 3pm each day that were actually discharged on that day. The target is 85%. This is not routinely being met.
- **Chart 4a** shows the number of New Allocations (Planned discharges for today minus delays from the previous day) per weekday against a target of 50 per weekday.
- **Chart 4b** shows the number of New Allocations (Planned discharges for today minus delays from the previous day) per weekend/Bank Holiday against a target of 20 per day on weekends/Bank Holidays. Due to the reduced number of planned discharges at the weekend this could be a negative number if the number of delays from the previous day was higher.

General Practice Appointments





Primary Care Priorities

- **Back to 19/20 appointment levels**
- **Increase in same day appointments**
- **Implement PCN DES around access**

All Appointments	Total
Jan-19	558,421
Jan-20	566,021
Jan-21	485,950
Jan-22	543,435
Jan-23	620,230

Appointment Levels
Target – increase from 19/20
Performance: Target met
The LLR Appointments by type graph (left) shows the monthly number by type of general practice appointments from April 2019 to January 2023.

Total appointment types show an increase (↑ 10.2%) from December. The number of face-to face appointments has also increased (↑ 12.1%) compared to the previous month.

LLR Appointments by Type		
	Latest Month	Previous Month
Measure	January-2023	December-2022
Face-to-Face	466,763	416,553
Home Visit	1,766	1,486
Telephone	121,822	113,219
Unknown	20,451	23,502
Video/Online	9,428	8,215
Grand Total	620,230	562,975

Same day appointments
Target – increase month on month
Performance: Reduced in Jan 23
The graph left shows the % of appointments that took place on the same day they were booked. There has been little variation over the last two years (since Sept 2020), although there has been a slight dip in Sep/Oct in each of the last 3 years, with a figure of 47.7% in Dec 22 and 45.1% in Jan 23. The % of appointments seen on the same day as booked has reduced (↓ 2.6%) from last month.

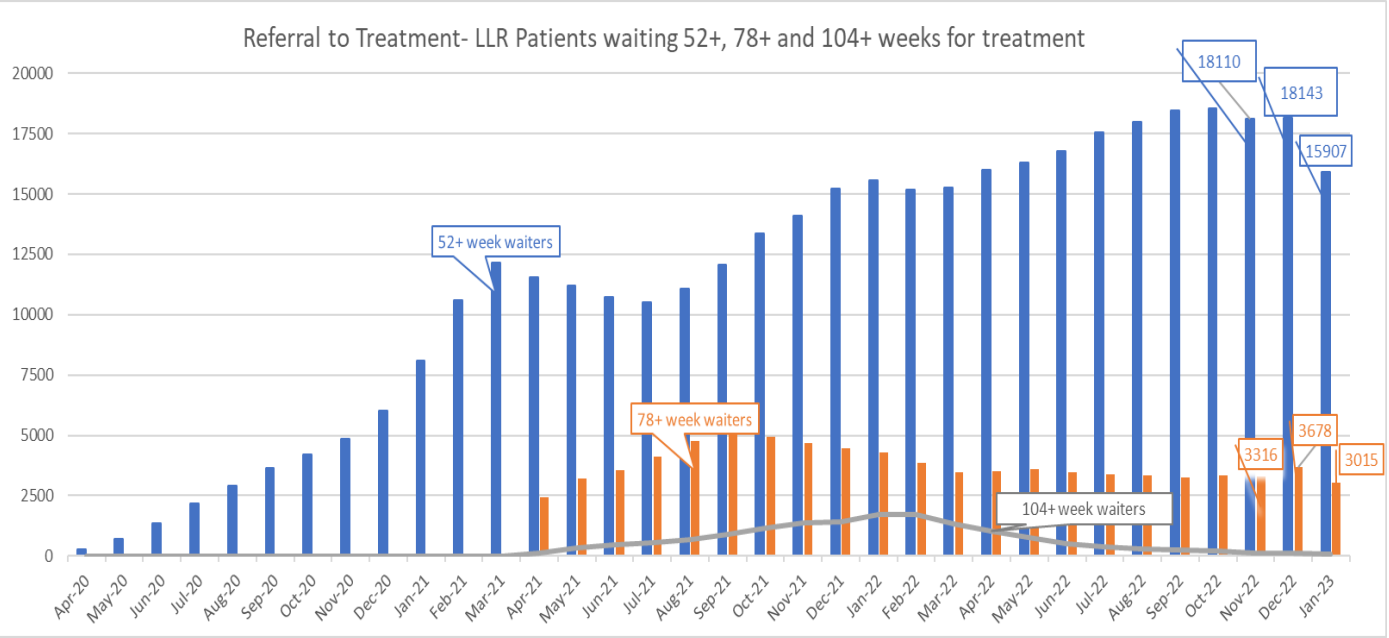
Data source: https://digital.nhs.uk/data-and-information/publications/statistical/appointments-in-general-practice

Elective Long Waits (LLR patients at all LLR providers)

The total LLR waiting list size at the end of Jan was 133,869 a **reduction of over 5000** LLR patients from Dec which stood at 139,034.

**Jan numbers are based on unvalidated data and are likely to change when data is formally published by NHSE/I*

At the end of Jan, 52+ week waiters stood at 15,907. 78+ week waiters stood at 3015, which is a **reduction** of over 600 patients from Dec. 104+ week waiters continue to **steadily decline** and stood at 77 at the end of Jan.

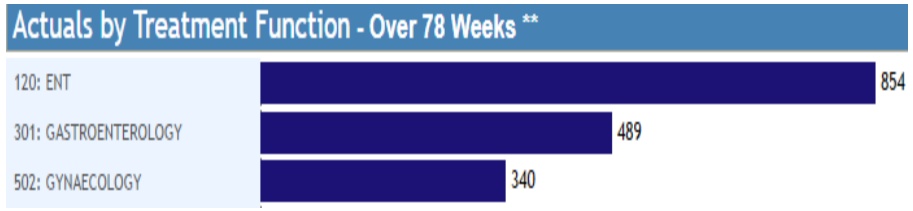


LLR Performance	All specialities	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23
	Patients waiting over 52 weeks for treatment	15989	16279	16780	17528	17970	18473	18560	18110	18143	15907
	Patients waiting over 78 weeks for treatment	3514	3594	3453	3374	3359	3251	3358	3316	3678	3015
	Patients waiting over 104 weeks for treatment	1036	772	488	366	276	236	194	129	103	77

Overall waiting list numbers have increased and this has been experienced nationally.

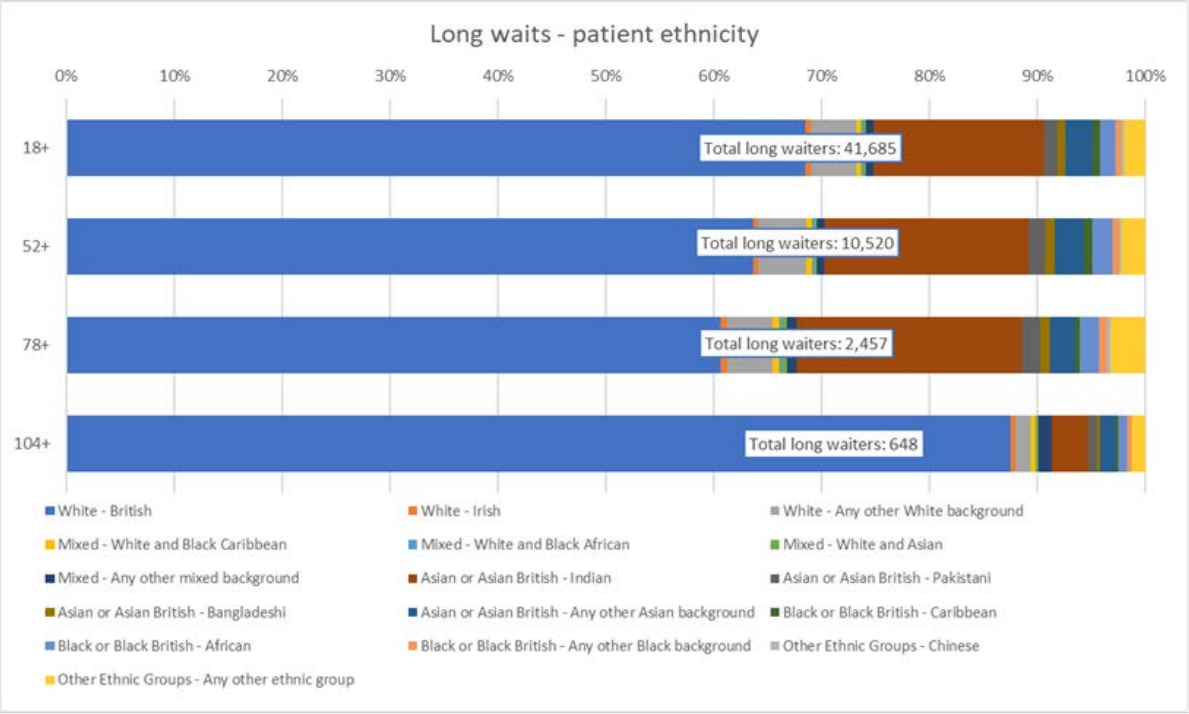
- The highest number of >52wk waiters for LLR patients are in Gastroenterology , ENT, Gynaecology and Ophthalmology

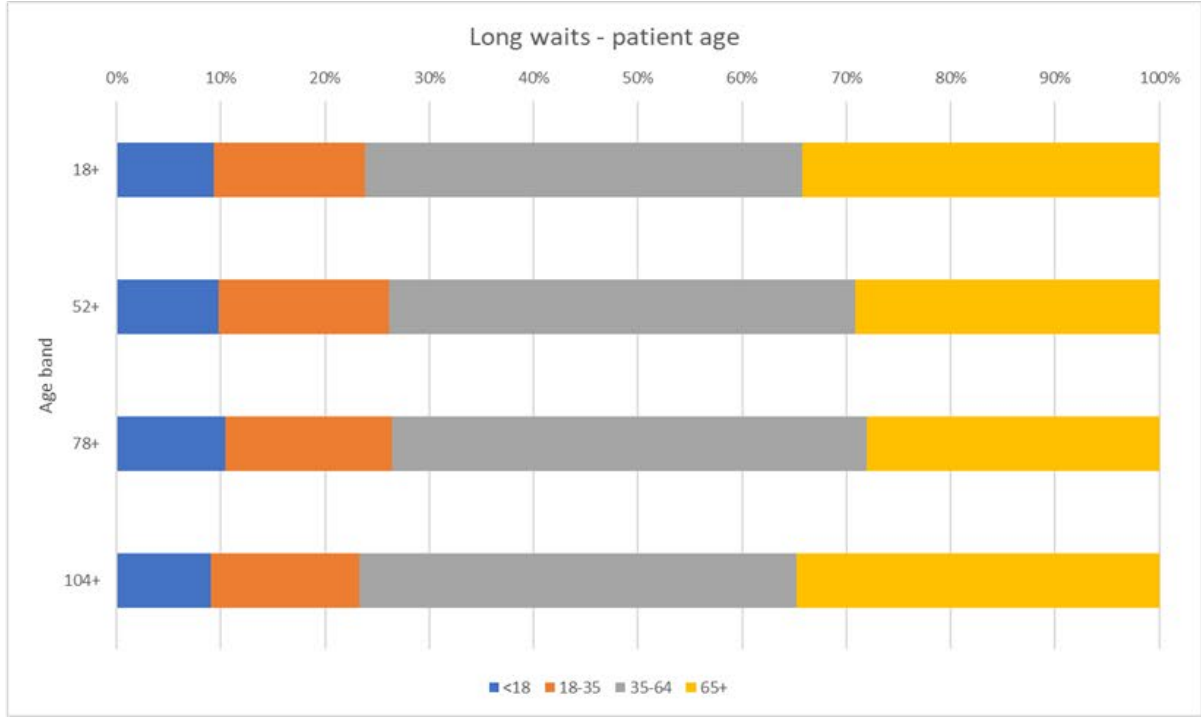
- The highest number of >78wk waiters for LLR patients are in ENT, Gastroenterology and Gynaecology



- The highest number of >104wk waits for LLR are in General Surgery and ENT

Elective Waiting List: ICB by Age & Ethnicity





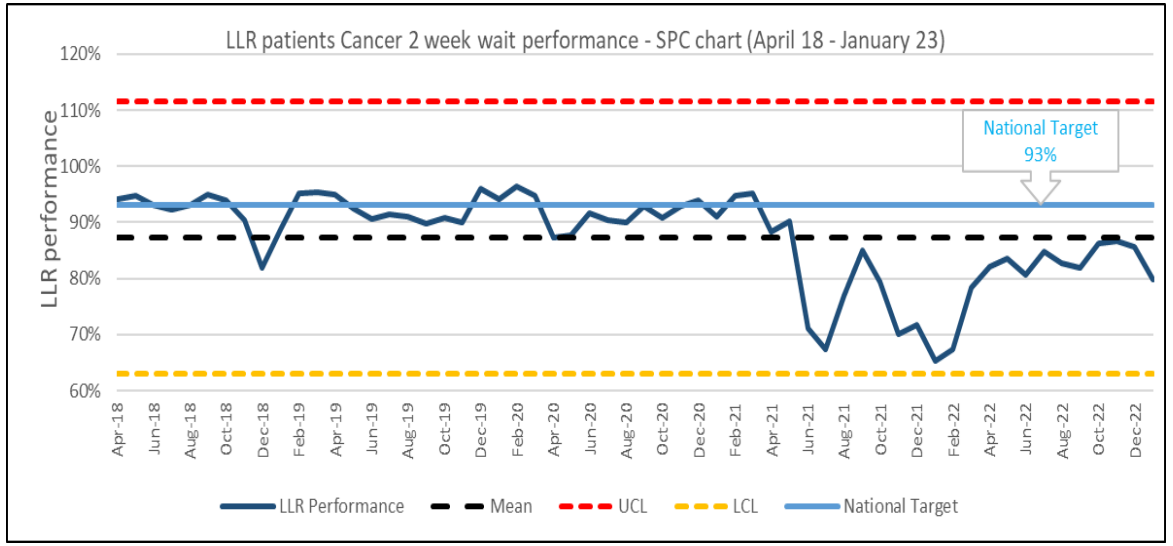
DATA: 19.02.23

The majority of patients waiting for treatment are aged 35 to 64 years (41.9%) followed by over 65 years (34.8%).
This pattern is similar across all waits.

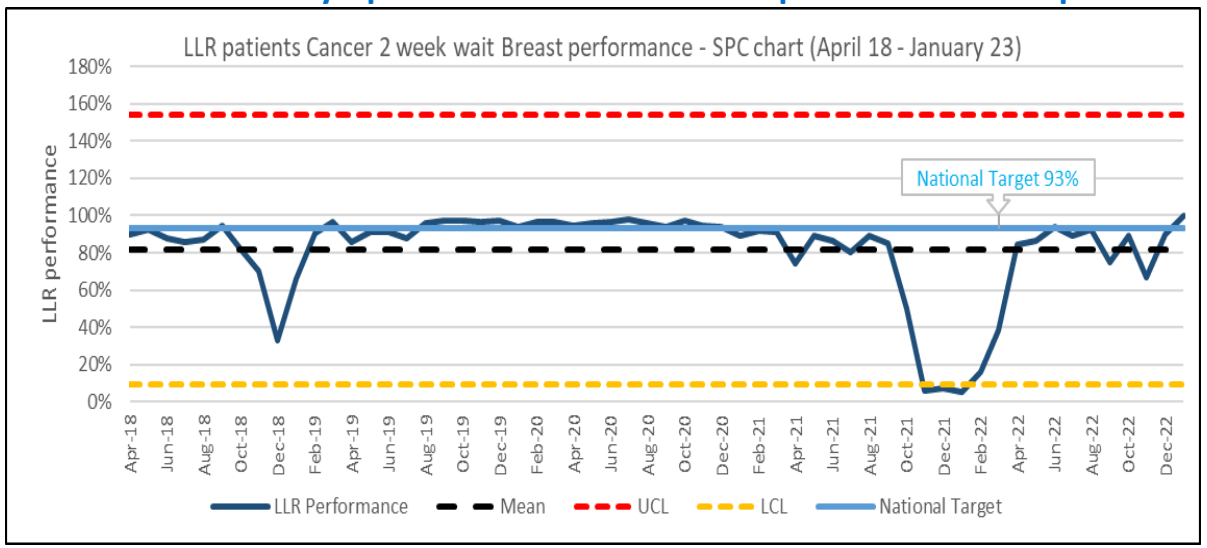
Patients of white ethnicity make up 72.2% of the total waiting list.

