Meeting Title	**Leicester, Leicestershire and Rutland (LLR) Integrated Care Board meeting** (meeting held in public)	**Date**	**Thursday, 10 August 2023**
Meeting no.	**10**	**Time**	**Meeting in public: 9:00am – 11:30am**
Chair	**David Sissling** **Independent Chair, ICB**	**Venue / Location**	MSTeams

REF	AGENDA ITEM	ACTION	PRESENTER	PAPER	TIMING
ICB/23/85	Welcome and Introductions	To receive	David Sissling	**Verbal**	9:00am
ICB/23/86	Apologies for Absence: •	To receive	David Sissling	**Verbal**	9:00am
ICB/23/87	Notification of Any Other Business	To receive	David Sissling	**Verbal**	9:00am
ICB/23/88	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**	9:00am
ICB/23/89	To consider **written questions received in advance** from the Public in relation to items on the agenda	To receive	David Sissling	**Verbal**	9:05am
ICB/23/90	Minutes of the meeting held on 13 July 2023	To approve	David Sissling	**A**	9:15am
ICB/23/91	Matters arising and actions for the meeting held on 8 June 2023	To receive	David Sissling	**B**	
ICB/23/92	Update from the Chair	To receive	David Sissling	**Verbal**	9:20am
ICB/23/93	Update from ICB, Acute Sector and Mental Health and Community Sector	To receive	Andy Williams /Angela Hillery / Richard Mitchell	**Verbal**	9:25am
SHARING CASE STUDIES AND PATIENT STORIES					
ICB/23/94	Community Pharmacy	To receive	Dr Nil Sanganee / Paul Gilbert	**C** **presentation**	9:35am
STRATEGY AND SYSTEM PLANNING					
ICB/23/95	Briefing on NHS Dentistry	To receive	Dr Nil Sanganee / Caroline Goulding	**D** **presentation**	9:50am
ICB/23/96	NHS Long Term Workforce Plan	To receive	Alice McGee	**E**	10:05am
ICB/23/97	Winter Plan 2023/24	To approve	Richard Mitchell	**F**	10:20am

REF	AGENDA ITEM	ACTION	PRESENTER	PAPER	TIMING
OPERATIONAL					
ICB/23/98	LLR Delivery Partnership Summary Report (ICB and system operational performance)	To receive	Rachna Vyas	**G**	10:35am
ICB/23/99	LLR ICB Finance Report	To receive	Caroline Gregory	**H**	10:50am
ASSURANCE					
ICB/23/100	Assurance report from the Finance Committee	To receive	Cathy Ellis	**I**	11:05am
ICB/23/101	Assurance report from the System Executive Committee	To receive	Andy Williams	**J**	
ICB/23/102	Assurance report from the Quality and Safety Committee	To receive	Pauline Tagg	**K**	
ICB/23/103	Assurance report from the Audit Committee	To receive	Darren Hickman	**L**	
ICB/23/104	Assurance report from the Health Equity Committee	To receive	Prof Azhar Farooqi	**M**	
ICB/23/105	Performance assurance briefings from UHL and LPT	To receive	Richard Mitchell / Angela Hillery	**N1** **N2**	
ICB/23/106	Summary of the East Midlands Joint Committee held in April and June 2023	To receive	David Sissling	**O**	
ANY OTHER BUSINESS					
ICB/23/107	Items of any other business and review of meeting	To receive	David Sissling	**Verbal**	11:25am

The next regular meeting of the LLR Integrated Care Board meeting will take place on **Thursday 12 October 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.*

A

Minutes of the NHS LLR Integrated Care Board ("the ICB" or "the Board") Held in Public, Thursday 13 July 2023 9:15am – 10:25am, Loros Professional Development Centre, Groby Road, Leicester, LE3 9QE

Members present:

Mr David Sissling	NHS LLR ICB Independent Chair and Chair of the meeting
Mr Andy Williams	Chief Executive, NHS LLR ICB
Dr Sulaxni Nainani	Deputy Chief Medical Officer, NHS LLR ICB (deputising for Dr Nil Sanganee)
Ms Chris West	Deputy Chief Nursing Officer, NHS LLR ICB (deputising for Dr Caroline Trevithick)
Ms Caroline Gregory	Interim Chief Finance Officer, NHS LLR ICB
Ms Sarah Prema	Chief Strategy 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 Martin Samuels	Partner Member - local authority sectoral representative (Strategic Director, Partner Social Care and Education, Leicester City 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
Dr Janet Underwood	Chair, Healthwatch Rutland
Ms Cathy Ellis	Chair of Leicestershire Partnership NHS Trust
Cllr Sarah Russell	Chair of Leicester City Council Health and Wellbeing Board
Cllr Diane Ellison	Chair, Leicester City Council Health and Wellbeing Board

In attendance:

Mrs Daljit Bains	Head of Corporate Governance, NHS LLR ICB
Ms Charlotte Gormley	Corporate Governance Officer, NHS LLR ICB (note taker)

Approximately members of the public attended to observe the meeting.

ITEM		LEAD RESPONSIBLE
ICB/23/74	**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/23/75	**Apologies for absence from Members and Participants:** • Dr Caroline Trevithick, Chief Nursing Officer, LLR ICB	

ITEM		LEAD RESPONSIBLE
	• Dr Nil Sanganee, Chief Medical Officer, NHS LLR ICB • Mr Richard Henderson, Chief Executive, East Midlands Ambulance Service • Cllr Louise Richardson, Chair of Leicestershire Health and Wellbeing Board	
ICB/23/76	**Notification of Any Other Business** No additional items of business had been notified.	
ICB/23/77	**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 reviewed on a regular basis.	
ICB/23/78	**Consider written questions received in advance from the Public in relation to items on the agenda** Mr Sissling thanked members of the public for their attendance and for submitting questions in advance of the meeting. Mr Andy Williams advised that the allocated time for this agenda item had been extended to enable sufficient response to questions. The questions received focused in the main on a recent flooding incident at East Leicestershire Medical Practice (ELMP) and the LLR Five Year Plan. He confirmed that all questions would be responded to directly and for the purposes of the meeting the responses were categorised into themes. **1. Questions in relation to reducing health inequalities and business continuity** In response to questions raised by Kate Howells and Peter Howells (Patient Participation Group (PPG) Chairs); Bina Patel (Practice Manager); Dr Surinder Sahota; Cenker Inan; Daxa Patel; Mr S Patel (Patient at ELMP); Rt Hon. Keith Vaz; and Mr Ion Taralunga (Patient at ELMP), Mr Williams confirmed that the ICB was working closely with the Practice following the recent flooding incident. A three-phased approach had been adopted. **Phase One -** immediate action had been taken to support the Practice to enact its Business Continuity Plan to ensure patient services could continue. This phase was completed with the Practice telephone lines being operational and clinical services being delivered from several local buildings and Practices including Humberstone Medical Centre, Merlyn Vaz Health Centre, and St Elizabeth's Medical Centre. An administrative function had been established at Merlyn Vaz Health Centre. Reduced telephone access was secured for the practice the day after the flood, with full telephone access restored on the following Thursday. In addition, the Practice had secured mobile vehicles to provide some clinical services on the Uppingham Road site providing blood tests, health checks, chronic disease management, vaccinations, and GP appointments for less complex patients. Leicestershire Partnership NHS Trust (LPT) relocated their services within their own estate and St Peter's Health Centre. Mr Williams confirmed that the ICB continued to work closely with the Practice and remained in close daily contact to ensure they had sufficient capacity to safely run their services.	

ITEM		LEAD RESPONSIBLE
	Phase Two - the second priority involved working with the Practice and NHS Property Services (NHS PS) to bring the property safely back into operation. A report of the damage to the building was completed and NHS PS were finalising the responsive programme of works. It was anticipated that this work would take approximately 8-12 weeks to complete. **Phase Three –** Mr Williams confirmed that phase three would consider the longer-term options for the development of the Practice. This work would involve a range of partners including the Practice, patients and the public, NHS PS, the ICB and other NHS partners to determine a preferred way forward. It was noted that projects of this nature would typically take 3 to 5 years from the scoping stage to the operation of the new facility. The ICB confirmed its commitment to facilitate and support this work. In terms of relevant health equity aspects, Mr Williams confirmed that tackling inequity was a core purpose of all ICBs and this was a key principle within the LLR Five-Year Plan. **2. Questions highlighting historical concerns** In response to questions raised by Kate Howells and Peter Howells (ELMP PPG Co-Chairs), Mr Williams advised that NHS PS had confirmed that maintenance issues were not a contributory factor, but rather flooding was caused by a large volume of rainfall over a short period of time. The building would however be assessed by NHS PS for remedial work to mitigate the risks in the future. **3. Question in relation to research and innovation (supporting collaborative research with UHL as a partner)** In response to questions from Danni Brookes (Placement and Research Officer, ELMP), Mr Williams confirmed that the ICB had not been approached officially regarding support for research and innovation at ELMP. The ICB was committed to research and innovation and would work to support collaboration across primary and secondary care. It was noted that ELMP had a positive reputation locally for research and innovation, and the Practice may wish to give this further consideration as part of the third phase and the longer-term future of the Practice. It was expected that GP Practices involved in research would ensure they had adequate facilities to support future research, either within the primary care estate or within Trust facilities. **4. Primary Care Estates Strategy and details** In response to questions raised by Cllr Zuffar Haq, Mr Williams advised that primary care estates were highlighted as a significant issue within the Five-Year Plan and a Primary Care Estates Strategy had been developed for LLR. He confirmed that plans were in place to improve premises for primary care in Leicester City. Mr Williams confirmed that the ICB does not provide capital to primary care but rather contributions are made as revenue payments for premises. Practices requiring priority support had been identified as part of the Primary Care	

ITEM		LEAD RESPONSIBLE
	Estates Strategy, 20 of which were located within Leicester City. Engagement work would take place with these practices. Support was also available in the form of development aids and grants. Work was ongoing with the Primary Care Networks (PCNs) to determine additional ways that the ICB might contribute. Mr Williams confirmed that £330k had been allocated in minor improvement grants for relevant areas of work, with £250k committed to be applied over a four-year period. Mr Williams confirmed that the ICB does not hold data as to how many Practices operate out of detached, terraced, and residential buildings. The ICB does however hold data on the condition of Practice sites, and this had been taken into account in the identification of priority sites within the Primary Care Estates Strategy. **5. Process for asking Questions of the Board** In response questions raised by Cllr Zuffar Haq, Mr Williams confirmed that members of the public are encouraged to submit their questions three days in advance of the Board meeting in order for officers to provide a considered response at the meeting where possible. Questions and answers would be published in full, and it was emphasised that there are alternative ways to engage with the ICB, including via the enquiries email address llricb-llr.enquiries@nhs.net . **6. Question relating to public engagement** In response to questions raised by Mr Rana (Patient at ELMP), Mr Williams confirmed that the ICB had supported the Practice to communicate with its patients and surrounding Practices about the short- and medium-term plans. Mr Williams confirmed that the ICB was aware of a petition that had been signed calling for a new GP Surgery and reiterated the three-phase approach and process as described earlier. The importance of the patient and public voice in the process was acknowledged, and Mr Williams agreed to attend a meeting organised by the ELMP PPG later in July 2023. Mr Williams welcomed the opportunity to respond to the questions posed and confirmed that the ICB continues to support the Practice. **7. Question in relation NHS at 75 celebrations** In response questions raised by Mrs Alli, Mr Williams confirmed that the ICB was delighted to be part of the wider NHS celebrations and joined many of its partner organisations with their celebrations including the Tea Party hosted by UHL. The ICB had representatives at the national celebrations in Westminster Abbey and at Park Runs across the county. The ICB also celebrated with its staff via an online event, a historical exhibition in County Hall and issued thank you certificates to every member of staff for their service to the NHS. Mr Sissling thanked members of the public for submitting questions and confirmed that an individual response would be provided for each question raised. Mr Sissling advised that he had visited ELMP following the recent flooding incident and had witnessed the extensive damage. He reflected on the strong sense of pride, loyalty, and ambition for the practice shown by patients	

ITEM		LEAD RESPONSIBLE
	and local people. He acknowledged the strength of support for a new build in the next 4-5 years. The Chair stated that he felt it would be appropriate for Professor Farooqi to address the meeting as he is a partner at the practice. Professor Farooqi welcomed the opportunity to make some comments and observations. He reflected on a complaint made to the CCG by the PPG five years ago regarding the standard of the premises. It was disappointing that no responsive action had been taken. Professor Farooqi described the disruption in services as a result of the flooding and believed it appropriate to draw the Board's attention to the seriousness of the position in terms of delivery of services, patient access, and potential quality and safety considerations. Professor Farooqi expressed his thanks to a range of individuals and organisations including the ICB for their support. He expressed his gratitude to the Practice team for their commitment to re-establish services, and to patients for their support and forbearance. He noted that the 5 Year Plan committed the ICS to a number of pledges including the delivery of more care in the community, with increased access to GPs and specialists, and reduced health inequalities. He considered the current ELMP premises to be outdated and unsafe. He saw a clear opportunity to deliver the LLR Five Year Plan pledges for the ELMC population through a collaborative effort with joint services delivered by a range of partners. This would also enable enhanced research, training and workforce development. Mr Sissling thanked Professor Farooqi for his perspective and echoed his thanks to Practice staff and supporting organisations. He invited one further question from the public gallery. Ms Khudeja Amer-Sharif (Shama Women's Centre) raised a concern regarding patient access and engagement for those from minority communities, outlining struggles presented due to language and transportation issues. She queried what actions would be put into place over the next few months to provide services closer to home and to address language barriers and also sought clarification of the measures which would be put into place to monitor patient safety incidents resulting from the recent flooding. In response, Mr Williams confirmed that the position was being reviewed daily. He acknowledged that disruption to services was unavoidable, however issues were being resolved as they became apparent. Regarding language and transportation, Mr Williams advised that the ICB's main priority was supporting the Practice in terms of patient safety but was very conscious of the need to recognise the diversity of the local population. Mr Williams reiterated the ICB's commitment to doing everything possible to address the situation in the short term, and priority given to returning to a normal pattern of service as quickly as possible. Mr Sissling closed the item by affirming that public questions and challenges were genuinely welcomed. He confirmed that opportunities would be taken to meet with staff and the local population to ensure good engagement characterised the short- and longer-term responsive action.	

ITEM		LEAD RESPONSIBLE
ICB/23/79	**Minutes of the meeting held on 8 June 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 8 June 2023.	
ICB/23/80	**Matters Arising and actions for the meeting held on 8 June 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/23/81	**Update from ICB Chair** Mr Sissling advised that Councillor Louise Richardson (Chair of the Leicestershire Health and Wellbeing Board) would be co-chairing the LLR Health and Wellbeing Partnership with immediate effect. This was in line with the process agreed whereby each of the Health and Wellbeing Board Chairs co-chair the meeting on a rotational basis. **It was RESOLVED to:** • **RECEIVE** the update.	
ICB/23/82	**LLR Five Year Plan (Paper C)** Ms Prema introduced the item and advised that the ICB has a legal duty to develop a strategic plan for the next five years. The focus was on increasing access and outcomes for patients and decreasing the equity gap. Key delivery outcomes were outlined. The Plan had been developed with contributions from the Board, Collaboratives, and partner organisations but also drew on insights from patients, the public, and the analysis of public health data. Feedback on circulated draft versions had enabled amendments to some of the content. NHS England had confirmed that the Plan was in line with relevant guidance. It was noted that an outcomes framework was in development to enable progress and delivery to be monitored. Ms Prema anticipated the delivery plan would be reviewed and refreshed annually. Ms McGee advised that, subject to approval, engagement with the public, stakeholders and partners would commence in the near future and continue as the plan was implemented. There would be a focus on the 13 pledges to the public. It was noted that the Plan had been published on the ICB website with a note advising that it was subject to Board approval. Members observed that transformational change would need to be enabled by changes in the pattern of financial investments and by appropriate improvement capabilities. The focus on tackling inequity must remain strong. Members asked if the plan would be summarised and translated into appropriate languages. It was also requested that where possible, stock images used within the document be replaced by pictures of local people and staff. Ms Prema confirmed that a range of formats were being explored including the drafting of a shorter version of the Plan. Ms Prema also confirmed	

ITEM		LEAD RESPONSIBLE
	that images used throughout the document would be reviewed. In addition, signposting to the respective Health and Wellbeing Strategies would be strengthened and the Plan would be reviewed following publication of the NHS Long Term Workforce Plan publication. Dr Chotai emphasised that the term "primary care" traditionally referred to primary medical care, however following the recent delegated functions this reference now applies to pharmacy, optometry and dental primary care services (PODs). Therefore, the Plan should clarify whether the reference applies to all primary care services or specific groups. Sir Mayur Lakhani welcomed the plan but observed that the plan on a page would benefit from greater reference to 'integration'- within our services and as part of anchor institutions. Ms Prema advised that final amendments would be made to the Plan as discussed and the Board would receive progress on delivery through quarterly updates from the LLR Delivery Partnership. The first of these reports is expected in August 2023. Overall, the Board welcomed the dynamic nature of the plan and the approach to engagement. Mr Sissling expressed thanks to Ms Prema and to all who had contributed to the development of the Five-Year Plan. **It was RESOLVED 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).	**Sarah Prema**
ICB/23/83	**LLR ICB Board Assurance Framework (BAF) 2023/24 (Paper D)** In introducing the report, Ms Gregory confirmed that actions requested by the Board, including alignment of the BAF to the Five-Year Plan, had been completed. She advised that there had been no changes to the overall strategic objectives and strategic risks. These remain as agreed in April 2023 although a number of risk statements had been strengthened. It was proposed that the BAF be updated and reviewed by the Executive Management Team on a bi-monthly basis to enable appropriate oversight by the designated Committees. Ms Gregory drew attention to specific updates, including the increase in residual / current risk score for BAF risk 4 (financial viability) which had increased from 12 to 20 in June 2023. This therefore triggered the need for further controls and mitigating actions. It was noted that the Finance Committee consider finance risks on a monthly basis. A request was made to clarify the timescales over which the 2 highest scoring risks- finance and health inequity- could be reduced. Consideration to this request would be given by the Executive Management Team with a report back to the Board.	**Caroline Gregory / Sarah Prema**

ITEM		LEAD RESPONSIBLE
	The Board observed that at future meetings a report on each of the highest rated risks should be considered to enable the Board to receive a detailed overview of controls and assurances. A discussion took place regarding the coordination of security, particularly the infiltration of organisations through means other than cyber-attacks. It was confirmed that digital security was overseen by the Digital Strategy Board and that learning would be taken from the national security work that had taken place. Mr Sissling expressed thanks to Ms Bains and Ms Gregory. **It was RESOLVED 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.	
ICB/23/84	**Items of any other business and review of the meeting** There were no additional items of business. The meeting closed at 10:33am.	

Date and Time of next meeting:
The next meeting of the NHS LLR Integrated Care Board would take place on **Thursday 10 August 2023,** 9:00am to 11:30am, meeting to be held in public via MSTeams.

B

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

Action Log

Key

Completed	On-Track	No progress made

Minute No.	Meeting Date	Item	Responsible Officer	Action Required	To be completed by	Progress as at August 2023	Status
ICB/23/82	13 July 2023	LLR Five Year Plan	Sarah Prema	To make the amendments to the Plan as discussed at the meeting, in particular the following areas: • Translating the plan into other media, format and languages to enable a more accessible Plan. • Where possible, stock images to be replaced or be representative of local patient population and staff. • Signposting to the respective Health and Wellbeing Strategies to be strengthened. • Plan to be reviewed in line with the NHS Long Term Workforce Plan publication. • To ensure consistency in the use of the term “primary care”. • Plan on a page to reference to ‘integration’.	End July 2023	**ACTIONS COMPLETED**	**Green**
			Sarah Prema / Rachna Vyas	Quarterly updates on progress against the Plan to be presented through the LLR Delivery Partnership report.	August 2023	Initial report from the LLR Delivery Partnership on the agenda for August 2023 ICB Board meeting. Future reporting timescales captured on the Board forward planner. **ACTION COMPLETE**	**Green**

Minute No.	Meeting Date	Item	Responsible Officer	Action Required	To be completed by	Progress as at August 2023	Status
ICB/23/83	13 July 2023	LLR ICB Board Assurance Framework 2023/24	Caroline Gregory / Sarah Prema	Reports detailing assurance on the high rated risks (i.e. finance and health equity) to be presented to the Board.	August 2023 / September 2023	A report on the ICB financial position is presented to the Board at each meeting. In respect of health equity, it is proposed that an initial detailed review is undertaken at the next Board development session. **Subject to the Board's agreement, request that this action be closed and the item captured on the Board forward planner.**	**Amber**

C

NHS
Leicester, Leicestershire and Rutland

Community Pharmacy Consultation Service (CPCS)

Dr Nil Sanganee & Paul Gilbert

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

A proud partner in the:

Leicester, Leicestershire and Rutland
Health and Wellbeing Partnership

Community Pharmacy Clinical Services

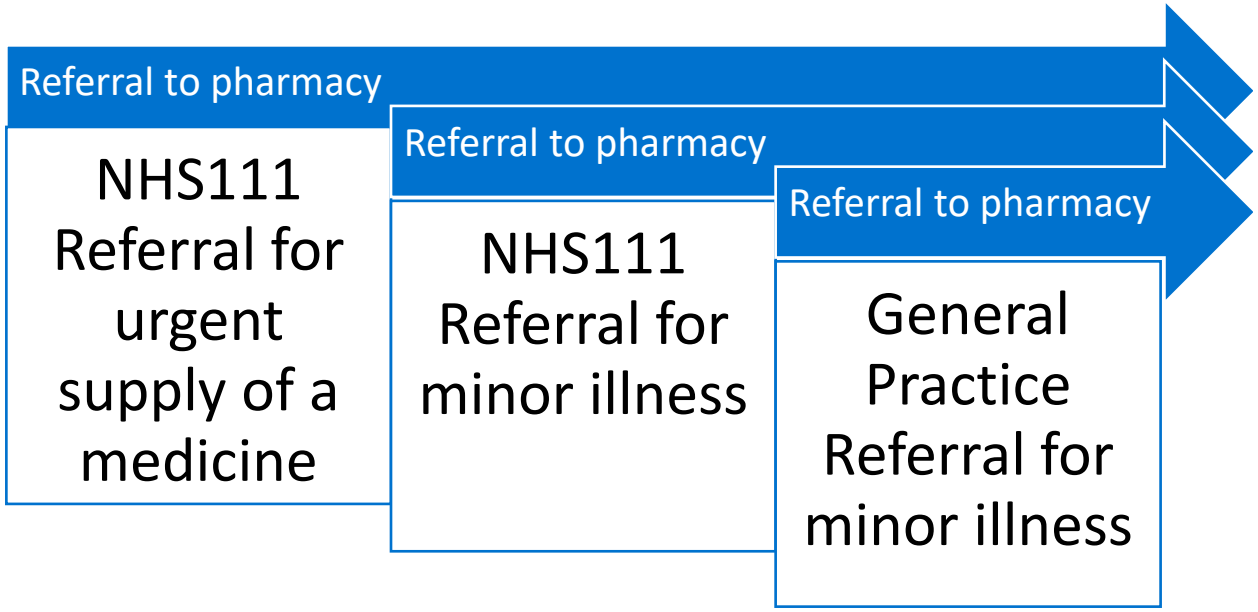
Existing Services

- Community Pharmacy Consultation Service
- Discharge Medicines Service
- Oral Contraception and Emergency Contraception
- End of Life Medicines
- Stop Smoking
- Blood Pressure Checks
- New Medicines Service
- Flu Vaccination
- Extended Care

Future Services

- Independent Prescribing
- Common Conditions Services

CPCS - Background



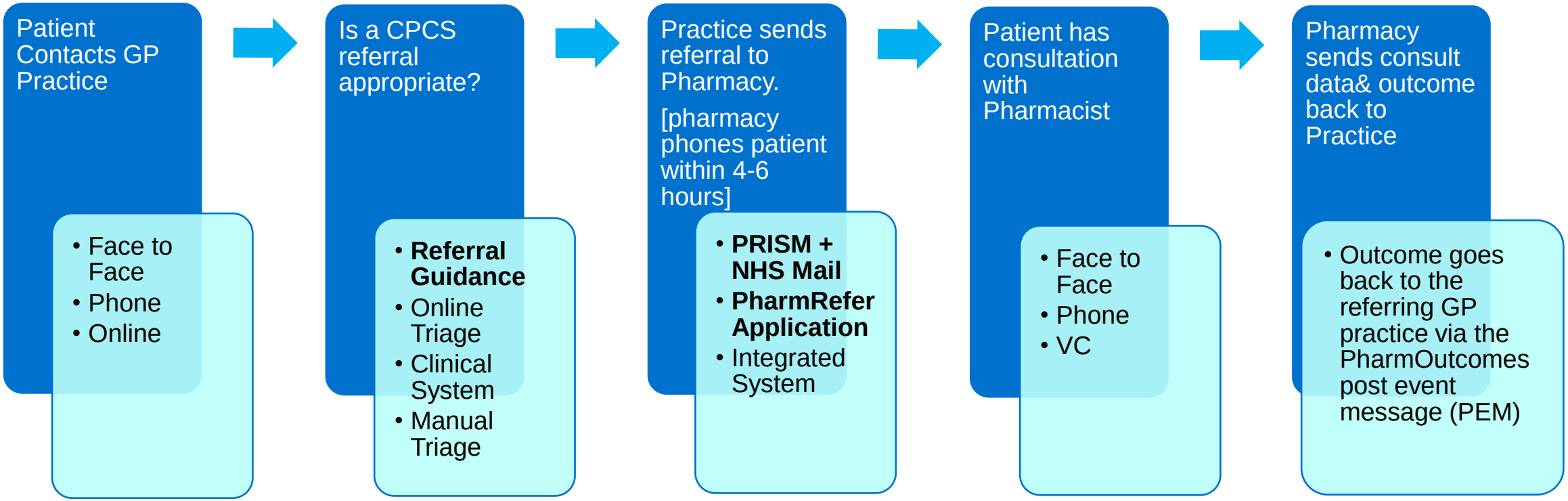
- Increased recognition that community pharmacy can play a role in supporting patients access care
- A digital referral to a pharmacy
- Estimated that 6-8% of all GP consultations could be safely transferred to pharmacy
- Better use of pharmacy teams
- More timely care for patients
- Frees up GP capacity

Referral Guidance Tool to support Surgery Referrals into NHS Community Pharmacist Consultation Service (CPCS)

Service suitability	The service is only for patients aged over 1 year.

