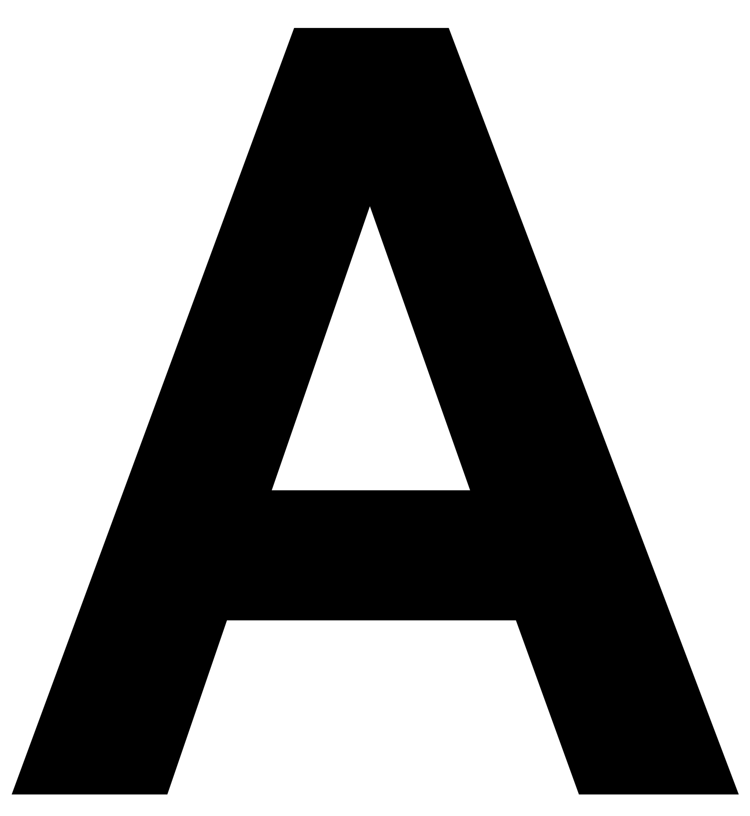
Meeting Title	**Leicester, Leicestershire and Rutland (LLR) Integrated Care Board meeting** (meeting held in public)	Date	**Thursday, 13 July 2023**
Meeting no.	**9**	Time	**Meeting in public: 9:15am – 10:10am** **Confidential meeting: 10:10am**
Chair	**David Sissling** **Independent Chair, ICB**	Venue / Location	Loros Professional Development Centre, Groby Road, Leicester, LE3 9QE

REF	AGENDA ITEM	ACTION	PRESENTER	PAPER	TIMING
ICB/23/74	Welcome and Introductions to the extraordinary meeting held in public	To receive	David Sissling	**Verbal**	9:15am
ICB/23/75	Apologies for Absence: • Dr Nil Sanganee • Dr Caroline Trevithick *(Ms Chris West deputising)*	To receive	David Sissling	**Verbal**	9:15am
ICB/23/76	Notification of Any Other Business	To receive	David Sissling	**Verbal**	9:15am
ICB/23/77	Declarations of interest relating to agenda items *Members are reminded of their obligation to declare any interest they may have on any issues arising at the meeting which might conflict with the business of the NHS LLR ICB*	To receive	David Sissling	**Verbal**	9:15am
ICB/23/78	To consider **written questions received in advance** from the Public in relation to items on the agenda	To receive	David Sissling	**Verbal**	9:20am
ICB/23/79	Minutes of the meeting held on 8 June 2023	To approve	David Sissling	**A**	9:25am
ICB/23/80	Matters arising and actions for the meeting held on 8 June 2023	To receive	David Sissling	**B**	
ICB/23/81	Update from the Chair	To receive	David Sissling	**verbal**	9:30am
STRATEGY AND SYSTEM PLANNING					
ICB/23/82	LLR Five Year Plan	To approve	Sarah Prema	**C**	9:35am
ICB/23/83	LLR ICB Board Assurance Framework 2023/24	To approve	Caroline Gregory	**D**	9:55am
ANY OTHER BUSINESS					
ICB/23/84	Items of any other business and review of meeting	To receive	David Sissling	**Verbal**	10:10am

The next meeting of the LLR Integrated Care Board meeting will take place on **Thursday 10 August 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 8 June 2023
9:00am – 10:45am, 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
Ms Alice McGee	Chief People Officer, NHS LLR ICB
Ms Rachna Vyas	Chief Operating Officer, NHS LLR ICB
Professor Azhar Farooqi	Non-Executive Member – Inequalities, Public Engagement, Third Sector and Carers, NHS LLR ICB
Mr Darren Hickman	Non-Executive Member – Audit and Conflicts of Interest, NHS LLR ICB
Ms Simone Jordan	Non-Executive Member – Remuneration and People, NHS LLR ICB
Ms Pauline Tagg	Non-Executive Member – Safety, Performance and Transformation, NHS LLR ICB
Mr Richard Mitchell	Partner Member - acute sector representative (Chief Executive, 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)
Mr Mark Andrews	Partner Member – local authority sectoral representative (Chief Executive, Rutland County Council)
Dr Nainesh Chotai	Primary Care Sector representative
Sir Mayur Lakhani	Clinical Executive Lead, NHS LLR ICB

Participants:

Ms Harsha Kotecha	Chair, Healthwatch Leicester and Leicestershire
Ms Cathy Ellis	Chair of Leicestershire Partnership NHS Trust
Cllr Louise Richardson	Chair of Leicestershire Health and Wellbeing Board
Cllr Sarah Russell	Chair of Leicester City Council Health and Wellbeing Board

In attendance:

Mr David Williams	Group Director of Strategy & Partnerships Leicestershire Partnership NHS Trust & Northamptonshire Healthcare NHS Foundation Trust
Mrs Daljit Bains	Head of Corporate Governance, NHS LLR ICB
Ms Charlotte Gormley	Corporate Governance Officer, NHS LLR ICB (note taker)
Ms Sarah McKenzie	Board Secretary, Northamptonshire ICB (observing)

Six members of the public joined to observe the meeting.

ITEM		LEAD RESPONSIBLE
ICB/23/53	**Welcome and Introductions** Mr David Sissling welcomed colleagues and members of the public to the meeting. The meeting was held in public and was confirmed as quorate.	
ICB/23/54	**Apologies for absence from Members and Participants:** • Martin Samuels, Partner Member - local authority sectoral representative (Strategic Director, Partner Social Care and Education, Leicester City Council) • Dr Janet Underwood, Chair, Healthwatch Rutland	

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<tr><th>ITEM</th><th></th><th>LEAD RESPONSIBLE</th></tr>
<tr><td></td><td>• Councillor Diane Ellison, Chair, Leicester City Council Health and Wellbeing Board</td><td></td></tr>
<tr><td>ICB/23/55</td><td>Notification of Any Other Business
No additional items of business had been notified.</td><td></td></tr>
<tr><td>ICB/23/56</td><td>Declarations of Interest on Agenda Items
No specific declarations were noted on agenda items. The register of interests is published on the ICB website and is reviewed on a regular basis.</td><td></td></tr>
<tr><td>ICB/23/57</td><td>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 advised that members of the public were welcome to contact the ICB outside of the formal cycle of Board meetings.

The questions received, and the responses provided were as follows:

<u>Question received from Councillor Ramsay Ross</u>
1. Can the ICB confirm that the Draft LLR Five Year Joint Forward Plan 2023/24 to 2027/28 has been completed in compliance with the requirements of the undernoted:

i) NHS Plan of 2019; and
ii) B1940, Guidance on developing the joint forward plan, 23rd December 2023

Mr Andy Williams confirmed that the Draft LLR Five Year Joint Forward Plan does take account of the NHS Plan and the guidance issued on developing a joint forward plan.

<u>Questions from Sally Ruane</u>
1. What number of responses have so far been received from the public to the five-year plan consultation and what steps were taken to advertise this consultation?
2. Will the revised scheme for the UHL reconfiguration go back to public consultation?

In response to the first question, Mr Williams advised that 61 surveys had been completed to date, with an additional 119 surveys partially completed. In terms of promoting the consultation of the Five-Year Plan, Mr Williams confirmed:
• The consultation had been advertised on the LLR ICB website.
• It was emailed twice to 1,186 Citizens Panel members and included in their newsletter; emailed twice to the PPIAG, PPG Network, over 550 voluntary groups and included in VCSEA newsletter.
• The details were emailed twice to local councillors, MPs and key partners such as Healthwatch, District Council Chief Executive Officers, MPs, and Local Authorities.
• EMAS, Derbyshire Health United, Local Medical Committee, Local Dental Committee, Local Optical Committee, Police, Fire Service and the three Universities were sent details.
• The consultation was featured in the Five on Friday e-newsletter in the previous week and promoted on the LLR ICB Facebook, Twitter and Instagram pages.</td><td></td></tr>
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ITEM		LEAD RESPONSIBLE
	In response to the second question, Mr Williams advised that there were no plans to re-open the consultation on the 'Building Better Hospital' programme. The principles for the programme remain the same and confirmation had recently been received from the Government that funding would be available for UHL. Plans will continue to be implemented in line with the outcome of the public consultation and LLR ICB will work with partner organisations to ensure ongoing engagement with the population to provide updates as the work progresses. <u>Questions from Mr Manohar Patel</u> *1. ICB/23/34 - Since November 2022, the number of patients waiting over 62 days for their cancer treatment has more than halved. What are the numbers?* *2. Cancer: Improvement in performance for 2WW. There has been a marginal improvement in performance for the 2ww standard, however remains under national target of 93%. When do we expect to reach the national target of 93%?* *3. It has been noted that the Trust position for Cancer remains a challenge and will continue to do so whilst plans are implemented. What are the plans?* *4. Alerts - Cancer and elective harm reviews. Assurance had not been received in respect of the harm review report for cancer and elective care since quarter two. Why assurances have not been received?* *5. NHS 75 England Cancer Waiting Times 2022-23 data for RWE University Hospitals of Leicester NHS Trust All Care All Cancers are 40.53% for the national average. Are we ever going to increase the averages?* In response to the first question, Mr Williams advised that, as of 8th November 2022, a total of 952 patients on the two week-wait pathway had been waiting over 62 days. As of 31st March 2023, this number had decreased to 437 patients waiting over 62 days. In response to the second question, Mr Williams advised that there has been a steady increase in two week wait referrals and March 2023 saw a 9.4% increase on April 2022 referral volume. This increase has offset the benefits associated with the provision of additional capacity. It was agreed that a visual representation of the performance data will be shared with Mr Patel following the meeting. With the improvement work in place, it is expected that the 93% target will be achieved within the next 12 months. In response to the third question, Mr Williams advised that UHL is committed to an agreed reduction in 62-day backlog performance by March 2024 in line with the national requirement. The focus will then move to achievement of the existing constitutional standards in 2024/25. UHL continues to work on improving performance to ensure delivery against agreed trajectories. A system-wide Cancer Summit was held in May 2023. A number of key themes were addressed, including training and review of the pathway to enhance patient experience. In response to the fourth question, Mr Williams advised that the Quarter 3 report was shared at the UHL Trust Leadership Team Meeting (TLT), the UHL Quality and Outcome Committee (QC), the LLR Cancer Summit in May and the LLR Cancer Design Group (Quality and Performance Sub-Group) in June. The report is presented quarterly. There are plans to present the Quarter 4 and Annual Report to the TLT, QC and LLR Q&P subgroup in August/September 2023 at the latest.	

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ITEM		LEAD RESPONSIBLE
	In response to the fifth and final question, Mr Williams advised that focus remains on clearing the 62-day backlog to enable further improvements against the standard. The plans in place will enable a clear reduction in backlog numbers, supporting a return to 62-day performance standard. Mr Richard Mitchell added that he and the cancer team at UHL would be happy to meet with Mr Patel to discuss his queries and concerns in further detail. Mr Sissling thanked members of the public for their questions.	
ICB/23/58	**Minutes of the meeting held on 13 April 2023 (Papers A)** The minutes were confirmed as an accurate record. **It was RESOLVED to:** • **APPROVE** the minutes of the ICB Board meeting held on 13 April 2023.	
ICB/23/59	**Matters Arising and actions for the meeting held on 13 April 2023 (Paper B)** Progress made against actions was noted and the request to close specific actions was supported. **It was RESOLVED to:** • **RECEIVE** the update and progress made in relation to the actions.	
ICB/23/60	**Update from ICB Chair** Mr Sissling welcomed new participant members: Councillor Sarah Russell and Councillor Diane Ellison, Chairs of the Leicester City and Rutland Health and Wellbeing Boards respectively. He advised that letters of thanks would be written on behalf of the Board to their predecessors, Councillor Vi Dempster and Councillor Sam Harvey. Successor arrangements for the position of Co-Chair of the LLR Health and Wellbeing Partnership were being discussed with Local Authority colleagues. As the LLR ICB approaches its first anniversary, Mr Sissling observed there is an opportunity to reflect on the achievements and the progress made over the last year and consider future developments and strategic direction. Mr Sissling made reference to the national self-assessment tool for ICBs which would be explored in future meetings. He acknowledged the recent reflections offered by Partner Members which provided a good foundation for the self-assessment review. Mr Sissling offered his observations and reflections on the work of the ICB. He drew attention to the Boards ability to strike an appropriate balance between strategic and operational matters. He highlighted the significant improvements which had been achieved in a range of operational areas. It was, for example, significant that the ICB had exited the national Tier 1 support arrangements for urgent care- a result of effective partnership working. It was also noted that positive feedback has been received from NHS England in relation to the draft LLR Five Year Plan. Mr Sissling highlighted the opportunity for the Board to continue to drive towards excellence in all its work, ensuring that the public are engaged and involved throughout the process. **It was RESOLVED to:** • **RECEIVE** the update.	

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ITEM		LEAD RESPONSIBLE
ICB/23/61	**Update from ICB, Acute Sector, Mental Health and Community Sector** Ms Angela Hillery highlighted activity undertaken within LPT, including the National Volunteers Week, Carers Week, Armed Forces Week, and the tenth anniversary of the Leicestershire Recovery College. She noted a range of important developments. These included a summit on Children and Young People's Services. The opening of Westcotes Lodge has, moreover, provided additional clinical spaces and clinicians to work with young people with an extra 210 appointments per week. Ten new Mental Health Crisis Cafes have also been introduced. Mr Richard Mitchell provided the following update: • Confirmation received from the Secretary of State that the UHL capital programme will be supported and is able to proceed. Investment will deliver new women's and children's hospitals, increase intensive care capacity, extend research and education, and enable improved recruitment and retention. • The first phase of the East Midlands Planned Care Centre is now complete with further development to follow. • Leicester has been identified as one of the top places to live and work according to the Good Growth Citizens Index. The new hospital programme will further strengthen Leicester's profile as a great place to live, work, and receive care. • The East Midlands Acute Provider Network has met and agreed joint working approaches to enhance equity, access, and digital capabilities. • UHL were the fourth Trust in the Midlands to achieve a financial excellence accreditation at level 2. This is a significant achievement particularly as the Trust had experiences a range of financial challenges. • The Trust's strategy was currently under review. The updated strategy would be launched over the coming months. Mr Williams noted that delivery of the 2023/24 operational plan would be challenging. Success would depend on progress in a wide range of areas including our ability to be effective at "place" level alongside the delivery of complex improvement programmes. It was noted that a meeting had been convened by the LMC regarding to explore options to respond to the challenges facing the future of Primary Care. Mr Williams described the specific complexities in sustaining the reductions in waiting times- for both elective and urgent cate. He assured the Board that appropriate programmes of work were in place. **It was RESOLVED to:** • **RECEIVE** the verbal reports.	
ICB/23/62	**LLR Learning Disabilities and Neuro-disability Collaborative (presentation)** In introducing the presentation, Mr David Williams advised that the responsibility for the Learning Disabilities and Neuro-disability collaborative is shared with Leicestershire County Council, with active engagement from Leicester City Council and Rutland County Council. Mr David Williams emphasised the aim of the collaborative was to support individuals in living good and fulfilling lives, whilst reducing pressures on urgent and emergency care and sharing learning to improve care. A clear vision for	

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ITEM		LEAD RESPONSIBLE
	the collaborative had been established. Prevention was highlighted as a key area of focus, to be achieved in part through improved access to regular physical assessments and annual health checks. As of March 2023, LLR achieved a completion rate of 81.1% for annual health checks. This is higher than the Midlands average of 78%. LLR had a compliance rate of 97% for the completion of health action plans, which is higher than the Midlands average of 96%. It was noted that there has been an increase in hospital admissions for children with neurodiverse needs. Work is ongoing to enable sustainable community care options. Mr David Williams drew attention to the Oliver McGowan training available to colleagues across LLR, presenting an opportunity to champion and change practice. Ms Tagg advised that she had completed the training and found it to be insightful and beneficial. Ms Tagg encouraged all Board members to complete the training. Professor Farooqi sought clarification as to why annual health checks had to carried out by General Practitioners. In response, Mr David Williams advised that it is beneficial for the relevant group of individuals to have periodic contact with their GP and the wider primary care team. He also highlighted the need to review the circumstances of those not taking advantage of the health check to ensure they were provided with appropriate support. Professor Farooqi noted that the implementation of a health action plan requires lifestyle support that is not easily readily available to patients. Mr David Williams acknowledged this and stated this matter was receiving appropriate attention. Mr. Sissling thanked Mr. Williams for the helpful presentation and commented on the positive work which is being progressed. the Board would welcome a further update toward the end of 2023. **It was RESOLVED to:** • **RECEIVE** the presentation.	
ICB/23/63	**Addressing health equity in our Five-Year Plan (FYP) (Paper D)** Ms Sissling observed that health inequalities was identified as a high-risk area within the ICB's Board Assurance Framework (BAF) and as such it was appropriate for the Board to receive this overview and assurance report. Ms Prema assured the Board that health equity and reducing health inequalities was a core theme within the FYP. The approach adopted to address health inequalities includes the implementation of the Health Equalities Framework alongside local place level Health and Wellbeing Plans. It was a common theme underpinning all proposed programmes of work but with some very focussed action and relevant public pledges. Professor Farooqi added that a Health Equalities Support Unit has been established with a focus on data to assist with identifying priorities for the ICB and the system. In relation to the Core20Plus5, Ms Ellis queried whether the 'plus' groups had been agreed by the ICB or by 'place' leads. In response, Ms Prema confirmed that plus populations have been determined at place level through consideration by the three Health and Wellbeing Boards.	

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ITEM		LEAD RESPONSIBLE
	Mr Andrews noted there are a significant number of individuals across LLR who are living in deprivation but are not within deprived communities. As such, inequality cannot be identified solely through the use of consolidated data. This re-inforced the need for local approaches with an emphasis on local access to care as indicated by Pledge 7. Ms Prema agreed that Pledge 7 is important in terms of increasing health equity. Ms Hillery welcomed the focus on children and young people, noting that more work is needed to understand and respond to a complex range issues only some of which relate to the NHS. Mr Mitchell enquired whether a plan had been devised to deliver the pledges recognising the current challenges and limited resources. Ms Prema advised that a number of detailed delivery programmes were being developed based on a realistic assessment of resource availability. The plan implies a shift of resources into prevention initiatives and work programmes. Ms Tagg queried how the Board would receive assurance to demonstrate delivery against the pledges within the FYP. Mr Sissling noted that this is to be considered over the coming months as the plans are further developed. It was confirmed that health equity will continue to feature prominently on the Board agenda. **It was RESOLVED to:** • **RECEIVE** the update.	
ICB/23/64	**ICB and System operational performance report (Paper E)** Ms Vyas reported that a single, unified performance report is being developed covering performance, finance, workforce and equity aspects. This report would be used by the Boards committees. The new approach received positive feedback from both the Finance Committee and the Quality and Safety Committee. Ms Vyas drew attention to specific areas of current performance, including improvement in access for GP appointments and in cancer and elective care waiting times. The position was also positive for a range of key indicators relating to mental health and learning disabilities. For those areas where performance was less strong, comprehensive improvement plans were in place. Mr Sissling acknowledged that the report may require refinement over time but recognised the benefits of an integrated approach. It was noted that the Board would receive the new format of the report at the next meeting. **It was RESOLVED to:** • **NOTE** the revised infrastructure in place for delivery of the Operational Plan 2023/24, including oversight of performance. • **RECEIVE and NOTE** the interim performance report for May 2023.	
ICB/23/65	**LLR System Finance monthly report (month 12) (Paper F)** Ms Gregory provided an update on the LLR system finance position at year end, highlighting that the overall system position was a deficit of £14.5m. This was in line with the revised control total agreed with NHS England and approved by the Board. UHL reported a deficit of £12.5m, LPT a deficit of	

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ITEM		LEAD RESPONSIBLE
	£2.7m, whilst the ICB reported a £0.615m surplus. The system delivered its Cost Improvement Programme (CIP) excluding specified system-wide efficiencies. Capital spend for the system totalled £113.5m against the £116.8m of funding received. It was noted that the ICB financial position incorporated the three months of operation for the Clinical Commissioning Groups (CCGs) and nine months operation as an ICB. The Board received assurance that the CCGs and ICB have achieved the targeted surplus of £0.6m as agreed with NHS England, finishing with a final surplus of £0.615m and subject to audit, had achieved its other financial duties. **It was RESOLVED to:** • **RECEIVE and NOTE** the financial position as at month 12 across LLR system and the surplus of £0.615m achieved for the ICB. • **RECEIVE** for assurance.	
ICB/23/66	**Assurance report from the Finance Committee (Paper G)** Ms Ellis introduced the report. She reported that NHS England representatives had recognised LLR finance committee as a national exemplar. It was reported that the 2023/24 financial plan was currently rated as 'red' due to cost improvement plan risks. System reporting was to be developed to enable improved tracking of delivery, emerging risks and remedial actions. The risk register had been updated to include the delegation of pharmacy, optometry and dental services. **It was RESOLVED to:** • **RECEIVE** the report for assurance.	
ICB/23/67	**Assurance report from the System Executive Committee (April 2023 and May 2023) (Paper H)** Mr Williams advised of a correction to the report, paragraph 18 (f) to read: '*The revised cost of the Community Diagnostic Centre was approved by NHS England, this was an additional cost of £10.025m.*'' Members noted the amendment. **It was RESOLVED to:** • **RECEIVE** the report for assurance.	
ICB/23/68	**Assurance report from the Quality and Safety Committee and terms of reference (Paper I)** Ms Tagg highlighted that the delegation of pharmacy, optometry and dental primary care services was highlighted as a 'red' risk recognising the Committee had not yet worked through the detail of the risks associated with the responsibility for delivering the services. Dr Sanganee advised the Board that a recent LLR Cancer Summit meeting provided an opportunity for partners to review the risks identified by the Committee in greater detail at speciality level. The summit had reviewed and commended the significant progress which had been made since a previous similar event held in 2022, particularly in the areas of specialist nursing, diagnostics testing and pathway development. Work is ongoing in key areas to build on these achievements and to address priority challenges. Ms Tagg advised the Board that the Committee would increasingly be adopting an integrated approach recognising many of the risks were inter-related.	

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ITEM		LEAD RESPONSIBLE
	The proposed amended terms of reference were approved. **It was RESOLVED to:** • **RECEIVE** the report for assurance. • **APPROVE** the terms of reference as at Appendix 1.	
ICB/23/69	**Assurance report from the Audit Committee and terms of reference (Paper J)** The Board received assurance from Mr Hickman that all risk areas rated as amber are being taken forward. The review of the Annual Report and Accounts this would take place at the next meeting of the Committee. Furthermore, Mr Hickman advised that the Committee continue to review the effectiveness of the BAF and related risk management arrangements. **It was RESOLVED to:** • **RECEIVE** the report for assurance. • **APPROVE** the current terms of reference as they stand, noting they remain unaltered (a copy of the terms of reference are available within the LLR ICB's Governance Handbook).	
ICB/23/70	**Assurance report from the Health Equity Committee and terms of reference (Paper K)** Prof Farooqi introduced the paper and advised that there were no risks to draw to the Board's attention. He commended the proposal for a Board development session focusing on the Health Equalities Framework, further details will be made available once this has been arranged. **It was RESOLVED to:** • **RECEIVE** the report for assurance. • **APPROVE** the current terms of reference as they stand, noting they remain unaltered (a copy of the terms of reference are available within the LLR ICB's Governance Handbook).	
ICB/23/71	**Summary report from LLR Health and Wellbeing Partnership (HWP) (Paper L)** Mr Sissling introduced the report which summarised the areas covered at the most recent meeting of the HWP. Of particular significance was an agreement to review the future priorities and focus for the partnership. The report was received and noted. **It was RESOLVED to:** • **RECEIVE** the report for assurance.	
ICB/23/72	**LLR ICB Governance Handbook update (paper M)** Ms Gregory advised that the ICB Governance Handbook had been reviewed and a link had been provided within the report to the updated document. Ms Gregory drew attention to pertinent sections within the Governance Handbook. These included sections setting out the change to the Board composition and amendments to the Scheme of Reservation and Delegation following the establishment of the East Midlands ICBs' Joint Committee for primary care services delegation. The Board approved the amendments to the ICB Governance Handbook. **It was RESOLVED to:**	

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ITEM		LEAD RESPONSIBLE
	• **APPROVE** the updated LLR ICB Governance Handbook at Appendix 1 (this includes the amendments to the component parts of the Handbook).	
ICB/23/73	**Items of any other business and review of the meeting** Dr Chotai sought assurance that the introduction of diagnostic hubs supports the principle of providing care closer to home. Mr Williams affirmed this and emphasised the scope for developments in the role played by primary care services in relation to the provision of diagnostic services. Furthermore, Dr Chotai observed that the term 'Primary Care' was predominantly used in reference to primary medical services and GP practices. There would be a need to be precise about the use of the term as the ICB became directly responsible for the wider delegated primary care functions. This point was noted. The meeting closed at 10:43am.	
Date and Time of next meeting: An extraordinary meeting of the NHS LLR Integrated Care Board will take place on **Thursday 13 July 2023** (time to be confirmed). The meeting will be held in public.		

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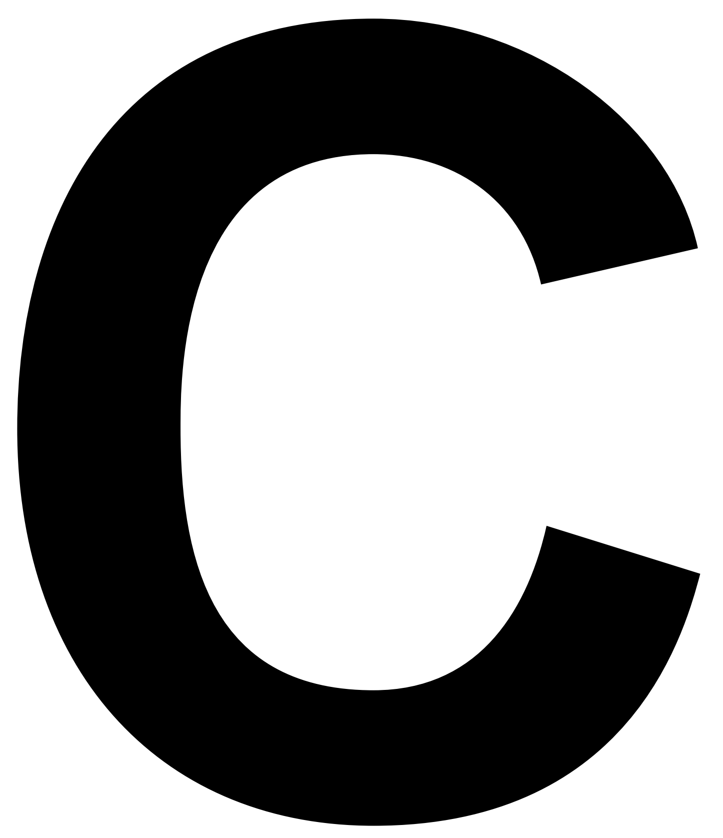
NHS Leicester, Leicestershire and Rutland (LLR) Integrated Care Board

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 July 2023	Status
ICB/23/38	13 April 2023	LLR ICB Board Assurance Framework 2022/23 and 2023/24	Caroline Gregory / Daljit Bains	To review the BAF in line with the Five Year Joint Forward Plan and to sense check the strategic risks against the strategic priorities.	July / August 2023	Item on the agenda for review at the July 2023 Board meeting. **ACTION COMPLETE**	**Green**



Name of meeting:	Leicester, Leicestershire and Rutland Integrated Care Board (public)		
Date:	Thursday 13th July 2023	Paper:	C
Report title:	Leicester, Leicestershire and Rutland Integrated Care Board 5-Year Plan		
Presented by:	Sarah Prema, Chief Strategy Officer, LLR ICB Alice McGee, Chief People Officer, LLR ICB		
Report author:	Jo Grizzell, Senior Planning Manager, LLR ICB Sue Venables, Head of Engagement and Insights, LLR ICB Melanie Shilton, Campaigns, Behaviour Change and Projects Manager		
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:

- **APPROVE** the LLR ICB 5-Year Plan (5YP) (appendix 1)
- **RECEIVE** and **NOTE** the delivery plan (annex) (appendix 2)
- **RECEIVE** and **NOTE** the supporting outcomes framework (appendix 3)
- **RECEIVE** and **NOTE** the report of findings (appendix 4)
- **APPROVE** the Communications and Engagement Plan (appendix 5).

Purpose and summary of the report:

1) At its meeting on 11th May 2023, the LLR ICB Board approved the LLR ICB 5-Year Plan (draft) enabling us to move to a period of engagement from 18th May to 7th June 2023. A comprehensive communications and engagement plan was also approved.

2) As per the NHS England guidance, the plan is to be published on the LLR ICB public facing website on 30th June 2023 with the caveat that it's 'final subject to LLR ICB Board approval'. This approach was also agreed by NHS England.

3) A review meeting took place with NHS England on 24th May 2023 after which formal feedback was received stating that the LLR ICB 5YP is excellent with a high level of content, which was both detailed but written in a way that is understandable to all. NHS England also confirmed that the 5YP covers all of the required areas.

4) It is also important to note that statements have been received from the Leicestershire County and Rutland County Health and Wellbeing Boards agreeing that the Five-Year Plan takes account of the respective Health and Wellbeing Strategies. At the time of writing this paper the statement from the Leicester City Health and Wellbeing Board is pending due to the pre-election period and then subsequent reshuffle of posts in the Executive.

5) Chapter 3 of the 5-Year plan sets out the delivery plan for the ICB, the actions that will transform health and care for LLR. This is accompanied by a supporting delivery plan (annex), included in Appendix 2. This sets out a more detailed delivery plan for each of the priorities which includes the interventions, actions, timeline and anticipated impact that will be implemented through the 5-Year plan. These delivery priorities are mapped to the pledges, with clear accountability for delivery. It is anticipated that the accountable committee, collaborative or partnership will monitor progress against the delivery plan and outcomes framework and provide assurance to the System Partnership and the LLR ICB Board that progress is being made.

6) The 5-Year plan sets out the ICBs pledges to the people of Leicester, Leicestershire and Rutland. An outcomes framework has been developed by Strategic Business Intelligence in collaboration with the Midlands and Lancashire Commissioning Support Unity (MLCSU) and ICB leads. This outcomes framework has been developed to measure the progress that the ICB makes towards the delivery of the pledges. The outcomes framework is included in Appendix 3. The framework sets out the pledge, the national metric and data source that will be used to measure progress, the rationale for the metric and the accountability for delivery against the metric. This is the committee, collaborative, or partnership that will be responsible for delivery of the plan.

7) Following the engagement phase, feedback has been analysed and considered. Where appropriate, the 5YP has been further refined. In addition, a Report of Findings has been produced (appendix 4).

8) Finally, a post publication communications and engagement plan has been produced which sets out activities over the coming months (appendix 5).

Appendices:	Appendix 1 – LLR ICB 5-Year Plan Appendix 2 – Delivery plan (annex) Appendix 3 – Outcomes framework Appendix 4 – Report of Findings Appendix 5 – Communications and Engagement Plan
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.*	It will be the responsibility of each of the accountable committees, collaboratives, partnerships etc to ensure that any risks associated with the delivery of the plan are incorporated within their operational risk registers. They should also ensure that any risks meeting the relevant criteria are escalated to the Board Assurance Framework as necessary.
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 Report of Findings and Communications and Engagement Plan are appended.
e) Has due regard been given to the Public Sector Equality Duty? If so, how and what the outcome was, provide which page / paragraph this is outlined in within the report.	Equality Impact Risk Assessments (EIRAs) will need to be undertaken in relation to service developments in line with existing processes.

Leicester, Leicestershire and Rutland Integrated Care Board 5-Year Plan
Thursday 13th July 2023

Introduction

1) At its meeting on 11th May 2023, the LLR ICB Board approved the LLR ICB 5-Year Plan (draft) enabling us to move to a period of engagement from 18th May to 7th June 2023. A comprehensive communications and engagement plan was also approved.

2) As per the NHS England guidance, the plan is to be published on the LLR ICB public facing website on 30th June 2023 with the caveat that it's 'final subject to LLR ICB Board approval'. This approach was also agreed by NHS England.

3) A review meeting took place with NHS England on 24th May 2023 after which formal feedback was received stating that the LLR ICB 5YP is excellent with a high level of content, which was both detailed but written in a way that is understandable to all. NHS England also confirmed that the 5YP covers all of the required areas.

4) It is also important to note that statements have been received from the Leicestershire County and Rutland County Health and Wellbeing Boards agreeing that the Five-Year Plan takes account of the respective Health and Wellbeing Strategies. At the time of writing this paper the statement from the Leicester City Health and Wellbeing Board is pending due to the pre-election period and then subsequent reshuffle of posts in the Executive.

5) Chapter 3 of the 5-Year plan sets out the delivery plan for the ICB, the actions that will transform health and care for LLR. This is accompanied by a supporting delivery plan (annex), included in Appendix 2. This sets out a more detailed delivery plan for each of the priorities which includes the interventions, actions, timeline and anticipated impact that will be implemented through the 5-Year plan. These delivery priorities are mapped to the pledges, with clear accountability for delivery. It is anticipated that the accountable committee, collaborative or partnership will monitor progress against the delivery plan and outcomes framework and provide assurance to the System Partnership and the LLR ICB Board that progress is being made.

6) The 5-Year plan sets out the ICBs pledges to the people of Leicester, Leicestershire and Rutland. An outcomes framework has been developed by Strategic Business Intelligence in collaboration with the Midlands and Lancashire Commissioning Support Unity (MLCSU) and ICB leads. This outcomes framework has been developed to measure the progress that the ICB makes towards the delivery of the pledges. The outcomes framework is included in Appendix 3. The framework sets out the pledge, the national metric and data source that will be used to measure progress, the rationale for the metric and the accountability for delivery against the metric. This is the committee, collaborative, or partnership that will be responsible for delivery of the plan.

7) Following the engagement phase, feedback has been analysed and considered. Where appropriate, the 5YP has been further refined. In addition, a Report of Findings has been produced (appendix 4).

8) Finally, a post publication communications and engagement plan has been produced which sets out activities over the coming months (appendix 5).

Report of Findings (appendix 4)

1) Public engagement on the 5-Year Plan for Leicester, Leicestershire and Rutland Integrated Care Board ran from Thursday 18 May to Wednesday 7 June 2023. The feedback and insights have been analysed and a Report of Findings produced which outlines thematically the insights.

2) Prior to the engagement, conversations with key strategic partners have been ongoing in Leicester, Leicestershire and Rutland in the development of the plan for a number of months.

3) In addition, multiple sources of data collected from 2019/2020 to the present, from patients, family carers, staff and public has been used to inform the Plan. These insights have captured the views of the most vulnerable and those with protected characteristics demonstrating that we have discharged our legal duty under the Public Sector Equality Duty (s.149, Equality Act 2010).

4) A Confirm and Challenge meeting was held with the Public and Patient Involvement Assurance Group (PPIAG) in March 2023 to discuss if the insights have influenced the development of the Plan to date. Assurance was given, with a requirement to revisit the group for further assurance post engagement. Therefore, in June, the PPIAG undertook with the ICB a second Confirm and Challenge. The group were able to assure that the insights gathered during the engagement had impacted the final draft plan being presented to the LLR ICB Board.

5) The engagement was promoted through multiple channels and a total of 187 people responded to the engagement and their insights have been reviewed again previous Report of Findings.

    - 167 people responded to the online questionnaire.
    - 20 people responded directly to the email inbox

6) Key themes that people discussed as important to them:

    - Prevention, healthy lifestyles, health education and self-care
    - Joined up care
    - More efficient screening, triage and diagnosis
    - GP/primary care access and improvements
    - Digital and Technology
    - Funding
    - Communications
    - Local and accessible services – transport and mobility, waiting times
    - Improve outpatients
    - Recognise dementia as a long-term condition

7) The insights captured have been reviewed against the draft 5YP and alongside other key considerations including clinical appropriateness and safety, quality of care, value for money and affordability. This has then influenced some to the next draft version which will be put to the LLR ICB Board and sent to NHS England.

Communications and Engagement Plan (appendix 5)

8) The Communications and Engagement Plan has been produced to support the launch of NHS Leicester, Leicestershire and Rutland Integrated Care Board's Five-Year Plan, by setting out how we will build on previous engagement with local audiences to launch the document and communicate progress.

9) The purpose of the Communications and Engagement Plan is to raise awareness of the plan overall and specific sections, increase people's knowledge about local services and the local priorities, and report progress and achievements.

10) The audiences that are relevant in this Communications and Engagement plan will vary depending on the aspect of the plan to be communicated, but will include patients and the public, staff, stakeholders and partners.

11) The Communications and Engagement Plan will be delivered in two phases: activities to launch the plan and an ongoing content strategy to keep people informed of progress. A 'staff first' principle will be used during the launch phase to ensure those involved in delivery understand their individual contribution and can act as ambassadors on the front line.

12) The launch plan will commence on Friday 14th July 2023, following formal approval of the Five-Year Plan by the ICB Board. It will ensure communication with all audience groups using channels such as online, media, social media, email, newsletters, online and offline meetings, all using a range of accessible assets.

13) The content strategy will start following the main summer holiday period, commencing in October 2023. A more targeted approach will be taken during this phase to provide content and engage in a relevant, digestible and accessible way, structured around the 13 pledges and key achievements that feature in the Five-Year Plan.

14) Throughout, patients and communities will be invited to help us ensure content is accessible, choose what aspects of the plan they want to hear more about and get involved in specific interventions and refreshes of the Five-Year Plan.

15) Where possible, communications activity will be carried out, within existing budgets, by the Communications and Engagement teams working for the ICB, University Hospitals of Leicester NHS Trust and Leicestershire Partnership Trust. Recommendations may be made for additional funding to make information accessible.

16) Communications and engagement activity will be measured at several levels against the objectives of the Communications and Engagement plan: inputs, outputs, out-takes and outcomes.

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

- **APPROVE** the LLR Integrated Care Board 5-Year Plan (5YP) (appendix 1)
- **RECEIVE** and **NOTE** the delivery plan (annex) (appendix 2)
- **RECEIVE** and **NOTE** the supporting outcomes framework (appendix 3)
- **RECEIVE** and **NOTE** the report of findings (appendix 4)
- **APPROVE** the Communications and Engagement Plan (appendix 5).

Appendix 1

Appendix 1

Our Five-Year Plan 2023/24 – 2027/28

FINAL SUBJECT TO APPROVAL

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Foreword

We are pleased to present the Leicester, Leicestershire and Rutland (LLR) Integrated Care Board's Five-Year Plan which sets out how we will improve care and outcomes for patients, reduce the equity gap across LLR and become financially sustainable. The emphasis within this plan is on partnership, integration and continuous improvement.

We have made considerable progress since we were established in July 2022. We have delivered significant improvements to the urgent care pathway; reduced planned care waiting lists; modernised mental health services and offered one of the highest appointment rates for primary care in the country. Many of these achievements reflect effective joint working across the LLR health and care system. We now commit to build on this progress as we know we still have a lot more to do.

We face a number of challenges which will require concerted responsive action in both the short and the longer term. Some of these challenges relate to access for primary care, hospital and mental health services. And we are particularly conscious of the extended waiting times for some children and young people's services. Another challenge concerns our workforce which is populated by colleagues working with outstanding dedication and professionalism. But we currently have a very significant number of vacancies which affects our ability to meet demand. Perhaps our biggest challenge, however, is to ensure we focus to much greater extent on the prevention of ill-health whilst reducing the stark health and wellbeing inequities which currently exist.

We are confident we can respond to the challenges described above. However, this will require well planned continuous change. It will also require strong partnership working involving the NHS, the wider public sector and the community and voluntary sector. Finally, it will require us to work ever more closely with the public, individually and through their communities.

The plan sets out a number of pledges that we commit to deliver over the next five years. These are based on the things the public have told us are really important. In addition, the plan sets out our key focus areas (Chapter 3) that we believe will enable us to overcome our challenges and improve access and equitable outcomes for the people of Leicester, Leicestershire and Rutland in a financially sustainable manner.

Over the next five years we intend to strengthen and further develop our collaborations. We envisage, for example, ever more closer working with our Local Government partners, through the LLR Health and Wellbeing Partnership and at a Place level in Leicester City and the counties of Leicestershire and Rutland. We will also be developing strategic alliances with neighbouring ICBs where there is benefit in doing so. And we will work collaboratively with other ICBs at an East Midlands level on those services where commissioning responsibility is being delegated from NHS England to Integrated Care Boards.

In order to deliver on this plan our commitment to the people of Leicester, Leicestershire and Rutland is work together and to focus, at all times, on your interests and your health and wellbeing.

Andy Williams Chief Executive LLR Integrated Care Board	David Sissling Independent Chair LLR Integrated Care Board
Angela Hillery Chief Executive Leicestershire Partnership Trust	Richard Mitchell Chief Executive University Hospitals of Leicester

Our Pledges to local people

Our Pledges to local people

Over the next 5 years, we will:

Improving health equity	Preventing illness	Keeping People well	Right care, right time, right place	Health and Wellbeing Hubs
Pledge 1 **Improve the health** of our most deprived communities and **narrow the gap** between those who have the best and the worst health	**Pledge 2** Spend more money on **preventing people becoming ill** in the first place	**Pledge 3** Identify the **frailest in our communities** and wrap care and support around them	**Pledge 4** Improve and maintain access to **routine general practice appointments** **Pledge 5** Reduce Category 2 (emergency calls such as stroke patients) **ambulance response times** **Pledge 6** Reduce and maintain waiting times in the **Accident & Emergency** department	**Pledge 7** Provide more joined up, holistic and person-centred care, **delivered closer to home**

Elective care	Learning Disability & Autism	Mental Health	Children & Young People	Women's Health, including Maternity	Our People
Pledge 8 Reduce **waiting times for consultant-led hospital treatment**	**Pledge 9** Increase the percentage of people on GP **learning disability** registers who receive an annual health check and health action plan	**Pledge 10** Reduce **inequity in access to mental health services** across each of our neighbourhoods	**Pledge 11** Improve access to, experience of, and outcomes of care **for children and young people** - with a special focus on driving up health equity	**Pledge 12** We will engage with, listen to, **empower and co-produce services with women and girls**	**Pledge 13** We will shape **our people** and services around the needs of our population by **improving workforce retention, reducing agency usage and growing our workforce** to ensure we are fit for the future.

Our progress in meeting these Pledges will be tracked and reported on at the ICB meetings in public

Our Plan on a Page

Delivered Across Our Life Course Approach

- Best Start in Life
- Staying Healthy and Well
- Living and Supported Well
- Dying Well

Our Vision: Working together for everyone in Leicester, Leicestershire and Rutland to have healthy, fulfilling lives

Core Purpose of our ICS (Our Strategic Objectives)

Improve outcomes in population health and healthcare	Tackle inequalities in outcomes, experience and access	Enhance productivity and value for money	Help the NHS support broader social and economic development	Deliver NHS constitutional and legal requirements

Our Principles : Everything we do is centred on the people and communities of LLR and we will work together with respect, trust, openness and common purpose to:

Ensure that everyone has equitable access to health and care services and high quality outcomes	Make decisions that enable great care for our residents	Deliver services that are convenient for our residents to access	Develop integrated services through co-production and in partnership with our residents	Make LLR health and care a great place to work and volunteer	Use our combined resources to deliver the very best value for money and to support the local economy and environment

Our Delivery Priorities

Improve Health Equity	Preventing Illness	Keeping People Well	Right care at the right time	Health and Wellbeing Hubs	Elective Care	Learning Disabilities and Autism	Mental Health	Children and Young People	Women's Health and Maternity	Our People

Our Pledges to local people

Pledge 1	Pledge 2	Pledge 3	Pledge 4 / Pledge 5 / Pledge 6	Pledge 7	Pledge 8	Pledge 9	Pledge 10	Pledge 11	Pledge 12	Pledge 13
Improve the health of our most deprived communities and narrow the gap between those who have the best and the worst health	Spend more money on preventing people becoming ill in the first place	Identify the frailest in our communities and wrap care and support around them	**Pledge 4** Improve access to GP appointments **Pledge 5** Reduce ambulance Response times **Pledge 6** Reduce A&E waiting times	Provide more joined up, holistic and patient-centred care, delivered closer to home.	Reduce waiting times for hospital treatment	Increase the percentage of people on GP learning disability registers who receive an annual health check and health action plan	Reduce inequity in access to mental health services across each of our neighbourhood	Improve access to, experience of, and outcomes for children and young people - with a special focus on driving up health equity.	Listen to voices of women and girls to co-produce and transforms services.	We will shape our people & services around the needs of people by building a one team & culture to maximise the people potential of the LLR population.

Chapter 1: Introduction

1.1 The purpose of this document

This five-year plan (the Plan) sets out how NHS services will be arranged and delivered to meet the physical and mental health needs of local people in LLR over the next five years i.e., 2023/24 to 2027/28. The LLR Integrated Care Board (ICB), which includes our NHS Trusts, is accountable for the delivery of this Plan, working with our Councils and wider partners.

The National Health Service Act 2006 (as amended by the Health and Care Act 2022) requires our ICB and our partner trusts to prepare this Plan before the start of each financial year. 2023/24 is the first year of this Plan, which will be updated each year, from 2024/25 onwards.

We face significant health and care challenges in LLR, and these are described in Chapter 2. Working with our Councils and wider partners, we have developed an Integrated Care Strategy that sets out the direction of travel to address these challenges for LLR. Our three upper-tier Councils (also known as our Places) have also worked with partners to develop Joint Health and Wellbeing Strategies (Leicester City Council JHWS; Rutland County Council JHWS; Leicestershire County Council JHWS) that focus on the specific challenges in each of their areas, as identified through their Joint Strategic Needs Assessments (JSNA) (Leicester City Council JSNA; Rutland County Council JSNA; Leicestershire County Council JSNA. Furthermore, we are working with district councils to develop Community Health and Wellbeing Plans.

This document supports the delivery of the Integrated Care Strategy and Joint Health and Wellbeing Strategies, as well as the national NHS commitments. It sets out how, over the next five years, we will practically transform the delivery of NHS care to improve performance and outcomes, reduce inequity in health and healthcare, and achieve financial sustainability.

1.2 Who this document is for

We have made every effort to write this document as clearly and plainly as possible. However, it does contain some detailed and technical information regarding our future plans. Where this is unavoidable (for example, the inclusion of detailed data to support our clinicians and Partners), we have included links to supporting information.

No single document can meet the needs of every reading audience and, therefore we will also produce separate summary documents and bespoke resources for specific audiences to explain our future plans.

Audiences for whom this document should be particularly helpful include:

- Our patients and local people
- NHS and social care staff and teams
- NHS leaders at all levels and across all our organisations
- Clinical leaders across primary, community, mental health, hospital and specialist services
- NHS Board non-executive members
- County and district council councillors and executives
- Local authority housing, education, planning and environmental services leaders
- Voluntary and community sector leaders
- Healthwatch and patient group leaders
- Health and care focussed charities
- Police and fire and rescue services leaders
- Health and Wellbeing Board members

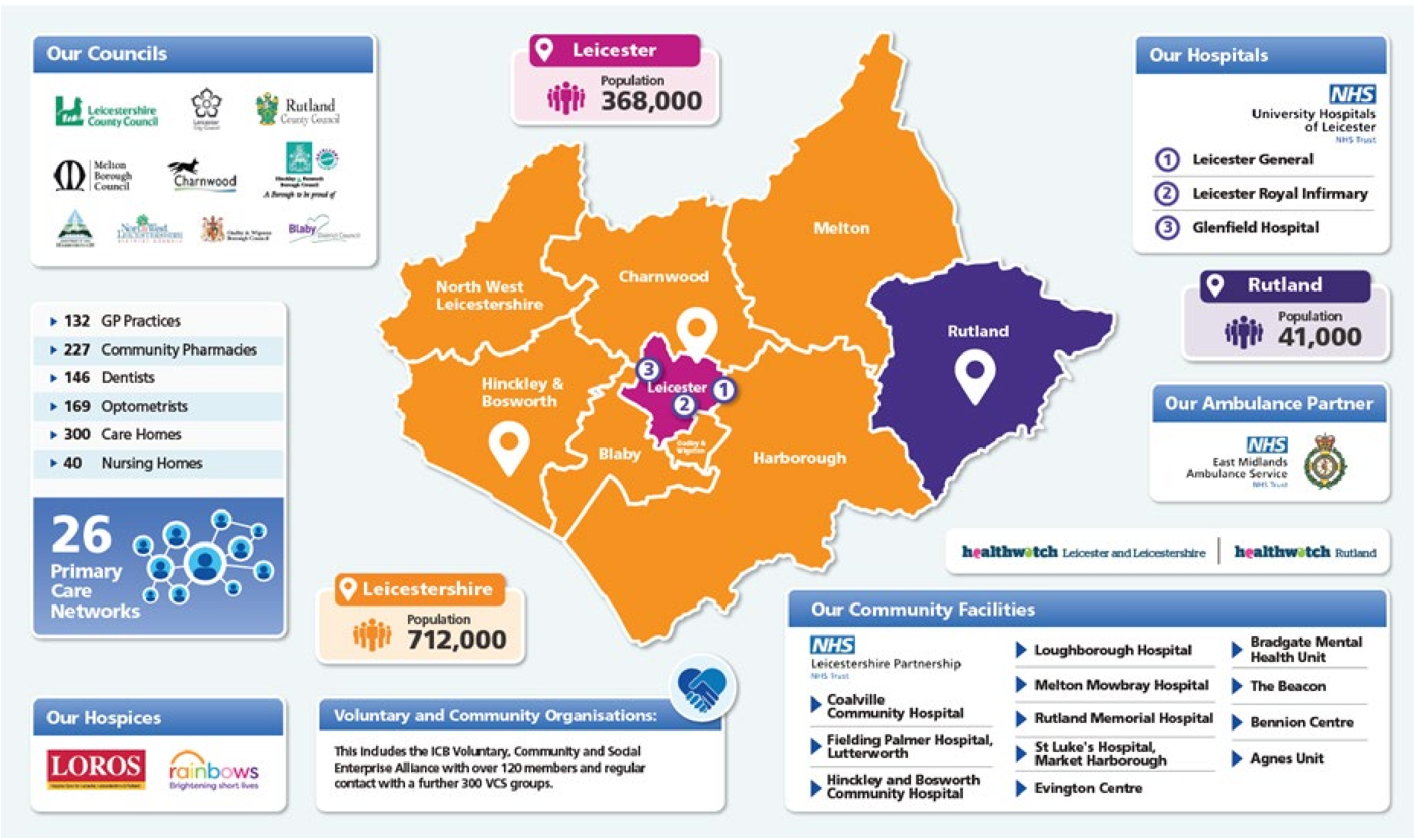
- NHS England
- Local Authority Health Overview and Scrutiny Committee members
- Universities, higher and further education leaders

1.3 About us

About LLR

We serve 1.1million people across rural, market towns and urban areas.