Cancer Waits

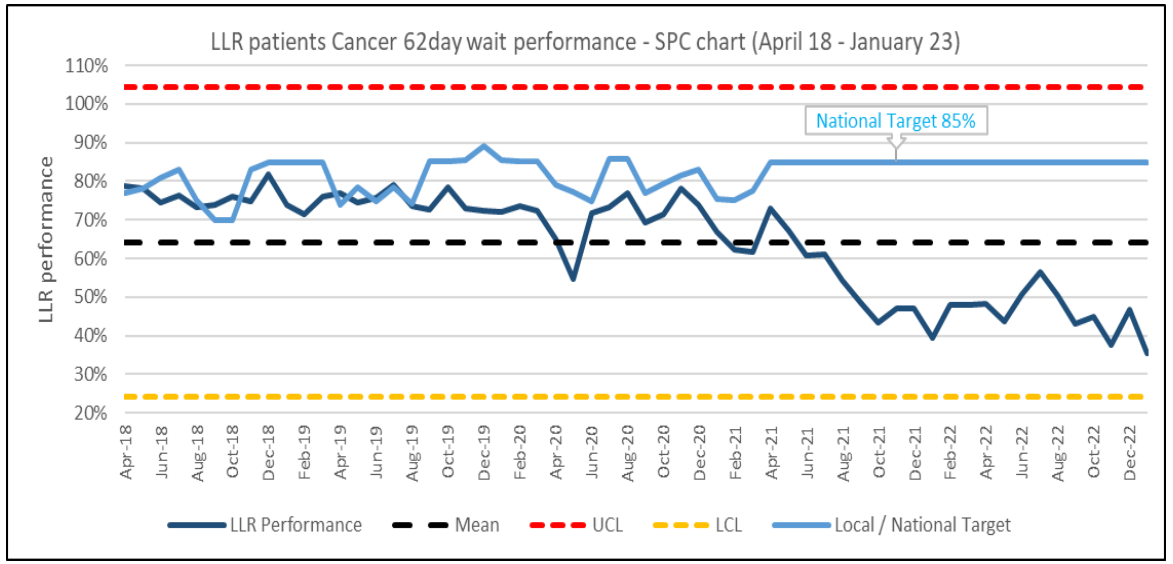
2 week wait Cancer Performance for LLR patients at all LLR providers



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



62 day wait Performance for LLR patients at all LLR providers



January's performance for 2 week wait breast symptom achieved 100%, an improvement from December (90%). Performance for the 2 week wait (80%) and 62 day wait (35%) have seen a deterioration from December.

Despite pathway improvements the 2WW standard remains at risk due to sustained increase in demand and workforce challenges in both admin and clinical areas. There is some pressure whilst key services work through their backlog position. Noticeable interventions are the expanded Lower GI pathway and the Non Site Specific Symptoms pathway, both of which went live in January. Additionally UHL is an early adopter of the Artificial Intelligence based teledermatology solution.

Learning Disabilities & Autism (LDA)

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

Sub-ICB	Monthly count of patients aged 14+, on the practice's LD register who have received a learning disability health check by the GP practice										22/23 HC's Year to date	Q1 - Q4 only 22/23 Plan	Expected Prevalence as per 22/23 planning round	% Health Checks to Jan 23 only against expected prev.
	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23				
East Leicestershire and Rutland	22	30	43	76	38	101	81	97	85	100	673			55.6%
Leicester City	33	38	82	96	234	138	133	138	86	218	1196			55.0%
West Leicestershire	22	37	91	73	72	91	53	120	113	116	788			48.8%
LLR IBC	77	105	216	245	344	330	267	355	284	434	2657	4032	4993	53.2%

Annual Health Checks (AHCs) From national data sources LLR had 2657 completed AHC's from April 22 to the end of January 23, this is 53% as at Jan 23; target 75%.

- Work completed to reach people who have not had an AHC for 2 years, with almost half of those identified being successfully contacted. It is expected the GPs will do a year end push to meet the target.
- NHSE confirmed we are currently on track to meet the 75% national target for annual Health Checks.

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

22/23 PLAN ADULTS				
	Q1	Q2	Q3	Q4
CCG Commissioned	17	16	15	15
NHSE Commissioned	13	13	13	13
TOTAL Commissioned	**30**	**29**	**28**	**28**

22/23 ACTUALS ADULTS				
	Q1	Q2	Q3	Q4
CCG Commissioned	17	15	18	
NHSE Commissioned - ADULTS only	14	13	14	
TOTAL Commissioned	**31**	**28**	**32**	

	Q1	Q2	Q3	Q4
CHILDREN Inpatients 22/23 PLAN	5	4	4	4
NHSE Commissioned - CHILDRENS only ACTUAL	5	8	9	

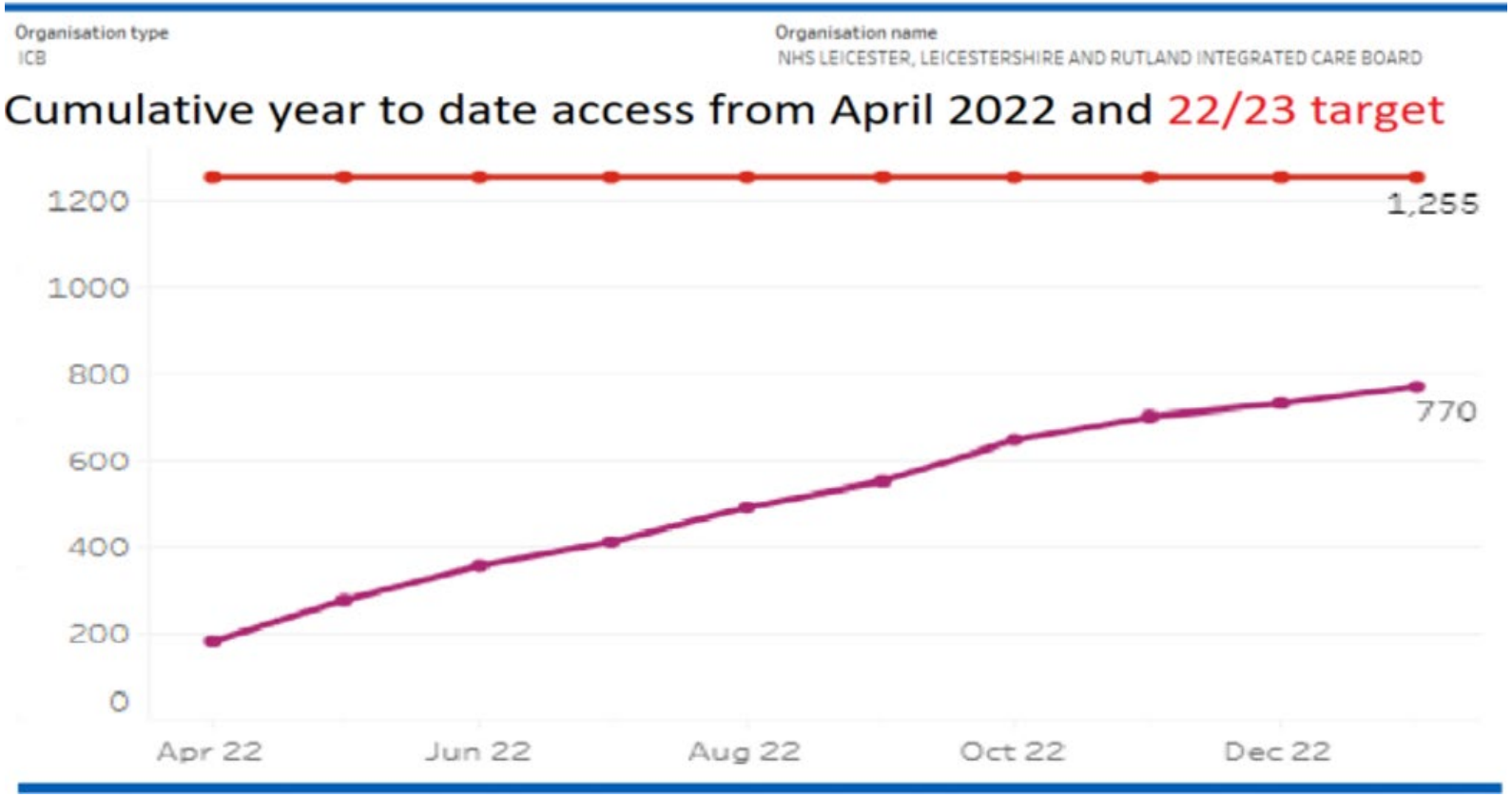
Inpatients – A total number of 41 inpatients for all ages, with an increase in both adult inpatients and CYP inpatients. The increase for Q3 was partly due to:-

- There were two urgent admissions to the Agnes Unit (due to escalation in risks, community CTRs were not held)
- An increase in CYP planned admissions following community CETRs.

Maternity

Perinatal Mental Health Dashboard

Access



From national data sources;
Cumulative year to date access: 770
22/23 target: 1,255

The cumulative number of women who had at least one attended Face to Face or Videoconferencing contact with specialist Perinatal MH services from the start of the financial year (22/23) to Jan 23.

Maternity safety is national priority and concern. The Trust utilises a perinatal surveillance scorecard which provides oversight of the quality and safety of the service at UHL. The scorecard is produced in line with the Perinatal Quality Surveillance Model designed by NHSE to support sharing safety intelligence and includes 5 areas of focus: 1)Patient Safety, 2) Workforce, 3) Training, 4) Friends and Family and 5) Outcomes

Maternity

Measure	Latest Period	Unit of Measurement	England	ICB					
				NHS Bedfordshire, Luton and Milton Keynes Integrated Care Board	NHS Bristol, North Somerset and South Gloucestershire Integrated Care Board	NHS Cambridgeshire and Peterborough Integrated Care Board	NHS Coventry and Warwickshire Integrated Care Board	NHS Leicester, Leicestershire and Rutland Integrated Care Board	NHS Northamptonshire Integrated Care Board
Choices in Maternity Services	2021	Score out of 100	68.5	65.2	66.5	67.4	63.6	72.3	69.3
Woman reported Continuity of Carer	2022	Percentage	10.8%	14.4%	9.5%	6.7%	10.1%	9.4%	14.6%
Women not offered a choice about where to have their baby	2022	Percentage	19.0%	23.6%	7.4%	13.5%	21.1%	2.5%	25.4%

- **2021 CQC Maternity Survey-** LLR ICB scores 72.3 out of 100, the **highest score** for *Choices in Maternity Services* when compared with ICB Peers
- **2022 CQC Maternity Survey** *(women reported Continuity of Carer)*- LLR ICB is **below the England average** and ranks 5 out of 6 against ICB Peers.
- **2022 CQC Maternity Survey** *(women not offered a choice about where to have their baby)*- LLR ICB ranks **1 out of 6 against ICB Peers.**

As a part of the national maternity thematic review the CQC inspection at UHL commenced on 28th February 2023 and is ongoing.

NHSE Regional Perinatal Team and LLR Local Maternity & Neonatal System conducted an Ockenden Insight Visit to UHL during July 2022 which generated several actions for attention, this included strengthening communication across the service on plans and actions, plus recognition of the impact on compliance due to the lack of a Maternity Voices Partnership (MVP) across the LLR system. Progress is being made against the recommendations outlined within the Ockenden Report, however challenges remain in terms of pace of change and improvement with particular focus on workforce planning and sustainability.

Actions:

- The trust have engaged in the redesign of the MVP being led by the LLR ICB.
- Task and finish group has been established to review the maternity website. MVP involvement to be progressed once in place. Multiple innovative solutions to support effective communication with women in progress

2022/23 NHS System Oversight Framework

In Jan 22 NHSE/I provided an update on performance data for a number of key metrics from the 22/23 System Oversight Framework (SOF).

The following table provides details of those 22/23 metrics where LLR ICS are in the **highest** quartile (top 25%), and their rank against all reporting ICS's, according to the nationally produced dataset.

March Report - SOF Update 20.02.23		
NHS Oversight Framework Metric	**Period**	**Rank**
S063c: Proportion of staff who say they have personally experienced harassment, bullying or abuse at work from patients/service users, their relatives or other members of the public	2021	1/42
S086a: Inappropriate adult acute mental health placement out of area placement bed days	Sep22 - Nov22	1/42
S053a: % of atrial fibrillation patients with a record of a CHA2DS2-VASc score of 2 or more who are treated with anticoagulation drug therapy	2021-22	2/42
S051a: Number of people supported through the NHS diabetes prevention programme as a proportion of patients profiled	22-23 Q3	3/42
S074a: FTE doctors in General Practice per 10,000 weighted patients	2022 09	3/42
S084a: Number of children and young people accessing mental health services as a % of population	2022 11	3/42
S085a: Proportion of people with severe mental illness receiving a full annual physical health check and follow-up interventions	2022 12	4/42
S110a: Access rates to community mental health services for adult and older adults with severe mental illness	2022 11	4/42
S116a: Proportion of adult inpatient settings offering tobacco dependence services	2022 10	4/42
S001a: Number of general practice appointments per 10,000 weighted patients	2022 11	5/42
S108a: Number of Completed Referrals to Community Pharmacist Consultation Service (CPCS) from a general practice	2022 11	5/42
S067a: Leaver rate	2022 11	7/41
S007a: Total elective activity undertaken compared with 2019/20 baseline	2022 09	7/42
S013c: Diagnostic activity levels: Endoscopy	2022 12	7/42
S053b: % of hypertension patients who are treated to target as per NICE guidance	2021-22	7/42
S109a: Units of Dental Activity delivered as a proportion of all Units of Dental Activity contracted	2023 01	8/42
S013c: Diagnostic activity levels: Endoscopy	2022 12	9/42
S108b: Number of Completed Referrals to Community Pharmacist Consultation Service (CPCS) from NHS111 per 100,000 population	2022 11	9/42
S040a: Methicillin resistant Staphylococcus aureus (MRSA) bacteraemia infection rate	2022 12	10/42

The following table provides details of those 22/23 metrics where LLR ICS are in the lowest performing quartile (bottom 25%), and their rank against all reporting ICS's, according to the nationally produced dataset.

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

March Report - SOF Update 20.02.23		
NHS Oversight Framework Metric	**Period**	**Rank**
S013b: Diagnostic activity levels: Physiological measurement	2022 12	42/42
S009c: Total patients waiting more than 104 weeks to start consultant led treatment	2022 12	41/42
S009b: Total patients waiting more than 78 weeks to start consultant led treatment	2022 12	40/42
S009a: Total patients waiting more than 52 weeks to start consultant led treatment	2022 12	39/42
S022a: Stillbirths per 1,000 total births	2020	39/42
S041a: Clostridium difficile infection rate	2022 12	39/42
S044b: Antimicrobial resistance: proportion of broad-spectrum antibiotic prescribing in primary care	Dec21 - Nov22	39/42
S107a: Percentage of 2-hour Urgent Community Response referrals where care was provided within two hours	2022 11	37/42
S011a: Cancer - percentage of patients on the waiting list who have been waiting more than 62 days	w/e 05/02/2023	36/42
S037a: Percentage of patients describing their overall experience of making a GP appointment as good	2022	36/42
S042a: E. coli bloodstream infection rate	2022 12	36/42
S081a: Access rate for IAPT services	2022 09	35/42
S060a: Aggregate score for NHS staff survey questions that measure perception of leadership culture	2021	32/42
S101a: Outpatient follow up activity levels compared with 2019/20 baseline	2022 12	32/42

Appendix 2

NHS Leicester, Leicestershire and Rutland Integrated Care Board

Strategic Commissioning Group
Terms of Reference (~~v2, September 2022~~)

1. CONSTITUTION

The Strategic Commissioning Group (the Group) is established by the NHS Leicester, Leicestershire and Rutland Integrated Care Board (the Board or ICB) as a sub-group of the System Executive Committee, which is a Committee of the ICB, in accordance with the Constitution of the ICB.

These terms of reference set out the membership, the remit, responsibilities and reporting arrangements of the Group and may only be changed with the approval of the Board following recommendation from the System Executive Committee.

The Group will be chaired by the Chief Strategy Officer. It is a Group established by the Board and its members are bound by the Standing Orders and other policies of the ICB.

2. STATUTORY FRAMEWORK

In line with the Statutory Framework governing the primary medical services arrangements are as follows:

> The Health and Care Act 2022 amends the NHS Act 2006 by inserting the following provisions:
> ***13YB Directions in respect of functions relating to provision of services***
> *(1) NHS England may by direction provide for any of its relevant functions to be exercised by one or more integrated care boards.*
> *(2) In this section "relevant function" means—*
> *(a) any function of NHS England under section 3B(1) (commissioning functions);*
> *(b) any function of NHS England, not within paragraph (a), that relates to the provision of—*
> *(i) primary medical services,*
> *(ii) primary dental services,*
> *(iii) primary ophthalmic services, or*
> *(iv) services that may be provided as pharmaceutical services, or as local pharmaceutical services, under Part 7;*
> *(c) any function of NHS England by virtue of section 7A or 7B (exercise of Secretary of State's public health functions);*
> *(d) any other functions of NHS England so far as exercisable in connection with any functions within paragraphs (a) to (c).*
> ***82B Duty of integrated care boards to arrange primary medical services***
> *(1) Each integrated care board must exercise its powers so as to secure the provision of primary medical services to such extent as it considers necessary to meet the reasonable requirements of the persons for whom it has responsibility.*
> *(2) For the purposes of this section an integrated care board has responsibility for— (a) the group of people for whom it has core responsibility (see section 14Z31), and (b) such other people as may be prescribed (whether generally or in relation to a prescribed service).*

In exercising its functions, the ICB must comply with the statutory duties set out in NHS Act, as amended by the Health and Care Act 2022, including:

a) Having regard to and acting in a way that promotes the NHS Constitution (section 2 of the Health Act 1989 and section 14Z32 of the 2009 Act);
b) Exercising its functions effectively, efficiently and economically (section 14Z33 of the 2006 Act);
c) section 14Z34 (improvement in quality of services),
d) section 14Z35 (reducing inequalities),
e) section 14Z38 (obtaining appropriate advice),
f) section 14Z40 (duty in respect of research),
g) section 14Z43 (duty to have regard to effect of decisions)
h) section 14Z44 (public involvement and consultation),
i) sections 223GB to 223N (financial duties), and
j) section 116B(1) of the Local Government and Public Involvement in Health Act 2007 (duty to have regard to assessments and strategies).