CONDITIONS	What conditions are SUITABLE for referral to pharmacists?			Do NOT refer in these circumstances	
BITES / STINGS	•Bee sting •Wasp sting	•Stings with minor redness	•Stings with minor swelling	•Drowsy / fever •Fast heart rate	•Severe swellings or cramps
COLDS	•Cold sores •Coughs	•Flu-like symptoms	•Sore throat	•Lasted +3 weeks •Shortness of breath	•Chest pain •Unable to swallow
CONGESTION	•Blocked or runny nose	•Constant need to clear their throat	•Excess mucus •Hay fever	•Lasted +3 weeks •Shortness of breath	•1 nostril (only) blocked •Facial swelling
EAR	•Earache	•Ear wax •Blocked ear	•Hearing problems	•Something may be in the ear canal •Discharge	•Severe pain. •Deafness •Vertigo (dizziness)
EYE	•Conjunctivitis •Dry/sore tired eyes •Eye, red or Irritable	•Eye, sticky •Eyelid problems	•Watery / runny eyes	•Severe pain •Pain 1 side only	•Light sensitivity •Reduced vision
GASTRIC / BOWEL	•Constipation •Diarrhoea •Infant colic	•Heartburn •Indigestion	•Haemorrhoids (piles) •Rectal pain, •Vomiting or nausea	•Severe / on-going •Lasted +6 weeks	•Patient +55 years •Blood / Weight loss
GENERAL	•Hay fever	•Sleep difficulties	•Tiredness	•Severe / on-going	
GYNAE / THRUSH	•Vaginal discharge	•Vaginal itch or soreness		•Diabetic / Pregnant •Under 16 / over 60 •Unexplained bleeding	•Pharmacy treatment not worked •Had thrush 2x in last 6 months
PAIN	•Acute pain •Ankle or foot pain •Headache •Hip pain or swelling •Knee or leg pain	•Lower back pain •Lower limb pain •Migraine •Shoulder pain	•Sprains and strains •Thigh or buttock pain •Wrist, hand or finger pain	•Condition described as severe or urgent •Conditions have been on-going for +3 weeks	•Chest pain / pain radiating into the shoulder •Pharmacy treatment not worked •Sudden onset
SKIN	•Acne, spots and pimples •Athlete's foot •Blisters on foot •Dermatitis / dry skin •Hair loss	•Hay fever •Nappy rash •Oral thrush •Rash - allergy •Ringworm/ threadworm	•Scabies •Skin dressings •Skin rash •Warts/verrucae •Wound problems	•Condition described as severe or urgent •Conditions have been on-going for +3 weeks	•Pharmacy treatment not worked •Lesions(sores)/blisters with discharge •Diabetes related?
MOUTH / THROAT	•Cold sore blisters •Flu-like symptoms •Hoarseness	•Mouth ulcers •Sore mouth •Sore throat	•Oral thrush •Teething •Toothache	•Lasted +10 days •Swollen painful gums •Sores inside mouth	•Unable to swallow •Patient has poor immune system •Voice change
SWELLING	•Ankle or foot swelling •Lower limb swelling	•Thigh or buttock swelling •Toe pain or swelling	•Wrist, hand or finger swelling	•Condition described as severe or urgent •Condition ongoing for +3 weeks	•Discolouration to skin •Pharmacy treatment not worked •Recent travel abroad

GP-CPCS Referral Journey



Possible outcomes from Pharmacy Consultation

Advice only

Sleeping Difficulties – pharmacist identifies patient recently started working shifts.

Pharmacist gives appropriate advice.

Advice + Supply of an over the counter product?

Adult Headache - pharmacist eliminates red flags.

Symptoms of Tension headache described.

Pharmacist offers self care advice and suggests treatment with OTC paracetamol.

Advice + Referral on to another NHS service

18 month child with evident conjunctivitis.

Referral into Extended Care (PGD) service.

[may be an internal pharmacy referral or to a neighbouring pharmacy which is PGD-accredited]

Advice + Signpost

Patient with lower back pain - pharmacist eliminates red flags.

Provides self-care advice to the patient. Advise, if it doesn't resolve may require physio services.

Explains how to access physio services in the local area.

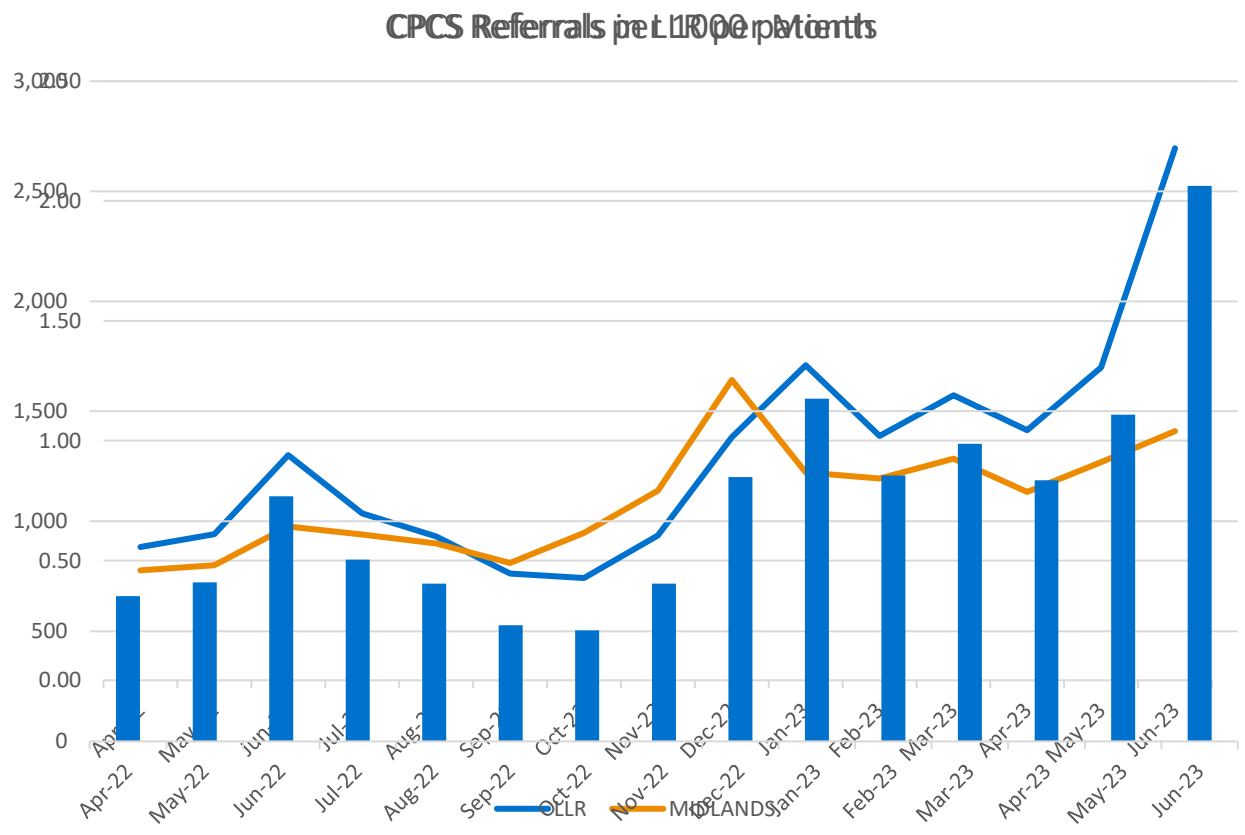
Advice + Refer back to Practice

Young adult male with headache – consultation identified a blow to the head occurred during boxing training.

Pharmacist contacts practice using *back door* number to make a fast-track referral back to see GP.

LLR current GP-CPCS Performance

- Increasing uptake across LLR
- 60% of practices now making referrals as of June 2023
- Reasons for success
  - Whole system engagement
  - New referral route
  - Great teams in primary care



Comparison with Midlands ICBs

	Total Referrals June 23	Change in Referrals May – June 23	Change in Referrals May – June 23 %	Change of Practices Referred May – June 23	Referrals per 1000 population
BLACK COUNTRY	1,677	170	11%	19	1.24
BSOL	1,869	138	8%	7	1.12
C&W	987	-3	0%	0	0.93
H&W	801	132	20%	-2	0.98
STW	414	-5	-1%	-2	0.83
SSOT	2,256	-144	-6%	-4	1.91
DERBYSHIRE	693	53	8%	1	0.63
LINCS	503	86	21%	-1	0.62
LLR	2,525	1,041	70%	23	2.22
NORTHANTS	501	8	2%	-2	0.63
NOTTS	425	135	47%	-3	0.34
Totals	12,651	1,611	15%	36	1.08

What the LLR ICB Has Done

- Raised the profile of community pharmacy and CPCS within the ICB and with system wide stakeholders, especially GP and PCN colleagues
- Worked with the Community Pharmacy Leicestershire and Rutland to support community pharmacists to have the correct resources, skills and attitude to delivering the service
- Took a data led approach with support from NHSE
- Problem solved and facilitated engagement at a very local level
- Co-ordinated all the work within LLR

CPCS – Barriers to Improvement

Barriers	What we're doing
Inconsistent availability from pharmacies	Working with the Local Pharmaceutical Committee (LPC) Working with Directory of Services Team
Time consuming referral process	Launched PharmRefer and supporting uptake
Unawareness of service	Included in Active Signposting Training LPC Support Pack Professional and public support materials
Patients referred back to practice (bounce backs)	Encourage use of triaging software Facilitating engagement between practices and pharmacies Challenging inappropriate bounce backs
Patient reluctance	Empower reception staff with additional training, development and information

CPCS – Next Steps

- Introduce referrals from emergency department and urgent treatment centres
- Work with LPC to tackle variation in provision
- Support more practices and primary care networks to start referring
- Proactive engagement to support local problem solving
- Developing an appointments platform for community pharmacy
- Increase use of the next tier of services through the regional Extended Care Service (urinary tract, skin and ear infections).
- Increase direct to patient communications to highlight role of community pharmacy
- Support local delivery of future national Common Conditions Service

Thank you and any questions

D

Name of meeting:	**Leicester, Leicestershire and Rutland Integrated Care Board** (public)		
Date:	**Thursday 10th August 2023**	**Paper:**	**D**
Report title:	**NHS Dental Services in Leicester, Leicestershire and Rutland**		
Presented by:	Dr Nil Sanganee, Chief Medical Officer, LLR ICB Caroline Goulding, Head of Primary Care Services (East Midlands) East Midlands Primary Care Team		
Report author:	Jo Grizzell, Senior Planning Manager, LLR ICB Caroline Goulding, Head of Primary Care Services (East Midlands) East Midlands Primary Care Team		
Executive Sponsor:	Dr Nil Sanganee, Chief Medical Officer, LLR ICB		

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

Recommendations:

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

- **RECEIVE and NOTE** for assurance the current position of NHS dental services (primary and secondary care) across Leicester, Leicestershire and Rutland.

Purpose and summary of the report:

The purpose of this report is to provide members with an overview of NHS dental services (primary and secondary) across Leicester, Leicestershire and Rutland. The attached presentation will give further information in relation to:

- NHS primary care dental services, provision and activity across Leicester, Leicestershire and Rutland.
- Primary care dental initiatives in place to improve access to NHS dental services.
- Contract terminations.
- Secondary care dental service provision including initiatives.

In addition, the Board is asked to note that, included within the recently published LLR 5-Year Plan an intervention has been included to develop a plan to improve access to NHS dentistry. This will be developed during 2023/24 and will be co-produced with the NHS Nottingham and Nottinghamshire hosted primary care team.

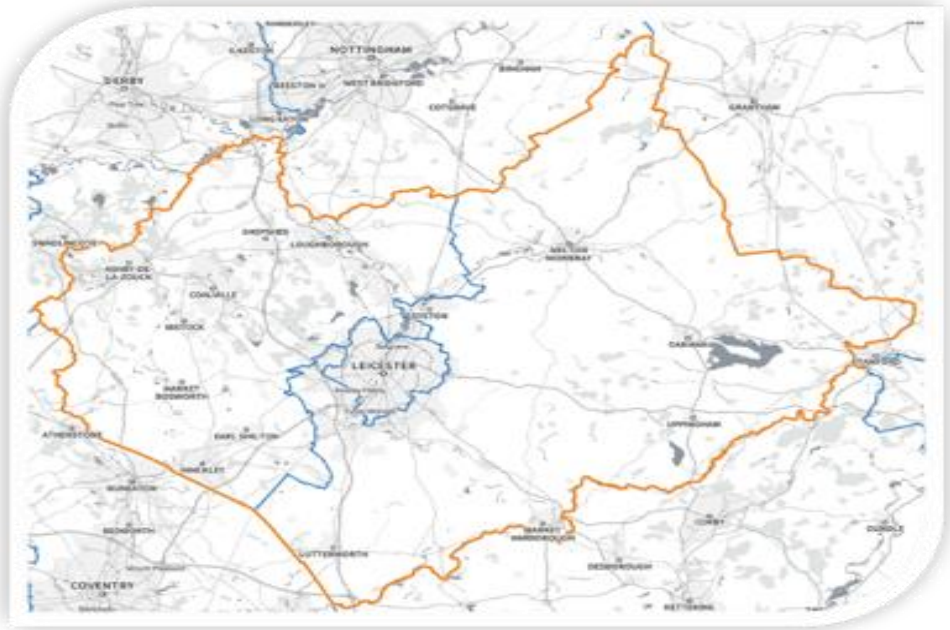
Appendices:	Appendix 1 – NHS dental services in Leicester, Leicestershire and Rutland (presentation)
Report history (date and committee / group the content has been discussed / reviewed prior to presenting to this meeting):	N/A

The report is helping to deliver the following strategic objective(s) – *please tick all that apply***:**		
1. 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.*	The hosted team are in the process of reviewing the existing risk register for all PODs services. Once reviewed the ICB will adapt it for its own purposes and where applicable any risks meeting the criteria for escalation to the Board Assurance Framework will be actioned accordingly.
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.	Communications and engagement activity are undertaken as necessary. This is coordinated via the hosted team in conjunction with the LLR ICBs communications and engagement team.
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 in the context of this paper

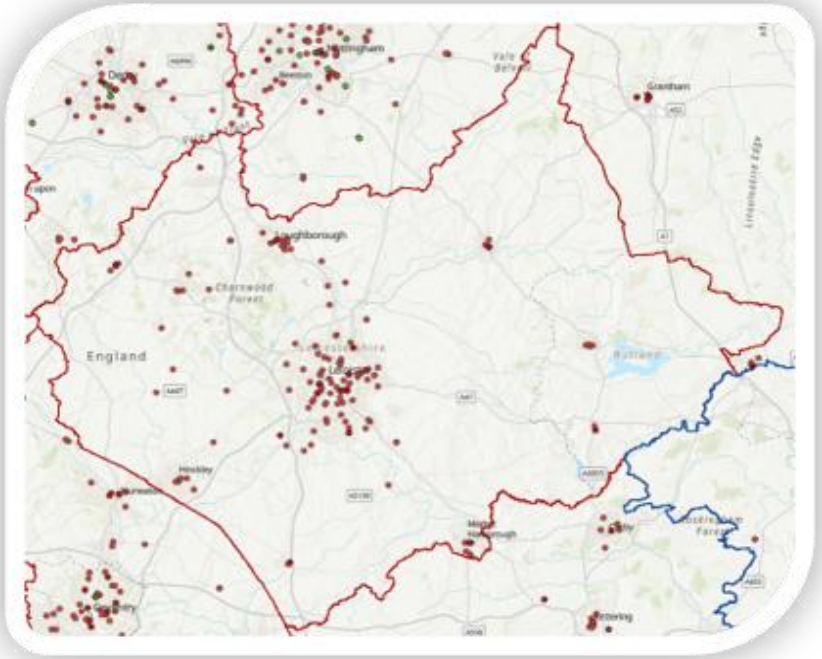
NHS Dental Services in Leicester, Leicestershire & Rutland ICB



- NHS Nottingham and Nottinghamshire Integrated Care Board
- NHS Leicester, Leicestershire and Rutland Integrated Care Board
- NHS Northamptonshire Integrated Care Board
- NHS Lincolnshire Integrated Care Board
- NHS Derby and Derbyshire Integrated Care Board

Location of NHS Dental Services

- 141 NHS General Dental Service Contracts/Personal Dental Service Agreements/ Personal Dental Service Plus Agreements
- **6** Specialist Orthodontic Practices
  13 GDS Practices that provide orthodontics
  7 Specialist Orthodontic Pathway Providers
- **5** 8am-8pm NHS Dental contracts (Loughborough, Oakham, Melton Mowbray, Westcotes, Leicester)
- **5** Community Dental Services sites across LLR
- **1** Acute Trusts providing Orthodontics / Oral & Maxillofacial surgery.
- **10** providers of IMOS Services



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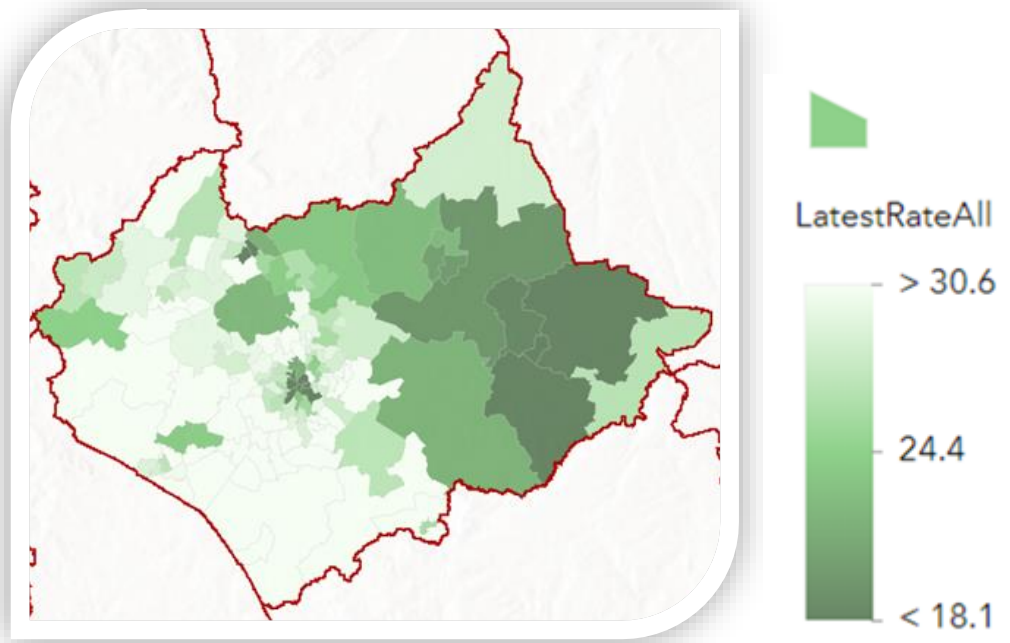
- NHS Lincolnshire Integrated Care Board
- NHS Derby and Derbyshire Integrated Care Board

Dental Access

Overall dental access rates (July 2022- December 2022) for LLR ICB indicate 27.3% of the total population are accessing NHS dental care, this is higher than the national average of 23.96%

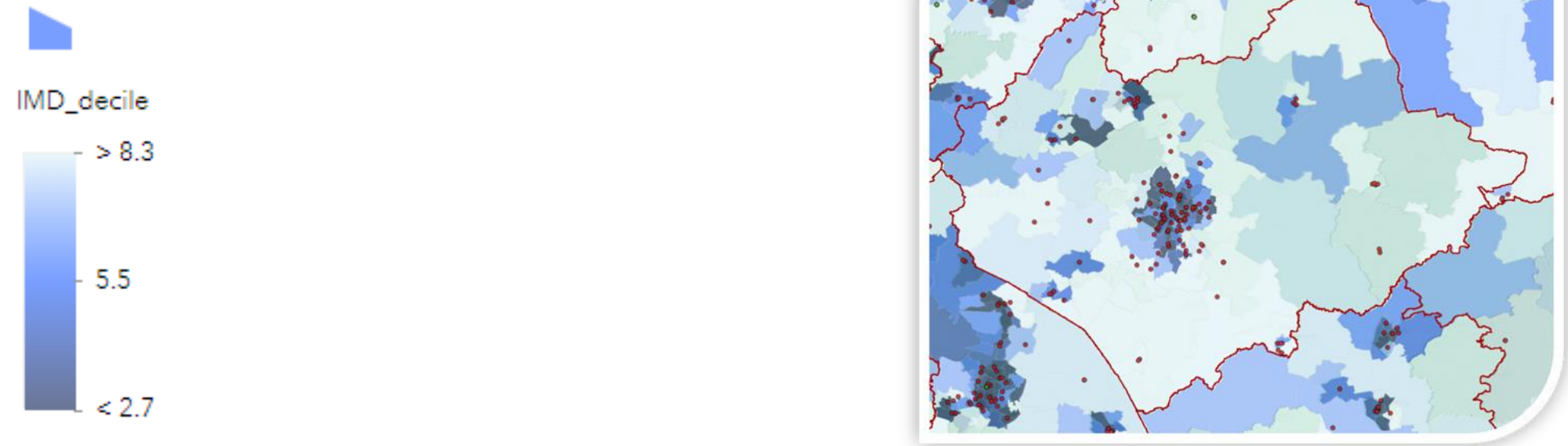
Group	Pop. Accessing NHS Dentistry	Total Pop.	Access Rate	Comparison to National Average
All	302,637	1,107,597	27.3%	higher
Adults	200,374	872,335	23.0%	higher
0-17	102,375	235,262	43.5%	higher

The visual map shows the level of dental access for LLR ICB by Middle Super Output Area.