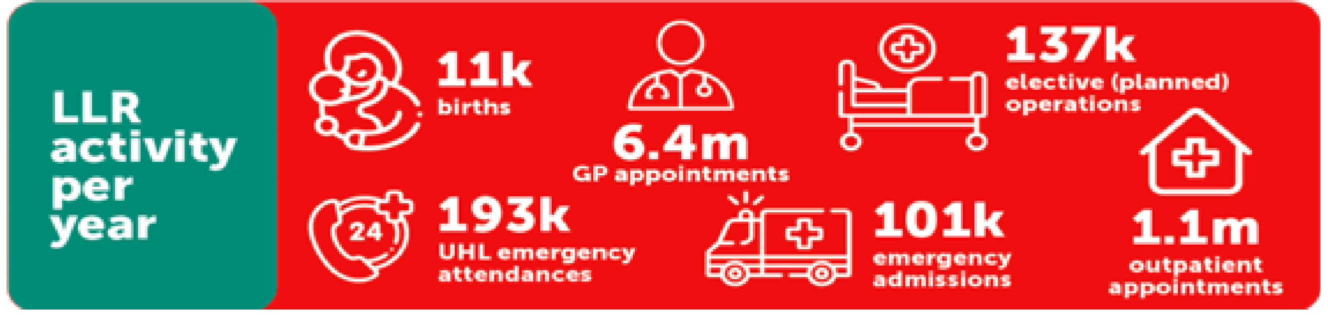
Our Health and Care Landscape



Figures accurate as of March 2023

Key facts and figures

LLR is a busy place…



(2021/22 data)

About the LLR ICB

Our ICB (known as NHS Leicester, Leicestershire and Rutland) is a statutory body created to provide infrastructure support to the NHS. We do not directly provide care (although a lot of our work supports the delivery of care). We spend over £2 billion on health and care services for the 1.1 million people of LLR every year. Our contribution to the front line is delivered by discharging our responsibilities effectively and efficiently through our main providers of NHS services and by working with our wider partners.

Our ICB's role can be summarised as working with partners to:

- Identify the health and care needs of its population;
- Develop service plans to meet those needs, reflecting national and local priorities;
- Support the implementation of those plans and service delivery more widely;
- Evaluate the effectiveness of services and take action to correct or improve these where required; and
- Be accountable to NHS England and our local population for the public funds it spends and the outcomes and outputs of the services it commissions.

About the LLR ICS

The ICB is part of the LLR Integrated Care System (ICS) alongside our local NHS trusts and councils. GPs, other health and care providers, Healthwatch and the voluntary and community sector also play a critical role in coming together to plan and deliver joined up (integrated) health and care services to improve the lives of local people. We manage this work through the LLR Health and Wellbeing Partnership.

Integrated care puts the patient or service user at the centre by removing traditional divisions between hospitals and family doctors, between physical and mental health, and between NHS and council services. In the past, these divisions have meant that too many people experienced disjointed care and, in some cases, poor experience and outcomes. It's about giving people the support they need, joined up across local councils, the NHS, and other partners.

The core purpose of our ICS (Our Strategic Objectives), therefore, are to bring partner organisations together to:

- Improve outcomes in population health and healthcare
- Tackle inequalities in outcomes, experience and access to health and care
- Enhance productivity and value for money
- Help the NHS support the broader social and economic development in an area
- Deliver NHS constitution and legal requirements

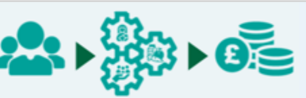
The ICB's strategic objectives support our overall vision and provide an overarching set of goals that we aim to achieve. The delivery of our strategic objectives will be underpinned by our values and principles. The pledges describe what we will measure to determine the extent to which our strategic objectives have been achieved. Our Board Assurance Framework will describe the principal / strategic risks that could impact the ICB achieving its strategic objectives if the strategic risks were to materialise.

Our system operates at three levels:

Neighbourhood
Neighbourhoods' are the cornerstone of our ICS. Based on 26 groups of GP Practices, known as primary care networks, they work together to manage care closer to home for populations of 30-50k patients. They develop multidisciplinary teams working with councils, the community and voluntary sector, to care for those with long-term conditions. GPs, practice and community nurses and staff will work with partners to wrap care around the most vulnerable.

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

System
At a system level the statutory Integrated Care Body and its partners will analyse need, set priorities and desired health outcomes, and allocate funding.



1.4 Our Vision, Principles and Life Course approach

We worked closely with partners and stakeholders to develop a shared vision and principles that act as a 'golden thread' for how we operate in LLR: for how we focus on a better future for local people; for how we transform and improve health and care; and for how we interact with each other.

Our Vision

Working together for everyone in Leicester, Leicestershire and Rutland to have healthy, fulfilling lives

Our Principles

Everything we do is centred on the people and communities of LLR and we will work together with respect, trust, openness and common purpose to:		
Ensure that everyone has equitable access to health and care services and high-quality outcomes	Make decisions that enable great care for our residents	Deliver services that are convenient for our residents to access
Develop integrated services through co-production and in partnership with our residents	Make LLR health and care a great place to work and volunteer	Use our combined resources to deliver the very best value for money and to support the local economy and environment

Our Life Course approach

Adopting the life course approach means identifying opportunities for minimising risk factors and enhancing protective factors through evidence-based interventions at important life stages, from the perinatal period through early childhood to adolescence, working age, pre-conception and the family-building years, and into older age. It also capitalises on the potential to deliver an inter-generational approach to health improvement and reduce health inequalities from generation to generation and improve conditions of daily life.

1.5 A clinically led approach

We have ensured that the development, implementation and ongoing delivery of services for local people are clinically led and underpinned by a clinical strategy.

Our clinical strategy (currently drafted and being discussed widely with clinicians) sets out 'guiding principles' that underpin and, thereby deliver our life course approach (see 1.4). These principles are: "*population health*", "*management of illness*" and "*clinical culture*" (Table 1, below).

Table 1: Summary of our clinical strategy guiding principles

LLR Clinical Strategy: Guiding Principles		
Population Health **Our focus will be on:**	**Management of Illness** **Our focus will be on:**	**Clinical Culture** **Our focus will be on:**
Prevention of disease and promotion of health and wellbeing	Shared Decision Making	Research and Innovation
Aims of Population Health Management	Support for the clinical team	Stewardship of healthcare resources
The broader social determinants of health	Patient and carer activation/engagement	Professional Support
Improving health equality	Healthcare Integration	Scrutiny of outcomes
Public health risks	Well supported primary care	Communication and Transparency
Community Engagement	Hospital care	

The clinical strategy represents our "thinking" about how health and care should be provided, whereas this Plan details the actions (the "doing") that will be undertaken to deliver the clinical strategy and the process by which decisions about these actions are prioritised. The clinical strategy aligns with the Integrated Care Strategy, but also extends the broad objectives set out in that document by providing specific and enduring clinical values which, we believe, will maintain a clear direction for the work of the ICB in the coming years.

Figure 1: Our LLR Clinical Model

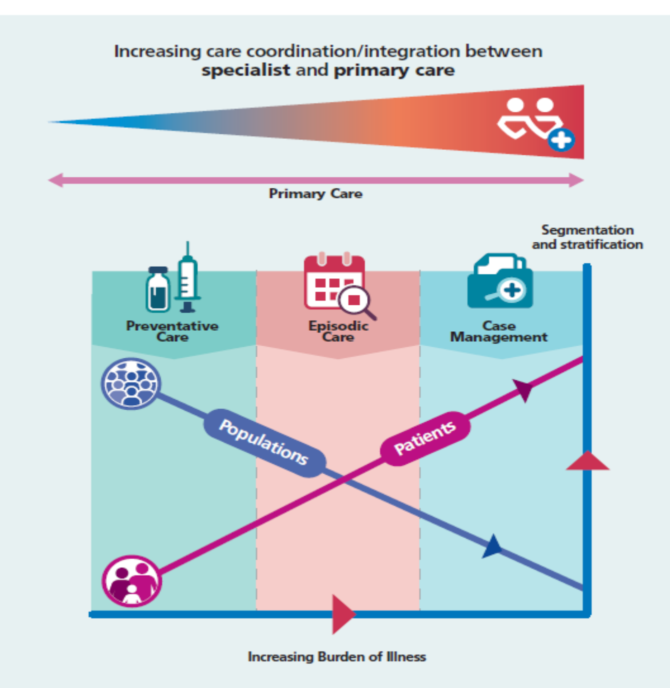


Figure 1 summarises our overarching clinical model. It describes the broad role of the ICS in promoting population health and managing individual illness. It demonstrates the critical role that stratified prevention interventions make, at a population level, to maintain and optimise general population health, as well as the increasing need to stratify smaller cohorts of patients, for individual case management, as multimorbidity increases. All of this is underpinned by the central role of primary care.

1.6 Our approach to developing this plan

Aligning to wider system partner's ambitions

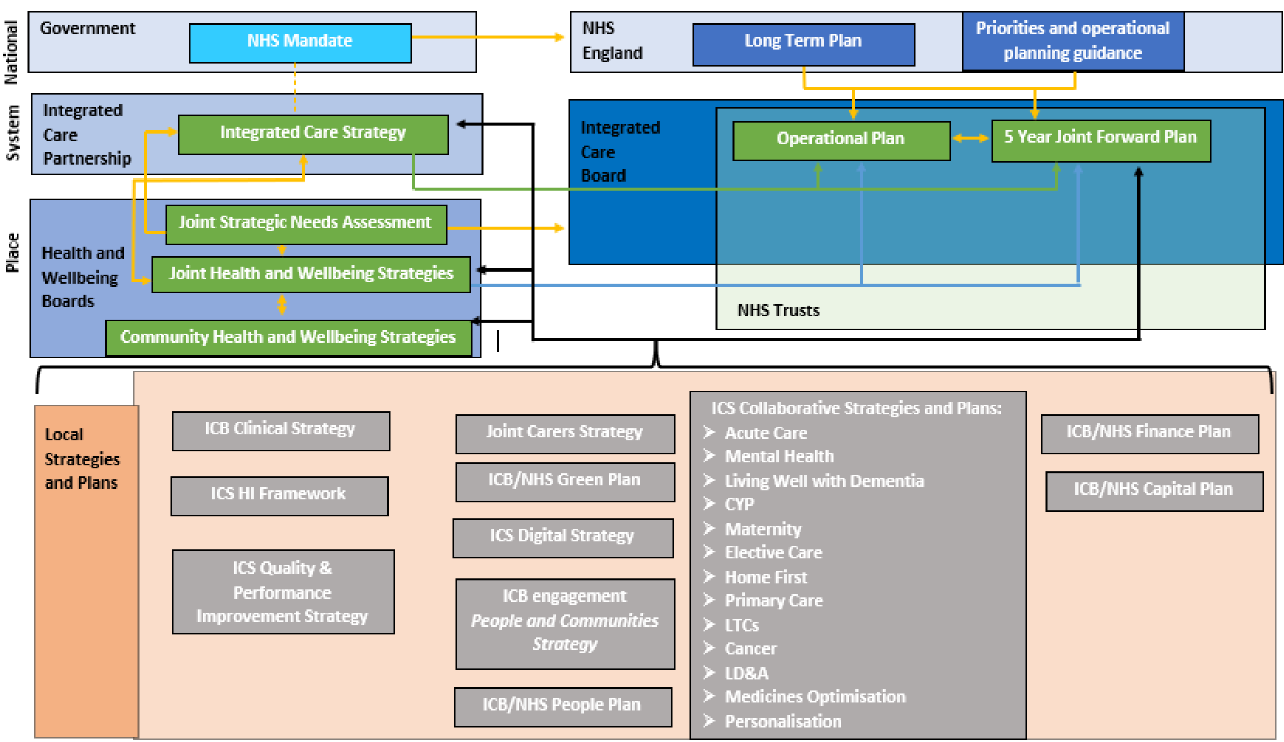
This Five-Year Plan is a shared delivery plan: for universal NHS commitments; for the ICB's commitments within our LLR Integrated Care Strategy; as well as for our commitments within the Council's Joint Health and Wellbeing Strategies. We have ensured that all key stakeholders, including Health and Wellbeing Boards, our NHS Trusts, Councils, primary care, Healthwatch, clinical leaders and NHS England have had the opportunity to influence the development of this Plan.

At the beginning of Chapter 3, we have included a summary table to demonstrate how this Plan (including the detailed local strategies and plans that underpin it – see Figure 2, below) takes account of partner's ambitions, as well as how our agreed LLR system-wide priorities are translated into deliverables

Reflecting universal NHS commitments and building on existing local strategies and plans

Figure x, below, demonstrates how this is the delivery Plan for universal NHS commitments, as well as our ICB local priorities and our system partner's ambitions. We have also ensured that this Plan ties together and presents a cohesive picture for delivery of our local clinical, enabling, financial and collaborative strategies and plans.

Figure 2: Relationship of our 5-yearfive year plan with other strategies and plans



Delivery focused

Chapter 3 (Delivery Plan) focusses on how we will deliver our commitments across the range of services and areas, over the coming years. We have been deliberately specific, ensuring that aims, actions and outcomes are evidence based and measurable in order that we can track our progress against what we said we would do.

1.7 How we have used insights and engagement to shape this plan

This Plan is underpinned by firm foundations of involvement, engagement and co-production with people and communities, over the past years. It has also been built on an inclusive learning culture, to understand the needs of our population and design services appropriate to those needs.

Local people's insights have informed this Plan

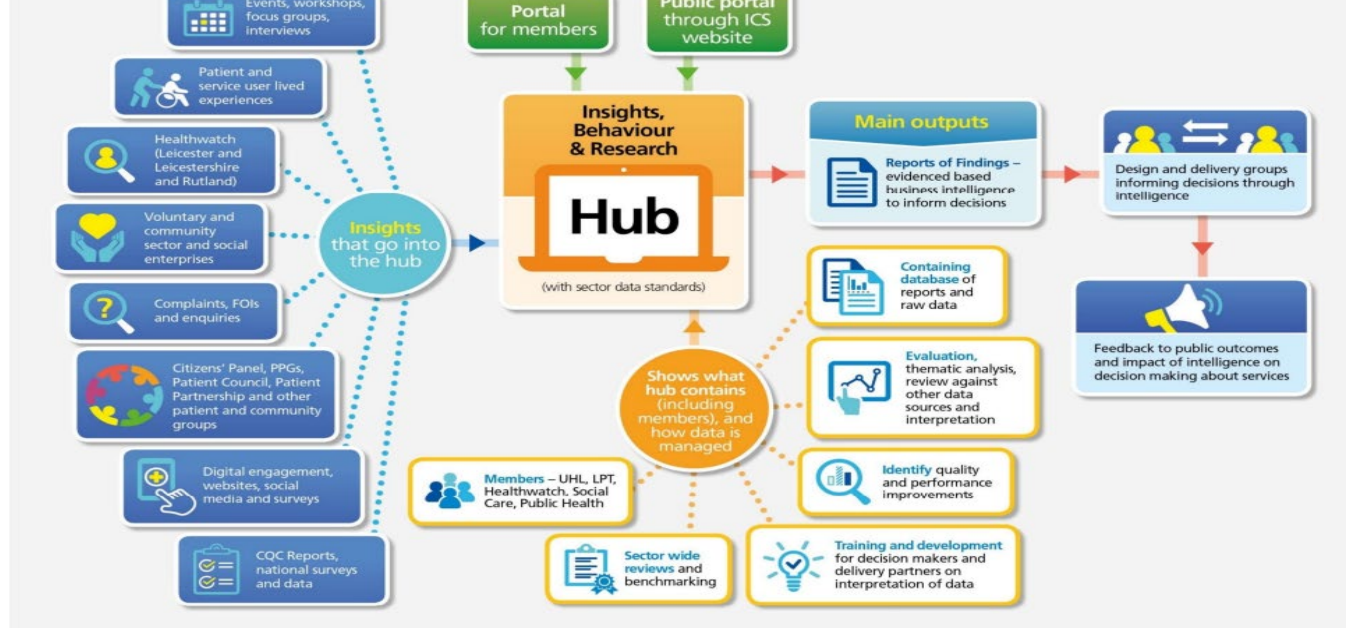
We have undertaken large-scale involvement projects, with local people, over the last 3 years. The insights and data from this work is evidenced and has informed the service-specific future arrangements within this Plan. These projects have seen quantitative and qualitative data gained from nearly 50,000 people including patients, service users, staff and carers, as well as seldom heard people and work with communities who represent people with protected characteristics.

Engagement and consultation, between 2020 and 2023, has included:

- Building Better Hospitals for the Future (2020, 5,675 people)
- Step Up to Great Mental Health (2021, 6,650 people)
- Covid-19 hesitancy engagement (2020, 4,094 people)
- Local primary care survey (2021, 5,483 people)
- National primary care survey (2022, 14,426)

In addition, numerous smaller insight projects undertaken by system partners and Healthwatch Leicester and Leicestershire and Healthwatch Rutland have influenced this Plan, as have the insights from the three consultation exercises undertaken by our councils in respect of their Joint Health and Wellbeing Strategies. Figure 3, below, summarises how we capture insights and how these are then used to support service improvement.

Figure 3: How engagement and insights inform the design and delivery of local health and care services



The Voluntary, Community and Social Enterprise Alliance (VCSE)

The VCSE Alliance aims to facilitate better partnership working between the ICB and the VCSE sector, as well as enhancing the role of the sector in strategy development and the design and delivery of integrated care.

The VCSE alliance:

- Encourages and enables the sector to work in a coordinated way;

- Provides the ICS with a single route of contact and engagement with the sector and links to communities; and
- Better positions the VCSE sector in the ICS and enables it to contribute to the design and delivery of integrated care and have a positive impact on heath priorities, support population groups and improve health equity.

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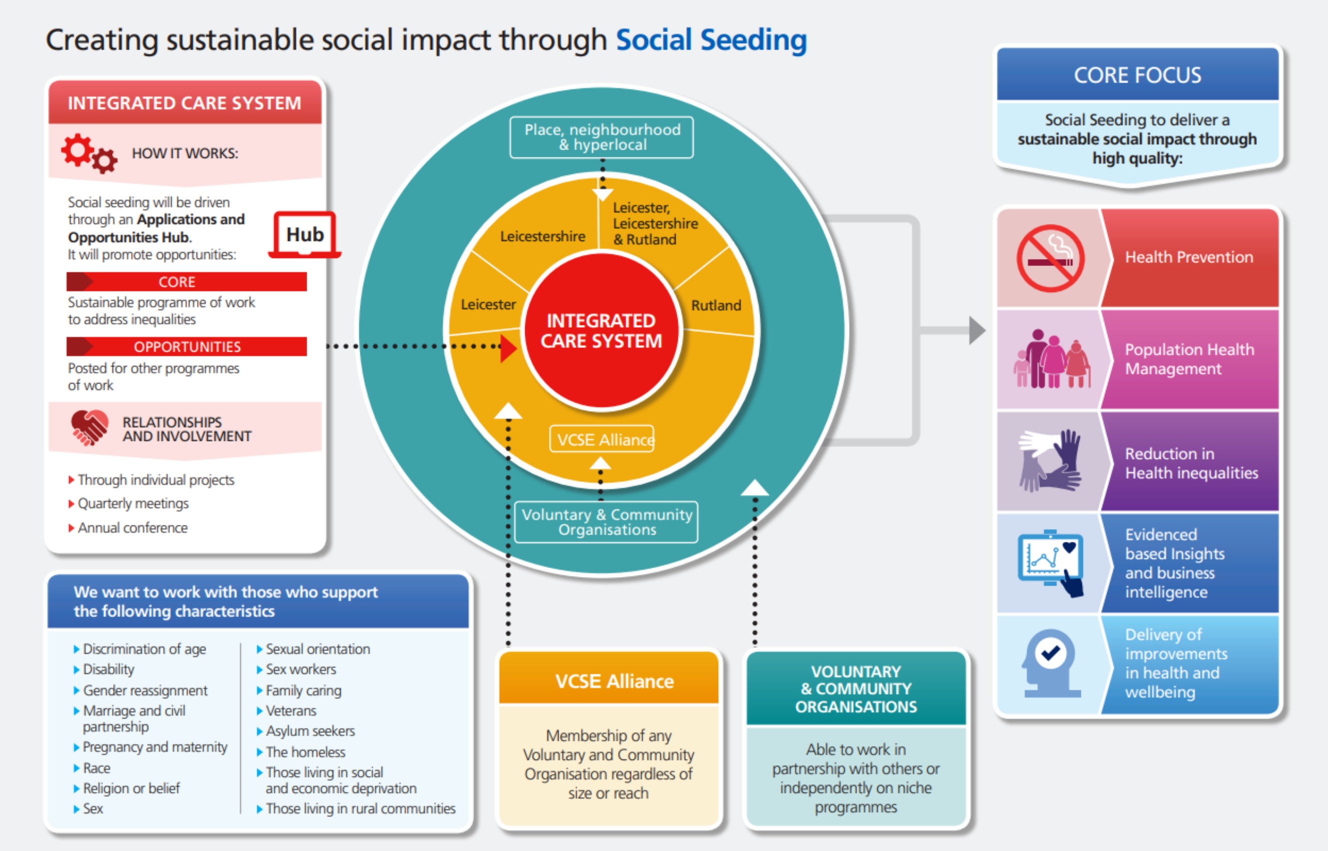
Figure 4, below, describes a co-designed model of how this diverse and creative sector are effectively involved in service redesign work, governance, system workforce, population health management and leadership and organisational development plans.

Figure 4: The LLR VCSE model

Leicester, Leicestershire and Rutland **Voluntary, Community and Social Enterprise Alliance**



Involving our stakeholders in validating this Plan

We wanted to validate our understanding of the insights collected, and gain assurance that these have influenced, not just specific parts of this Plan, but also the overall scope and direction of the Plan itself. To do this, we have implemented a comprehensive engagement process with key stakeholders, as well as with wider audiences, between May and June 2023, to gain their feedback on this Plan, before it is finalised. We will prepare and publish a summary of engagement findings, however, some of the feedback we received, and which resulted in changes to the Plan include:

- Stronger references to our role in supporting the Armed Forces Covenant;
- Incorporating measures that can be used to demonstrate success in delivering our Pledges;
- Acknowledgement of national and local NHS dental services issues and that we will produce a plan to address these, locally;
- Sharpening the interventions we will make and adjusting timelines to provide more focus on actions that need to be taken in the short-term; and
- Strengthening our prevention plans, including in respect of physical activity.

1.8 Statement of support from HWBs

Leicestershire County Council HWB

The HWB agrees that the Five-Year Plan takes account of the Leicestershire Health and Wellbeing Strategy

Leicester City Council HWB

The statement from Leicester City Council HWB is pending.

Rutland County Council HWB

The Rutland HWB agrees that the Five-Year Plan takes account of the Rutland Joint Health and Wellbeing Strategy

Chapter 2: Where we are now

In this chapter, we provide an overview of health and wellbeing in LLR, as well as a snapshot of our performance, our finances and workforce.

2.1 Overview of health and wellbeing

We highlight, here, key facts relating to the health and wellbeing of our population. We have produced a more detailed Overview of Health and Wellbeing in LLR document, and our council's Joint Strategic Needs Assessments and Joint Health and Wellbeing Strategies (see 1.1) contain detailed analysis of wellbeing and need.

Summary of deprivation

Figure 5 shows those areas of LLR where the population is in the most deprived 20%, nationally, as identified by the Index of Multiple Deprivation (IMD).

Figure 5: Most deprived neighbourhoods in LLR

Leicester, Leicestershire and Rutland

STP/ICS map showing neighbourhoods (LSOAs) in 2019 Index of Multiple Deprivation deciles. Dark blue is for the most deprived decile, light blue is for the second most deprived decile. Other deprivation deciles are left unshaded.

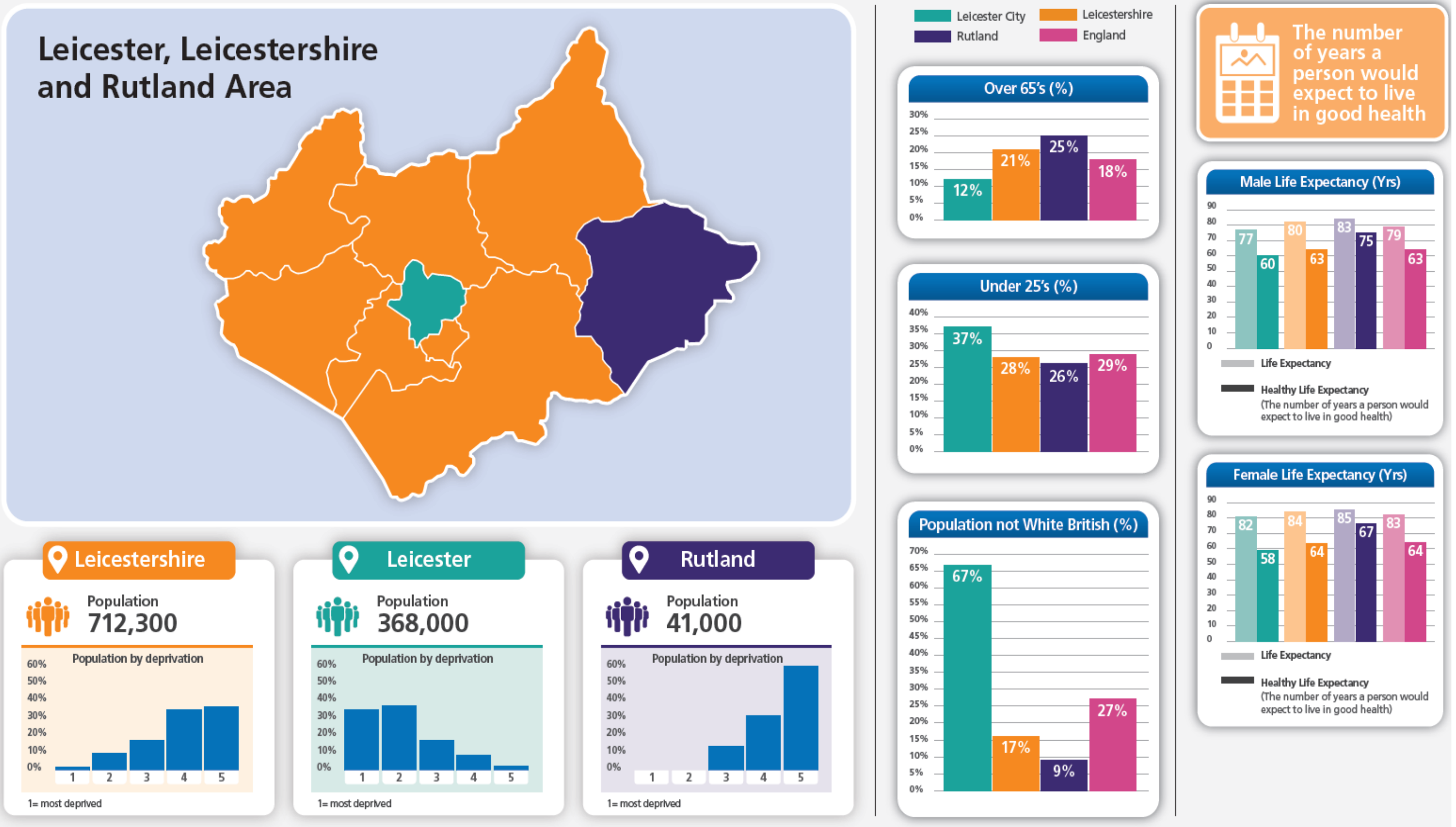
Interactive version can be viewed in tableau: https://tabanalytics.data.england.nhs.uk/#/site/viewpoint/views/PopDemo_CORE20/CORE20?:iid=1 (OKTA account required)

13% of our registered patients (153,284) live in the 20% most deprived neighbourhoods in England (see Table 2). 85.3% of those (130,794) live in Leicester, 14.6% of those (22,321) live in Leicestershire and 0.1% of those (169) live in Rutland.

Table2: LLR registered patients and those that live in the 20% most deprived areas in England

	Registered patients living in 20% most deprived areas in England	Total registered patients	% of total registered patients
Leicester	130,794	413,074	31.7%
Leicestershire	22,321	688,401	3.2%
Rutland	169	40,035	0.4%
Total for LLR	153,284	1,141,510	13%

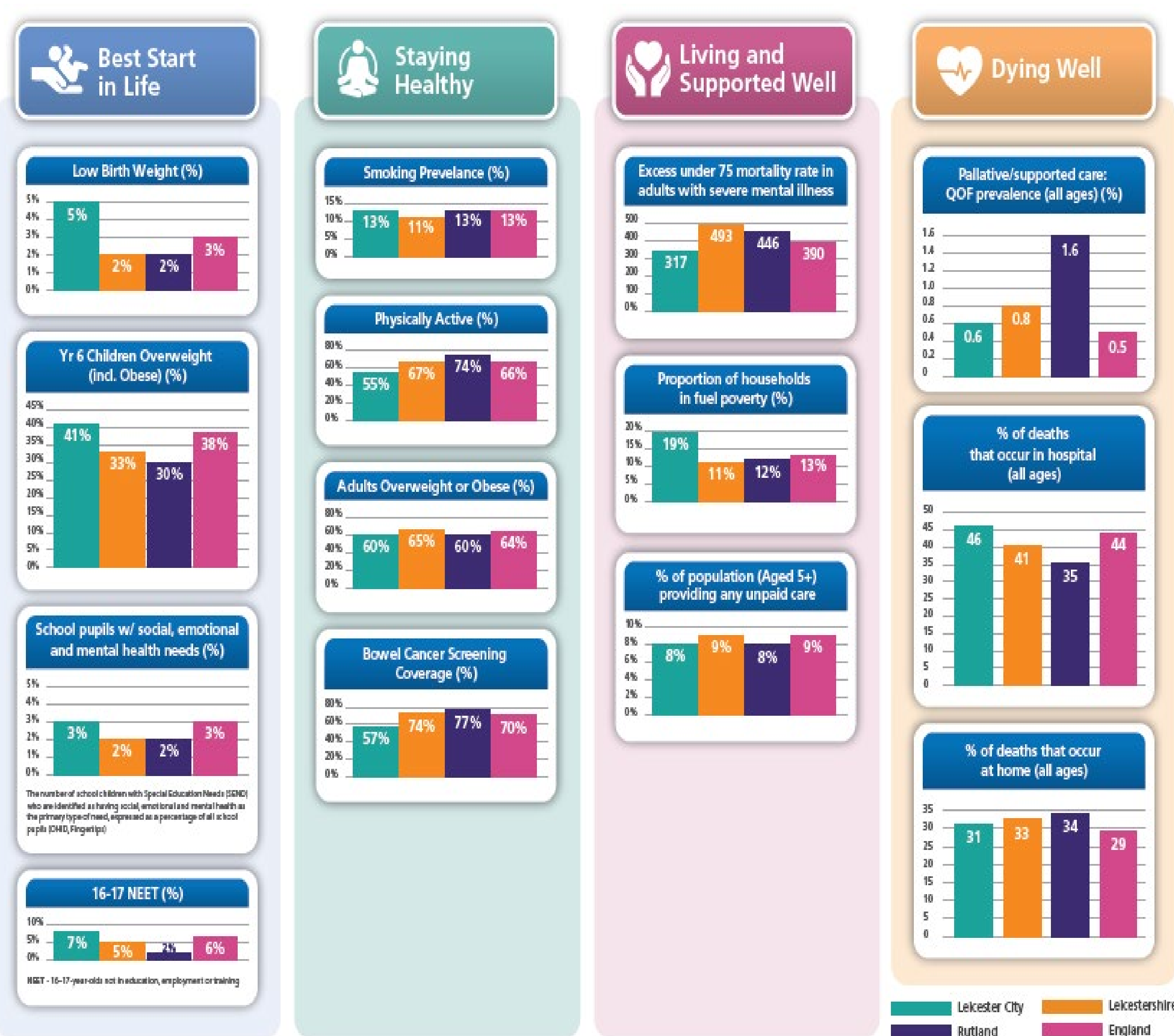
Summary of health and wellbeing facts and figures



This (right hand side) infographic describes the the number of years a person would expect to live in good health compared to their life expectancy. For example, a male living in leicester might expect to live (on average) for 77 years, of which 60 years would be in good health.

The above infographic describes deprivation across Leicestershire, Leicester and Rutland, in blocks from 1 to 5, with block 1 being the most deprived and block 5 being least deprived.

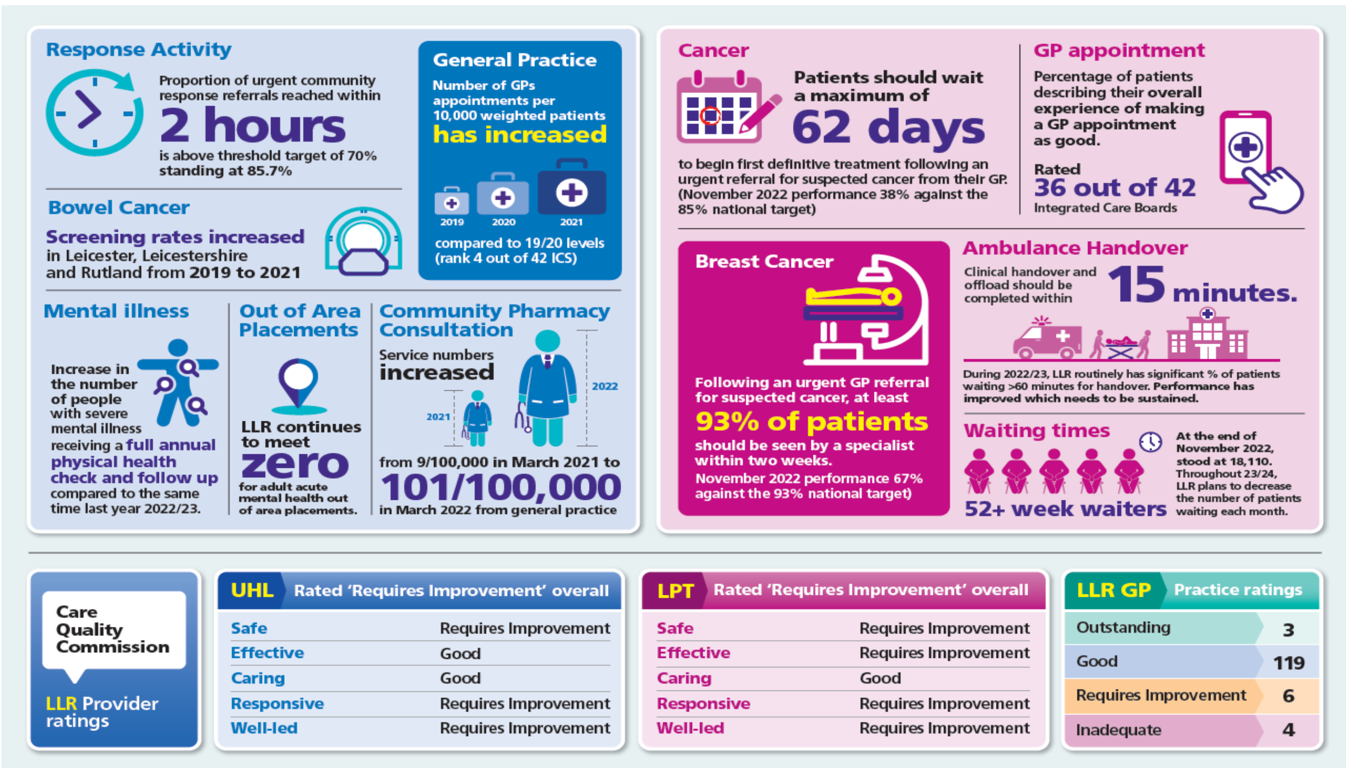
The infographic, below, describes how each of Leicester, Leicestershire and Rutland currently performs against key health and wellbeing indicators at each of the four-life course stage (see 1.4).



2.2 Our Performance

We highlight here some key areas where we are performing well and key areas where our performance needs to improve.

Our Performance and Quality



UHL	Rated 'Requires Improvement' overall
Safe	Requires Improvement
Effective	Good
Caring	Good
Responsive	Requires Improvement
Well-led	Requires Improvement

LPT	Rated 'Requires Improvement' overall
Safe	Requires Improvement
Effective	Requires Improvement
Caring	Good
Responsive	Requires Improvement
Well-led	Requires Improvement

LLR GP	Practice ratings
Outstanding	3
Good	119
Requires Improvement	6
Inadequate	4

2.3 Our Finances

Local and national context

We have a history of financial challenges, the causes of which are not unique to LLR.

These challenges must be addressed for us to become financially sustainable in the longer term. National and local pressures that impact on LLR finances include:

- current cost of living crisis across all service provision;
- cost inflation beyond funded levels;
- workforce shortages;
- intense pressures on urgent care and primary care;
- supply and demand challenges within social care;
- waiting lists at an unprecedented level;
- mental health services capacity;
- expectations on quality, access and better health and social care at a time of increased operational pressure; and
- an uncertain outlook with significant pressure across public finances

Our numbers

In recent history, LLR has incurred financial deficits (overspends) in each year. In 20/21 and 21/22, a combination of extra funding for Covid-19 and reduced elective care costs (as appointments and surgeries were cancelled) has enabled the system to achieve a break-even financial position.

In 22/23 we planned to break-even and ended the year with a deficit of £15m. We were unable to keep within our planned resources, despite utilising significant non-recurrent revenue streams and financial mitigations, for the following reasons:

- reduced funding
- increased pressure on urgent care;
- increased mental health need;
- elective waiting list recovery;
- recruitment to safer staffing models of care;
- high levels of inflation;
- agency staff costs; and
- lack of funding for social care manifesting impacting on out of hospital discharge pathways.

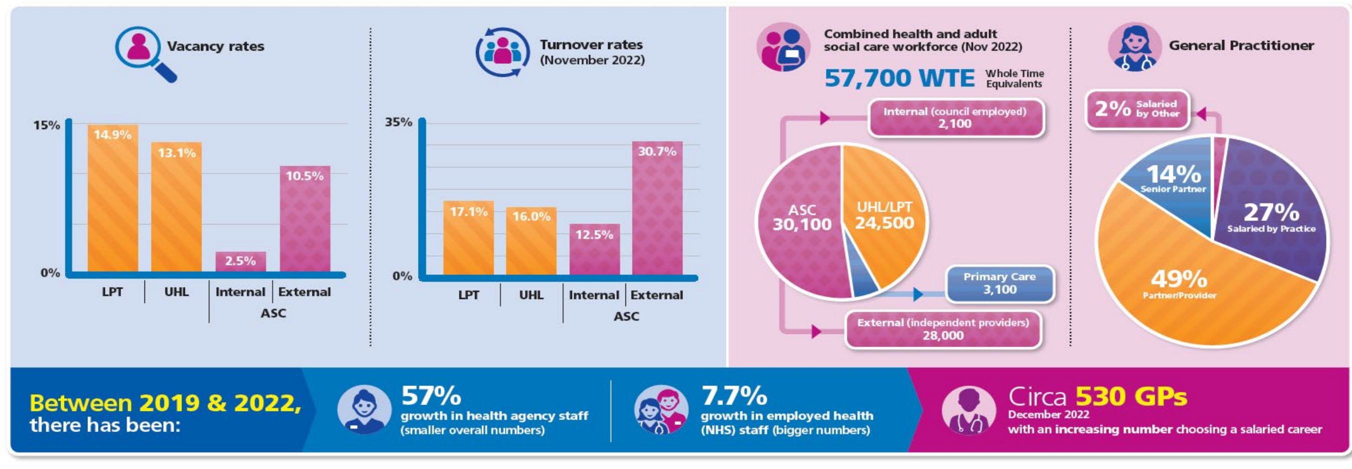
Due to the use of non-recurrent revenue streams and other non-recurrent financial benefits to support 22/23, we now face a much greater challenge in 23/24 and beyond. Our plan for 23/24 is to deliver a £10m deficit as a system, this includes an extremely challenging savings target of £131.5m which is equivalent to 6.4% of our system allocation.

Chapter 6, Our Finances, describes our plans to achieve longer-term financial sustainability.

2.4 Our People

Our people are our greatest asset, and we highlight below some key local workforce information and indicators. Chapter 7, Our People, considers our future people planning.

Our People



Chapter 3: Delivery Plan

Delivering a realistic and pragmatic transformative plan for LLR

Every part of our health and care system is facing a challenge like never before. We have emerged from the Covid-19 pandemic in a weaker state across the nation, with every system reporting severe pressures. Despite best efforts across the health and care, demand continues to outstrip capacity, leading to poorer access to care, poorer experience of care and poorer outcomes for local people. Whilst this is universally reported, research has shown a deeper impact on those who have faced historical inequity.

Insights from our staff and our communities tells us that we must focus on three key areas – making it easier to **access care** when it is needed, making it easier for our **teams to be able to deliver this care** in an effective and efficient manner and ensure this care will **deliver equitable outcomes** for local people.

We have notable examples of this focus being delivered in each of our places and neighbourhoods. This should give us confidence that it is possible to reimagine how we receive and deliver care to our communities; our challenge will be to grow these local initiatives into systematic models of care, whilst retaining a local focus at the heart of design and delivery.

In this Chapter, we describe how we begin that journey, by setting out a vision for an integrated system of care which allows enough flexibility to take the needs of our local communities into account but, at the same time, enables us to set and meet an equitable standard of care and outcomes for those we serve.

We know that we deliver the best outcomes when people, communities, clinicians, practitioners and local teams come together to tackle a challenge, no matter the size. The freedom to innovate, trial, assess, evaluate and re-align, (often in the face of significant pressure to simply put a *sticking plaster* solution in), has underpinned our most successful improvements across LLR. We must, therefore, continue to be brave, to support this evidence-based approach and enable our teams to work with our communities to reimagine service delivery at pace.

The subsequent sections within this Chapter focus on the interventions we intend to make, across key service areas, to deliver a truly integrated system of care. Table 3, below, demonstrates how this Plan translates our system-wide priorities, as well as partner's JHWSs into deliverables.

Table 3: Chapter 3 alignment with system priorities and partner ambitions

					This Plan Chapter 3: Delivery Plan:								
LLR System Priorities	**Integrated Care Strategy**	**Leicester JHWS**	**Rutland JHWS**	**Leics. JHWS**	**Prevention**	**Keeping people well**	**Access the right care**	**Integrated teams**	**Elective care**	**LD&A**	**Mental health**	**Children & Young People**	**Women's health**
Improving health equity	☑	☑	☑	☑	☑	☑	☑	☑	☑	☑	☑	☑	☑
Preventing illness and helping people to stay well	☑	☑	☑	☑	☑	☑	☑	☑	☑	☑	☑	☑	☑
Best start in life		☑	☑	☑	☑		☑	☑			☑	☑	☑
Living and supported well	☑	☑	☑	☑	☑	☑	☑	☑	☑	☑	☑	☑	☑
Dying well		☑	☑	☑		☑	☑	☑					
Championing integration	☑		☑		☑	☑	☑	☑	☑		☑		☑
Mental health		☑	☑	☑	☑	☑	☑	☑		☑	☑	☑	☑
Access to services	☑	☑	☑		☑	☑	☑	☑	☑	☑	☑	☑	☑
Our role as an '*Anchor*' organisation	☑		☑	☑									

3.1 Preventing illness

What do we mean by Prevention?

It's helpful to think of prevention as having three elements:

Primary (Prevent)
Reducing the risk factors that contribute towards ill health, for example, through clean air legislation or immunisation programmes (Primary prevention)

Secondary (Reduce) - Increasing the early detection and diagnosis of disease to achieve better outcomes; slow or reverse disease progression, for example, cancer screening programmes and targeted weight management services (Secondary prevention)

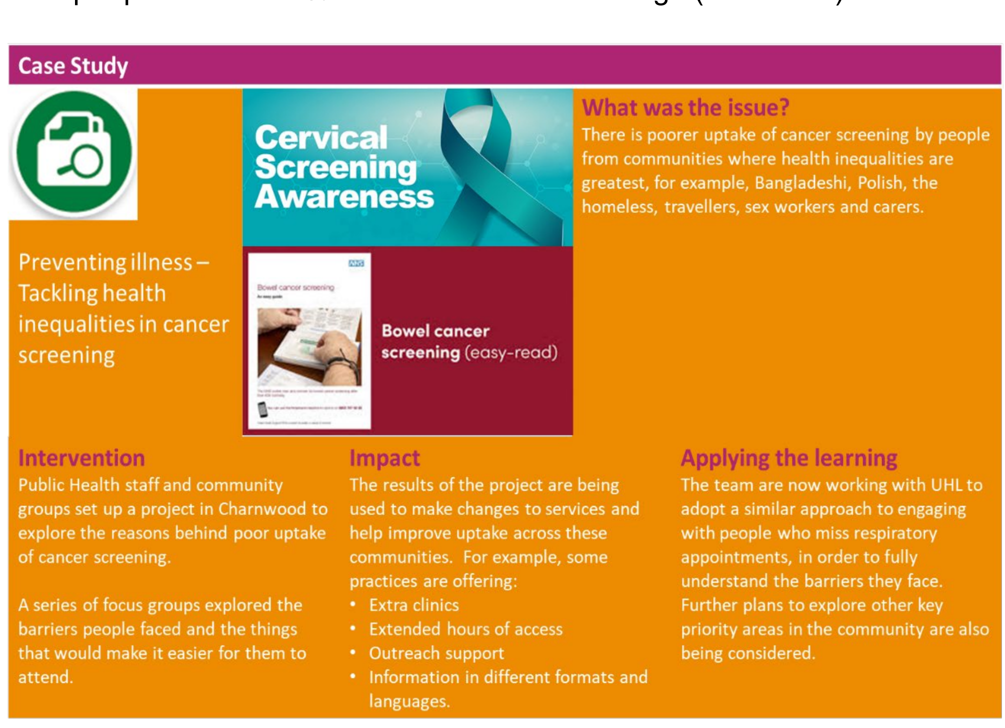
Tertiary (Delay) - Provide appropriate support and interventions for people living with long-term conditions, for example, stroke and cardiac rehabilitation programmes (Tertiary prevention)

Local context

Between 2017 and 2019, there were 3,734 preventable deaths in under 75 year-olds in LLR (the Office for Health Improvement & Disparities), an average of 1245 per year and 45% of all deaths in under 75 year olds. Cancer, cardiovascular disease and respiratory disorders are the three most common causes of local preventable deaths – all three are linked to the building blocks of health also known as the wider determinants of health. To have a healthy society, we need all of the right building blocks in place: stable jobs, good pay, quality housing and education. Missing and weakened building blocks disproportionately impact communities with the highest health inequities. For example, in Leicester, household incomes per person are 37% lower than the UK average (2018 data).

Our approach

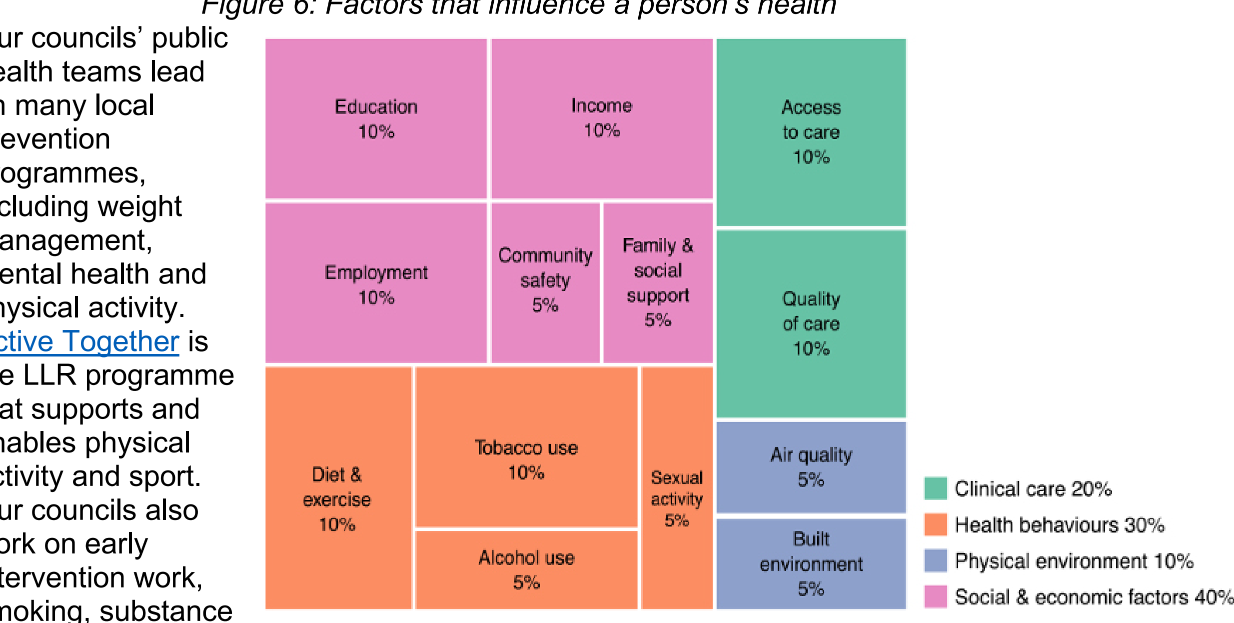
We plan to shift the dial toward focusing more on preventative services and interventions. Although our finances are challenged (see Chapter 6), we believe that more upstream investment in prevention is critical if we are to have an impact towards healthier lifestyles, effectively manage long term conditions and frailty (see 3.2) and improve health equity (see 4.1). It makes sense to intervene to keep people as healthy as possible for as long as possible. Furthermore, unless we make this change, our urgent and emergency care system (see 3.3) will never be large or efficient enough to cope with the numbers of older and increasingly unhealthy people.



The NHS as a local prevention Partner

Access to and the quality of healthcare accounts for about 20% of what influences a person's health. The other 80% is influenced by the physical environment, social and economic factors and a person's lifestyle choices (see Figure 6). Our NHS interventions complement the important role that individuals, communities, local government and national government play. The NHS can also play a major role in its local community through providing high quality employment across the full range of communities it serves, supporting a healthy workforce in a way that improves health equity, as well as supportive ways to help people into work through skills development. It also plays a big part in the local economy through procurement; housing, estates and land use; and sustainability. For instance, improving air quality through how organisations encourage staff to travel to work and the feasibility of using public transport to get there.

Figure 6: Factors that influence a person's health



Our councils' public health teams lead on many local prevention programmes, including weight management, mental health and physical activity. Active Together is the LLR programme that supports and enables physical activity and sport. Our councils also work on early intervention work, smoking, substance misuse and sexual health services.