In addition, the Procurement, Patient Choice and Competition (no") Regulations 2013 and any subsequent procurement legislation that applies to the ICB will also be adhered to.

3. PURPOSE OF THE GROUP

The Group has been established to provide the ICB Board, through the System Executive Committee, with assurance on review, planning and procurement in respect of commissioning / de-commissioning of and investment / disinvestment in healthcare services across the ICB area. This includes primary care services ~~across the ICB area~~ (i.e. primary medical care, pharmacy, optometry and dental services) and secondary care dental. The Group has been established in accordance with the statutory framework to enable collective decision making. The Group will be the decision-making body for the management of the delegated functions and will exercise the delegated powers in accordance with the delegation agreement(s) entered into between the ICB and NHS England.

~~In the first instance, this relates to delegations as set in the primary medical services delegation and support the development of systems and processes in preparation for future delegations in respect of commissioning pharmacy, optometry and dentistry services across the ICB area.~~

The focus of the Group will be commissioning across the ICB area and ensuring focus at place-level to support equity of access and warranted health inequity.

The Group will provide regular assurance updates to the Board through the System Executive Committee in relation to activities and items within its remit.

4. DELEGATED AUTHORITY

The Group is a formal sub-group of the System Executive Committee as established by the ICB. The Board has delegated authority to the Group as set out in the Scheme of Reservation and Delegation and may be amended from time to time.

The Group holds only those powers as delegated by the Board of the ICB and is subject to any directions made by NHS England in line with the delegation agreement.

5. MEMBERSHIP AND ATTENDANCE

Membership

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

The Board will appoint no fewer than five members of the Group (from the ICB). Other attendees of the Group need not be members of the ICB, but they may be.

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

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

Members

- ICB Chief Strategy Officer (Chair) or named deputy
- ICB Chief Nursing Officer or named deputy (vice Chair)
- ICB Chief Operating Officer or named deputy
- ICB Chief Finance Officer or named deputy
- ICB Chief Medical Officer or named deputy
- ICB Chief People Officer or named deputy
- ICB Clinical Adviser

Only members of the Group have the right to attend these meetings. Other individuals may be invited to attend all or part of any meeting as and when appropriate. Attendees do not have voting rights.

Chair and vice chair

In accordance with the Constitution, this meeting will be chaired by the Chief Strategy Officer of the ICB and another member will be nominated as the vice Chair of the Group.

The Group shall satisfy itself that the ICB's policy, systems and processes for the management of conflicts (including gifts and hospitality, and bribery) are effective.

If the Chair of the meeting has a conflict of interest then the vice Chair or, if necessary, another member of the Group will be responsible for deciding the appropriate course of action.

6. MEETING QUORACY AND DECISIONS

The Group shall meet on a monthly basis. Additional meetings may be convened on an exceptional basis at the discretion of the Group's Chair.

Quoracy

For a meeting to be quorate a minimum of four members will be required with the following being present: meeting Chair or vice Chair, plus the Chief Finance Officer, and the Chief Nursing Officer or the Chief Medical Officer (or their respective named deputies).

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

Where members are unable to attend they should ensure that a named and briefed deputy is in attendance who is able to participate on their behalf.

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

Decision making and voting

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

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

Where there is a split vote, with no clear majority, the Chair of the Group will hold the casting vote. The result of the vote will be recorded in the minutes.

The Group may conduct its business on a 'virtual' basis through the use of appropriate technological support including telephone, email or other electronic communication. Where meetings are held in person, if a decision is needed which cannot wait for the next scheduled meeting, the Chair may conduct business on a 'virtual' basis through the use of telephone, email or other electronic communication.

7. RESPONSIBILITIES OF THE GROUP

The responsibilities of the Group will be authorised by the Board of the ICB. Responsibilities of the Group vary for each element of primary care, this is dependent upon the timing and level of functions delegated.

a) in relation to **overarching commissioning / de-commissioning and investment / dis-investment** decisions the Group will:

- Provide oversight and make decisions in relation to healthcare commissioning including but not limited to primary care delegated functions, other direct and specialised delegated functions, personalisation of care (e.g. continuing healthcare), prescribing, mental health and acute commissioning.
- To approve business cases for healthcare procurement (for commissioning or decommissioning and/or investment or disinvestment) with a total financial value up to £10,000,000 in total over the period of the contract (or three years if the investment is not time limited) for the ICB.
- Develop final proposals for the procurement process and approve these proposals in line with delegated authority.
- Monitor progress of procurement processes for healthcare services within the remit of the Strategic Commissioning Group and provide assurance and recommendations to the System Executive Committee and / or the ICB Board as appropriate.
- Subject to the delegated authority, make recommendations to the System Executive / ICB Board on the outcome of the procurement evaluation or approve the award of contracts to the preferred bidder, if within the level of authority delegated to the Strategic Commissioning Group.
- Keep under review progress made with commissioning and procurement activity, and other activity which should inform commissioning plans including finance and performance. Where necessary, report to the System Executive any such information which they should be aware of, particularly where it suggests that plans should be amended and escalation of risks identified.
- To approve contract award for healthcare procurements for a total financial value up to £10,000,000 in total over the period of the contract (or three years if the investment is not time limited) for the ICB.
- Where required, approve any contract variation to health care contracts for the ICB, including any changes to funding arrangements subject to the overall contract value not exceeding £10,000,000 in total for the ICB.
- Ensure that suitable policies and procedures are in place to comply with relevant regulatory, legal and code of conduct requirements.

b) In relation to commissioning of **primary medical services** it is expected that the Group will:

- To oversee the development of a system-wide Primary Care Strategy and make recommendation to the Board of the ICB for approval.

- Seek assurance that the Primary Medical Services Contracts are managed and varied in accordance with the terms of the Primary Medical Services Contracts, including District Valuer endorsed rent reviews.

- Approve contractual action such as issuing branch/remedial notices, removing a contract, boundary changes etc in accordance with the terms of the Primary Medical Services Contracts.

- Ensure appropriate action is taken in response to escalation of quality and safety risks and issues from the Risk Panel to secure improvement in the quality of services and improve efficiency in the provision of the services, which may

include taking timely action to enforce contractual breaches, serve notices or provide discretionary support.

- Ensure value for money is achieved under any Primary Medical Services Contracts.

- Agree local prices, managing agreements or proposals for local variations and local modifications.

- Seek assurance of compliance with any relevant Mandated Guidance issued from time to time.

- Manage the design (where applicable) and commissioning of any Enhanced Services, including re-commissioning these services annually where appropriate, in line with the delegation agreement.

- Have oversight of development of primary care networks

- Seek assurance from the relevant sub-group in the design of any Local Incentive Schemes for Primary Medical Services providers, ensuring the design is sensitive to the differing needs of the population, where appropriate (in line with delegation agreement).

- Approve Primary Medical Services provider mergers and closures in line with the delegation agreement.

- Make decisions in relation to management of poorly performing primary medical services providers in line with delegation agreement.

- Be responsible for making decisions in relation to the Premises Cost Directions Functions. This will include applications for new payments and revisions to existing payments under the Premises Costs Directions.

- Subject to the delegated authority, be responsible for procurement and new contracts. To approve the outcome of the procurement evaluation and approve the award of contracts to the preferred bidder, if above level of authority then to make recommendation to the System Executive or the Board as appropriate in line with Scheme of Delegation.

- To approve decisions within the delegated financial authority. Make recommendations to the System Executive Committee and or the Board, as appropriate, in relation to decisions above delegated authority.

- To co-ordinate a common approach to the commissioning and delivery of primary care services.

- Provide the System Executive Committee with an accurate understanding of the current and forecast performance position. Oversee the recovery plans to address and mitigate any risks.

c) In relation to commissioning of **primary care dental, optometry and pharmacy services, secondary care dental, specialised acute and specialised pharmacy services** the Group will:

- develop a framework in line with national requirements and have oversight of the pre-delegation assessment in preparation for delegation to be authorised by NHS England.
- Seek assurance through the governance arrangements established on a regional footprint for primary care commissioning (e.g. Tier 1 and Tier 2 committees) to ensure the LLR ICB is fulfilling its duties in line with the Delegation Agreements.
- Consider and make recommendations to the System Executive Committee or the LLR ICB Board for decisions outwith the remit of the Tier 1 and Tier 2 Committees.

~~d)The Group will develop a framework in line with national requirements and have oversight of the pre-delegation assessment in preparation for the delegation from NHS England of some of the **specialised acute and specialised pharmacy services.**~~

d) Additional responsibilities across all areas of primary care will be:

- Oversight of its programme of work and monitor delivery and ensure that any identified risks have associated mitigations in place.

- Ensure appropriate interface with the Clinical Executive Group and the Quality and Safety Committee for oversight of clinical prioritisation and assurance of quality and patient safety respectively.

- Oversee the development of the estates and premises programme for primary care services and seek assurance from the Primary Care Premises and Estates Review Group.

- Oversight of primary care workforce and resilience.

- Ensure that suitable policies and procedures are in place to comply with relevant regulatory, legal and code of conduct requirements. Approve policies aligned to the delegated functions.

- Seek assurance from sub-groups:
  - Primary Care Transformation Board
  - Primary Care Premises and Estates Review Group
  - High Risk and Complex Care Panel
  - Childrens' Continuing Care Panel

8. ACCOUNTABILITY and REPORTING ARRANGEMENTS

The Group is directly accountable to the ICB through the System Executive Committee. The minutes of meetings shall be formally recorded. The Chair of the

Group shall report to the System Executive Committee after each meeting and provide a report on assurances received, escalating any concerns where necessary.

Budget and resource accountability arrangements and the decision-making scope of the Group are as delegated. In the event of any conflict between the ICB Scheme of Reservation and Delegation in respect of ~~primary care delegation~~ functions delegated from NHS Engalnd, the Delegation Agreement will prevail.

The Group will advise the Audit Committee on the adequacy of assurances available and contribute to the Annual Governance Statement

The Group may establish working groups and other such time-limited groups. However, it cannot delegate its functions to any such groups. The Group will receive scheduled assurance report from its working groups.

9. BEHAVIOURS AND CONDUCT

ICB values

Members will be expected to conduct business in line with the ICB values and objectives. Members of, and those attending, the Group shall behave in accordance with the ICB's Constitution, Standing Orders, and Standards of Business Conduct / Conflicts of Interest Policy.

Equality and diversity

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

10. DECLARATIONS OF INTEREST

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

11. SECRETARIAT AND ADMINISTRATION

The Group shall be supported by the Corporate Governance Team this will include ensuring that:

- The agenda and papers are prepared and distributed in accordance with the Standing Orders having been agreed by the Chair with the support of the relevant executive lead;
- Attendance of those invited to each meeting is monitored and highlighted to the Chair those that do not meet the minimum requirements;
- Good quality minutes are taken in accordance with the Standing Orders and agreed with the Chair and a record of matters arising, action points and issues to be carried forward are kept;
- The Chair is supported to prepare and deliver reports to the Board;

- The Group is updated on pertinent issues/ areas of interest/ policy developments;
- Action points are taken forward between meetings and progress against those actions is monitored.

12. REVIEW

The Group will review its effectiveness at least annually and complete an annual report submitted to the Board.

These terms of reference will be reviewed at least annually and more frequently if required. Any proposed amendments to the terms of reference will be submitted to the Board for approval following consideration by the System Executive Committee.

The Group will utilise a continuous improvement approach in its delegation and all members will be encouraged to review the effectiveness of the meeting at each sitting.

Date of approval: ~~**8 December 2022 by the LLR Integrated Care Board**~~

Date of review: ~~**December 2023**~~

Name of meeting:	**Leicester, Leicestershire and Rutland Integrated Care Board meeting**		
Date:	13 April 2023	**Paper:**	**L**
Report title:	**Assurance Report from the Remuneration Committee**		
Presented by:	Simone Jordan, Non-Executive Member and Chair of the Committee		
Report author:	Daljit K. 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.
- **APPROVE** the proposed changes to the terms of reference as at Appendix 1.
- **APPROVE** the request for inclusion of the Chief Operating Officer and the Chief People Officer as voting members of the ICB Board and **APPROVE** amendments to the ICB Constitution to reflect the change in Board composition.

Purpose and summary of the report:

This report provides a summary of the key outcomes following the meeting of the Remuneration Committee held in March 2023.

Due to the confidential nature of the discussions the content of the report remains limited to items for consideration in the public session of the Board meeting, further areas of assurance will be provided to the Board in a confidential session. A summary of the level of assurance provided by the Committee is detailed in paragraph 5.

Appendices:	• Appendix 1 – terms of reference for the Remuneration Committee
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.	Chief People Officer and the Chief Operating Officer will both be directly conflicted and therefore will not participate in the discussion relating to this report.
☐	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.*	There is a risk of not complying with the fundamental governance arrangements. The report provides assurance that the Committee continues to fulfil its remit in line with the governance arrangements approved by the Board.
b) Does the report highlight any resource and financial implications? If so, provide which page / paragraph this can be found within the report.	None specifically in relation to this report.
c) Does the report highlight quality and patient safety implications? If so, provide which page / paragraph this is outlined in within the report.	None specifically in relation to this report.
d) Does the report demonstrate patient and public involvement? If so, provide which page / paragraph this is outlined in within the report.	None specifically in relation to this report.
e) Has due regard been given to the Public Sector Equality Duty? If so, how and what the outcome was, provide which page / paragraph this is outlined in within the report.	Not specifically in relation to this report, however the principles are adhered to.

Assurance Report from the Remuneration Committee

Introduction

1. This report aims to provide assurance to the Board that the Committee continues to discharge its responsibilities in line with the authority delegated to it. There are no risks or issues for escalation.

Terms of reference

2. The Remuneration Committee supported the proposal for oversight of the ICB workforce agenda and therefore requests that the Board considers the proposed changes to the terms of reference to enable the Committee to fulfil this requirement. The proposed amendments to the terms of reference are highlighted within Appendix 1.

Executive Director Board Membership

3. The Committee considered and supported the request for inclusion of the Chief Operating Officer and the Chief People Officer as voting members of the ICB Board.

4. The ICB Board is requested to consider this recommendation for approval noting that, subject to approval, any change to the Board composition will require a change to the ICB Constitution.

Summary of assurance from the Committee

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

Key area	Level of assurance	Rationale for level of assurance	Risk(s) to escalate where required
1. Committee governance arrangements	**Green**	• Terms of reference and governance arrangements in place.	N/A
2. Other areas to be considered in future confidential meetings.	**Green**	• N/A	N/A

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.
Blue	Not considered at the meeting as item not due.

Recommendations

The LLR Integrated Care Board is asked to:

- **RECEIVE** the report for assurance**.**
- **APPROVE** the proposed changes to the terms of reference as at Appendix 1.
- **APPROVE** the request for inclusion of the Chief Operating Officer and the Chief People Officer as voting members of the ICB Board and **APPROVE** amendments to the ICB Constitution to reflect the change in Board composition.

Appendix 1

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

1. Constitution

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

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

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

2. Purpose

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

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

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

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

- Elements of the nominations and appointments process for Board members;
- Oversight of executive board member performance.
- Oversight of the ICB people agenda including oversight of redundancy processes for ICB staff as they arise

3. Authority

The Remuneration Committee is authorised by the Board to:

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

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

4. Membership and attendance

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

No individual should be present during any discussion relating to:

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

5. Meetings Quoracy and Decisions

The Committee will meet in private.

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

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

Quorum

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

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

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

Decision making and voting

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

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

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

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

6. Responsibilities of the Committee

The Committee's duties are as follows:

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

- Determine all aspects of remuneration including but not limited to salary, (including any performance-related elements) bonuses, pensions and cars;

- Determine arrangements for termination of employment and other contractual terms and non-contractual terms.

For all staff:

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

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

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

Additional functions of the Committee include:

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

7. Accountability and reporting

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

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

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

8. Behaviours and Conduct

Benchmarking and guidance

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

ICB values

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

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

Equality diversity and inclusion

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

9. Declarations of interest

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

10. Secretariat and Administration

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

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

11. Review

The Committee will review its effectiveness at least annually.