Location of NHS Dental Services against Index of Multiple Deprivation

Map: Location of NHS dental services against Index of Multiple Deprivation:



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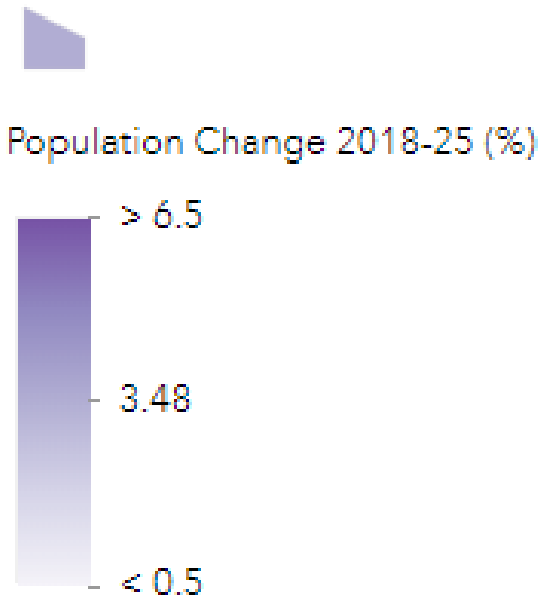
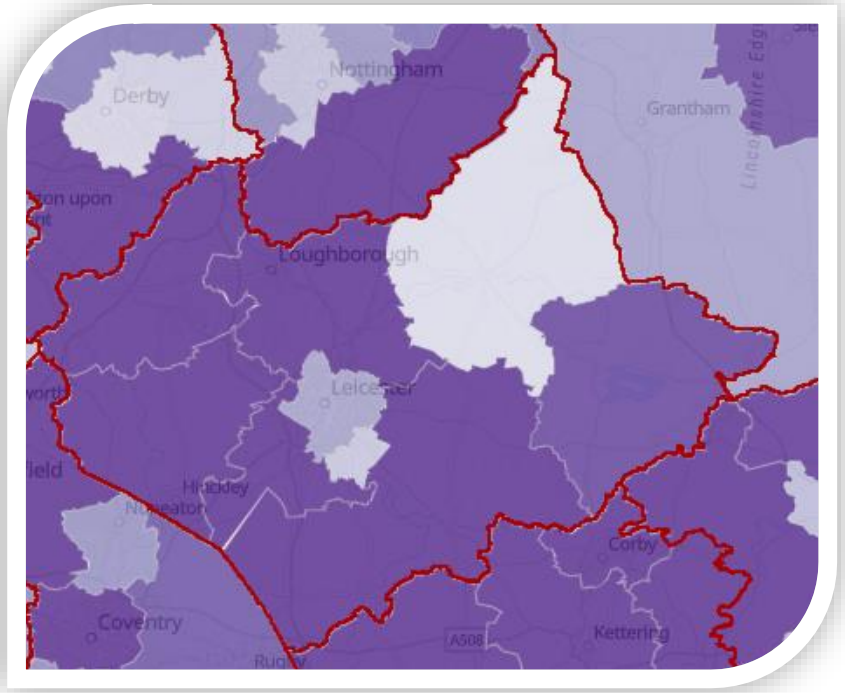
Population Change: 2018-2025





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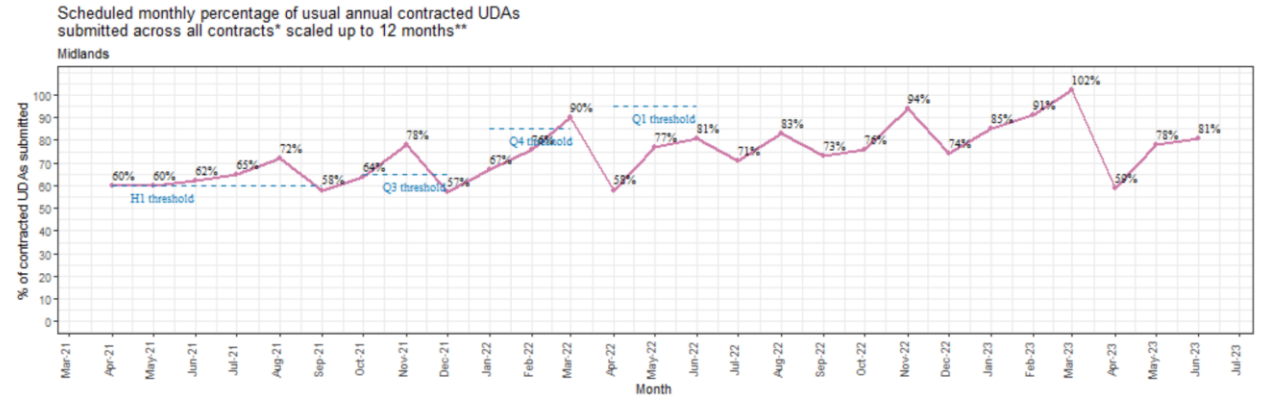
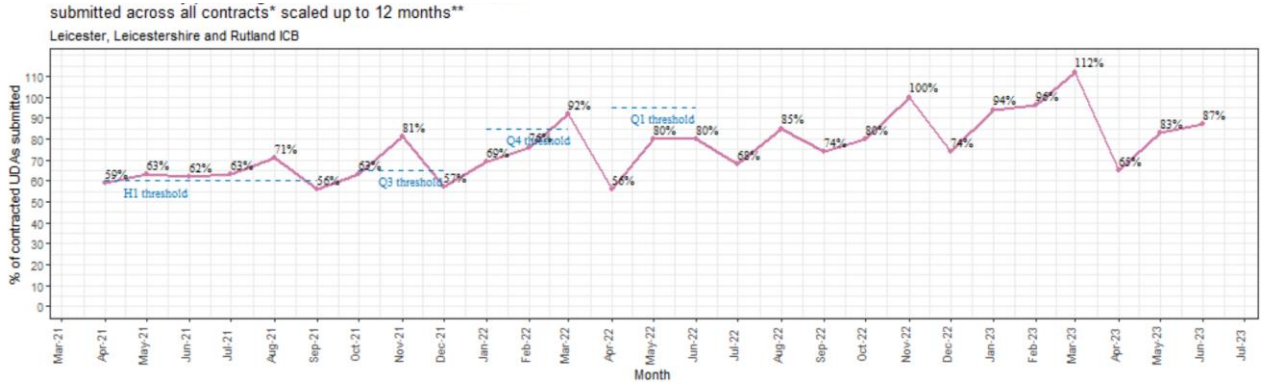
UDA Delivery Trend





*Excluding contracts with annual contracted UDA < 100. Excluding prototype contracts up until April 2022.
**These are scheduled months and April data is for the reporting period 1st April - 21st April therefore the April data has been scaled up by 18 instead of 12.

- Activity delivery is higher than the Midlands average
- Recruitment impacts on service delivery
- Aspects of care required by higher needs patients**.**
- This graph shows the LLR average monthly performance of the **133** GDS/PDS/PDS+ contracts scaled up by 12 months measured against the delivery thresholds (60% for Apr-Sep 21, 65% for Oct-Dec, 85% for Jan-Mar and 95% for Apr-Jun 22).

- NHS Nottingham and Nottinghamshire Integrated Care Board
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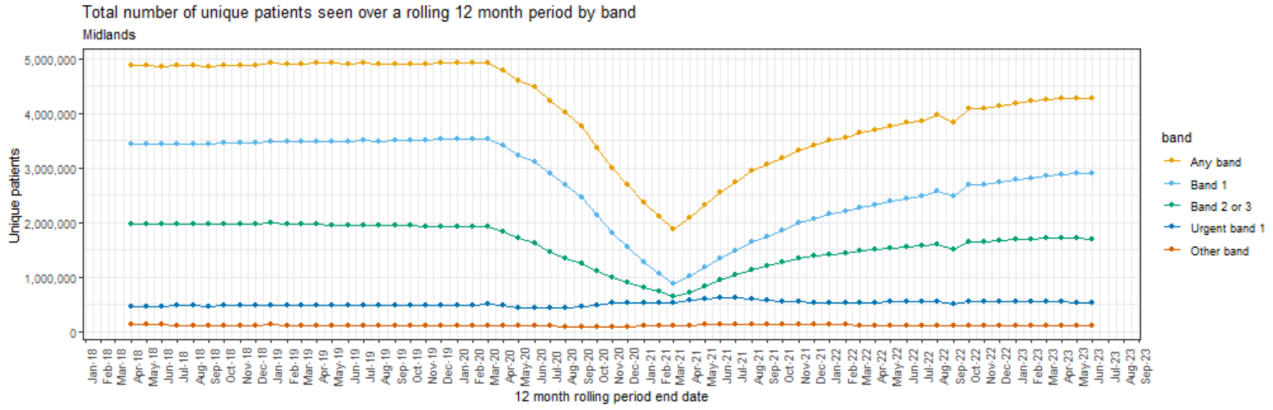
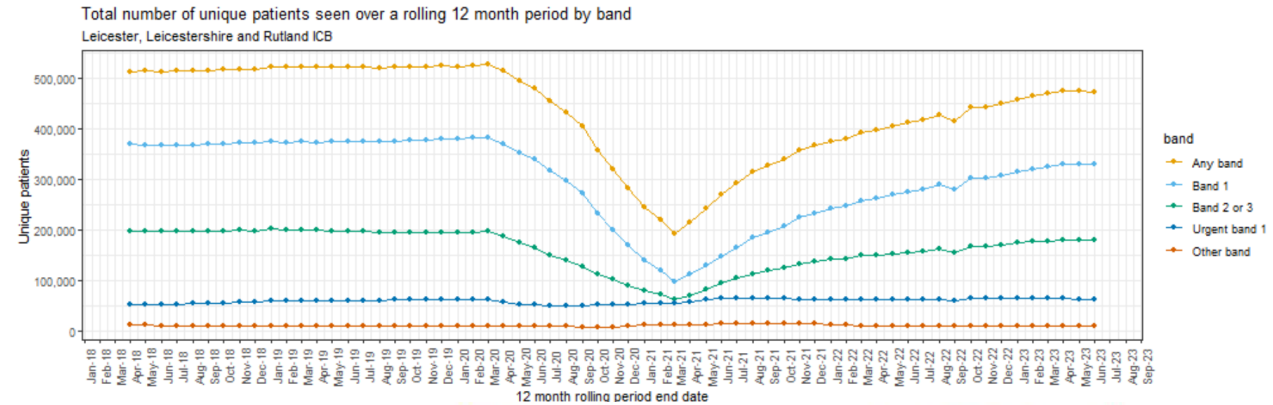
Number of Unique Patients seen over a rolling 12-month period





*N.B. this analysis uses unique patients per contract** and does not take into account patients who have been seen at more than one dental practice.
**INCLUDING contracts with annual contracted UDA < 100 and prototype contracts.

- **Midlands - 88% of Patient Access Retained (Pre-Pandemic levels)**
- **LLR - 92% of Patient Access Retained (Pre-Pandemic levels)**

- NHS Nottingham and Nottinghamshire Integrated Care Board
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LLR Primary Care Dental Initiatives

Weekend Access Scheme:

- The initiative is to enable dental providers to see and treat more patients than they have capacity for during their normal contractual opening hours.
- Enable participating providers to deliver more face-to-face activity than any nationally agreed dental target for 2022/23.

ICB	Number of Providers	Number of Approved Sessions	Value of Approved Sessions
LLR	6	274	£137,000

LLR Primary Care Dental Initiatives

Additional Orthodontic Case Starts:

- The initiative is to address lengthy waiting times for orthodontic treatment which have been exacerbated due to the COVID-19 pandemic.
- NHS England – Midlands invited applications from existing NHS orthodontic providers that want to provide additional non-recurrent orthodontic activity during 2022/23. Non-recurrent activity commissioned under this scheme will be added to the providers 2022/23 contract target. Ideally, orthodontic treatment under this scheme will have commenced by the 31 March 2023, however in view of the late notification and the ongoing challenges relating to the COVID-19 pandemic, there will be flexibility for any non-recurrent activity not delivered prior to 31 March 2023 to be carried forward to 2023/24 providing case starts are initiated with appliance fitted prior to 31 March 2024.

2022/23 Approved Case Starts

ICB	Number of Case Starts
LLR	844

LLR Primary Care Dental Initiatives

Community Dental Services Support Practice Scheme:

- The purpose of this scheme is to relieve pressure on Community Dental Services by securing additional capacity in child friendly CDS Support Practices. This will be to provide Level 1 services for certain defined groups of patients.
- The aim is to free up the specially trained staff in the Community Dental Service so that they can focus on using their skills to deal with the most complex cases and increase access for children.
- Where suitable, paediatric patients will be referred from CDS services into a child friendly CDS Support Practice to receive care.
- Phase 3 due to be launched 2023 in targeted geographical areas

ICB	Number of Providers	Number of Approved Sessions per Week
LLR	1	2

LLR Primary Care Dental Initiatives

Community Dental Services (CDS) Waiting List Initiative:

- Non recurrent investment of £62,048 to support waiting list initiatives for LLR Community Dental Services during 21/22.
- The waiting list initiatives are to run additional sessions for new referrals, first and follow up appointments for patients with open courses of treatment.
- Prior commitment has been secured for 22/23 to support reducing GA waiting list, subject to securing additional sessions at the hospital trust

Waiting list initiative - Intermediate Minor Oral Surgery (IMOS):

2021/22

- Non recurrent investment to support IMOS providers in reducing waiting times for patients to be seen within 6 weeks of referral into the specialist service.
- At June 2022, there were 3,173 LLR patients accepted onto the IMOS pathway and 2,038 have been waiting over 6 weeks to be treated. This has been reduced by nearly 1,500 patients from June 2021 when the waiting list initiative was launched in 2021/22

2022/23

- Non recurrent investment of £119,077.20 has been secured to support IMOS providers to treat patients waiting over 18 weeks into the specialist service
- At April 2022 the number of patients waiting was 682 and at August 2022 this had reduced to 440 patients, a reduction of 242 patients (35%)

Contract Terminations

Contract Terminations – Melton Mowbray (legacy hand back), Oakham, Ashby de la Zouch, Barrow Upon Soar

ICB	Number of Terminated Contracts
LLR	4

- 12,500 UDAs have been dispersed on an interim basis whilst we recommission general dental services
- The dental activity from a terminated contract will not be lost.
- NHSE are continually working with Public Health colleagues to review the dental access data and understand the impact for patients. The normal process for terminations is to undertake a review and recommission the dental activity by dispersal to local dental practices surrounding the terminated contract or via a full procurement process.

Secondary Care Dental

- NHS Nottingham and Nottinghamshire Integrated Care Board
- NHS Leicester, Leicestershire and Rutland Integrated Care Board
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Secondary Care Dental:

Referral to Treat (RTT) and Referrals

- Please see Appendix 1 for the latest position in respect of Oral Surgery in May 2023 including graphs showing the trends for both 18 weeks and 52 week waits.
- The updated May 2023 RTT position for Oral Surgery shows that (in respect of the East Midlands) the recovery in respect of the performance against the 18-week standard remains plateaued between 45% and 50%. (The figure for May 2023 is 46.9% an improvement from 45.5%). The number of 52-week waiters has increased from 2,103 to 2,155. The proportion of the total waiting list that has been waiting 52 weeks is at 10%.
- The 104-week waits have remained at 0 in April 2023.

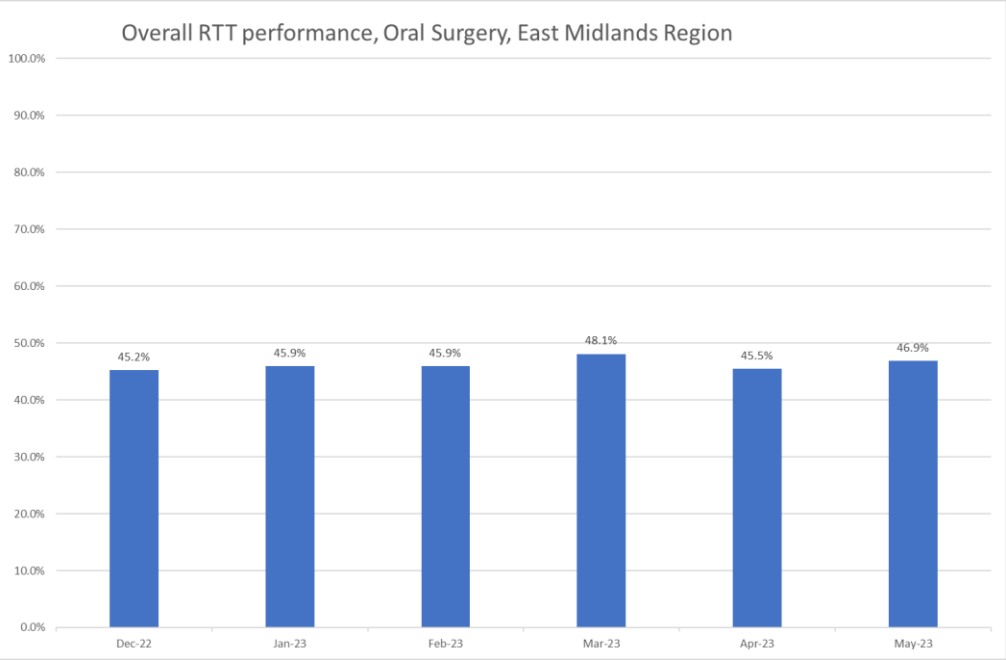
78 Week Waits

- The Business Analysis team continue to produce monthly reports from the Waiting List Minimum Dataset in order to monitor position and identify Trusts who may be at risk of failing to meet the 31 March 2024 deadline. We are currently awaiting the latest report for this dataset.

65 Week Waits

- All Trusts are required to meet a revised national target to reduce waiting lists, so no patients are waiting over 65 weeks by the end of March 2024.
- The published RTT data at May 2023, showed 444 patients are waiting over 65-weeks. The trend data is being updated and awaiting for this to be published.
- The 65-weeks wait discussions are being built into the 2023/24 contracting round and assurance that the Trusts Pricing Activity Matrix (PAM) has sufficient activity to support meeting this target.

East Midlands Secondary Care Dental Overall RTT Performance



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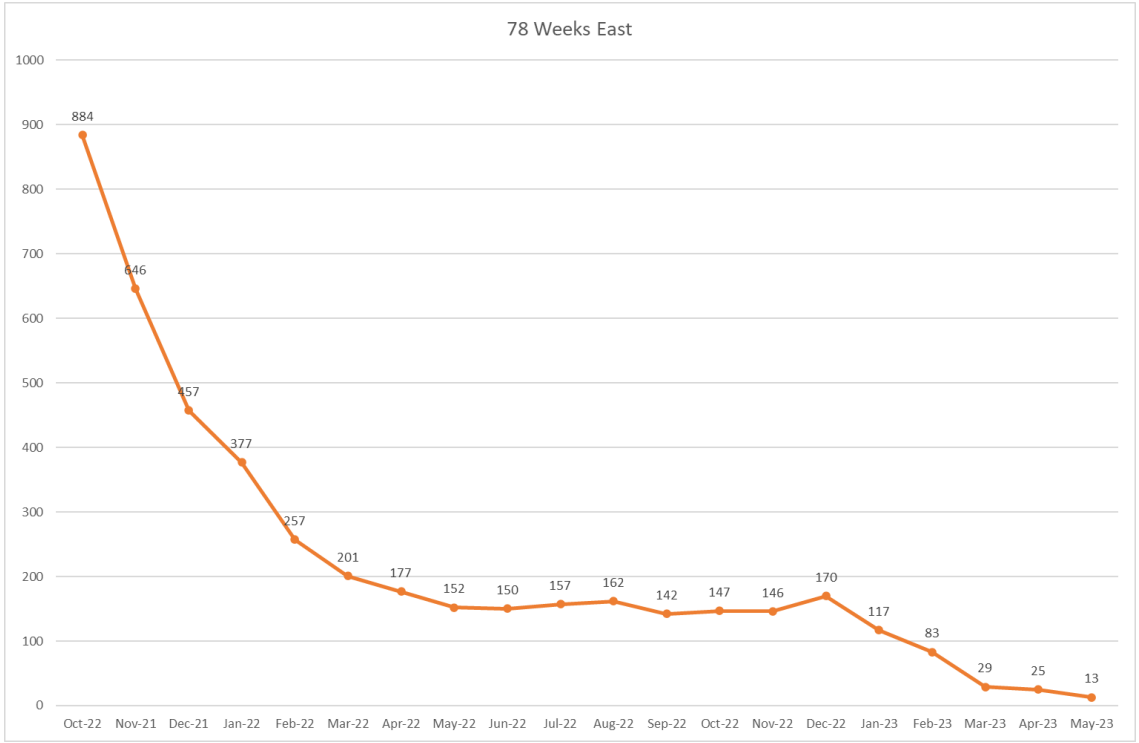
East Midlands Secondary Care Dental 78 Week Wait Summary Position



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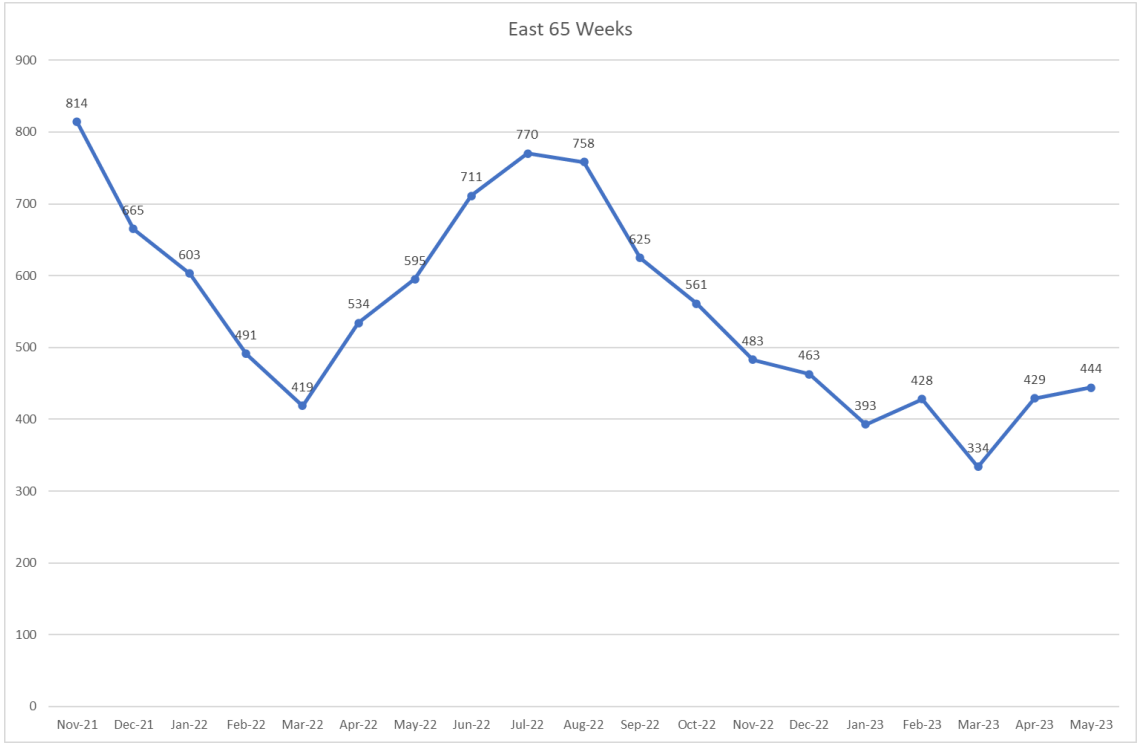
East Midlands Secondary Care Dental 65 Week Wait Summary Position