Public health teams are also responsible for commissioning programmes such as 0-19 Healthy Child Programme including school nursing. Our councils also deliver many upstream prevention interventions to create an environment that supports community wellbeing, including those that tackle the wider determinants of health.

More information regarding our prevention work can be found in the Joint Health and Wellbeing Strategies and Community Health and Wellbeing Plans (see 1.1), as well as in Better Care for All, our health inequalities framework (see 4.1).

What people have told us matters to them
People tell us that they want to be empowered to play a greater role in caring for themselves and preventing ill-health, so they can make informed decisions that improve their health and wellbeing. People need better information, explanation and an understanding of their condition based on a foundation of good relationships between people and health and care staff, trust and empathy, tailored to acknowledge and appreciate cultural backgrounds and traditions. They need to be signposted to appropriate support services and local community groups. Carers told us that they need consistent information and be involved and better enabled to care for their loved ones, preventing deterioration and further ill-health.

Summary of key interventions

Responding to the local context, business intelligence and insights from people, table 4 below summarises the key system-wide interventions we intend to make, over the coming years that will

have the greatest impact on prevention and improving health equity, and for which the local NHS is the lead Partner for delivery.

Specific interventions relating to, for example, keeping people well, mental health or children and young people, can be found within those sections of this Chapter.

A Delivery Plan, underpinning these interventions, can be found at Annex 1 to this Plan. Detailed 2023/24 actions can be found in the LLR ICB 2023/24 Operational Plan.

Table 4: Summary of key prevention interventions we will make

Intervention	Timeline
Strategic and infrastructure interventions	
1. Redirect a proportion of annual growth allocation monies to prevention	24/25
2. Explore, with our Partners, the potential benefits to be gained from developing an LLR system-wide prevention strategy	23/24
3. Expand Healthy Conversation Skills training and embed in all organisations (Making Every Contact Count Plus) as a key prevention enabler	23/24 to 27/28
4. Capitalise on our dynamic research LLR community to maximise and embed benefits of research into prevention	23/24 to 27/28
Risk factor interventions	
5. Alcohol – Establishment of Alcohol Care Teams, providing an in-reach service. Ongoing development, monitoring, expansion, oversight and service improvement	23/24 to 27/28
6. Smoking – Deliver tobacco dependence identification and treatment services in secondary care, including across inpatient, maternity and mental health services	23/24 to 27/28
7. Obesity - Supporting people to access the NHS Digital Weight Management Programme	23/24 to 27/28
8. Diabetes - Supporting people at risk of type two diabetes to access the NHS Diabetes Prevention Programme and expand provision of diabetes structured education, including through digital and online tools	23/24 to 27/28
9. Cardiovascular disease and Respiratory - Improve detection and management of atrial fibrillation, hypertension and high cholesterol	23/24 to 27/28
10. Implement a focussed tuberculosis programme aimed at eradicating TB in LLR	23/24

How the above interventions will contribute to improving health equity
We know that unhealthy lifestyle choices tend to cluster and compound one another, and that these lifestyle choices tend to cluster more often in people from lower socio-economic groups. (See, for example, Meader, N., King, K., Moe-Byrne, T. et al. A systematic review on the clustering and co-occurrence of multiple risk behaviours. BMC Public Health 16, 657 (2016)). By (a) Focusing on co-producing accessible and culturally effective services to address the key risky lifestyle choices and (b) proportionately providing those services according to population need, we will directly address the main proximate causes of variation in life expectancy and healthy life expectancy seen between the most and least affluent parts of LLR.

3.2 Keeping people well

Effectively managing long term conditions, multimorbidity and frailty

Local context

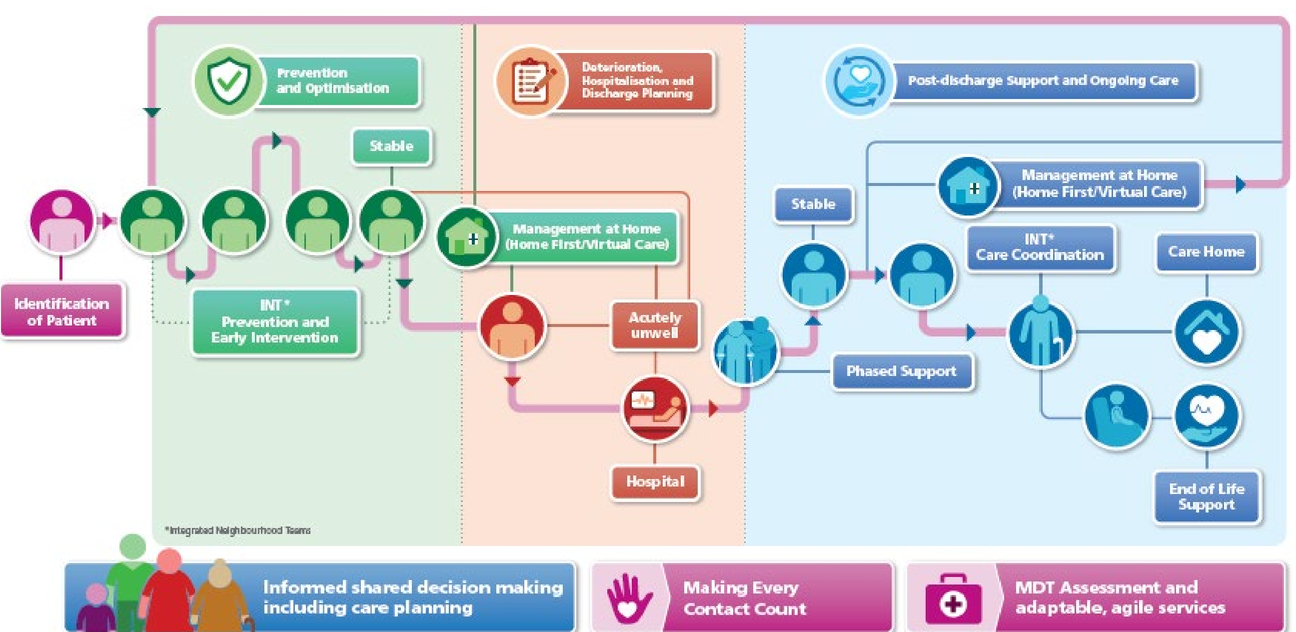
Much of the difference in life expectancy and healthy life expectancy, both between communities within LLR (due to health inequity) and when we compare LLR to other places and regions, occurs because of the prevalence, growth, and impact of long-term conditions and frailty.

Population Health Management approach

Our approach to keeping people well focuses on using a Population Health Management approach (see 4.2) to **case-find and diagnose people (including older people) with a long-term condition early**, optimise their care to delay further deterioration or development of further disease and ensure that they, and their carer(s) are supported in the right place with the right care in a crisis (see Figure 7).

Figure 7: Our care plan for people with long term conditions, multimorbidity and frailty

Integrated System of Care for People with frailty or Multimorbidity



Effectively managing multimorbidity and frailty

We know from our local insights that once a person develops more than a single long-term condition, the care they receive can become fragmented as different specialist care professionals look after different diseases. People with multimorbidity, including older people and their carer(s), have told us that they want to be looked after by the same health and care professionals with continuity where possible.

We will deliver a **structured and holistic care plan for people with multimorbidity and/or frailty,** covering a range of interventions, provided in a local care setting, where possible, with the person's

named GP supported by a care coordination function. This will be a pre-cursor to the launch of the **proactive care service** through primary care networks in the next few years.

The proactive care service will include, for example, structured medication reviews, care planning, assessment for wider needs such as assistive technology, support for remote monitoring, personalised care packages and a crisis plan. The service will integrate the proactive and reactive offers of support across health, care and wider community services, taking account of the needs of the person's carer(s). Whilst people may be identified as potentially suitable through the risk stratification process, the person's GP will retain clinical judgement about final inclusion in this cohort.

We are reviewing our end-of-life strategy to ensure that people have a personalised and comfortable end-of-life with appropriate support to carers and families.

This service will be available for any person with five or more long term conditions or those with a clinical frailty score of 7.

More recently, primary care networks have been resourced to provide support to this cohort of patients in a comparable manner. Wrapping this up into one framework will support our providers to deliver care and our patients to understand what support is available to them in a holistic way.

This focus on structured, check-listed care is not new; simply a way to support people to access preventative care earlier and to ensure that they, and their carer(s)/support network, know what to do when a crisis occurs.

What people have told us matters to them
People living with long term conditions want to be able to look after themselves, where possible, but also know that support exists for them, when they need it. People are anxious when they first request help, and they can experience delays in receiving an initial assessment or diagnosis, including those with a mental health condition or autism. People and family carers need improved, appropriate and accessible information, support and advice throughout the illness, from a trusted source and to develop a relationship with health and care professionals to build confidence about caring for themselves. They also need professionals to have more knowledge about their condition and a greater understanding of the impact of their illnesses on their carers, families and communities.

Summary of key interventions

Responding to the local context, business intelligence and insights from people, table 5 below summarises the key interventions we intend to make over the coming years.

A Delivery Plan underpinning these interventions can be found at Annex 1 to this Plan. Detailed 2023/24 actions can be found in the LLR ICB 2023/24 Operational Plan.

Table 5: Summary of key interventions we will make to keep people well

Intervention	Timeline
With a focus on improving health equity:	
1. Undertake modelling to understand the qualitative and spend shifts that would result from delivering more up-stream evidence-based treatments	23/24
2. Drive up primary care identification of people with diseases (and their carers) to expected prevalence levels	23/24 & 24/25
3. Improve disease management in Primary care	23/24 & 24/25
4. Expand self-management and self-care programmes	23/24 & 24/25
5. Implement a proactive care framework	23/24 to 27/28

Successful implementation of 1 to 5, above, will allow us to: 6. Reduce the prevalence of an initial long-term condition leading to multimorbidity 7. Begin to slow the rate of increase in the incidence of long-term conditions	 From 27/28 From 27/28

How the above interventions will contribute to improving health equity
"The burden of non-communicable diseases reduces both the life expectancy and healthy life expectancy of adults across England, disproportionally affecting people by age, gender, ethnicity and socio-economic status. This is driven in part by the high and unequal prevalence of morbidity and underlying risk factors among the population". Research and analysis Annex C: data on the distribution, determinants and burden of non-communicable diseases in England OHID December 2021. The interventions described above to improve diagnosis and management of chronic disease will be undertaken proportionate to population need – recognising that the barriers to living successfully with chronic disease are greater for some groups than for others. Proportionately allocating resources to those with the greatest need will ensure that, as we improve the health of all our people, nobody is left behind.

3.3 Right care, right time, right place

Access to same-day health and care in our communities – an overview

People tell us that access to most care, particularly same-day care, is challenging, complex and frustrating, with the easiest access point at times being the Emergency Department. Some of our primary and community teams tell us of their frustration of having to refer patients to a hospital because they do not have access to the right diagnostics or referral rights to a particular service, leading to a poor patient experience of care. Our emergency department teams say that it is, sometimes less time-consuming to admit a patient than to find the right community service for their patient, especially when these services are "full". Our ward teams describe their difficulties in preparing patients for discharge and our social care teams regularly talk about their frustration in discharging patients onto a sub-optimal pathway, impacting on their experience of delivering care and the patient's longer-term outcomes.

Every part of our urgent care pathway is under constant pressure; demand outstrips capacity, resulting in patients often attempting to access care through multiple channels across the traditional boundaries of general practice, community based urgent care centres and/or acute services.

Our ambition is to break down these siloed services and create an integrated same-day access service based on local needs, an expanded and integrated care system outside of hospital settings and a system-wide discharge hub, enabling people to be seen in the right place at the right time. This will not only improve access to care across LLR, it will also allow us to consider local needs within communities, adapting to meet neighbourhood needs as we learn.

This overarching system of care will be made up of a set of integrated and seamlessly interlinked triage functions, with a clinical navigator directing and redirecting patients to the most appropriate care setting with the most appropriate clinician onto the right care pathway. This will be supported by a local 'directory of services,' accessible 24 hours a day, seven days a week to all access points, outlining the appropriate service based on the need described.

This approach will enable us to provide systematic right care at the right time in the right place, with a strong focus on the needs of local communities.

Primary Care

A new strategy for primary care (General Practice)

The gap between what people and communities want and need from primary care and what we are currently able to deliver is simply too big. To bridge this gap, we have developed a Primary Care Strategy to translate our vision for primary care into a framework for action that provides a mechanism to assure delivery of national and local requirements, including those set out by NHS England in the Delivery Plan for Recovering Access to Primary Care. Our Primary Care Strategy will 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 present in primary care; and
- New models of care driven by changing public expectations, patient need and a focus on improving population health.

The Strategy will deliver our ambitions for primary care, these being:

- Breaking down traditional barriers and eradicating the historic divide in health and social care;
- Building on our collaborations; working with people, staff, partners and communities to understand what we need to do differently, working with them as equal partners to shape, design and deliver care;
- Improving health equity, closing the gap in variation and consistency of services to enhance people's experience;
- Developing a model of care that is fully integrated, multi-disciplinary and responsive to the specific needs of the population, focussed on prevention, self-care and shared health outcomes;
- Providing timely access to anticipatory and same day urgent care when it is needed;
- Ensure urgent care is safe, coherent, streamlined, locally accessible and a convenient alternative to A&E for patients who don't need hospital care;
- Make mental health and wellbeing services an integral part of primary care;
- Implement new models of care for key patient groups, including older people, the vulnerable and those with long term conditions;
- Give due regard to the Armed Forces Covenant, engaging with, enabling access and meeting the needs of the armed forces community
- Build services around people, in their neighbourhoods, closer to home;
- Empower people to play an active role in managing their own health, supporting the prevention and self-care agenda;
- Grow our multi-disciplinary primary care workforce, attracting, retaining, and developing staff, ensuring they are valued and supported through a positive culture;
- Make best use of our limited resources, providing care in the right place, in the right way, at the right time; freeing up our clinicians to care for the most acutely unwell; and
- Make primary care services available and accessible to our communities in local, fit for purpose premises which can offer a range of services and facilitate integrated teams.

Pharmacy, Optometry and Dental services (PODs)

In April 2023, NHS England delegated commissioning responsibilities for Pharmacy, Optometry, Dental services (PODs) and Secondary Care Dental services to our ICB. Additionally, in April 2024, NHS England will delegate commissioning responsibilities for a number of specialised acute and pharmacy services.

Locally, we are operating with our neighbouring East Midlands ICBs through a joint working arrangement, led by the East Midlands Joint Committee. This provides the platform for multi-ICB strategic planning and decision-making.

Primary care is the front door of the NHS, located in our towns, villages, high streets and communities. Increased autonomy at a local level will permit ICBs to plan and deliver more joined up primary care services that are locally led and locally responsive. This will enable us to deliver better health and care so that people can receive high quality services that are planned and delivered where people need them.

We recognise that local people are currently unable to register as an NHS dental patient. Notwithstanding the national contractual context, we will develop a plan, during 23/24, to address access to local NHS dental services.

Furthermore, during 2023/24, we will:

- **Work with our partners** across Community Pharmacy Leicestershire and Rutland, Local Dental Committee (LDC) and the Local Optometric Committee (LOC) to fully engage, collaborate, scope, plan and capitalise on the opportunities delegation permits.
- **Build networks** across different elements of primary care to work towards more holistic local primary care provision. We will do this by exploring opportunities to strengthen cross-sector working and synergy, for example between General Practice and Community Pharmacy via the Community Pharmacist Consultation Service (CPCS).
- **Build relationships** across both the region and system to increase capacity and capability and develop effective collaboration between colleagues at all levels to support with delegated responsibilities.
- Explore opportunities to **improve health equity** through a system lens, for example, links between oral health, deprivation and health inequalities.
- Opportunities to **review and revamp entire pathways** across multiple same sector providers, for example, ophthalmology with better coordination across primary care, secondary care and the independent sector.
- Explore opportunities for **local transformation**. Whilst recognising that many areas of transformation are restricted by national contracts, there may be opportunities for local transformation especially around workforce (for example opportunities for cross-sector working between primary and secondary dental care) and service provision (for example, out of hours emergency dental care and secondary care infrastructure).
- Define **system-wide workforce transformation** and new ways of working through the development of new operating models and removal of potential barriers including definition of the place and neighbourhood offers.
- Advise and influence an agreed approach to the **clinical and quality ICS priorities and workforce strategy**. This includes supporting the employment and deployment of staff to facilitate movement of staff and develop skills needed to deliver new models of care.
- Work collectively to manage the delegation of **specialised acute and pharmacy services.**
- Collectively produce a robust plan for the **transformation of POD services** for 2024/25 onwards.

Accessing same-day urgent care

People will access services through a range of channels to suit them; NHS 111 online, NHS 111 telephony, a neighbourhood contact centre, local GP practice telephony or the NHS app. People will be signposted to the most appropriate care setting with the most appropriate clinician, for example, pharmacists, GP's, nurses, paramedics and mental health practitioners.

Where self-care is most appropriate, advice will be given, where needed, through a range of channels. If same-day access is needed, an appointment will be booked with the appropriate professional(s) in their community. This could be with pharmacy services, paramedics, nurses, eye care services, mental health services, social prescribers, GP's or straight into community diagnostic services such as x-ray or minor injury. For our armed forces community, we begin piloting a single point of contact during 2023/24.

Where the need is more for planned care and not for same-day care, people will be offered an appointment as needed with the right professional or service.

Where capacity is not available in general practice or wider primary care services, people will be referred into the right services within our walk-in/booked service sites in each place and neighbourhood, such as urgent treatment centres.

Streamlining access in this way will ensure people get access to the right care faster, releasing time for clinical expertise to support those people with long term conditions, older people or those living with frailty, who benefit most from continuity of care.

Accessing same-day community care

People requiring same-day care that cannot be provided in the above services will be referred on to our **LLR Urgent Care Coordination Hub**. From here, services such as our 2-hour health and social care crisis response services, immediate mental health support, access to a virtual ward, physical ward or palliative care support will be arranged with the person and/or their carer/support.

Case Study

Right care, Right time, Right place – Pre transfer clinical discussions

What was the issue?

LLR has a growing population of significantly frail older people living in long-term residential care, as well as in the community. These people may have cognitive and functional impairment, with underlying complex co-morbidity and it is important to minimise admission into hospital.

Intervention

A clinically-led pilot scheme for pre-transfer clinical discussion and assessment (PTCDA) was introduced on 31 March 2020, bringing together system partners from across primary care, community care, secondary care, ambulance service and social care personnel, all working together in new ways to promote both an effective community response and to avoid assessment duplication.

This would often entail a swift clinical discussion with a consultant geriatrician or geriatric emergency medicine consultant for supportive decision-making around hospital admission and exploring safer alternatives that might entail community-led work with other partners.

Impact

- Integrated working has upskilled the knowledge of frailty and end-of-life care, resulting in a significant decrease in the risks posed to care home residents and older people living in the community by hospitalisation.
- It is estimated that the pilot has so far led to the avoidance of 577 hospital admissions, 2,885 bed days and 730 ambulance journeys.
- The collective financial savings of the PTCDA pilot scheme to date total approx. £400k.
- Working closely as a team has created a culture of respect that has helped to reduce the duplication of assessments, benefitting both patients and staff.

Applying the learning

The provision of enhanced community assessment bundles, as an alternative to hospital admission, is often the preferred option for people, their carers and families.

The PTCDA pilot can now be accessed by any community-based clinician who is considering admitting a person with significant frailty/complex comorbidity, whether from a care home or their own home. This includes East Midlands Ambulance Service (EMAS) paramedics and technicians, general practitioners and other practice-based clinicians.

The Hub will access both system-wide services, such as virtual wards, as well as localised service provision within each place and neighbourhood.

The hub will comprise of clinical and practitioner teams, covering physical and mental health, with a strong focus on ensuring the contact concludes with the person in the right care setting.

To enable this, we will **expand community services** such as virtual wards, our 2-hour health and social care crisis response services, our step-up intermediate care offer and our urgent treatment centres to ensure capacity is available in these settings of care. Alongside this, we will expand our **community diagnostic offer,** based on local population needs, ensuring that access is equitable across LLR.

Accessing same-day acute care

People requiring acute care will also be referred through to the right acute care service, following a digitally enabled clinician-to-clinician conversation, accessed through the LLR Urgent Care Coordination Hub. This could be via an ambulance to same-day emergency care services or straight into an acute bedded service, as appropriate.

People who call 999 and do not present with an immediate, life-threatening need or require emergency care, will also be navigated to the right care through the Hub.

If people access walk-in services, such as general practice, an urgent treatment centre or A&E, without being navigated to that service prior to arrival, we will apply the same clinical triage function through our **primary care front door service**. This way, people become clearer on the right service for them, and those who need to be seen in those services, are seen quicker. As exceptions to this approach arise, clinical advice will always be followed.

By signposting people in this manner, we know we can manage demand across primary, community and acute care, make it as convenient as possible for people and their carers and make delivering care a better experience for our teams. This will enable us to deliver a service responsive to people's needs, delivering care in the right place and at the right time.

Expanding our discharge capacity across health and care

We know that some people remain in hospital for longer than necessary. This is not good for their outcomes or their independence. To tackle this, we will ensure that everyone admitted to an inpatient service will have an estimated discharge date and that joined up discharge planning will support discharge in a timely manner.

Case Study

Right care,
Right time,
Right place
– Facilitating hospital discharge

What was the issue?
An 84 year old person was admitted to the Leicester Royal Infirmary following a Stroke. Following recovery, they were moved to a Community Hospital to complete rehabilitation goals. Following assessment by an Occupational Therapist, it was found that there was no space in their home for a hospital bed, hoist, and equipment due a cluttered environment.

Intervention
The Lightbulb Project, hosted at Blaby Council, brings partners together to meet people's health needs inside their homes, for example, installing equipment such as shower chairs and offering energy advice.
The hospital enablement team coordinated a meeting with the Lightbulb project and the person's family, and an agreement was reached on clearance of the hallway and lounge, which happened within a week.

Impact
This enabled hospital equipment to be delivered, along with a specialist chair, and the person was discharged home with a package of care.
The intervention costs were much less than the cost of a hospital bed or a residential placement.

Applying the learning
In 2022/23, the Lightbulb Project helped over 900 people who were being discharged across mental health and acute hospitals.

Firstly, those people who can leave hospital, with no further care needs, will leave in a safe and timely manner. This will involve all our partners within LLR adhering to best practice guidelines for discharge, ensuring that this cohort of people, including older people, is safely discharged in a timely manner, ensuring effective co-ordination and communication with carers and families.

The second cohort of people are those requiring some form of onward care after leaving hospital. These people will be referred into the **LLR Integrated Discharge Hub**, where a group of multi-professional health and care teams will be tasked with ensuring people are discharged in a safe and timely manner, either to their home or to a place in which long-term care decisions can be made with rehabilitation and recovery support, again, ensuring effective co-ordination and communication with carers and families.

We recognise that the current intermediate care offer needs to evolve to support this process. People will be provided with an integrated **intermediate care** offer, designed to help them move from hospital into the right care setting, for example, this could involve domiciliary services, therapy services or home-based reablement. This will be supported by growing our local social care workforce in each of our places and neighbourhoods.

The core of this system of care will be that each of the individual functions act as part of an **integrated system of care**. Our ethos across each of these pathways will be 'right place, right time, right care,'

regardless of which organisation or service the person has accessed. This, and the connections between each service, will be vital to success.

Local evidence base

We have been trialling this system throughout the winter of 2022/23, with positive experiences reported by patients and staff delivering the services.

Some of our general practices have been trialling the use of cloud-based telephony, enabling call waiting times to be reduced significantly and patients navigated efficiently and effectively to the right service.

Northwest Leicestershire Primary Care Network have been navigating patients calling their general practices to their Community Pharmacy Service, freeing up significant GP time for those with more serious needs. People report a highly efficient service and practice staff appreciate the space this creates for other patient cohorts.

At a system level, we have piloted an unscheduled care hub, comprising of multi-professional staff groups who are navigating people, who have originally called 999, to the right place at the right time. 85% of people have been safely navigated to the right care, freeing up ambulance teams and supporting patients in their own homes.

Our central access point for mental health has been triaging and navigating patients to the right mental health service since the Covid-19 pandemic, enabling acute services to be freed up to support those with immediate mental health support. This supports people to avoid the emergency department and access the right care, quickly.

The emergency department, working with our community and primary care providers, have been triaging people at the front door of the department. Those with non-emergency needs are offered a booked appointment at one of our community sites; this means people are treated quickly and safely in an alternative setting and frees up capacity within the emergency department for more serious interventions. This is enabling between 30 and 60 people per day to be seen outside of A&E.

Investing in our social care workforce throughout the winter of 2022/23 has seen a marked increase in staff retention rates across our three places and has enabled hundreds of hours of additional care to be delivered in local settings.

What will this deliver?

Based on the above, if we scale our offer of the system of care described, we expect to see clear improvement against a range of measures, qualitative and quantitative:

- People should report easier access to a range of primary care services; triaged and booked an appointment suitable to their needs in the right timeframe;
- We should see an increase in use of alternative channels, such as NHS 111 / online and the NHS app to access services;
- We should see an increase in localised, personalised care being delivered by a multi-agency, multi-professional team with coordinated continuity of care for the patient and their carer/family. We should see a decrease in presentations to the emergency department and an overall decrease in GP contacts for this cohort of people;
- We should see less people accessing or being referred to multiple access points before a definitive decision, resulting in an effective and efficient experience of care for them and their carer/family;
- More equitable service across the 24-hour period; with local care being provided by local services based on local need, increasing equity of access and in a longer term, equity of outcomes; and
- People should see better longer-term outcomes from the care they receive, as they would be discharged in a safe and timely manner.

We will work at system, place and neighbourhood level to design and implement this model of care, tailored to each community. Deliverables against agreed baselines will also be agreed and monitored to ensure efficacy of service and of experience.

What people have told us matters to them
People tell us that they are frustrated about not being able to make appointments easily and in a timely way. Their GP is seen as vitally important. Often, people want 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 then devise a treatment pathway and provide advice about their condition – many people, and their carers, see this as the gateway to them being able to look after their own health more effectively. People and their carers experience 'story telling fatigue', having to repeat information about their health and treatment to each healthcare professional they encounter. People tell us that they need more care closer to home to improve the problems experienced by wider access issues, including travel and transport. However, people and their carers tell us that providing care at home can feel like waiting for the next crisis to happen, if it is done without appropriate support and services being in place, which involves family, carers and community. Many people want care at home to be more appreciative of emotional and cultural issues through trust and empathy. Community hospitals are seen as an important part of people's treatment closer to home. People, their carers and families feel that a supported discharge is essential to recovery and wellbeing, however, they are currently experiencing difficulties with discharges, feeling that there is a lack of process for clear and timely discharge, and joined up working between family/carers, health and social care. Sorting out medication sometimes feels chaotic. Insights from people also tell us that the urgent care system responds to illness rather than supporting health creation. The system should help people to recognise what they can do for themselves, encouraging them to care for themselves, when possible. NHS 111 and other urgent care services can contribute to building community resilience, especially amongst those living with long term conditions and those with young children. People also tell us they are confused about what services are for and where to go, especially for out of hours care and when there is an urgent physical or mental health need.

Summary of key interventions

Responding to the local context, business intelligence and insights from people, table 6 below summarises the key interventions we intend to make, over the coming years.

A Delivery Plan, underpinning these interventions, can be found at Annex 1 to this Plan. Detailed 2023/24 actions can be found in the LLR ICB 2023/24 Operational Plan.

Table 6: Summary of key interventions we will make to deliver equitable access to the right care at the right time

Intervention	Timeline
Urgent and emergency care and Homefirst	
1. Streamline to a single point of access for same-day urgent care	23/24 & 24/25
2. Implement an Urgent Care Coordination Hub	23/24 to 25/26
3. Implement the LLR Integrated Discharge Hub	23/24
4. Implement the Urgent Treatment Centre (UTC) model across LLR	24/25

Primary Care	
5. Maximise primary care capacity to meet demand for services and ensure the pt is seen in a timely manner, by the right service, first time	23/24 & 24/25
6. Streamline access processes including digital access	23/24 & 24/25
7. Optimise triaging to appropriate services, including pathways wider than primary care	23/24 & 24/25
8. Support PCN development, expansion and maturity, with a particular focus on PCNs that are experiencing difficulties	23/24 & 24/25
9. Develop an transition pathway for PCNs to evolve into INTs (Fuller stocktake report)	23/24 & 24/25
10. Undertake PCN estate reviews, leading to understanding of and proposed projects for estate development (Primary Care Estate Strategy)	23/24
11. Develop a plan to address local NHS dental access	23/24 to 24/25
Personalisation	
12. Develop a Personalisation Strategy	23/24
13. Increase Social Prescribing Link Worker capacity and referrals	23/24
14. Liberty Protection Safeguards service:	
a. Develop and deliver training in identifying need	23/24
b. Implement Liberty Protection safeguards service	24/25 to 25/26
15. Embed a working culture that embraces personalisation as the default approach to supporting people	From 23/24
16. Implement processes to create All Age Continuing Care Model	From 23/24

How the above interventions will contribute to improving health equity
The above interventions will improve health equity by creating more capacity in the system for those with complex health needs (disproportionately older people, those from minority ethnic groups, or less affluent neighbourhoods), as those with minor illness/injury will be seen in the right place. Expanded access will better support those for whom standard healthcare offers are inaccessible. The focus on improving the resourcing and stability of healthcare provision in underserved areas will begin to address the "inverse care law" which sees those with the greatest need for healthcare often having the lowest provision.

3.4 Integrated community health and wellbeing hubs

Creating the right environment for community health and wellbeing

To deliver the right care at the right time, we will need to systematically create and embed a 'team of teams' ethos, where teams across health and care work with local communities to embed the right care, right time approach within **community health and wellbeing hubs**. We know from our local pilots that, when our teams work in partnership, outcomes for patients are better and teams report a better experience of delivering services. This is especially true when services are delivered within local communities, using community assets, to focus on holistic, person-centred care.

Bringing teams together into one infrastructure is not a new idea. However, the scale of our ambition will require our health and council partners to think differently under the "one public estate" ethos. Delivery of local community health and wellbeing hubs will require us to look at our infrastructure in a completely different manner, with estates becoming a catalyst to integration, with a focus on health and care need, rather than simple buildings.

What is delivered in each hub would be tailored to local needs. However, if the basic premise of these hubs is to support teams to get patients the right care at the right time in the right place, then they should have direct links into and out of the services described earlier at 5.3. For example, the local primary care network may wish to use facilities to provide a community based, same day access service; the local 2-hour response service could be based there, working in partnership with a consultant out-reach clinic; local practices could run scheduled long term condition management support from these hubs; digital inclusion could be supported through a hub for virtual outpatient appointments. What is important is that provision in these local centres is based on the needs of the local communities, with a clear and unambiguous focus on equity.

What people have told us matters to them
Consistency and continuity of care are important to people. They recognise the need for closer integration between services to avoid 'story telling fatigue'. Delivery of good quality healthcare through a joined-up approach and the exchange of accurate information across organisations is seen as vital. Aligned IT systems is critical, as some people experience poor quality of transfer of information between services. People do want more care closer to home, but that care needs to be accessible. Some services, while physically closer to home, may not be served by public transport or have car parking and drop-off facilities, which are key factors for many.

Summary of key interventions

Responding to the above, table 7 below summarises the key interventions we intend to make over the coming years.

A Delivery Plan, underpinning these interventions, can be found at Annex 1 to this Plan. Detailed 2023/24 actions can be found in the LLR ICB 2023/24 Operational Plan.

Table 7: Summary of key interventions we will make to develop community health and wellbeing hubs

Intervention	Timeline
1. UEC Collaborative to lead engagement with all partners to ensure ownership and agreement of approach	23/24
2. Complete the development of Community Health and Wellbeing Plans	23/24
3. Develop a comprehensive understanding of current primary care and community health and care estate	23/24
4. Undertake a baseline assessment of current health and care staff capacity and skills, based on agreed hub sequencing	23/24 to 25/26
5. Agree geography, location, number and sequencing of Hubs across LLR	23/24
6. Develop Delivery Plans to roll-out all Hubs between 2024/25 and 2027/28	23/24
7. Establish hubs, based on agreed hub sequencing	24/25 to 27/28
8. Establish subsequent wave hubs, based on agreed hub sequencing	24/25 to 25/26

How the above interventions will contribute to improving health equity
Our model of community health and wellbeing hubs is founded on the approach of managing population need and not just healthcare demand. This approach will create an effective and efficient system of care which is person-centred and actively orientated to addressing the wider determinants of health, as well as the presenting problems of immediate healthcare need. The hub approach will allow us to place health and healthcare in their local social context though a "Healthy Conversations" model and the co-location of a variety of non-NHS support offers alongside NHS services.

3.5 Optimal Pathways for Elective Care

Local context

The impact of the Covid-19 pandemic is still being felt locally, in the amount of time people are waiting for routine operations and elective treatment. Waiting lists are significantly longer than they should be and there is much work to do, over the next few years, to reduce lists to pre-pandemic levels.

During the pandemic, resources were prioritised on the most urgent patients and those with cancer. Referrals slowed, as people with potential surgery or treatment needs were more reluctant to come forward. The impact of this was a significant growth in patients waiting longer.

Our approach

We are taking decisive action to address waiting list backlogs. A Planned Care Partnership (see 5.1) has been established to lead our approach, with membership from across our partner organisations, and we are already delivering improvements, for example:

- Since March 2022, over 50,000 people, who would have been waiting over 78 weeks by April 2023 for their care, have been treated
- From October 2022 to April 2023 the number of people waiting for elective care decreased by 7,118 to 133,514
- As of April 2023, the number of patients waiting over 62 days for their cancer treatment is half of what it was in November 2022.

Over the next 1 to 3 years, we expect waiting lists to stabilise, waiting times to further improve and additional capacity to become available.

Summary of key interventions

Our strategy (summarised at Figure 8) is built on delivery of eight key interventions linked to improving process, productivity and capacity.

Figure 8: Our elective care strategy

Elective Care Strategy
Timely, Inclusive and Convenient Access to Planned Care

Year 1 – 22/23
- Stabilise waiting list
- Deliver zero 104+
- Reduce 78+ week waits
- Reduce 62 day and 104+ day cancer waits

Year 2 – 23/24
- Channel long term conditions and diagnostics out to community PCN/Primary Care
- Longer term agreements with IS
- Community Diagnostic Centre's – (2&3)

Year 3 – 24/25
- Elective hub fully operational
- Net importer of activity into capacity
- Upper Quartile Productivity
- Digital Leader

Interventions Via Planned Care Partnership
1. Productivity Improvements
2. OP Transformation
3. Pathway Changes
4. Validation
5. IncreasingCapacity
6. PartnershipWorking
7. Reducing Health Inequalities
8. Income Generation

Enabling strategies
- Digital
- Workforce
- Communications and Engagement
- Health Inequalities
- Prevention
- Diagnostics

Productivity / Processes/ Partnerships

What people have told us matters to them
People have told us that services do not always meet the needs of people when they first try to access help and some people experience delays in receiving an initial assessment or accurate diagnosis, as well as for the treatment itself. People would like more explanation of tests and treatments before a visit, to reduce confusion and, while they wait for treatment, they would like information and support such as pain management tools to help them cope. They would also like more support and appropriate follow-up after treatment, to help their recovery. Community hospitals are seen as an important part of patients' treatment closer to home to avoid visit to larger hospitals.

High-level deliverables against these eight key interventions (see figure 8) are set out in table 8, below. A more detailed Delivery Plan can be found at Annex 1 to this Plan. Detailed 2023/24 actions can be found in the LLR ICB 2023/24 Operational Plan.

Table 8: High-level deliverables against the eight elective care interventions, by timeline

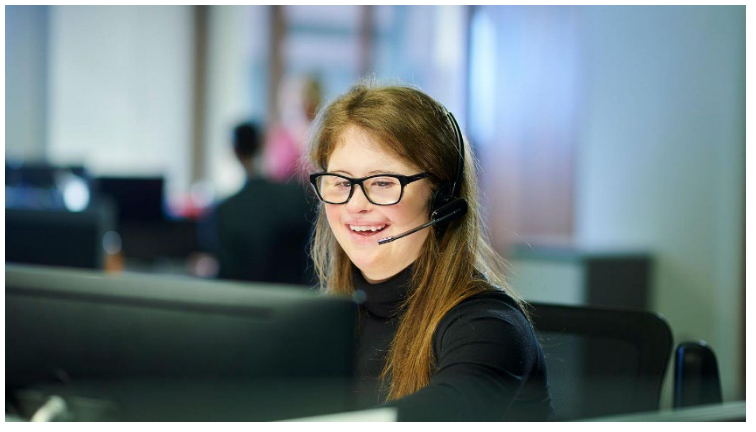
<table>
<tr><th>Interventions</th><th>Deliverables</th><th>Timeline</th></tr>
<tr><td rowspan="7">1. Productivity Improvements
2. Outpatient Transformation
3. Pathway Changes
4. Validation
5. Increasing Capacity
6. Partnership Working
7. Improving Health equity
8. Income Generation</td><td>• Begin activity flows through the East Midlands Planned Care Centre with further capital work to be fully operational in 24/25
• Build Community Diagnostic Centre 2 at Hinckley for activity to be delivered in 24/25
• Implement a range of community diagnostics in 13 PCNs and introduce GP direct access to diagnostics</td><td rowspan="4">23/24</td></tr>
<tr><td>• Invest in the Referral Support Service to support early triage and shorter outpatient waiting times
• Transformation of first tranche specialty end-to-end pathways</td></tr>
<tr><td>• Deliver 2023/24 elective priorities including a reduction in 62+ day cancer and 65+ week wait RTT</td></tr>
<tr><td>• Strengthen the LLR productivity programme in outpatients, theatres and diagnostics working with the National GIRFT team to meet recommendations</td></tr>
<tr><td>• East Midlands Planned Care Centre to be fully operational
• Community Diagnostic Centre 2 at Hinckley to be fully operational
• Expand the range of community diagnostics to a wider cohort of PCNs</td><td rowspan="3">24/25</td></tr>
<tr><td>• Expand the Referral Support Service for both Elective and long-term condition patients in the community
• Transformation of second tranche specialty end-to-end pathways</td></tr>
<tr><td>• Deliver 2024/25 elective priorities including 52+ week wait RTT</td></tr>
</table>

	• Work with EMCA to implement targeted lung health checks	
	• Develop case for Community Diagnostic Centre 3 if required • To become a net importer of activity to the East Midlands Planned Care Centre supporting the wider Region	25/26 & 26/27
	• Transformation of third tranche specialty end-to-end pathways	

How the above interventions will contribute to improving health equity
Ill health and associated disability are disproportionately distributed across our population, with those from the least affluent parts of LLR having the most barriers (including lower health literacy) to equitable access to diagnostic and elective treatment. Making equity impact assessments an essential precursor to elective service redesign will ensure that, as we recover elective performance and design new offers, we resource services proportionate to population need. Equitable access to elective care will reduce unwarranted and avoidable variation in outcomes from conditions amenable to elective intervention.

3.6 Learning Disabilities & Autism

Local Context



We know that there are considerable health inequalities for local people with a learning disability and/or autism (LDA). Our learning from deaths reports tell us that if you live in LLR with a LD, your life will be up to 25 years shorter than other people in LLR.

We believe that there could be even greater inequalities for individuals from different communities and we have more work to do to understand and address inequalities in our services.

Our Ambition for people with LDA, their Families and Carers

We are applying a person-centred, proactive, preventative and population health management approach, to better bring together service users, carers, families, health, social, community and independent partner organisations, thus enabling services to wrap around the person's needs. This means providing timely care and support interventions, better care co-ordination and preventing escalation.

Our approach

We have established a LLR LDA Collaborative to co-ordinate the transformation of LDA health services, as well as oversee the quality, performance, and outcomes of wider LDA services across the system, including ensuring the local implementation of the national Mental Health and LDA Quality Transformation Programme. The Collaborative works closely with the LLR local authorities and other stakeholders and oversees delivery of our LDA Operational Plan. Furthermore, we are part of the East Midlands Alliance for Mental Health and Learning Disabilities, which strengthens joint working and supports delivery across the region.

What people have told us matters to them
People have told us that they feel there should be a better understanding of learning disabilities and autism in the NHS and the impact that it has on carers and the whole family. People with learning difficulties feel they are more likely to be digitally excluded. They told us that getting a diagnosis can be a challenge and young people with learning disabilities, in particular, find hospital appointments particularly stressful and disempowering. Both young people and adults want more communications about services in a way they can understand. Family carers want support to care, particularly to avert a crisis happening to their loved one or themselves.

Summary of key interventions

Responding to the local context, business intelligence and insights from people t*able* 9 below summarises the key interventions we intend to make, over the coming years.

A Delivery Plan, underpinning these interventions, can be found at Annex 1 to this Plan. Detailed 2023/24 actions can be found in the LLR ICB 2023/24 Operational Plan.

Table 9: Summary of key learning disability and autism interventions we will make

Intervention	Timeline
1. Reduce adult and children mental health inpatient numbers through regular review of plans, with system escalation for individuals with a delayed discharge	23/24
2. Reduction in the use of out of county inpatient mental health hospitals	23/24
3. Increase the percentage of people on GP learning disability resisters who receive an annual health check and health action plan	23/24
4. Learning from Deaths Reviews (LeDeR) completed within 6 months and learning shared on a quarterly basis with system partners enabling improvement in services.	23/24
5. Continue to address health inequalities and deliver on the Core20PLUS5 approach	23/24 to 24/25
6. Optimisation of autism assessment services	23/24
7. Ensure appropriate quality assurance processes are in place across the collaborative to strengthen local LDA community health and social care services	23/24 to 24/25
8. Implement No Wrong Door Themes	23/24 to 27/28

How the above interventions will contribute to improving health equity
People with a learning disability or autism, as well as their families and carers, all too often experience unfair and avoidable variation in access, experience of care and outcomes from healthcare in LLR. The above interventions are targeted to address those areas where our performance is poor. The resources deployed, aimed both at people and their carers, will be proportionately allocated so that we make the most progress in taking down barriers to equity. Our “No Wrong Door” approach is founded on our commitment to listening to people with lived experience.

3.7 Mental Health

Children and young people, adults and older people

Local Context

One in four adults experience at least one diagnosable mental health problem in any given year, and the life expectancy of people with severe mental illnesses can be up to 20 years less than the general population.

The Leicester, Leicestershire and Rutland JSNA's and JHWSs (see 1.1) provide a comprehensive picture of local mental health challenges, with some key insights being:

Leicestershire:

- Performs significantly better than England for percentage of school pupils (secondary and primary age) with social, emotional and mental health needs and children in care (<18 years). However, over the last five years, the trend is increasing and getting worse.
- Performs significantly worse than England for the gap in the employment rate for those in contact with secondary mental health services and the overall employment rate.
- Levels of dementia diagnosis are poorer than the national targets set by NHS England.

Rutland:

- Performs better than the England average for most indicators examining mental health risk factors, for example, children living in deprivation and premature morality in adults with severe mental illness.
- The armed forces community experience greater loneliness, in particular spouses of those serving.

Leicester City:

- Performs worse than the England average for most indicators examining mental health risk factors.
- One in ten children report having a mental health problem; many more say they feel stressed or overwhelmed.
- Particular challenges from severe mental illnesses, reported problems with wellbeing and use of opiates.

Across LLR, there are long waits for, and fragmentation of, support and offers. Local people also experience longer than average mental health hospital stays.

Our Ambition for mental health

We are committed to working in partnership with local people to achieve equity across all communities in:

- Increasing **mental wellbeing**;
- Improving the **experience, acceptance and understanding** for people who live with, work with or experience mental health challenges;
- Providing timely access to the **right mental health support** tailored to the individual's needs as locally as possible; and
- Delivering good mental health and physical health **outcomes** to improve the quality and **longevity** of life.

Our approach

We have focused on making material improvements to services for people with mental health needs, supported by a sizeable investment programme. These include:

Case Study

Mental Health – Crisis Cafés

What was the issue?
Support for people who need immediate help with their mental health.

Intervention
Leicestershire Partnership NHS Trust established a network of local Crisis Cafés to support people with immediate mental health needs. The cafes are drop in centres for anyone to talk about their mental health. Trained staff listen and provide practical support and advice.

Impact
Café clients attend for a wide variety of reasons (loneliness, anxiety, depression, isolation, IT help, warmth) and staff provide support, advice, signposting and referrals.
Client testimonials suggest that the service is appreciated.

Applying the learning
There are currently 14 Cafés across LLR, with plans to provide 25 serving local communities.

- Introduction of a central access point (providing a direct way that people can get access to mental health support);
- Introduction of a mental health urgent care hub to provide a safe and tailored place for urgent help;
- Significant improvements to the environment, care and flow of mental health acute inpatient services, allowing people to be treated locally;
- Development of a community rehabilitation service to support people to live in the least restrictive environment possible;
- Mental health teams to support children's mental health, better and earlier, in their school environment;
- Navigation of children and young people into the best offers available to meet their needs earlier;
- Introduction of important new roles and offers such as Crisis Cafes (see case study), peer support worker, and widespread voluntary sector offers (Getting help in neighbourhoods); and
- Improving the dementia care pathway to support delivery of the Living Well with Dementia Strategy.

We also consulted with local people, during 2021 (see below), to get their views about how we could improve support to adults and older people who need mental and emotional support urgently, as well as about community mental health care and treatment planned in advance.

The consultation demonstrated high levels of support for the proposed changes and insights from people, carers and families have informed our ambition to:

- Organise and deliver most of our services and offers into neighbourhoods, so that they can be joined up and tailored to meet the specific needs of the local communities and individuals, their carers and families;
- Have a clear no-wrong door approach that ensures that wherever people present they are helped to the right support for them;
- Provide clear continuity and joined up support for people that ensures that they are not bounced between services;
- Deliver outcome focused support for people to ensure that offers are meeting their recovery goals, as well as their needs and those of their carers/families; and
- Focus on improving the wellbeing of the different communities to reduce mental health needs, supporting people as early as possible to minimise the escalation of any needs and to deliver high quality support and interventions as locally to where people live as possible.

To deliver our approaches, we have strong collaborative working arrangements between statutory mental health services and the voluntary sector network. We established a Mental Health Collaborative in 2022 to coordinate decisions, strategy and action, both within each place and across LLR. Furthermore, we are part of the East Midlands Alliance for Mental Health and Learning Disabilities, which strengthens joint working and supports delivery across the region.

What people have told us matters to them
Our 'Step up to Great Mental Health' public consultation, to which over 6,500 people contributed during 2021, has provided us with rich insights about what local people think and want. People have told us that mental health services should be treated as being equally important as physical health services. People tell us that they want a simple way of accessing mental health support and want to be able to immediately self-refer to a service if it is a crisis. Information needs to be accessible to everyone and services promoted. Prevention and early intervention are vital, as is appropriate self-help guidance, referrals and improved and timely access. People also tell us that they want to have services that are joined up, provided by proficient staff and provided in more local settings. Continuity of care that involves carers, family and the wider community is vital with no restrictions on access for older people. People value online services, including for diagnosing and consulting, but only when appropriate to their condition. People want the needs of those that are vulnerable to be met with services that reflect the needs of diverse communities.

Summary of key interventions

Responding to the local context, business intelligence and insights from people table 10 below summarises the key interventions we intend to make, over the coming years.

A Delivery Plan, underpinning these interventions, can be found at Annex 1 to this Plan. Detailed 2023/24 actions can be found in the LLR ICB 2023/24 Operational Plan.

Table 10: Summary of key mental health interventions we will make

Intervention	
1. Reorganise and expand mental health provision into eight neighbourhood teams across LLR	23/24
2. Establish a new neighbourhood approach for children and young people	24/25 to 26/27
3. Deliver a modernised workforce model across all agencies in each neighbourhood	23/24 to 25/26
4. Reorganise mental health inpatient provision to deliver high quality and financially sustainable provision	23/24 to 25/26
5. Deliver expanded, seamless and accessible psychological therapies step 2, 3 and 4	23/24 to 25/26

How the above interventions will contribute to improving health equity
The above interventions will make mental health support much more accessible and delivered in a way that breaks down barriers to engagement for those from the CORE20Plus cohorts, including for children and young people. The focus on better physical health for those with Serious Mental Illness (SMI) and the move to ensure mental and physical health needs are dealt with in an integrated model of care will directly address a known disparity in life expectancy and healthy life expectancy between this group and their peers without SMI. The Neighbourhood model will make services more culturally sensitive.

3.8 Children and Young People

Local context

A growing number of children are living longer with life-limiting and/or complex health conditions. There are also a significant number of children and young people who attend hospital services but could better be cared for within a community or home setting.

There is some duplication of services, staff and equipment across health, social care, education and voluntary sectors, leading to a lack of cohesion, as well as financial and workforce inefficiencies.

The impact of Covid19 and the continuing pressure on services has resulted in delays in access to treatment, increasing the number of children and young people on waiting lists. Therapies, Mental health, Neurodevelopmental pathway and community paediatrics have seen a 30% increase in referrals. There is clear evidence that the full spectrum of more intensive services for children and young people across LLR are seeing a significant increase in demand, whether in the form of requests for social care, mental health support, community health services or urgent and emergency care. Not only does this represent a significant impact on the LLR population in terms of poor life experience and the potential for ongoing dependence on services, but the increase in demand is also pushing many of these services to the brink in terms of their capacity, while the associated costs are threatening the financial stability of all partners across the health and care system.

Preventing children and young people from reaching the stage where they need health and social care specialist services is a key priority to reduce demand in the system. The three levels of prevention, from universal to tertiary, are all critically important to improving children and young people health and wellbeing outcomes.

Our vision for children and young people's services

Our vison for children and young people (CYP) across LLR is for an equitable health service which are safe, personalised, kinder, professional and more family friendly; where every child and young person can have early access to care as close to home as. We want every CYP to be supported to reach their potential and feel safe and cared for in the family and community. We want our staff to be supported to deliver care, which is family

Case Study

Children and Young People – *Early Help* to children and families

What was the issue?

Our aim is to provide services that strengthen resilience and improve outcomes for vulnerable children and families. However, these services were being provided by different teams across different organisations and locations, leading to a disjointed and uncoordinated experience for children and their families.

Intervention

Development of 'family hubs', where integrated services are delivered to children and families by professionals who work together through co-location, data-sharing and a common approach to their work. Families only have to tell their story once and service provision (e.g. mental health support, SEND family worker, midwifery, computer skills, housing advice, digital access, etc) is integrated.

Impact

- There is 'no wrong front door' for families.
- Families receive the right service at the right time, and at the lowest possible level of service involvement, being able to self help where possible.
- Families and staff have a better understanding of available services and referral pathways
- Staff have a better understanding of the roles and remits of other services and are actively seeking opportunities to co-deliver where to do so will contribute to better outcomes for families.

Applying the learning

Focus on building and developing connections and resources in communities and neighbourhoods and ensuring that we are responsive to local need and listen to the voice of children, families and communities.

centred, working in high performing teams, in organisations which are well led and in cultures which promote innovation, continuous learning, and break down organisational and professional boundaries.