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

Date of approval: 14 July 2022 approved by the Board of the LLR ICB

Date of review: July 2023

M

Name of meeting:	**Leicester, Leicestershire and Rutland Integrated Care Board meeting**		
Date:	**13 April 2023**	**Paper:**	**M**
Report title:	**Assurance Report from the ICB Quality and Safety Committee**		
Presented by:	Pauline Tagg – Chair of ICB Quality and Safety Committee		
Report author:	Imran Asif – Corporate Governance Officer		
Sponsor:	Dr Caroline Trevithick – Chief Nursing Officer Dr Nilesh Sanganee - Chief Medical 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 Integrated Care Board is asked to:

- **RECEIVE** the report for assurance.

Purpose and summary of the report:

1. This report provides a summary of the key areas of discussion and outcomes following the meeting of the ICB Quality and Safety Committee meeting held on 2 March 2023. 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 below.

	• 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.*		Yes, assurance at pathway and provider level supporting improvements and input against the current risks of LLR BAF 01 and LLR BAF 02. This Committee will review risks associated with quality at design group / collaborative level on a quarterly basis.
b) Does the report highlight any resource and financial implications? If so, provide which page / paragraph this can be found within the report.		No.
c) Does the report highlight quality and patient safety implications? If so, provide which page / paragraph this is outlined in within the report.		Yes. Quality and safety risks considered in the System Quality Report and the Primary Care highlight.
d) Does the report demonstrate patient and public involvement? If so, provide which page / paragraph this is outlined in within the report.		Report from Chairman of PPIAG.
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.		

Assurance Report from the ICB Quality and Safety Committee

1.0 Introduction

1.1 This report provides a summary of the key areas of discussion and outcomes from the ICB Quality and Safety Committee (QSC) held on 2 March 2023. The report also covers items for escalation and consideration by the Board ensuring that it is alerted to emerging risks or issues. The following provides a short summary of the key areas of discussion.

2.0 ICB Chief Nursing Officer/ Chief Medical Officer Quality Assurance Report

2.1 QSC members were informed that due to the frequency of the meetings the ICB CNO/CMO quality assurance report would be used to alert the QSC to key areas of progress and or concern and that the minutes of each System Quality Group would be shared with the QSC for information.

2.2 At the regional quality group, systems shared progress on clinical prioritisation, quality assurance and quality improvement taking place in Primary Care. The Midlands Maternity Escalation Policy & Perinatal OPEL framework is being embedded into the LLR System Control Centre and system escalation processes. It was noted that the Midlands Urgent and Emergency Care (UEC) Strategic needs assessment was presented and will be considered through the LLR Acute Care Collaborative/Winter Board to ensure we are using this Population Health Management evidence approach to incorporate prevention approaches to longer term UEC planning

2.3 The Chief Nursing Officer and Chief Medical Officer visited the UHL Emergency Department on the 3 February 2023 to review challenges faced by staff and to better understand patient's journey and experience. The enthusiasm and passion to deliver high quality care in the most pressured of environments was evident and it was clear that there were demonstrable benefits of some of the structural changes that have been made e.g. Pod, ambulance handover bus and Pre-transfer Unit as well as the transformation of clinical models and an ability to manage risk differently. There is ongoing work ensuring that we match clinical need and acuity with the right service, time and professional, as well as wanting to educate and support behavioural change in our population in a safe way

2.4 QSC members were alerted to an increase in healthcare acquired infections. The Infection Prevention and Control Q3 update noted that annual trajectories had been breached by UHL for MRSA, MSSA, bacteraemia and C.diff which is consistent with national data. UHL is committed to learning from each incident to address any themes/root causes to eliminate causes of bacteraemia.

2.5 It was noted that the System Quality Group had received assurance from UHL and LPT on their approach to Safer Staffing. It was noted that the work on the financial plan for 2023/2024 poses a challenge to investment for additional staff and work is taking place to balance the operating plan against the financial plan to minimise risk.

3.0 System Quality Provider Updates

3.1 UHL did not have any items of escalation.

3.2 LPT highlighted 4 areas of work:

- a quality and safety review had taken place following the Panorama programme into Mental Health Care in Greater Manchester to provide assurance regarding the internal mechanism for assuring safety.

- Safe staffing remained an area of concern with plans in place.
- Clostridium difficile cases were above expected levels, but this was in line with national trends likely due to increased antibiotic therapy in response to Covid.
- The People and Culture Committee has been established to focus on workforce issues and provide a quality lens.

3.4 EMAS noted the support that had been provided by system partners to reduce the pressure on ambulance handovers and delays. Significant efforts have been made to ensure a reduction in number of hours lost per day from 200 to 25/40. There have been no serious incidents reported for LLR since January 2023.

3.5 QSC received the General Practice Quality Overview report. The improvements in Oakham Medical Practice was noted following the outcome of the CQC review in January 2023 when it received an overall good rating.

3.6 Information was shared on the update of childhood immunisations in Primary Care for February 2023. It was reported that for some GP Practices and PCNs the performance was significantly lower than regional and national averages. As a result, a task and finish group was established in January 2023 to implement a two-stage approach. Stage one will see a health inequalities project developed to increase uptake in vaccinations across all ages. Stage two will focus on sustainability, reduction in health inequalities, understanding barriers to childhood vaccinations and improving education and awareness.

4.0 Operational Plan Submission – Quality Assurance

4.1 QSC were informed that the ICB quality team have been engaged with the development, planning and oversight of the annual operational plan. The submission deadline is 23 March 2023 with System Executive Committee reviewing the Plan submission on the 10 March 2023.

4.2 The LLR system will likely be declaring a financial deficit for 2023/2024 which may impact on the business cases which can be funded for the System. There are conversations ongoing currently around supporting business cases which support the system in meeting our statutory duties or have in year cost savings. 147 business cases were submitted for review. A clinical executive subgroup will be reviewing the quality impact assessments to determine the impact of not funding some of the business cases received.

4.3 QSC members requested that the operational plan be brought back to the Committee in May 2023 following its formal ratification for oversight and assurance around plans for 23/24.

5.0 Quality section for Five Year Forward Plan

5.1 QSC reviewed the Quality Approach submission for the 5YJFP. This is a short narrative around how the system is approaching quality improvement, assurance and priorities over the next five years. Quality is the golden thread throughout the Plan however there is a specific section around the system approach.

5.2 The QSC members requested that the Five Year Forward Plan is brought back to the QSC in May 2023 after its formal ratification at the Board for assurance that clinical and patient safety risks had been assessed and mitigated.

6.0 Quality Strategy Framework 2022/2024 and Implementation Plans 2022/2023 and 2023/2024

6.1 The System Quality Group developed a quality implementation framework around our approach to quality based on the National Quality Board responsibilities and functions of an ICB and the 5 Year Joint Forward Plan approach to Quality. The internal Framework will be dynamic allowing for innovation and research to support new ways of working.

6.2 In order to progress with quality in LLR, work needs to be undertaken around developing a new set of system quality measures, ensuring that we are measuring what matters most to our people: focusing on co-production and improving patient experience. This needs to complement the plans of our local healthcare providers and their ambitions for care for the forthcoming year with measurable outcomes.

6.3 The QSC members requested that the Quality Strategy Framework and Implementation Plan for 2023/2024 is brought back to the QSC in May 2023 in line with the operational plan and five year forward plan for review so that they be considered together.

7. Pharmacy, Optometry and Dentistry (PODs)

7.1 NHSE will be delegating POD services to ICBs from April 2023. Nottingham and Nottinghamshire ICB have been nominated to be the host ICB for the East Midlands region. The LLR ICB will be meeting with the N&N ICB to define boundaries and responsibilities.

7.2 There is considerable uncertainty around the POD services, including concerns around the level of quality risks. The LLR ICB will be setting up a steering group to manage the transition of delegated services. The QSC will receive a paper on PODs in May 2023 which will outline in more detail the arrangements.

8.0 Quality Internal Audit Report

8.1 The QSC received the Quality Governance Framework – Phase 1 review from internal audit for assurance. The Audit Committee have been sighted on this report.

9.0 Update from Public and Patient Involvement Assurance Group (PPIAG)

9.1 The QSC were updated of three issues which the PPIAG has been focusing on: -

- **Enhanced access**
  PPIAG noted that the LLR system is transitioning from an old system to a new contract. Feedback from patient engagement was positive, however, concerns were raised on Sunday services.
- **Primary care**
  PPIAG acknowledged the level of pressure the primary care service is under. Number of appointments offered have increased, yet patient feedback remains that there is issue with access. Concerns remain with the narrow demographics for PPGs, further work is needed to ensure patient engagement and experience is inclusive.
- **Children and Young People**
  Concerns that across the LLR system more effort is needed to improve the level of engagement with children and young people, we have examples of pockets of good work such as the exercise with asthma services. This will be factored into the CYP Quality review.

10. LLR System Quality Risk Register – Top Risks and Mitigations

10.1 QSC were provided with a new model template for the quality and safety system risk register. The layout, wording and format have been updated so they are consistent with other ICB committees.

10.2 The QSC members reviewed the risks on the register and agreed the following: -

Performance Quality and Safety – The LLR ICB may not meet the NHSE/I performance metrics within the oversight framework. Resulting in potential patient harm, poor quality outcomes, not providing the timely care for patients.
Workforce – There is a risk that the workforce capacity restrictions across NHS providers will impact on the quality of care that can be provided to citizens of LLR. It was agreed that the risk is managed by Peoples Board. Decision was made to keep the risk on the register for oversight and ensure it aligns to the Peoples Board.
CYP Waiting Times – There is a risk within LLR care for CYP is not timely
CYP Services – Following the Quality Risk Summit for CYP the risk can be combined with CYP Waiting Times.
Access to Primary Care – To be Incorporated into the Performance Quality and Safety risk and close.

10.3 **Sole Providers in LLR** – There is a risk within LLR that the system has minimal resilience due to the sole acute and community / mental health providers in the system. It was agreed to expand this risk to include narrative on fragile services and quality of provider partners.

10.4 **Risk of infection outbreaks across multiple providers** – Consensus was that this risk could be removed because sufficient mitigations are in place. It was agreed to leave the risk on the register for an additional quarter and monitor progress.

10.5 It was agreed to escalate the risks which were red to the Board Assurance Framework. (Performance Quality and Safety, including primary care access, CYP Waiting Times & Services.

11. Summary of assurance from the Committee

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

Key area	Level of assurance	Rationale for level of assurance	Risk(s) to escalate where required
1. ICB Chief Nursing Officer/ Chief Medical Officer Quality Assurance Report	**Amber**	• Challenges for safer staffing within LLR system remain however UHL & LPT report plans in place to try and address the gaps, using of international nurses • and support newly qualified pipeline. • Increase in healthcare acquired infections are noted.	
2. System Quality Provider Updates	**Amber**	• Further work is required to improve uptake in childhood immunisations in Primary Care.	
3. Annual Operational Plan Submission – Quality Assurance	**Amber**	• Assurance received regarding the process for understanding clinical risk in relation to the Annual Operational Plan • Insufficient detail was provided on the quality input to the operational plan and therefore felt a lack of assurance at this stage.	

		• Operational Plan to be brought back to the QSC in May 2023.	
4. Quality section for Five Year Forward Plan	**Amber**	• QSC members requested that the Five Year Forward Plan be brought back to QSC in May 2023 and reviewed in line with the operational plan.	
5. Quality Strategy Framework 2022/2024 and Implementation Plans 2022/2023 and 2023/2024	**Amber**	• Assurance received regarding actions in place for 22/23 • The triangulation of the operational plan, five year forward plan and quality strategy framework and implementation plan for 2023/2024 to be brought back to the QSC in May 2023.	
6. Pharmacy, Optometry and Dentistry (PODs)	**Red**	• There is sufficient uncertainty for the delegation of PODs services. • Further information to be provided by NHSE and QSC to receive a paper in May 2023.	
7. Quality Internal Audit Report	**Green**	• Quality Governance Framework – Phase 1 review provided for information.	
8. Update from Public and Patient Involvement Assurance Group (PPIAG)	**Amber**	• PPIAG provided update for enhanced access, primary care and CYP services.	
9. LLR System Quality Risk Register – Top Risks and Mitigations	**Not rated**	• First iteration of new format of risk register was shared. • Risk to be escalated to the BAF and reviewed on a quarterly basis.	

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.
Blue	Not considered at the meeting as item not due.

Recommendations

The LLR Integrated Care Board is asked to:

- **RECEIVE** the Quality and Safety Committee report for assurance.

N

Name of meeting:	**Leicester, Leicestershire and Rutland Integrated Care Board meeting**		
Date:	**13 April 2023**	**Paper:**	**N**
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 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 meeting of the Audit Committee held in February 2023. 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 13.

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.

Assurance Report from the Audit Committee

Introduction

1. This report provides a summary of the key areas of discussion and outcomes from the meeting of the Audit Committee held in February 2023. The report also covers items for escalation and consideration by the Board ensuring that the Board is alerted to emerging risks or issues. The following provides a short summary of the key areas of discussion.

External and Internal Auditors

2. The **External Auditors** advised that the audit planning is in progress and that there were no significant issues to report at present.

3. The **Internal Auditors** confirmed that all historic audit actions prior to 1 July 2022 had been closed and any actions previously relating to financial controls were currently being tested in the finance audit reviews for 2022/23. The following reports had been issued by the Auditors following the completion of the relevant internal audits and all reports provided a positive assurance:

    a. Quality Governance Framework Phase 1 review.
    b. Governance Phase 1 review.

4. The Committee were assured that work underway to support counter fraud, bribery and corruption was progressing well in line with the agreed plan.

5. The Committee reviewed the draft internal audit and counter fraud plans for 2023/24 prior.

Risk Management arrangements

6. An overview was provided of the current Board Assurance Framework (BAF) and risk management arrangements in place across the ICB. Current arrangements were noted as being effective and the Committee supported the work underway to review and improve processes, recognising the need to ensure risk management arrangements continue to be dynamic and 'live'.

7. The Committee acknowledged the work underway to develop the ICB BAF for 2023/24, noting that the new strategic objectives were still in development.

ICB Annual Report and Accounts timeline

8. An overview of the timeline for completion of the LLR CCGs' and the ICB's Annual Reports and Accounts was provided, detailing the actions to take place to enable the production of the reports. Members will be given the opportunity to contribute to and review a draft iteration of the report ahead of the submission deadline.

Accounting Policies

9. The ICB is required to have a set of accounting policies which form the basis for producing the year-end accounts. The Committee approved the accounting policies subject to a review of the Annual Accounts and changes that may be result.

Waiver of Standing Orders

10. The report was received for assurance.

Loss and Special Payments

11. The Committee were assured of no new losses or special payments as at 31 January 2023.

Roles and responsibilities training session

12. The Internal Auditors facilitated a short training session for the Audit Committee members providing an opportunity for members to enhance their knowledge and understanding about their role on the Audit Committee. The Committee will also be taking a lead on coordination of review of the effectiveness of the Committees and will be seeking this assurance for onward reporting to the ICB Board.

Summary of assurance from the Committee

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

Key area	Level of assurance	Rationale for level of assurance	Risk(s) to escalated where required
1. Committee governance arrangements		• N/A	N/A
2. Progress against External Audit Plan	**Green**	• Positive progress in being made.	N/A
3. Progress against Internal Audit Plan	**Green**	• Positive progress was evidenced.	N/A
4. Progress against Counter Fraud Plan	**Green**	• Positive progress was evidenced.	N/A
5. Timely implementation of internal audit recommendations	**Green**	• Positive progress was evidenced.	N/A
6. Effectiveness of the ICB risk management arrangements	**Amber**	• Positive progress continues to be made, the level of assurance is amber to reflect the work underway to further develop the ICB BAF.	N/A

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.
Blue	Not considered at meeting as item not due.

Recommendations

The LLR Integrated Care Board is asked to:

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

o

Name of meeting:	**Leicester, Leicestershire and Rutland Integrated Care Board meeting**		
Date:	13 April 2023	**Paper:**	**O**
Report title:	**Assurance Report from the Health Equity Committee**		
Presented by:	Professor Azhar Farooqi, Non-Executive Member		
Report author:	Charlotte Gormley, Corporate Governance Officer		
Sponsor:	Sarah Prema, Chief Strategy and Planning 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 Integrated Care Board is asked to:

- **RECEIVE** the report for assurance.

Purpose and summary of the report:

1. This report provides a summary of the key areas of discussion and outcomes following the meeting of the Health Equity Committee held on 21 February 2023. 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 14.

Appendices:	• Appendix 1 – Cancer and Childhood Immunisation Data by Health Inequalities
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.*	There is a focus on providing assurance that health inequalities are being addressed in an appropriate and systematic way.
b) Does the report highlight any resource and financial implications? If so, provide which page / paragraph this can be found within the report.	Assurances received in relation to investments into primary care and national funding (paragraph 12).
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 due regard is considered within reports presented to the Committee.