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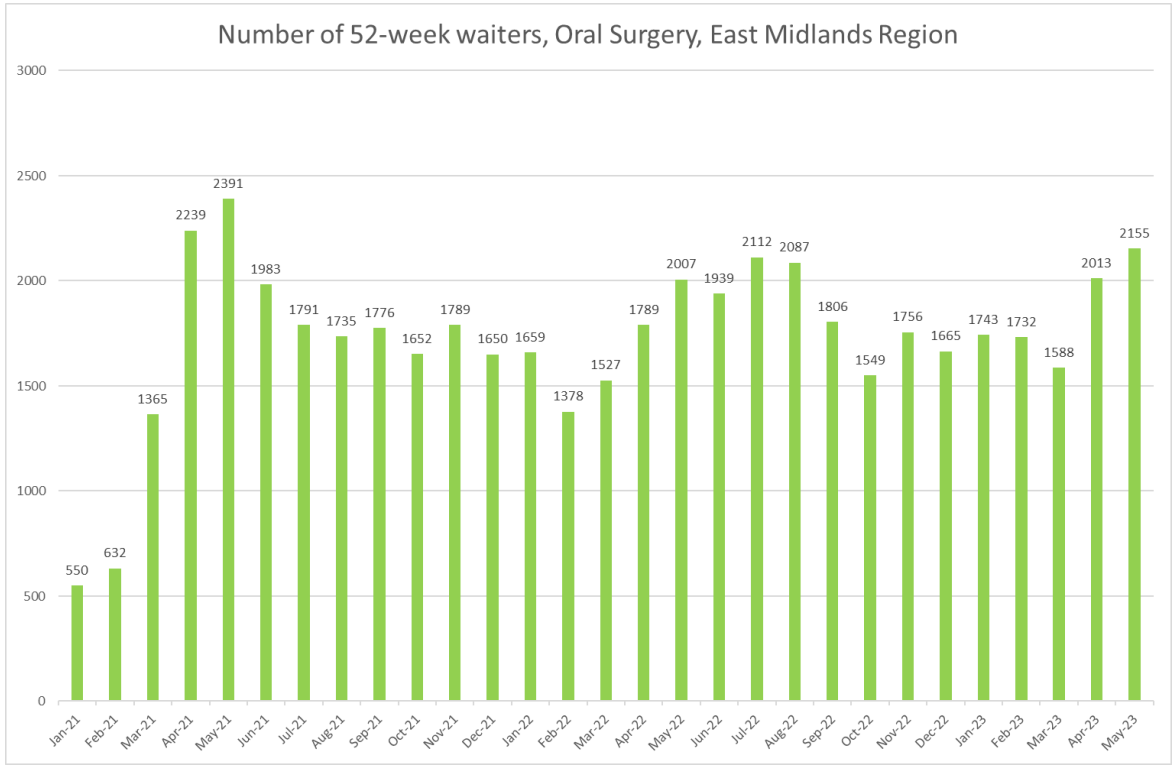
East Midlands Secondary Care Dental 52 Week Wait Summary Position



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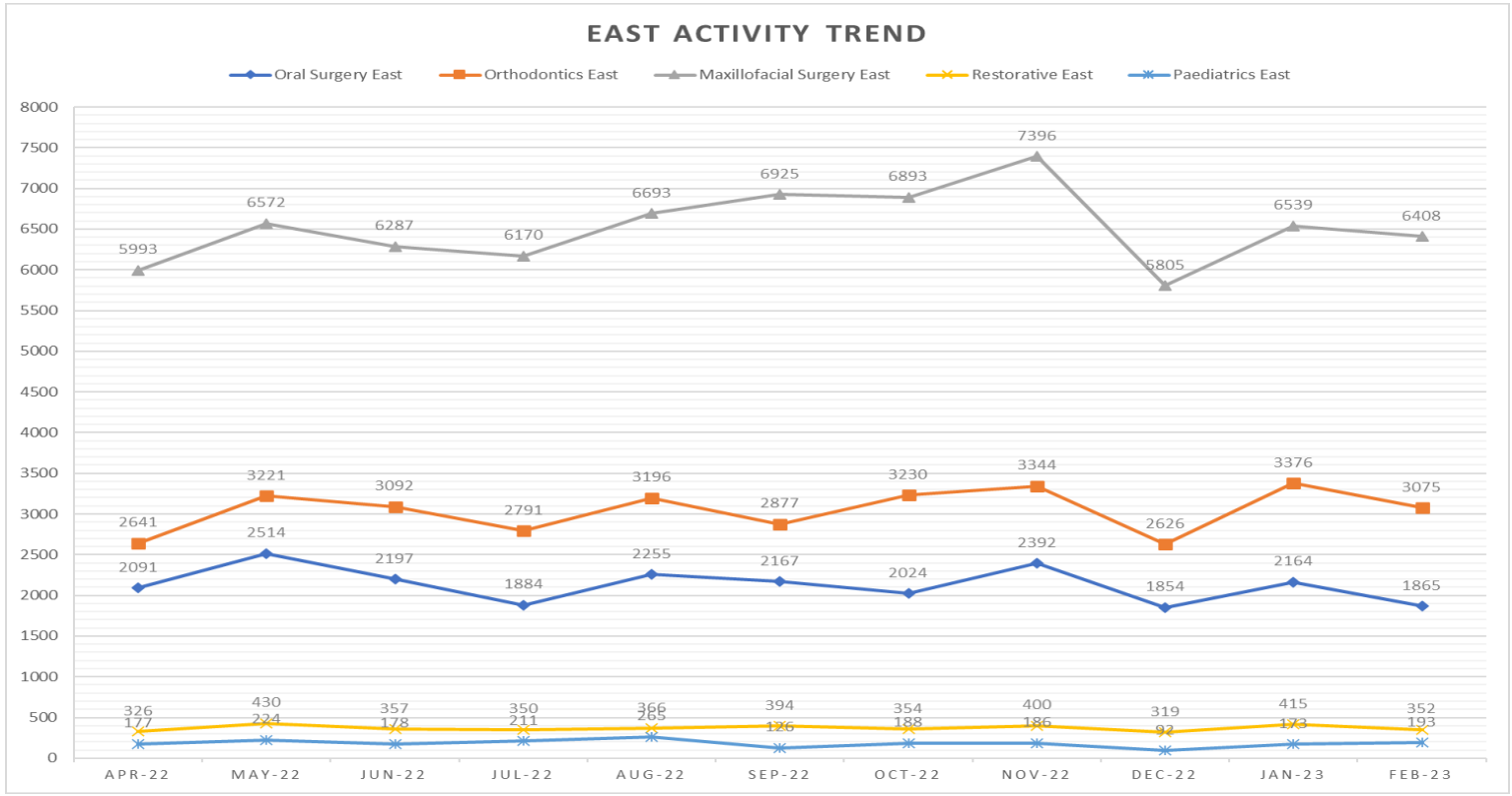
East Midlands Secondary Care Dental Activity Trend



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LLR Secondary Care Dental Initiatives

Secondary Care Dental Waiting List Initiative:.

- 2021/22 non recurrent investment of £35,791 was secured to support secondary care dental waiting list initiatives for UHL.
- The waiting list initiatives are to address 104, 78 and 52 week waits in the secondary care dental speciality Oral and Maxillofacial surgery.
- Further commitment of £466,000 has been secured to support waiting list initiatives in 2022/23.

Oral Health Promotion Dental Initiatives

Oral Health Promotion and Improvement:

- Recurrent investment of £150,000 for a 2-year period 2021/22 and 2022/23 has been allocated to LA to ensure that local people have access to the information and support they need to maintain good oral health.
- Non recurrent investment of £100,000 per ICB to support distribution of toothbrushing packs to food banks and other venues
- £5,000 non recurrent to support each local authority's oral health promotion services' training resources
- £10,000 non recurrent investment to promote a social marketing campaign around oral cancer prevention will be used to carry out part of the LA action plan in summer 2023

Challenges

National

- Challenges for NHS Dentistry existed prior to the pandemic
- Access to services
- Profession discontent with current contract

LLR

- Access to services
- Contract hand backs
- Oral Cancer Rates
- Legacy Secondary Care Closed Orthodontic Waiting List

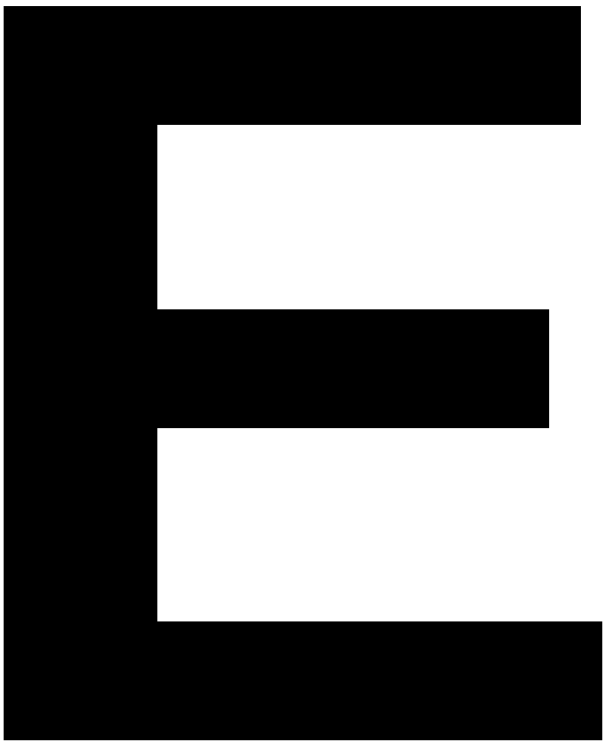
Opportunities

Dental Contract Reform

- Introduce enhanced UDAs to support higher needs patients, recognising the range of different treatment options currently remunerated under Band 2
- Improve monitoring of and adherence to personalised recall intervals
- Established a new minimum indicative UDA value
- Address misunderstandings around use of skill mix in NHS dental care, whilst removing some of the administrative barriers preventing dental care professionals from operating within their full scope of practice
- Take steps to maximise access from existing NHS resources, including through funding practices to deliver more activity in year, where affordable
- Improve information for patients by requiring more regular updating of the Directory of Services
- New patient tariff anticipated to be announced in 2023/24

Opportunities

- Severe Multiple Disadvantaged Pilot Scheme
- Completion of Refreshed Oral Health Needs Assessment to support future commissioning of General Dental Services to meet local population needs
- Review of patient facing non recurrent investments are being undertaken to increase access to services
- NHS Communications Team have drafted a series of stakeholder briefings to update key partners and the public on the situation with respect to NHS dental services. These have been distributed to local authorities, Directors of Public Health and ICBs. We have also engaged with local Healthwatch, and they have shared intelligence on local concerns or on difficulties people may be having accessing NHS dental services.
- Local Dental Network (LDN) Chairs collaboratively working with Managed Clinical Networks at place and neighbourhood level, Integrated Care Systems, Consultants in Dental Public Health, Commissioners and Health Education England to ensure optimum provision of care for patients.
- Getting it Right first time (GIRFT) to find and share best practice and reduce unwarranted variation in ways of working in Primary Care



Name of meeting:	**Leicester, Leicestershire and Rutland Integrated Care Board**		
Date:	10 August 2023	**Paper:**	**E**
Report title:	**NHS Long Term Workforce Plan**		
Presented by:	Alice McGee, Chief People Officer		
Report author:	Alice McGee, Chief People Officer		
Executive Sponsor:	Alice McGee, Chief People Officer		

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

Recommendations:

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

- **RECEIVE and NOTE** the NHS Long Term Workforce Plan and the associated next steps for Leicester, Leicestershire and Rutland ICS

Purpose and summary of the report:

In June 2023 the NHS published its first of a kind 15 year workforce strategy. The document describes a long term plan for the NHS workforce in relation to increased training, new approaches to retention and a defined approach to reform and transformation.

The report provides the Board with an overview of the national NHS Workforce Plan alongside the approach the Leicester, Leicestershire and Rutland ICS will take for implementation.

Appendices:	LLR Talent and Leadership Report 2023
Report history (date and committee / group the content has been discussed / reviewed prior to presenting to this meeting):	N/A

The report is helping to deliver the following strategic objective(s) – *please tick all that apply*:		
1. 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	
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☐	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.*		All NHS providers and the ICB have a risk in relation to workforce capacity and availability, by implementing the long term plan will create a sustainable workforce for the future
b) Does the report highlight any resource and financial implications? If so, provide which page / paragraph this can be found within the report.		The NHS Long Term Plan is funded nationally for all elements of the education expansion
c) Does the report highlight quality and patient safety implications? If so, provide which page / paragraph this is outlined in within the report.		
d) Does the report demonstrate patient and public involvement? If so, provide which page / paragraph this is outlined in within the report.		
e) Has due regard been given to the Public Sector Equality Duty? If so, how and what the outcome was, provide which page / paragraph this is outlined in within the report.		

NHS Long Term Workforce Plan

10 August 2023

Introduction

1. In June 2023 the NHS published its first long term strategic workforce plan. The plan focusses on the NHS workforce however the LLR People Board and partner organisations recognise that in LLR, focussing the approach to integrated health and social care workforce will ensure that the ICS has a holistic approach to sustainable workforce.

2. The long term plan focusses on three key themes:

    a. **Train**. Significantly increasing education and training to increase the NHS workforce. This will include a significant growth in apprenticeships and other alternative routes into professional roles. The training will also expand significantly to increase new roles to meet the changing needs of the patients and the transformation agenda for the NHS
    b. **Retain**. Focussing on improving culture and leadership to retain our current workforce. This will include improving approaches to flexibility and an integrated health and well being offer for all staff.
    c. **Reform**. Improving productivity by working and training in different ways. The reform theme focusses on ensuring staff have the right skills in the right places that harness new technology and freeing up clinician time.

3. Following the publication of the Long Term Workforce Plan, a series of national and regional briefings have taken place. To support the implementation of national plan the NHS is expecting a series of operational guidance documents and detail on the plans. This will include an Education Expansion Plan and a Long Term Workforce Operational Delivery Plan.

4. It is important to note that whilst the NHS Long Term Plan was published in June 2023 there are several other national policy and strategy documents in relation to the People agenda that LLR are already implementing which include:

    a. ICS and organisational Leadership (Kark Report, Messenger Review, Fuller Stocktake)
    b. Agency reduction programme
    c. Maternity leadership and capacity (Ockenden review)
    d. Talent Management and Diversity of Talent pipeline
    e. Equality Delivery Scheme

5. Appendix 1 summarises the progress to date against the Regional Talent Board recommendations as an example of the work already taking place within LLR. Each of the workstreams currently within the People Board programme has a similar approach to reviewing progress and context of the interventions.

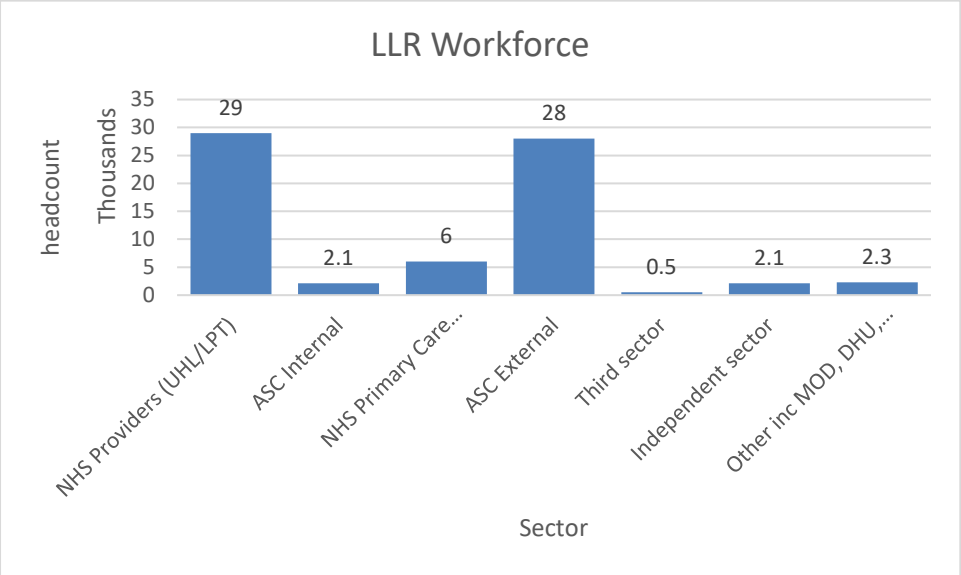
Leicester, Leicestershire and Rutland ICS

6. When considering the Long Term Workforce Plan it is important to understand the starting position for LLR. In 2023 the ICS has approximately 70,000 staff and workers delivering health and social care. Table 1 below summarises the headcount across all sectors and providers within LLR ICS

7. Within LLR, the approach to an integrated and sustainable workforce is not a new concept. The People Board has been working across health and social care to attract, retain and train our workforce in the best way for a number of years. The publication of the NHS Workforce Plan will enable the People Board and our constituent organisations to continue to build on the successes of working together to deliver a sustainable workforce.

8. On 9th October 2023 a workshop for leaders across LLR has been organised to focus on the implementation of the NHS Long Term Plan. The workshop intends to bring together leaders and staff from across partner organisations to explore the themes in the NHS Workforce Plan and create a localised plan across health and social care. ICB Board members have been invited to this event and members are encouraged to attend.

Table 1 – workforce profile



9. The Long Term Workforce Plan sets out some detailed figures for expansion of education, increasing the staffing numbers significantly and targets for improving retention. Further work is still required to understand how these will translate into local figures for LLR, particularly for some professional groups where the national intention is to target growth based on geography.

10. Whilst we wait for national detail on growth and details there are a number of actions and next steps that LLR can take, some of which are already part of the LLR People Plan. Table 2 summarises the actions that the Long Term Workforce Plan describes should be done at a system level.

11. For each of the actions now required at system level an initial assessment has been taken as to whether the LLR People Board already has plans in place, capacity or whether this

would be considered a new activity. This RAG rating is in relation to readiness at system level, rather than the work that is currently taking place at organisation level.

12. Recognising that the Long Term Plan is for delivery across 15 years the ICB and partners will consider how to prioritise these actions, including what success will mean for LLR ICS

Table 2 – ICS responsibilities

Action	RAG rating
Expansion of apprentice capacity	
Prominent leadership and delivery of being an Anchor Institution	
Supporting expansion of the volunteer workforce including the use of Cadets	
Attraction campaigns and recruitment once together for specific roles	
Prominent leadership and delivery of the Equality, Diversity and Inclusion Action Plan	
Leading and supporting organisations on creating compassionate and inclusive leader	
Creating an Employee Value Proposition by 2024	
Creating an integrated health and well being offer for staff	
Creating a consistent and high quality Occupational Health service at system level	
Implementing national recruitment reforms	
Prominent leadership and delivery of health and social care career pathways	
Inclusive Talent Management	

Next Steps

13. The ICB Board, as well as the Health and Well Being Partnership (ICP), will have responsibility to ensure implementation of the Long Term Workforce Plan. The system wide event in October 2023 will be a key part of the understanding and design of the system approach to implementation of the Workforce Plan.

14. The People Board will have responsibility for setting out the delivery mechanisms and outcomes for each of the themes in the workforce plan, and report these to System Executive and Board for assurance. It is also recognised that some actions will be best placed taken at organisational level and therefore the People Board will focus its efforts to delivering those actions that are required at system level where doing activities once and at scale have a better outcome.

Recommendations

The Board is asked to

- **RECEIVE and NOTE** the NHS Long Term Workforce Plan and the associated next steps for Leicester, Leicestershire and Rutland ICS

Appendix 1 – Talent and Leadership Report

1. Introduction

This paper sets out the national and regional context with regards to talent management, reflecting government reviews. It also describes our response to the regional ask from the Regional Talent and Leadership Board (May 23) for identifying, developing and deploying the wealth of talent working within our organisations. A summary of work undertaken in creating an open and inclusive talent community across LLR is also provided.

2. National and Regional Context

There have been several governmental reviews about leadership, talent and management in the NHS in recent years. These include the Kark, Kirkup, Ockenden, Messenger & Pollard, Hewitt and the NHS Continuous Improvement review.

To maximise the impact of the national response to these reviews, an overarching strategic plan with three-year roadmap is being co-developed with leaders across health, social care, the third sector and local government to deliver an integrated NHSE Management and Leadership Development Programme of work. This programme is being overseen by the NHS Management and Leadership Advisory Group (MALAG) who will provide advice, support and a steer to ensure the programme maximises its impact whilst supporting the strategic priorities of the NHS, including delivery of the Long-Term Plan, Long Term Workforce Plan and annual planning guidance.

Taking account of the NHS England Operating Framework, the Group will inform the successful delivery of the activity across the NHS (actively aligned with Social Care where possible) with key priorities for 23/24 being:

1. Board leadership competencies incorporating Kark recommendations and Board support offers
2. The new national Induction for health and social care [Messenger recommendation 1a]
3. Board induction for new NEDS and Chairs [Part of Messenger Recommendation 6]
4. Leadership for improvement – an offer for Chairs and CEOs [part of the NHS Continuous Improvement Review and NHS Impact]
5. First time managers programme and management code [Messenger recommendation 3 and 1b]
6. Support and development for aspiring directors

In addition, following the publication of the NHS EDI Improvement Plan, regional teams will work with systems to attract more diverse talent and enable more equitable career progression for under-represented groups.

3. Working with LLR and the changing role of NHS England

The role of NHS England is changing. The 'creating the new NHS England' programme merging Health Education England and NHS Digital with NHS England into a more streamlined operating model will mean it will only deliver work that it's best placed to do enabling ICBs to be led locally. Regional teams will continue to work with LLR and other systems on the following:

- How we co-create the evidence-based strategy for transformation and improvement in talent and leadership.
- Agreeing expectations and outcomes for Talent and Leadership development.
- Continuing to provide subject matter expertise that we can use to support implementation and provide intensive improvement support if needed.
- Facilitating and enabling access to licenced and directly commissioned nationally quality assured leadership development.
- Provision of career development programmes such as the Aspiring CEO programme.
- Identifying, developing and deploying senior talent

From a talent management perspective, NHS England will solely focus their efforts on developing the talent pipeline for board level roles and this will encompass the following:

- Aspiring directors
- Aspiring CEOs
- Existing directors
- NEDs and Chairs

NHSE will support LLR to implement our plans through developing, designing, co-ordinating, convening and facilitating access to high quality evidence-based interventions, best practice, activity, and guidance.

NHSE will translate national policy to fit local circumstances ensuring that this addresses regional health inequalities and priorities. In this way NHSE will work with LLR to reflect local realities and enable us to oversee the delivery of the NHS Providers workforce responsibilities in relationship to Talent, Leadership and EDI as described in the 5-year joint forward plan, System Workforce Improvement Model (SWIM), EDI Improvement plan and in the 10 ICS People functions.

4. Diversity of the talent pipeline

We observe from WRES data that Board representation across the Midlands is poor. The Midlands has a population with 38.3% ethnic diversity and our workforce comprises of 18.9% of staff from a BME background. Yet only 13.2% of Voting execs are from a BME background. We also know that across the Midlands, white applicants are more than 1.46 times more likely to be appointed.