Our approach

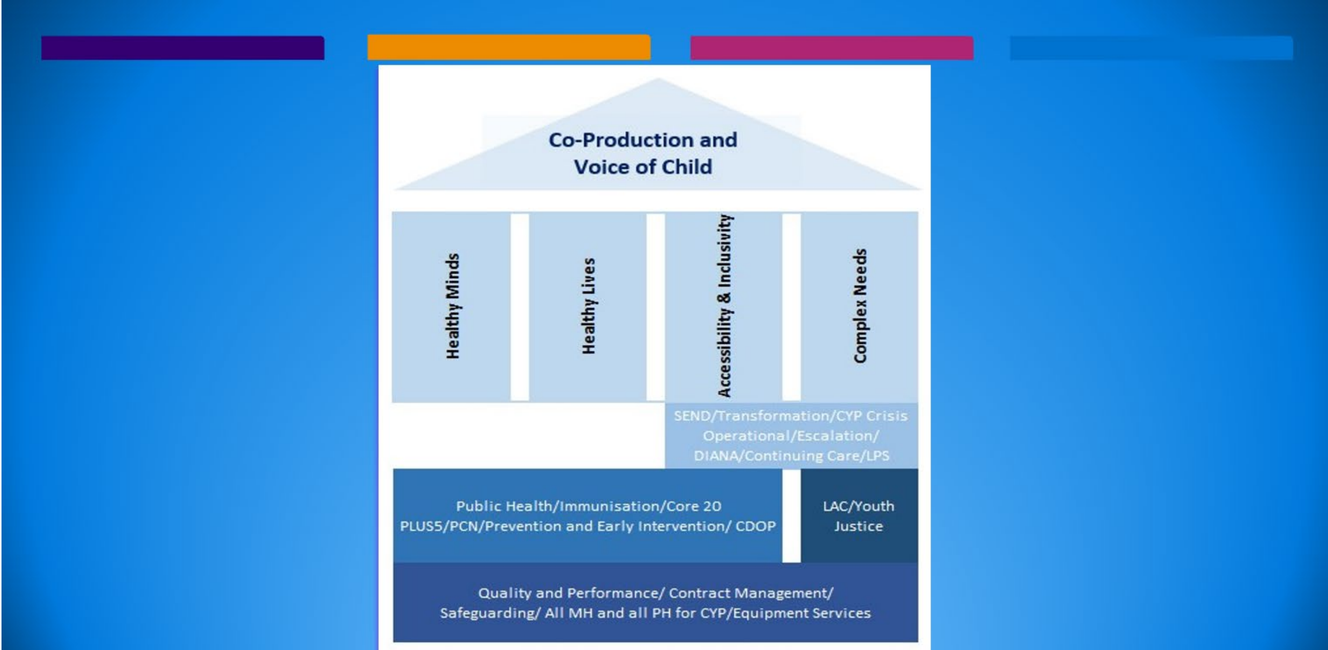
We will reshape the children and young people's portfolio, bringing all components across health and care together into a children and young person's collaborative partnership. This `collaborative` will have the voice of children and young people at its centre and will bring clinical and senior colleagues together from across the health sector, acute and community services, our local authorities, and voluntary sector providers. We have an ambition to address investment in children and young people's services in relation to health investment allocated to the rest of the population and develop a different and innovative commissioning model.

Our emerging strategy for children and young people built upon the `strategic pillars` - Healthy Minds, Healthy Lives, Accessibility & Inclusion and Complex Needs (see figure 9), will have:

- The voice of the child at its centre
- Prevention to be a part of every pathway.
- Integrated pathways across ICB to support CYP to achieve their potential.
- Early interventions and specialist support to effectively manage long term conditions
- Access to timely services delivered as close to home as possible by multi professional teams
- A competent skilled workforce that works across the acute and community system
- Using intelligence to address health inequalities
- Better preparation for adulthood and so improving transition pathways

Our strategy will align also with Urgent & Emergency Care, Cancer, Elective, Long Term Conditions, Maternity, All-aged Mental Health and Learning Disability and Autism collaboratives plus learning from reviews of serious incidences and child /infant deaths.

Figure 9: The 'Strategic Pillars' model for children and young people



What people have told us matters to them
Children and young people have told us that they want to be listened to, taken seriously and understood. They tell us they want to be informed about their health, spoken to, not through, their parent or carer. They want a health care system which disrupts their education as little as possible,

and to understand that children and young people come with families, who also need to be considered.

They want information about health to be easily accessible and in places where they congregate. If the information is too difficult for a young people to process, then it must be produced in a way which makes sense to child and young person, including easy reads, videos, animation, podcasts and infographics.

Children and young people want staff in healthcare to treat them with respect and be aware of the issues facing them today. They want all professionals, who come into their lives, to recognise that they have a responsibility to support them into adulthood.

The assumption that children and young people are digital experts and, therefore, digital is the solution to engaging with them, is not that clear cut. Safeguarding, access and anxiety of miss-communicating their condition due to lack of knowledge, language and the power dynamic of child to adult conversation, concern young people. Finally, children and young people understand the importance, for all their peers, to have the best start in life followed by staying healthy and well. These are not outcomes; these are realities to them.

Summary of key interventions

Responding to the local context, business intelligence and insights from people, table 11, below, summarises the key interventions we intend to make, over the coming years.

A Delivery Plan, underpinning these interventions, can be found at Annex 1 to this Plan. Detailed 2023/24 actions can be found in the LLR ICB 2023/24 Operational Plan.

Table 11: Summary of key children and young people interventions we will make

Intervention	Timeline
1. Enhance the current partnerships and collaboration and alignment to system and place-based strategies	23/24
2. Actively promote the voice of children and young people and their participation in strategic and operational developments	23/24 to 24/25
3. Address variations and equity in our health system using learning and outcomes from preventative programmes such as CORE20PLUS5 programme	23/24 to 24/25
4. Improve neurodevelopmental pathways and services for children and young people	23/24 to 27/28
5. Address barriers to accessing to mental health services for CYP and develop the locality neighbourhood model (See Chapter 3.7)	24/25 to 27/28
6. Remove barriers to accessing acute and community paediatric care pathways	23/24 to 25/26
7. Reduce waiting lists for accessing acute and community paediatric care pathways	23/24 to 24/25
8. Reducing the impact of demand upon children`s urgent and emergency care and develop preventative solutions	23/24 to 26/27
9. Working with regional and local networks and collaboratives to transform paediatric critical care and paediatric care pathways	

How the above interventions will contribute to improving health equity

Our Health Inequalities Framework (see 4.1) emphasises the importance of the best start in life. The above interventions, especially (though not exclusively) those from the CORE20Plus5 programme, will directly address prevalent risks relating to good outcomes for children and young people. This work will be linked to elements of our adult programmes through risk stratification and population profiling (see 4.2) so that support for adults with complex needs will be co-ordinated with support for children in the same households.

3.9 Women's Health, including Maternity

Local context

Across LLR, women live longer than men, however, women spend a significantly greater proportion of their lives in ill health and disability when compared with men. Too often women's voices are not listened to, as detailed in the Ockenden review. Insufficient focus is placed on women-specific issues such as miscarriage or menopause. Locally, services for women's health are fragmented or duplicated across multiple pathways and organisations. Through this plan we make a commitment to improve the health of women across LLR; through better coordinated and tailored services we will make significant improvements to access, experience and outcomes.

Women's health through a life course approach

We will adopt **a life course approach to women's health** ensuring we focus on understanding the changing health and care needs of women and girls across their lives, from puberty to adolescents, young adults to later life, and not on interventions for a single condition often at a single life stage. This aligns with the approach detailed in the Women's Health Strategy for England 2022.

Our vison for women's services

We will ensure that our health and care system listen to the voices of women and girls; their health care needs will be understood and services will be developed and tailored to meet their specific needs. Integral to this ambition is to drive transformation through a **system-wide women's health collaborative** that brings partners together to plan, design and implement change underpinned by insights and engagement. Key focus areas will be centred around, but not limited to, women's general health and wellbeing, health promotion and education, screening, sexual and reproductive health, maternity, gynaecology, women's cancers, women's mental health, safeguarding and menopause. Over the next five years we a have a clear ambition and plan to improve health outcomes for all women and girls across LLR.

Our vision for maternity services

Our vison for maternity services across LLR is for an **equitable service which is safe, personalised, kinder, professional and more family friendly**; where every woman has access to information to enable her to make decisions about her care; and where she and her baby can access support that is centred around their individual needs and circumstances. We want our staff to be supported to deliver care which is women centred, working in high performing teams, in organisations which are well led and in cultures which promote innovation, continuous learning, and break down organisational and professional boundaries.

We will work to the Three Year Delivery Plan for Maternity and Neonatal Services, continuing to make progress towards the national safety ambitions to reduce stillbirth, neonatal mortality, maternal mortality and serious intrapartum brain injury. We will embed the Ockendon and East Kent recommendations, as well as any other national reports and reviews that take place. Our Local Maternity & Neonatal System (LMNS) will continue to provide oversight and respond to MBRRACE recommendations and other internal and external reviews, such as CDOP. This will be done by focusing on improving our maternal and infant mortality rates by working as a system aligned to the

perinatal quality surveillance model. We will monitor and commission (where appropriate) external perinatal/maternal mortality reviews of our serious incidents, to ensure we embed learning. We will ensure that we have sufficient staff in place to realise our maternity transformation ambitions.

What people have told us matters to them
Women and families want to be empowered through the provision of high-quality information, advice and guidance. Mothers tell us they experience inconsistent and often conflicting information which confuses them. They feel that the best way to deliver information is through classes, directly by healthcare professionals, as well as through information online. Pregnant women told us that they need more time for appointments and to see the same midwife. They also want to feel listened to, particularly at the time of labour and giving birth. Antenatal classes are seen as vital for wellbeing and women also value post-natal support including ease of access to mental health services. A better understanding and appreciation of cultural backgrounds is felt to be important to build trust and empathy. Equity for mothers and babies from Black, Asian and mixed ethnic groups and those living in the most deprived areas is vital.

Summary of key interventions

Responding to the local context, business intelligence and insights from people, table 12, below, summarises the key interventions we intend to make over the coming years.

A Delivery Plan, underpinning these interventions, can be found at Annex 1 to this Plan. Detailed 2023/24 actions can be found in the LLR ICB 2023/24 Operational Plan.

Table 12: Summary of key women's health and maternity interventions we will make

Intervention	Timeline
Women's Health	
1. Establish a Women's Health Collaborative to transform the current fragmented and un-coordinate care into better access, quality, experience and outcomes for women	23/24
2. Build relationships with women's groups, ensuring that we understand their needs and they have a voice in planning services across health care.	23/24
3. Lead the East Midlands Assisted Fertility Policy review and undertake an options appraisal to agree how we will meet new assisted conception recommendations in women's health strategy.	23/24 to 27/28
4 Work with system leaders to agree local models for implementation of women's health hub across LLR, to provide social, emotional and health support, including sexual health, menopause and social prescribing.	23/24 to 27/28

Intervention	Timeline
Maternity	
5. Listen to women and staff with compassion, to include:	
• Co-produce services via the LLR MVNP	23/24 onwards
• All women offered personalised care and support plans	23/24
• Undertake a whole pathway options appraisal on maternity information systems.	23/24 to 24/25
6. Support our workforce:	
• Increase fill rates against funded establishment for maternity staff	23/24 to 27/28
• Recruitment and retention plans in place	23/24
• Develop a positive and dynamic culture	23/24 to 25/26
7. Develop and sustain a culture of Safety:	
• Implement the Ockendon and East Kent actions and recommendations to reduce stillbirth, neonatal mortality, maternal mortality and serious intrapartum brain injury	23/24 to 25/26
• Develop clinical leadership	23/24 to 25/26
• Implement NHS- Patient Safety Incident reporting Framework (PSIRF) approach	23/24 to 25/26
8. Meet and improve standards and structures:	
• Maternity digital strategy outlining how women will access their records and interact digitally with their plans	23/24 to 24/25
• We will implement best practice consistently, including the updated Saving Babies Lives Care Bundle and new "MEWS" and "NEWTT-2" tools.	23/24 to 24/25

How the above interventions will contribute to improving health equity
The establishment of a Women's Health Collaborative and undertaking a needs assessment will support focused improvement programmes to address avoidable and unfair variation in access, experience and outcomes, both between women and their male peers, and between women from different ethnic and socio-economic groups. We know that LLR is an outlier in some key areas, such as maternal health amongst women from minority ethnic backgrounds, as well as some CORE20 and Inclusion groups. Specific work to improve this position is included in the above interventions.

3.10 Measuring and monitoring success

Managing delivery

We have established a delivery framework for this Plan (see 5.1), with clear accountability for driving and monitoring success. This means that all interventions, across all the priority areas in this chapter, have a specific Collaborative or Partnership – with multi-professional membership from across our partner organisations – that has responsibility for delivery. For example, the LDA Collaborative is accountable for delivering the LDA interventions.

Annex 1, to this Plan, sets out the key actions and timelines for each intervention, as well as the impact and/or outcomes that each intervention is expected to deliver. Our Collaboratives and Partnerships will monitor progress against this annex and, indeed, will usually have access to a much more granular and bespoke data set, taking into account both local and national performance requirements.

Delivering our Pledges to local people

The Collaboratives and Partnerships will also be accountable for delivering our Pledges to local people. Table 13, below, summarises the measures we have identified and against which each Pledge's progress will be monitored, as well as the Collaborative or Partnership accountable for delivery.

Some pledges will be delivered in one or two years, whereas others, for example *improving health equity*, will be delivered over the longer term. Measures against some pledges are still to be defined, particularly where we are re-organising our focus on a particular area, for example *Children & Young People*, and some measures may change because of national policy, for example ambulance response times or waiting list targets.

Table 13: Measuring success against our Pledges

Delivery Priority	Pledge	Measures we will use	Reasoning	Accountability
Improving health equity	**Pledge 1** **Improve the health** of our most deprived communities and **narrow the gap** between those who have the best and the worst health	1) Life expectancy and healthy life expectancy 2) Gap in life expectancy between most and least deprived populations	These measures are reported, nationally. Therefore, we know the current position (baseline) and we can track improvements in local life expectancy and healthy life expectancy, as well as success in improving equality in life expectancy.	LLR ICB via the Health Equity Committee
Preventing illness	**Pledge 2** Spend more money on **preventing people becoming ill** in the first place	Under 75 mortality rate from causes considered preventable, targeting: - Cancer - Cardiovascular disease - Respiratory disease Prevention spend measure to be defined during 23/24	Cancer, cardiovascular disease and respiratory disorders are the three most common causes of local preventable deaths (see 3.1). All or most deaths from these causes could mainly be avoided through effective prevention interventions. These preventable mortality rates are calculated, nationally. Therefore, we know the current position (baseline) and we can track reductions in preventable deaths achieved through (amongst other interventions) increased spend on prevention.	Prevention Partnership (TBC)
Keeping People well	**Pledge 3** Identify the **frailest in our communities** and wrap care and support around them	Proportion of patients with moderate or severe frailty that have a care plan in place	There are no national metrics available. Therefore, we will use local date to construct a baseline of the percentage of patients with moderate or severe frailty and that currently have a care plan in place. Care planning is a good indicator of the effectiveness with which we are supporting frail people. We can then measure progress in increasing the proportaion of people with moderate or severe fraility and that have a care plan in place.	Urgent & Emergency Care Partnership

Delivery Priority	Pledge	Measures we will use	Reasoning	Accountability
Right care, Right time, Right place	**Pledge 4** Improve and maintain access to **routine general practice appointments**	Trajectory to deliver appointments in general practice	This measure is reported, nationally. Therefore, we know the current position (baseline) and we can track our progress, month-by-month, to deliver our GP appointment targets.	Urgent & Emergency Care Partnership
	Pledge 5 Reduce Category 2 **ambulance response times**	Category 2 ambulance response times	Category 2 ambulance calls are those that are classed as an emergency or a potentially serious condition, for example, a person may have had a heart attack or stroke or be suffering from sepsis or major burns. Response times are recorded and reported, nationally, and, therefore, we can track our progress as we seek to respond to 90% of Category 2 calls in 30 minutes for 2023/24.	Urgent & Emergency Care Partnership
	Pledge 6 Reduce and maintain waiting times in the **Accident & Emergency** department	Accident & Emergency waiting times	95% of patients seen in A&E within 4 hours is the national target and which is reported on month-by-month. We can, therefore, track our progress on recovering our local position to reach and maintain the 95% target.	Urgent & Emergency Care Partnership
Health and Wellbeing Hubs	**Pledge 7** Provide more joined up, holistic and person-centred care, **delivered closer to home**	Measure to be defined during 23/2	Once the geography, location, number and sequencing of Hubs across LLR is clarified, during 23/24, suitable measure(s) can be more readily defined.	Urgent & Emergency Care Partnership
Elective care	**Pledge 8** Reduce **waiting times for consultant-led hospital treatment**	Referral to Treatment (RTT) waiting times	The amount of time a person waits from when they are referred by a GP to when the consultant-led treatment begins (known as Referral to Treatment (RTT)), are reported monthly. Therefore, we can track our progress in reducing the number of people waiting 18 weeks (the national standard) or more for treatment, as we recover our elective position.	Planned Care Partnership
Learning Disability & Autism	**Pledge 9** Increase the percentage of people on GP **learning disability** registers who receive an annual health check and health action plan	Number/percentage of learning disability Annual Health Checks carried out for persons aged 14 years or over.	People with a learning disability often have poorer physical and mental health than other people. The Annual Health Check is a GP service to identify all patients aged 14 and over with learning disabilities, to maintain a learning disabilities 'health check' register and offer them an annual health check, which will include producing a health action plan. Data is collected via the Quality & Outcomes Framework (QOF) and we can, therefore, track our progress in increasing the numbers/percentage of people on GP learning disability registers who receive an annual health check and health action plan.	LDA Collaborative
Mental Health	**Pledge 10** Reduce **inequity in access to mental health services** across each of our neighbourhoods	Budget allocation analysis, with a five-year plan to progressively align mental health investment more proportionately to the most disadvantaged areas in LLR.	Suitable and useable metric(s) to be piloted in 23/24, with implementation from 24/25.	Mental Health Partnership
Children & Young People	**Pledge 11** Improve access to, experience of, and outcomes for **children and young people** - with a special focus on driving up health equity	Interim measure: Waiting times for CYP services in 23/24. During 23/24, we will develop metrics across the CYP Pledge	We are reshaping children and young people's services, bringing all components across health and care together into a children and young people's partnership. The emerging CYP Strategy will help distill the appropriate metrics to deliver our Pledge, during 23/24, and which will be implemented for 24/25 onwards.	Children & Young People's Partnership
Women's Health, including Maternity	**Pledge 12** We will engage with, listen to, **empower and co-produce services with women and girls**	Maternity Friends and Family Test across four stages of care: - Antinatal care setting - Birth setting - Postnatal ward setting - Postnatal community setting	The Friends and Family Test (FFT) is an important feedback tool that supports people who use NHS services to provide feedback on their experience. Listening to women's views helps identify what is working well, what can be improved and how. The FFT asks people if they would recommend the services they have used and offers a range of responses. The FFT is reported, nationally. Therefore, we know the current position (baseline) and we can track improvements in women's experience of maternity services.	Women's Partnership
Our People	**Pledge 13** We will shape **our people** and services around the needs of our population by **improving workforce retention, reducing agency usage and growing our workforce** to ensure we are fit for the future.	Measures to be defined during 23/24		LLR People Board

Conclusion

The vision outlined in this chapter may seem a long way off – but the passion with which our people have come together to articulate this vision and associated plans demonstrates our ambition to build a sustainable and equitable future.

Through the pandemic, this system and the people within it, came together to transform services overnight in the most extraordinary manner. We now need to call upon that spirit to deliver this plan so that we realise our original goals – to make it easier to **access care** when it is needed, make it easier for our **teams to be able to deliver this care** in an effective and efficient manner and to ensure this care will **deliver equitable outcomes** for the people of Leicester, Leicestershire and Rutland.

Our success will be measured, not just in the traditional dashboards of inputs and outcomes, but also by looking at people's experiences of the care that they receive. We will 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; 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.

Clearly, some of these will continue beyond the life of this five-year plan as we seek to address systemic and historic challenges and, indeed, pivot to tackle any new challenges which arise. However, in partnership with our communities and our teams across statutory, voluntary, community and faith services, we can design, deliver and evidence the success of this vision, building a durable foundation for further improvements in access, equity and outcomes of care.

Chapter 4: Cross cutting themes

In this chapter, we describe how we will address important themes that reach across all the service delivery areas identified in Chapter 3.

4.1 Improving health equity

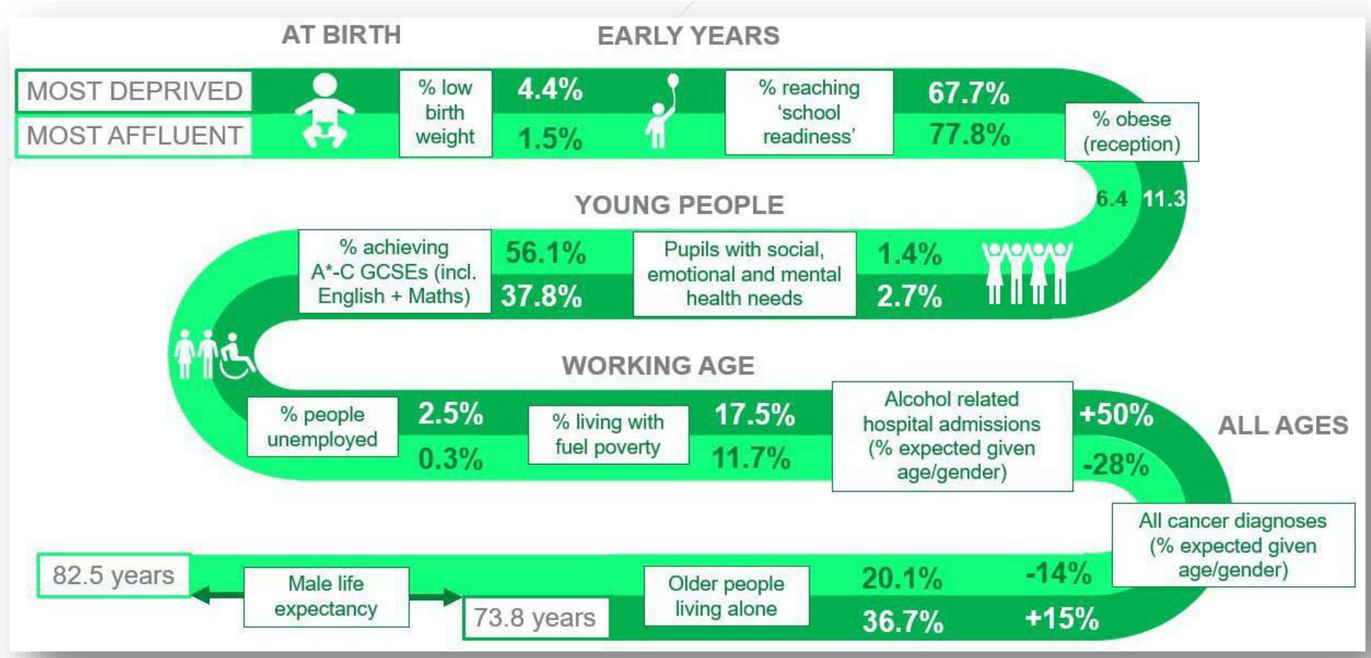
What do we mean by health equity?

Health equity is about removing the avoidable and unfair differences in health between different groups of people. Health equity concerns not only people's health but the differences in care they receive and the opportunities they have to lead healthy lives.

Why focussing on this is important to us

There are stark gaps in health equity across 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. Furthermore, people from less affluent areas will be spending a greater proportion of their (often shorter) lives in poor health compared to people from more affluent parts of our area (see figure 10).

Figure 10*: Difference in health indicators between the most and least deprived local areas of LLR*



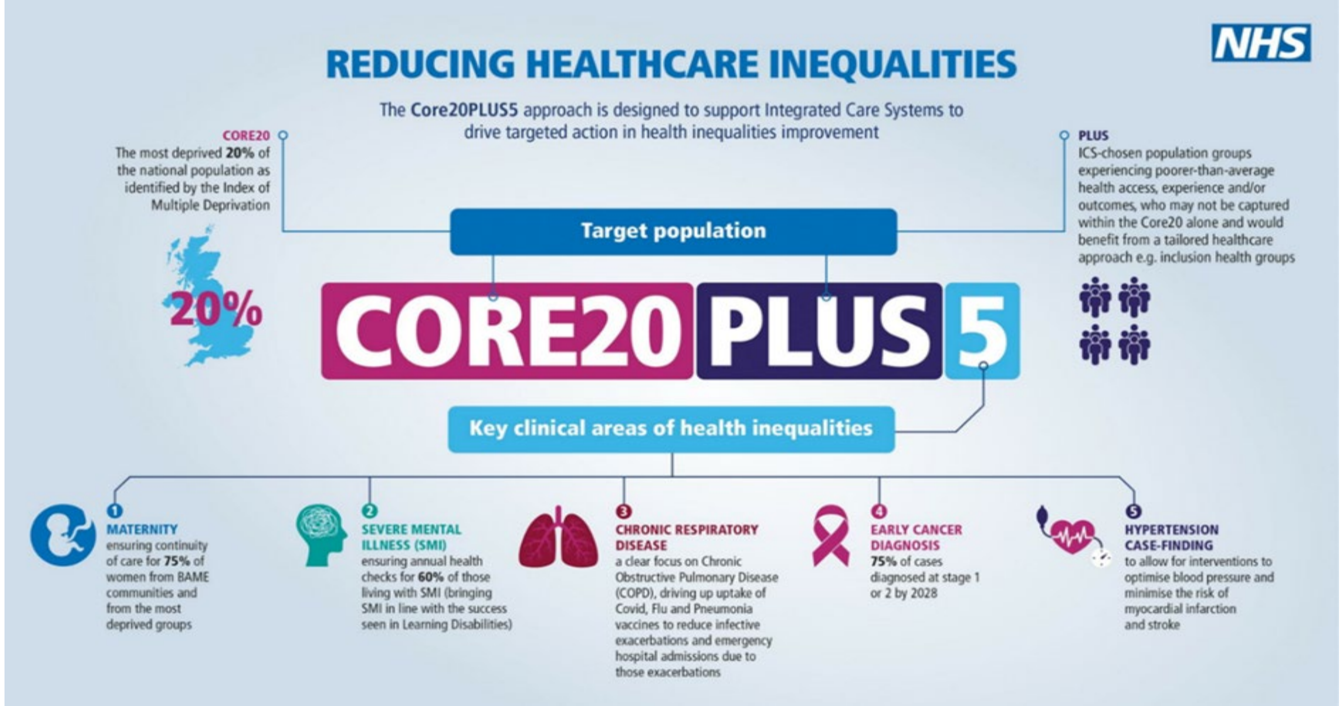
We want local people to be healthier, with everyone having a fair chance to live a long life in good health. Therefore, this Plan aims to 'level up' services and funding.

Our approach – Core20PLUS5

Core20Plus5 is the national approach to improving health equity and focuses on:

1 The people in LLR who live in the 20% most deprived parts of England (whom we know have disproportionately poor access and outcomes);
2 LLR seldom heard and underserved groups with additional barriers to good outcomes, such as those with learning disabilities, ethnic minority groups, carers and older people; and
3 Five key clinical areas (within 2, above) which are known to have the greatest adverse impact on life expectancy and healthy life expectancy (see Figure 11). More information about this approach, as well as on the CORE20Plus5 approach for children and young people can be found in Better Care for All, our Health Inequalities Framework.

Figure 11: The Core20Plus5 approach to improving health equity



System-wide interventions to improve health equity

Action to improve health equity happens at a number of levels. Firstly, we have included interventions, that the local NHS will implement, within the relevant sections of this Plan, most specifically, Chapter 3 (Delivery Plan).

We also work with our councils to support the delivery of health equity improvements highlighted within their Joint Health and Wellbeing Strategies (see 2.1) and Community Health and Wellbeing Plans.

Finally, key system-wide interventions are led by all LLR partners, with the ICB as a core Partner, and these are set out in Table 14, below, with more information available in the LLR Health and Wellbeing Partnership Integrated Care Strategy.

Table 14: Our key system-wide interventions to improve health equity

Intervention [From the LLR Integrated Care Strategy]	Timeline
1. Apply our Health Inequalities Framework principles across our three Places	23/24 onwards
2. Make investment decisions across LLR that reflect the needs of different communities	23/24 onwards
3. Establish a defined resource to review health inequalities across LLR	23/24 to 25/26
4. Ensure people making decisions have expertise of health inequity and how to reduce it	23/24 onwards
5. Improve data quality and use to enable a better understanding of and reduce health inequity	23/24 onwards
6. Health equity audits will inform all commissioning or service design decisions	23/24 onwards
7. Staff will be trained to understand and champion approaches to reducing health inequalities	23/24 onwards

Case Study

Improving health equity – Covid19 vaccine hesitancy in St Matthews

What was the issue?

Covid19 vaccine uptake data by ethnic group demonstrated that Leicester's Somali population had 49% uptake in over 50s, at March 2021, compared with 78% in the population overall. Over half of the Somali population live in two neighbouring areas of the city; St Matthews and St Peters.

Intervention

In-reach pop up clinic at a local faith centre

Community engagement:

- Zoom webinars hosted by a local GP and community leader
- YouTube video cascaded via the local community Whatsapp group
- Written materials sent to local shops, mosques, schools and community organisations
- Information sharing on the COVID helpline by population advocates
- Social media activity

Impact

Within a week of the interventions (by end March 2021), uptake in the over 50s Somali population had increased from 49% to 60%.

By August 2021, dose 1 uptake in the over 50s Somali population had reached 78%.

Applying the learning

The interventions have been used to target other communities and work settings where vaccine hesitancy existed.

4.2 Population Health Management

What do we mean by Population Health Management (PHM)?

At its most basic, PHM uses data – be that health, social care, education, demographic or housing data – to understand the needs of a population. Its main purpose is to help identify groups (cohorts) of people and match them to the correct intervention to improve health outcomes.

PHM includes two key tools – segmentation and stratification:

- Segmentation essentially means dividing people into groups. This could be by common illness, groups of illness, age or other factors
- Stratification is simply another term for sorting, but there is more analysis applied here, as the sorting is into risk factors

Principles of our Population Health model

The "Manage Need, Not Just Demand" model

- Prevention at every stage: Prevent – Reduce - Delay
- Parity of esteem for mental and physical health
- Health as co-production between clinicians, communities, families and individuals
- Relentless transformation for greater health equity - of access to care, experience of care, and outcomes of care. Driving up health equity will require integrated and collaborative work with partners to address the wider determinants of health alongside NHS care
- Focus on value-based commissioning of services with Partners – including a proportionately universal approach to resource allocation
- Evidence-based treatment, at scale where possible – research to fill in the gaps in the evidence
- A "learning culture" to improve the model – rigorous evaluation based on the quintuple aim of PHM
- A life-course approach to optimal health – it's never too late to improve experience of care or outcomes of care

Our approach

Make every contact by the NHS count **(MECC)**

We will use all types of contact that people have with the NHS to promote health and help people prevent illness or manage it effectively (see 3.1).

Self-management and self-care programmes delivered at scale for those with chronic conditions

Living well and staying well when you have a condition that cannot be cured requires practical skills and a knowledge of when to look for support from others. These skills will be taught and refreshed through structured programmes based on the latest theories of learning and behaviour change (see 3.2).

Population needs profiling

We will utilise, for example, JSNAs, risk stratification, segmentation, impact profiling and feedback from people with lived experience.

Integrated Care for a targeted cohort

With multi-morbidity/frailty or evident disadvantages in the wider determinants of health (see 3.3).

Time-bound (though intensive) case-management
For a small cohort of people with emergent instability of symptoms.

A shared record that is well-coded and well-tended
This is essential both for continuity of intent/care AND as the basis for better health equity and evaluation of schemes (see 4.6).

A tiered matrix of out-of-hospital urgent and emergency care
Bring comprehensive assessment and senior decision makers to bear on presenting illness in a timely and appropriate manner. Linked back to risk stratification profiles and self-management programmes (see 3.3).

A well-structured programme of informal carer support
This will include identification, registration, health checks, vaccination, respite, benefits optimisation, training and skills.

Delivering prevention, health promotion and treatment on a household footprint
Rather than to individuals, where possible.

Work in concert with other system Partners to help address issues relating to the wider determinants of health
Beyond the scope of this Plan – though a core part of our approach.

Case Study

Population Health management – better end-of-life support

What was the issue?
The team at Willows Health in Leicester had previously struggled to proactively identify people who were potentially nearing the end of their lives, in order to ensure they are given appropriate care and support

Intervention
The team adopted a PHM approach and, using a new algorithm called the Mortality Risk Score, they were able to identify a number of patients who had not previously been included on the palliative care register.

Impact
This approach has supported care planning work with palliative care patients and enabled the team to provide patient-centred reviews and end-of-life care plans for those with higher levels of risk.

Applying the learning
The team are now able to offer the right support to a greater number of patients who are nearing the end of their life.

4.3 Quality Improvement

Core Responsibilities and Functions

Our approach to quality and performance improvement is underpinned by our Quality and Performance Improvement Strategy, as well as NHS England's Quality Functions and Responsibilities of Integrated Care Systems, which summarises how quality functions are expected to be delivered:

1. Establishing quality governance arrangements, including a System Quality Group
2. Putting in place quality systems and assurance
3. Implementing arrangements to ensure patient safety
4. Improving people's experience of care
5. Ensuring clinical effectiveness
6. Safeguarding arrangements
7. Enacting new duties (abuse and violence, mental health and quality improvement programmes): and
8. Sustainability.

Our Priorities for quality improvement

Patient Safety

Whilst our individual healthcare providers are accountable for their learning responses to patient safety incidents, we work collaboratively, across LLR, to facilitate and provide supportive oversight, including in the implementation of the new Patient Safety Incident Response Framework (PSIRF). The PSIRF sets out the NHS's revised approach to developing and maintaining effective systems and processes for responding to patient safety incidents for the purpose of learning and improving patient safety.

Infection Prevention and Control

We work collaboratively with our healthcare providers, bringing oversight, leadership, support, and guidance to ensure effective management in the prevention and control of infections.

Serious Violence Duty

We work as a member of the LLR Strategic Partnership Board (SPB) with local authority, police, justice system, fire and rescue and other Partners to share information and collaborate on interventions to prevent and reduce serious violence and crimes. In order to discharge our duties under the Police, Crime, Sentencing and Courts Act 2022, the SPB will develop and implement a Strategy to prevent and reduce serious violence across LLR. At a more local level, we are members of Community Safety Partnerships (CSPs), which provide a multi-agency approach to tackling local issues with the aim of making communities safer.

Safeguarding

It is the responsibility of each of our Partner organisations to ensure that people in vulnerable circumstances are safe and receive the highest possible standard of care. We are committed to promoting the safety and wellbeing of children, young people and adults who may be at risk of abuse or neglect and ensuring the health and well-being of Looked After Children.

Working closely with our Local Authorities, healthcare providers, safeguarding partnership and network of professionals we deliver against agreed Safeguarding Adults and Children's Boards Business plans. This work includes but is not limited to:

- Child Protection-Information Sharing
- Serious Violence Duty
- Female Genital Mutilation
- Prevent
- Modern Slavery and Human Trafficking
- Domestic Abuse
- Child Exploitation
- Mental Capacity
- Child Death Overview Panel

Special Educational Needs and Disability (SEND)

The ICB is working in partnership with Leicester City, Leicestershire and Rutland Councils, University Hospitals Leicester and Leicestershire Partnership NHS Trust, to collaborate in improving services and support for children and young people with SEND, as directed by the SEND Code of Practice 2015 (Children and Families Act 2014).

As an ICB we will:

- Commissioning services in partnership with our local authorities for children and young people aged 0-25 years old with SEND
- Working with local authorities and NHS health organisations to contribute to the Local Offer and provide information about health care services
- Working closely with: Leicester City and Rutland Parent Carer Forums and Leicestershire SEND Hub; supporting groups that represent young people with SEND; Health Watch; the voluntary sector; and community groups
- Making health care provision available where exceptional clinical health needs related to education are specified in Part C and G of individual Education, Health and Care Plan (EHC plan), as part of our commissioning role
- To work with local authorities in making decisions at all key stages for EHC plans.

Our NHS health organisations will:

- Supporting identification and support for children and young people requiring SEND provision and promote Individual Health Care Plans (IHCPs)
- Responding to requests for advice for EHC plans within the required time frame
- Working with local authorities to contribute to the local offer of SEND services available
- Working closely with: Parent Carer Forums supporting groups that represent young people with SEND; Health Watch; the voluntary sector; and community groups.
- The ICB SEND Designated Clinical Officer (DCO) is a dedicated role that supports Leicester, Leicestershire & Rutland and LLR ICB in implementing and embedding-statutory responsibilities for children and young people with SEND. The DCO supports health colleagues across the ICB and our health providers to ensure children and young people 0-25 with SEND have the right health support to achieve the best outcomes they possibly can. The DCO also works with the local authorities in making decisions at all key stages for EHC plan and agrees the health services within an EHC plan.

Medicine Optimisation and Safety

We will enable transformation and support the pharmacy workforce to:

- Reduce health inequalities through improving access and optimisation of medicines
- Tackling antimicrobial resistance
- Tackling overprescribing and reducing the prescribing of drugs of dependence
- Reduce the environmental impact of medicines and dispensing
- Transform community pharmacy to support acute and elective care pathways
- Develop an integrated system workforce approach driven by the pharmacy faculty; and

- Reduce patient harm from medicines.

Maternity

We will respond to the NHSE Single Delivery Plan for Maternity by listening to our women, growing and supporting our workforce and supporting the positive leadership culture. This will be underpinned by our approach to safety and delivering a personalised, equitable service. Specific focus will be on:

- Improving the Maternity Voices Partnership
- Integrating 1001 days into our maternity transformation programme
- Embedding the learning from national maternity reviews including Ockenden and Kirkup
- Implementing the Saving Babies Lives Care Bundle
- Increasing personalisation and choice
- Improving access to the perinatal mental health service
- Improving the safety culture across our services.

Strategic Commissioning

The planning and delivery of the 5-Yearfive year plan and yearly Operational Plans are underpinned by the quality and safety strategy, implementation of quality improvement methodologies and processes that ensure the impact on patients and staff are fully understood and therefore inform decision making, thereby minimising risk and potential harm as a result of competing demands for limited system financial resources.

We will use Equality and Quality Impact Risk Assessment tools and Clinical Prioritisation Framework to evaluate any plans and business cases that are developed. By doing so, we ensure that decisions are based on an understanding of the impact on equity, clinical risk and quality, and identification of risk that can be mitigated. The equity focused approach enables us to consider the needs and perspective of all groups, and to address potential health inequalities that may arise.

Our goal is to make informed decisions, promote better health outcomes and a fairer healthcare system for everyone.

Direct Commissioning Delegation

On 1st April 2023, we assumed responsibility for community Pharmacy, Optometry and Dental services (PODS) from NHS England. The aim of delegating POD services is to make it easier for organisations to deliver joined up and responsive care, delivering high quality primary care services for our population. Work is taking place across the East Midlands area to review what this will look like, operationally.

Quality assurance: measuring and monitoring quality

The success of our approach to quality improvement is measured against the three core elements of quality (see Figure 12)

Figure 12: The three core elements of quality

1. Effectiveness

Clear quality improvement priorities based on a sound understanding of quality issues within the context of our local resident's needs, variation and inequalities. This also includes sharing data and intelligence across the system in a transparent and timely way.

2. Patient and Public Experience

Meaningful engagement ensures that people using services, the public and staff shape how services are designed, delivered and co-evaluated. This includes working together in an open way with clear accountabilities for quality decisions, including ownership and management of risks, particularly relating to serious quality issues.

3. Safety

Sharing data and intelligence across the system in a transparent and timely way and moving to a culture of shared learning, review and understanding of care. The safety agenda includes recognising the impact of decisions made at system level given the financial constraints the system may experience. In order to do this effectively LLR is developing a joint equality and quality impact assessment framework to support the assurance of our decision-making which is clinically led.

We have robust quality assurance arrangements in place, the key elements being:

Quality and Safety Committee

Receives intelligence from the System Quality Group and provides assurance to the ICB.

System Quality Group

With membership from across our NHS, primary care and local authority partners, this group has responsibility for sharing quality intelligence, learning, engagement improvement and planning.

Clinical Executive Group

Interdependent, but separate to the ICS quality function, this Group provides clinical leadership to the ICS.

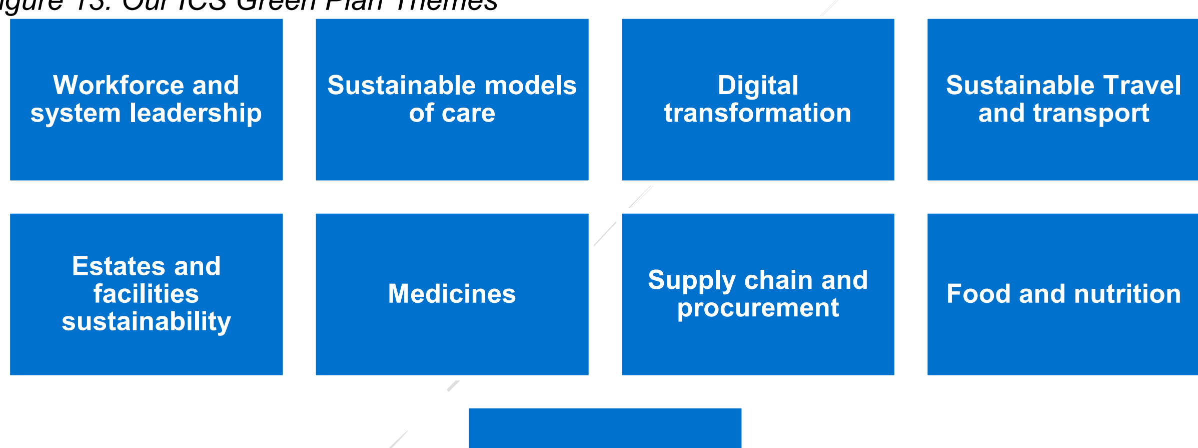
4.4 Delivering a Net Zero NHS

We launched our LLR ICS Green Plan in February 2023 and this sets out how our local NHS:

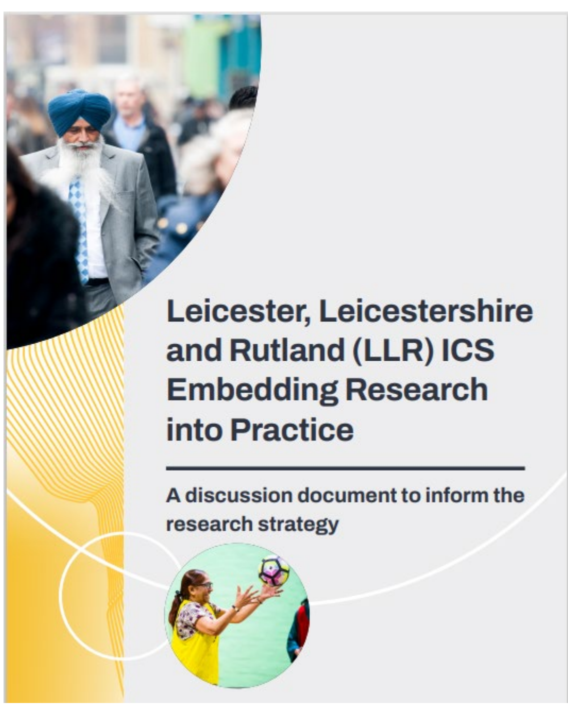
- Plans to deliver against the targets and actions in the Delivering a Net Zero NHS report.
- Supports the NHS-wide ambition to become the world's first healthcare system to reach net zero carbon emissions
- Plans to prioritise interventions which simultaneously improve patient care and community wellbeing while tackling climate change and broader sustainability issues across LLR; and
- Work collaboratively to deliver tangible reductions in emissions and improved outcomes.

The plan articulates where we can lever our collective resources for the widest benefit, including improving health equity. It is structured across nine themes (see Figure 13) each underpinned by a set of key actions.

Figure 13: Our ICS Green Plan Themes



4.5 Research and innovation



Our vision

We will ensure that research and innovation play a central role across our ICS partners. There is already a substantial breadth and scale to research activities across LLR, through our research infrastructure organisations and universities. This work is described in more detail in our discussion document "Embedding Research into Practice"

We have established a Research Strategy Board to steer and oversee the continued development and maturity of our research activities. This Board brings together institutional partners and other stakeholders across the range of health, social care, local authority and higher education institutions. Working with these partners, we will deliver the vision set out in Saving and Improving Lives: The Future of UK Clinical Research Delivery. This will be achieved by building on existing strengths and infrastructure, developing new areas of research and ensuring integration with clinical service and communities.

Principles underpinning our ICB research approach:

1. To support research funding applications being made by our academic, health and care partners, where these are relevant to the work of the ICB
2. To support the conduct of research studies undertaken by academic, health and industry partners across the breadth of its work
3. To provide a forum to bring together partners (including research infrastructure such as the Leicester Biomedical Research Centre, Applied Research Collaboration – East Midlands and Leicester Clinical Research Facility) to form productive clinical-academic networks that can work together to respond to specific research calls from national funding bodies (Medical Research Council and National Institute for Health and Care Research) in a timely way
4. Ensure processes are in place to provide robust research governance and quality assurance. We have already taken important steps to achieve this through the integration of our ICB research governance operations with those of UHL
5. Endeavour to facilitate participation in research across all areas of health and social care so that patients are routinely offered participation in research studies as part of their care; and
6. Support (with appropriate data governance) access to clinical data for the purposes of research for our partners.

The ICB is not a research funding body but, where feasible and where resources permit, the ICB will seek to build capacity for research across partners and within the clinical workforce through:

- A focus on promoting and supporting research activity involving primary care and, more generally, into prevention and health inequity
- An ambition to increase the number of non-medical clinicians as participants in our research active communities; and
- Promoting the analysis and utilisation of local clinical and care data through our partnership with academic institutions and research infrastructure, with the purpose of informing service transformation and evaluation, as well as the establishment of new models of care.

Research into practice in LLR

Developing new treatments for cancer – Immunotherapy for mesothelioma

Mesothelioma is a devastating disease caused by asbestos – the only occupation-caused lung cancer. In light of poor treatment options, the National Institute for Health and Care Research (NIHR)-funded James Lind Alliance Mesothelioma priority-setting partnership, identified the top research question as whether boosting the immune system with new immunotherapy agents could improve survival rates. We led a clinical trial called CONFIRM (CheckpOiNt Blockade for Inhibition of Relapsed Mesothelioma) funded by Cancer Research UK & Standup to Cancer. This compared the immunotherapy nivolumab with placebo and received television coverage on Channel 4.

Improved survival was seen and presented as a plenary in the 2021 World Lung Cancer Conference.
Leicester has led at a global level, advances in treatment for mesothelioma. In addition to CONFIRM, the Cancer Research UK funded VIM study, comparing chemotherapy with vinorelbine versus active symptom control, demonstrated benefit and now this drug is used widely in the NHS. Leicester has pioneered therapy for mesothelioma based on the tumour genetic makeup with MIST, the world's first mesothelioma platform trial (funded £3M by the British Lung Foundation). It has demonstrated an improvement in overall survival for patients with relapsed mesothelioma. Nivolumab is now available on the NHS, constituting a change of practice in the UK

4.6 Supporting broader social and economic development (anchor institutions)

What are anchor institutions?

Anchor institutions are large organisations that are likely to remain in an area and have a significant stake in their local area. They have “sizeable assets that can be used to support their local community’s health and wellbeing and tackle health inequalities, for example, through procurement, training, employment, professional development, and buildings and land use”.

Our NHS partners are anchor institutes, being large organisations and substantial employers with significant spending power. Fully utilising the opportunities of anchor institutions could result in substantial impact on health and wellbeing equity. This can happen through addressing the wider determinants of health in a way that is appropriate to large health organisations and their broader impact than the clinical health and wellbeing outcomes.

Figure 14 shows the wider determinants of health. It shows the interaction between environmental, social and cultural factors on health and wellbeing. Unemployment and the conditions that people live and work in influence people’s health and wellbeing. It is in these areas, plus the general socio-economic outlook of an area, where anchor institutions can play a wider role beyond healthcare delivery.

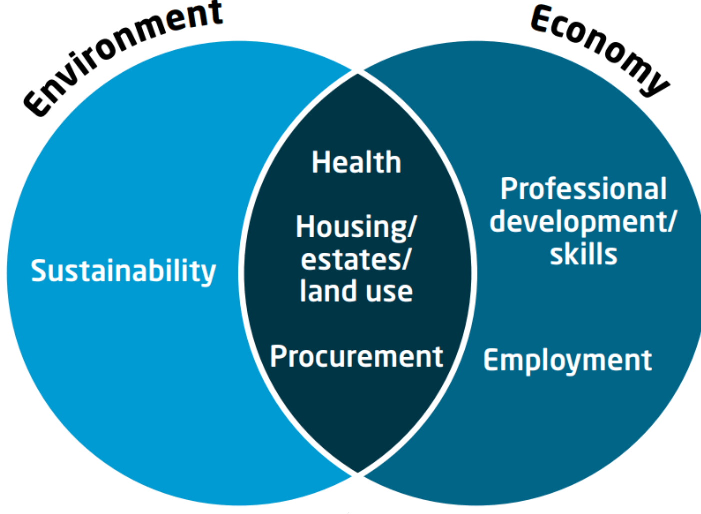
Figure 14: The Wider Determinants of Health, The Dahlgren-Whitehead rainbow model

The King’s Fund model for anchor institutions considers two broad categories of the environment and the economy (see figure 15). It sets out a possible structure to develop further thinking and action plans for our anchor institutions.

Our current actions and plans for this area inlcude:

- Bring together partners from the NHS, local authority, primary care, independent care providers, third sector and education to support, develop and grow our local health and social care workforce through the LR ICS ‘One Workforce’ approach. Working in partnership with local communities to make a difference, for example being a good employer and creating opportunities for local communities to develop skills and access jobs in the local health and care sector, particularly aimed at disadvantaged and under-represented communities.
- Through our Estates programme, we will explore opportunities to better harness NHS buildings and spaces to share benefits, co-locate services with our public sector and voluntary sector partners and support our local communities.

Figure 15: The key areas of interest for anchor institutions in the health and social care sector



- Through the revised procurement practices outlined within our LLR ICS Green Plan, we will promote the redirection of investment to support our local suppliers and economy. Adoption of Social Value Model will ensure that economic, social and environmental wellbeing is a key consideration in our supply chain actions.
- Through the LLR Health and Wellbeing Partnership, we will ensure that the ICB works with our local partners beyond health to cascade good and innovative practice, model civic responsibility across our anchor network. We will influence wider economic development and environmental balance, in order to improve people's health and wellbeing and reduce health inequalities.

Chapter 5: Enabling delivery of this Plan

In this chapter, we describe the building blocks that, put together, provide the essential framework within which we can deliver our preventive work, keep people well, improve health equity and deliver the best possible health and care for local people. We describe how we will maximise the benefits of new digital technologies, as well as how we will make sure our estate is fit for purpose and used effectively.