Assurance Report from the Health Equity Committee

Introduction

1. This report aims to provide assurance to the Board and a summary of the key areas of discussion and outcomes, aligned to the Committee's delegated authority, following the meeting of the Health Equity Committee held on 21 February 2023. The report also covers items for escalation and consideration by the Board ensuring that it is alerted to emerging risks or issues.

Assurance on delivery

2. The ICB approved in principle the proposal to set up an LLR Health Inequalities Unit as part of its approval in February 2022 of the LLR Health Inequalities Framework "Better Health for All".

3. The Committee considered and approved the **LLR Health Inequalities Support Unit (HISU) Steering Group Terms of Reference.** The Steering Group would set the strategic priorities of the HISU, monitor the work plan, report back to the Health Equity Committee regarding progress, identify and agree resourcing of the HISU, and champion work within the wider system. These responsibilities may revert to the Health Equity Committee in 6-12 months once the HISU has been established.

4. It was proposed that a development session focusing on health equality be held in summer 2023 to facilitate the engagement of the Integrated Care Partnership.

5. **Assurance Report February 2023** – the Committee received an update on the progress of strategic actions to reduce health inequalities, including the recruitment of six fuel poverty advisors, and the LLR Health Inequalities Champions Programme which will commence in March 2023.

6. A concern was identified regarding the quality of maternity data received from the LMS. The Committee received assurance that a Maternity Equity Strategy with twelve key actions has been agreed and a delivery group meets monthly. The continuity of carer scheme has also been relaxed as a national standard. An update will be provided at the next meeting of the Committee to explore this area in greater detail.

7. A particular area of interest in relation to cancer and childhood immunisation data by health inequalities is appended to this report for the Board's information (see Appendix 1).

8. **Health Equity Committee focus areas / deep dives 2023/24** – the Committee considered and agreed two clinical topics which would be the initial focus of analytical deep dives for the assurance of the system. The HISU will provide an initial focus on cancer screenings, education, treatment, and outcomes, and childhood immunisations.

9. **Health Equality and Inclusion at UHL and LPT – consider approach** – it was agreed that UHL and LPT would provide reports regarding Health Equality and Inclusion to the Committee at alternate meetings. These reports will inform discussion and decision-making. Updates will also be provided regarding internal workstreams.

10. The **Primary care workforce update – Leicester City Place Plan** provided assurance that workforce modelling is being based on population need and data driven insights. Data is utilised to inform planning, decision-making, investment, and balancing pressures. The retention workstream was identified as critical. A long-term Workforce Plan is to be published in Summer 2023.

11. The Committee received assurance that deployment of nursing staff into the community is equitable, as caseload, acuity, and staffing numbers are taken into consideration. A workforce dashboard is in place to monitor this.

12. The Committee is reasonably assured of the action plan in place for the primary care workforce and will continue to receive reports as to progress.

13. The Committee held a discussion regarding investment into primary care and national funding. It was agreed that a stock take is required to ensure funding has been well spent. A report is to be presented at the next meeting of the Committee exploring the intended purposes of the investments and whether funds have been distributed in the way intended.

Summary of assurance from the Committee

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

Key area	Level of assurance	Rationale for level of assurance	Risk(s) to escalate where required
1. Assurance on delivery	**Amber**	• A Steering Group for the Health Inequalities Support Unit has been established and Terms of Reference have been approved. • A Maternity Equity Strategy is in place and the Committee will receive further updates regarding maternity. • Cancer and childhood immunisations have been identified as the initial areas of focus for the HISU. • The Committee are reasonably assured as to the action plan for the primary care workforce and will continue to receive updates.	N/A

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.
Blue	Not considered at meeting as item not due.

Recommendations

The LLR Integrated Care Board is asked to:

- **RECEIVE** the report for assurance.

Appendix 1

NHS
Leicester, Leicestershire and Rutland

Cancer & Childhood Immunisation data by Health Inequalities

March 2023

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

Overview

Analysis uses General Practice Deprivation Scores (Indices of Multiple Deprivation Score (2019) as a consistent and recognised measure.

(https://fingertips.phe.org.uk/search/imd%202019#page/6/gid/1/pat/223/par/E40000011/ati/221/iid/93553/age/1/sex/4/cat/-1/ctp/-1/yrr/1/cid/4/tbm/1)

Cancer: slides 3 – 7

- Cancer Screening uptake: For bowel, breast and cervical (ages 50-64yrs only) screening there is generally a higher uptake of screening in the least deprived practices. There are a number of practices with a mid-range Deprivation Score that have a low uptake.
- Cancer diagnosis from a 2 week wait referral (Conversion rate) is consistent across practices
- Least deprived practices generally have a higher recorded prevalence of cancer.

Childhood Immunisations: slides 8-10

- Range of uptake across the 10 most deprived practices.

  3 of these 10 practices had a higher uptake of DTaP/IPV/Hib 12 Mnth & MMR 24mths compared with the LLR average.

  1 of these 10 practices had a higher uptake of MMR 60mths compared with the LLR average.
- Local work & analysis being undertaken to support this programme.

Cancer

- Cancer screening uptake for practices with the highest deprivation scores in LLR
- By GP practice & Deprivation Score:
    - Bowel / Breast / Cervical Screening
    - 2 week wait referrals resulting in a diagnosis of cancer
    - Cancer Prevalence
- Example of Practice level Fingertips data

Example of local work

Task & Finish Group to explore why Leicester City has the worst outcomes in England for colorectal cancer and actions to try and improve performance. Led by Dr Pawan Randev (East Midlands Cancer Alliance CRUK Primary Care Lead & LLR ICB Cancer Lead).

Table showing the % cancer screening uptake of the 10 GP practices with the highest deprivation scores in LLR, compared with LLR and Leicester City uptake .

10 Practices with highest Deprivation Score (2019) (RAG based on LLR uptake)	Cancer Screening Uptake % 2021/22			
	Bowel Cancer 60-70 yrs	Breast Cancer 50-70 yrs	Cervical Cancer 25-49 yrs	Cervical Cancer 50-64 yrs
LLR Uptake	**69%**	**58%**	**69%**	**76%**
Leicester City CCG uptake	**57%**	**46%**	**61%**	**71%**
C82053 - Hockley Farm Med Pract (A Nana)	61%	47%	68%	69%
C82624 - The Practice Beaumont Leys (Spirit)	53%	49%	58%	65%
C82610 - The Parks Medical Centre (B Hainsworth)	61%	33%	63%	68%
C82100 - The Hedges Medical Centre (Sa Bailey)	62%	55%	75%	73%
C82046 - Saffron Group Practice	60%	51%	65%	64%
C82626 - Pasley Road Health Centre (Tk Khong)	62%	58%	65%	74%
C82008 - Oakmeadow Surgery (Ra Leach / PR Jones)	66%	45%	73%	75%
C82019 - Sturdee Road Health and Wellbeing Centre (G Singh)	64%	60%	77%	76%
C82094 - Beaumont Lodge Medical Practice	63%	66%	70%	78%
Y02469 - Heron GP Practice	48%	20%	53%	62%
Number of Practices with uptake higher than LLR	0	2	4	1

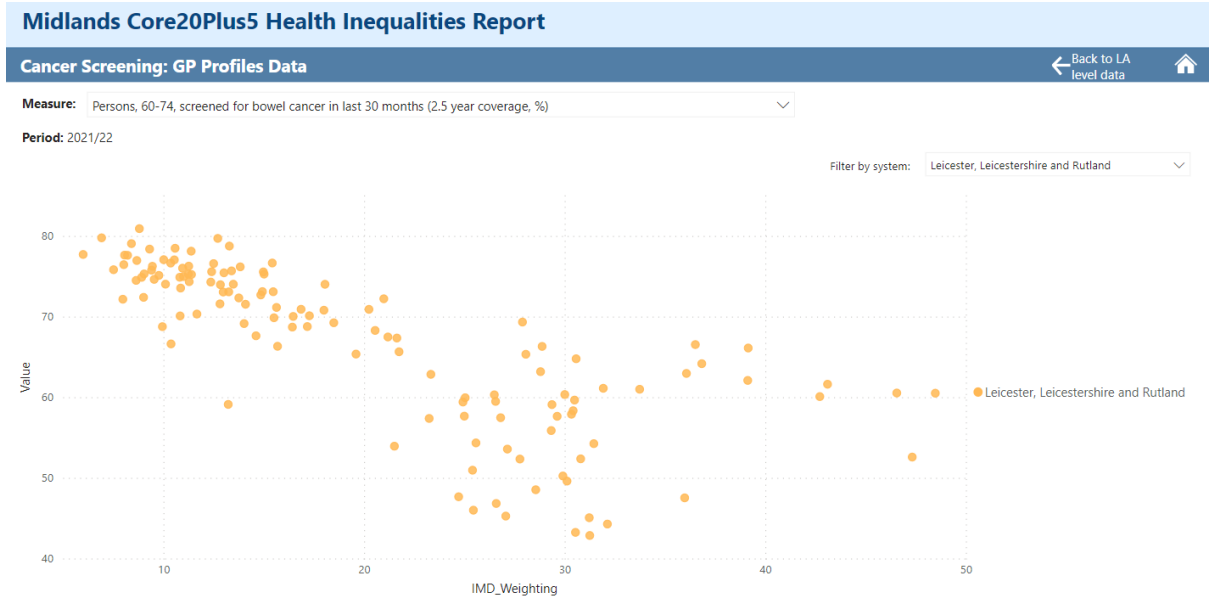
The following slides show a number of cancer measures, at practice level, against the deprivation score for that practice. Data for 2021/22.

Practices to the left of the graphs have a lower deprivation score to practices on the right..

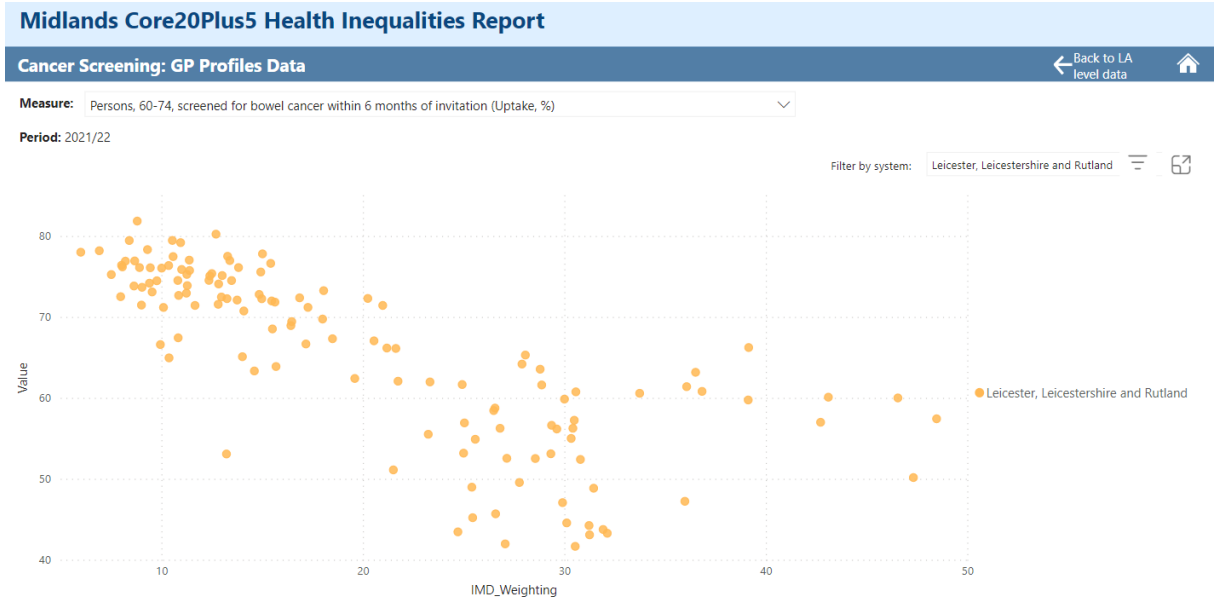
Source: Midlands Core20+5 Health Inequalities Report (https://app.powerbi.com/view?r=eyJrIjoiN2M5MDBmODYtN2UyNC00NmUxLThkODctMjI2ODk4YzgyNmVjIiwidCI6IjAzMTU5ZTkyLTcyYzYtNGIyMy1hNjRhLWFmNTBlNzkwYWRiZiJ9&pageName=ReportSection09771d33d820ad1956e0)

Bowel Screening

The graphs below indicate that, generally, least deprived practices have a higher uptake of bowel screening.



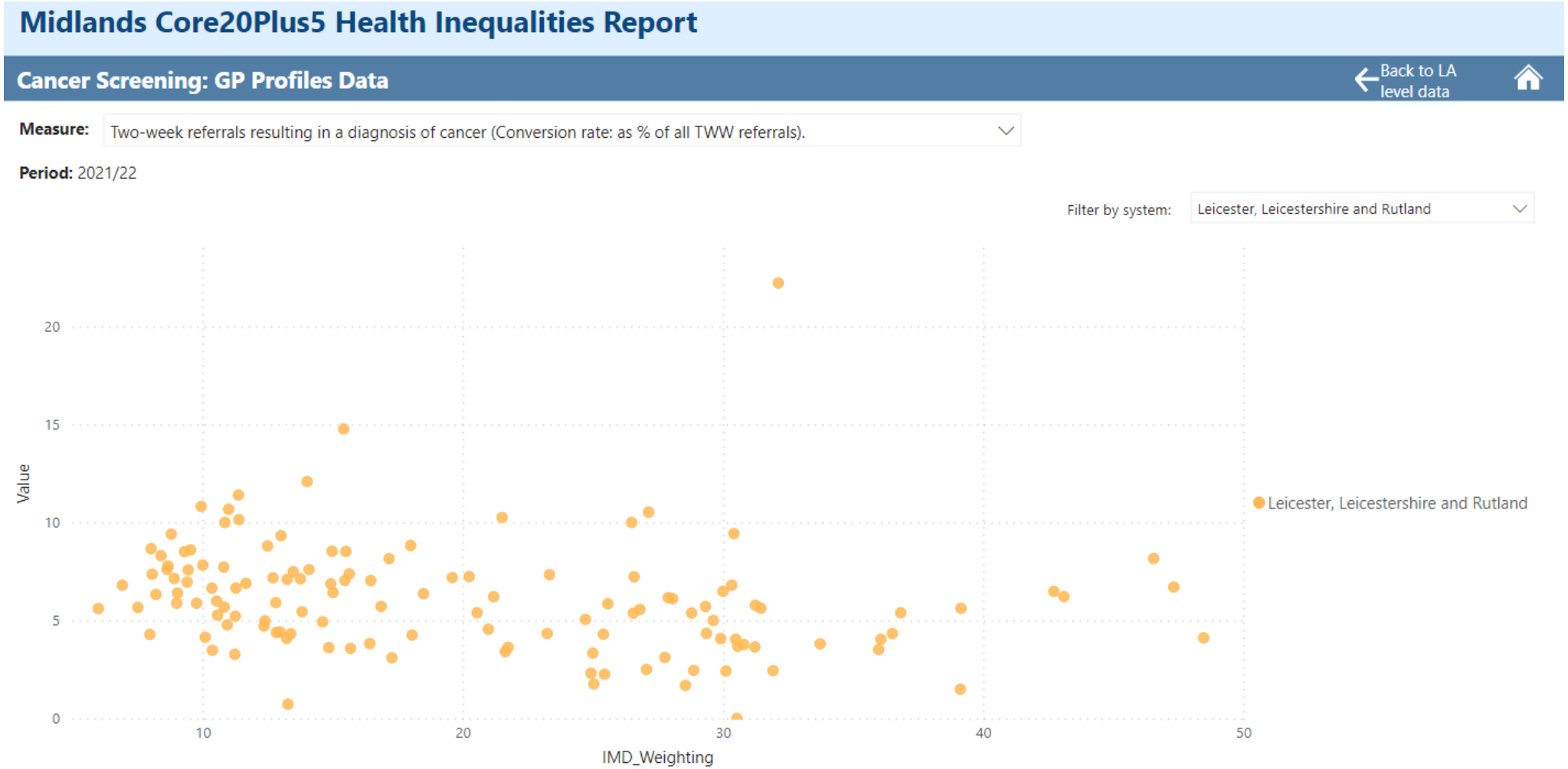
The chart above shows Persons, 60-74, screened for bowel cancer in last 30 months (2.5 year coverage, %) on the Y axis and IMD score (2019) on the X axis for GP practices within the selected system(s).



The chart above shows Persons, 60-74, screened for bowel cancer within 6 months of invitation (Uptake, %) on the Y axis and IMD score (2019) on the X axis for GP practices within the selected system(s).

2 week wait referrals resulting in diagnosis of cancer

The graph below indicate that there is not much difference in 2ww cancer referrals, resulting in a cancer diagnosis across practices.



The chart above shows Two-week referrals resulting in a diagnosis of cancer (Conversion rate: as % of all TWW referrals). on the Y axis and IMD score (2019) on the X axis for GP practices within the selected system(s).