Below is a diversity profile of voting board members across the two NHS organisations and ICB in LLR, which shows the majority have a positive diversity profile at Board level

Organisation	**Ethnic Minority Voting Board Members**	**Ethnic Minority Workforce Overall**	**Difference**
Leicestershire Partnership NHS Trust	27.3%	24.8%	+2.5%
University Hospitals of Leicester NHS Trust	8.3%	40.7%	-32.3%
LLR ICB	26.3%	31.6%	-5.3%
Source: WRES Data Feb 2023			

5. Regional Aspirant Director Talent Pool

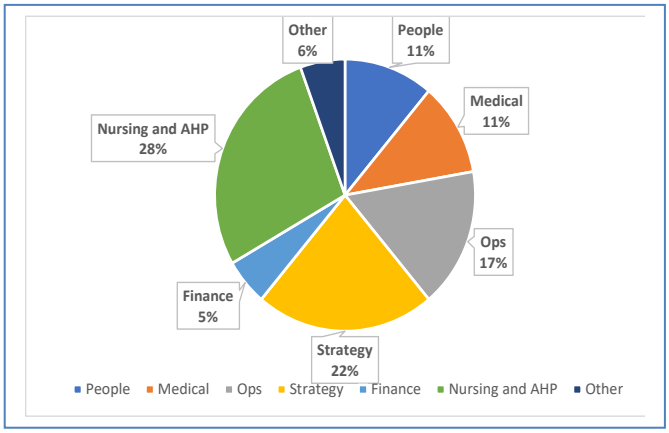
A key aim of the regional response to these challenges is to surface diverse leaders who have the ambition and potential to transition to Executive Directors roles so that we have ample supply of leaders willing to take their next step. Following an ask to all systems for nomination of individuals, the regional talent pool membership is now significantly larger with well over 100 leaders representing a range of backgrounds, and professional roles.

In April, new talent pool members were invited to welcome events which aimed to introduce them to the talent pool offer. Talent pool members were also asked for their views on what would make the most impact for their career development. They stated overwhelmingly that mentoring, experience of working in a system, awareness of career opportunities (both substantive and interim) and connecting with each other were the most important themes.

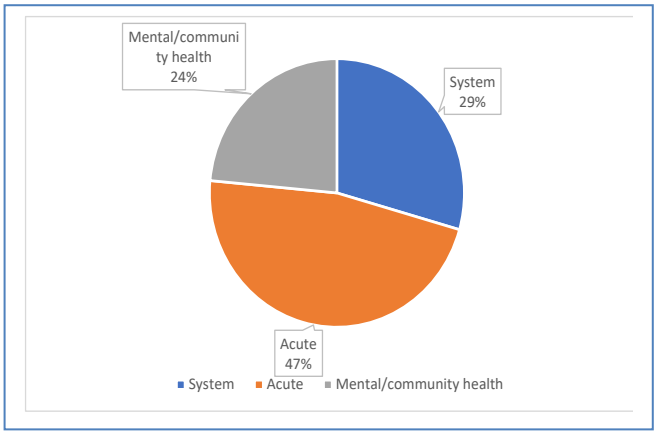
LLR is the third highest represented system in the talent pool and the breakdown of LLR talent pool members is illustrated below.

- 18 talent pool members from LLR
- 72% female, 28% male
- 72% white, 28% BME

Professions breakdown



Types of LLR organisations represented



As recommended by the Regional Talent Board (May 23) we need to make the regional talent pool our first choice of contact when we have board level vacancies across LLR which would be suitable for first time directors, either on a substantive or interim basis.

It's also recommended that we Identify and encourage sub-board level senior leaders to join the regional aspirant director talent pool to benefit from career support and exposure.

6. Leadership Development Interventions

202 leaders across LLR registered to attend a range of programmes and events delivered by the NHSE Midlands leadership team. In relation of programmes, the highest attended interventions were the Complete Leadership Series, LLR Collaboration to Improve Care and the System Convening Masterclass. In addition 5 ICB Board Members participated in the Primary Care BAME Network Programme.

7. Developing an Open/Inclusive Talent Community Across LLR

As part of our LLR Culture and Leadership Programme (one of three national pilot sites), we have completed an in-depth diagnostic to ensure we have a deep understanding of the appetite & readiness for system talent management approaches that enhance (not duplicate) organisational approaches across LLR. This has involved working with partners from across all areas of health, local government, and VCSE/ third sector to enable us to agree where focussed open/ inclusive talent management approaches should be implemented across LLR.

Key outcomes from the diagnostic work identified the following:

- In relation to developing an 'inclusive talent community', there are differing views on what this means across LLR e.g. it is viewed as being about everyone; specific under-represented groups; specific professional roles; and/ or leadership positions
- People want meaningful action that is focussed on strengthening diversity e.g. considering intersectionality around gender, age, race and other components such as educational attainment and/ or financial security
- There is a clear sense that many individuals lack personal agency around their own career development and/ or the skills/ knowledge to 'craft' a rewarding career. Talent management is often 'done to'. Connected to this, the majority of leaders are considered as lacking the time, skills and/ or experience to have impactful talent conversations and/

or take meaningful actions to support others. Talent management conversations are (for the majority) not happening and/ or not happening until people reach senior positions.
- People want inclusive talent management approaches to be individualised and not 'homogenous or process-focussed'.
- People felt that inclusive talent management should focus on (1) attract/ retain, (2) develop/ nurture and (3) succession/ exit, with the majority of people sharing that 'develop/ nurture' was the most important areas to address.
- The boldest approaches were viewed as being digitally enabled; focussed across the whole system and supported by high levels of trust between different organisations and shared approaches/ processes.

To address these key themes we are now looking to progress key workstreams that will address the key needs identified by LLR colleagues. These are likely to include the following (to be reviewed at the Think Tank event on the 9th October):

Proposal	Action	Impact
Inclusive Talent Management – Career Conversations for Individuals	Develop a 'pilot' Masterclass (including tools/ materials such as 'Conversation Starters') for Individuals to attend	Support individuals to understand • Personal Brand • Career Crafting • Cultural Intelligence • Authority, Presence, Impact • How to Have Great Career Conversations
Inclusive Talent Management – Career Conversations for Leaders	Develop a 'pilot' Masterclass (including tools/ materials such as 'Conversation Enablers') for Managers/ Leaders to gain insights into Talent Management approaches e.g. 'Career Conversations' and 'Talent Huddles/ Pipeline'	Support individuals to understand • Career Crafting • Cultural Intelligence/ Inclusive Teams • Talent Huddles • How to Lead Great Career Conversations
Developing Diverse Leaders Programme	Based on the success of the pilot/ externally delivered DDL programme - and with a view to sustainability - develop an LLR Diverse Leaders Programme	Support individuals to understand • Personal Brand • Career Crafting • Authority, Presence, Impact • How to Have Great Career Conversations
Talent Huddle/ Pipeline	Develop a 'Talent Huddle/ Pipeline' approach for critical diversity and/ or critical roles	

8. LLR Developing Diverse Leadership (DDL)

The LLR DDL programme is a system level development programme, aimed at Black, Asian and Minority Ethnic aspiring leaders within Nursing, Allied Health Professionals, Midwifery, bands 5-7 and their line managers. Uniquely, the programme offers leadership development programmes for participants and line managers from a range of organisations, with shared Action Learning Sets to the two groups and their learning.

The programme is underpinned by the inclusion of Organisational Leads, Executive Sponsorship and Executive & Senior Leadership support, mentoring and guidance, because we identified that

the provision of a development programme in isolation is not enough to engender change. As of July 2023, we are in the process of finalising the Action Learning Sets that form part of this programme, and outcomes/ Career Tracking will be managed for the next 18-months. However, early feedback is telling us that within 9-months of the programme starting, there are positive outcomes for both participants and line managers.

To demonstrate the benefits of the programme, see below links to two testimonials from participants who have been on the programme and gone on to further their career because of the learning.
https://youtube.com/shorts/35DoIyZInqM?feature=share
https://youtube.com/shorts/9mdzJNhSygg?feature=share

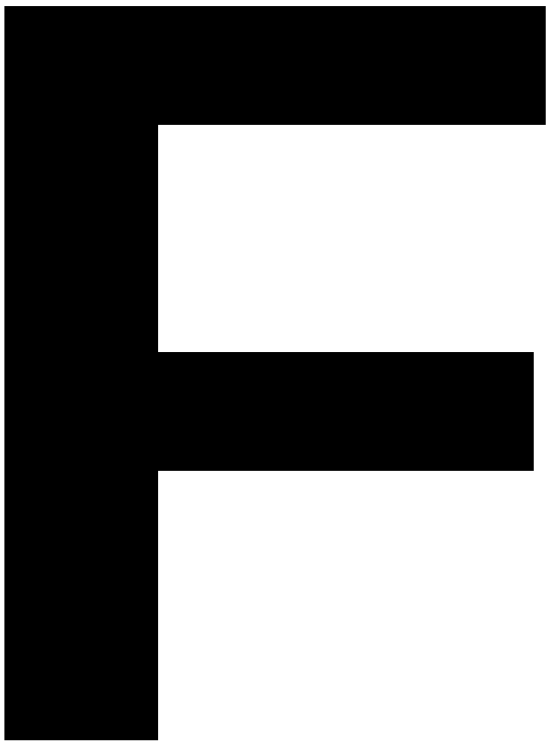
9. Developing Me Developing You

Currently in LLR we have the successful DDL programme (as above), however there is a lack of opportunity for those within Band 8a and 8b both locally, regionally, and nationally. Having a focus on this cohort of staff would bring us closer to having an impact on diverse visible strategic leaders moving into deputy or executive leadership roles. To do this we have been working with Cavita Chapman (clinical talent management specialist) to produce the Developing Me: Developing You talent acceleration pilot programme.

The programme has been designed to support manager, whilst they support the development journey of Black Asian Minority Ethnic nurses, midwives and AHPs. Enhancing the career progression of both groups will be a key feature of this programme.

Evidence based successful interventions such as reverse mentoring, sponsorship and talent management will be embedded within the programme along with a psychological wrap around, to ensure the safety and well-being of all participants.

The programme will have structured interventions focused on organisational cultural transformation, career progression, leadership enablement and psychological support. In addition, it will provide participants space, time, and opportunities to share learning and to co-produce strategies that make a real difference to career aspirations and trajectories. We are currently recruiting onto this programme 24 places in total with a September commencement date.



Name of meeting:	**Leicester, Leicestershire and Rutland Public Integrated Care Board**		
Date:	10 August 2023	**Paper:**	**F**
Report title:	Winter Plan 2023/24		
Presented by:	Richard Mitchell, Chief Executive, University Hospitals Leicester NHS Trust Rachna Vyas, Chief Operating Officer, LLR ICB		
Report author:	Richard Mitchell, Chief Executive, University Hospitals Leicester NHS Trust Rachna Vyas, Chief Operating Officer, LLR ICB		
Executive Sponsor:	Richard Mitchell, Chief Executive, University Hospitals Leicester NHS Trust		

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

Recommendations:

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

- **APPROVE our winter plan for 2023/24**

Purpose and summary of the report:

In the last 12 months, LLR has made significant progress in its UEC performance, including a sustained improvement in ambulance handover times – with over 90% less time lost to ambulance handover delays when compared to 2022. It is important we use the learning from this improvement to drive further progress in the rest of 2023/24 and beyond

Sustaining this improvement will require focus in five areas:

Increase capacity, to help deal with increasing pressures on Leicester hospitals which see 19 in 20 beds currently occupied.

- Dedicated revenue and capital for additional capacity at Glenfield and 52 (25 new) community beds as part of the permanent bed base for next winter/spring.
- New ambulances will be available across the East Midlands, the majority of which will be on the road by next winter.
- 'Same day' emergency care services will be in place across the LRI and the Glenfield hospital, so patients avoid unnecessary overnight stays.

Grow the workforce, as increasing capacity requires more staff who feel supported.

- More clinicians will be available for 111 online and urgent call services to offer support, advice, diagnosis and, if necessary, referral. From this April we will launch a new targeted campaign to encourage retired clinicians, and those nearing retirement, to work in 111 rather than leaving the NHS altogether.
- We will grow the workforce with more flexible ways of working and increase the number of Emergency Medical Technicians next year to respond to incidents and support paramedics.

Speed up discharge from hospitals, to help reduce the numbers of beds occupied by patients ready to be discharged.

- At the Autumn Statement 2022, the government made available up to £2.8 billion in 2023/24 and
- £4.7 billion in 2024/25 of additional funding to put the adult social care system on a stronger financial
- footing. Locally this includes Adult Social Care funding of £4.77M to increase the Better Care Fund
- in 2023/24, and the new Adult Social Care Market Sustainability & Improvement Fund of £9.65M.
- We will further enhance our integrated care hub for our bed base ahead of next winter. This will support faster discharge to the right setting, so that people do not stay in hospital longer than necessary.
- We will continue to embed new approaches to step-down care, so for example, people who need physiotherapy can access care as they are being discharged from hospital before they need to be assessed by their local authority for long-term care needs.
- New discharge information will be published, with new data collected from this April.

Expand new services in the community, as up to 20% of emergency admissions can be avoided with the right care in place.

- Ahead of next winter we will offer more joined-up care for older people living with frailty; this includes ensuring 100% of our patients able to access urgent community response within 2 hours, 80% of our frail patients having clear, accessible and proactive care plans and falls services will cover the whole LLR footprint – meaning the right people help you get the care you need, without needing an admission to hospital if it's not necessary.
- Greater use of 'virtual wards', which allow people to be safely monitored from the comfort of their own home, will be achieved by an extra 199 beds to provide 236 beds in total by this autumn.

Help people access the right care first time, as 111 should be the first port of call and reduce the need for people to go to A&E.

- By April 2024, urgent mental health support through NHS 111 will be universally available.
- From this April, new data will allow the public to easily see and compare the performance of their local services.

We will also tackle unwarranted variation in performance in the most challenged local systems.

- We will continue to embed our clinically led programme to reduce unwarranted variation, working with our 20 practices where we note the highest levels of variation. Intensive support will be in place for those neighbourhood areas struggling the most.

To support the recovery of urgent and emergency care services, the LLR system has committed to targeted funding in both acute services and the wider system. This includes:

- £14.3M of dedicated funding to support capacity in urgent and emergency services, building on the national funding used over winter 2022/23 to support an increase our overall capacity.

- £4.7M of additional social care discharge funding over 2023/24 (with 2024/25 to be confirmed), building on the £500 million Adult Social Care Discharge Fund and £200M funding for step-down

care during winter 2022/23, to be pooled into the Better Care Fund and used flexibly on the interventions that best help discharge patients to the most appropriate location for them – part of social care investment of up to £7.5 billion over the next two years.	
Appendices:	
Report history (date and committee / group the content has been discussed / reviewed prior to presenting to this meeting):	UEC system partners

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.*	**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 2** - Health inequalities and outcomes – failure to adequately address health inequalities and 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 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 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 6** - Emergency preparedness, resilience and response (EPRR) – failure to be adequately prepared to respond to major and / or business continuity incidents. **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.
b) Does the report highlight any resource and financial implications? If so, provide which page / paragraph this can be found within the report.	
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Delivery plan for recovering urgent and emergency care services

Leicester, Leicestershire & Rutland Integrated Care System

Final v4.0 / 31 July 2023

Contents

Our commitment to the public in publishing this plan is to improve waiting times and patient experience. We will:

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Executive summary

Urgent and emergency services have been through the most testing time in NHS history with a perfect storm of pressures impacting the whole health and care system but causing the most visible problems at the 'front doors' of our services such as General Practices, 111 services and Emergency Departments.

Nationally staff prepared extensively for winter, putting in place thousands more same-day appointments, thousands more beds, more call handlers, 24/7 care control rooms and respiratory hubs, and often working at the limits of their endurance.

Despite their best efforts, increasing length of stay, alongside the demands of flu and COVID peaking together, has seen hospital occupancy reach record levels. This means patient 'flow' through hospitals has been slower.

As a result, patients are having to spend longer in A&E and waiting longer for ambulances. Hospitals are fuller than pre-pandemic, with 19 out of 20 beds at UHL beds (occupancy in Apr 2023 is 94%) occupied; up to 200 beds occupied by an LLR patients who are clinically ready to leave UHL, LPT or an out of area bed each day in April 2023 and the number of the most serious ambulance call-outs has been at times up by 12.9% on pre-pandemic levels. These pressures have also taken their toll on our staff, who have had to work in an increasingly tough environment.

The challenge is not just in ambulances or emergency departments, and so neither are the solutions. Recovery will require different types of providers working together and joining up care better for patients, led by local systems and backed by additional investment. We also know this is not unique to Leicester with many similar challenges faced by regions and nations across the UK and across the world.

To support recovery, this plan sets out our ambitions, including:

- Patients being seen more quickly in our emergency department: with the ambition to improve to 76% of patients being admitted, transferred or discharged within four hours by March 2024, with further improvement in 2024/25.

- Ambulances getting to patients quicker: with improved ambulance response times for Category 2 incidents to 30 minutes on average over 2023/24, with further improvement in 2024/25 towards pre-pandemic levels.

These ambitions would represent one of the fastest and longest sustained improvements in emergency waiting times in the local NHS's history. Meeting these ambitions provides a focus for recovery, but they will not be enough on their own. Successive analysis has demonstrated the importance of looking at multiple metrics to support better outcomes for patients. We will therefore begin to publish more data on time spent in A&E, including 12 hour waits from time of arrival, and we are working with social care partners on a better measure of discharge to ensure we are measuring the whole patient journey in hospital. Performance against these metrics will fluctuate in response to COVID and other viral illness, as well as the usual seasonal pressures.

But even before the pandemic, pressure on urgent and emergency care had been growing, with changes in demographics and new types of care available, meaning the need for services has been growing every year. And looking forward, our growing and ageing population will see this continue.

We also need to reform and provide a genuinely better experience for patients. Our plan builds on the investment and evidence-based actions taken during winter 2022/23 to increase capacity and resilience, by taking steps to embed what works for patients while also creating space for people to innovate. It also builds on the experience during COVID, which brought out the best in our local NHS and care services – with new services scaled quickly, genuine innovation focused on improving patient care, and better working across different types of care provider centered on the needs of patients.

Through partnerships between acute, community and mental health providers, primary care, social care and the voluntary sector, our ambition is to create a sustainable system that provides more, and better, care in people's homes, gets ambulances to people more quickly when they need them, sees people faster when they go to hospital and helps people safely leave hospital having received the care they need.

This plan sets out how the NHS and partners across Leicester, Leicestershire & Rutland will make this a reality and continue to transform patient care at scale.

Meeting this challenge will require sustained focus on five areas:

- **Increasing capacity** – investing in more hospital beds and ambulances, but also making better use of existing capacity by improving flow.

- **Growing the workforce** – increasing the size of the workforce and supporting staff to work flexibly for patients.

- **Improving discharge** – working jointly with all system partners to strengthen discharge processes, backed up by more investment in step-up, step-down and social care, and with a new metric based on when patients are ready for discharge, with the data published ahead of winter. Work closely with providers to increase P0 discharges and reduce lost and delayed discharges.

- **Expanding and better joining up health and care outside hospital** – stepping up capacity in out-of-hospital care, including virtual wards, so that people can be better supported at home for their physical and mental health needs, including to avoid unnecessary admissions to hospital.

- **Making it easier to access the right care** – ensuring healthcare works more effectively for the public, so people can more easily access the care they need, when they need it.

To support the recovery of urgent and emergency care services, the LLR system has committed to targeted funding in both acute services and the wider system. This includes:

- £14.3M of dedicated funding to support capacity in urgent and emergency services, building on the national funding used over winter 2022/23 to support an increase our overall capacity.

- £4.7M of additional social care discharge funding over 2023/24 (with 2024/25 to be confirmed), building on the £500 million Adult Social Care Discharge Fund and £200M funding for step-down care during winter 2022/23, to be pooled into the Better Care Fund and used flexibly on the interventions that best help discharge patients to the most appropriate location for them – part of social care investment of up to £7.5 billion over the next two years.

Delivery will require prioritisation at a system level, but also local flexibility within each place. There will not be a one size fits all solution, and local places, working with social care and other partners continue to develop local plans reflecting local needs across LLR.

Why we need a UEC Recovery Plan

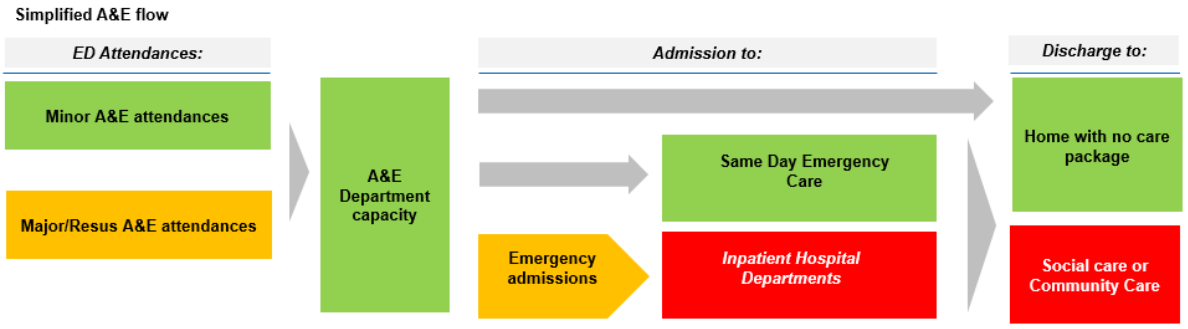
A. Why are we seeing pressures on Urgent and Emergency Care?

Current pressures

COVID is having a lasting impact on NHS services. Throughout 2022 there were never less than 3,800 people in England in hospital with COVID on any given day, with more than 9,000 on average across the year. This means not just more patients, but also knock-on impacts on the length of time patients are in hospital and more beds closed for infection control.

Occupancy levels for general and acute hospital beds have risen in recent years and have been persistently high over 2022, with around 94% of beds at Leicester Hospitals and 92% (LPT) of beds at Leicestershire Partnership Trust filled on average. High bed occupancy is a key driver of worsening A&E performance, which in turn has a direct impact on ambulance 'handover' and response times. This is because when hospitals are fuller it is harder to find free beds for patients that need to be admitted from the emergency department, which means it is harder to bring new patients into the emergency department.

The figure below provides a simplified picture of A&E patient flow, highlighting the current constraints in hospital.



As set out in the diagram, the key driver for performance is high occupancy, with difficulty discharging patients, both internal and external factors, resulting in increased length of stay and knock-on difficulties admitting people as inpatients to hospital departments.

From April 2021 to October 2022, average length of stay in Leicester Hospitals increased by 5% (from 12% to 17%) compared to the national increase of 18%. The UHL average length of stay for emergency admissions was 9.6 days in the rolling six months up to March 2023 compared to the peer median of 10.3 days and provider median of 10.6 days in the same time period.

There were an average of 742 patients with >7day LOS at UHL each day in February 2023. Long length of stay has also significantly increased in mental health inpatient care, reflecting increased acuity and challenges around discharge, with 20% of all people staying for more than 60 days. Increasing length of stay is driven by several factors including:

- Increasing complexity of care with patients having more comorbidities, in part linked to COVID.
- Delayed discharge: while the majority of people are treated and discharged within 48 hours of an emergency admission, for some discharge is more challenging. There are around 200 UHL, LPT and OOA beds occupied by LLR patients who are clinically ready to leave (April 2023) compared to 195 each day in April 2022 (an increase of 2.5%). Nationally, there have been up to 14,000 inpatients who do not clinically need to be in hospital, increasing by more than 10% over the last year – accounting for around 13% of occupied beds. This challenge exists across all settings, including mental health.