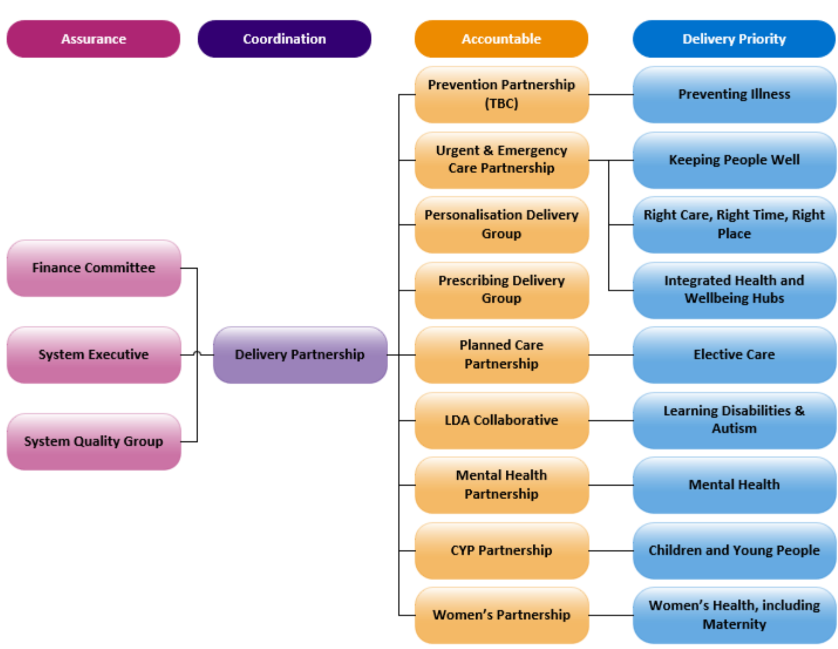
5.1 Our approach to transformation

To deliver this Plan, we have organised ourselves to focus on those services and areas we want to transform. Each of these areas is led by a Collaborative or Partnership (See figure 16) with multi-professional membership from across our partner organisations. Clinical and managerial leadership is also shared across our partners.

The ethos of these groups is to identify areas where outcomes are sub-optimal or could be improved and work together to transform the pathways across the system to address the issue. Ultimately, these Groups are tasked with improving outcomes and health equity, based on a population health management approach (see 4.2) whilst ensuring best value for money across health and care services.

The transformation portfolio is led, predominantly through our ICB transformation teams. However, as we mature as a health and care system, our providers are taking the lead on more programmes of transformation. Regardless of leadership of each programme of work, the objectives for each are agreed collaboratively across the programme of work and read across to both Health and Wellbeing Board objectives in each of our places, as well as individual provider operational plans and strategies.

Figure 16: Our Partnership structure:



Each collaborative or partnership requires system-wide intelligence to function. Our programme infrastructure, therefore, has embedded within each team digital, workforce, estate, finance and other expertise, intelligence and insights, in order to inform a high-quality decision-making process and to evidence both short and medium-term improvements.

We recognise that interdependencies are often missed through this individual programme approach, with vital intelligence missed within and between groups. To ensure that

interdependencies are understood and to allow for system-wide expertise to confirm and challenge programmes of work, the LLR Delivery Partnership brings together each collaborative or partnership monthly. This allows for a coordinated, standardised set of reporting to be taken to ICB sub-committees to either provide assurance on delivery of transformative objectives or seeks support through a standardised escalation process from the sub-committee structure.

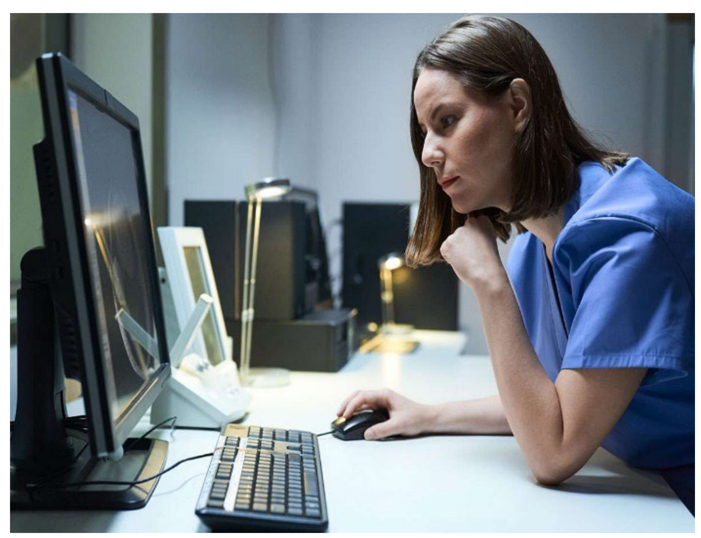
For example, escalations can be made seeking support to the System Quality Group or the ICB Finance Committee monthly. This ensures that transformation programmes have a space to evidence delivery but also to escalate any issues impacting on delivery for further senior support. This approach drives delivery, collaboratively, and considers the complexities of working in a matrix fashion across health and care.

Each transformation programme uses a quality improvement methodology and seeks to implement an inquiry led approach, rather than an advocacy led approach, ensuring that decision-making process is of high quality, and is underpinned by sound and rational analysis of both need and impact.

The complexity of delivering transformation, considering equity, resource utilisation, quality, performance and other national, regional and local mandates, should not be underestimated. Our programme structure and, therefore, infrastructure is as agile as it can be across the multiple layers of governance across health and care. Changes to the structure and infrastructure are implemented at pace, as required, as we seek to deliver this Plan in partnership with all our partners and local people.

5.2 Digital and data

Our digital vision



Our digital approach is enabling and proactive, transforming culture, processes and operating models, harnessing the technologies of the digital age to respond to raised expectations of the public, patients and service users, whilst protecting health equity for all our population.

We are achieving this vision by ensuring we have good digital governance and leadership, delivered through an integrated model for health and social care, linking in with clinical collaboratives to provide a coherent and connected service for local people and our workforce. This will improve patient and service user experience, overall efficiency and value for money.

Our Digital Strategy, which includes our NHS partners and adult social care within scope, will deliver the following seven long-term strategic goals:

- We will have a clear and empowered governance structure
- We will have levelled-up all partners will have a consistent level of digital maturity
- UHL will have a mature Electronic Patient Record (EPR) system with tight integration to niche departmental systems, capable of sharing data with the Shared Care Record
- The ICS will have digital capacity and capability to support future digital needs
- Data quality will have been improved so it can be used for secondary purposes such as Population Health Management
- We will consolidate duplicated systems into a cohesive digital ecosystem; and
- Supported the transformation of care pathways such as maternity, end of life and long-term conditions with digital enablement.

Our digital strategy will require additional investment, over the next three years which will be subject to NHSE allocation announcements or bidding. This will require a collaborative system-first approach, with the endorsement and support of all partner organisations and the resource capacity to focus on the transformation programme.

System-wide digital and data interventions

We have included the service specific digital and data interventions we intend to implement under the relevant section of Chapter 3 (Delivery Plan). Key system-wide digital and data interventions we intend to implement are set out in Table 15 below.

Table 15: Our key system-wide digital and data interventions

Intervention	Timeline
1. Establish an ICS-wide Digital Team	23/24
2. Digitally enabled GP Front door to support Primary Care Access	25/26
3. Data Strategy to support Population Health Management	23/24
4. Tackle Digital Exclusion and increase uptake of NHSApp	23/24 onwards
5. Electronic Patient Record in UHL	23/24
6. LLR Care Record	23/24

5.3 Our estate

What is the 'estate'

By *estate,* we mean the sum total of real property - buildings, land, vehicles, and equipment - which comprises our assets.

An overview

Our Partners are working more closely together as an ICS, and this has provided the opportunity, for the first time, to consider the totality of our NHS, local authority, primary care and other estate. Limitations and constraints that our individual Partners experienced in the past with their estate, can now be considered in a wider context, where the opportunities and resources of scale can bring benefits. For example, we can look at over and under-provision, the proximity of one Partner's buildings to another, as well as the opportunities to expand and contract, across the totality of our estate.

Our Estates Strategy

Each of our Partners have their own estates strategy, including a Primary Care Estates Strategy, developed by the ICB. During 2023/24, we will develop an overarching LLR ICS Estates Strategy, across all our Partners, setting out where we can collectively make the best use of our estate to be ready for implementation by April 2024. Some of the key areas we expect the strategy to focus on are:

Planning for growth

Working closely with our local authority planning partners to understand the scale and timescale for housing growth (Strategic Growth Plan (llep.org.uk), and assessing the associated healthcare needs that this will bring, as well as the need for health estate. We also have a key role in maximising the funding available (S106 funding) for health estate.

Integrated Health and Social Care Teams (or Health and Care Hubs)

Managing the estate implications of bringing health and care teams together to provide more integrated and personalised care to local people (see 3.4).

Changing working practices

Covid-19 enforced changes to working styles, some of which have now become standard practice, and which set the tone for future arrangements. The estate will need to adapt to support these new working styles. This increases the opportunities to move operational and support services to more convenient locations to achieve wider benefits.

One Public Estate

There are opportunities to drive efficiencies, share benefits, and co-locate services with our public sector and voluntary and community sector partners, where this is beneficial to local people, patients and service users.

Effective utilisation of our estate

One of our key priorities will be to ensure that we are making the most effective use of our estate including our community sites and those properties owned by NHS Property Services and Community Health Partnerships. One of our key priorities will be to ensure that we are making the most effective use of our estate including our community sites and those owned and managed by NHS Property Services and Community Health Partnerships. The Strategic Estates Team has built essential

relationships to ensure the ICB receives regular, timely, utilisation data whilst also exploring opportunities for long-term tenancy arrangements seeking to maximise usage. Working collaboratively with our Partners is a crucial step towards achieving this goal.

UHL reconfiguration programme

The reconfiguration programme will deliver the reconfiguration of Leicester's Hospitals to create two acute hospitals: The Leicester Royal Infirmary, and Glenfield Hospital, whilst re-purposing the Leicester General Hospital. It will build on the investment to date to support four main areas of activity, which we aim to complete by 2030. This clinically led programme of transformation will deliver the change that was publicly consulted on in 2020:

- Development of a new women's hospital at the Leicester Royal Infirmary
- Creation of a dedicated children's hospital, also at the Leicester Royal Infirmary
- Expanded intensive care facilities at the Leicester Royal Infirmary and Glenfield Hospitals
- The separation of planned and emergency care services where possible, including new wards, theatres, out-patients and a day case unit with theatres at Glenfield.

The re-purposing of the Leicester General Hospital site will include:

- East Midlands Planned Care Centre high volume, low acuity care (Out-Patients and Day Cases)
- Diabetes Centre of Excellence
- Community Diagnostic hub, including imaging facilities (scans and x-rays)
- Stroke Recovery Services with inpatient beds
- Midwifery Led Unit (re-located from St Mary's in Melton Mowbray).

Over the last five years, over £160 million has been invested to successfully achieve the following:

- The opening of the East Midlands Planned Care Centre (EMPCC) Phase 1 at the General Hospital (May 2023). When the Centre is fully open in late 2024, approximately 100,000 patients will be seen each year
- Interim ICU and associated services move from the General Hospital to the LRI and Glenfield Hospital (2022)
- East Midlands Congenital Heart Centre move from Glenfield Hospital to the LRI (2021)
- The new Emergency Floor and Emergency Department (April 2018)
- The move of vascular services from the Royal to the Glenfield site and the opening of a new Angiography Suite (May 2018)
- A new hybrid theatre (May 2018) offering 'state-of-the-art' imaging equipment to allow a greater proportion of new and complex procedures not previously possible.

Primary Care Estate Strategy

Our Primary Care Estate Strategy aims to support General Practice primary care services, as well as our wider partners, to provide high-quality services delivered from modern, fit-for-purpose and flexible premises. The Strategy objectives are to:

- Gather data and intelligence to understand the condition, capacity and utilization of our GP primary care estate;
- Prioritize those premises in need of improvement, expansion or replacement and implement a programme and framework to drive and support premises improvements;
- Ensure systems are in place to challenge and support GP Practices, NHS and private landlords to maintain and invest in their premises including areas such as addressing backlog maintenance, health and safety and the quality of the premises;
- Improve the quality and condition of the estate and the physical capability and capacity for primary care provision;
- Support the development of Primary Care Networks, Place services and the delivery of new models of care;
- Address population growth/housing developments through maximising the potential of developer contributions to support premises improvements and increased capacity;

- Collaborate with ICS partners to manage and develop our combined estate at system, Place, neighbourhood and individual premises level;
- Reduce risk & improve service resilience at local and system levels;
- Increase efficiencies through improved utilization of existing primary care and the wider
- public estate;
- Rationalise and dispose of surplus or unfit NHS estate;
- Maximise future estate flexibility and develop a greener NHS through smart estate design solutions to support sustainable service models; and
- Support improvements in service efficiency and better outcomes for our residents.

System-wide estate interventions

We have included the service specific estate interventions we intend to implement under the relevant section of Chapter 3 (Delivery Plan). Key system-wide estate interventions we intend to implement are set out in Table 16 below.

Table 16: Our key system-wide estate interventions

Intervention	Timeline
1. Develop an LLR ICS Estates Strategy 2. Improve the effective utilisation of the health estate 3. Oversee and refine Section 106 application and spending mechanism 4. Work collaboratively with public sector estates partners	23/24 From 23/24 23/24 From 23/24

Chapter 6: Our Finances

Local context

In recent history, LLR has incurred financial deficits (overspends) in each year. In 2020/21 and 2021/22, a combination of extra funding for Covid-19 and reduced elective care costs (because, for example, appointments and surgeries were cancelled) enabled the system to achieve a break-even financial position.

In 2022/23, we planned to break-even, but additional challenges from inflation, workforce costs and emergency and mental health demand have led the system to revise our forecast, in year, to a £15m deficit.

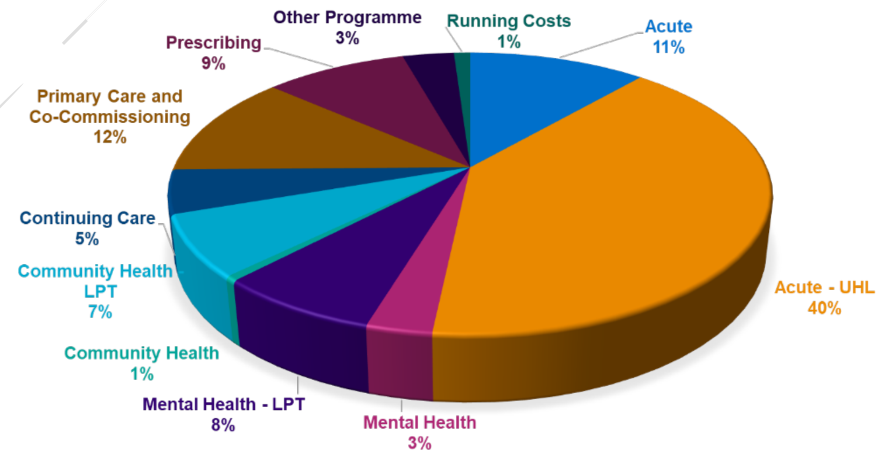
As a system, we are working well, collectively, and there is transparency and openness in the management of the financial position. We fully intend to retain these strong relationships and build further on them.

In 2023/24, our financial plan is extremely challenging, with an efficiency requirement of £131.5m, which is 6.4% of our system allocation. There are significant financial risks (£204m including non-delivery of some efficiencies) at the outset of the year which need to be mitigated to ensure delivery of the £10m planned deficit.

Taking all of the above into account, our financial strategy needs to build upon the system control we have developed and support transformation to bring the system into a sustainable position. The following sections describe how we will achieve that for the local health and care system.

How we currently spend our resources

Of the £2bn LLR has to spend, over half (51%) goes into providing hospital care, with 19% spent on community and mental health services and 21% across Primary Care Services (including Prescribing).



Achieving our financial goal

Our goal is to support the delivery of this 5YP within the resources available to us.

We will do this by:
- Investing in health inequalities and prevention;
- Reducing unnecessary attendances through interventions that keep people at home;
- Better flow – more timely discharge through use of Out of Hospital interventions, social care, etc.;
- New pathways – alternatives to improve the patient journey / digital first;
- Improving productivity/increase value in healthcare;

- Seeing more patients through the existing clinical capacity – repatriate spend on IS etc.;
- Achieving better value from enabling functions e.g. more efficient use of estate, reduced internal transactions;
- Reducing unwarranted variation in the costs of care;
- Investing more in upstream self-care to reduce significant costs and demand for services, as well as downstream, such as intensive hospital care, by ensuring timely and appropriate access to primary care services;
- Right sizing activity by addressing the issues that have occurred during covid such as backlog for elective care – using digital and other means so that this also improves the quality of the clinical experience; and
- Ensuring we have the infrastructure to support this by focusing on improving environment through upgrading our estate, maximising efficiency and best value through effective procurement, reducing carbon footprint and taking advantage of new innovative technologies.

Financial Principles

Our financial strategy is underpinned by the following principles to ensure that a sustainable financial position is achieved:

- Continuing to ensure strong financial control across the system, sharing openly and transparently our financial positions so we can best manage our finances collectively;
- Ensuring we set aside sufficient funding to support growth and to cover the costs of inflation;
- Productivity and efficiency must deliver at least 3% per year through moving to upper quartile in performance and elimination of waste;
- Consider the total resource allocation of £2bn across LLR and not just the use of new growth funds coming to the system;
- Evolve the role of partnerships to devolve resource through ‘lead provider’ collaborative arrangements as agreed for ‘Urgent and Emergency Care’;
- Set aside a small amount of additional funds for investment each year which following appropriate prioritisation will enable us to:
    - Invest wisely into programmes that can have a positive impact on our overall financial position and give the best value to local people;
    - Ensure we invest into prevention as well as treatment;
    - Invest in the areas where we can make a longer term impact in terms of both patient and financial benefits;
    - Support specific schemes, using a process for prioritisation and approval that will be consistently applied through a robust business case process; and
    - Focus service reconfiguration to enable reduced demand and reliance on acute services with more resilience in out of hospital and community based services.

Our financial challenge

Our current Medium Term Financial Plan (MTFP) model (see Table 17), projects a recurrent system gap, by the end of 2027/28, of £227m. This is the case if we adopt a ‘do nothing’ approach to efficiency delivery from 2024/25 onwards. In addition, the plan includes deficit repayments of £22m so that the overall financial challenge, over the next 4 years, is £248m.

If we also include the efficiency challenge in 2023/24 (£131.5m), the full scale of the financial challenge, over the next 5 years, is £380m.

Table 17, Modelling our system financial challenge

	System				
	24/25	25/26	26/27	27/28	5 Yr
23/24 Plan	(10,002)				
Remove 23/24 NR items	(70,706)				
Opening Surplus/(Deficit)	**(80,708)**	**(120,865)**	**(169,965)**	**(197,311)**	**(197,311)**
Tariff Inflation	**(36,798)**	**(38,449)**	**(40,591)**	**(42,411)**	**(158,249)**
Tariff Efficiency	**(7,848)**	**(8,088)**	**(8,334)**	**(8,589)**	**(32,859)**
Growth	**(47,075)**	**(49,325)**	**(52,213)**	**(54,704)**	**(203,317)**
Allocation increase	51,563	69,862	73,793	76,445	271,664
Investments (Elective Hub)	-	(23,100)	-	-	(23,100)
Additional efficiency	-	-	-	-	-
Efficiency schemes	-	-	-	-	-
Recurrent Surplus/(Deficit)	**(120,865)**	**(169,965)**	**(197,311)**	**(226,569)**	**(226,569)**
Deficit repayment	(7,264)	(7,264)	(7,264)	-	(21,791)
Total Surplus/(Deficit)	**(128,129)**	**(177,228)**	**(204,574)**	**(226,569)**	**(248,360)**
Total movement in period	**(47,421)**	**(56,363)**	**(34,610)**	**(29,258)**	

This model starts with an underlying exit position from 2023/24 of £81m deficit (thereby assuming full delivery of the 2023/24 plan).

There are many assumptions underpinning this model and it gives the best estimate we can generate of the scale of financial challenge we face.

Our proposed financial strategy – 5 year summary

The national ask, excluding any local adjustments, represents a pressure of £123m for the system within the 5 year period. Adding in local investments and pre-existing pressures deteriorates the position further to £248m (see Table 17).

Our proposed financial strategy (see Table 18) allows for a level of anticipated cost pressures as well as transformational investment which will support the delivery of a 3% efficiency. This has a beneficial impact on the value of uplifts applied as expenditure is reduced.

A further non-recurrent efficiency of £21.8m will be required to cover the historic deficit repayment

Table 18: 5 year financial strategy summary

5 Year Bridge Exluding 23/24 Risk	System £000
Uplift assumptions on I&E	(394,425)
Allocation increase	271,664
National ask	(122,761)
Elective Hub	(23,100)
Deficit repayment	(21,791)
23/24 Underlying pressure	(80,708)
Do nothing challenge	(248,360)
Cost pressures	(40,000)
Investments	(58,800)
3% efficiency	312,319
Impact on uplifts	13,059
NR efficiency required	21,791
Proposal challenge	10

Our proposed financial strategy – Year-by-year

Table 19 and figure 17 illustrate the year-by-year proposed financial strategy for the system to reach a sustainable breakeven position by 2027/28 via gradual investment and efficiency delivery over the medium term.

Table 19: Year-by-year financial strategy summary (£000)

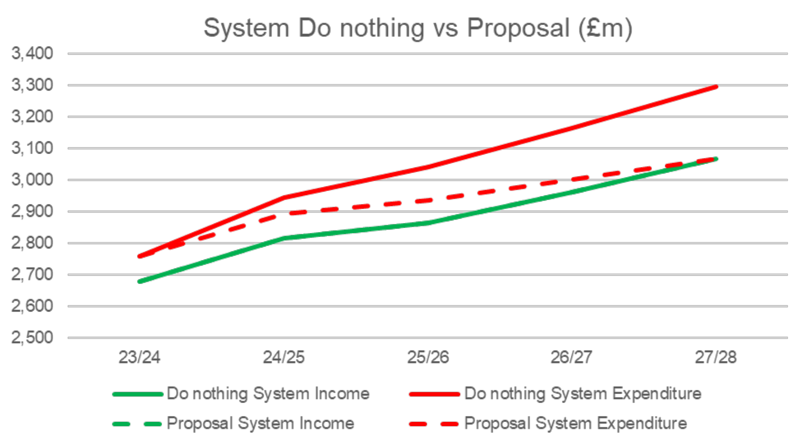
	24/25	25/26	26/27	27/28
Recurrent cost pressures	(10,000)	(10,000)	(10,000)	(10,000)
Recurrent Investment	(14,700)	(14,700)	(14,700)	(14,700)
3% Efficiency	75,603	77,008	79,127	80,581
Financial position	(77,226)	(71,947)	(40,575)	10

The following assumptions have been made:

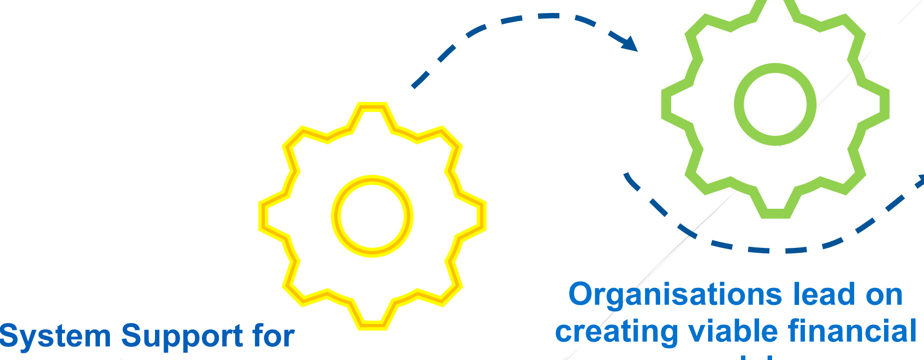
- Inevitable cost pressures to mitigate clinical risks have been provided for, recurrently, at £10m a year;
- Transformational investments have been funded, recurrently, at £14.7m a year; it is assumed the focus of these investments will be in line with strategic intentions of the five-year plan; and
- A 3% efficiency on costs has been applied across all areas and organisations each year.

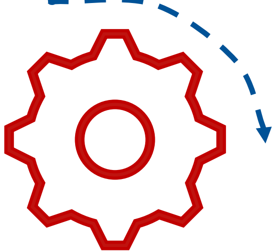
Figure 17: Year-by-year financial strategy summary (£000,000)

It can be seen, from the above, that investing a small amount and planning to save a realistic amount, recurrently, each year, will result in deficits within each year but will ultimately lead to a sustainable position. As is the case in 2023/24, it is likely we will need to seek further opportunities (non-recurrent or otherwise) to improve the financial position, each year, so that we can attempt to deliver a breakeven position in each year.



Method of delivery - Partnerships





System Support for the Strategy
This strategy will only deliver if all system partners, including LA's are on board.

Organisations lead on creating viable financial models
Organisations employ the clinicians and support staff and deliver the care, so need to be content that the financial model will deliver

Partnerships lead on system action to recycle the money
The opportunity for transformation comes from working across the pathway to minimise cost growth. It is recognised that there may have to be some 'invest to save' to deliver these benefits.

Chapter 7: Our People

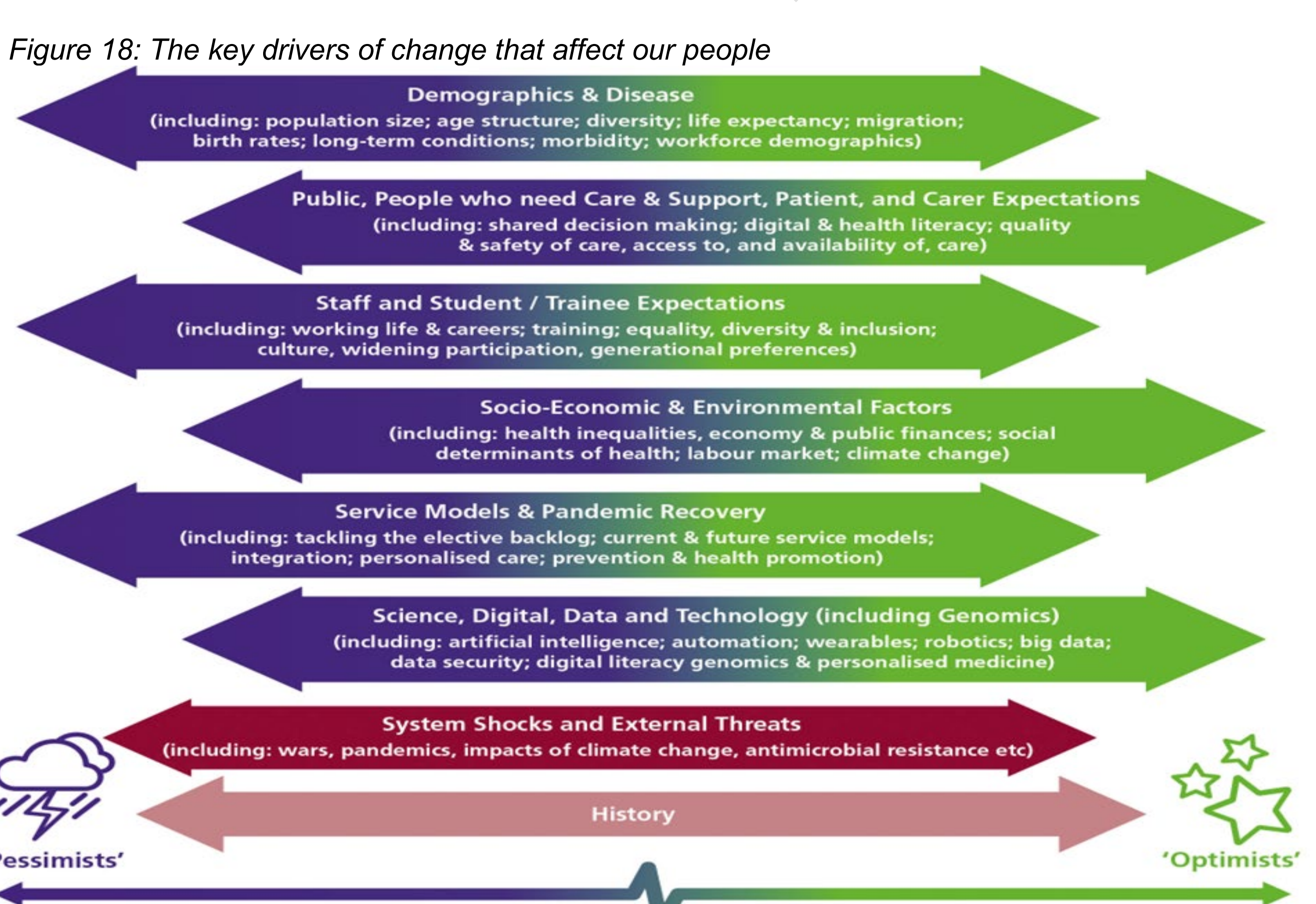
Local context

We have a combined health and adult social care workforce of 57,700 (see 2.4) – this is our greatest asset in providing local health, mental health and care services. These past three years have seen an unprecedented demand on services, as well as on our people, who have adapted and responded magnificently to the Covid 19 pandemic. As we recovery and respond to a post-pandemic environment, we face several challenges, the most critical being:

- Retention: retaining the workforce and skills we currently have;
- Attraction: attracting new talent and future pipeline of recruits;
- Growing for the future: to ensure we have the right skills, at the right time, in the right place, delivered by the right person; and
- Supply: filling current vacancies across health and Care to address the significant shortfall across GPs, nurses, midwives and other professional groups.

These challenges are significant and are driven by a combination of change factors which affect our workforce, including demographics, the labour market and working life expectations (See figure 18).

Figure 18: The key drivers of change that affect our people



Our People vision

Our aim is to make the LLR health and care system a great place to work and volunteer.

This is supported by our people vision:

Shaping our people & services around the needs of our population

Build a One Team, One People culture
Cultural change - behaviour change – Our collaboration will deliver fantastic care

Maximise the people potential of the LLR population and support wider economic & social recovery (Local Jobs For Local People)

Our people vision is underpinned by the following principles:

- Long term strategic people planning through different lenses: neighborhood, place and system;
- Connecting Multi-Year Education Training and Investment planning (METIP) with workforce growth, Future planning and models of care;
- Data informed and evidence-based decision making, and business intelligence driving our focus;
- Attractive and supportive employment packages;
- Sustainable people solutions linked to our LLR people and communities;
- Growing for the future with training at the heart of developing our people; and
- Partnership working across all health and care providers, voluntary services and educational and training sector.

Our approach

In response to the challenges, our People Strategy is delivering intervention programmes to enable attraction, recruitment, retention and supply of people. At the heart of our plans is ensuring we are looking after our people's health and wellbeing, as well as creating a compasisonate and thriving culture.

Case Study

Our people – *Developing diverse leaders*

What was the issue?
Whilst we have many success stories of colleagues from diverse backgrounds stepping up into leadership roles, our data showed that there are differences in progression to leadership roles in nursing, Allied Health Professionals (AHP) and midwifery, for colleagues from BAME backgrounds, compared to other ethnic groups.

Intervention
A pilot programme - Developing Diverse Leaders (DDL) - for nursing, AHP and midwifery colleagues.

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
- Informal networking and support opportunities for participants
- 'drop-in' sessions with Executive Leaders and access to coaching and/ or mentoring via the LLR Leadership Academy
- Ongoing check-ins and career reporting to understand each participants career aspirations and career successes over the next two-years.

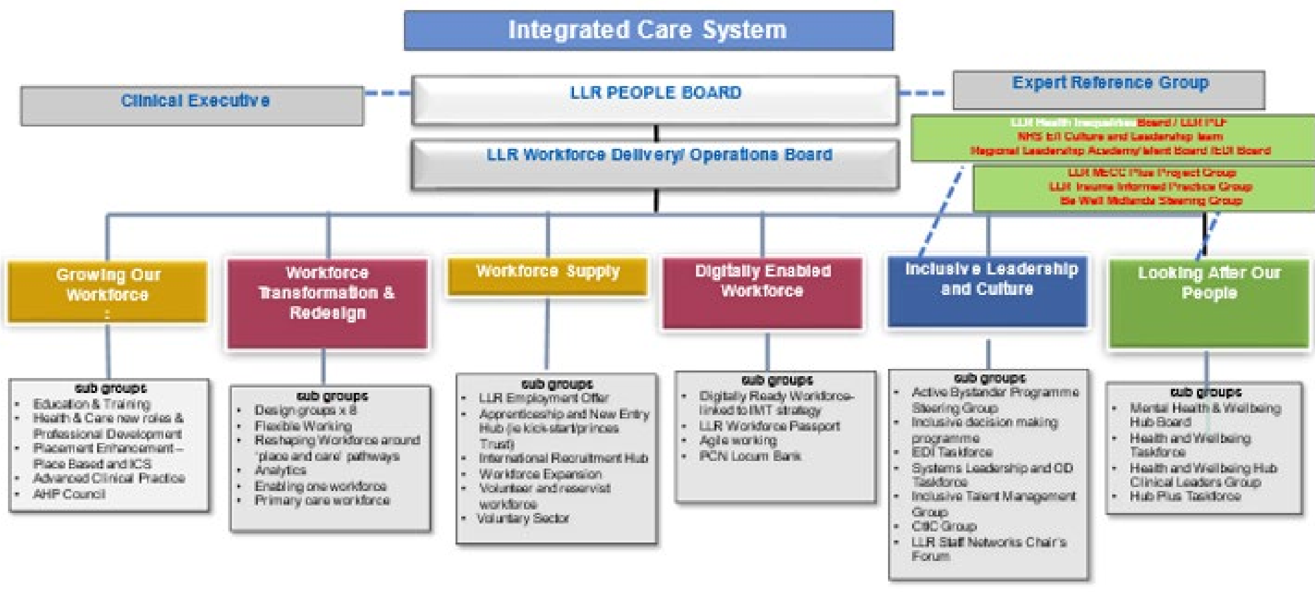
Impact
The programme is ongoing, however, reported impacts include:

- Relationships and trust has developed within the groups, consolidating into ongoing peer-to-peer support
- Participants have reported key 'moments of impact' and increased confidence levels
- opportunities for reflective practice have been welcomed, and many participants are already sharing their new knowledge and understanding with other colleagues.

Applying the learning
The longer-term outcomes of this programme are being tracked, however, this pilot programme is already demonstrating the power and impact that comes from BAME colleagues having the opportunity to focus on their own development.

Our LLR People Board, which has representation from across all our partners, oversees our people intervention programmes, which are summarised in figure 19.

Figure 19: Our people intervention programmes



Organisational, leadership and people development

We have an amazingly diverse and talented group of people who work for us, and alongside us. We know that, at times, the work is not easy and some of the problems we face cause frustration. And yet we come together, we try, and we find solutions. We observed and experienced this during Covid 19 – *we don't want to lose that LLR spirit*. We want to build on our reputation as trailblazers, so we make the LLR Health and Care community the place in which people want to work, make their careers, develop, grow and thrive. When this happens, when staff feel that where they work is inclusive, respects difference and that they belong, people feel valued, and we know that this translates directly into the quality and experience of care that people receive.

We have an ambitious programme of work under the Inclusive Leadership and Culture workstream, as part of our LLR People and Culture Plan, and which will make a difference, on the ground, to our staff. When we can do this more consistently, at the level to which we aspire, we will create the inclusive environment we all want and deserve. We are committed to working together with respect, trust and openness to deliver our BIG three challenges:

- '**getting the basics right** – the pounds, the waits and the care';
- '**Health Equity** – our defining way of working and our added value'; and
- '**People** – our opportunities to make LLR a great place to work, contributing to society and treating our people well'.

LLR is already building on a strong foundation of innovative and collaborative working, but we are not complacent. Our workforce and local people deserve and have come to expect more of us.

We need to ensure that we understand and appreciate difference and support people from different backgrounds and cultures to have fulfilling careers and feel that they belong. We are enabling our leaders to be inclusive in the culture they create and decisions that they make on behalf of our organisations and LLR. We want everyone who works in LLR, or experiences health and care in our system, to feel valued, respected and that they belong and that together we enable more good days.

Chapter 8: Governance

Overview of governance

Governance arrangements have been established to support the delivery of this Plan in the form of a Delivery Partnership.

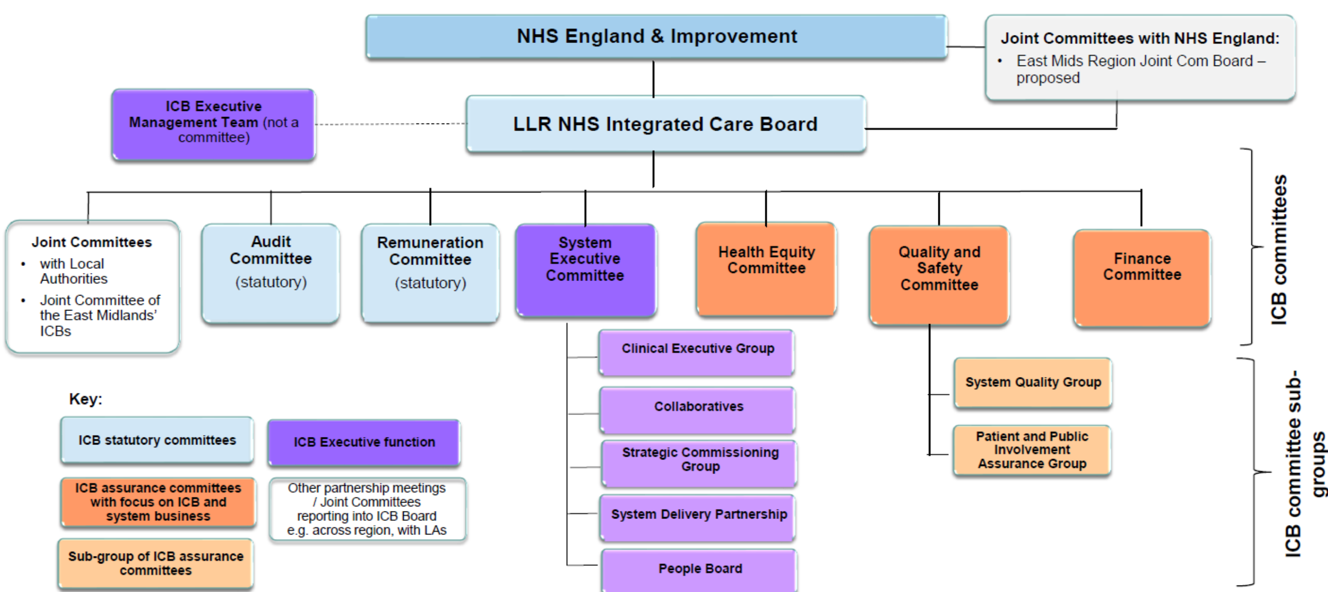
Our delivery framework

The structure included at chapter 4.4, 'our approach to transformation', outlines our delivery framework and accountability arrangements. It also includes arrangements for monitoring and escalation i.e., to the System Quality Group, Finance Committee, etc. when required.

Our approach to risk management

LLR Integrated Care Board has in place a Risk Management Strategy and Policy which sets out the ICB's approach to risk management as an organisation. Effective risk management will be essential in enabling the ICB Board to focus and prioritise resources in order to meet the ICB's strategic objectives as well as delivering the vision and key requirements of the Five-Year Plan. Partner organisations will be responsible for the risk management arrangements within their respective organisations. Risks impacting partners across the system, including the ICB, will be given due consideration through the appropriate governance arrangements which may include for instance consideration of the impact of the risk(s) through an appropriate ICB committee(s), through the appropriate collaborative(s), or through a partner organisation's own internal governance arrangements.

The system governance structure is outlined at figure 20, below.



Glossary of terms used

Acronym	Explanation
A&E	Accident and Emergency
ARC	Applied Research Centre
CAMHS	Child and Adolescent Mental Health Services
CDOP	Child Death Overview Panel
CFS	Clinical Frailty Score
CHWP	Community Health and Wellbeing Plans
CPCS	Community Pharmacy Consultation Service
CPF	Clinical Prioritisation Framework
CQC	Care Quality Commission
CSP	Community Safety Partnership
CYP	Children and Young People
EIRA	Equality Impact Risk Assessment
FOIs	Freedom of Information (Requests)
GH	Glenfield Hospital
GIRFT	'Get it right first time'
HIF	Health Inequalities Framework ('Better Care For All')
HWBs	Health and Wellbeing Boards
ICB	Integrated Care Board
ICS	Integrated Care System
IS	Independent Sector
IT	Information Technology
JHWS	Joint Health and Wellbeing Strategy
JSNA	Joint Strategic Needs Assessment
LAC	Looked After Children
LBRC	Leicester Biomedical Research Centre
LCRF	Leicester Clinical Research Facility
LD&A	Learning disability and autism
LDC	Local Dental Committee
LGH	Leicester General Hospital
LLR	Leicester, Leicestershire and Rutland
LMC	Local Medical Committee
LOC	Local Optometric Committee
LPC	Local Pharmaceutical Committee
LPS	Liberty Protection Standards
LPT	NHS Leicestershire Partnership Trust
LRI	Leicester Royal Infirmary
LTCs	Long Term Conditions
MBRRACE	Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries in the UK
MECC	Making Every Contact County
METIP	Multi-year Education Training and Investment planning
MFFD	Medically Fit for Discharge
MIST	Medication Information and Safety Tips
MRC	Medical Research Council
NIHCR	National Institute for Health and Care Research
NHSE	NHS England
OP	Out-patient
PCN	Primary Care Network
PH	Public Health
PHM	Population Health Management

POD	Pharmacy, Optometry and Dental services
PPGs	Patient Participation Groups
PSIRF	Patient Safety Incident Response Framework
QIA	Quality Impact Assessment
QOF	Quality and Outcomes Framework
RTT	Referral to treatment
SPB	Strategic Partnership Board (LLR)
TB	Tuberculosis
UHL	NHS University Hospitals of Leicester
UTC	Urgent Treatment Centre
VCS	Voluntary and Community Sector
VIM	The name of a randomised controlled phase II trial of oral vinorelbine as second line therapy for patients with malignant pleural mesothelioma undertaken by The University of Leicester

Appendix 2

Appendix 2

Preventing Illness

Pledge: Spend more money on preventing people becoming ill in the first place

Strategic and infrastructure interventions

Intervention	Actions	Timeline	Impact/Outcome
Redirect a proportion of annual growth allocation monies to prevention	Fully understand system financial position and agree allocative principles	23/24	Actively and deliberately move resource and focus upstream to preventative services and interventions. The longer term impact and outcome should be a reduction in pressure and demand on operational delivery of health services. Improve the health of our most deprived communities and narrow the gap between those who have the best and the worst health.
	Formulate and agree proportion of growth to be allocated to prevention alongside timeframe	23/24	
	Undertake modelling analysis to guide how best resources should be deployed to deliver greatest impact on achieving health equity, including evaluation	23/24	
	Formal allocation of monies to prevention	24/25 (Provisional)	
Explore, with our Partners, the potential benefits to be gained from developing an LLR system-wide prevention strategy	Scoping paper detailing proposal developed and presented to establish system-wide prevention collaborative who, if supported and established, will drive production of LLR system-wide prevention strategy	23/24	Currently, local efforts on prevention are commissioned and overseen across multiple partners, with limited opportunities for synergy, collective focus and resource allocation. Prevention efforts coordinated and delivered via a cohesive collective longer term system strategy informing future iterations of the ICB 5YP could facilitate greater impact and improvement at an expedited rate; go further, faster on prevention.
	LLR system-wide prevention strategy produced and published (Support and benefit permitting)	24/25	
Promote, expand and embed the Making Every Contact Count Plus (MECC+) training and approach as a key enabler to maximising prevention efforts and reach, known in LLR as Healthy Conversation Skills (HCS)	Embed appropriate level of Healthy Conversation Skills (HCS) training for roles with opportunities for prevention and signposting across the ICS workforce i.e. e-Learning, e-MECC Lite and full HCS e.g. for new starters; build capacity and sustain the delivery of e-MECC Lite and full HCS programme across relevant staff groups	23/24 onwards	Increased confidence and competence across the workforce to have healthy conversations and take action, with improved knowledge and understanding of prevention, wider determinants of health and behaviour change. Improved awareness of local signposting/referral routes resulting in an increase number of referrals to lifestyle and wider prevention services.
	Targeted engagement and co-design work with staff and volunteers from organisations across the ICS who have most contact with those who experience health inequalities to 1) understand barriers and opportunities to MECC and signposting, and 2) provide training, resources and follow-up	23/24 onwards	Improved reach, sustainability, feasibility and acceptance of the training programme and approach across the ICS workforce, promotion of multi-agency working and relationship building across organisational boundaries.
	Expand the number of and support offers for HCS trainers to deliver e-MECC Lite and full HCS to ensure all relevant staff and volunteers have equitable access to the training programme	23/24 onwards	
	Utilise MECC+ principles and approach to inform the design of clinicals pathways and interventions to ensure equity of access and enable prevention at all levels	23/24 onwards	
	Seek funding to conduct applied research in prevention and public health from national funders (eg NIHR)		The primary purpose of undertaking research is to address unanswered questions relevant to prevention of disease and improvement in public health. Achieving

Capitalise on our dynamic research community to maximise and embed benefits of research into prevention	Enhance the chance of successful applications for funding through collaboration with academic partners facilitated by the ICB Research Strategy Board	23/24 onwards	this impact will require successful completion and dissemination of funded research in this area. We anticipate the research undertaken in this area will offer early opportunities for implementation into routine clinical care with resultant improvement in outcomes (assuming that this is indicated by the findings of the relevant study).
	If funding applications are successful, work with local health and academic partners to bring research projects to a successful conclusion and disseminate the findings	27/28	We recognise also that there is substantial evidence that research active health organisations achieve better outcomes for the populations they serve and improved engagement and morale within the workforce.
Risk factor interventions			
Alcohol – Establishment of Alcohol Care Teams, providing an in-reach service. Ongoing development, monitoring, expansion, oversight and service improvement.	Agreed trajectories for roll-out and governance/oversight arrangements confirmed	Completed	Upskilling and training of staff to support longer term reduction in alcohol related ED admissions. Implementation of sustainable permanent locally funded service model. Increased identification of people at risk of alcohol dependency and referrals to ACT Long-term (5-10yr) reduction in number of patients presenting with alcohol-dependency related injuries at ED
	Establishment of 7-day, multi-agency, multi-disciplinary team providing clinical advice, in-reach capacity to identify and assess alcohol dependent patients in ED and across UHL wards	23/24	
	Delivery of training to UHL staff on alcohol dependency identification, case management and, where appropriate medically assisted withdrawal	23/24	
	Provision of clinical advice to UHL staff on managing patients identified with alcohol dependency	Ongoing/ completed	
	Integrated alcohol service and data sharing across sectors	24/25	
	Ongoing development, monitoring, expansion, oversight and service improvement	23/24	
	Implementation of sustainable locally funded solution	23/24	
Alcohol - staff screening and support offer	Investigate options for providing alcohol support services to staff to improve individuals' mental and physical health linked to risky drinking (e.g. nationally validated ASSIST-lite tool)	23/24	Ensures that our people also have access to timely support services.
CVD-R - Improve detection and management of AF, hypertension and high cholesterol.	Develop a plan to work collectively with Practices and PCNs to promote and increase NHS Health Checks	23/24	Improve detection of AF, Hypertension and High Cholesterol / capacity of service providers, Primary Care and PCNs levels of physical activity etc
	Ensure that more patients that are eligible for and would benefit from lifestyle services are referred into LiveWell/ First Contact Plus	24/25	Increased referrals into lifestyle services and subsequent improvements in health as a result of quitting smoking, increasing levels of physical activity etc
	Explore the need to increase capacity in lifestyle services if referrals increase significantly	24/25	
	Work collaboratively with the Medicines Optimisation Team on the Community Pharmacy Hypertension Service and AF Detect, Protect and Perfect project	23/24	Improve detection of AF, Hypertension and High Cholesterol / closer proximity to patient's home to enable patient engagement / increased patient outcomes and better optimisation
	Implement FH NICE recommended service	23/24	Increase case-finding of FH patients and help manage their condition to avoid serious CV events
	Review LTC Champions programme from 22/23 and develop new strategies around pro-active care @ home, including BP @ home	23/24	Improve optimisation of AF, Hypertension and High Cholesterol

Implement a focussed tuberculosis programme aimed at eradicating TB in LLR	National rates of TB = 7/100k population; rates in Leicester remain 40/100k (amongst the worst in England) - similar rates to Southern American and Eastern European countries. Therefore we will work with local and national partners to develop plans to tackle patients at-risk of LTBI/TB lost to testing during COVID-19 and previous years, including those individuals and groups arriving into the system through legal and illegal migration routes	23/24	Evidenced-based community risk assessment for TB outbreak Improved outcomes for at-risk individuals/communities Robust TB outbreak response plans Improved migrant reception health check and support offer
Diabetes - Supporting people at risk of Type 2 diabetes to access the NHS Diabetes Prevention Programme and expand provision of diabetes structured	Quarterly Diabetes Prevention Steering Group has been established to oversee activities to tackle the potential impacts of diabetes on individuals. The Group will: - review referral and milestone 1 data for the local Diabetes Prevention Programme * use local data to identify and develop plans that seek to address any gaps caused by known health inequalities * encourage best practice for referrals across local providers and general practice * proactively engage with local community and faith groups to increase awareness of the risk factors for developing diabetes (particularly in groups with known health inequalities), including a social media campaign * ensure links are developed and maintained with related local weight management and healthy lifestyle programmes	23-25	Delivery of nationally agreed trajectories Increased awareness of T1 + T2 diabetes Long-term reduction in the number of people developing Type 2 diabetes and developing known health impacts from poor self-management
Diabetes - Supporting people who meet the criteria to access the NHS Type 2 Diabetes Path to Remission Programme (T2DRP)	The DPSG will: * monitor referral rates, establish medium term improvement trajectories and support the development and delivery of local improvement plans. * undertake commissioning activities with the local diabetes collaborative to identify appropriate delivery partners. * work with delivery partners to develop a plan for the roll-out of T2DRP across LLR * support clinicians to deliver accurate data reporting requirements * oversee the development of a targeted communications plan to raise awareness and improve identification in communities known to be impacted by health inequalities	23-25	Reduce the number of patients with Type 2 diabetes entering remission, particularly amongst known at risk groups and communities affected by health inequality factors (e.g. socio-economically deprived)
Diabetes - Increasing referrals to structured education and nationally funded platforms for people living Type 1 and Type 2 diabetes	Local platform offers are already in place; however, practices/interventions will be adapted to include the new national platforms indicated. The DPSG will review referral data and individual uptake rates of local solutions to identify areas for improvement	23-25	Broader service offer for patients to engage with and adopt to support self-management of their diabetes. Increased awareness of and numbers of users of national platforms long-term reduction in the number of people developing complications related to poor self-management of their diabetes
Diabetes - Ensuring all people with diabetes aged 12 years and over receive all nine NICE recommended care processes on an annual basis.	The DPSG will work with UHL and other partners to review service offers and delivery against the NICE recommendations and develop plans to delivery any improvements needed	23-25	Improved understanding of local service offers Improved service quality leading to a long-term reduction in the number of people developing conditions linked to the poor self-management of diabetes.
	Explore adoption of the Food Active NHS Declaration on Healthy Weight	23/24	Explicit support regarding the importance of a WSA approach to Healthy Weight and the role of the NHS in this.