Example of Fingertips data available at Practice level

Source: https://fingertips.phe.org.uk/search/cancer

Lower Similar Higher

Indicator	Period	C82053 - Hockley Farm Med Pract (A Nana)			PCNs (v. 28/10/22)	England	England		
		Recent Trend	Count	Value	Value	Value	Lowest	Range	Highest
Cancer: QOF prevalence (all ages)	2021/22	→	310	2.8%	1.6%*	3.3%	0.1%		
% reporting cancer in the last 5 years	2022	→	-	4.7%	2.4%*	3.2%	0.0%		
Patients with cancer reviewed within 6 months of diagnosis (denominator incl. PCAs) - retired after 2020/21	2020/21	↑	37	97.4%	86.9%*	78.4%	0.0%		100%
New cancer cases (Crude incidence rate: new cases per 100,000 population) New data	2020/21	→	-	417	-	456	10		
New cancer cases treated resulting from a Two Week Wait referral (Detection rate: % of all new cancer cases treated)	2021/22	→	25	45.5%*	51.2%*	54.4%*	0.0%		0%
Two-week wait referrals for suspected breast cancer (Number per 100,000 population)	2021/22	→	95	866	680*	824	0		
Two-week wait referrals for suspected lower GI cancers (Number per 100,000 population)	2021/22	→	97	884	397*	799	0		
Two-week wait referrals for suspected lung cancer (Number per 100,000 population)	2021/22	→	22	201	79*	97	0		
Two-week wait referrals for suspected skin cancer (Number per 100,000 population)	2021/22	→	116	1,058	664*	936	0		
Number of emergency admissions with cancer (Number per 100,000 population)	2021/22	→	74	675*	350*	514*	0		
Number of emergency presentations (Number per 100,000 population)	2021/22	→	13	119*	67*	88*	0		
Number of other presentations (Number per 100,000 population)	2021/22	→	41	374*	211*	365*	0		
Two-week referrals resulting in a diagnosis of cancer (Conversion rate: as % of all TWW referrals).	2021/22	→	25	4.1%*	4.3%*	6.2%*	0.0%		
Two-week wait referrals for suspected cancer (Number per 100,000 population)	2021/22	→	608	5,544	3,216*	4,323	210		
Bowel cancer screening coverage: aged 60 to 74 years old	2021/22	↑	841	60.5%	64.0%*	70.3%*	17.4%		100%
Bowel cancer screening uptake: aged 60 to 74 years old	2021/22	↑	406	57.4%	62.5%*	69.6%	0.0%		85.7%
Two-week wait referrals for suspected cancer (Number per 100,000 population). Five years combined data.	2017/18 - 21/22	–	2,753	5,062	2,814*	3,719	323		
Two-week referrals resulting in a diagnosis of cancer (Conversion rate: as % of all TWW referrals). Five years combined data.	2017/18 - 21/22	–	131	4.8%	4.9%*	6.8%	0.4%		
New cancer cases treated resulting from a Two Week Wait referral (Detection rate: % of all new cancer cases treated). Five years combined data.	2017/18 - 21/22	–	129	53.3%	52.6%*	53.5%	6.7%		76.7%
Two-week wait referrals for suspected breast cancer (Number per 100,000 population). Five years combined data.	2017/18 - 21/22	–	429	789	579*	701	26		
Two-week wait referrals for suspected lower GI cancers (Number per 100,000 population). Five years combined data.	2017/18 - 21/22	–	450	827	377*	672	9		
Two-week wait referrals for suspected lung cancer (Number per 100,000 population). Five years combined data.	2017/18 - 21/22	–	113	208	76*	96	0		
Two-week wait referrals for suspected skin cancer (Number per 100,000 population). Five years combined data.	2017/18 - 21/22	–	512	941	566*	779	9		
Patients with cancer reviewed within 12 months of diagnosis (denominator incl. PCAs)	2021/22	–	27	100%	96.6%*	95.1%	0.0%		100%
Patients with cancer who had an opportunity for a discussion within 3 months of diagnosis (denominator incl. PCAs)	2021/22	–	31	73.8%	78.3%*	56.4%	0.0%		00%

Childhood Immunisations

- MMR 24mths, MMR 60mths & DTaP/IPV Booster uptake for practices with the highest deprivation scores in LLR
- Example of Practice level Fingertips data (Adult & Childhood Imms)

Examples of local work

LLR ICB (Primary Care Quality Team) working with practices with lowest uptake, identify reasons & understand barriers for low uptake (workforce & clinic room capacity), super-vaccinators & clinical leads into community & engaging with 'communities of interest'. (amy.walker58@nhs.net and samantha.keating5@nhs.net)

Leicestershire County Council Health Equity Audit looking at childhood immunisations, using data from LPT, analysed by age / gender / ethnicity / deprivation. Due to be published at the end of April 2023. (kajal.lad@leics.gov.uk)

Table showing the MMR 24mths, MMR 60mths & DTaP/IPV Booster uptake of the 10 GP practices with the highest deprivation scores in LLR, compared with LLR and Leicester City uptake.

10 Practices with highest Deprivation Score (2019)	Early Childhood Immunisation Uptake % Q1 22/23 (Cover Report NHSE)		
	DTaP/IPV/Hib 12 Mnth Uptake	MMR 24mths	MMR 60mths
LLR Uptake	**95%**	**93%**	**90%**
Leicester City CCG uptake	**92%**	**90%**	**81%**
C82053 - Hockley Farm Med Pract (A Nana)	85%	91%	85%
C82624 - The Practice Beaumont Leys (Spirit)	88%	86%	47%
C82610 - The Parks Medical Centre (B Hainsworth)	100%	90%	71%
C82100 - The Hedges Medical Centre (Sa Bailey)	94%	81%	86%
C82046 - Saffron Group Practice	97%	98%	85%
C82626 - Pasley Road Health Centre (Tk Khong)	92%	86%	0%
C82008 - Oakmeadow Surgery (Ra Leach / PR Jones)	100%	100%	96%
C82019 - Sturdee Road Health and Wellbeing Centre (G Singh)	92%	83%	76%
C82094 - Beaumont Lodge Medical Practice	93%	96%	86%
Y02469 - Heron GP Practice	94%	64%	53%
Number of Practices with uptake higher than LLR	3	3	1

Example of Fingertips data available at Practice level

Better 95% Similar Worse 95%

Source: https://fingertips.phe.org.uk/search/immunisations

Indicator	Period	C82053 - Hockley Farm Med Pract (A Nana)			CCGs (from Apr 2021)	England	Leicester City		
		Recent Trend	Count	Value	Value	Value	Worst/ Lowest	Range	Best/ Highest
Influenza immunisation given 1st Aug - 31st Mar to patients with COPD (denominator incl. PCAs) - retired after 2020/21	2020/21	→	302	71.7%	77.7%	81.4%	50.0%		0%
Flu vaccination coverage of patients with diabetes (denominator incl. PCAs) - retired after 2020/21	2020/21	→	539	73.2%	76.1%	76.7%	40.9%		95.1%
Patients with CHD immunised against flu (denominator incl. PCAs) - retired after 2020/21	2020/21	→	222	76.6%	79.8%	82.0%	25.0%		94.9%
Patients with stroke who got influenza immunisation given 1st Aug - 31st Mar (denominator incl. PCAs) - retired after 2020/21	2020/21	→	141	72.3%	76.4%	79.4%	0.0%		100%
MMR vaccination for one dose (2 years) <90% 90% to 95% ≥95%	2020/21	–	105	95.5%	90.0%	90.3%	72.3%		100%
Dtap / IPV / Hib vaccination (2 years) <90% 90% to 95% ≥95%	2020/21	–	101	91.8%	94.2%	93.8%	66.0%		100%
Babies who received at least 3 doses of a DTaP vaccine before the age of 8 months	2021/22	–	83	88.3%	87.9%*	90.6%	58.0%		100%
Children who received at least 1 dose of MMR vaccine between the ages of 1 and 1.5 yrs	2021/22	–	108	80.6%	84.4%*	88.2%	42.9%		100%
Children, aged 5, who received a reinforcing dose of DTaP/IPV and at least 2 doses of an MMR vaccine between the ages of 1 and 5 yrs	2021/22	–	135	87.7%	79.9%*	80.6%	32.0%		100%
Patients, aged 80, who received a shingles vaccine between the ages of 70 and 79 yrs	2021/22	–	12	38.7%	47.3%*	56.6%	0.0%		

P

Name of meeting:	**Leicester, Leicestershire and Rutland ICB Board meeting (public)**		
Date:	13 April 2023	**Paper:**	**P**
Report title:	**ICB Register of Interests 2022/23 and Register of Gifts and Hospitality 2022/23**		
Presented by:	Caroline Gregory, Chief Finance Officer		
Report author:	Daljit K. Bains, Head of Corporate Governance		
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 Board is asked to:

- **APPROVE** the ICB's Register of Interests 2022/23 as at 31 March 2023 (Appendix 1), subject to any further amendments / additions identified during the meeting.

- **APPROVE** the gifts and hospitality register 2022/23 as at March 2023 (Appendix 2).

Purpose and summary of the report:

Purpose:

1. The purpose of this report is to assure the Board that:

    - the ICB is compliant with the legal requirement to have in place statutory registers to record individual interests; and
    - these systems and processes demonstrate transparency and compliance with the ICB's governance arrangements, particularly in the management of conflicts of interest as outlined within the ICB Constitution and conflicts of interest policy.

2. The Board is requested to approve the year-end statutory registers.

Introduction

3. All Board members and employees, in particular employees involved in decision making processes, have a legal obligation to act in the best interests of the ICB. They have a duty to conduct NHS business with probity demonstrating high standards of corporate and personal conduct including impartiality, integrity and objectivity in the execution of their roles and responsibilities. There is a requirement to adhere to the standards of probity outlined in the *'Seven Principles of Public Life'* (i.e. the Nolan Principles).

4. The *Code of Accountability for NHS Boards* and the ICB's *Conflicts of Interest, Gifts and Hospitality and Sponsorship Policy*, which is aligned to NHS England's guidance, set out the requirement that all Board members and staff should declare any conflict of interest that arises in the course of conducting NHS business.

5. A conflict of interest occurs where an individual's ability to exercise judgement or act in one role is, or could be, impaired or otherwise influenced by his or her involvement in another role or relationship. This could be actual or perceived. Interests fall into four categories outlined below. A benefit may arise from the making of a gain or the avoidance of a loss:

a. **Financial interests:** where an individual may get direct financial benefits from the consequences of a commissioning decision.
b. **Non-financial professional interests:** where an individual may obtain a non-financial professional benefit from the consequences of a commissioning decision, such as increasing their professional reputation or status or promoting their professional career.
c. **Non-financial personal interests:** where an individual may benefit personally in ways which are not directly linked to their professional career and do not give rise to a direct financial benefit.
d. **Indirect interests:** where an individual has a close association with an individual who has a financial interest, a non-financial professional interest or a non-financial personal interest in a commissioning decision.

6. All persons referred to within the scope of the ICB's Policy must declare all interests. Declarations of interest should be made as soon as reasonably practicable and by law within 28 days after the interest arises (this could include an interest an individual is pursuing).

7. Some staff, Board and committee members are more likely than others to have a material influence on the use of taxpayers' money because of the requirements of their role.

8. Key decision-making staff may also include management, administrative and clinical staff who have the power to enter into contracts on behalf of the ICB; and / or are involved in decision making concerning the commissioning of services, purchasing of goods, medicines, medical devices or equipment and formulary decisions.

Register requirements

9. As a minimum, the ICB is required to publish the register of interests, and register of gifts and hospitality of decision making staff, Board and committee members at least annually in a prominent place on the ICB website.

10. The Accountable Officer is responsible for an annual review of the Register of Interests. A review of the content of the register has been undertaken ahead of this report being presented to the Board and members are proactively reminded and invited to review their entries and ensure the content is current.

11. The ICB's Board level Register of Interests is appended at **Appendix 1** and published on the ICB website. This register is maintained by the Head of Corporate Governance.

12. The register containing conflicts declared by decision-making staff is also maintained by the Corporate Governance Team and is also published on the ICB website.

Register for Gifts and Hospitality

13. A 'gift' is defined as any item of cash or goods, or any service, which is provided for personal benefit, free of charge or at less than its commercial value.

14. All gifts of any nature offered to ICB staff, Board and committee members by suppliers or contractors linked (currently or prospectively) to the ICB business should be declined, whatever their value. The person to whom the gifts were offered should also declare the offer to the Head of Corporate Governance so the offer, which has been declined, can be recorded on the register.

15. The register is maintained by the Head of Corporate Governance and updated on a regular basis. The current register has been reviewed and is as at **Appendix 2.**

Internal Audit review

16. The Internal Auditors will be conducting an annual audit on the ICB's conflicts of interest

arrangements to provide assurance to the Audit Committee and the Board that effective systems are in place. This audit review is yet to take place.	
Appendices:	• Appendix 1 – LLR ICB Register of Interests as at March 2023. • Appendix 2 – LLR ICB Gifts and Hospitality Register as at March 2023.
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 governance arrangements.

Appendix 1

NHS LEICESTER, LEICESTERSHIRE AND RUTLAND INTEGRATED CARE BOARD

Declarations of Interest - 2022 - 2023 (v6, March 2023)
N.B. including dates "to", "from" or both as per guidance relating to the interest where new or circumstances have changed through the year.

Name	Job Title / Role	Financial Interests	Non-financial professional interests	Non-financial personal interest	Indirect Interests	Actions to be taken to mitigate the risks (see Conflicts of Interest Policy for details)
Mr David Sissling	Chairman	Wife is a manger at University Hospitals of Leicester NHS Trust (current).	Work for NHS England / Improvement (Midlands Region) as a Senior Leadership Advisor 1 day per week in the main providing coaching and mentoring support to NHS leaders (current). Member of the National Senior Salaries Review Body (work circa 25 days a year). Advising Ministers of salaries of senior public sector leaders including NHS (current).	N/A	N/A	Appropriate actions to be taken as necessary during system-wide meetings and during conduct of business, partciualrly in relation to matters concerning UHL. Action will be taken dependent on the nature of the conflict.
Mr Andy Williams	Chief Executive	N/A	Chair and Trustee of Brap - charity working in the rights and equality field. Director of Jupiter Phase 3 Management Company (not remuenrated) - residents property management. .	Warden of Birmingham Cathedral - non remunerated position. Foundation Governor of St Matthews Primary School, Smethick - non remunerated position.	Wife is Acting Director at Dudley and Walsall Mental Health Partnership NHS Trust.	Appropriate action would be taken during procurement processes. Interests are non-financial in the main. However, if a direct potential or actual conflict of interest arises then appropriate action to be taken in line with the Policy.
Dr Caroline Trevithick	Chief Nurse	NICE Expert Advisor Panel.	Royal College of Nursing Nurse & Midwifery Council. Awarded the title and status of Honorary Doctorate of Science from Loughborough University.	N/A	N/A	Appropriate actions to be taken as necessary and dependent on the nature of the conflict.
Ms Nicci Briggs	Chief Finance Officer (until 31 July 2022)	N/A	Chair of HFMA Digital council Member of HFMA Policy & Research Cttee	Finance Committee Independent Member for Brooke Weston Trust - non remunerated position. Volunteer Blind Veterans.	N/A	N/A
Ms Caroline Gregory	Interim Chief Finance Officer (from 1 August 2022)		Member of the Chartered Institute of Public Finance & Accountancy (CIPFA).	Parish Councillor on Hook Norton Parish Council (from May 2020 - May 2024)		Appropriate will be taken if necessary, although limited action required as the Council is outside of the geographical area of LLR.
Mrs Alice McGee	Chief People Officer	N/A	N/A	N/A	N/A	N/A

Name	Job Title / Role	Financial Interests	Non-financial professional interests	Non-financial personal interest	Indirect Interests	Actions to be taken to mitigate the risks (see Conflicts of Interest Policy for details)
Mrs Rachna Vyas	Chief Operating Officer	N/A	Awarded the title and status of Honorary Lecturer at the University of Leicester from 19 July 2021 to 18 July 2024.	Trustee on the Board of a national charity called Growing Points, helping refugees and those from disadvantaged backgrounds into professional careers.	Registered as a patient at Evington Medical Centre a Practice in LLR. No financial interest in Practice.	Note that interest in GP Practice is not a direct financial interest for the individual, and as a member of the Executive Management Team it may not be possible for the individual not to participate in the decision-making process in committee meetings relating to this Practice. However, if a direct potential or actual conflict of interest arises then appropriate action to be taken in line with the Policy.
Ms Sarah Prema	Chief Strategy Officer	Local Public Sector Director at Leicester LIFT Co.	N/A	N/A	Registered as a patient at Birstall Medical Practice which is a Practice in LLR. Son is employed by Boots in Leicester working as a trainee Pharmacist Assistant.	Appropriate actions to be taken as necessary and dependent on the nature of the conflict.
Dr Nilesh Sanganee	Chief Medical Officer	GP Partner - Principal at Castle Medical Group. GP appraiser for NHS England. Trustee of Friends for Castle Medical Group - Registered Charity. Director of Sanganee Medical Ltd. Company which includes my non-practice work e.g. GP appraiser work, Selection Centre Assessment for GP trainees and RCGP work. (With effect from 4 October 2022 Sanganee Medical Ltd was dissolved). Practice is a member of the LLR Provider Company Castle Medical Group is a member of the North West Leicestershire GP Ltd. Examiner for the MRCGP with the RCGP. Director of Sangco Ltd, a residential property letting company (from 25 June 2022). Practice has a contractual relationship with Derbyshire Health CIC, note also that DHU CIC and the LLR Provider Company have an affiliation.	Professional Membership Details - British Medical Association (BMA). Professional Membership Details - Royal College of General Practitioners. Professional Membership - General Medical Council. Professional Membership Details - Medical Defence Union. Senior Fellow of the Faculty of Medical Leadership and Management.	N/A	Indirect interest in respect of discussions and decisions made relating to GP Practice property relating to Practice premises, which is under a lease from a third party.	In relation to financial interests, to ensure individual does not participate in the decision-making process in committee meetings (e.g to absent themselves from meetings at the relevant point on the agenda); during procurement processes individual to seek advice if and up to which part of the process individual can be involved in, or not involved with at all etc. For other declarations, appropriate actions to be taken as necessary in line with the Policy, dependent on the nature of the interest declared and whether a conflict arises.