As set out in the diagram, the number of attendances is not the thing primarily driving performance, but they do create additional pressure. Following a reduction in activity at the start of the pandemic as fewer people came forward for care, demand has been consistently rising. Attendances have recently been just above pre- pandemic levels: Nationally, December was the busiest month on record for emergency departments in England with nearly 2.3 million attendances, 18,000 higher than the previous high. Locally, we saw 22,657 A&E attendances at UHL in Dec 22 compared with 22,536 in Dec 19. The ambulance service also responded to 18% more category 1 calls nationally in December compared to a 12.9% increase seen locally. We have continued to see admissions from COVID as well as other respiratory illnesses, with more than 350,000 COVID admissions since this time last year nationally, with 5,388 of these within LLR.

Taken together, even though there are more beds open now than immediately before the pandemic, occupancy remains very high, reducing patient 'flow' through hospitals and creating longer delays for patients at the front door and in the community. That said, evidence-based interventions put into place as part of our local winter planning have shown positive impact:

- Attendances at our Emergency Department have stabilized since the introduction of patient streaming with an average of 26 patients streamed into booked community slots instead
- Our community based Acute Respiratory Hubs have seen 8,971 patients in the period December 2022 to March 2023.
- Our General Practices have provided 12% more appointments during winter 2022/23 than in winter 2019/20.
- The numbers of complex patients (Pathways 1-3) awaiting a discharge plan has fallen from 228 (31/12/2022) to 192 (26/04/2023) over winter, despite over 192 additional bedded or non-bedded services being open.
- Since the revised ambulance assessment process at the Leicester Royal has been in place, ambulance handovers delays over 60mins have reduced from 38% in Dec 22 to 6% in Feb 23, with an average clinical handover of just over 30 mins in March 2023.

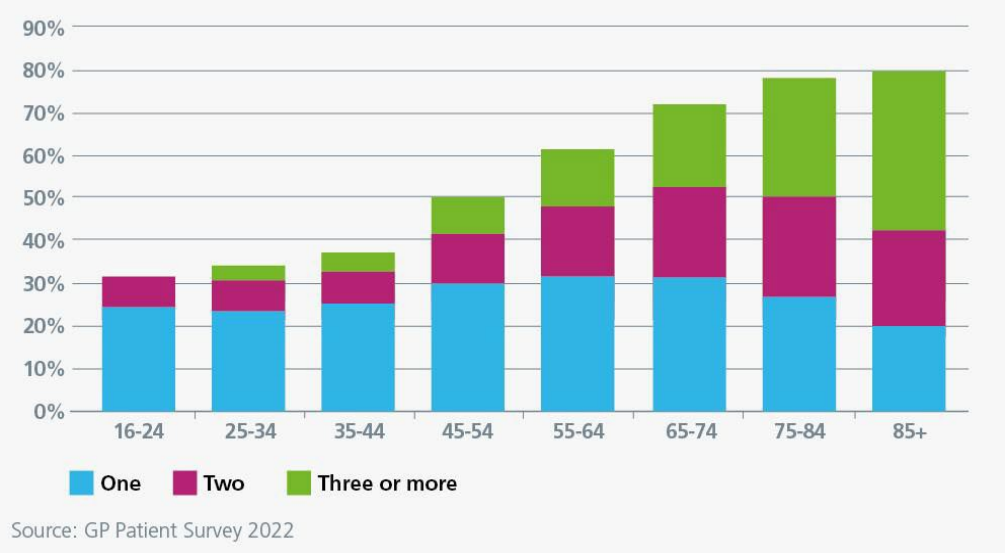
However, we know constrained UEC performance has a disproportionate impact on those who experience health inequalities. In 2021/22 NHS Digital reported that patients who live in the 10% most deprived areas (3.0 million people) were twice as likely to attend ED

departments in England when compared to people living in the 10% least deprived areas (1.5 million people). Locally we know that for LLR, the 1.7% of patients living in most deprived areas have a 33% chance of an emergency admission in the next 12 months, compared with 1.3% of those living in least deprived. Our plans therefore must include action on equity and preventative services for these populations.

Longer term trends

The immediate challenges for UEC services come on top of longer-term trends. The need for health and care is continuing to increase as a consequence of population growth, ageing in the population and greater numbers of people living with long- term conditions. The number of people aged over 85 could increase by 55% over the next 15 years. More than 25% of the adult population in England now lives with two or more long-term conditions, increasing the likelihood of admission to hospital. [ii] In 2019, 33% of people over 18 were estimated to be living with complex multimorbidity, having doubled from 15% in 2004.[iii]

Proportion of age cohorts living with long-term conditions



Source: GP Patient Survey 2022

Around 8% of people aged 50 or over are estimated to be frail, as high as 16% in parts of England.[iv] England is not the only country facing these challenges, countries across Europe are seeing rising levels of multimorbidity.

A growing and ageing population, with rising morbidity means that the need for UEC services rises every year:

- Demand for NHS 111 has continually increased, with annual growth of 6% a year in 111 calls received in the five years before the pandemic.
- Pre-pandemic ambulance services have faced the challenge of 4% increase in demand year on year.
- A&E including emergency departments and urgent treatment centres have seen rising demand in terms of acuity, with faster growth rates for older age people. Demand for major emergency departments has risen gradually but consistently since 2003.

- In 2019 there were 25.6 million A&E attendances (2.1 million a month), 20% more than in 2011. Emergency admissions grew by 28% over the same period to 6.5 million nationally. For UHL there has been an increase of 24.1% for A&E attendances from 205,561 in 2011/12 to 255,106 in 2019/20. For admissions there has been an increase of 31.1% from 76,348 in 2011/12 to 100,128 in 2019/20
- There are constraints and waits in social care, for service users to receive assessments and reviews in the community. The delay creates a risk of individuals moving into unplanned services as their needs are not addressed in a timely way.

The need for UEC mental health services is also growing. Community-based crisis services have seen a sustained increase in referrals since before the pandemic. Long waits for people with mental health needs in A&E are increasing, and people with mental health needs often report poor experiences relating to long waits. LPT are trialing some dedicated crisis inpatient beds, for people who need a short stay to stabilise their mental health and are quickly discharged back into the community for ongoing support.

B. What we will deliver for patients and the public

Our vision for UEC is for patients to have access to the right care, in the right place, at the right time. Our hospitals will be appropriate for some seriously ill patients but are often not the best place for many people whose needs are better met in a different way. Delivering this ambition will mean supporting more strengths-based, patient-centred, personalised care, accessed closer to, or at, home – but also more integrated services.

We will take the opportunity of new and existing technologies to enable people to access care in different ways and support staff in the NHS to deliver better care. New digital technologies provide the opportunity to change the way in which services are provided, but also transform the way in which people access services. We will support patients to manage their own health as they build on their knowledge and skills to improve their confidence.

We recognise that patients want better communication on time spent in A&E, want a better understanding of how to access the right care to avoid multiple handovers between services, and want greater continuity of care so that they do not have to repeat their story as they go through the system.

We will ensure that services reflect the needs of different groups of people, including all age groups, people with mental health issues and dementia and people with learning disability and autism. The plan takes proactive steps to tackle known inequalities, particularly for groups who are disproportionate users of UEC services.

The plan sets out how we will achieve headline ambitions of patients spending less time in emergency departments, and ambulances getting to patients more quickly. While these ambitions provide an immediate focus, they are only part of the patient journey. We will also need to ensure focus across the pathway, including on long waits in emergency departments, on discharge and access to proactive care in our general practices, as we

deliver this plan.

Achieving these ambitions in the next two years will be challenging. However, local partners are committed to this plan and the partnership approach needed to drive sustainable transformation. We recognise that delivering this vision will not happen overnight but we also recognise we are not starting from scratch. We will learn from and adapt our collective experience from winter 2022/23 and scale up the things we know will enable transformative change.

We know that urgent and emergency care is part of a more integrated health and care system; therefore, this plan will align fully with the principles of the Fuller Stocktake report as well as our planned improvements in access to general practice across the LLR footprint in line with the Access Improvement Plans our Primary care Networks are developing.

Meeting this challenge will require sustained focus on the five areas in the rest of the document:

1. Increasing capacity
2. Growing the workforce
3. Improving discharge
4. Expanding care outside hospital
5. Making it easier to access the right care

These actions consider the views of a wide range of stakeholders, from our clinicians and practitioners across the LLR footprint to our patients and our communities. It draws on a diverse range of opinion and experience, as well as views of patients and users, with each intervention being evidence-based and locally piloted.

1. Increasing urgent and emergency care capacity

We will need to increase the number of beds and ambulances if we want to reduce time spent in A&E and ensure hospitals are not as full. We will also work to make the most of the capacity we do have, with better processes and faster spread of best practice. We will increase capacity and reduce waiting times through:

A. Additional hospital bed capacity
B. Increasing ambulance capacity
C. Improving processes and productivity

A. Additional hospital bed capacity

Ambition:
There is a well-established link between high bed occupancy rates in hospitals and worse A&E performance.[vi] When hospitals are busy, it becomes more difficult to ensure patients get the care they need and can lead to longer time spent in A&E. Worsening A&E performance in turn has a direct impact on ambulance handovers and response times. We therefore need to reduce the current bed occupancy, which over 2022/23 has consistently been above 95%, back towards the 92% level which is safer and more efficient as it improves flow through hospitals.

Hospitals have tended to have higher occupancy levels in England compared to other countries, despite historically lower lengths of stay. The need for acute care will continue to increase over the coming years, and ongoing levels of COVID are creating additional pressures on hospital capacity. While we will act across all parts of health and care, increasing the number of staffed hospital beds to lower our occupancy levels ahead of next winter will be a fundamental part of the plan.

Through the additional funding for winter 2022/23 and through the year, Leicester Hospitals and Leicestershire Partnership Trust have already increased the number of staffed hospital beds by 79:

Ashton	24
Ward 22	16
Pre-Transfer Hub	12
Coalville W4	27

This increase in capacity is to be maintained for 2023/24 and we will also put in place further physical beds ahead of next winter

How we will deliver:
Compared to the originally planned levels of beds in 2022/23, there will be at least 52 additional staffed beds in 2023/24.

This additional bed capacity needs to be in the places that will deliver the greatest benefit to patients - based on our local demand and capacity modelling, we will put into place the following (subject to receipt of capital funding):

- **Additional beds in UHL by Q4 2023/24.**
- **52 additional beds (25 new) at LPT by Q3 2023/24.**

We will work in partnership to ensure that the new beds are put in place as sustainably as possible, to reduce the impact of surge periods on other services, including theatres and research facilities.

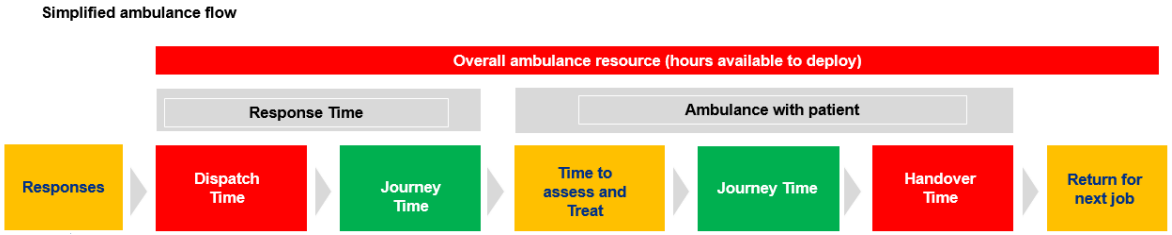
B. Increasing ambulance capacity

Ambition:
One of the main causes of longer waits for ambulances is delays handing patients over from the ambulance crew to hospital staff because the emergency department is full. On average more than 187 hours a day were lost to handover delays in December 2022 across LLR. Whilst this has reduced to an average of 32 hours per day in February 2023 since the introduction of an expanded ambulance assessment area at the LRI, this is still time when ambulances could be back on the road.

Therefore, on its own, reducing A&E waiting times will lead to an improvement in ambulance responses as flow improves out of, and therefore in to, emergency departments.

However, analysis of ambulance response times indicates that handover delays are not the only cause of slower ambulance response times. We have seen increases in sickness and other staff absence. We have also seen the complexity of ambulance crews' work increase meaning each incident is taking longer: the number of the most serious ambulance callouts has, at times, increased by one third since before the pandemic and there has been a long-term increase in the time ambulances are spending at the scene as crews provide more care directly with the patient. Therefore, additional ambulance capacity, not just additional beds, is needed to meet next year's 30-minute ambition for Category 2 ambulance response times.

The simplified ambulance flow diagram below shows the importance of handover times to ambulance performance, and the wider range of factors involved.



As well as increasing capacity, we need to ensure that ambulance services focus on emergency incidents and where ambulance services can add most value. In some cases, it may be more appropriate for other services, including urgent community response or mental health crisis teams, to respond to patients on scene.

How we will deliver:
To respond to these pressures, grow the fleet and better support the workforce, NHS England will ask ambulance services and lead commissioners to determine, by March 2023, their capacity plans for 2023/24 and identify gaps. As part of that process ambulance services will look at ways to reduce sickness absence and how additional support could be given to staff.

This additional capacity will be largely delivered through more crew hours on the road, but we will also release capacity through better health and wellbeing for staff meaning a reduction in sickness absence, productivity gains, and through better links between the ambulance service and community services.

New ambulances will be available during 2023/24 across the East Midlands footprint, with the majority expected to be available ahead of winter, as part of ongoing improvement and replacement of our fleet.

The LLR system will work with East Midlands Ambulance Service and related partners such as DHU Healthcare to increase capacity and ensure patients receive the most appropriate care, including:

- **Single point of access for paramedics**: To ensure consistent and rapid access to clinical advice and alternative services, and to reduce unnecessary conveyance, we will implement a single point of access for paramedics. Single points of access provide a single, simple route for referrals to hospitals. They are staffed by qualified clinicians, able to ensure patients get referred to the most appropriate service for their needs.
- **Call assessment, triage and streaming via our unscheduled care hub:** By autumn 2023, we will work with EMAS to increase clinical assessment of calls in our Nottingham ambulance control and directly link this to our local Unscheduled care hub. This additional clinical input will ensure that the sickest patients are prioritised for ambulances and that patients who do not need a face-to-face response can be transferred quickly to services more appropriate for their needs via the UCH. This will include urgent community response, urgent treatment centres, same day emergency care (SDEC), mental health services, social care and primary care.

- **Forecasting:** We will work with EMAS improve forecasting of call demand and further develop the 'Intelligent Routing Platform' to manage the distribution of calls throughout England when individual services are under pressure and therefore reduce 999 call answering delays.

Right place, right time, right care: Navigating mental health pathways

Partners across health and care have developed a multi-agency approach to supporting patients with urgent mental health needs.

Mental health professionals have been embedded in the LLR unscheduled care hub since November 2022. A mental health dispatch pathway has been developed so that all appropriate 999 mental health calls, whether they are police/fire or ambulance calls, are routed into the mental health professional in the hub. This allows partnership working across health and care to determine the most appropriate response for the patient and supports the 999 service.

This has meant more people with mental health needs have their needs met over the phone or are conveyed to more appropriate services. By February 2023, approximately 72% of calls directly handled by the mental health desk could be managed over the phone, without the need for ambulance dispatch. Patient and carer feedback has been excellent, with notable positive feedback from both ambulance and teams working in the hub as well.

C. Improving processes and standardising care

Ambition:
We know from patients how important it is to have a smooth experience in hospital, and to not experience too many unnecessary delays in situations like waiting for your test results or moving to a different part of the hospital. There is still significant variation between processes in hospitals, showing an opportunity to learn from where things are being done best and have a less confusing experience for patients. As we increase capacity, we will use existing capacity as effectively as possible by standardising processes so that patients get the right care at the right time, including when moving between organisations.

We will reduce variation in care when patients arrive at A&E, ensuring greater consistency in direct referrals to specialist care, and access to same day emergency care (SDEC) so patients avoid unnecessary overnight stays. We will also standardise the first 72 hours in hospital so that patients are assessed, get any required scans, and start their treatment as soon as possible.

We will continue to make effective use of our 'system control centre' (SCCs). These pioneering centres use data to respond to emerging challenges and bring together experts from across the system to make better, real-time decisions. They will continue to ensure the highest quality of care possible for the LLR population by balancing the clinical risk within and across acute, community, mental health, primary care, and social care services.

We will also work towards implementing new response time standards for people requiring urgent and emergency mental healthcare in both A&E and in the community, to ensure timely access to the most appropriate, high-quality support.

How we will deliver:
By April 2023, we will adopt and adapt the new improvement programme to support standardisation of care, working with clinical leadership to set out common principles for providers, including developing professional networks to support peer- to-peer learning and challenge, leadership and best practice. This programme will be supported by national 'improvement collaboratives' as a mechanism for systematically adopting good practice.

Same day emergency care (SDEC) means shorter stays for patients and fewer unnecessary delays to leaving hospital. Current pressures often mean hospitals need to use their same day emergency care staff and space for other emergency care. We will spread best practice to ensure greater resilience ahead of next winter so that Leicester Hospitals provide appropriate SDEC seven days a week with a minimum opening of 12 hours per day, including for medical and surgical services as outlined in the 'SAMEDAY' strategy. Other SDEC services opening hours are designed to meet patient need.

We will work in partnership with our Primary Care Networks to design and deliver acute frailty services and SDEC, both of which will support reducing avoidable admissions and provide smoother care for patients, using the new frailty Commissioning for Quality and Innovation (CQUIN) incentive to support delivery of frailty services and link funding to quality improvement.

Paediatric early warning systems provide a consistent way of recognising deterioration in a child's clinical status, enabling early intervention and referral to alternative services if needed. We will implement the standardised paediatric early warning system for our inpatient settings by June 2023, which will be expanded into A&E, community, ambulance and primary care services, to deliver a cross-system approach.

We will provide streamlined pathways for mental health patients who need to remain in acute settings until their care can be transferred, with particular reference to better working with children and young people's mental health services, working-age adults and older adults, including people with dementia.

This will be supported by access to 24/7 liaison mental health teams (or other age-appropriate equivalent for children and young people) that are resourced to be able to meet urgent and emergency mental health needs in both A&E and on the wards, within one hour and 24 hours respectively.

We will fully embed year-round, our system control centre (SCCs) ensuring that it is appropriately resourced with autonomous clinical decision making across the system. The SCC will enable us to work with local authorities and other partners to ensure capacity, including in care providers, is used effectively and that the NHS provides support where needed.

We will implement digital tools that support decision making in near real time, including an electronic bed management system. We will work with NHS England as they continue to develop and roll out the A&E Admissions Forecasting Tool.

2. Increase workforce size and flexibility

Ambition:
NHS staff have faced immense pressures in recent years during the pandemic, and recovery will impose new ones. The COVID pandemic showed the remarkable flexibility of our staff to step into new roles, but it has also led to fatigue. While leaver rates reduced at the height of the pandemic, we know there are critical staff shortages across LLR, with a combined NHS Provider vacancy rate of 12.1% (excluding primary care). GPs and nurses in Leicester City have also seen a declining trend. Staff shortages have been an increasing issue since Covid-19 and exacerbated by winter pressures, surge conditions and industrial action.

Staff in post are under enormous pressure and experiencing high stress levels, due to this situation - this is borne out by the latest Pulse Survey, whereby 21.7% of respondents reported feeling negative, due to a high workload, competing demands, and being overworked. The net result is a high turnover of staff and an increase in sickness/absence, due in part to low morale, burnout, and psychological issues.

LLR has a variety of initiatives in place to address some of the above issues:

LLR is an Exemplar for the NHS England Retention Programme and a short to medium term plan is in place to mitigate some of the above issues, this includes for example: promotion and expansion of non-pay benefits and cost of living support available, development of a retention metrics dashboard, supporting improved understanding of the workforce and monitor change and improvements.

LLR has a well-established Care Workstream, delivered by LLR Academy, which include national and regional health and wellbeing programmes.

The LLR Academy also delivers Quality Improvement programmes, including the development of an LLR-wide QI Network, and Inclusive Culture and Leadership programmes.

Delivering the ambitions in the plan will require not just an increase in workforce, but also a change in the way that people work and opportunities for people, including recently retired clinicians, to return to work. We know that the scaling of out of hospital care requires rapid expansion of the community workforce and the development of more flexible and integrated teams. Key priorities are transforming primary and community care pathways, to reduce emergency attendances, hospital admission, including training community nurse in urgent and emergency care. Within our primary care workforce strategy is a focus on integrated teams, wrapped around a population and ensuring the combined skills of an MDT approach across health and are, will ensure the person is seen by the right time, right intervention, in the right place and by the right person.

LLR has a well-established apprenticeship programme, which will be expanding into targeted parts of the system, to ensure we are developing a future workforce pipeline. We also host an excellent Work Experience Portal, which can be used by existing health and care staff, those wishing to start a career in the NHS or Social Care and employers and education organisations looking for placements or to recruit staff.

How we will deliver:
While all areas of the NHS workforce are under pressure, we know that there are specific areas of the UEC workforce which we need to expand. Key priorities include the following:

Development of 'One Workforce' – a sustainable, long term, system-wide, integrated solution (strategic priority), through partnership working and co-production-based on complete health and care pathways (e.g, Home First, Discharge). Charnwood Pilot: Heart Failure Collaborative Intermediate Care Model-streamlining hospital discharge to community and social care provision, with rapid assessment within 48 hours post-discharge, supporting the principle of Right care, Right time, Right Place- will be implemented post-pilot. Charnwood MDT training taken place to enhance the skills and wellbeing of the team, thereby supporting portfolio and career pathways, leading to improved retention of those staff)

- **Paramedics** – Paramedics /Trainee Paramedics have consistently grown since March 2022. Ongoing recruitment of Primary Care ARRS roles, including Paramedics, continue to ensure that projected paramedic workforce gaps are mitigated through undergraduate student intakes, apprenticeships, and a focused retention improvement plan, to be developed in partnership with East Midlands Ambulance Service (EMAS) as part of the current strategic planning approach.

  Longer term planning for workforce growth in this area will be achieved through collaborating with Health Education Institutions and medical schools to ensure our approach to multi-year education and training investment planning is aligned to the health population needs and sit as part of the future workforce requirements.

- **Advanced practice** – we will continue to increase the numbers of advanced practitioners in priority areas including in emergency care. Advanced practice enables clinicians to take on expanded roles, supports the standardisation of same day emergency care and helps make the most effective use of multi-disciplinary teams.

- **Mental health** – we will continue to expand the mental health workforce within UEC and mental health services. Continued progress towards our local ambition of 75 peer support workers (further 20 planned in 23/24). Progression of peer support workers into further career roles has commenced and been encouraged (increasing reflection of local users).

  We will continue to develop the workforce mix in community services, including physiotherapists, occupational therapists, speech and language therapists and dieticians to support people to participate in daily living. We will continue the

development of advanced and consultant roles alongside the development of a strong and well-trained therapy and rehabilitation support and associate practitioner workforce.

As well as growing the workforce, we will support staff to work more flexibly. Flexible temporary workforce is an area of focus across LLR organisations, offering opportunities for retaining staff currently in post, flexing their skills across into areas of service need. We are well-skilled in doing this across LLR, with recent examples noted in the implementation of LLR Workforce Bureau, bank staff model, Care Homes Mutual Aid, facilitated by the LLR Workforce Sharing Agreement and development of the Digital Staff Passport.

For our work to scale virtual wards, we will work with NHS England to develop a national workforce recruitment capacity and capability plan. 7 out of 11 virtual wards have been mobilized (in addition to existing COVID & COPD VWs) with 100 beds open so far. This integrated workforce model is positively impacting the ability to discharge patients safely. These models have proven attractive to applicants and provided opportunities for advanced care practitioners.