Obesity - Supporting local whole systems approaches to healthy weight	Provision of healthy weight training for health professionals to encourage more conversations with their patients about weight management	24/25	Improved levels of knowledge about healthy weight and obesity amongst healthcare staff Improved food offer with more healthy options within NHS healthcare settings
	Work with PCNs who have identified tackling obesity as a priority area - where progress has been made, use their learning to encourage other PCNs to take action	23/24	
	Train and support social prescribers to become confident in discussing opportunities and resources available to patients to support achievement of a healthy weight	24/25	
	Build on national standards regarding provision of healthier food and drink in NHS healthcare settings	24/25	
Tobacco/Smoking – Deliver tobacco dependence identification and treatment services in secondary care, including across inpatient, maternity and mental health services.	Develop system plan for roll out of Tobacco cessation services	Completed	Reduced smoking prevalence Reduction in the SATOD (Smoking at Time of Delivery) rate Reduction in the proportion of NHS staff smoking Long-term reduction in tobacco-related illnesses Reduction in pre-term births Reduction in health inequalities
	Adapt the inpatient model for expectant mothers and their partners to provide a smoke-free pregnancy pathway supported by focused sessions and treatments	23/24	
	Increase the proportion of pregnant smokers taking up the offer of support to quit by improving engagement with potential referrers and simplifying referral systems	24/25	
	Use innovative support to increase the proportion of smoke-free pregnancies, including a pilot incentive scheme for pregnant women	23/24	
	All people admitted to hospital who smoke are offered NHS-funded tobacco treatment services, with continued support into the community post-discharge	Achieved: ongoing monitoring + improvement 23/24	
	Development of a robust pathway for tobacco dependency support after discharge from Mental Health inpatient settings including the national Quality Improvement in Tobacco Treatment (QuITT) programme	23/24	
	Implement the updated staff tobacco dependency offer (STDO) for 23/24 and agree the support for tobacco dependency for staff for 24/25 and beyond	23/24	
	Support national call for evidence of impact of vaping in children	tbc	

Keeping People Well - Effectively managing long term conditions, multimorbidity and frailty

Pledge: Identify the frailest in our communities and wrap care and support around them

Intervention	Actions	Timeline	Impact/Outcome
Undertake modelling to understand the qualitative and spend shifts that would result from delivering more up-stream evidence-based treatments	A health needs assessment to be undertaken to understand, key areas for prioritisation across LLR	Q2 to 4 2023/24	Informed decision-making Prioritisation at a system level
	Model the five-year impact of LTC initiatives for Secondary Care and Primary Care		Effective allocation of resources
Drive up primary care identification of diseases to expected prevalence levels	Collaborate with Public Health to identify and support reduction in prevalence gaps	Q2 to 4 2023/24	Reduce the prevalence of an initial LTC leading to multimorbidity and begin to slow the rate of increase in the incidence of LTCs
	Agree risk stratification tool to support Primary Care target key areas of low prevalence		
	Include Community Pharmacy in identification programmes		
	Evaluate the Long-Term Conditions Champions pilot and implement key learning		
Improve disease management in Primary care	Develop a strategic approach for people with multimorbidity and frailty for LLR, to inform commissioning of the Complex Care specification	Q2 to 4 2023/24	Begin to slow the rate of increase in the incidence of LTCs.
	Support the development of multi-disciplinary teams to manage LTCs		Deploying the wider workforce (including ARRS roles) into LTC management, to reduce GP workload.
	Identify LTC management opportunities in the Integrated Neighbourhood team's model		
Implement a proactive care framework	Undertake a review of the Complex Care specification as part of the primary care future funding model to ensure alignment to the Proactive Care Framework	Q2 to 4 2023/24	Supporting and enabling practices to prioritise clinical activity by stratifying patients of highest risk. Improved personalised care offer for patients. Continuity of care for people with multimorbidity and frailty
Reduce the prevalence of an initial LTC leading to multimorbidity	x	X	**SEE ABOVE**
Begin to slow the rate of increase in the incidence of LTCs	x	X	**SEE ABOVE**

Making it easier to equitably access the right care at the right time

Pledge: Improve and maintain access to routine general practice appointments

Urgent and Emergency Care and Homefirst

Intervention	Actions	Timeline	Impact
Streamline to a single point of access for same-day urgent care	UTCs single service specification	2023/24 - 2024/25	Develop consistent care pathways regardless of where primary / urgent care patients access the LLR System - LRI ED / NHS111 / Urgent Care Walk In / General Practice
Implement an Urgent Care Coordination Hub	Fully understand unscheduled care activity across LLR services including any gaps and opportunities Workshops to look at how we shape the delivery model Scoping paper detailing proposal, to be presented at various collaboratives Work with EMAS in terms of ambulance rightsizing and CAT2 segmentation. Enabling changes to compliment each other and improve care pathways	2023/24 - 2026/27	UCCH established 2022, actively pulling from the EMAS stack. From 23/24 onwards the model will have a focus on the EMAS stack but will shift to a proactive model where we are reaching patients before they hit the EMAS stack and ED. Navigating patients to appropriate services in a timely manner, ensuring the right interventions at the right time. Thus, supporting a reduction in EMAS activity and ED attendance. Effective case management of patients with development of care plans and remote monitoring that supports interventions in a planned and unplanned manner. 24/25, support the implementation of a single point of contact that supports the consolidation of our unscheduled care contracts. Creating a seamless patient journey where interventions can be deployed in a timely and effective manner, supporting patients to safely remain at "home"
Implementation of physical integrated Discharge team in UHL to work alongside existing LLR Integrated discharge hub	Partner workshops to look and agree hub model. Updated paper to be taken through collaborative	2023/24	Fully functional 06/2023 - 25% reduction in lost discharges, will result in better utilisation of community services resource. Supporting flow across UHL. Reducing the number of patients on the ED bed wait list. Reduction in patients functional decline and deconditioning due to early flow. Joint short-term decision-making as an integrated MDT, further enhancing patient experience, and improving relationships within health and care.
Implement the Urgent Treatment Centre (UTC) model across LLR	A full review of Urgent Treatment Centres across LLR has been carried out, with a view to re-design services to better suit the needs of patients and the resources available. The variation in clinical pathways across services with similar names does not resonate with the public who will default to the 'easiest to understand' service in the LRI Emergency Department. Continuing to review service pathway enhancements to best meet the urgent and emergency care needs of local populations, including capital funding to support longer term improvements.	24/25	Implementation of the Urgent Treamtent Centre model across LLR suited to the needs of local populations.

Primary Care

Intervention	Actions	Timeline	Impact
	Plan to increase capacity in Primary Care Networks, which includes the scaling up of additional roles in primary care, increasing the flexibility for primary care networks (PCNs) to do this, and taking further action to support general practice		

<table>
<tr>
<td rowspan="3">Maximise primary care capacity to meet demand for services and ensure the pt is seen in a timely manner, by the right service, first time.</td>
<td>To support the expansion of general practice capacity and reduce both workload and administrative burden; various plans have been outlined which include collaborative working with NHSE on the Accelerate Programme, D&C workshops, etc.
introducing further flexibility into the Additional Roles Reimbursement Scheme (ARRS) - GP assistant role to help reduce administrative burden for GP teams, and a digital and transformation lead role to support patients and practice teams to optimise digital tools and embed transformation</td>
<td rowspan="3">2023/24 - 2024/25</td>
<td rowspan="3">Population health management and utilisation of services:
Demographic changes, other factors contribute to this increased demand, including medical advances meaning more care can be conducted in the community, increasing patient expectations and pressures on other sectors such as primary, social and acute care.
NHSE plans to recruit more ARRS staff to meet the needs / demand in primary care. The government is on track to deliver on manifesto commitment of 26,000 more primary care staff to help improve patient access to appointments and reduce backlog. Further increased investment to improve access and expand GP capacity by retaining and recruiting staff.
ARRS Dashboard outlines the number of staff recruited by PCNs across LLR - ensuring these staff are utilised to improve access and meet the PCN DES requirements - Enhanced Access, Structured Medication Reviews, Enhanced Care Homes, Early Cancer Diagnosis, CVD, Personalised Care Plans, Tackling Health Inequality, Proactive Care and Anticipatory Care. This will support 'tackling the 8am rush' and recover general practice</td>
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<td>Retiring or deferring of 2023/24 investment and impact fund (IIF) indicators, worth £37m, and allocating this funding to PCNs via a monthly PCN capacity and access support payment, for the purchase of additional clinical services or workforce to increase access to core services this winter</td>
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<td>PCN DES - Capacity and Access Improvement - The aim of the CAP funding is to provide the space, funding, and licence for PCNs to focus on making improvements to help manage demand and improve patient experience of access, so patients can access care more equitably and safely, prioritised on clinical need. It also supports the accurate recording of general practice activity, so that improvement work can be data-led</td>
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<tr>
<td>Streamline access processes including digital access</td>
<td>Practices across LLR audited and signed up to offer digital access.
Enable patients in over 90% of practices to access NHS App
100% of practices using digital telephony by Dec 2025</td>
<td>23/24 / 24/25</td>
<td>Continue to monitor online access - appts offered, utilised, type of appointments. Improve functionality of NHS app and usage to manage demand and provide patient choice. Empower patients to manage their own health.
This will support 'tackling the 8am rush' and recover general practice</td>
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<tr>
<td>Optimise triaging to appropriate services, including pathways wider than primary care</td>
<td>The GP contract in 2023/24 has been updated to reflect the different ways that patients now contact their practice whether this in person, online or by telephone. Patients will be treated equitably and can expect a response on the same day they contact their practice. This response may include information signposting to another service, for example a community pharmacy, based on an assessment of need. Patients seeking routine care should have an appointment within two weeks of contact where appropriate</td>
<td>23/24 - 24/25</td>
<td>GMS contract - effective 15th May 2023.
Patients offered an appointment or signposted effectively
All practices must have access to an online consultation system to support triage.
• Patient requests should be triaged wherever possible to decide on what the most appropriate mode of care delivery is for that patient and to enable care to be provided by the right healthcare professional with the right level of urgency.
• Practices should continue to provide remote consultations (online, phone, video) alongside face-to-face care for those that need it. The approach should be tailored to the person, the circumstance and their needs
This will support 'tackling the 8am rush' and recover general practice</td>
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Support PCN development, expansion and maturity, with a particular focus on PCNs that are experiencing difficulties	The aim of the CAP funding is to provide the space, funding, and licence for PCNs to focus on making improvements to help manage demand and improve patient experience of access, so patients can access care more equitably and safely, prioritised on clinical need. It also supports the accurate recording of general practice activity, so that improvement work can be data-led. a. National Capacity and Access Support Payment: 70% of funding (£172.2m) will be unconditionally paid to PCNs, proportionally to their Adjusted Population1, in 12 equal payments over the 2023/24 financial year2, an average of ~£11.5k/month/PCN In line with the reinvestment commitment relating to IIF earnings, the PCN capacity and access support payment must be used to purchase additional workforce and increase clinical capacity to support additional appointments and access for patients	23/24 - 25/26	PCN Capacity and Support payment can support with development and maturity of the PCN: Continue collaboration and integrated working with partners to meet the needs of the local population. Reduce variability across practices and identify gaps, address staffing issues and focus on meeting the DES requirements across the PCN. Find more efficient ways of working - back office function, CBT, Online, staffing across PCN, estates, etc Promote innovation and collaboration with partners, voluntary organisations, etc Improve the patient experience through the implementation and delivery of the CAIP plan - integration with PPG, Healthwatch, LPT, Voluntary organisations, patient groups, etc to improve and measure innovation. This will support 'tackling the 8am rush' and recover general practice
Develop a transition pathway for PCNs to evolve into INTs (Fuller stocktake report	Fuller Steering group established to review and monitor the implementation of 8 domains under the Fuller Stocktake Framework for the ICB - H&W sub-groups have been set up across Place; updating on progress against each of the domains Collaborative working has been progressed across ICB, PCNs, Local Authority, LPT, Vol Organisations, in the delivery and implementation of the Health and Wellbeing plans across LLR PCNs involved in the delivery of the Health and Wellbeing plans - communicating these to staff and other partners to agree the timescales and delivery / planning City PCNs have agreed to delivery on 5 key priorities for the year - aim to work collaboratively with leads to take these forward and highlight any barriers/challenges to the ICB Leicestershire and Rutland - progressing with the implementation of their H&W Plans at various levels of maturity	23/24 - 24/25	The Fuller Stocktake impact will focus on best practice across LLR and aims to measure the impact of: - Engagement and collaboration of teams and services working in a more integrated way across health and social care and public health, including co-locating staff in integrated neighbourhood teams - Through the updated GMS contract, practices to offer patients choice on how they access care when they need it; this would refer to appropriate GPAD mapping and signposting to services such as CPCS and use of ARRS staff. -Providing more proactive, personalised care with multi-disciplinary teams of professionals and putting patients, who may have complex needs, including those with multiple long-term conditions, at the centre; - Improving patient experience, with single care records and integrated plans supporting general practice to provide the continuity of care that patients so value; and helping people to stay well for longer as part of a more ambitious and joined-up approach to prevention for the whole of health and care. This will support 'tackling the 8am rush' and recover general practice support reducing bureaucracy between primary and secondary care improving the interface to enable better patient care and transition between services/pathways

Undertake PCN estate reviews, leading to understanding of and proposed projects for estate development (Primary Care Estate Strategy)	Primary Care Estates team undertaking an audit of all estates across LLR. Audit progressed in waves and will provide key information on where priorities need to be considered and opportunity for scoping locally. Implementation of the Health and Wellbeing plans to interlink with collaborative working with partners to address any estates/premises potential	23/24	Creation of a PCN estates strategy, supported by a developed clinical strategy, is one of the areas that PCNs need to consider. To do this PCNs need to understand all current available estate, usage, and identify the premises needed to deliver the clinical strategy. Collaboration of the PCN Estates Strategy with Primary Care Strategy, Workforce and other ICB strategies to ensure these are tied into the wider delivery of services through NHS property noting the workforce and pt footfall. The health and care service needs of our population drive our local Estates planning. Buildings play an important role in improving the quality of the patient experience, service integration and staff recruitment/retention; including the additional funding to recruit ARRS and ensure they have the appropriate space to delivery care.

Personalisation

Intervention	Actions	Timeline	Impact
Develop a Personalisation Strategy	Review LLR Personalisation Readiness report and identify gaps in personalisation programme	Q2 23/24	To ensure personalisation is embedded within all pathways to make effective use of Enabling Choice, Supported Self Management, Personalised Care and Support Plans, Shared Decision Making, Social Prescribing Link Workers and Personal Health Budgets.
	Collaborate with partners in ICB, UHL, LPT and PCNs to develop a Personalisation Strategy aligned to the 6 key principles of personalised care		
Increase Social Prescribing Link Worker capacity and referrals	Collaborate with PCNs to promote role of SPLW	Q1 23/24	To ensure SPLW are recognised as a valued member of the PCN team helping to drive efficient and effective use of resources
	Encourage completion of framework competencies for SPLW	23/24 to complete 24/25	
	Gather data and report on impact of SPLW on efficiency and effectiveness of PCN	Q1 23/24	
Liberty Protection Safeguards service: a) Develop and deliver training in identifying need b) Implement Liberty Protection safeguards	Map outstanding cases and action plan programme of work to resolve any outstanding cases	Q2 23/24	To have a system which is ready for the delivery of the new LPS pathway and takes into consideration the Liberty Protection Safeguards
	Identify implications and training model to be cascaded across LLR	Q1 24/25	
	Plan programme of delivery of new model through years 2 and 3	24/25 onwards	
Embed a working culture that embraces personalisation as the default approach to supporting people	Collaborate with partners to embed the strategy	24/25 contract inclusion	Working with partners to ensure personalisation is embedded appropriately across all pathways in primary and secondary care
	Ensure contracts are effectively used to promote the 6 elements of personalisation as appropriate in each setting		
Implement processes to create All Age Continuing Care Model	Review MLCSU contract specification and align to an All Age Continuing Care Model taking into consideration the statutory requirements of the frameworks for continuing healthcare and continuing care	by Q4 23/24	To create a new specification for the delivery of Continuing Care to encompass all ages whilst aligning this to statutory frameworks. This will ensure improved transition in and out of eligibility and from childhood to adulthood

Integrated community health and wellbeing hubs

Pledge: Provide more joined up, holistic and patient-centred care, delivered closer to home

<table>
<tr><th>Intervention</th><th>Actions</th><th>Timeline</th><th>Impact</th></tr>
<tr><td>UEC Collaborative to lead engagement with all partners to ensure ownership and agreement of approach</td><td>Ensure integrated community health and wellbeing hubs are a standing item on UEC Collaborative meeting agendas</td><td>23/24</td><td rowspan="8">Through the delivery of these Integrated Community Health and Wellbeing Hubs we will realise our pledge to provide more joined up, holistic and patients centred care, delivered closer to home. The impact of these hubs will be to create an effective and efficient system of care which is person-centred and actively orientated to addressing the wider determinants of health, as well as the presenting problems of immediate healthcare need. The hub approach will allow us to place health and healthcare in their local social context though a “Healthy conversations” model and the co-location of a variety of non-NHS support offers alongside NHS services. What is delivered in each hub will be tailored to local need but could include provision of primary care, holistic support programmes to address digital fluency, virtual outpatient appointments, targeted and tailored screening/vaccination programmes, VCSE/community led programmes and initiatives and health promotion / preventative programmes. The vision of community based, integrated health and social care, with care delivered closer to home, is key and crucial to our integrated care system. Our hubs will move this vision to reality and simultaneously impact upon the four core purposes of an ICS:

•Improve outcomes in population health and healthcare
•Tackle inequalities in outcomes, experience and access
•Enhance productivity and value for money
•Help the NHS support broader social and economic development</td></tr>
<tr><td>Complete the development of Community Health and Wellbeing Plans</td><td>Establish a working group comprising of all key partners in the district.

Complete robust needs assessment.

Undertake stakeholder engagement and review of needs assessment.

Identify priorities within the district and undertake a prioritisation exercise to agree a manageable number of key priorities to focus on in the next 12 months.

Establish working groups for each priority area to produce a robust action plan.

Produce a written community health and wellbeing plan.

Regular reporting into district partnerships on progress against priority action plans.</td><td>23/24</td></tr>
<tr><td>Develop a comprehensive understanding of current primary care and community health and care estate</td><td>Undertake a review of the community health and care estate
Revisit the Primary Care Estates Strategy</td><td>23/24</td></tr>
<tr><td>Undertake a baseline assessment of current health and care staff capacity and skills, based on agreed hub sequencing</td><td>Work with the People and Innovation directorate to collate the data required</td><td>23/24 - 25/26</td></tr>
<tr><td>Agree geography, location, number and sequencing of Hubs across LLR</td><td>Engage with wider stakeholders including Local Authorities to determine local needs
Ensure there is sufficient funding to establish the hub/s</td><td>23/24</td></tr>
<tr><td>Develop Delivery Plans to roll-out all Hubs between 2024/25 and 2027/28</td><td>UEC to develop delivery plans</td><td>23/24</td></tr>
<tr><td>Establish hubs, based on agreed hub sequencing</td><td>UEC to develop delivery plans</td><td>24/25 - 25/26</td></tr>
<tr><td>Establish subsequent wave hubs, based on agreed hub sequencing</td><td>x</td><td>24/25 - 27/28</td></tr>
</table>

Optimal Pathways for Elective Care

Pledge: Reduce waiting times for hospital treatment

Intervention	Deliverable	Actions	Timeline	Impact
Increasing Capacity - Demand and Capacity models in place at a UHL and System level to inform business case development and planning and opportunities to use existing estate	Begin activity flows through the East Midlands Planned Care Centre with further capital work to be fully operational in 24/25	Programme in place led by the UHL Reconfiguration Team to deliver Phase One from June 2023. This is using mobile attachments while the Brandon Unit is refurbished in 23/24	23/24	1,470 additional day cases across General Surgery and Urology will be delivered from the mobile theatre and ward attachment in 23/24 having a positive impact on the Day Case impact and the 78 and 65 week rates.
	Build Community Diagnostic Centre 2 at Hinckley for activity to be delivered in 24/25.	Appoint a contractor and commence site enabling work July 23. Plan to start activity May 23	23/24	Interim activity of approx 5k tests between MRI and Endoscopy (FY 23/24).
	Implement a range of community diagnostics in PCNs and introduce GP direct access to diagnostics	To Commence PCN cardio-resp diagnostics. To get to System Execs by end of May 23	23/24	Cost £900k (in 23/24) to deliver 18,000 tests in Primary Care in a range of Cardiac and Respiratory tests reducing waiting times for appointments in UHL
	East Midlands Planned Care Centre to be fully operational	Programme in place led by the UHL Reconfiguration Team to deliver Phase Two from November 2024	23/24 24/25	The expected full year effect of the additional activity in 25/26 is 550 Inpatients, 18,000 Day case procedures, 19,000 New Outpatients appointments, 19,000 Outpatient procedures and 54,000 Follow ups. This will have a significant impact on the backlog and moving us back towards a 52week wait target.
	Community Diagnostic Centre 2 at Hinckley to be fully operational	Operational by Q4 24/25	24/25	This will then deliver 50,000 extra investigations across imaging, endoscopy, audiology and Cardio Respiratory tests. The 50,000 is the full year impact which will be seen in 25/26
	Expand the range of community diagnostics to a wider cohort of PCNs	To deliver a whole year effect of cardio respiratory diagnostics including a full service review. To also review what other tests can be done in primary care.	24/25	Cost £1.1m to deliver 25,000 Cardio Respiratory tests out of PCN's. Also will be able to move other tests, such as firbo-scan, out into PCN's in 24/25.
	Develop case for Community Diagnostic Centre 3 if required	Work with national team to identify any funding to support a third CDC in LLR	25/26 26/27	Providing more community diagnostiics to increase the % of early disgnosis for cancer patients
	To become a net importer of activity to the East Midlands Planned Care Centre supporting the wider Region	Promote the EMPCC as a centre for high volume low complexity procedures	25/26 26/27	The equalisation of waits for high volume low complexity procedures, locally and across the region. Additional income brought into the system for investment.
Pathway Changes - Support Demand Management and to maximise the use of Community resources to ensure that only people that require Secondary Care elective support are referred.	Invest in the Referral Support Service to support early triage and shorter outpatient waiting times	Business Case to be developed to roll out and enhanced form of RSS across key UHL Specialities over the next 2 years (ie 23/24 and 24/25). Paln to complete Business Case by end of June 23. Plan to role RSS out to Gynaecology, Respiratory Medicine, General Surgery and elements of Radiology. Also how it can support cancer areas . Support primary care with A&G , tests and investigations requested from secondary care and remote monitoring	23/24	For Gynae a reduction to UHL waiting to help support delivery of waiting times (estimate 20% deflection away fromn secondary based on 5 GPSi's being trained in Gynaecology). Further work to be underataken across a number of other specialties.
	Transformation of first tranche specialty end-to-end pathways	Develop a plan for Gynae, Respiratory Med, Cardiology and General Surgery working alonside the RSS that takes into account self management, primary prevention, GP Upskilling and triage and community provision of the upskilling of the RSS Triage. This will link with the GP direct access to diagnostics programme. This will be worked up as part of the RSS Business Case	23/24	A reduction in GP referrals to secondary care therefore having a direct impact to help reduce waiting lists. Will reduce the steps in the patients journey taking out both new and f-up appointments within each specialty pathway, as patient will be referred to the right place first time and will attand their appointment with the relevant diagnostic.
	Expand the Referral Support Service for both Elective and LTC patients in the community	To roll out to more specialties	24/25 25/26	To be worked through in year 1 The agrees list of Specialites for role out to be worked through in 24/25. Impact will be a reduction in referrals to ensure:- * Reduced waiting times to be maintained and reduce further * Improve the number of patients that could be seen locally * Only patients that need secondary care get referred to secondary care * To provide value for money ensure that work done in the Community is done at less than tarrif. * Improve the quality of care to the patients and reduce unnecessary hospital visits
	Transformation of second tranche specialty end-to-end pathways	To roll out to more specialties	24/25 25/26	To be worked through in year 1 The agrees list of Specialites for role out to be worked through in 24/25. Impact will be a reduction in referrals to ensure:- * Reduced waiting times to be maintained and reduce further * Improve the number of patients that could be seen locally * Only patients that need secondary care get referred to secondary care * To provide value for money ensure that work done in the Community is done at less than tarrif. * Improve the quality of care to the patients and reduce unnecessary hospital visits
	Work with EMCA to implement targeted lung health checks	Working through the agreed programme across LLR implementing all elements of the agreed proposal.	24/25	Improved diagnosis and treatments (all varieties) for patients with lung cancer, having a positive impact on mortalilty and quality of life
	Transformation of third tranche specialty end-to-end pathways	To roll out to more specialties	25/26 26/27	The agreed list of Specialites for role out to be worked through in 24/25. Impact will be a reduction in referrals to ensure: * Reduced waiting times to be maintained and reduce further * Improve the number of patients that could be seen locally * Only patients that need secondary care get referred to secondary care * To provide value for money ensure that work done in the Community is done at less than tarrif. * Improve the quality of care to the patients and reduce unnecessary hospital visits
Productivity Improvements - Improving productivity across planned care including outpatients, diagnostics and theatres. **Outpatient Transformation** - Improving the efficiency of processes, building internal capacity through better use of our asset and building strong links with our partners to increase efficiency and	Strengthen the LLR productivity programme in outpatients, theatres and diagnostics working with the National GIRFT team to meet recommendations	Theatre productivity programme in place with 5 key projects Outpatient transformation strategy to be launched in Q1 2023 Allocate resource to establish a diagnostic productivity programme in 23/24	23/24	For theatre productivity the impact will be an Improvement in overall theatre utilisation to 85% / Increase day surgery rates / Reduction in on the day cancellations / Increase average cases per list and focus on pre-op assessment For Outpatients and Diagnostics the impact will be focused specialist advice, to those who need it most, to minimise new referrals in pressured specialities. Improvement in non-attendance rates with a focus on those at highest risk of non-attendance. Efficient outpatient capacity to enable more equitable access. Improved patient and staff experience. Treating more patients where possible closer to home and avoiding unnecessary outpatient attendances where clinically appropriate. Resources will be utilised effectively and efficiently across all elective programmes, delivering value for money (VFM).
Validation - Reduction in size of UHL waiting lists through plan to carry out technical, administrative and clinical validation of the full waiting list.	Deliver 2023/24 elective priorities including a reduction in 62+ day cancer and 65+ week wait RTT	Planned Care Partnership in place from April 2023 to oversee and ensure integrity of the plans for delivery in 23/24	23/24	Co-ordinated approach to delivery with a focus on the 8 key interventions, underpinned by health inequalities, finance, contracting and the digital strategy
	Deliver 2023/24 elective priorities including 52+ week wait RTT	Multiple actions in place via the 8 key Interventions as managed by the Planned Care Partnership	24/25	The impact of this will be zero over 52 week waits by March 25
Partnership Working - LLR to maximise the opportunity for working with system, regional and national partners to supporting the reduction in the overall waiting list and improve the VFM in delivery of services	Deliver 2023/24 elective priorities including a reduction in 62+ day cancer and 65+ week wait RTT	Planned Care Partnership in place from April 2023 to oversee and ensure integrity of the plans for delivery in 23/24	23/24	Co-ordinated approach to delivery with a focus on the 8 key interventions, underpinned by health inequalities, finance, contracting and the digital strategy
	Deliver 2023/24 elective priorities including 52+ week wait RTT	Multiple actions in place via the 8 key Interventions as managed by the Planned Care Partnership	24/25	The impact of this will be zero over 52 week waits by March 25
Reducing Health Inequalities - Ensure all interventions and planning objectives align and support reducing and improving Health Inequalities across access, experience and outcomes of care	Deliver 2023/24 elective priorities including a reduction in 62+ day cancer and 65+ week wait RTT	Planned Care Partnership in place from April 2023 to oversee and ensure integrity of the plans for delivery in 23/24	23/24	Co-ordinated approach to delivery with a focus on the 8 key interventions, underpinned by health inequalities, finance, contracting and the digital strategy
	Deliver 2023/24 elective priorities including 52+ week wait RTT	Multiple actions in place via the 8 key Interventions as managed by the Planned Care Partnership	24/25	The impact of this will be zero over 52 week waits by March 25

Invest in the Referral+A16:B16 Support Service to support early triage and shorter outpatient waiting time+J12s

Income Generation - Deliver the ICB/UHL objectives relating to the Value Weighted Activity(VWA) as detailed in the 2023/24 plan	Deliver 2023/24 elective priorities including a reduction in 62+ day cancer and 65+ week wait RTT	Planned Care Partnership in place from April 2023 to oversee and ensure integrity of the plans for delivery in 23/24	23/24	Co-ordinated approach to delivery with a focus on the 8 key interventions, underpinned by health inequalities, finance, contracting and the digital strategy
	Deliver 2023/24 elective priorities including 52+ week wait RTT	Multiple actions in place via the 8 key Interventions as managed by the Planned Care Partnership	24/25	The impact of this will be zero over 52 week waits by March 25

Mental Health

Pledge : Reduce inequity in access to mental health services across each of our neighbourhoods

Intervention	Actions	Timeline	Impact
Reorganise and expand mental health provision into eight neighbourhood patches within LLR geography	Development and testing of new standard operating guidance and workforce model for the new neighbourhood teams	23/24	Reduced escalation of mental health needs, improved long-term mental health outcomes, reduced preventable mental health urgent care and inpatient usage, increased access to mental health support for under-represented communities, care closer to home, reduced 'bouncing' between services, improved service user experience
	Testing of new model in two sites within Leicester, Leicestershire and Rutland	23/24	
	Roll out of the new integrated model, workforce changes and further recruitment in each neighbourhood	23/24	
Establish a new neighbourhood approach for children and young people	Scoping of what resources and services are required at a local neighbourhood level versus current services available including access to CAMHS services	24/25-26/27	Access to services for C&YP will be available at the right time in the right place closer to home adopting a neighbourhood approach.
	What are the gaps if any. Identify service provision to address the needs of C&YP.		
	Identify what the financial allocation will be to implement any services		
	Ensure that services address any health inequality or health inequity		
Deliver a modernised workforce model across all agencies in each neighbourhood	Redesigning the workforce model pathways) to maximise skill mix, improve the design of existing staff roles, increase career paths and better reflect local population	23/24 - 25-26	Significant reduction in vacancies, significant reduction in agency and vacancy cover focused bank shifts, improved staff and wellbeing and satisfaction,
	Iteration and implementation of recruitment plan to increase recruitment through coordinated recruitment campaigns and incentives and introduction of new roles		
	Iteration of workforce plan relating to increasing retention and development of existing staff through strengthened career pathways harnessing apprenticeships, entry roles, training and coaching within organisations and explore coordination across system partners		
	Deliver the workforce plan in relation to strengthening engagement, ownership and Co-design to improve satisfaction, motivation and involvement of staff in ongoing design of services		
	Deliver the workforce plan in relation to culture, ways of working and development through actions relating to cultural competency, diverse recruitment and active quality improvement with addressing inequality of experience and construction within workforce		
Reorganise mental health inpatient provision to deliver financially sustainable and high quality provision	To deliver a therapeutic inpatient model in line with national guidance.	23/24 - 25/26	The patient experience will be improved throughout their inpatient journey, leading to better long term outcomes.
	Design and implement a new Alternative Hospital pathway that maximises local care in the least restrictive environment.		
	Complete mental health bed modelling focussing on points of delivery across the system		
	Implement new workforce and bed modelling		
Expanded seamless and accessible psychological therapies through steps 2, 3 and 4	Development and delivery of psychological skills and competence of wider workforce (through structured skill based education)	23/24 - 25/26	Reduced length of time of service, improved long-term outcomes, reduced 'bouncing' between services, improved service user experience
	Implement expansion and performance improvement plan for NHS talking therapies offers (Step 2 and 3)		
	Implement new Step 3.5 offer and pathway to minimize gaps in psychological offers		
	Further develop and implement the psychological and trauma informed offer and therapies as an integrated component of new neighbourhood teams		
	Further develop and implement targeted specialist psychological therapies including for people with a diagnosis of personality disorder		
Ensure seamless and joined up mental health	Evaluate the integrated neighbourhood offers for both mental health and physical health		Improved overall longevity of quality life for people with SMI and for people with long term

and physical health care within each neighbourhood and each institutional setting	Develop a shared operating model for mental health and physical health for neighbourhoods	27/28	conditions with mental health needs, improving compliance with best support for people, reduced duplication
	Implement shared operating model		

Learning Disabilities & Autism

Pledge: Increase the percentage of people on GP learning disability registers who receive an

Intervention	Actions	Timeline	Impact
Reduce adult and children mental health inpatient numbers through regular review of plans, with system escalation for individuals with a delayed discharge	Ongoing commitment to LDA Integrated Hub weekly discharge planning meetings for adults and young people. Focus of this team is quality of in-patient care and timely and appropriate discharge. This joint collaborative working has now become business as usual and will continue to drive high quality care and timely discharge	23/24	Duplication of work removed. Gaps in processes causing delays identified and reduced. Consistent approach in systems and processes. Obstacles to discharge anticipated and proactive measures in place to reduce. Process timelines reduced. Appropriate length of stay and timely discharge.
	Development of a bespoke CYP 12 Stage Discharge Process Joint initiative working with CAMHS Collaborative/NHSE. Workshops set up to adjust basic 12 stage process and make bespoke for CYP. Testing of new template. Roll out of new process to all CAHMS Collaborative commissioned CYP specialist mental health wards	23/24	Prevention of delayed transfers of care. Timely discharge All requirements necessary for a timely discharge anticipated and delivered. Young people receive the care and support they require in the least restrictive environment possible.
	Implementation of new escalation process for children and young people. New pathway agreed by LLR health and social care. Escalation process to be initiated when integrated hub team agree that existing business as usual discharge planning processes are not being effective and significant barriers to discharge remain	23/24	Prevention of delayed discharge. Removal of barriers to discharge - when a more bespoke approach and very senior management support is required.
	Recruitment of dedicated CYP case manager to sit within the dedicated LDA integrated Hub (12 month fixed term contract)	23/24	Increased case worker capacity to focus on CYP admission avoidance and timely discharge.
	Implementation of NHSE Discharge Protocol. To include: 1. Housing demand analysis based upon last 3 years requirement for both supported Living and Residential Care. 2. Collaborative working between health and social care to liaise with potential community providers to ensure provision of high quality housing which will meet identified demand (volume and type)	23/24	More accurate understanding of future housing needs for this population. Will enable more accurate planning of future pipeline of community placement provision and ensure appropriate community placements are available when required. Reduce delayed discharges of individuals due to community placement unavailability in the appropriate locality.
	Expansion of the LLR Keyworker service to include individuals aged 18-25	23/24	Additional keyworker support to the individual and family to prevent deterioration in well-being and crisis. Support both timely discharge and admission avoidance.
	Further development of the effectiveness of the Dynamic Support Pathway (DSP) in line with new national guidance/minimum standards. Roll out communication and training across LLR	23/24	Early identification of potential crisis leading to system wide response to reduce risk and offer any additional support required to maintain the wellbeing of the individual in the least restrictive environment. Prevention of inappropriate admissions.
Reduction in the use of out of county inpatient mental health hospitals	Development of Agnes Unit - There is an identified gap in local inpatient provision for people with learning disabilities with/without autism with complex behaviour that challenges for longer-term rehabilitation treatment programmes. Development of new service specification for the Agnes Unit. Individuals with more complex needs to be able to receive the treatment they require within the Agnes Unit	23/24	Reduced out of area placements with alternative hospital providers, patients will receive high quality care close to home, families and carers and existing community health and social care support.
	Monthly joint discharge planning meeting with Impact Provider Collaborative which focusses on the discharge of individuals in out of county low secure/medium secure units. Currently there are no Impact Collaborative beds within county. By default - all individuals transferred from prison or court are placed in an out of county hospital bed	23/24	Timely discharge/return to prison of individuals from these out of county units once treatment plan has been completed. Identify opportunities to repatriate individuals back to Agnes Unit.
Increase the percentage of people on GP learning disability registers who receive an	Evaluation of optimum staffing requirement (capability) to deliver in line with desired quality outcomes. Source funding to maintain this resource(Current pilot evaluation will inform capability requirement)	23/24	Appropriate workforce in place to enable delivery of health checks to individuals requiring additional support to receive the checks they require. All reasonable adjustments will be possible to ensure attendance.
	Evaluate current work plan against commissioned specification/core responsibilities and priorities review service specification and make adjustments to working practices as required	23/24	Ensure activities of the PCLN team are focussed upon key priorities and a consistent approach is in place.
	To work with Primary Care to ensure all PCNs are aware of the Investment Impact Fund which now includes delivery of annual health checks and completion of health action plans.	23/24	Additional payments will be available and will encourage primary care practices to work collaboratively to deliver a higher percentage (minimum 60%) of health checks required within their population.

learning disability registers who receive an annual health check and health action plan	Explore the use of digital apps to support access to annual health checks and improved health action plans	23/24	Increase the awareness and accessibility of AHC and Health Action Plans
	Ongoing monthly monitoring of individual practice performance against AHC delivery. New data triangulation process in place to ensure accuracy of performance. Practices not on performance trajectory will contacted by AHC Delivery Group and options for improvement agreed	23/24	Increased delivery of AHC
	Quality audit of AHC and HAPs (working collaboratively with individuals with lived experience) to ascertain the quality of current health checks. Updated LLR health check template (identifies what good looks like) now rolled out. Training on new template now in progress	23/24	Improved quality of the health check and HAP. Streamline easy to use amended template will give back capacity and result in additional health checks being completed
Learning from Deaths Reviews (LeDeR) completed within 6 months and learning shared on a quarterly basis with system partners enabling improvement in services.	Thematic analysis of respiratory deaths.	23/24	Identify aspiration pneumonia preventable deaths and support LDA Collaborative Deteriorating Patient workstreams.
	Thematic analysis of aspiration pneumonia deaths.	23/24	New Aspiration Pneumonia Protection Pathway, resulting in potential to reduce deaths from aspiration pneumonia by up to 33%
	Provision of appropriate weighing equipment for GPs.	23/24	Improvement in weight management, and reduced weight-related conditions.
	Reprioritisation within the LeDeR programme	23/24	100% compliance with requirement to complete all reviews within 6 months of referral, allowing more timely analysis and actions to be shared with partners at regular intervals in a planned way.
Continue to address health inequalities and deliver on the Core20PLUS5 approach	Establish a Health Inequalities group that can provide a place for system partners to review the LDA population health data	23/24	Greater awareness of the LDA population health data across the system
	Develop a dedicated LDA Health Inequalities Plan to target areas of deprivation and increased health needs	23/24	Targeted place-based LDA programmes of work to reduce high levels of inequality.
	Secure capacity for a LDA Joint Strategic Needs Assessment for LLR	24/25	Provide a more detailed analysis of the LDA health needs to better inform the system.
	Consider incorporating health inequalities indicators as part of the clinical waiting list prioritisation to ensure those with greatest needs/risks are seen sooner	23/24	Reduction in health inequalities within the Core20plus groups due to reduced waiting times
Optimisation of adult autism assessment services	Secure recurrent funding for the additional capacity within the AAAS	23/24	Increased capacity within the team to better meet the 127% increased demand. Reduced wait times and improved patient flow from referral to discharge.
	Targeted support to GP practices making high levels of inappropriate referrals	23/24	Improved patient experience as people will be referred to the appropriate service. Reduced referrals into service (2022 70% of referral were discharged following 1st appointment - i.e. not autistic), increasing capacity and reduced waiting times.
	As waiting times reduce to introduce the provision of post diagnostic support	24/25	Improved patient experience and reduced likelihood of patients requiring support from mental health services/ inpatient admissions as patients will be better able to understand themselves.
Ensure appropriate quality assurance processes are in place across the collaborative to strengthen local LDA community health and social care services	Establish a quality group that can provide a place for partners to review systems and processes and to agree and adopt any learning from never events and improve system oversight and activity around quality assurance	23/24	A blueprint for system learning is developed that supports our citizens with LDA and which improves the way partners work together with each other and in support of people.
	Develop a process to share and learn from significant incidents, never events, complaints and reports in the LLR LDA system and other LLR collaboratives/services, including use of NHSEI Futures and networking platforms. Re-establish multiagency community of practice events	23/24	A blueprint for system learning is developed that supports our citizens with LDA and which improves the way partners work together with each other and in support of people.
	Develop a process to receive assurance that learning has been embedded into practice and process to measure the impact of implementation of learning.	23/24	A blueprint for system learning is developed that supports our citizens with LDA and which improves the way partners work together with each other and in support of people.
	Quality Group to receive regular performance information (dashboard), validate the data and seek to understand causality and how this can be addressed via a system wide approach. Escalate accordingly	23/24	Areas of concern are identified quickly and highlighted for investigation.

community health and social care services	Undertake a quality benchmarking process which audits our local arrangements against the themes of admission avoidance, hospital discharge, inpatient care, commissioning, safeguarding and workforce. This will identify specific actions to be progressed by the collaborative to improve services and support and the way we work together in support of people with LDA	23/24	There is consensus on areas of strength which are celebrated and used to inform practice in other areas and we develop an action plan for areas of our work/arrangements that need to improve. People and families are aware of what we are doing and agree with our focus and our teams feel listened to.
	Review arrangements around what works with a focus on prevention: workforce training such as the Oliver McGowan Training is rolled out to all staff, early indicators of concern processes are robust and PBS is adopted as a minimum standard	24/25	We have good systems in place to share information so that we work to prevent escalations due to poor quality care and support. The expectations around PBS are understood and we support our providers to ensure that PBS is a core minimum standard across all our services and support
	Support the piloting of initiatives which focus on improving the quality of care for our LDA citizens in LLR	24/25	We support the implementation of any initiatives designed to improve the quality of care in LLR - the learning is used to assess their impact on the quality of care and whether people and families feel their support is achieving the outcomes that are important to them.
Implement No Wrong Door Themes	Raised awareness of requirements across all system partners and contact points	25/26	All system partners contact fully informed and agreement for shared information and guidance resource in place.
	Co-produce shared resource for all system points of contact	25/26	All contact points across LLR will have access to the same information at the same time and be able to offer support and refer the person to the most appropriate place.
	Identify workforce training and support requirements	24/25	Clear training and support plan in place

Children and Young People

Pledge: Improve access to, experience of, and outcomes for children and young people - with a special focus on driving up health equity

Intervention	Actions	Timeline	Impact
Enhance the current partnerships and collaboration and alignment to system and place-based strategies	Assess partnership workplans for CYP Design Group and CYP Leaders Collaborative	23/24	Secures cross-organisation commitment to improving health and care outcomes for children and young people. Develop shared learning and skills utilisation with new ways working to address strategic commissioning gaps.
Actively promote the voice of children and young people and their participation in strategic and operational developments	Scope all previous and current engagement work across the system and develop Summit for CYP.	23/24-24/25	Lived experience and journey through health services for children and young people reported to have improved.
Address variations and equity in our health system using learning and outcomes from preventative programmes such as CORE20PLUS5 programme.	Align delivery plans and ensure shared initiatives address health inequalities	23/24 - 25/26	Increased financial investment in health services for CYP and greater share relative to whole population. Improves equity in service offer. Better real-time use of data aligned to ICB strategic objectives and details CYP strategy to address prevailing health inequalities and barriers to access health
Improve neurodevelopmental pathways and services for children and young people	Working groups develop service improvement and mitigation plans	23/24 - 27/28	More earlier screening, assessment and earlier intervention enabling CYP to be supported at home, school and community.
Address barriers to accessing to mental health services for CYP and develop the locality neighbourhood model	This is covered by the All-Age mental health chapter	24/25 - 27/28	
Remove barriers to accessing acute and community paediatric care pathways	Develop shared learning and skills utilisation with new ways working to address workforce gaps. Sustain focus on SEND and LAC statutory agenda responsive to the growing demand and complexity of need, and connect funding streams across early years, education, health and social care	23/24 - 25/26	More earlier screening, assessment and earlier intervention enabling CYP to be supported at home, school and community.
Reducing the impact of demand upon children`s urgent and emergency care and develop preventative solutions.	Pathway work to address unnecessary delays, reasons for attendance, signposting options and post-attendance safe transfer and discharge. Promote positive experience across services. To reduce unnecessary hospital attendances and admissions for CYP with long term conditions such as asthma, diabetes and epilepsy	23/24 - 24/25	Improve flow of patients through the primary, community and acute systems and more use of universal health services and self care. ore CYP using personalised care plans, manage their own conditions with a reduction in acute and emergency presentations.
Working with regional and local networks and collaboratives to transform paediatric critical care and paediatric care pathways	Transform critical care pathways for CYP enabling better access for both L2 and L3 and managing demand and capacity. To continue to support development of tertiary and quaternary paediatric specialist services to ensure LLR remains a centre of excellence as well as support neighbouring ICSs	23/24 - 26/27	Improved patient experience, reduction in CYP accessing out of area specialist acute facilities with services closer to the patients home. Children missing less education.