Name	Job Title	Financial Interests	Non-financial professional interests	Non-financial personal interest	Indirect Interests	Actions to be taken to mitigate the risks (see Conflicts of Interest Policy for details)
Darren Hickman	Non-Executive Member - Audit	Non-Executive Director - Leicestershire Partnership NHS Trust (January 2014 - June 2022) Non-Executive Director & Risk Chair, Earl Shilton Building Society (Nov 20 to present) Non-Executive Director of Northampton Children's Trust (Sept 2020 to present) Director of D&JH Services Ltd a consulatncy and property managemnet company (Jul 2021 to Present)	N/A	N/A	N/A	Note that individual held a position previousy as a NED within the provider Trust however has stood down from that position prior to commencing the role in the ICB. Therefore no longer conflicted.
Simone Jordan	Non-Executive Member - People and Remuneration	Managing Director - Simone Jordan & Associates Ltd (from 2015 to date) Vice Chair - Royal Orthopaedic Hospital NHS Foundation Trust: Associate NED from 2017-2020, and Vice-Chair from 2021 to present. Non-Executive Director - George Eliot Hospital NHS Trust (from 2018 to present)	Visiting Fellow - Nottingham Business School (from 2015 to December 2022) Member of Chartered Institute of Personnel and Development	N/A	N/A	In relation to financial interests, to ensure individual does not participate in the decision-making process (e.g to absent themselves from meetings at the relevant point on the agenda); during procurement processes individual to seek advice if and up to which part of the process individuals can be involved in, or not involved with at all etc. For other declarations, appropriate actions to be taken as necessary in line with the Policy, dependent on the nature of the interest declared and whether a conflict arises.
Pauline Tagg	Non-Executive Member - Quality, Performance and Transformation	Co-owner of Approved Fire Protection Ltd. Chair of East Midlands Ambulance Service NHS Trust (ended 31 July 2022). Chair of VISTA (sight loss charity and care home provider).	N/A	N/A	N/A	In relation to financial interests, to ensure individual does not participate in the decision-making process (e.g to absent themselves from meetings at the relevant point on the agenda); during procurement processes individual to seek advice if and up to which part of the process individuals can be involved in, or not involved with at all etc. For other declarations, appropriate actions to be taken as necessary in line with the Policy, dependent on the nature of the interest declared and whether a conflict arises.

Name	Job Title	Financial Interests	Non-financial professional interests	Non-financial personal interest	Indirect Interests	Actions to be taken to mitigate the risks (see Conflicts of Interest Policy for details)
Prof Azhar Farooqi	Non-Executive Member - Health Inequalities, Public Engagement, Third Sector and Carers	GP Partner at East Leicester Medical Practice and part owner. Director of A Farooqi Limited which provides clinical research and quality service. Part owner and share-holdings exceeding 25%. GP Practice (East Leicester Medical Practice) is a member of the LLR GP Provider Company with less than 1% ownership. Honorary Professor, Department of Health Sciences at University of Leicester and Clinical Director Centre of Ethnic Health Research University of Leicester. East Leicester Medical Practice in receipt of NHS England research funding via National Institute of Healthcare Research. East Leicester Medical Practice acts as the lead practice for Across Leicester Academy (a consortium of 7 city practices) providing undergraduate medical teaching to a number of medical schools. Practice was a member of the Aegis Primary Care Network (1 July 2019 - August 2021). From 1 September 2021 Practice is a member of Salutem Primary Care Network. National and international presentations and lectures as part of research or academic and postgraduate education roles including non-promotional educational activity sponsored by charities and pharmaceutical companies. East Midlands Clinical Research Network - Clinical Director appointef from 1 June 2021, Division 5, East Midlands Clinical Research Network hosted by University Hospitals of Leicester NHS Trust on behalf of the National Institute of Health Research (position is remunerated). Co-director of Regional Diabetes and Vascular Clinical Network, NHS England Midlands. Son, Dr Imran Farooqi, is a partner at the East Leicester Medical Practice.	Fellow of the Royal College of General Practitioners. Member of the British Medical Association. Member of the Leicester Medical Society.	N/A	Indirect interest in respect of discussions and decisions made relating to GP Practice property, however does not own the Practice premises as these are leased from NHS Property Services.	In relation to financial interests, to ensure individual does not participate in the decision-making process (e.g to absent themselves from meetings at the relevant point on the agenda); if involved in procurement processes then individual to seek advice to clarify if they can / cannot be involved and at what stage. For other declarations, appropriate actions to be taken as necessary in line with the Policy, dependent on the nature of the interest declared and whether a conflict arises.
Mark Andrews	Partner Member - Local Authority Sectoral representative	Chief Executive of Rutland County Council.	N/A	N/A	Spouse is a Director for Worldwide Clinical Trials, a Contract Research Organisation (from July 2022).	In relation to financial interests, to ensure individual does not participate in the decision-making process in committee meetings (e.g to absent themselves from meetings at the relevant point on the agenda); during procurement processes individual to seek advice if and up to which part of the process individual can be involved in, or not involved with at all etc.

Name	Job Title	Financial Interests	Non-financial professional interests	Non-financial personal interest	Indirect Interests	Actions to be taken to mitigate the risks (see Conflicts of Interest Policy for details)
Martin Samuels	Partner Member - Local Authority Sectoral representative	Strategic Director, Social Care & Education, Leicester City Council	N/A	N/A	N/A	In relation to financial interests, to ensure individual does not participate in the decision-making process in committee meetings (e.g to absent themselves from meetings at the relevant point on the agenda); during procurement processes individual to seek advice if and up to which part of the process individual can be involved in, or not involved with at all etc.
Mike Sandys	Partner Member - Local Authority Sectoral representative	Director of Public Health for Leicestershire County Council and Rutland County Council.	N/A	N/A	N/A	In relation to financial interests, to ensure individual does not participate in the decision-making process in committee meetings (e.g to absent themselves from meetings at the relevant point on the agenda); during procurement processes individual to seek advice if and up to which part of the process individual can be involved in, or not involved with at all etc.
Richard Mitchell	Partner Member - Acute Sector representative	Chief Executive, University Hospitals of Leicester NHS Trust. Occasional consultancy work (less than £500 per year).	Chair East Midlands Cancer Alliance (work with NHS England / Improvement). Chair Midlands Leadership Board (work with NHS England / Improvement). Chair Midlands East pathology Network.	N/A	N/A	In relation to financial interests, to ensure individual does not participate in the decision-making process in committee meetings (e.g to absent themselves from meetings at the relevant point on the agenda); during procurement processes individual to seek advice if and up to which part of the process individual can be involved in, or not involved with at all etc.
Angela Hillery	Partner Member - Acute Sector representative (community and mental health)	Chief Executive, Leicestershire Partnership NHS Trust	N/A	N/A	N/A	In relation to financial interests, to ensure individual does not participate in the decision-making process in committee meetings (e.g to absent themselves from meetings at the relevant point on the agenda); during procurement processes individual to seek advice if and up to which part of the process individual can be involved in, or not involved with at all etc.

Name	Job Title	Financial Interests	Non-financial professional interests	Non-financial personal interest	Indirect Interests	Actions to be taken to mitigate the risks (see Conflicts of Interest Policy for details)
Dr Nainesh Chotai	Partner Member - primary care sector representative	GP Partner at Glenfield Surgery and Groby Surgery. Director of G&G Surgery Ltd, company providing general medical practice activities (since May 2017). Clinical Director of G3 Primary Care Network. Director and shareholder in Glenfield Pharmacy Ltd. GP Practice is a member of the LLR GP Provider Company. Director of Southmeads Properties Ltd. Director of Southmeads Professional Services & Investments Ltd. (since March 2013). Providing management consultancy activities other than financial management. Director of Leicester, Leiecstershire and Rutland Local Medical Committee Ltd (resigned on 25 August 2022).	N/A	N/A	Wife is a franchise holder in Wigston, Oadby and Blaby Specsavers Opticians.	In relation to financial interests, to ensure individual does not participate in the decision-making process in committee meetings (e.g to absent themselves from meetings at the relevant point on the agenda); during procurement processes individual to seek advice if and up to which part of the process individual can be involved in, or not involved with at all etc.
Prof Mayur Lakhani	Clinical Executive Lead	Chair – FMLM Faculty of Medical Leadership & Management Company Director – The office of Dr Mayur Lakhani CBE Limited Undergraduate teaching - University of Leicester & Nottingham. GP Principal Highgate Medical Centre GMS contract Independent contractor at Highgate Medical Centre (GP), GMS practice Highgate Medical Centre is part of Charnwood Federation and Soar Valley PCN (July 2019). Highgate Medical Centre is a member of LLR Provider Company Visiting Professor, Division of Health Sciences, University of Leicester (Honorary) Spouse is a Practice Manager and non-clinical partner at Highgate Medical Centre and director of Charnwood GP Network Ltd. Honoraria to be received from LuminaDx and Pulse Magazine (CRP/D-Dimer Testing, point of care (undertaken as a GP and not in ICB capacity). Chair, Session on Lipid Management and secondary prevention, Sanofi (undertaken as a GP and not in ICB capacity). Panel Member of a (national) GP Consultancy (GPCA) – ad hoc work. Undertaken as a GP not in ICB capacity. Clinical Advisor, Arden and GEM CSU. (undertaken as a GP and not in ICB capacity).	Professional Membership Details Royal College of General Practitioners Professional Membership Details British Medical Association Professional Membership General Medical Council Professional Membership Details Medical Defence Union Professional Membership Details Royal College of Physicians Edinburgh Professional Membership Details Royal College of Physicians London Professional Membership Details Fellow of Royal College of GPs Professional Membership Details Member of the Faculty of Medical Management & Leadership. Professional Membership Details Medical Examiner trained and Medical Examiner member of Royal College of Pathologists Clinical Lead, UHL, non-site specific cancer pathway, and Cancer Board.	N/A	N/A	In relation to financial interests, to ensure individual does not participate in the decision-making process in committee meetings (e.g to absent themselves from meetings at the relevant point on the agenda); during procurement processes individual to seek advice if and up to which part of the process individual can be involved in, or not involved with at all etc.

Appendix 2

LEICESTER, LEICESTERSHIRE AND RUTLAND INTEGRATED CARE BOARD

Register of Gifts & Hospitality 2022-23 (v2 reviewed January 2023)

Ref	Name of receipient and job title	Date of offer / receipt of gift / hospitality	Description of gift / hospitality	Estimated Value £	Supplier / Offeror Name and Nature of Business	Details of Previous Offers or Acceptance by this Offeror/ Supplier	Details of the officer reviewing and approving the declaration made and date	Declined or accepted and date	Reason for declining or accepting	Other Comments
1	Hitesh Parmar, Medicines Optimisation Pharmacist	1 November 2022	Offered Amazon vouchers.	£50	Optimise Rx (FDB) (provider commissioned to provide electronic prescribing support tool for prescribers in LLR)	None	Gill Stead Head of Medicines Optimisation November 2022	Declined November 2022	N/A	
2	Rachna Vyas, Chief Operating Officer	16 December 2022	Gift hamper	£40	Phoenix Health Partnership	None	Andy Williams, Chief Executive January 2023	Accepted (arrived by post) December 2022	Accepted as item arrived in post and declared in line with policy.	

Name of meeting:	**Leicester, Leicestershire and Rutland ICB Board meeting**		
Date:	13 April 2023	**Paper:**	**Q**
Report title:	**ICB Board forward planner**		
Presented by:	Caroline Gregory, Chief Finance Officer		
Report author:	Daljit K. Bains, Head of Corporate Governance		
Executive Sponsor:	Caroline Gregory, Chief Finance Officer		

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

Recommendations:

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

- **APPROVE** the updated ICB Board forward planner for 2023/24.

Purpose and summary of the report:

1. The ICB Board forward planner is updated at regular intervals, in conjunction with the Executive Management Team and Board members, to ensure that it remains current. The forward planner captures key strategic aspects of business reserved for the Board, including assurance reports on functions delegated to officers and / or committees of the Board.

2. The Board is asked to approve the updated version as at Appendix 1 for 2023/24, noting that the section on proposed topics for future Board development sessions is to be reviewed further.

Appendices:	• Appendix 1 – ICB Board forward planner 2023/24
Report history (date and committee / group the content has been discussed / reviewed prior to presenting to this meeting):	• October 2022 – ICB Board approved the forward planner.

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.	☒

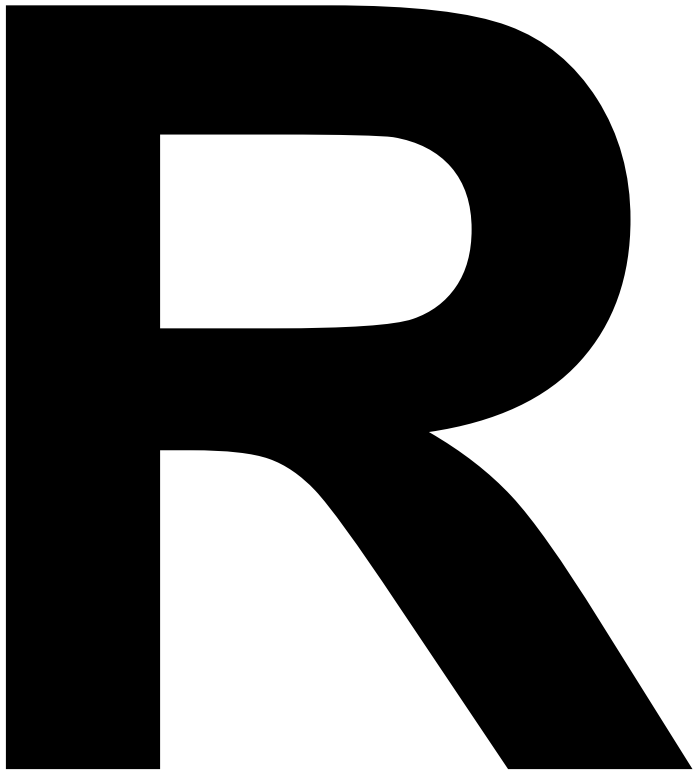
6. Value for money	Develop and deliver services with providers that are evidenced based and offer value for money.	☒
7. Integration	Deliver integrated health and social care.	☒