Our 5-year workforce plan with a key component of Emergency Flow expansion - for example the staffing of 3 additional wards at Glenfield, over 2 years staffed through a mix of temporary and substantive workforce. Ongoing successful recruitment of international nurses-1100 recruited since 2017 and healthcare support workers. Additional workforce will be recruited to the Transit Hubs which will contribute to safe staffing over the ED floor as currently staff are redeployed to cover gaps in the transit hubs. Four separate hubs will be created at Glenfield and the LRI sites undertaking functions such as cohorting and discharge. The multi-organisational practices of discharge hubs are being enabled by innovative workforce practices to enable the sharing of staff across organisational boundaries.

Example: LLR Virtual wards

Workforce across a range of disciplines remains a significant challenge for the LLR system and this has had an impact to enhance the Virtual Wards Model.

Geriatrician capacity is limited and therefore alternative roles as GPs with special interest (GPwSI), consultant ACPs, and senior nurse roles have been implemented for the frailty Virtual Ward. 2 x Advanced care Practitioners have been recruited for the Frailty Virtual Ward and these models have been attractive to applicants and provided more opportunities for alternative role and skill mix within the team.

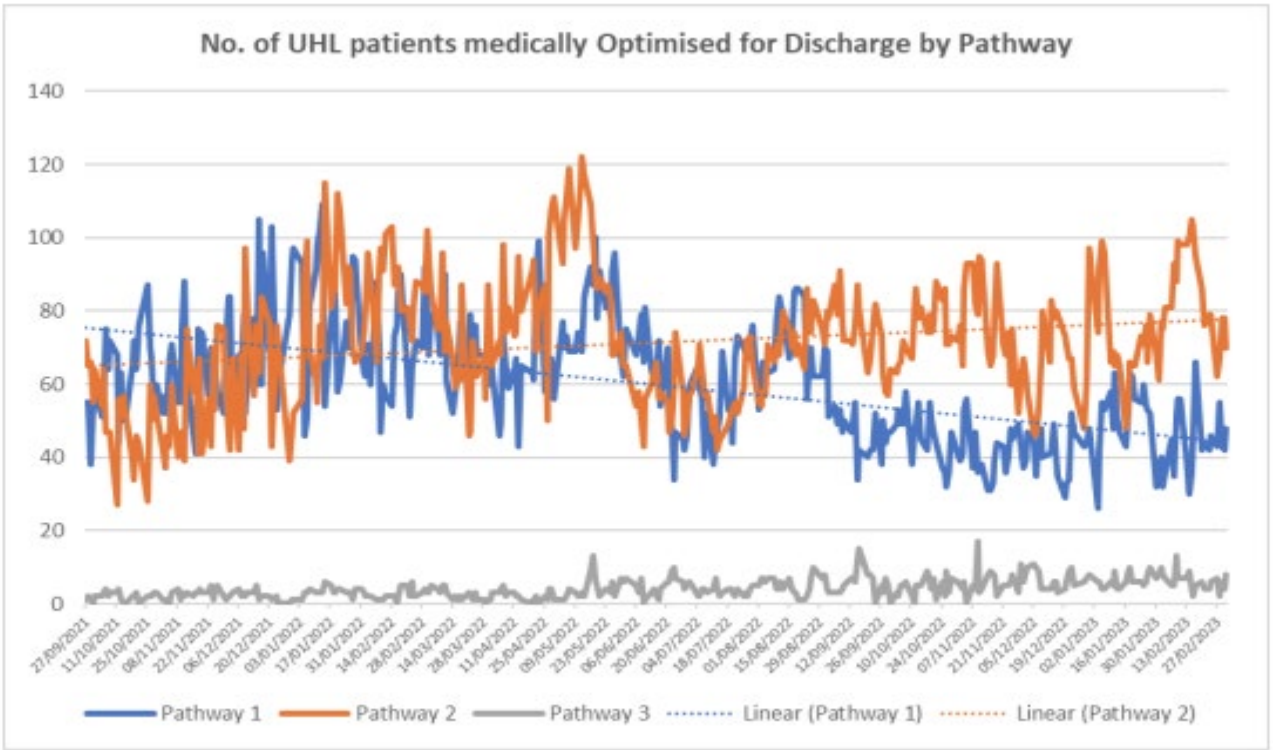
3. Improving discharge

Although having more hospital beds and more staff will help, it is also important to make sure patients are not in hospital for longer than necessary. We know that long stays in hospital are not good for patients or their independence and can lead to poorer health and economic outcomes.

Whilst discharge delays increased significantly over the pandemic, we have seen a significant and sustained improvement locally.

That said, there is much more to be done; we know both delays in discharge processes and shortages of capacity in social care and community care are making it more challenging to discharge patients from hospitals and mental health services. There are currently around 192 patients (including all UHL, LPT and out of area) patients remaining in hospital who no longer need to be there. On average, around 24% of patients with delayed discharges are awaiting the start of home-based care, 16% are awaiting residential or nursing home placements and 24% are waiting to begin intermediate care.

In order to deliver the 92% occupancy UHL has a bed gap of circa 350 beds. The bed bridge model closes the UHL gap by 248 beds by March 2025.



(Data taken from LLR Discharge Hub data Summery February 2023)

Current Discharge Status

	Total pts MOFD on S1	Patients with a planned discharge for today	Patients with a future plan	Patients awaiting an outcome
UHL	140	21	3	116
LPT	39	3	1	35
OOA	13	3	2	8
Total	**192**	**27**	**6**	**159**

(Data taken from S1 Sitrep 26.04.2023)

To improve discharge there must therefore be a sustainable increase in capacity in step-down services ('intermediate care') and social care, especially domiciliary care, and an improvement in discharge processes within hospitals and between hospitals, community services, local authorities and social care.

We will therefore improve discharge by:

A. improving joint discharge processes
B. scaling up intermediate care
C. scaling up social care services.

A. Improving joint discharge processes

Ambition:
As well as increasing capacity and improving the pathway within hospitals, we need to ensure that people are not in hospital unless they need to be and to improve the experience of patients when they leave hospital.

Discharge planning should begin when patients are admitted to hospital to ensure that people can get home or to a more appropriate setting as soon as possible, with services in place if needed.

We will work in collaboration with social care partners to ensure appropriate processes are in place to facilitate prompt discharge in NHS settings, including in community and mental health trusts. These processes should include early access to senior decision-makers to ensure patients get specialist advice sooner, removing avoidable delay.

We will work with our local government partners and the social care sector to ensure an integrated approach to building capacity, so that patients have rapid and reliable access to the joined-up health and care services they need when leaving hospital.

How we will deliver:
We will continue our implementation of the best practice interventions set out in the '100-day discharge challenge' across NHS settings. We have seen good progress so far, with the number of hospital process-related delays reducing by 25% since this approach was rolled out. This has now been extended to community and mental health settings.

The average daily P1-3 allocations for UHL, with detail of the discharges that did not occur:

	May	June	July	August	September	October	November	December	January	February	Trend
Average Number of discharge plans provided to UHL Mon to Fri	46	49	44	44	49	46	49	51	51	48	
Average Number of discharge plans provided to UHL Sat and Sun (Inc. Bank Holidays)	21	24	23	25	23	25	28	26	26	20	
Average Number of UHL patients with a same day plan becoming unwell	3	3	3	2	3	4	5	4	4	3	
Average Number of UHL patients experiencing a delayed discharge	8.5	11	11	10	13	11	11	12	8	6	

Systematic discharge planning between health and social care should start from the point of admission by identifying patients with complex discharge needs, setting an expected date of discharge, and working with families and carers to plan discharges. Everyone admitted to an inpatient bed should, on admission, have an estimated discharge date. Systems for discharge planning and delivery need to ensure timely transfers of care throughout the week, including evenings and weekend. IDT to work with UHL and LPT to reduce daily lost discharges.

Since COVID we have had a virtual discharge hub in place. We are now working towards implementing a 'care transfer' hub through an Integrated Discharge Team (IDT) to ensure that patients who do not need a hospital bed are discharged in a safe and timely way, either to their home or to a place in which long-term care decisions can best be made with rehabilitation and recovery support. The IDT will ensure:

- Clear plans for delivery, across all partner organisations, including agreed outcomes and data sharing arrangements.
- In reach support across Front Door wards
- A shared process to work with patients, their families and carers, and all professionals from admission, with all staff in the IDT sharing responsibility for delivering safe and timely discharge. The IDT will be focused on the most complex discharges and working to ensure that any assessments for long-term care are not completed in an acute setting.
- Strong and shared leadership at all levels, with clear accountabilities and responsibilities. We know this works best where there is a clearly identified senior leader accountable for flow across all partner organisations.
- A multidisciplinary staff mix, including social workers, case managers and clinical staff co-located in the IDT, who are empowered to make autonomous and accountable decisions that are respected across all partner organisations.
- Real-time evidence and insight into capacity and demand management planning across the local health and social care system.

Right place, right time, right care: LLR Integrated Discharge Hub

LLR's integrated discharge hub delivers an integrated service across seven days with a commitment from health and social care partners to cover 8am to 8pm, seven days a week.

Plan

- Reintroduce IDT on site from March 2023
- Increase IDT ward and board round attendance
- Increase voluntary services presence on wards from April 2023
- Ward therapist to be trusted assessors for ASC reablement services – commenced March 2023
- Ward therapist to act as trusted assessors for patients requiring low level ASC support, reducing triage time -planned June 2023
- UHL Discharge Specialist Team to review patients face 2 face and recommend short term care on behalf of MLSCU reducing triage time/delays -planned June 2023
- Increase usage of reablement pathways to support appropriate reduction of maintenance packages of care
- Increase pathway awareness with discharge teams and wards staff to encourage timely discharge
- Regular development and education sessions for IDT staff
- IDT to focus and reduce number of lost discharges daily
- Supporting consistent utilisation of criteria led discharge

B. Scaling up intermediate care

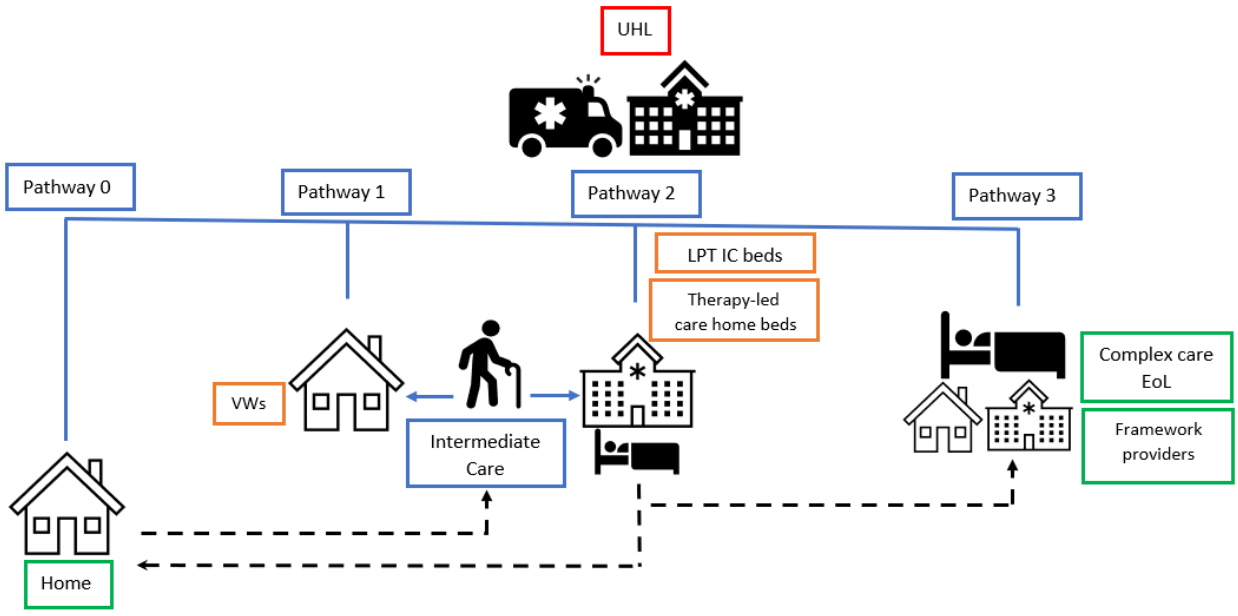
Ambition:
NHS England has begun a programme of work to develop and pilot a new approach to intermediate care, working with local authorities and voluntary and community partners. This expansion of 'step-down' care is designed to help people move from hospital into more appropriate settings for their needs, with the right wrap-around support for their rehab and reablement. This needs to be accompanied by growing the workforce, to ensure that we can deliver more care packages and good flow through community beds where required.

As an example, for people who need physiotherapy to regain their muscle strength, assessments of any longer-term care needs would take place after this initial recovery period and could take place in the person's own home.

Chapter 4 'Expanding care outside hospital' further details action to bolster 'step up' care (designed to help prevent hospital and emergency admissions) and 'step down' care (supporting timely and appropriate discharge).

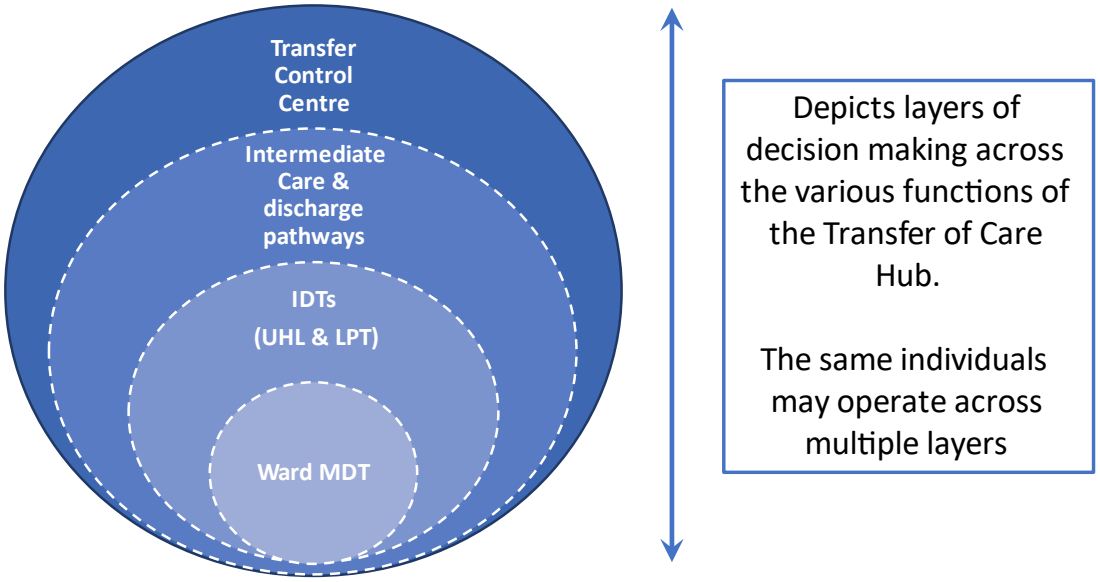
How we will deliver:

The LLR vision is to adopt a consistent Home First approach, underpinned by intermediate care, that ensures people are supported to remain independent, in their usual place of residence, for as long as possible.



The vision will be achieved through the establishment of a refreshed 'transfer of care' hub with four distinct functions:

1. Ward-based MDT: patient facing clinical decision-making; implement C-LD
2. Integrated Discharge team: focus on complex discharges – F2F reviews
3. IC and discharge pathways: ensure right care, right place, right time.
4. Transfer Control Centre: Discharge BI and operational coordination across the system



Development of this model will be coordinated through the Intermediate Care Delivery Group and will focus on the following:

1. Retain focus on reducing unwarranted variation in P0 discharges across 7 days.
2. Aspire to have no more that 20% of patients placed in spot-purchased residential P2 placements by November 2023.
3. Ensure consistent data collection of people discharged into long-term maintenance home care packages (P3) across LLR.
4. Revisit, with the support of Newton Europe, LLR demand and capacity modelling to right size P1 ensuring all patients discharged home are assessed for home-based intermediate care (intake model).
5. The LLR Intermediate Care Delivery Group undertake focused work for LPT beds to become the predominent destination for P2 discharges/transfers.
6. Continue to work with strategic workforce colleagues to facilitate recruitment of sufficient reablement and rehabilitation capacity in community settings.
7. Refocus MDT/IDT discharge support to LPT to mitigate risk of increased MOFD and ensure good flow.
8. LPT bed demand and capacity modelling to determine capacity required for a step-down intermediate care model. Once this model is in place, explore options for step-up.

C. Scaling up social care services

Ambition:
Alongside these improvements to discharge processes and intermediate care, local government, the NHS and the social care sector will work together to improve access to social care, with a particular focus on domiciliary care, supported by the Better Care Fund, additional social care funding and the government's reforms to adult social care.

How we will deliver:
At the Autumn Statement 2022, the government made available up to £2.8 billion in 2023/24 and £4.7 billion in 2024/25 of additional funding to put the adult social care system on a stronger financial footing. This will support an increase in capacity and improve the quality of and access to care for many of the most vulnerable in society.

Locally, the funding includes:

- Adult Social Care Discharge funding of £2.26m for Leicester City Council, £2.48m for Leicestershire County Council and £0.03m for Rutland Council. This will increase the 'Better Care Fund' in 2023/24 to build additional adult social care and community-based reablement capacity to reduce hospital discharge delays through delivering sustainable improvements to services for individuals.
- the new Adult Social Care Market Sustainability and Improvement Fund of £3.68m for Leicester City Council, £5.65m for Leicestershire County Council, and £0.32m for Rutland Council to make improvements to target areas of activity including
    - Increasing fee rates paid to adult social care providers in local areas
    - Increasing adult social care workforce capacity and retention
    - Reducing adult social care waiting times

The government is also allowing local authorities to increase the adult social care precept up to 2% per year in 2023/24 and 2024/25.

4. Expanding care outside hospital

The challenge of recovering urgent and emergency services also presents an opportunity. For decades we have known that many patients can receive better, safer, more convenient care outside hospital. We have seen in the pandemic the NHS's ability to design and expand new types of care and provide better care in people's homes. We know that backing those models that have been shown to work can give a better experience for patients and avoid unnecessary admissions and improve discharge. We will do this by:

A. expanding and better joining up new types of care outside hospital
B. expanding virtual wards.

A. Expanding and better joining up new types of care outside hospital

Ambition:
People's care needs can often be best met outside hospital. We know that up to 20% of emergency admissions are potentially avoidable with the right care in place. Care closer to, or at, home without the need for hospital admission is not only often more convenient for patients, but through timely access can help to avoid the deconditioning and prolonged recovery that can accompany a hospital stay.

Personalised care approaches such as supporting self-management, shared decision-making and one-off personal health budgets, alongside providing patients with the right information and support to make decisions, can enable them to manage their own care and avoid the need for hospital care for longer.

Community health services, including therapy services, help keep people well at home and in community settings close to home, and support people to live independently. When community services are delivered in combination with personalised care, they can reduce pressures on hospitals and emergency services by supporting patients at home and in the community, as well as provide them with greater choice and control, leading to improved patient experience and outcomes.

Falls are the number one single reason why older people are taking to the emergency department, and around 30% of people 65 and over will fall at least once a year.[ix] Care outside hospital is of particular importance for older people living with frailty, who are much more likely than younger people to be admitted to hospital, and likely to have a longer stay when they are admitted. Through better joint working and sharing of information between services we can help improve care for people who fall or are living with frailty.

Continued focus on mental health crisis prevention and a joined-up community response will ensure people are accessing the best service for their needs in a timely way, reducing avoidable admissions to hospital.

Making use of new technology and better collaboration, including between ambulance services and community care, will enable care that would often currently be delivered in a hospital to be delivered closer to people's homes. For example, the use of 'NHS @home' approaches can support people to recover, keep well and manage their health and wellbeing at home, and help reduce the need for hospital care due to supported condition management at home.

Adult social care plays a vital role in working with health services to provide the community support that prevents unnecessary admissions. Working in partnership with acute and community health services, the voluntary and community sector and care providers, our local authorities will continue to promote wellbeing and prevent unnecessary hospital admissions.

How we will deliver:
Many people can be best supported by a quick response from services in their community. Urgent community response (UCR) teams provide urgent care to people in their homes which helps to avoid hospital admissions and enable people to live independently for longer. Through these teams, people who urgently need care can get fast access to a range of health and social care professionals within two hours. Locally, these services are well embedded at place level, and regular exceed national standards.

Ahead of next winter, our aim will be to improve use of UCR including consistently meeting or exceeding reaching 80% of patients referred within two hours, with a service that operates for at least 12 hours a day in each of our three place footprints.

The population has aged and has increasingly complex conditions, and so we will make sure services are better joined up – with healthcare that works for patients.

We will immediately scale up falls and frailty services based on our learning from winter 2022/23, and help these services be better joined up with ambulances and existing UCR services so they can work together to provide a network of support for patients. Our UCR services will work in partnership with the Unscheduled Care Hub to implement a step up model into care and with the Integrated Discharge hub to provide speedy access to step down care – all designed to prevent or minimize stays in our acute bedded services where appropriate.

We will also roll out adult and paediatric Acute Respiratory Infection (ARI) Hubs to provide timely access to same day urgent assessment, preventing hospital attendance and ambulance conveyances through Winter 2023/24. Our ambition is that a longer-term community-based model of care is established, integrated across primary, secondary and community care, and will be a key point of referral for, or to, virtual wards.

We will continue the transformation of community mental health services and build on the recent expansion of community-based crisis services to ensure that our patients have a range of open-access age-appropriate services which meet local population needs, alongside 24/7 Crisis Resolution and Home Treatment provision.

We will continue to roll out High Intensity User Services, adopt good practice in supporting patients who are experiencing homelessness or rough sleeping, and embedding family support workers in A&E settings to provide additional support to children and families presenting with non-urgent issues.

High frequency users of services can also be supported to tackle social and practical issues that affect their health and wellbeing through working with social prescribing link workers, who can link them to a range of community assets depending on their needs and preferences. This may include help to stay active, make social connections, and manage their health conditions.

Right place, right time, right care: Pre-transfer clinical discussion and assessment service

Our Pre-Transfer Clinical Discussion & Assessment service joins up hospital-based secondary care expertise and a dedicated GP-led assessment service, linked to the urgent community response pathway. This provides an integrated service that aims to keep people with frailty safe and well at home, avoid hospital admission if possible, and provide a seamless transition to secondary care if it becomes necessary.

Our EMAS crews are able to contact the PTCDA service whilst with the patient at their home, followed by a triage consultation with Consultant Geriatrician or GP input. The most suitable outcome for the patient is agreed, for example inclusion on a virtual ward for observation and monitoring and/or further face-to-face assessment by a consultant or community advanced clinical practitioners.

So far, this has led to an 80% reduction in ambulances conveying frail patients to ED (from care homes in particular) and gives frail older adults an alternative to hospital admission. Where necessary, patients are then stepped up into further care as required, care plans and ReSPECT plans are updated and shared with carers and /or family and the patient's GP is informed of any changes.

B. Expand virtual wards

Ambition:
One example of better, more convenient care for patients is hospital care at home through 'virtual wards', which are bridging the gap between hospitals and patients' homes. Virtual wards combine technology and face-to-face provision to allow hospital-level care including diagnostics and treatment, using many of the same staff that work in hospitals. In some cases, virtual wards can replace the need for admission, and in others facilitate people being able to safely leave hospital sooner.

Virtual wards enable patients to remain in their own home supported by family or carers to recover more quickly in a more comfortable environment. The evidence base for virtual wards is growing, with clinical evidence to show that virtual wards are a safe and efficient alternative to NHS bedded care, particularly for patients living with frailty.

Our ambition is to scale up capacity ahead of next winter to 236 virtual ward beds with a longer-term ambition of reaching 40-50 virtual wards per 100,000 people. As well as continuing to increase capacity, we need to increase utilisation of virtual wards to 80% by September 23 so we make more of the capacity we already have.