Women's Health and Maternity

Pledge : Listen to voices of women and girls to co-produce and transforms services

Women's Health

Intervention	Actions	Timeline	Impact
Establish a Women's Health Collaborative to transform the current fragmented and un-coordinate care into better access, quality, experience and outcomes for women	Identify a women's health strategic lead	23/24	Women's Health strategy embedding into the ICB plans and recognised as a core priority and key focus on boosting health outcomes for all women and girls
	Development of a women's and maternity team with identify responsibility / capacity to delivery of this agenda		
	Established a women's collaborative to develop a work plan with agreed ICB priorities for the next 3-5 years		
	Identify a programme budget to support the agenda		
To build relationships with women's groups ensuring that we understand their needs and they have a voice in planning services across health care.	Work with peoples and innovation team, women's groups, Local Authorities/ Voluntary sector to establish a women's voices forum and website	23/24	Radically improve the way in which the health and care system engages and listens to all women and girls. Have a well established user forum which actively contributes to the development and transformation of women's services. Ensuring we have true co-production and women's voices are heard
	Plan a programme of engagement including a number of key events across the system		
	Identify a small budget for user engagement and link with other women's groups such and Maternity Voices Partnerships		
Improving access to NHS fertility treatment for all couples including female same-sex couples and assessing the use of non-clinical access criteria locally	Nottingham and Nottinghamshire ICB leading on East Midlands Assisted Fertility Policy review and undertake an options appraisal to agree how we will meet new assisted conception recommendations within the Women's Health Strategy	23/24 - 27/28	Have an equitable consistent approach to certificate care for all couples across LLR / East Midlands
Work with system leaders to agree local models for implementation of women's health hub across LLR, to provide social, emotional and health support including sexual health, menopause and social prescribing	Review what current services are on offer and ask women what they want. Review best practice, develop local models and pilot different approaches Develop role out across LLR and audit outcomes	23/24	Boost health outcomes for women and girls by having a clear joined up basket of offers that are easy to access ,promote equity, target inequalities and reduce duplication and inefficiencies

Maternity

Intervention	Actions	Timeline	Impact
Listening to women and staff:	Co-production via LLR MVNP	23/25	Safe high-quality care and improve the safety and experience of those using maternity and neonatal services by helping to address health inequalities.
	Undertake a whole pathway options appraisal on maternity information systems.		
	Implement pelvic health service and bereavement care		
	All women offered personalised care and support plans		
	We will continue to increase PMH referrals and ensure we hit 10% target by 23/24	23/24	
	Provide support to capital projects to increase and better align neonatal cot capacity	23/24 - 24/25	
	· We will continue to implement our maternity health equity and equality plan	22/27 22/23	
	Publish LLR maternity equity plan		
	Increase fill rates against funded establishment for maternity staff.		Right numbers of the right staff are available to provide

Growing and developing the workforce:	Recruitment and retention plans in place Changing culture and behaviours	27/28 23/24 - 23/26	the best care for women and babies through regular local workforce planning, including meeting staffing establishment levels and achieving fill rates by 2027/28 for midwifery.
Develop and sustain a culture of safety..	Implement the Ockendon and East Kent actions and recommendations to reduce stillbirth, neonatal mortality, maternal mortality and serious intrapartum brain injury. Develop clinical leadership. Implement NHS PSIRF approach	23/24 - 25/26	A positive safety culture that improves the experience of care and outcomes for women and babies and supports staff to thrive.
Meeting and improving standards and structures.	Implement all elements of SBLCB Maternity digital strategy outlining how women will access their records and interact digitally with their plans We will implement best practice consistently, including the updated Saving Babies Lives Care Bundle by 2024 and new "MEWS" and "NEWTT-2" tools by 2025	23/24 - 24/25	Best clinical practice implemented for all families, by having high quality data to inform the decisions of clinicians and leaders, and having digital tools that enable information to flow underpinning safer, more personalised, and more equitable care

Appendix 3

Appendix 3 - LLR ICB 5YP Outcomes Framework (V1.1)

Delivery Priorities	Our Pledges to local people		National Metric	Definitions Sign Post	National Target	Baseline	Data Source	Reasoning	Accountability
Improving health equity	Pledge 1	Improve the health of our most deprived communities and narrow the gap between those who have the best and the worst health	1) We will increase life expectancy and healthy life expectancy 2) We will reduce the gap in life expectancy between most and least deprived populations	Fingertips	There is a national target set out in the levelling up white paper - Mission 7: By 2030, the gap in Healthy Life Expectancy (HLE) between local areas where it is highest and lowest will have narrowed, and by 2035 HLE will rise by five years. https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/1054766/Technical_annex_-_missions_and_metrics.pdf	Leicester Life expectancy 2021 Male 75.6 Female 79.7; Gap in life expectancy 2018-2020 Male 8.3 Female 5.9, Healthy life expectancy 2018-2020 Male 59.6 Female 57.5 Rutland Life expectancy 2021 Male 82.9 Female 85.5; Gap in life expectancy 2018-2020 Male NA Female NA, Healthy life expectancy 2018-2020 Male 74.7 Female 66.8 Leicestershire Life expectancy 2021 Male 79.7 Female 83.6; Gap in life expectancy 2018-2020 Male 6 Female 4.9, Healthy life expectancy 2018-2020 Male 62.9 Female 63.6	OHID Fingertips Profiles	These measures are reported, nationally. Therefore, we know the current position (baseline) and we can track improvements in local life expectancy and healthy life expectancy, as well as success in improving equality in life expectancy.	LLR ICB via the Health Equity Committee
Preventing illness	Pledge 2	Spend more money on preventing people becoming ill in the first place	We will reduce the under 75 mortality rate from causes considered preventable, targeting: - Cancer - Cardiovascular disease - Respiratory disease Awaiting finance prevention spend measure.	Fingertips		Baseline year is 2021 - data will lag a bit but we should be able to replicate the methodology from the mortality data held by M CSU through the DSCRO to bring it more current and track in year	OHID Fingertips Profiles	Cancer, cardiovascular disease and respiratory disorders are the three most common causes of local preventable deaths (see 3.1). All or most deaths from these causes could mainly be avoided through effective prevention interventions. These preventable mortality rates are calculated, nationally. Therefore, we know the current position (baseline) and we can track reductions in preventable deaths achieved through (amongst other interventions) increased spend on prevention. Awaiting finance prevention spend measure	Prevention Partnership (TBC)
Keeping People well	Pledge 3	Identify the frailest in our communities and wrap care and support around them	We will increase the proportion of patients with moderate or severe frailty that have a care plan in place	Local metric derived from ACG tool in Aristotle	No national target Using Aristotle data from the ACG tool, this baseline will be constructed using the percentage of patients with moderate or severe frailty that have a care plan in place.	57% of patients with moderate or severe frailty have a care plan in place	Aristotle ACG data, May 2023	There are no national metrics available. Therefore, we will use local date to construct a baseline of the percentage of patients with moderate or severe frailty and that currently have a care plan in place. Care planning is a good indicator of the effectiveness with which we are supporting frail people. We can then measure progress in increasing the proportion of people with moderate or severe frailty and that have a care plan in place.	Urgent & Emergency Care Partnership
Right care at the right time	Pledge 4	Improve and maintain access to routine general practice appointments	We will continue the trajectory to deliver more appointments in general practice by the end of March 2024	NHS Digital	There is an Operational Plan 23/34 target which is base on 'Planned number of appointments'. Continue the trajectory to deliver more appointments in general practice by the end of March 2024	March 24 693,532	NHS Digital - National Data	This measure is reported, nationally. Therefore, we know the current position (baseline) and we can track our progress, month-by-month, to deliver our GP appointment targets.	Urgent & Emergency Care Partnership
	Pledge 5	Reduce Category 2 ambulance response times	We will improve Category 2 ambulance response times to an average of 30 minutes, across 2023/24	NHS Ambulance Quality Indicators	This measure is part of the LLR Planning Master Recovery Plan		SUS/EMAS Portal or Cat 1 - national EMAS data https://www.england.nhs.uk/statistics/statistical-work-areas/ambulance-quality-indicators/	Category 2 ambulance calls are those that are classed as an emergency or a potentially serious condition, for example, a person may have had a heart attack or stroke or be suffering from sepsis or major burns. Response times are recorded and reported, nationally, and, therefore, we can track our progress as we seek to respond to 90% of Category 2 calls in 30 minutes for 2023/24.	Urgent & Emergency Care Partnership
	Pledge 6	Reduce and maintain waiting times in the Accident & Emergency department	We will improve Accident & Emergency waiting times, so that 95% of patients attending should be admitted, transferred or discharged within four hours - NB Nationally need to achieve 76% by March 24	NHS England A&E Data	95% of patients attending A&E should be admitted, transferred or discharged within four hours		https://www.england.nhs.uk/statistics/statistical-work-areas/ae-waiting-times-and-activity/ae-attendances-and-emergency-admissions-2023-24/	95% of patients seen in A&E within 4 hours is the national target and which is reported on month-by-month. We can, therefore, track our progress on recovering our local position to reach and maintain the 95% target.	Urgent & Emergency Care Partnership
Health and Wellbeing Hubs	Pledge 7	Provide more joined up, holistic and person-centred care, delivered closer to home	Measure to be defined during 23/24	GP Patient Survey - Analysis Tool (gp-patient.co.uk)	Use GP Patient Survey - looking for How satisfied are you with the general practice appointment times that are available to you? Q16. Were you satisfied with the appointment (or appointments) you were offered? Q18. What did you do when you did not get an appointment?	Improvement in satisfaction with GP appointments times and appointment types	GP Patient Survey	Once the geography, location, number and sequencing of Hubs across LLR is clarified, during 23/24, suitable measure(s) can be more readily defined.	Urgent & Emergency Care Partnership
Elective Care	Pledge 8	Reduce waiting times for consultant-led hospital treatment	Referral to Treatment (RTT) waiting times	NHS England RTT Data	18 weeks / 52 weeks / 78 weeks -Consultant-led Referral to Treatment Waiting Times	Reduction	https://www.england.nhs.uk/statistics/statistical-work-areas/rtt-waiting-times/rtt-data-2022-23/	The amount of time a person waits from when they are referred by a GP to when the consultant-led treatment begins (known as Referral to Treatment (RTT)), are reported monthly. Therefore, we can track our progress in reducing the number of people waiting 18 weeks (the national standard) or more for treatment, as we recover our elective position.	Planned Care Partnership
Learning Disability & Autism	Pledge 9	Increase the percentage of people on GP learning disability registers who receive an annual health check and health action plan	We will increase the number/percentage of learning disability Annual Health Checks carried out for persons aged 14 years or over.	NHS England LDA	In Operational Plan 23/24 - set as Quarterly Targets	23/24 Q4 1512 or 30.25%	QOF	People with a learning disability often have poorer physical and mental health than other people. The Annual Health Check is a GP service to identify all patients aged 14 and over with learning disabilities, to maintain a learning disabilities 'health check' register and offer them an annual health check, which will include producing a health action plan. Data is collected via the Quality & Outcomes Framework (QOF) and we can, therefore, track our progress in increasing the numbers/percentage of people on GP learning disability registers who receive an annual health check and health action plan.	LDA Collaborative
Mental Health	Pledge 10	Reduce inequity in access to mental health services across each of our neighbourhoods	Measured by a budget allocation analysis, with a five-year plan to progressively align mental health investment more proportionately to the most disadvantaged areas in LLR.	From 24/25, piloted in 23/24	Measured by a budget allocation analysis with a five-year plan to progressively align investment more proportionately to known hot spots of need. (No big bang changes so as not to destabilise services)			Suitable and useable metric(s) to be piloted in 23/24, with implementation from 24/25.	Mental Health Partnership
Children & Young People	Pledge 11	Improve access to, experience of, and outcomes of care for children and young people; with a special focus on driving up health equity	Interim measure: We will reduce waiting times for CYP services in 23/24. During 23/24, we will develop metrics across the CYP Pledge		Process target: Publish a LLR Children and Young People System Strategy in Year 2			We are reshaping children and young people's services, bringing all components across health and care together into a children and young people's partnership. The emerging CYP Strategy will help distil the appropriate metrics to deliver our Pledge, during 23/24, and which will be implemented for 24/25 onwards.	Children & Young People's Partnership
Women's Health, including Maternity	Pledge 12	We will engage with, listen to, empower and co-produce services with women and girls	We will use the Maternity Friends and Family Test to monitor improvement across four stages of care: - Antenatal care setting - Birth setting - Postnatal ward setting - Postnatal community setting	NHS England FFT	friends and family test as it is a single measure but asked at 4 stages of service	November 2022- FFT- Birth- LLR ICB scores 95.1%. This is above the England average. November 2022- FFT- Postnatal Community- LLR ICB scores 100% and is above the England average of 92.5%. November 2022-FFT- Postnatal Ward- LLR ICB is above the England average. November 2022-FFT- Antenatal- LLR ICB scores 96.8%. This is above the England average.		The Friends and Family Test (FFT) is an important feedback tool that supports people who use NHS services to provide feedback on their experience. Listening to women's views helps identify what is working well, what can be improved and how. The FFT asks people if they would recommend the services they have used and offers a range of responses. The FFT is reported, nationally. Therefore, we know the current position (baseline) and we can track improvements in women's experience of maternity services.	Women's Partnership
Our People	Pledge 13	We will shape our people and services around the needs of our population by improving workforce retention, reducing agency usage and growing our workforce to ensure we are fit for the future	To be determined during 23/24						LLR People Board

	Pledge	National Metric	National Target	Baseline	Data Source	Lead
Pledge 1	Improve the health of our most deprived communities and narrow the gap between those who have the best and the worst health	Life expectancy at birth, Healthy life expectancy at birth, Inequality in lfe expectancy at birth	National target set out in the levelling up white paper Mission 7: By 2030, the gap in Healthy Life Expectancy (HLE) between local areas where it is highest and lowest will have narrowed, and by 2035 HLE will rise by five years.		OHID Fingertips Profiles	

Metric	Time period	Area	Value	
Life expectancy at birth, Male	2021	Leicester	75.6	
Life expectancy at birth, Male	2021	Rutland	82.9	
Life expectancy at birth, Male	2021	Leicestershire	79.7	
Life expectancy at birth, Female	2021	Leicester	79.7	
Life expectancy at birth, Female	2021	Rutland	85.5	
Life expectancy at birth, Female	2021	Leicestershire	83.6	
Inequality in life expectancy at birth, Male	2018-2020	Leicester	8.3	8.3
Inequality in life expectancy at birth, Male	2018-2020	Rutland	No data	NA
Inequality in life expectancy at birth, Male	2018-2020	Leicestershire	6	6
Inequality in life expectancy at birth, Female	2018-2020	Leicester	5.9	5.9
Inequality in life expectancy at birth, Female	2018-2020	Rutland	No data	NA
Inequality in life expectancy at birth, Female	2018-2020	Leicestershire	4.9	4.9
Healthy life expectancy at birth, Male	2018-2020	Leicester	59.6	
Healthy life expectancy at birth, Male	2018-2020	Rutland	74.7	
Healthy life expectancy at birth, Male	2018-2020	Leicestershire	62.9	
Healthy life expectancy at birth, Female	2018-2020	Leicester	57.5	
Healthy life expectancy at birth, Female	2018-2020	Rutland	66.8	
Healthy life expectancy at birth, Female	2018-2020	Leicestershire	63.6	

Life expectancy 2021 Male 75.6 Female 79.7
Life expectancy 2021 Male 82.9 Female 85.5
Life expectancy 2021 Male 79.7 Female 83.6

Gap in life expectancy 2018-2020 Male 8.3 Female 5.9
Gap in life expectancy 2018-2020 Male NA Female NA
Gap in life expectancy 2018-2020 Male 6 Female 4.9

Healthy life expectancy 2018-2020 Male 59.6 Female 57.5
Healthy life expectancy 2018-2020 Male 74.7 Female 66.8
Healthy life expectancy 2018-2020 Male 62.9 Female 63.6

Leicester Life expectancy 2021 Male 75.6 Female 79.7; Gap in life expectancy 2018-2020 Male 8.3 Female 5.9, Healthy life expectancy 2018-2020 Male 59.6 Female 57.5
Rutland Life expectancy 2021 Male 82.9 Female 85.5; Gap in life expectancy 2018-2020 Male NA Female NA, Healthy life expectancy 2018-2020 Male 74.7 Female 66.8
Leicestershire Life expectancy 2021 Male 79.7 Female 83.6; Gap in life expectancy 2018-2020 Male 6 Female 4.9, Healthy life expectancy 2018-2020 Male 62.9 Female 63.6

Trend Data from 2010-2020

Leicester Life expectancy 2021 Male 75.6 Female 79.7; Gap in life expectancy 2018-2020 Male 8.3 Female 5.9, Healthy life expectancy 2018-2020 Male 59.6 Female 57.5 Rutland Life expectancy 2021 Male 82.9 Female 85.5; Gap in life expectancy 2018-2020 Male NA Female NA, Healthy life expectancy 2018-2020 Male 74.7 Female 66.8 Leicestershire Life expectancy 2021 Male 79.7 Female 83.6; Gap in life expectancy 2018-2020 Male 6 Female 4.9, Healthy life expectancy 2018-2020 Male 62.9 Female 63.6

Indicator Name	Life expectancy at birth
Area Type	Counties & UAs (from Apr 2023)
Age	All ages
Category Type	(blank)

Sum of Value	Column Labels								
Row Labels	2010 - 12	2011 - 13	2012 - 14	2013 - 15	2014 - 16	2015 - 17	2016 - 18	2017 - 19	2018 - 20
Female									
Leicester	81.65132	81.71765	81.68921	81.61164	81.66495	81.854	81.93216	82.23	81.51
Leicestershire	83.75384	83.90505	83.87115	83.91678	83.99158	84.07701	84.17201	84.31	84.07
Rutland	84.68529	85.57237	85.67141	85.20431	85.45952	85.79171	85.88075	85.4	84.99
Male									
Leicester	76.93527	77.17874	77.3374	77.1251	77.25045	77.00376	77.15362	77.51	76.82
Leicestershire	79.92701	80.08676	80.33404	80.51359	80.70845	80.79799	80.71352	80.86	80.45
Rutland	80.7938	81.0661	81.39242	81.81058	82.18443	82.39544	82.78983	83	83.15

Indicator Name	Healthy life expectancy at birth
Area Type	Counties & UAs (from Apr 2023)
Age	All ages
Category Type	(blank)

Sum of Value	Column Labels								
Row Labels	2010 - 12	2011 - 13	2012 - 14	2013 - 15	2014 - 16	2015 - 17	2016 - 18	2017 - 19	2018 - 20
Female									
Leicester	57.07404	57.6685	56.96018	59.94368	59.33669	59.24098	57.68207	57.23	57.48
Leicestershire	66.10534	64.6237	64.72337	65.76784	65.80101	65.66958	63.90752	63.64	63.63
Rutland	70.954	70.78982	68.84591	70.56825	70.24925	68.41623	66.41763	63.06	66.83
Male									
Leicester	57.76571	56.8569	58.77956	59.08834	60.3537	60.33563	58.65324	60.25	59.62
Leicestershire	64.90439	63.83062	64.72543	63.59111	65.15338	65.15294	63.77102	63.52	62.87
Rutland	64.42411	65.45903	68.8678	71.16394	68.73167	69.84607	69.64444	71.48	74.65

	Pledge	National Metric	National Target	Baseline	Data Source	Lead
Pledge 3	Identify the frailest in our communities and wrap care and support around them	Local metric derived from ACG tool in Aristotle	No national target Using Aristotle data from the ACG tool, this baseline will be constructed using the percentage of patients with moderate or severe frailty that have a care plan in place.	58% of patients with moderate or severe frailty have a care plan in place	Aristotle ACG data, May 2023	Mark Pierce

Indicator	**May-23**
Number of patients with moderate or severe frailty	26290
Number of patients with a care plan	15120
% of patients with moderate or severe frailty with a care plan	**58%**

Source: Aristotle PHM Risk Segmentation Tool

Appendix 4

Appendix 4

Insights to support the development of the 5-Year Plan for Leicester, Leicestershire and Rutland Integrated Care Board

Content

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1. Introduction

Integrated Care Boards (ICBs) and their partner trusts have a duty to prepare a first 5-Year Plan (5YP). The Plan will be sent to NHS England on 30 June 2023 and will also be published on the LLR ICB website. The Plan will be presented to the LLR ICB Board on 13 July 2023 where formal approval will be sought.

The 5YP would describe how the ICB and its partner trusts intend to arrange and/or provide NHS services to meet their population's physical and mental health needs.

Close engagement with partners has been essential in the development of 5YP including:

- people for whom the ICB has core responsibility: i.e., those registered with a GP practices associated with the ICB or unregistered patients who usually reside in the ICB's area (as described in the ICB constitution)
- anyone else they consider it appropriate to consult: e.g., specific organisations with an interest in the plan or whose views it would be useful to obtain, and out-of-area patients who receive treatment funded by the ICB.

Conversations with key strategic partners has been ongoing in Leicester, Leicestershire and Rutland in the development of the plan for number of months:

- LLR ICB Board
- LLR Health and Wellbeing Partnership
- Health and Wellbeing Boards (Leicester, Leicestershire and Rutland)
- Local authorities (Leicester, Leicestershire and Rutland)
- LLR ICB Clinical Executive
- LLR ICB System Executive
- Primary Care Network Clinical Directors Forum
- University Hospitals of Leicester (UHL) Board
- Leicester Partnership NHS Trust (LPT) Board
- LPT Executive
- Primary care providers
- NHS collaboratives, networks and alliances (Mental Health, Learning Disability and Autism, Acute Care, Children and Young People, Elective Care, Home First, Primary Care Transformation Board, Long Term Conditions, Cancer, Local Maternity and Neonatal System Board
- Leicester and Leicestershire Healthwatch
- Rutland Healthwatch
- Public and Patient Involvement Assurance Group

In addition, insights and data generated from previous local patient, carer, staff and public engagement exercises has been used to inform the Plan. The ICB has a history of engagement and involvement with a range of stakeholders. Public and

patient participation has been refined over time with the ICB doing more work to understand the needs of the local population and share the insights, learning and business intelligence to inform design and delivery of care. Ultimately to improve the lives of local people, improving their health and wellbeing.

Insights and data have been analysed from multiple sources of data collected during 2020/21, 2021/22 and 2022/23 including acute and maternity reconfiguration, Covid-19 report, primary care (local and national) and mental health, totalling qualitative insights from 52,000 people. This data has then been examined against 80 local reports, produced by NHS bodies and other local organisations produced during the last 3-5 years including the Report of Findings Report for engagement on enhanced access to GP practices, which involved 44,000 people.
.
The insights have captured the views of the most vulnerable and those with protected characteristics demonstrating that we have discharged our legal duty under the Public Sector Equality Duty (s.149, Equality Act 2010). The key themes coming from the work are shown in Appendix 2.

A Confirm and Challenge meeting was held with the Public and Patient Involvement Assurance Group (PPIAG) in March 2023 to discuss if the insights have influenced the development of the Plan to date. Assurance was given, with a requirement to revisit the group for further assurance post engagement. Therefore, a second Confirm and Challenge session has taken place in June 2023.

Therefore, in June, the PPIAG undertook a second Confirm and Challenge with the ICB. The group were able to assure that the insights gathered during the engagement had impacted the final draft plan being presented to the LLR ICB Board. They made the following observations and recommendations for next steps in communications:

Observations:

- Readable concise document
- Evidence of engagement
- Evidence that insights have been used to develop the plan

Recommendations for future communications of plan:

- Consider the environment in which the document is being communicated in. The Plan is forward thinking, therefore is positive about transformation, while the current experiences of some people are less positive.
- Communicate where and how individual delivery will happen and signpost to any relevant documents.
- Communicate the important content within the document in an innovative way, accessible and understandable by all, rather than the document itself.
- Communications to health professionals/clinicians.
- Communicate what good will look like and progress towards achievements.

- Important for further engagement with those responsible for driving improvements in the wider determinants of health.

2. Purpose of this report

This report outlines thematically the insights from the public engagement which ran from Thursday 18 May to Wednesday 7 June 2023 and aligns it with insights gathered previously. It includes the details of the engagement, the audiences who responded and for those that completed it, equality data. We have included some examples of direct quotes from patients, carers, staff and stakeholders to merely illustrate the theme. This in no way demonstrates the extent of the qualitative insights collected.

3. What we have done

During the period of engagement our communications focused on raising awareness of the draft Plan and encouraging people to take the opportunity to find out more and give their views.

The engagement was promoted through ICB channels: social media (organic and paid), media and stakeholder bulletins including 5 on Friday. We also worked with partners including staff, providers, local authorities, the Voluntary, Community and Social Enterprise Alliance, Patient Participation Groups, Healthwatch Leicester and Leicestershire and Healthwatch Rutland, Youth Advisory Board, LPT People's council and UHL Patient Members and the Citizens' Panel to amplify the messages and maximise opportunities for people to make comments and be involved in shaping the plan.

We also sent personal emails, both introductions and reminders to parish, district, county and city councillors, senior NHS managers, senior local authority managers, Chairs of key committees and Boards, staff including those in General Practice, MPs, Local Medical Committee, Local Pharmaceutical Committee and Local Dental Committee, Leicester and Rutland Local Optometric Committee and wider community organisations.

Engagement Questions

To provide a framework for people to feedback their views on the draft 5-Year Plan, we put together a short questionnaire, linked to our website, with the following questions:

1. What else do you think we should consider as part of our buildings blocks to support us to deliver our preventive work, keep people well, improve health equity and deliver the best possible health and care for local people?
2. Tell us what you think our priorities are when delivering the plan?
3. Is there anything else you would like to tell us to help with our plans?

4. Responses

A total of 187 people responded to the engagement.

- 167 people responded to the online questionnaire.
- 20 people responded directly to the email inbox.

From the 167 online responses some people have expressed what is important to them about health services. They may not have taken the opportunity to review the summary slides or read either some or all of the draft plan. While other people have reviewed the Plan. The breakdown of the 167 people:

- 137 people who answered some or all of the questions identified as a patient or member of the public
- 10 people who answered some or all of the questions identified as an NHS employee
- 7 people who answered some or all of the questions identified as responding on behalf of another public sector organisation
- 3 people who answered some or all of the questions identified as responding on behalf of a patient representative organisation
- 10 people who answered some or all of the questions identified as responding on behalf of a voluntary group, charity or social enterprise

While some people did answer all three questions many choice to answer only those important to them.

- 74 people answered question 1
- 72 people answered question 2
- 57 people answered question 3

Only 79 people chose to provide their demographic profile, which is optional. The demographic data is shown as Appendix 1.

20 people/organisations chose to send a response via email. In some cases, these responses were very detailed in nature. The breakdown of these responses is:

- 20 staff
- 11 representing organisations including councils or voluntary and community sector organisations

5. Key Factors and Themes

The analysis undertaken across the three questions, highlights common factors and themes that are important to stakeholders, patients, staff and the public. We have aligned these with previous insights that informed the Plan development.

Prevention, healthy lifestyles, health education and self-care

Insights previously outlined the importance of strengthened prevention and health education.

During this engagement people reinforced this. They see prevention as a priority with the need for healthcare to be about ‘prevention rather than cure’ and it should be instilled into people from an early age.

They also see links between prevention and infrastructure projects, particularly in the city e.g., cycling and walking routes.

People also advocated a multi-agency approach to promoting physical activity including joint messaging, advocacy and intelligence.

Education initiatives to help adults and children with social emotional issue was also suggested to enable people to be more empowered to cope with stressful times.

“I do feel that people over a certain age (40/50) should be routinely called in once a year for a full MOT.”

Better health education in early years, throughout school life, to give people the tools to help themselves, through diet and improved exercise. These would help particularly mental health, especially if combined with improvements to local neighbourhoods and housing.”

“Enabling active travel through safe cycling and walking routes, throughout the City, not just where the City has natural traffic free paths.”

Joined up care

From previous insights people tell us that having joined-up and seamless care is important to them – both physical and mental health services and across health and social care services.

“Nothing works without joined up care systems and the proper funding to provide the service.”

"The plans are comprehensive and forwarding thinking. The main thing is to join it all together to provide a workable and useable system for all."

"Joining up health and mental health is crucial. They impact on each other hugely and yet there is very little communications between services for individuals."

"Seamless care where it doesn't matter which organisation is providing the care as far as the patient is concerned."

More efficient screening, triage and diagnosis

People want faster and more efficient screening, when waiting to see a specialist.

"Maybe video calls prior to a full assessment to establish if one is required."

They also want better responses to urgent referrals for treatment.

"Had to self-finance surgery at a private hospital last week after no response from 2 expedited urgent referrals to specialist services."

The responses and previous insights show that many people do have a level of understanding of appropriate use of services and appreciate that many use A&E services for routine checks. They see better triage outside of A&E as a solution.

"The system of duty of care needs to be less literal and cases sent to appropriate health care areas.".

One person suggested reviewing treatment pathways to see if some situations would be better adopting a 'diagnosis first' approach.

"In the case of mental health problems, diagnosis of the causes could lead to targeted interventions instead of generic interventions based on symptoms. In the case of joint problems, early scans and/or x-rays would enable personalised physiotherapy or surgical treatments, instead of standardised exercise programmes."

Others wanted assurance that triage and first contact with services is carried out by experienced NHS staff.

GP/primary care access and improvements

Access and improvements to GP practices services has been a key area of importance for people. Concerns include arranging pre-booked appointments and telephone access at 8am. People are also concerned about the reduction in the GP workforce. People also tell

us they want a consistent approach across practices, improvement to mental health services and a home visiting GP service.

"You are not allowed to pre-book appointments anymore yet when you call at 0800 you wait for an hour to be told there are not appointments."

"With regards to the closer to home treatment, don't take GPs from surgeries to take over treatments."

"There needs to be an NHS paid home visiting GP service for the genuinely housebound so that the sickest do not get the least care."

"GP practices must behave in a common manner so that all patients can be dealt with in a consistent and effective process."

Digital and Technology

Better phone technology and online communications with GPs was advocated by people. They also saw a place for innovation to support home visits.

"Video sets for patients at home to save house visits."

People also want better implementation of electronic medical records making them easily accessible even on a mobile device, feeling it would help people to make better decisions.

Funding

Appropriately funded services matter to people and it was a key theme discussed both in previous insights and in this engagement.

"Fund the health system, from primary care, mental health services, to A&E, linked to social services and care services."

Some people specifically wanted more funding, especially for children who due to circumstances may not have the best start in life. Others want more information on how services will be funded and measured.

"Those with adversity in childhood have poor adult health. We know this, so how can we focus on our children to be the best capable adults?"

Communications

People recognise the importance of more and good information, about hospital and GP practice services. Examples include notice boards, leaflets at reception desks and information sent to homes.

People ask that every contact between patient and health professional has a shared record attached.

“Shared record - however small to allow the patient to take as much responsibility as possible.”

People also asked us to be more explicit and bring to life experiences of children and young people with Special Educational Needs and their families.

Local and accessible services – transport and mobility, waiting times

People tell us that local and accessible services are important to them. They have concerns about travel, journey times and public transport.

“In an ideal world it would be great to think that if you needed help after hours, or at weekends you could see someone very local.”

“Try to consider health from the sufferer’s point of view. Tests at city hospitals are very difficult for older and very young people.”

People also tell us their concerns about waiting times for treatment and appointments.

Improve outpatients

People provided insights telling us of the importance of having more local facilities for tests and procedures when attending an outpatient appointment, to avoid attending further appointments – ‘a one stop shop’.

Recognise dementia as a long term condition

In previous insights people expressed that they would like more recognition of dementia as a long-term condition. This engagement reiterated similar. Family carers also need more support and signposts.

“If you are wanting to increase diagnosis, then you need to have identified services and support available to offer to patients and carers. No good diagnosing patients with dementia and then saying ‘on your bike, nothing more we can do, goodbye.”

People want to see the following included in the plan

- Dental

People want to see reference to other plans including:

- The Community Health and Wellbeing Plans

People want to see more support for the following:

- Help and care towards transgender community
- Women's problems and particularly the menopause
- Full training for staff with pay incentives to retain them when they are trained
- Staffing including a Workforce Plan
- Services for addicts
- Services for the homeless
- Support of malnutrition
- Improving hospital hygiene
- Long Covid
- Mental health and learning disabilities
- Caring for carers – carers who look after friends and family

People were pleased to see the following prioritised in the plan:

- Special needs including autism
- Women's services

Other comments

People provided insights in relation to the writing and style of the plan. They want it made easier to read, to make it accessible for more people and to slim it down. They want acronyms defined and no jargon. An easyread version to summarise the big picture was felt useful.

"It is hard to decipher specially what is planned, rather than broad objectives that meet your targets."

Some asked for regular progress updates on the delivery of the plan.

People also mentioned NHS structures and asked us to consider if the whole structure is working.

Some people expressed views on different approaches to the use of private sector organisations to support the delivery of health services, with some being in favour and others feeling that it was not the right approach.

What has happened to this information?

The insights captured have been reviewed against the draft 5YP and alongside other key considerations including clinical appropriateness and safety, quality of care, value for money and affordability. This has then influenced some to the next draft version which will be put to the LLR ICB Board and sent to NHS England.

Appendix 1

Demographic data

Only 79 people chose to provide their demographic profile, which is optional.

People identified as follows:

Sexual orientation:

- 29 male
- 48 female
- 1 prefer not to say

Identifying as the gender they were assigned at birth:

- 75 yes
- 4 prefer not to say

Age category:

- 0 - under 24 years old
- 1 – 25 to 34 years old
- 4 – 35 to 44 years old
- 13 – 45 to 54 years old
- 22 – 55 to 64 years old
- 24 – 65 to 74 years old
- 12 – 75 to 84 years old
- 1 – 85 years old +
- 1 – prefer not to say

Religion or belief

- 19 no religion
- 44 Christian
- 2 Hindu
- 2 Muslim
- 5 Other
- 6 Prefer not to say

Ethnicity

- 1 Chinese
- 3 Indian
- 1 Other Asian background
- 1 African background
- 2 Asian and White

- 1 Black African and White
- 65 British, English, Northern Irish, Scottish, Welsh
- 4 Other white background
- 1 Prefer not to say

Pregnant or have given birth in last 26 weeks

- 76 no
- 2 prefer not to say

Consider themselves as having a disability or suffering from poor health

- 29 – Yes
- 47 – No
- 3 – Prefer not to say

Disability or condition

- 17 Physical
- 2 Partial or total loss of vision
- 1 Learning disability/difficulty
- 8 Partial or total loss of hearing
- 11 Mental Health condition
- 23 Long standing illness or condition

Caring capacity

- 3 people care for young person(s) aged 24 or younger
- 6 people care for adult(s) 25 to 49 years of age
- 15 people care for older person(s) aged 50 or older
- 3 prefer not to say
- 51 do not identify as having a caring capacity

Relationship status

- 5 single
- 48 Married/Civil partnership
- 7 Separated or divorced
- 11 Partnered/living with a partner
- 4 Widowed/surviving civil partner
- 3 prefer not to say

Sexual orientation

- 3 bisexual (relationship with any gender/s)
- 1 Gay or lesbian (same sex relationship)
- 64 Heterosexual/straight (male to female relationship)

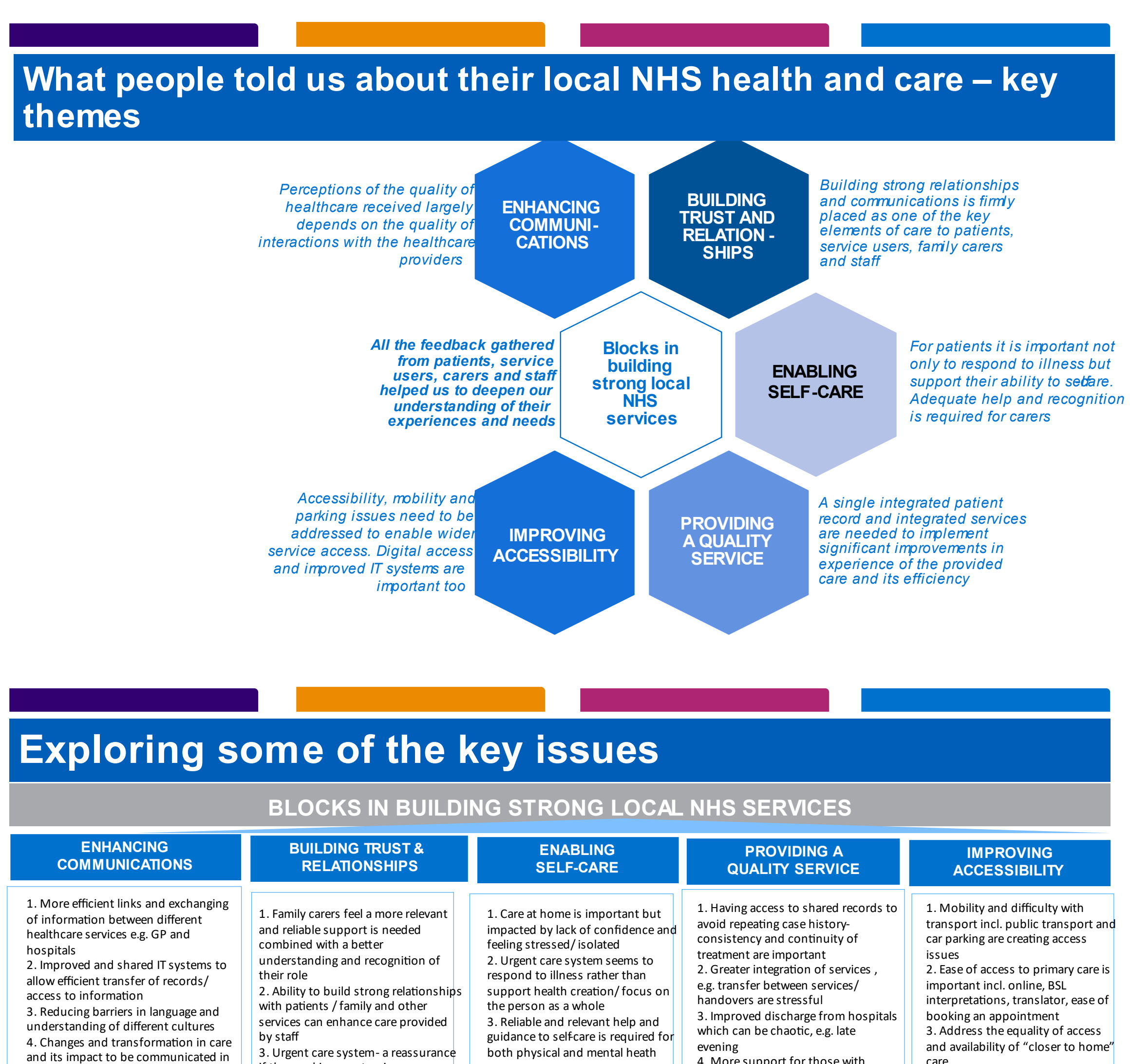
- 10 prefer not to say

Served in Armed Services

- 5 yes
- 72 No
- 1 prefer not to say

Appendix 2

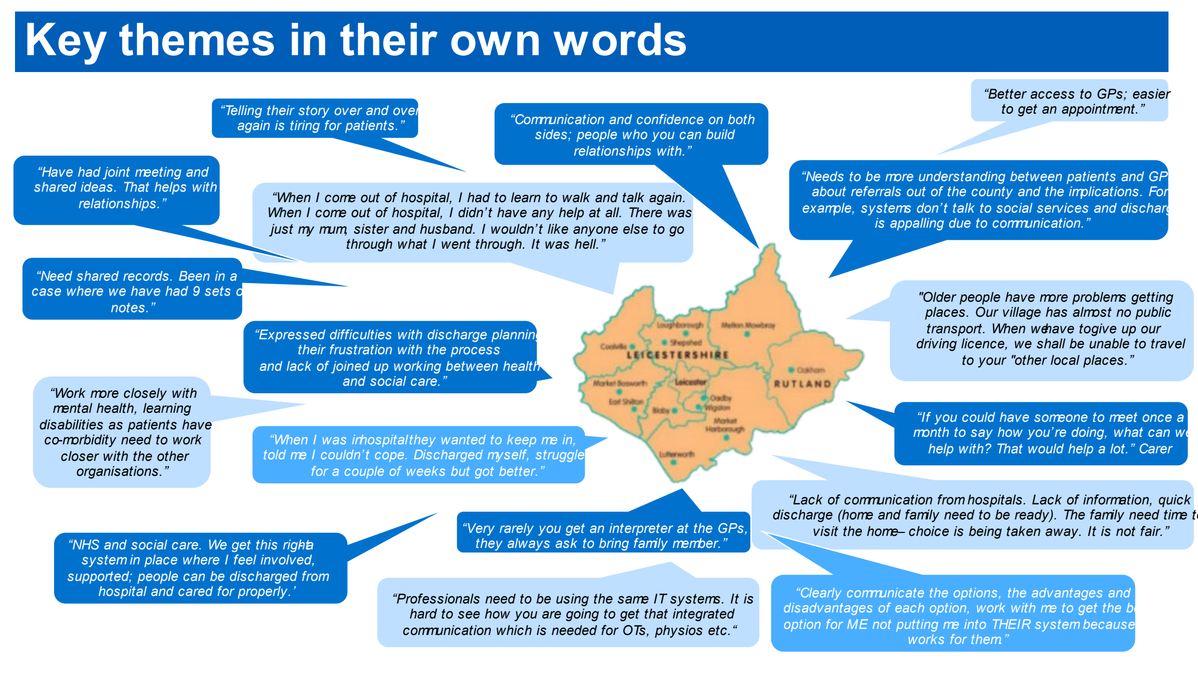
To inform the plan prior to this engagement we hear from people across a range of projects in 2020, 2021 and 2022. We reviewed theses insights against a range of reports produced pre-2020. This are the themes that emerge from what people told us:

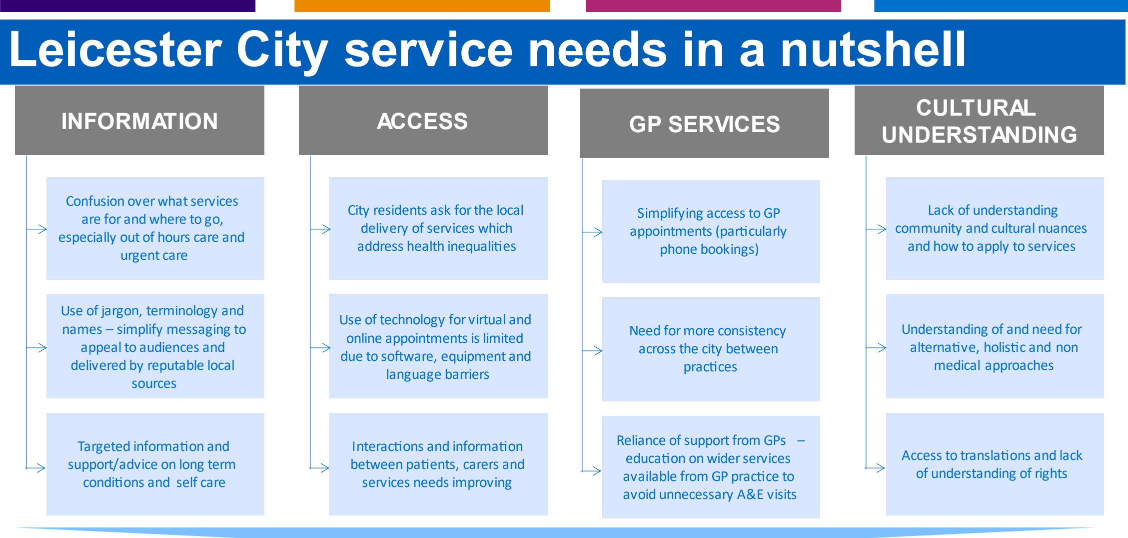


Exploring some of the key issues

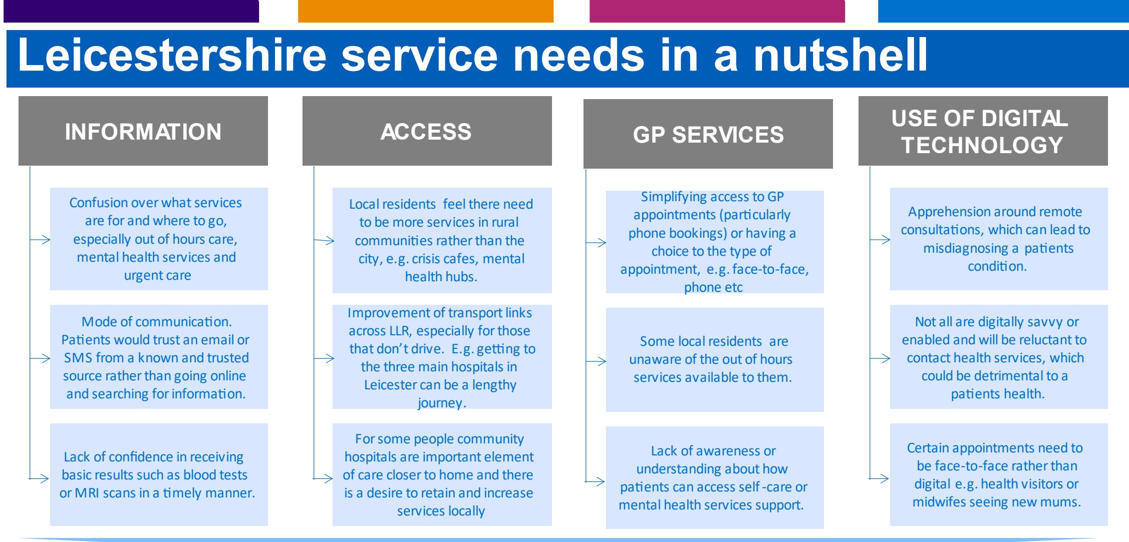
BLOCKS IN BUILDING STRONG LOCAL NHS SERVICES

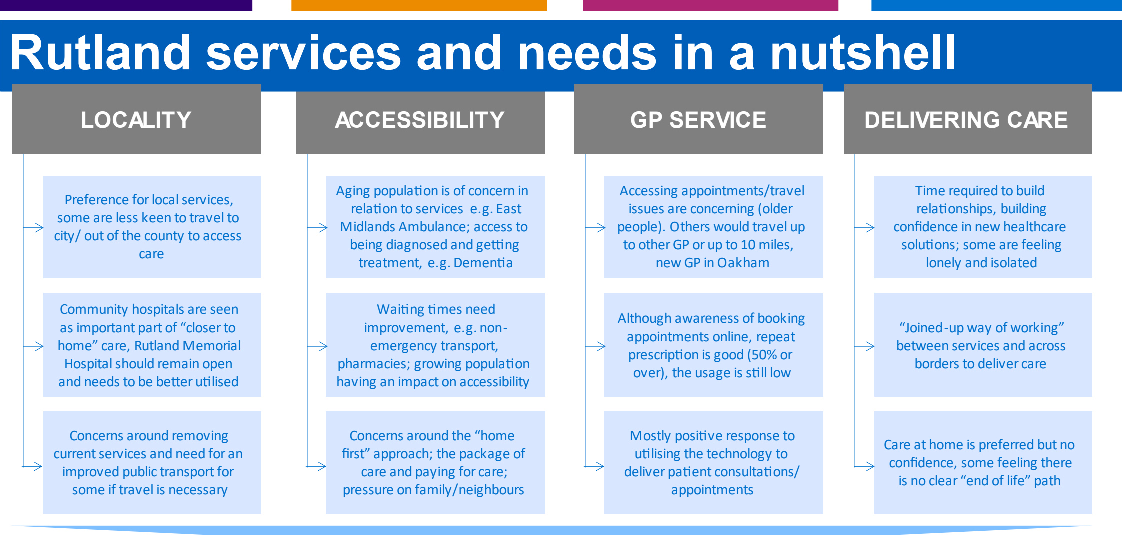
ENHANCING COMMUNICATIONS	BUILDING TRUST & RELATIONSHIPS	ENABLING SELF-CARE	PROVIDING A QUALITY SERVICE	IMPROVING ACCESSIBILITY
1. More efficient links and exchanging of information between different healthcare services e.g. GP and hospitals 2. Improved and shared IT systems to allow efficient transfer of records/ access to information 3. Reducing barriers in language and understanding of different cultures 4. Changes and transformation in care and its impact to be communicated in messages tailored to different communities including vulnerable groups. 5. Carers to be an integral part of communications about the person they care for 6. Consistent, simple and clear messaging delivered from source that is trusted by people and tailored to different communities 7. "Joined-up way of working" between services and across borders to deliver care	1. Family carers feel a more relevant and reliable support is needed combined with a better understanding and recognition of their role 2. Ability to build strong relationships with patients / family and other services can enhance care provided by staff 3. Urgent care system- a reassurance if the need is urgent or in emergency – for both physical and mental health users 4. Relations with services, incl. GP are important to people 5. Increased connections between community and healthcare providers	1. Care at home is important but impacted by lack of confidence and feeling stressed/ isolated 2. Urgent care system seems to respond to illness rather than support health creation/ focus on the person as a whole 3. Reliable and relevant help and guidance to self-care is required for both physical and mental heath users 4. Those with long term conditions want to be able to look after themselves when possible, but be sure that support exists if they need it	1. Having access to shared records to avoid repeating case history- consistency and continuity of treatment are important 2. Greater integration of services , e.g. transfer between services/ handovers are stressful 3. Improved discharge from hospitals which can be chaotic, e.g. late evening 4. More support for those with complex care needs 5. Improved quality of the end of life experience incl. how people are treated and spoken to 6. Important to have support before planned treatments and appropriate follow-ups 7. Concerns around the "home first" approach; the package of care and paying for care; pressure on family/neighbours	1. Mobility and difficulty with transport incl. public transport and car parking are creating access issues 2. Ease of access to primary care is important incl. online, BSL interpretations, translator, ease of booking an appointment 3. Address the equality of access and availability of "closer to home" care 4. Concerns around the access for rural communities and out-of-city residents 5. Waiting times are a concern- timely access to appropriate treatments 6. Digital consultations are supported , but only if appropriate to condition and choice should be offered, 7. Community hospitals are seen as important part of "closer to home" care and should be better utilised





COMMUNICATION & INFORMATION


Leicestershire service needs in a nutshell
INFORMATION
ACCESS
GP SERVICES
USE OF DIGITAL TECHNOLOGY
Confusion over what services are for and where to go, especially out of hours care, mental health services and urgent care
Mode of communication. Patients would trust an email or SMS from a known and trusted source rather than going online and searching for information.
Lack of confidence in receiving basic results such as blood tests or MRI scans in a timely manner.
Local residents feel there need to be more services in rural communities rather than the city, e.g. crisis cafes, mental health hubs.
Improvement of transport links across LLR, especially for those that don't drive. E.g. getting to the three main hospitals in Leicester can be a lengthy journey.
For some people community hospitals are important element of care closer to home and there is a desire to retain and increase services locally
Simplifying access to GP appointments (particularly phone bookings) or having a choice to the type of appointment, e.g. face-to-face, phone etc
Some local residents are unaware of the out of hours services available to them.
Lack of awareness or understanding about how patients can access self-care or mental health services support.
Apprehension around remote consultations, which can lead to misdiagnosing a patients condition.
Not all are digitally savvy or enabled and will be reluctant to contact health services, which could be detrimental to a patients health.
Certain appointments need to be face-to-face rather than digital e.g. health visitors or midwifes seeing new mums.
COMMUNICATION & INFORMATION


Rutland services and needs in a nutshell
LOCALITY
ACCESSIBILITY
GP SERVICE
DELIVERING CARE
Preference for local services, some are less keen to travel to city/ out of the county to access care
Community hospitals are seen as important part of "closer to home" care, Rutland Memorial Hospital should remain open and needs to be better utilised
Concerns around removing current services and need for an improved public transport for some if travel is necessary
Aging population is of concern in relation to services e.g. East Midlands Ambulance; access to being diagnosed and getting treatment, e.g. Dementia
Waiting times need improvement, e.g. non-emergency transport, pharmacies; growing population having an impact on accessibility
Concerns around the "home first" approach; the package of care and paying for care; pressure on family/neighbours
Accessing appointments/travel issues are concerning (older people). Others would travel up to other GP or up to 10 miles, new GP in Oakham
Although awareness of booking appointments online, repeat prescription is good (50% or over), the usage is still low
Mostly positive response to utilising the technology to deliver patient consultations/ appointments
Time required to build relationships, building confidence in new healthcare solutions; some are feeling lonely and isolated
"Joined-up way of working" between services and across borders to deliver care
Care at home is preferred but no confidence, some feeling there is no clear "end of life" path
COMMUNICATION & BUILDING RELATIONSHIPS

Appendix 5

Appendix 5

Communications and Engagement Plan

ICB Five-Year Plan

June 2023

ICB Communications and Engagement Team

Version 1.1

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

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Evaluation ..... **Error! Bookmark not defined.**

Summary

This Communications and Engagement Plan has been produced to support the launch of NHS Leicester, Leicestershire and Rutland Integrated Care Board’s Five-Year Plan, by setting out how we will build on previous engagement with local audiences to launch the document and communicate progress.

The purpose of the Communications and Engagement Plan is to raise awareness of the plan overall and specific sections, increase people’s knowledge about local services and the local priorities, and report progress and achievements.

The audiences that are relevant in this Communications and Engagement plan will vary depending on the aspect of the plan to be communicated, but will include patients and the public, staff, stakeholders and partners.

The Communications and Engagement Plan will be delivered in two phases: activities to launch the plan and an ongoing content strategy to keep people informed of progress. A ‘staff first’ principle will be used during the launch phase to ensure those involved in delivery understand their individual contribution and can act as ambassadors on the front line.

The launch plan will commence on Friday 14 July 2023, following formal approval of the Five Year Plan by the ICB Board. It will ensure communication with all audience groups using channels such as online, media, social media, email, newsletters, online and offline meetings, all using a range of accessible assets.

The content strategy will start following the main summer holiday period, commencing in October 2023. A more targeted approach will be taken during this phase to provide content and engage in a relevant, digestible and accessible way, structured around the 13 pledges and key achievements that feature in the Five-Year Plan.

Throughout, patients and communities will be invited to help us ensure content is accessible, choose what aspects of the plan they want to hear more about and get involved in specific interventions and refreshes of the Five-Year Plan.

Where possible, communications activity will be carried out, within existing budgets, by the Communications and Engagement teams working for the ICB, University Hospitals of Leicester NHS Trust and Leicestershire Partnership Trust. Recommendations may be made for additional funding to make information accessible.

Communications and engagement activity will be measured at several levels against the objectives of the Communications and Engagement plan: inputs, outputs, out-takes and outcomes.

Introduction

On 30 June 2023, NHS Leicester, Leicestershire and Rutland Integrated Care Board (the ICB) will publish its first Five Year-Plan which describes how we plan to work with partners to adapt and transform services from 2023/24 to 2027/28. Our collective aim is to help overcome local healthcare challenges, improve care and outcomes for local people, reduce the inequity gap between groups of people and achieve financial stability.

The plan is underpinned by firm foundations of involvement, engagement and co-production with people and communities, over recent years. It has also been built on an inclusive learning culture, to understand the needs of our population and design services appropriate to those needs. Quantitative and qualitative insights from nearly 50,000 people have informed the plan — including patients, service users, staff and carers, as well as seldom heard people and work with community groups who represent people with protected characteristics.

During May and June 2023, we undertook a further comprehensive engagement process with key stakeholders and wider audiences to validate our understanding of the insights collected from previous engagement and gain assurance in how these have influenced the Five-Year Plan.

This Communications and Engagement Plan has been produced to support the launch of the Five-Year Plan, by setting out how we will continue to engage with local audiences about the plan overall and specific sections, both to mark the launch of the document this summer and communicate progress throughout the plan's lifetime.

Communications and engagement objectives

The Communications and Engagement Plan aims to achieve the following:

- Raise awareness of the existence, purpose and contents of the Five-Year Plan, among the target audience, and where to find out more information.
- Provide opportunities for people to have a two-way dialogue with the ICB about the plan. This will aid people's understanding and help the ICB to shape services as the plan flexes to meet local need and undergoes its annual refresh.
- Increase people's knowledge about health and health services in Leicester, Leicestershire and Rutland, as well as our priorities.
- Promote and publicise the actions taking place to meet the needs of local people.
- Keep people informed about the progress against the plan marking key milestones, celebrating achievements, and highlighting the challenges we face.
- Help people to understand any new ways of accessing care, as services adapt and transform.