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 (v8 April 2023)	Lead Officer(s) / Sponsor(s)	2023/24 (meetings to be held bi-monthly and development sessions in intervening months)											
AGENDA ITEMS		**April**	**May (dev.)**	**Jun**	**July (dev.)**	**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	✓		✓		✓		✓		✓		✓	
Sharing case studies and patient stories	EMT	✓		✓		✓		✓		✓		✓	
STRATEGY AND SYSTEM PLANNING													
5-year Forward Plan - to review / approve	Sarah Prema	✓	✓	✓	✓						✓	✓	✓
Joint commissioning arrangements including delegation of NHS England commissioning functions (updates and / or for approval) - *post April 2023 this may include review of minutes from joint commissioning meetings as and when available and / or approval of arrangements (as required)*	Sarah Prema	✓											
Sustainable Development Strategy / The Green Plan - to review and approve (to go through System Executive in the first instance)	Mike Simpson												
People and Communities Strategy - to review progress tbc	Alice McGee												
Quality Strategy - to receive report on impact of strategy	Caroline Trevithick					✓							
Professional Leadership Strategy - to receive report on impact of strategy	Dr Nil Sanganee					✓							
Digital Strategy - to receive report on impact of strategy tbc	Alice McGee												
System level business cases (above resepctive committee delegation) - as required	EMT												
Thematic reviews e.g. estates, system flow etc	EMT												
Equality and Inclusion Strategy and Policy and Equalities Objectives - to approve	Alice McGee	✓											
Research and development - updates via the System Executive Committee - as required	System Executive												
OPERATIONAL													
ICB and System operational performance (including elective and urgent and emergency care)	Rachna Vyas	✓		✓		✓		✓		✓		✓	
The 2023/24 Operational Plan - to review and approve	Sarah Prema	✓											
The 2024/25 Operational Plan - to review	Sarah Prema							✓		✓		✓	
Winter Plan 2023/24 - for approval	Rachna Vyas					✓							
Update on system leadership, People Plan and recruitment	Alice McGee							✓					
Ockenden Review into maternity services - briefing / assurance of implementation of recommendations	Caroline Trevithick			✓						✓			
Primary Care Strategy - to review and approve	Dr Nil Sanganee	✓											
Update on people plan and workforce	Alice McGee							✓					
ASSURANCE													
Assurance Report from the Audit Committee	Caroline Gregory	✓		✓		✓		✓		✓		✓	
Assurance Report from the Remuneration Committee *(as required, to be presented in confidential meetings)*	Alice McGee	✓								✓			
Performance assurance report *(this report will be combined with the operational performance report above from June onwards)*	Andy Williams (Caroline Trevithick)	✓											
Assurance Report from the System Executive	Andy Williams	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Regular monthly 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	✓		✓		✓		✓		✓		✓	
Briefings following meetings of the Health Inequalities Advisory Group (as required)	Alice McGee												
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 and approve	Caroline Gregory			✓									
Standing Financial Instructions - to review and approve	Caroline Gregory			✓									
ICB Governance Handbook - to review and approve	Caroline Gregory			✓									
Standards of Business Conduct Policy / Conflicts of Interest - to review and approve	Caroline Gregory			✓									
Functions and decision map - to review and 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			✓									
ICB Board Assurance Framework 2022/23 - end of year version to be approved and closed.	Caroline Gregory	✓											
ICB Board Assurance Framework 2023/24 - opening version to be approved	Caroline Gregory	✓											
ICB Board Assurance Framework 2023/24 - end of year version to be approved and closed.	Caroline Gregory												
Register of Interests and Register of Gifts and Hospitality - end of year approval	Caroline Gregory	✓											
Corporate Policies for approval (as and when required)	EMT												
ICB forward planner - for review and approval	David Sissling	✓											
Undertake effectiveness review of the governance arrangements	Caroline Gregory and Board and Committee chairs			✓									
Proposed development session topics for 2023/24 (once agreed timescales will be confirmed):													
Constitution, governance and risk management	Caroline Gregory												
Board/Team Development (Values, behaviours, criteria for success, Cohesion)	Alice McGee												
Financial challenges													
Collaboratives	Sarah Prema												
Place and Integration	Rachna Vyas												
Addressing Health Equity	Sarah Prema												
Transformation and service development	Rachna Vyas		✓				✓						
Building Better Hospitals (transformation programme) (tbc)	Richard Mitchell (UHL)												
People and Communities	Alice McGee												
People Plan and running costs	Alice McGee												
Quality improvement	Caroline Trevithick												



Name of meeting:	**Leicester, Leicestershire and Rutland Integrated Care Board**		
Date:	**13 April 2023**	**Paper:**	**R**
Report title:	**Briefing note: Delivery of a safe winter through 22/23**		
Presented by:	Rachna Vyas, Chief Operating Officer, NHS LLR ICB		
Report author:	Rachna Vyas, Chief Operating Officer, NHS LLR ICB		
Executive Sponsor:	Rachna Vyas, Chief Operating Officer, NHS LLR ICB		

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

Recommendations:

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

- **RECEIVE for assurance** the briefing against delivery of the LLR winter plan.
- **NOTE** the impact of the delivery of the LLR winter plan, on both the ambulance handover and the 104-week trajectories.

Purpose and summary of the report:

This paper provides assurance against delivery of the ICB priority of a safe winter, covering improvements noted against key performance targets across the urgent and emergency care system and the elective recovery programme of work, and summarises key deliverables through 23/24

Appendices:	n/a
Report history (date and committee / group the content has been discussed / reviewed prior to presenting to this meeting):	Various iterations of this paper have been shared at organisational or system level 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.*	BAF 01 - Quality of care provided by acute providers. BAF 02 - Quality of care provided by non-acute providers. BAF 03 – Quality of care and service provided by emergency patient transport services. BAF 04 - Quality of care provided by non-emergency patient transport services BAF 07 - EPRR arrangements.
b) Does the report highlight any resource and financial implications? If so, provide which page / paragraph this can be found within the report.	No new funding requests Services referenced are funded via the Capacity Resilience Funding or Elective Recovery Funding
c) Does the report highlight quality and patient safety implications? If so, provide which page / paragraph this is outlined in within the report.	The plans put in place through the winter plan has supported mitigation of patient safety and quality issues caused by both operational pressures and industrial action where possible
d) Does the report demonstrate patient and public involvement? If so, provide which page / paragraph this is outlined in within the report.	None
e) Has due regard been given to the Public Sector Equality Duty? If so, how and what the outcome was, provide which page / paragraph this is outlined in within the report.	Any new services / service changes will be made with due regard to the Inclusive Decision-Making Framework and the PSED

Briefing note: Delivery of a safe winter through 22/23

April 2023

Introduction

1. This paper provides assurance against delivery of the immediate ICB priority of a safe winter, covering impact against key performance targets across the urgent and emergency care system and the elective recovery programme of work.
2. It also briefly sets out the key transformational priorities across the UEC pathway from April 2023 to September 2023, in readiness for winter 23/24.

Context

3. This section provides an overview of the LLR health and care system over Q4 22/23 including the system response to extra-ordinary events such as industrial action by the ambulance service and our doctors in training.

4. Whilst patient safety has been maintained as best possible, it is recognised that the patient experience of care has been, at times, sub-optimal across services. Staff have equally reported high levels of moral injury, particularly those in frontline acute services within primary care, EMAS and the Emergency Department.

Delivery of the winter plan

5. Performance against the LLR Winter Plan has been positive, with the majority of schemes delivering at 75-100% of expected impact. One notable exception has been that of virtual wards; this has been slower to evidence impact in some pathways, despite all partners committed to delivery of the programme. A recovery plan has been agreed and is in the process of being enacted across LLR, with full clinical ownership. Due to this, zero impact has been factored in across Q4.

6. Evidence of the impact of the winter plan thus far is most notably evident against the six winter metrics set out by NHS England for winter 22/23:

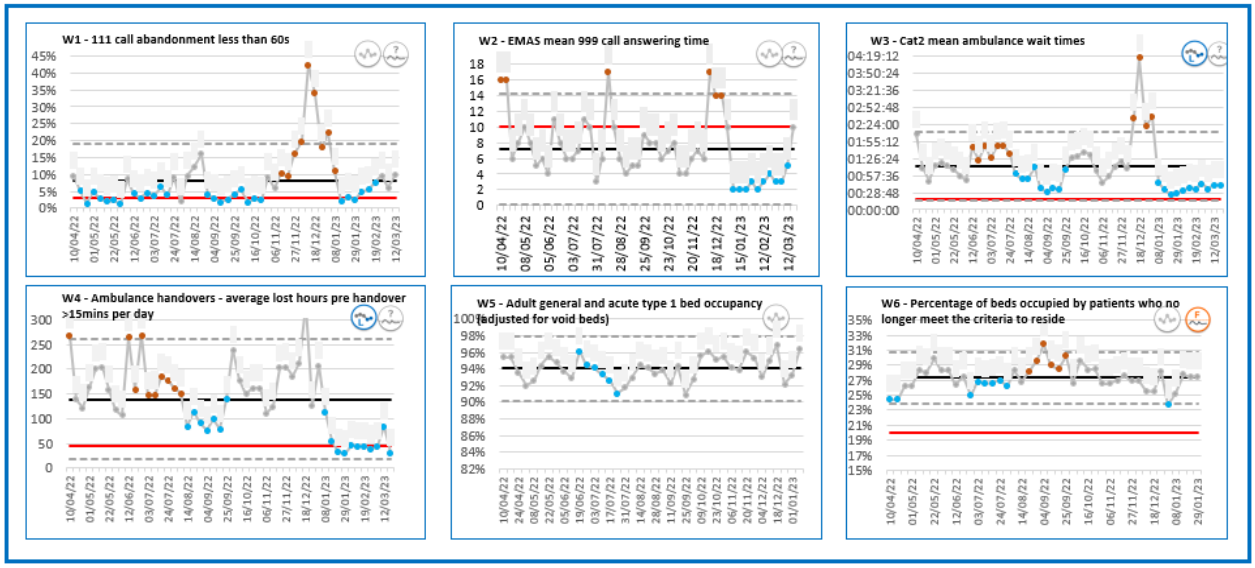


Figure 1: Performance of the six winter metrics

7. Notable improvement can be seen in the ambulance metrics – EMAS mean call answering times, category 2 mean ambulance wait times and the average time lost to ambulance handovers all show a significant and sustained improvement.

8. For the month of March 2023, the average clinical handover time (1st to 29th March) stood at 34 mins and 45 seconds. As a comparison, the average clinical handover time in Q3 22/23 stood 1hr 18mins and 52 seconds.

9. A quality improvement methodology has been employed through this winter and supporting winter plan schemes have evidenced successful impact, both in terms of input and outcomes:

    a. Primary care provided Acute Respiratory Infection hubs have provided nearly 9,000 additional appointments since launch, supporting our respiratory patients to be seen in a local setting. Of the 8,977 appointments to date, 107 patients had subsequently been referred to ED.
    b. The streaming service from the Emergency Department to local urgent treatment centres has been particularly successful, diverting upwards of 50 patients per day into more appropriate services with closed episodes of care. This has in turn reduced overcrowding within the Emergency Department, without causing pressure on partner services such as general practice. ED activity has largely remained within the UHL plan.
    c. The cohorting areas for handover have been successfully integrated as part of the emergency pathway at UHL, releasing ambulances in a timely manner to respond to emergencies in the community. As a result, mean cat 2 response times have been met since early January 2023 and continue to be met.
    d. Admission avoidance services continue to support our ethos of 'right place, right, time, right care', with the unscheduled care hub continuing to support ambulance inflow, step up models of care supporting ED attends and ED services successfully using SDEC and / or alternatives to admission. Emergency admissions into bedded services remain well below 19/20 levels and within UHL plan.
    e. Time to discharge continues to fall with complex discharge now taking place faster and more importantly, with patients being discharged onto the correct pathway for their needs, supporting longer term reablement outcomes. The traditional annual Dec-Jan peak in medically optimised for discharge patients has not been seen through quarter 4 2022/23, with the numbers of medically fit patients remaining within normal variation, despite 192 additional units of capacity being opened. The longest wait for a complex discharge in May 2022 (at its peak) was 138 days; in February 2023, this was 22 days.

10. Improvement has also been noted across the elective care pathway. Whilst the challenge remains significant there is continued good progress on the reduction of those patients waiting longest for definitive treatment.

11. Despite emergency pressures and the impact of industrial action etc, the year-end position for patients waiting over 104 weeks was 2 patients; both of these are booked through April 2023. The 78-week position remains on-track, and is expected to clear in June 2023, pending impact of any further industrial action.

12. There remains in place patient level senior oversight of the total cohort to ensure no avoidable breaches occur. In addition, weekly calls are in place with the UHL CEO/COO/Dep COO and System Director to ensure oversight of delivery.

Sharing clinical risk across the system

13. The LLR Clinical Executive has supported the delivery of the winter plan through winter 2022/23, identifying early on that risk was not always spread across the system. Our ambition is to move away from the current state, where a single organisation assess a risk, to a future state whereby we collectively understand where risk sits within the system collectively.

14. Progress has been made in reviewing the system triggers and escalations as part of our OPEL reporting, with further work required to truly share risk. This work is being led through the LLR Quality and Safety Committee.

15. This collective approach to understanding and adjusting our system risk appetite will be adopted by winter 23/24 and will support delivery of a safer winter whilst supporting our frontline teams to have a better experience of delivering care within LLR.

Preparing for winter 23/24 - the plan for the next 26 weeks

16. Given the learning from winter 22/23, feedback from our clinical and practitioner colleagues and using the patient experience feedback we have gathered, the system has in place a small set of priorities to deliver at scale between April 2023 and September 2023, in readiness for winter 23/24.

17. These schemes will deliver the relevant requirements set out in the operational plan:

- Increase physical capacity and permanently sustain the equivalent of 7,000 beds of capacity that was funded through winter 2022/23.
- Reduce the number of medically-fit-to-discharge patients, addressing NHS causes as well as working in partnership with local authorities.
- Increase ambulance capacity
- Reduce handover delays to support the management of clinical risk across the system.
- Maintain clinically led system control centres to effectively manage risk.
- Increase referrals into urgent community response, with a focus on maximising referrals from 111 and 999; and creating a single point of access where not already in place.
- Expand direct access and self-referral where GP involvement is not clinically necessary.
- By September 2023, put in place:
    - direct referral pathways from community optometrists to ophthalmology services for all urgent and elective eye consultations
    - self-referral routes to falls response, musculo-skeletal physiotherapy, audiology-including hearing aid provision, weight management, community podiatry, and wheelchair and community equipment services.
- Ensure people can more easily contact their GP practice.
- Transfer lower acuity care away from both general practice and NHS 111 by increasing pharmacy participation in the Community Pharmacist Consultation Service.

18. Design and delivery of services for each of these has been clinically led and aligns to organisational strategies across all partners in the ICS, including our social care colleagues.

Conclusions

19. Despite the challenges faced across the system, the LLR system has continued to improve and deliver against two key ICB performance trajectories – the ambulance handover and the 104-week trajectories. Work continues to embed transformative changes over the coming 26 weeks in readiness for winter 2023/24.

Recommendations:

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

- **RECEIVE for assurance** the briefing against delivery of the LLR winter plan.
- **NOTE** the impact of the delivery of the LLR winter plan, on both the ambulance handover and the 104-week trajectories.

S

Name of meeting:	**Leicester, Leicestershire and Rutland Integrated Care Board**		
Date:	**13 April 2023**	**Paper:**	**S**
Report title:	Delegation of Primary Pharmacy, Optometry & Primary and Secondary Dental Services (PODs) from NHSE to NHS Leicester, Leicestershire and Rutland Integrated Care Board		
Presented by:	Sarah Prema, Chief Strategy Officer		
Report author:	Jo Grizzell, Senior Planning Manager		
Executive Sponsor:	Sarah Prema, Chief Strategy Officer		

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

Recommendations:

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

- **RECEIVE and NOTE** the update on the delegation of PODs services with effect from the 1st April 2023.

Purpose and summary of the report:

The purpose of this report is to provide the LLR Integrated Care Board with the current position in relation to the delegation of PODs services from NHS England with effect from 1st April 2023.

Appendices:	None
Report history (date and committee / group the content has been discussed / reviewed prior to presenting to this meeting):	Not applicable

The report is helping to deliver the following strategic objective(s) – *please tick all that apply*:		
1. Health outcomes	Increase the health outcomes of the Leicester, Leicestershire and Rutland population.	☒
2. Health inequalities	Reduce health inequalities across the Leicester, Leicestershire and Rutland population.	☒
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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.*	Risks have been identified associated with the programme and have previously been shared with members. These have not been escalated to the Board Assurance Framework at this stage.
b) Does the report highlight any resource and financial implications? If so, provide which page / paragraph this can be found within the report.	None identified at this stage.
c) Does the report highlight quality and patient safety implications? If so, provide which page / paragraph this is outlined in within the report.	Not in the context of this paper.
d) Does the report demonstrate patient and public involvement? If so, provide which page / paragraph this is outlined in within the report.	NHS England has confirmed that they will be undertaking communications with patients and the public to ensure that they are aware of the changes. .
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.	NHS England has undertaken an equality impact assessment to ensure that there will not be a negative impact following the delegation of services.

Delegation of Primary Pharmacy, Optometry & Primary and Secondary Dental Services (PODs)
from NHSE to NHS Leicester, Leicestershire and Rutland Integrated Care Board

13 April 2023

Introduction

1. With effect from 1st April 2023 the Leicester, Leicestershire and Rutland Integrated Care Board was delegated the following services from NHS England:
    I. Primary Medical Care Services
    II. Primary Dental Services and Prescribed Dental Services
    III. Primary Ophthalmic Services
    IV. Pharmaceutical Services and Local Pharmaceutical Services

2. At its meeting in February 2023, the LLR ICB provided delegated authority to approve the following:
    I. Delegation agreement in respect of the above services.
    II. Agreement in relation to the establishment and operation of joint working arrangements.

3. On 31st March 2023, the above were signed, approved and submitted to NHS England.

4. Should members wish to have sight of these documents please contact jo.grizzell@nhs.net.

Recommendations:

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

- **RECEIVE and NOTE** the update on the delegation of PODs services with effect from the 1st April 2023.