Audiences

The audiences that are relevant in this Communications and Engagement plan will vary depending on the activity and the specific message or section of the plan being communicated. Overall, it will include:

- Our patients and public, including specific groups aligning to the 13 pledges and the focus areas described in the Five-Year Plan, such as:
    - People living in deprived communities
    - Carers
    - People of all ages
    - People with long term conditions
    - People with a learning disability or autism
    - People with a mental health condition
    - Parents
    - Women and girls
    - Children and young people
- ICB staff
- Collaboratives and partnerships, including place-based partnerships
- NHS and social care staff and teams
- NHS leaders at all levels and across all our organisations
- Clinical leaders across primary, community, mental health, hospital and specialist services
- Primary care staff (including GP practices, pharmacies, dentists and optometrists)
- NHS Board non-executive members
- MPs
- County, district and parish council councillors and executives
- Local authority housing, education, planning and environmental services leaders
- Voluntary and community sector leaders
- Healthwatch and patient group leaders
- Health and care focussed charities
- Police and fire and rescue services leaders
- Health and Wellbeing Board members
- NHS England
- Local Authority Health Overview and Scrutiny Committee members
- Universities, higher and further education leaders

Approach

The approach that this Communications and Engagement Plan will take to achieve the objectives is described below.

The plan will be delivered in two phases:

1. Activities that will launch the Five-Year Plan across all target audiences (The Launch Plan)
2. Ongoing publicity across a wide range of channels to celebrate achievements and keep people informed about latest developments and services. (The Content Strategy).

For each phase and the sub-initiatives of the content strategy, relevant audiences will be selected, with the message and promotional activities tailored to that audience. This is known as segmentation. This means that information will be provided in digestible and relevant portions, rather than always presenting the plan in its entirety.

A key theme of the Five-Year Plan is how we aim to reduce challenges in service provision and inequity in outcomes. This Communications and Engagement plan will apply this same principle to ensure we are addressing inequity through our communications and engagement approaches, and adopting best practice and maximising accessibility, where possible. We will work with the ICB's Voluntary, Community and Social Enterprise (VCSE) Alliance, Patient Participation Group Network and Citizens' Panel to guide us.

We will use the 13 pledges and the focus areas to guide and structure our communications and engagement activities.

An agile approach will be adopted to ensure the plan can flex to promote current achievements and adapt to changes in the Five-Year Plan based on local need.

The Five-Year Plan will be a golden thread in all ICB Communications and Engagement activity, constantly referencing how our work links back to the Five Year Plan in all we do.

A 'colleagues first' approach will be taken, immediately following the announcement of the plan's launch. This means that the initial effort of the campaign will be to engage with our people across the ICB and wider system who will be involved in delivering the plan so they understand how they will be contributing to the big picture and will be able to act as ambassadors when face-to-face with patients.

Implementation

Launch plan

The Five-Year Plan will be published by 30 June 2023 on the ICB website, pending approval by the ICB Board.

The launch plan will commence on Friday 14 July 2023, following formal approval of the Five-Year Plan by the ICB Board.

Activities

Channel	Details	Audience	Key dates
Online	A dedicated area of the ICB website will be set up to share the Five-Year Plan and progress.	Public and stakeholders	Go live on 14 July 2023 with developments to improve accessibility happening throughout the summer.
Video	Video featuring one or more of the plan signatories announcing approval of the plan and sharing key features. For use with staff, on the website, on social media and in stakeholder publications.	All	Issue on Friday 14 July 2023.
ICB staff email	Email to all ICB staff announcing the launch of the plan	ICB staff	14 July 2023
ICB staff e-newsletter	Feature article for LLR Connect.	ICB staff	21 July edition
ICB staff briefing	Presentation about the key features of the plan. Opportunity for staff to ask questions.	ICB staff	20 July
UHL and LPT internal communications	Article/email for use in e-newsletters and intranets. Explore opportunities for staff briefings/webinars.	UHL and LPT staff	14 July for article/email August for staff briefings/webinars
System partner internal communications	Explore opportunities for engaging with staff in the wider system, e.g staff	Local authorities, other health partners	TBC

Channel	Details	Audience	Key dates
	briefings, webinars, newsletters.		
Primary care and PCNs	Article/email for primary care. Explore opportunities for webinar or PLT session with each sub-group and PCNs and place-based teams.	Primary care staff	Issue on Friday 14 July. Align with existing meetings.
Media relations	Press release announcing the approval of the plan	Media and public	Issue on Friday 14 July 2023.
Social media	Posts announcing the approval of the plan, using the video, on ICB Facebook, Twitter, Instagram and Linked In accounts	Stakeholders, staff and public.	14 July 2023 and following week. Focus on individual pledges from September.
Five on Friday weekly e-newsletter	Article in Five on Friday newsletter	Wide stakeholder list, including MPs, councillors, community groups, staff.	14 July 2023
MP Flash Briefing	Short article for MPs announcing the launch of the plan	MPs	14 July 2023
PPG Network	Email to members and information posted on online forum. Presentation to take place at July meeting.	PPG Chairs and members	Email and forum: 17, July 2023 Meeting: 27 July.
VCSE Alliance	Content for newsletter and presentation at quarterly meeting. Information to be included at online discussion forum.	Voluntary sector	Newsletter and online forum last week in July. Quarterly meeting in August
Citizens' Panel	Information to be sent to members via email. Polls/surveys on Citizens' panel platform to inform accessible content.	Citizens panel members	Information to be sent 3rd week of July. Polls and surveys during August.
Youth Advisory Board	Attend the Board to present the plan and particular aspects of relevance to children and young people.	Children and young people	TBC

Channel	Details	Audience	Key dates
PPIAG	Regular meetings to keep the group up to date with progress and receive advice.		Already engaged on the plan. Will continue to keep them regularly informed of progress. Further confirm and challenge session will be held later in 2023.
Joint Health Overview and Scrutiny Committee	A date for a future meeting to present the plan is being explored.	Joint Health Overview and Scrutiny Committee	September 2023 (TBC)
Health and wellbeing Board	Explore opportunities for engaging further with Health and Wellbeing Boards.	Health and wellbeing Board	TBC
Local Committees – Local Medical Committee, Local Dental Committee, Local Pharmaceutical Committee and Local Optometry Committee	To explore mechanisms for engaging with these groups.	Primary care staff	TBC
Toolkit	Toolkit consisting of an article, email, web/intranet content, presentation, social media to allow others to promote the launch of the plan.	Stakeholders and staff	14 July, 2023
Summary document	Easy-read, summarised version of the plan in plain language.	Public	
HTML version of the plan	Publish the plan in chapters as html on the ICB website so it is accessible to people with screen readers and can be translated using web functionality	Public	
Presentation with voiceover and captions	This will summarise the plan in plain language and in an accessible way.	Public	
ICB Annual General Meeting	Include content in AGM programme, separate to core meeting.	Public and stakeholders	September, 2023

Channel	Details	Audience	Key dates
A conversation on the Five Year Plan	Host a live discussion on the plan, live streamed to ICB social media channels.	Public and stakeholders	September, 2023
Health and Care Together	Quarterly ICB newsletter featuring the plan and bringing it to life with case studies.	Stakeholders and staff	September

Content strategy

The content strategy will start following the main summer holiday period, commencing in October 2023. The purpose of the content strategy is to publicise the Five-Year Plan in sections to allow people to engage in more detail about topics that are relevant or of particular interest to them, and to allow the ICB to share particular progress in key areas.

The content strategy is formed of two parts:

- Publicising achievements against the plan, as they arise, to relevant audiences and using relevant activities.
- Timetable of planned topics

Publicising achievements

The mechanisms that will be used to publicise the achievements will vary depending on the topic, but could include:

- Press releases and media relations
- Social media
- Website article/blog
- Stakeholder newsletters and emails
- Video
- Podcast
- Livestreams and/or webinars
- Internal communications (intranets, emails, newsletters, staff briefings)
- Quarterly ICB newsletter (Health and Care Together)
- Flash briefings to MPs and quarterly MP briefings
- ‘A conversation on’ – quarterly ICB event
- Presentations to relevant patient and community-focused meetings, for example Voluntary, Community and Social Enterprise Alliance, Patient Participation Group Network and Citizens’ Panel
- Promotional toolkits.

From September 2023, the ICB will be launching an online innovation platform to raise awareness of achievements, best practice and good news stories. The platform will be closely aligned to the 13 pledges and focus areas in the Five-Year Plan.

Timetable of planned topics

Topics will be linked to the 13 pledges and the focus areas.

An example of how this could work in practice is shown below. The scheduling of activities will be dependent on developments, achievements and progress against each of the 13 Pledges, but the aim is to create a rolling 3 month plan of activities and topics to focus on. The views of patients and communities will be sought to inform the monthly topics through meetings, forum discussions and online polls.

Month	Topic
October-November 2023	Preventing illness
December 2023–January 2024	Accident and emergency waiting times
February-March 2024	Supporting the frailest in our communities
April-May 2024	Improving health equity
June-July 2024	Care closer to home and health and wellbeing hubs
August-September 2024	Elective care
October-November 2024	Learning disability and autism
December 2024-January 2025	Mental health
February-March 2025	Children and young people
April-May 2025	Women and girls
June-July 2025	One team and culture
August-September 2025	General practice appointments
October-November 2025	Category 2 ambulance responses.

For each topic, the relevant audience will be selected and activities and messaging will be developed that will be of interest to that audience (segmentation approach).

Publicising planned topics

The mechanisms that will be used to publicise the topics will vary, but could include:

- Press releases and media relations
- Social media
- Website article/blog
- Stakeholder newsletters
- Video
- Podcast
- Livestreams and/or webinars
- Internal communications (intranets, emails, newsletters, staff briefings)
- Quarterly ICB newsletter (Health and Care Together)
- ‘A conversation on’ – quarterly event
- Presentations to relevant patient and community-focused meetings, for example Voluntary, Community and Social Enterprise Alliance, Patient Participation Group Network and Citizens’ Panel.
- Factsheets
- Promotional toolkits

How we will make information accessible.

A key principle of this Communications and Engagement plan is how we will work with patients and communities to ensure information is accessible. We will be guided by patients and communities, but this may include:

- Adding information to the ICB website in html for people with screen readers and to allow the content to be translated using in-built website functionality. This will also reduce download times for people using the website via mobile data.
- Adding voiceovers and captions to presentations to aid understanding and allow the captions to be translated using Youtube functionality.
- Use of colour coding and icons on the website and other content to link topics together
- Attending face-to-face meetings and events where possible.
- Breaking information down into sections to improve understanding
- Working with local media and community radio stations to make information available
- Producing summary and easy-read information
- Eliminating jargon and writing in Plain English

Resources

Where possible, communications and engagement activity will be carried out, within existing budgets, by the Communications and Engagement teams working for the ICB, University Hospitals of Leicester NHS Trust and Leicestershire Partnership Trust.

Depending on the particular aspect of the plan being discussed, the team may recommend funding to make information accessible. For example:

- Providing printed/hard copy information
- External video production
- Translations
- Sign-language interpretation
- Graphic design
- Funding for community and voluntary sector to engage with their communities
- Advertising.

Measurement

Communications and engagement activity to support the launch of the Five-Year Plan overall will be measured at several levels against the objectives of the Communications and Engagement plan - awareness and understanding. These levels are:

- Inputs: resources, skills and insights
- Outputs: communications and engagement activity, assets and reach
- Out-takes: people's experience and engagement with the activity
- Outcomes: how objectives have been met.

This activity will be reviewed at a 6-month checkpoint and will be shared with the Five-Year Plan core working group within the ICB. This will help to inform the activity required to support annual refreshes of the plan.

The measurement of the content strategy part of the Communications and Engagement Plan should combine activities from a range of system partners. A mechanism for bringing this information together will be discussed and agreed by the system Communications and Engagement Group during the summer of 2023.

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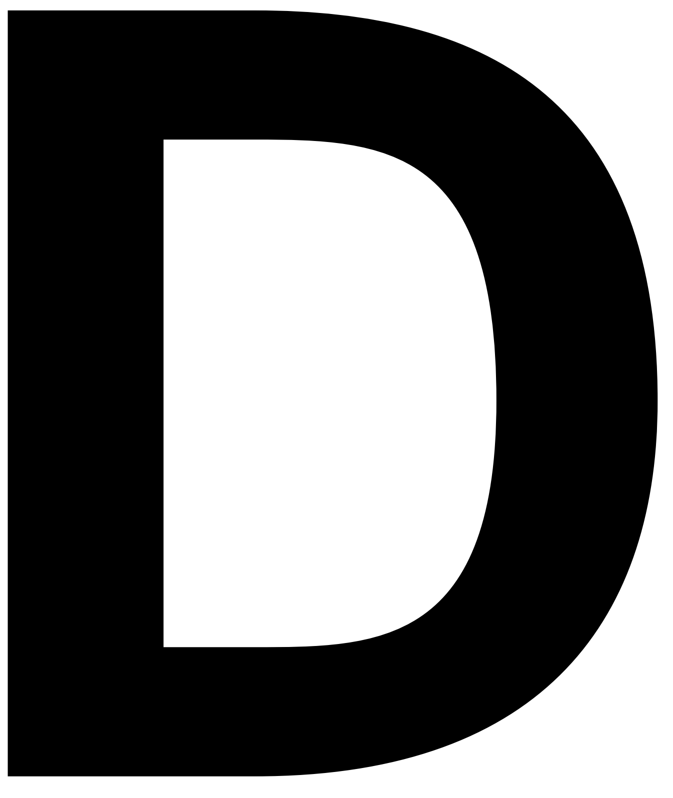
NHS Leicester, Leicestershire and Rutland is the operating name of
the Leicester, Leicestershire and Rutland Integrated Care Board



Name of meeting:	**Leicester, Leicestershire and Rutland ICB Board meeting** – meeting in public		
Date:	13 July 2023	**Paper:**	**D**
Report title:	**ICB Board Assurance Framework 2023/24 update**		
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 for assurance.
- **NOTE** the alignment of the Strategic Objectives in the BAF with the Five Year Plan.
- **APPROVE** the updated BAF including the amendments to the strategic / principal risk descriptions as detailed within Table 1 and support the review of the risk appetite score for BAF 2 (equalities).
- **APPROVE** the frequency of reviewing and updating the BAF (i.e. bi-monthly as a minimum) to enable appropriate review and oversight by the Executive Management Team.

Purpose and summary of the report:

This report aims to provide the Board with assurance that actions, as agreed in April 2023, have been implemented and are reflected in this next iteration of the ICB's BAF 2023/24 (Appendix 1), in particular the alignment of the BAF with the Five Year Plan. The report also aims to provide the Board with assurance that the risk management arrangements across the organisation continue to be fit for purpose.

The Board is asked to note that the BAF captures a snapshot of the ICB's risk profile at a point in time and that the content of the BAF will continue to be reviewed by the Executive Management Team at agreed intervals to ensure it remains up to date. Approval is being sought from the Board to support a bi-monthly review of the BAF by the Executive Management Team as opposed to updating it more frequently. The updated BAF is presented at Appendix 1 for approval including amendments to the risk descriptions, which are outlined in Table 1 within the report.

Appendices:	• Appendix 1 – LLR ICB BAF 2023/24 • Appendix 2 – Comparison of the strategic risk profiles across NHS partners in LLR
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. • April 2023 – July 2023 – each of the Board Committees have received and commented on the BAF

The report is helping to deliver the following strategic objective(s) – *please tick all that apply*:		
1. Improve outcomes	Improve outcomes in population health and healthcare.	☒
2. Health inequalities	Tackle inequalities in outcomes, experience and access.	☒
3. Value for money	Enhance productivity and value for money.	☒
4. Social and economic development	Help the NHS support broader social and economic development.	☒
5. NHS Constitution	Deliver NHS Constitutional and legal requirements.	☒

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 and risk management 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 Board Assurance Framework 2023/24

Introduction

1. This report aims to provide the Board with assurance that actions, as agreed in April 2023, have been implemented and are reflected in this next iteration of the ICB's BAF 2023/24; and for the Board to be assured that the risk management arrangements across the organisation continue to be fit for purpose.

2. The Board is asked to note that the BAF captures a snapshot of the ICB's risk profile at a point in time and that the content of the BAF will continue to be reviewed by the Executive Management Team at agreed intervals to ensure it remains up to date.

Governance arrangements

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

4. The Board has the responsibility to ensure appropriate risk management systems and processes are in place and are aligned to the ICB's Risk Management Strategy and Policy.

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. The Executive Management Team is also responsible for the regular review of the BAF in its entirety and evaluate strategic risks prior to escalation to the Board.

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

7. Each of the other Board assurance Committees will have oversight of strategic risk(s) within their scope of responsibility and provide the Board with assurance in relation to the mitigations and actions taken in managing the risk.

Actions agreed by the Board

9. In April 2023, the Board agreed a number of actions to support the next iteration of the BAF. The actions and progress made are detailed below:

    a. **Alignment to the Five Year Plan** – the Board recommended that the strategic objectives and strategic risks be reviewed and align with the Five Year Plan once consultation on the Plan had closed.

    The strategic objectives and strategic risks as identified within the BAF 2023/24 have been assessed against the Five Year Plan and it is noted that they are aligned. The strategic objectives have therefore been explicitly incorporated into the Five Year Plan. Subject to Board approval, the strategic objectives as agreed in April 2023 will continue to apply.

    b. **Risk descriptions** - it was agreed that some risk descriptions need to be rephrased to ensure consistency in articulating the cause and impact.
    Risk descriptions have been reviewed with the Executive Management Team and also the Committees. **Table 1** details the proposed amendments to the strategic risk descriptions (the BAF at **Appendix 1** also reflects the proposed risk descriptions).

c. **Each strategic risk was assigned to a Committee –** in addition to each risk having a responsible executive officer, each strategic risk was assigned a Board Committee to ensure oversight and to provide assurance to the Board.

Following the April 2023 Board meeting, all Board Committees have received the BAF in its entirety enabling each Committee to review the strategic risk(s) assigned to it, and also the broader risk profile to identify any interdependencies with other strategic risks. Each Committee has sought assurance from the executive officers in respect of controls and assurances in place and actions taken and have also offered observations and suggestions to support further action. Through the respective Committee assurance reports to the Board, each Committee will continue to report whether there is appropriate evidence in place that a strategic risk is being well managed.

d. **Alignment of the Board meeting agenda to key strategic risks** - the Board agenda will be aligned to the strategic objectives from August 2023 subject to further discussion with the Chair.

e. "**System risks"** – the Board agreed that it was key to identify the event that could potentially lead to a risk materialising and then identify which organisation would be responsible for managing and controlling this event. This would support determining whether the risk is already being managed through existing risk management arrangements within partner organisations.

These principles have been applied in the review of risks raised and discussed in Board Committees. Risks arising across the system will continue to be evaluated through the Committee structure to assess whether a risk solely relates to the ICB or whether there are implications for the ICB and other partner organisations. As alluded to in previous reports to the Board, the following principles will continue to apply:

i. The ICB BAF will 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
ii. The ICB BAF will capture 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). However, this element will continue to evolve as processes mature and develop.

f. **Risk profile across partner organisations –** the Board recognised that health inequity was the highest rated risk for the ICB currently and enquired about the risk profile across partner organisations.

An initial comparison of risks across the ICB, LPT and UHL was undertaken in November 2022 and a further review undertaken in April 2023 **(as detailed in Appendix 2).** Appendix 2 shows some common themes across the organisations, however the cause and the impact of risks vary given the nature of each organisation. It is noted that the ICB BAF risks have a strategic focus aligned to the ICB's role and strategic objectives, and some risks captured within UHL and LPT, although may appear operational in nature, are pertinent to the roles and responsibilities of the respective organisations.

g. **Interface of risks between the ICB and the LLR Health and Wellbeing Partnership (LLR HWP)** – the Board agreed to further consider the interface over the next few months. The Board may wish to consider strategic / principal "system" risks that may impact on the delivery of the Integrated Care Strategy for which the LLR HWP may be the appropriate forum to provide the oversight.

Updated ICB BAF 2023/24

10. The ICB BAF is a live document and has therefore been updated to reflect change in controls, gaps identified, and action taken. The strategic risks are monitored regularly by the Executive Team with updates received by the Committees for assurance and oversight. The updated BAF is as at **Appendix 1.**

11. The Board's attention is drawn to the following in relation to the BAF:

    a. **Change in residual risk scores -** across seven strategic risks the residual risk scores remain the same since April 2023, although some actions have been implemented. This is not unusual at this stage in the year, however this will be kept under review to ensure that actions identified are appropriate to ensure the exposure to each risk is mitigated in line with the risk appetite.

    For BAF risk 4 (financial viability), the residual risk score has been increased from 12 to 20 (impact 4 x likelihood 5 = 20) by the Chief Finance Officer in June 2023 reflecting the need for further controls and mitigating actions.

    b. The **risk scores for Risk 8 (workforce)** have been included, these were previously still being assessed.

    c. Risks rated high for the ICB:

    i. BAF 4 (financial viability) is now one of two high rated risks for the ICB.

    ii. BAF 2 (health inequity) also remains a high risk for the ICB at present with a residual risk score of 20. However, the Board is asked to note that the risk appetite is currently rated as 15. The ICB Risk Management Strategy and Policy states that the organisation has a low risk appetite for exposure to all categories of risk, **therefore the risk appetite score may need to be re-evaluated by the Executive Management Team subject to agreement by the Board.**

    d. **Frequency of review of the BAF -** the Board is asked to support and approve a bi-monthly review of the BAF by the Executive Management Team as a minimum. At present the content of the BAF is being reviewed every 2 – 3 weeks ahead of each Board Committee meeting that take place on a monthly basis. The proposed approach will enable the Executive Management Team to undertake appropriate oversight and also ensure there is sufficient time in between meetings for actions to be reviewed / implemented before presenting the BAF to the relevant committees / Board for assurance. The updates presented to the Committees will therefore be more meaningful and will aim to demonstrate actions taken. **The proposed change would mean that Committees that meet monthly would review the BAF at every other meeting rather than at every meeting.** In line with the Risk Management Strategy and Policy, the Board will continue to receive the BAF at least twice a year.

    e. As alluded to earlier in the report, **risk descriptions have been refined** to ensure consistency in articulating the risks, see **Table 1** below.

    f. **Table 2 provides a high level overview of the BAF** and the residual risk scores, the detail is contained within the BAF document at Appendix 1.

Table 1: strategic risk descriptions as approved in April 2023 and proposed amendments

Risk descriptions as approved in April 2023		Proposed change to risk descriptions (June 2023)
BAF 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.	➡	**BAF 1 – Partnership** The ICB is unable to develop and sustain a culture of collaboration / partnership working and thus unable to improve outcomes in population health and healthcare.
BAF 2 - Health inequalities and outcomes – failure to adequately address health inequalities and improve health equity and outcomes for the population of LLR.	➡	**BAF 2 – Health Inequity** Failure to adequately address health inequalities due to a lack of investment and / or lack of partnership working, therefore unable to improve health equity and outcomes for the population of LLR.
BAF 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.	➡	**BAF 3 – Demand and Capacity** Demand could exceed capacity in commissioned services due to a variety of factors. This could result in patients not accessing services in the right place, at the right time, at the right level of care.
BAF 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.	➡	**BAF 4 – Finance** The financial viability of the local health economy (over the short, medium and long term) cannot be assured due to a lack of robust transformation processes and tested schemes, this could impact organisational reputation, incur possible financial penalties and result in closer regulatory scrutiny.
BAF 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.	➡	**BAF 5 – Quality and Safety** Failure to maintain and improve the quality of services and meet the core standards could result in poor patient experience and potential harm and poor quality outcomes for patients.
BAF 6 - Emergency preparedness, resilience and response (EPRR) – failure to be adequately prepared to respond to major and / or business continuity incidents.	➡	**BAF 6 – Emergency Preparedness, Resilience and Response** Failure to have robust emergency preparedness, resilience and response (EPRR) processes in place due to lack of capacity and / or lack of partnership could result in inadequate response to major and / or business continuity incidents.
BAF 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.	➡	**BAF 7 – Cyber** A significant rise in new and unknown cyber-attacks (locally or nationally) 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.
BAF 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.	➡	**BAF 8 – Workforce** 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.

Table 2: High-level summary of the LLR ICB BAF 2023/24 (detail contained in Appendix 1)

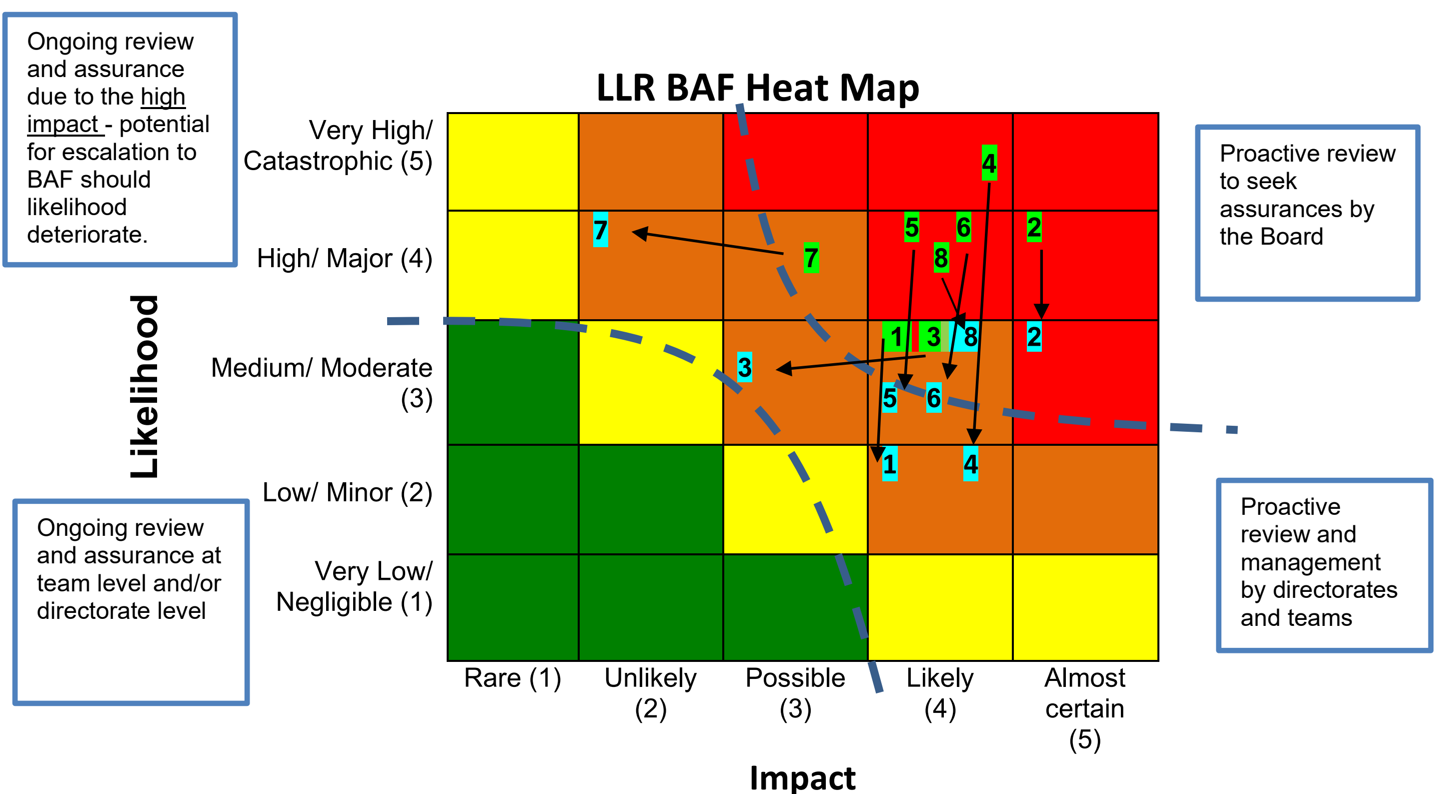
Strategic risk	Current / residual risk score (and trend)	Exec Lead	Committee oversight
BAF 1 – Partnership The ICB is unable to develop and sustain a culture of collaboration / partnership working and thus unable to improve outcomes in population health and healthcare.	12	AW	System Executive Committee / EMT
BAF 2 – Health Inequalities Failure to adequately address health inequalities due to a lack of investment and / or lack of partnership working, therefore unable to improve health equity and outcomes for the population of LLR.	20	SP	Health Equity Committee
BAF 3 – Demand and Capacity Demand could exceed capacity in commissioned services due to a variety of factors. This could result in patients not accessing services in the right place, at the right time, at the right level of care.	12	RV	System Executive Committee
BAF 4 – Finance The financial viability of the local health economy (over the short, medium and long term) cannot be assured due to a lack of robust transformation processes and tested schemes, this could impact organisational reputation, incur possible financial penalties and result in closer regulatory scrutiny.	20 ⇧	CG	Finance Committee
BAF 5 – Quality and Safety Failure to maintain and improve the quality of services and meet the core standards could result in poor patient experience and potential harm and poor quality outcomes for patients.	16	CT / NS	Quality and Safety Committee
BAF 6 – Emergency Preparedness, Resilience and Response Failure to have robust emergency preparedness, resilience and response (EPRR) processes in place due to lack of capacity and / or lack of partnership could result in inadequate response to major and / or business continuity incidents.	16	RV	System Executive Committee / EMT
BAF 7 – Cyber A significant rise in new and unknown cyber-attacks (locally or nationally) 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.	12	CG	Executive Management Team
BAF 8 – Workforce 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.	12	AMcG	Remuneration Committee / People Board

14. An alternative method of presenting the strategic risk profile is on a risk matrix "heat map". The intention of a heat map is to visually depict the risks to enable members to identify areas of focus and to seek assurance. The heat map at **Figure 1** details the current/ residual risk scores for each of the ICB's strategic risks and their respective risk appetite scores.

15. Each BAF risk in Figure 1 is represented by its unique BAF reference number with green to represent the current/ residual risk score and the blue to represent the risk appetite score (the score indicating the acceptable level of exposure to the risk should it materialise).

16. Figure 1 visually illustrates that the bigger the gap between the residual/current risk score and the intended risk appetite score, would indicate greater need for controls and mitigations to be put into place to reduce the gap. This provides an opportunity for the Board to seek assurance from the lead officers on the contribution of the controls and can help focus on those areas of specific concern.

Figure 1: ICB BAF 2023/24 Heat Map using 5 x 5 risk matrix and residual risk scores from Appendix 1 (June 2023)



BAF ref	Current/ Residual risk score (June 2023)	Risk appetite score (I x L)
1	4 x 3 = 12	4 x 2 = 8
2	5 x 4 = 20	5 x 3 = 15
3	4 x 3 = 12	3 x 3 = 9
4	4 x 5 = 20	4 x 2 = 8
5	4 x 4 = 16	4 x 3 = 12
6	4 x 4 = 16	4 x 3 = 12
7	3 x 4 = 12	2 x 4 = 8
8	4 x 3 = 12	4 x 2 = 8

Represents the movement between the current /residual score to the risk appetite.

Current/residual risk score is highlighted in green.

Risk appetite score is highlighted in blue.

Work in progress

17. A meeting of the Corporate Governance leads across the ICB, LPT and UHL is taking place in July 2023 to consider further the concept of “system risk” and risk appetite and what these means for the NHS partners in the first instance. Networking continues with other ICBs in the region to enable learning across organisations.

Recommendations

The LLR ICB Board is asked to:

- **RECEIVE** the report for assurance.
- **NOTE** the alignment of the Strategic Objectives in the BAF with the Five Year Plan.
- **APPROVE** the updated BAF including the amendments to the strategic / principal risk descriptions as detailed within Table 1 and support the review of the risk appetite score for BAF 2 (equalities).
- **APPROVE** the frequency of reviewing and updating the BAF (i.e. bi-monthly as a minimum) to enable appropriate review and oversight by the Executive Management Team.

Appendix 1

APPENDIX 1

Leicester, Leicestershire and Rutland Integrated Care Board

Board Assurance Framework 2023/24

(Version 4 as at June 2023)

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

Draft

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

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

Strategic risk	Current / residual risk score	Exec Lead	Committee oversight	Risk aligned to the LLR ICB Strategic Objective(s)					Page
				1.	2.	3.	4.	5.	
BAF 1 – Partnership The ICB is unable to develop and sustain a culture of collaboration / partnership working and thus unable to improve outcomes in population health and healthcare.	12	AW	System Executive Committee / EMT	✓	✓	✓	✓	✓	
BAF 2 – Health Inequalities Failure to adequately address health inequalities due to a lack of investment and / or lack of partnership working, therefore unable to improve health equity and outcomes for the population of LLR.	20	SP	Health Equity Committee	✓	✓		✓	✓	
BAF 3 – Demand and Capacity Demand could exceed capacity in commissioned services due to a variety of factors. This could result in patients not accessing services in the right place, at the right time, at the right level of care.	12	RV	System Executive Committee		✓			✓	
BAF 4 – Finance The financial viability of the local health economy (over the short, medium and long term) cannot be assured due to a lack of robust transformation processes and tested schemes, this could impact organisational reputation, incur possible financial penalties and result in closer regulatory scrutiny.	20	CG	Finance Committee			✓	✓	✓	
BAF 5 – Quality and Safety Failure to maintain and improve the quality of services and meet the core standards could result in poor patient experience and potential harm and poor quality outcomes for patients.	16	CT / NS	Quality and Safety Committee	✓	✓			✓	
BAF 6 – Emergency Preparedness, Resilience and Response Failure to have robust emergency preparedness, resilience and response (EPRR) processes in place due to lack of capacity and / or lack of partnership could result in inadequate response to major and / or business continuity incidents.	16	RV	System Executive Committee / EMT	✓	✓			✓	
BAF 7 – Cyber A significant rise in new and unknown cyber-attacks (locally or nationally) 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.	12	CG	Executive Management Team	✓				✓	
BAF 8 – Workforce 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.	12	AMcG	Remuneration Committee / People Board	✓	✓			✓	

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

<table>
<tr><th rowspan="2">Date risk identified</th><th rowspan="2">ICB Executive lead (risk owner)</th><th rowspan="2">ICB Committee oversight</th><th rowspan="2" colspan="2">Risk category (✓ applicable category(ies))</th><th colspan="2">ICB only or system risk (✓ one)</th><th rowspan="2" colspan="6">Risk rating (impact x likelihood = risk score)</th><th rowspan="2">Risk treatment (i.e. state whether to terminate, treat, transfer, or tolerate the risk)</th><th rowspan="2">If to be treated confirm frequency of review (e.g. monthly, quarterly)</th></tr>
<tr><th>ICB</th><th>System</th></tr>
<tr><td rowspan="4">March 2023</td><td rowspan="4">Andy Williams</td><td rowspan="4">EMT / System Executive Committee</td><td>Clinical</td><td></td><td rowspan="4">✓</td><td rowspan="4"></td><td>Gross/inherent risk score</td><td>4</td><td>x</td><td>4</td><td>=</td><td>16</td><td rowspan="3">Treat</td><td rowspan="3">Quarterly</td></tr>
<tr><td>Organisational</td><td>✓</td><td>Risk appetite score</td><td>4</td><td>x</td><td>2</td><td>=</td><td>8</td></tr>
<tr><td>Financial</td><td></td><td>Net/residual/ current risk score</td><td>4</td><td>x</td><td>3</td><td>=</td><td>12</td></tr>
<tr><td>Information</td><td></td><td colspan="6">Residual / current risk score trend since last report:</td><td colspan="2">↔</td></tr>
<tr><td colspan="7"></td><td colspan="6">Next review date:</td><td colspan="2">End July 2023</td></tr>
</table>

Draft

<table>
<tr><th rowspan="2">Key controls in place and rationale for current / residual risk score</th><th colspan="2">Internal and / or external assurances
Where can we gain evidence that our controls/systems on which we are placing our reliance are effective?</th><th rowspan="2">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?</th></tr>
<tr><th>internal</th><th>external</th></tr>
<tr><td>• 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.</td><td>• 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</td><td>• 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.</td><td>• There is room for more formal soliciting of partner evaluations of the state of our relationships and culture.</td></tr>
</table>

<table>
<tr><th colspan="6">Actions being taken to address gaps in controls and/or assurance</th></tr>
<tr><th rowspan="2">Detail the actions to be taken
What actions are required to bridge the gaps in controls and/or assurance?</th><th rowspan="2">Action to be completed by (date)</th><th colspan="3">Will the action reduce impact of risk score or likelihood or both?</th><th rowspan="2">Progress on action(s)
Brief note on updates/progress where appropriate and confirm when action completed.</th></tr>
<tr><th>Impact</th><th>Likelihood</th><th>Impact and likelihood</th></tr>
<tr><td>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.</td><td>30 August 2023</td><td></td><td></td><td>✓</td><td></td></tr>
</table>

Draft

Principal / strategic risk:

BAF 2 – Health Inequity

Failure to adequately address health inequalities due to a lack of investment and / or lack of partnership working, therefore unable to 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	Bi-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:						End August 2023	

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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. • Develop a culture that empowers staff to address health inequalities (as discussed at the Health Equity Committee in June 2023).

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• 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 *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)** *Brief note on updates/progress where appropriate and confirm when action completed.*
		Impact	Likelihood	Impact and likelihood	
Undertake a review of the quality of ethnicity coding in primary care and develop an improvement plan	September 2023			✓	Work in progress
Undertake more frequent profiling of access, experience, and outcomes data by Ethnicity and postcode to support Health equity initiatives across all clinical specialties	Ongoing			✓	Work in progress
Develop the information governance and data processing framework to support population health management.	March 2024			✓	
Consider and identify how organisational culture may need to be enhanced to enable staff to feel empowered to address health inequity.	October 2023			✓	

Draft

Principal / strategic risk:
BAF 3 – Demand and Capacity
Demand could exceed capacity in commissioned services due to a variety of factors. This could result in patients not accessing services in the right place, at the right time, at the right level of care.

Date risk identified	ICB Executive lead (risk owner)	ICB Committee oversight	Risk category (✓ applicable category(ies))		ICB only or system risk (✓ one) ICB	System	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)
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:						End July 2023	

Draft

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. This will primarily be led through the LLR Delivery Partnership, reporting into the System Executive Committee and escalating to Clinical Executive Group, & the Quality and Safety Committee as needed.	Assurance reports and mitigations plans reported to the ICB Board and relevant Committee.	NHS England Quarterly System Review meetings.	Development of an ICB level set of metrics, against all facets of the LLR 23/24 operational plan.
Revised Terms of Reference and governance in place for 2023/24, with a focus on performance, activity, finance, equity and quality by each programme lead.	Assurance reports and mitigations plans reported to the ICB Board and relevant Committee.	NHS England Quarterly System Review meetings.	Terms of reference being revised for 2023/24.

Actions being taken to address gaps in controls and/or assurance					
Detail the actions to be taken *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)** *Brief note on updates/progress where appropriate and confirm when action completed.*
		Impact	Likelihood	Impact and likelihood	
Development of an operational plan delivery dashboard detailing performance against the 31 nationally mandated indictors in the 2023/24 operational plan.	Yasmin Sidyot (30 June 2023)			✓	Draft dashboard completed, trialled in April 2023.
Development of a single summary report for System Executive, detailing performance against all facets of delivery, with SMART escalations for action from either the clinical exec, system exec or quality group	Yasmin Sidyot (via the internal ODG by 30 June 2023)			✓	Draft report for April being trialled.

Draft

Principal / strategic risk:

<u>BAF 4 – Finance</u>

The financial viability of the local health economy (over the short, medium and long term) cannot be assured due to a lack of robust transformation processes and tested schemes, this could impact 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	**Bi-monthly**
			Organisational	✓			**Risk appetite score**	4	x	2	=	**8**		
			Financial	✓			**Net/residual/ current risk score**	4	x	5	=	**20**		
			Information				**Residual / current risk score trend since last report:**						↑	
							Net risk review date:						August 2023	

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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 refreshed following submission of the 2023/24 ICB Operational Plan and Financial Plan, and aligned to the LLR ICB medium term financial plan. Proposes sustainable position at the end of the term.	Approval of the 5 Year Plan by the ICB Board.	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. **ACTION COMPLETE**
			Significant transformation and efficiency schemes will be required over the next few years to bring about balance both in terms of organisational and system designed programmes.
Long term capital programme developed to address infrastructure and IT risks.	Systemwide approach to reviewing and determining capital needs		Three year capital envelopes may not be sufficient to deliver all partners' capital asks.
System Finance Team monitor the system position and provide monthly reports to LLR ICB Finance Committee.	Financial performance reports are reviewed monthly by the Finance Committee and assurance reports reviewed by the Board.		The 23/24 financial plans include a number of risks and pressures across ICS which will need to managed in year, including unmitigated planning risks which crystallise in year
			The level of pressure currently (and for a sustained period) on the urgent care system could lead to a necessary increase in costs
			Recruitment and retention are key to system transformation and financial recovery. There is limited workforce available within the area and a number of competing employers. Lack of workforce may cause schemes to slip or costs to rise due to agency usage. Recruitment to additional posts may cause financial pressures.
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).

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Actions being taken to address gaps in controls and/or assurance					
Detail the actions to be taken *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)** *Brief note on updates/progress where appropriate and confirm when action completed.*
		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. **ACTION COMPLETE**
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. **ACTION COMPLETE**
Three year capital plan to be updated to reflect 2023/24 planning guidance.	**April 2023**		✓		On the Board agenda for April 2023 for approval. **ACTION COMPLETE**
Monthly finance report to Finance Committee refreshed to cover POD delegation and raise visibility over risks given magnitude	**May 2023**	✓			Finance Committee agreed new format **ACTION COMPLETE**
Financial Strategy to describe how over the longer term the system will achieve sustainable financial position.	**June 2023**			✓	Finance Committee supported in May and Board approval sought in June. **ACTION COMPLETE**
Implementation of NHSE Financial Controls	**July 2023**		✓		Comprehensive review to ensure to all of NHSE specified financial controls are in place and embedded in ways of working
Cost Improvement Plans to be established with credible schemes to enable financial targets for 2023/24 to be achieved.	**July 2023**		✓		Plans produced and will be risk assessed each month to identify any gaps in delivery through Delivery Programme Board and overseen by Finance Committee.
Systemwide review of capital needs and risks vs three year capital allocation	**July 2023**		✓		System Capital Group to drive work forward and identify issues chaired by UHL CFO.
HFMA financial sustainability audit	**September 2023**			✓	Update on progress being achieved on implementing actions coming out of the HFMA financial sustainability review
More comprehensive review of the financial impact of taking forward priorities in medium term plan to ensure	**September 2023**			✓	Detailed review as we head into 24/25 planning round through Delivery

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they can deliver cost efficiencies and are affordable					Programme Board and partnerships /collaboratives.
Taking forward development of Lead Provider Framework approach for UEC to enable cost improvement plan of circa £17m to be achieved	**June 2023**			✓	Strategy leads across ICB, UHL and LPT developing MOU and plan to be shared with System Exec end of June.
Ensure delivery of the financial plan for 2023/24 with an agreed deficit of £10m and an expectation from NHSE that we improve against that to deliver break even	**March 2024**			✓	Monthly finance reports and CIP scorecards along with overview of risks to be received and scrutinised by Finance Committee, System Execs and the ICB Board.

Principal / strategic risk:

BAF 5 – Quality and Safety

Failure to maintain and improve the quality of services and meet the core standards could result in poor patient experience and 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) ICB	System	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)
March 2023	**Caroline Trevithick / Dr Nil Sanganee**	Quality and Safety Committee	Clinical	✓		✓	**Gross/inherent risk score**	4	x	5	=	**20**	Treat	Bi-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:						End August 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. LLR Deliver Partnership reports to include section on Quality	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.
Quality Impact and Equality Impact Assessment of projects and business cases not receiving investment funding in 23/24	System Review Panel and Clinical Executive informed about assessment findings and impact on quality and outcomes	NHS E quarterly assurance meetings	Seek assurance and undertake review of completed EQIAs of the business cases that have not received investment. (this means that the residual risk score remains the same).

Actions being taken to address gaps in controls and/or assurance					
Detail the actions to be taken *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)** *Brief note on updates/progress where appropriate and confirm when action completed.*
		Impact	Likelihood	Impact and likelihood	
SROs and leads to complete QIAs & EIAs – notified in letter from ICB	**Chris West & Dr S Nainani**		✓		
Establish the System review Panel – to review and determine overarching level of risk associated with unfunded business cases EQIA policy and procedure to be reviewed and updated.	**Dr Nainani** **Chris West**		✓		

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Principal / strategic risk:

BAF 6 – Emergency Preparedness, Resilience and Response

Failure to have robust emergency preparedness, resilience and response (EPRR) processes in place due to lack of capacity and / or lack of partnership could result in inadequate response 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:						End 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 *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)** *Brief note on updates/progress where appropriate and confirm when action completed.*
		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). 2. Review the ICB's Corporate Business Continuity Policy and Plan following NHS England's review of the EPRR core standards (Corporate Governance Team in conjunction with the EPRR team).	End June 2023 End August 2023			✓	• Directorate level risk registers in place across all directorates / functions and table-top test exercise carried out on 8 June 2023.**ACTION COMPLETE** • 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.

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Principal / strategic risk:

BAF 7 – Cyber

A significant rise in new and unknown cyber-attacks (locally or nationally) 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:						End July 2023	

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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).

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Actions being taken to address gaps in controls and/or assurance					
Detail the actions to be taken *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)** *Brief note on updates/progress where appropriate and confirm when action completed.*
		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).

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Principal / strategic risk:

BAF 8 – Workforce

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) ICB	System	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)
March 2023	**Alice McGee**	Remuneration Committee / People Board	Clinical		✓		**Gross/inherent risk score**	4	x	4	=	**16**	Treat	**Bi-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:**							
							Next risk review date:						End July 2023	

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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 to understand trends of leavers and sickness rates.	Trends are being tracked and there has been no rise in workforce metrics. Current turnover rate is c.2% and sickness rates remain below 3%. Staff Survey results.		No gaps identified at present.
Participation and analysis of monthly, quarterly and annual staff survey.	Outcomes of staff survey shared with EMT and Remuneration Committee.		No gaps identified at present.
Regular staff briefings and communication about impact of Running Cost Allowance reductions.	Workforce reports presented to the Remuneration Committee at agreed intervals.		No gaps identified at present.
Analysis of exit interview questionnaires to understand any trends.	Analysis to be shared with EMT		Analysis reports to be presented to the Remuneration Committee in July 2023.
Annual appraisals to manage workload and priorities.	Dashboard assurance report to be produced for Remuneration Committee and EMT		Dashboard reports to be produced.

Actions being taken to address gaps in controls and/or assurance					
Detail the actions to be taken *(including 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)** *Brief note on updates/progress where appropriate and confirm when action completed.*
		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. **ACTION COMPLETE**
Analysis and dashboard reports to be produced for EMT and Remuneration Committee respectively providing an analysis of exit interviews and annual appraisals.	**End July 2023**			✓	Action being progressed

Appendix 1: Definitions and 5x5 Risk Matrix (as within the LLR ICB's Risk Management Strategy and Policy)

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'.

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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.

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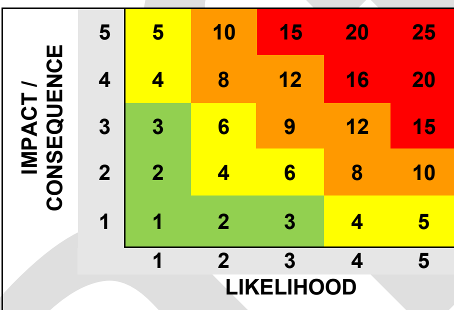
5 x 5 Risk Assessment Matrix (Risk Management Strategy and Policy)

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



IMPACT / CONSEQUENCE					
5	5	10	15	20	25
4	4	8	12	16	20
3	3	6	9	12	15
2	2	4	6	8	10
1	1	2	3	4	5
	1	2	3	4	5
	LIKELIHOOD				

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

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Appendix 2

Appendix 2

Comparison of Strategic Risks across LLR ICB, LPT and UHL (as at April 2023)

Theme	LLR ICB risk and current or residual risk score (LLR ICB BAF as at April 2023)	Provider organisations LPT risk and current or residual risk score (Organisational Risk Register as at January 2023)	 UHL risk themes identified, current or residual risk score to be determined (UHL BAF April 2023)
System working / culture of collaboration and partnerships	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 (12).		
Health inequalities / health equity (including equality and inclusion)	2. Failure to adequately address health inequalities due to a perceived lack of investment and lack of collaboration and partnership working, therefore unable to improve health equity and outcomes for the population of LLR (20).	Capcity and commitment to reach out to fully address health inequalities (12).	
		Not having an inclusive culture will affect staff and patient experience (9).	see under workforce.
Demand and capacity (including performance)	3. There is a risk that demand exceeds capacity in commissioned services due to variety of factors. This could result in the risk of patients not accessing services in the right place, at the right time, at the right level of care (12).	Increasing number of patients on waiting lists and increasing lengths of delay in accessing services (16)	Failure to meet national standards for timely urgent and elective care due to demand overwhelming capacity and delays access to services (20).
		Inappropriate management of performance impacting on ability to effectively deliver services (8).	
Finance	4.There is risk that due to a lack of robust transformation 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 (12) .	Inadequate control, reporting and management of Trust's 2022/23 **financial** position and therefore unable to deliver financial plan (9).	Audit opinion and misstatements in Trust's 2019/20 balance sheet (12).
			Lack of financial grip and control, goevrnance and financial processes (8).
			Failure to deliver 2022/23 financial plan forecast due to operational and inflationary pressures and recovery from Covid (12).
			Failure to deliver medium term financial plan due to operational and inflationary pressures and recovery from Covid (16).
Transformation		Not retaining or developing new business opportunities (12).	
Quality improvement	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 (16).	Closed cultures within services leading to poor patient care, staff and family experience (12).	Failure to improve patient safety, clinical effectiveness and patient experience due to lack of quality governance and assurance framework (20).
			Unable to provide safe, high quality, modern healthcare services due to IT infrastructure unfit for future (16).
			Unable to provide safe, high quality, modern healthcare services due to estate infrastructure unfit for future (16).
EPRR	6. Emergency Planning Resilience and Response (EPRR) arrangements (16)		
Cyber security	7. Cyber Security risk - the impact from new and previously unknown cyber threats is potentially significant across all LLR organisations (12).	Cyber threat landscape considered significant due to geopolicitical conflicts (16).	
Workforce / People agenda	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 (residual risk score to be confirmed).	Lack of staff capacity causing delays in incident management process (12)	Insufficient workforce capacity, capability and lacking diversity due to failure to recruit, retain, redesign and transform the workforce (20).
		A lack of staff with appropriate skills (12)	
		A lack of capacity within workforce model and a high vacancy rate is reduscing ability to pfollows up patients (20).	
		A high vacancy rate for registered nurses. AHPs, HCSWs and medical staff and therefore high usage of temporary workforce (16).	
		High agency usages resultng in high spend (20).	
		Impact of additional pressures on service delivery may compromise health and wellbeing of staff (9).	
Facilities and infrastructure		Facilities Management does not meet quality requirements (16).	Unable to address statutory requirements and address baklog mainteance requirements due to insufficient capital funding (20).
		Lack of information about accommodation to support strategic business planning (12).	
Green Plan		Trust does not have a Green Plan therefore non-compliance with the NHS commitment (12).	
Data quality		A lack of accessibility and reliability of data reporting and analysis (12).	
Research and innovation			
Other:		Restricted access and use of electronic patient record systems (16).	