How we will deliver:
Through winter 2022/23, we have rolled out 8 virtual ward pathways with 110 beds through investment in community provision for conditions including respiratory conditions, palliative and EoL and heart failure.

We will have 11 virtual wards by July 2023 and will aim to increase utilisation to 80% by September 23 across a broader range of conditions, with less variation and so more people can receive high-quality care from their own home.

We will increase utilisation of virtual wards from around 50% to 80% by September 2023. We will work with our local clinical and operational teams to ensure standardisation across their area to enable referrals, build patient engagement and benefit from economies of scale.

Implementation of a centralised hub to monitor and support patients to capture deterioration and offer treatment at its earliest point.

- Manage patients virtually who may otherwise need to be seen in ED
- Reduce unplanned admissions by detecting and dealing with deterioration early in disease trajectory
- Reduce length of stay on planned acute admissions, increasing throughput through both virtual and physical virtual wards.
- Reduce 90-day readmission rate by proactively monitoring for early decline
- Streamline patients into Virtual Wards for further diagnosis/treatment ensuring high utilisation of virtual wards expected from NHSE

Build on the Level 3 component (proactive care) to ensure maximum utilisation of Level 4 (Virtual wards)

This would include:

- Proactive monitoring for at risk admission groups
- Home First + model
- Tech Enhanced Living Service (e.g., in care homes)

We will support systems to build on the expansion of Home Treatment teams for people with acute health needs, with a focus on the quality of provision and therapeutic offer, underpinned by technology and data to better manage and plan care to avoid deterioration and unnecessary hospital admission.

5. Making it easier to access the right care

Ambition:
We need to ensure that the urgent and emergency care system is responsive to the needs of patients, and so people receive the right care in the right place, and in a timely way. NHS 111 is crucial to this, and we know that it can reduce demand on emergency care and be convenient for patients, especially with clinical input and oversight. But we also know that the percentage of 111 calls abandoned increased significantly during winter 2022/23 as pressures grew, and so we will need to provide more resilience to improve access for patients and reduce demand on UEC services.

Over the past ten years we have seen increased need for UEC services across all age groups and have heard in our engagement with patients that UEC services are complex to navigate.

We will make it easier for patients to access the care they need without feeling they have to go to A&E or call 999 and help make 111 online and calling 111 the first port of call so that patients can easily access the appropriate advice and be directed to the most effective care. The Fuller Stocktake recommendations, and the widespread commitment to them, provides an opportunity for services to integrate closely with all parts of primary care, so that people get the care they need, regardless of how they contact services.

Many patients will need clinical advice, and we know that can make a difference to patients, and so we are looking to better use clinicians in 111 for the patients who will benefit most. New technologies should help people to get clinical advice and be directed to the most effective care. Clinical advice to NHS 111 underpins our plan to assess and direct patients to the most appropriate point of care, whether that be self-care, pharmacy, general practice, advice from a paediatrician, mental health crisis centre, an urgent treatment centre, or another setting.

How we will deliver:
Over the pandemic we have seen the advantages of 111 online and we will further expand it through its continued promotion and development. It will be further connected with other services to mean patients are better directed to the right place. We will work to integrate 111 online with the NHS App.

We know from our engagement the importance of 111 to families. We will expand advice offered through NHS.UK and NHS 111 online to provide dedicated paediatric advice and guidance for families to support decision making around care options.

We will roll out paediatric clinical assessment services to ensure specialist input for children and young people is embedded within 111.

NHS England will undertake an extensive review of 111 services, including intensive trials of '111 First' following lessons learnt in the 2019 pilot. It will test the models and their effectiveness at directing patients to the clinicians and services who can best meet their needs with the minimum possible delay. This review will be aligned with priorities for primary care, including for community pharmacy, the forthcoming GP access recovery plan and implementation of the Fuller Stocktake report. The review will also explore the potential to incorporate advancements in technology, including AI and machine learning, within 111 services and we will work with NHS England to tailor these for our local populations.

NHS England will work with ICBs to increase 111 clinical input where it will have most impact, including to confirm which care setting is best for the patient – providing better care for patients and reducing demand on emergency services. We will ensure the clinical assessment of a greater proportion of NHS 111 Category 3 or 4 ambulance dispositions by April 2024.

Right place, right time, right care: The LLR Unscheduled care hub

The LLR system has established a system-wide Clinical Assessment Service (CAS) to remotely assess EMAS and 111 calls.

The CAS is staffed by experienced clinicians including clinicians with experience in General Practice, Integrated Urgent Care, Paediatrics, Mental Health and Emergency Medicine who are able provide the most appropriate response and where necessary direct the patient to the best care for them.

As a result, they've seen real positive outcomes on patient care, including 94% of patients who would have received a Category 3/4 ambulance response being clinically assessed as able to have their care needs met elsewhere in the community. Both patients and clinicians feel its benefits, with 93% of patients extremely likely or likely to recommend to friends and family, and 97% of clinicians would recommend working within the CAS due to the multi-disciplinary approach, the ability to learn from others as well as welcoming more hybrid roles.

We will do more to support people to access mental health support. Urgent mental health support will be universally accessible by using NHS 111 and selecting 'option 2' by April 2024. We will continue with our plans to sustain and enhance our 24/7 CCAP service, providing open access, freephone urgent mental health support for all ages, accessible using NHS 111. This will be further supplemented by future provision of 24/7 crisis text lines, which we will integrate into our local open access crisis pathways. We plan to introduce a local Mental Health Response Vehicle service by January 2024, which will work closely with EMAS to reduce inappropriate conveyance to ED.

The Directory of Services enables referrals into the most appropriate urgent care service from 111 and 999, supporting better management of patients. A platform rebuild will make it easier for staff in the NHS to direct people to the appropriate services and supports faster innovation of new services.

Some patients that come to emergency departments would get better, quicker care if they are navigated to an Urgent Treatment Centre. Locally, our clinicians have designed and implemented a consistent approach for patients who walk into the Emergency Department, which supports our patients to be seen in the most appropriate setting. Approximately 60 patients a day are being streamed to a booked appointment at a local UTC, with non-urgent patients also booked into out of hours or next-day services where appropriate. We will grow this offer through 23/24. Patients requiring minor injury or minor illness treatment will also have the option to go through to the MIaMI (Minor Illness and Minor Injury) unit for treatment, which supports our on-site UTC provision.

Right place, right time, right care: Streaming into community-based services

Streaming non-urgent patients from LRI ED to a booked appointment has been established as BAU from November 2022 at an average of 804/month from December 2022 to March 2023 with a trajectory to extend as additional sites mobilise. The profiling for introduction on a phased plan is detailed below.

Total Capacity for ED re-direction / increased acuity at Oadby	UHL/111 avg capacity (Nov 22 - Mar 23)	UHL avg capacity (Apr 23 - Jun 23)	UHL avg capacity (Jul 23 - Sep 23)	UHL/111 avg capacity (Oct 23 - Mar 24)	Un-utilised daily capacity 22/23 (yr avg)	CPCS enabled - GP referrals to CPCS (yr avg)
Oadby UTC	59	24	24	83		
Merlyn Vaz UTC	n/a	0	6	11	11	0
Merlyn Vaz OoH	9	12 (Jun 2023)	12	20	18	2
City Hub Westcotes	n/a	15	15	40	22	18
City Hub Saffron	n/a	n/a	Discussion required	10	4	6
City Hub Belgrave	n/a	n/a	Discussion required	14	7	7
TOTALS	**68**	**51** (was 77)	**57** (was 119)	**178**	**62**	**33**

- UCC and Extended Access Hub services will receive booked appointments from NHS111, UHL LRI ED Front Door or GP practice clinical triage recorded in the medical record.
- Capacity can be flexed across the wider system to minimise the number of unused appointments daily.
- Noting that streaming involves more than one contact point, it does support patient education on choice at their next time of need.

We will improve streaming from ED, urgent care services and NHS111 into Community Pharmacy services:

- CPCS baseline participation – 217/229 LLR community pharmacies
- CPCS activity baseline - 14,961 (LLR 2022/23)
  - 9,479 (Leicester City)
  - 5,482 (County & Rutland)
- CPCS trajectory – activity growth of 1% by March 2024

6. Delivering this plan

We will deliver this plan by putting in place the fundamentals that are essential to successful local delivery: a clinically led plan, accountability at every level, genuine transparency, on-the-ground support, and mechanisms to spread good practice and innovation.

A. Accountability at all levels

Delivery of the UEC recovery plan will reflect the new NHS operating framework, with alignment through the national, regional and local level, including DHSC and local authorities to ensure full involvement of social care. The LLR Integrated care board will be accountable for delivery across health, able to draw together different partners and provide a cross-system view of the interventions required for delivery.

The LLR ICB will be accountable for the relevant metrics outlined in the Operational Plan, through the services that we commission, recognising links to all parts of the system that have an impact on UEC.

Through each place-based governance structure, the LLR ICB and our local authorities will work with our provider partners to undertake systematic capacity and demand planning, with the aim of understanding the expected levels of need for social care and intermediate care services across LLR and develop shared plans to meet this need.

Local delivery
The delivery of this plan will sit with the LLR UEC Partnership and Richard Mitchell, Chief Executive of Leicester Hospitals will be the Senior Responsible Officer. The executive lead for this plan is Rachna Vyas, Chief Operating Officer of the LLR ICB.

The partnership will delivery all facets of value associated with this plan – performance improvements, equity, quality, financial improvements and resource utilization and partnerships. Advice / actions from colleagues from across the health and care system will be sought as needed.

Delivery of local plans will be also monitored by regional and national teams, providing oversight, support and intervention as appropriate to ensure delivery of the plans.

Appendix A contains the UEC Partnership Terms of Reference.

Appendix B contains the activity planning and budgets schedule.

B. Transparency

Transparent, high-quality data are important for improvement, providing insight across the whole journey but also identifying unwarranted variation.

To ensure greater transparency, more data will be made available to the public. This will be published by the LLR Integrated Care Board area by April 2023, and new metrics to monitor the effectiveness of discharge will be put in place. We will publish data on 12-hour delays from time of arrival in A&E from April, to support prioritisation of long waits as part of delivery. The public will be able to more easily see and compare the performance of their local services.

We will use data to help manage periods of high demand and increased pressure across systems and enable urgent system action. 'Faster data flows' will bring together data in a way that will reduce burdens on providers, and allow a more granular understanding of patient flow to support improvement.

C. Tiered intervention

Through national and regional teams, we will continue to work with NHS England to support and challenge ourselves to deliver this plan.

Building on experience from elective recovery and improvement in ambulance handovers, NHS England is developing three tiers of intervention, to be in place by April 2023:

- **Tier one: intensive support** – for systems off-target on delivery, support including on-the-ground planning, analytical and delivery capacity, "buddying" with leading systems and executive leadership.
- **Tier two: light touch** – for systems largely on-track, support including regional reviews and deep-dives to diagnose challenges and drive improvement.
- **Tier three: core offer** – universal support offer for systems on track, including specialty guidance, peer review and sharing of best practice.

The LLR ICB has been confirmed as Tier Three. We will work with NHS England through this approach; as with existing tiering arrangements these tiers will be reviewed frequently, and tiers will be publicly available information.

D. Reducing unwarranted variation

We will continue to embed a complementary, clinically and professionally led programme to reduce unwarranted variation. This programme will increase standardisation of what works across different areas of urgent and emergency care.

This programme will be supported by a stronger approach to improvement collaborative development. Building on the approaches of the Acute Winter Collaborative and Discharge "100 Day Challenge", subject-specific improvement collaboratives will be established to co-develop across systems and share emerging good practice, drawing on teams of experts.

E. Supporting innovation

We know that evidence is needed where innovative care is being developed. Through the national collaborative, we will work with regional and national teams to showcase where an approach is being trialed and work together to understand the benefits of scaling for spread and adoption.

Early priority areas for further exploration include models of remote clinical assessment including rehabilitation expertise, intermediate care models and virtual wards.

Name of meeting:	**Leicester, Leicestershire and Rutland Integrated Care Board**		
Date:	10 August 2023	**Paper:**	**G**
Report title:	LLR Delivery Partnership – summary report		
Presented by:	Rachna Vyas, Chief Operating Officer, NHS LLR ICB		
Report author:	Yasmin Sidyot, Deputy Chief Operating Officer, NHS LLR ICB		
Executive Sponsor:	Rachna Vyas, Chief Operating Officer, NHS LLR ICB		

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

Recommendations:

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

- **RECEIVE AND NOTE** the full contents of the report, the escalations made to each sub-committee of the Board and the revised framework being assessed for Q2

Purpose and summary of the report:

The ICB approved a one-year operational Plan and a five-year strategic plan in April 2023. The ICB has traditionally received a performance report (appendix one) in isolation to other areas of focus such as financial performance and quality assurance. This report aims to provide an integrated precis of progress against each programme area outlined in the joint system plans.

This is the first version of this integrated report; the intention of the paper is to highlight areas where programmes require support from ICB sub-committees to unlock wicked, systematic delivery issues as well as to celebrate success.

Not all Partnerships have produced highlight reports for July as each programme has its own different reporting process in place already. Equally, cost improvement programmes from providers are being triangulated across the system. These will be aligned in time for the August report to the ICB in September 2023.

Comments have been taken from the System Exec, system finance committee and the system quality committee through July, with some changes requested; these changes will be incorporated from the next report with a move to an 'assure, advise, alert' framework.

Appendices:	Appendix One – ICB performance report
Report history (date and committee / group the content has been discussed / reviewed prior to presenting to this meeting):	• The information in this report has been taken from a number of system reports, including highlight reports from the LLR Delivery Partnership.

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.*	BAF 1 – partnerships. BAF 2 – demand and capacity. BAF 5 – quality and safety. BAF 6 – EPRR.
b) Does the report highlight any resource and financial implications? If so, provide which page / paragraph this can be found within the report.	Yes, throughout paper
c) Does the report highlight quality and patient safety implications? If so, provide which page / paragraph this is outlined in within the report.	Yes, throughout paper
d) Does the report demonstrate patient and public involvement? If so, provide which page / paragraph this is outlined in within the report.	N/A
e) Has due regard been given to the Public Sector Equality Duty? If so, how and what the outcome was, provide which page / paragraph this is outlined in within the report.	Any new services / service changes will be made with due regard to the Inclusive Decision-Making Framework and the PSED

LLR Delivery Partnership – summary report
July 2023

Background

1. The LLR Delivery Partnership was established in May 2023 to drive delivery of the NHS LLR Operational Plan 23/24 and the relevant transformative plans outlined in the NHS LLR Joint Five-Year Plan 2023- 2028.

2. The newly established forum aims to be the key system forum for understanding and assuring delivery of the LLR operational plan and the LLR five-year transformative plan by exception, with the aim of identifying concerns from each partnership and either resolving these or escalating them to the most appropriate committee for support.

3. This is the first, integrated delivery report from the Delivery Partnership. The key aims of this report are to highlight areas of good practice, highlight areas of challenge and concern across the various partnerships /collaboratives and seek support where required from the system executive, system finance committee or the system quality committee. This report will be iterative and will naturally evolve, welcoming feedback from system partners to support with this.

Overall status against Operational Plan

4. This section provides a precis against each element of 'value' by partnership. It is intended to provide a *snapshot view* on performance against constitutional metrics outlined in the NHS Mandate, delivery of associated cost improvement programmes and assurance / escalations against equity and quality metrics. Partnerships will also take the opportunity in this section to celebrate successful transformation, moving the system closer to its ambition and vision. The ICB performance report is appended as Appendix 1, showing a more longitudinal view against each metric.

5. One issue to be resolved is the information used to inform performance reporting across the partnerships in particular. There is a great deal of variance in the quality and timing of reporting from national / regional / local data sets which means it is difficult to present an up-to-date view, triangulated with activity and financial reports. This is actively being worked on across the system.

6. Secondly, this report covers the programme areas of primary care, home first, major conditions, urgent care, mental health and learning disability & autism. It does not yet fully cover planned care, maternity, children's and young people and personalisation. For this month, performance against cost improvement plans has been outlined. These Partnerships are in the process of aligning their reporting in this format and this will be complete for the August report.

Primary Care Partnership – *delivered through the Primary Care Transformation Board*

Performance against Operational Plan

Standard	Plan	Actual	Status	Confidence in recovery / Year-end delivery
Everyone who needs a GP appointment gets one within two weeks and those who contact their practice urgently are assessed the same or next day according to clinical need	85-90% ranged standard	81.8 *May 23*		High All 26 PCN's have submitted high quality capacity plans, on track to deliver
Continue on trajectory to deliver more appts in general practice by March 2024	658,865	601,196 *May 23*		
Continue on trajectory to recruit ARRS roles by end of March 2024	521	521 *April 23*		High
Recover dental activity towards pre-pandemic levels		*Data not yet available*		
Overall assessment	**No escalations to System Executive**			

Finance

Team		Rag Rating	Plan	Actual / Forecast	Var	Confidence in delivery / mitigation
Primary Care	Review of associated budgets (based on outturn)	R	5,841	1,041	(4,800)	Low Mitigations being sought
Overall Assessment		**No further support required as yet from finance committee**				

Whilst delivery at M3 remains off-track, mitigating schemes are under assessment through the Primary Care transformation Board. Early assessment against M4 indicates mitigations of c£650k (clinical waste) and further efficiencies in primary care prescribing, shown against the medicines optimisation cost improvement programme.

Quality & Equity

The Primary care quality group has raised no specific unmitigated quality concerns.

From a programme perspective 2 key quality issues have been highlighted, with the potential to impact on quality and outcomes:

Issue	Action to date	Escalation
Respiratory surge w/c 11th June has highlighted the need for all age respiratory pathways to support system flow as BAU and not just specific to winter	Specification agreed for winter escalation plans; however there is no allocated budget for this in the financial plan. Equally, no financial allocation for any year-round service as it stands	Gap in service Risk to services understood – risk on quality outcomes / equity to be assessed
Phlebotomy in General Practice – a new delivery model is required across the system for primary and secondary care-initiated bloods	Risk has been added to System Quality Risk Log Business case in development	Gap in service Risk understood as part of business case process
Overall assessment	**Support required from Quality Committee to understand the risk to outcomes for these two areas**	

Successes to celebrate

Achievements	Outcome for our patients / colleagues
Significant improvement in CPCS (Community Pharmacy Consultation Scheme) referrals seen with 2,525 referrals, (a 70% increase from May). This means LLR is the highest performing system in the Midlands region for June. Since May we have seen an increase in the number of practices making referrals going from 50 to 80 practices, meaning that our patients are able to access	Patients who may not have been able to or need to access GP support on the day can access pharmacy support instead Supports practices to release GP/practice time for those who need this acuity of appointment
GP Access variation work continues with all 26 practices identified now signed up to the RCGP Programme. First wave of practices have completed the work	Tackling variation is supporting our ICB ambition to have equitable access to general practice services across LLR
89% of practices delivering against the benchmark of 75/1000 clinical contacts against a plan of 75%	
43% of same day appointments delivered against a plan of 42%	
75% of face-to-face appointments delivered against a plan of 70%	

Major Conditions inc Prevention and health inequalities - *delivered via the LTC Partnership*

Performance against Operational Plan

Standard	Plan	Actual	Status	Confidence in recovery / Year-end delivery
Increase % of patients with hypertension treated to NICE guidance to 77% by March 24	77% 23/24	80.17% *May 23*		High Plan in place
Increase percentage of patients between 25 and 84 years with a CVD score greater than 20 on lipid lowering therapies to 60%	60% 23/24	61.83% *May 23*		High Plan in place
Continue to address health inequalities and deliver on the CORE20PLUS5 approach	Part of each Partnerships plans			
Overall assessment	**No escalations to System Executive**			

Finance

There are no schemes specifically for major conditions as they are predominantly with provider CIP's, primary care or the prescribing programme. However, there are specific cost pressures in this programme area as a result of moving to a model of system finance and provider block contracts. For example, traditional prevention / optimisation / admission avoidance type schemes would have been funded as a system with agreement to shift funding across contracts across the system. In 23/24, with essentially block contracts, this has not been possible. This has resulted in a lack of funding for transformational pathways schemes. Specific examples include:

- Limited funding for ICKD project – this is a project led by UHL, which has noted better management of chronic kidney disease in the community and fewer emergency admissions. Funding for clinical time to progress this has not been found and the project is likely to cease in Oct 2023.
- Continuous Glucose Monitoring is a NICE recommended treatment, evidenced to optimise management of diabetes and will result in less acute care resource (outpatient / emergency admissions / SDEC). As funding cannot be released from contracts, this has not been funded.

There are other examples where clinicians across the system agree on a course of action to increase equity or outcomes for LLR people but teams are unable to transact due to the way in which finances have been set. This is a wicked issue that needs support to unpick so as to get the best value for the patients we serve.

Overall assessment	**Support required from Finance committee to assess and enable the movement of funds across the system to support the prevention and health inequality ambitions of the ICB**

Quality & Equity

The LTC programme has raised no specific unmitigated quality concerns.

From a programme perspective 2 key quality issues have been highlighted, with the potential to impact on quality and outcomes:

Issue	Action to date	Escalation
Diabetes management - OVIVA (type 2 diabetes structured education and behaviour change programme) The capacity commissioned requires review	Teams have discussed this with the provider, who are providing detailed referral activity to explore any variance. Alongside this, work will begin to map the diabetes service pathways to identify causation	Gap in service
Familial Hypercholesterolaemia The model of delivery has been costed on sign up of 5 ICB's and at present only 4 are participating, increasing costs to LLR	Currently looking at modifying the recruitment plan to mitigate the reduction in amalgamated funding for the overall model being hosted by Nottingham University Hospital	Potential reduction in service offer
Overall assessment	**Support required from Quality Committee to understand the risk to outcomes for these two areas**	

Successes to celebrate

Achievements	Outcome for our patients / colleagues
New provider for Type 2 Diabetes Remission Programme (Low Calorie Diet) agreed, mobilisation in progress	Part of our work on equity, this programme means that our newly diagnosed / pre-diabetic population can access a remission programme, impacting on their long term health outcomes
As part of the Integrated Chronic Disease Programme, their educational videos won the 'Excellence in Use of Technology in Pharmacy Practice'	Our patients can access a series of educational videos on chronic disease management, helping to optimise their care. These videos are accessible to all LLR patients and have a focus on targeted communities as part of our CORE20PLUS5 cohort
Local funding for Familial Hypercholesterolaemia secured and Midlands regional approach being planned	LLR is one of only a handful of ICB's without an FH screening service, impacting predominantly on our under-served communities. Launching a service locally will mean the prevention of heart attacks and strokes in our young adult population

Community health services – *delivered via our Home First Partnership*

Performance against Operational Plan

Standard	Plan	Actual	Status	Confidence in recovery / Year-end delivery
Consistently meet or exceed the 70% 2-hour community response standard	70%	92% *May 23*		High
Reduce unnecessary GP appts by streamlining direct access pathways*	Metric under assessment, no national guidance			
Overall assessment	**No escalations to System Executive**			

*Reducing unnecessary GP appointments by streamlining direct access and setting up local pathways – although the system has direct and self-referral pathways for key areas such as Falls, MSK, Podiatry and tier 2 weight management services, there is further work to do across a number of other areas where streamlining referral can reduce unnecessary GP appointments. A joint Primary Care and Home First plan is being developed.

Finance

Team	Scheme name	Plan	Actual / Forecast	Var	Rag	Confidence in recovery / Year-end delivery
Non acute	Contract changes	600	600	0		High
Non acute	BCF, discharge funding, community SDF	No overspend planned; further efficiencies being assessed				High Slippage will support system baseline
Overall assessment				**No escalations to Finance Committee**		

No other CIP has been attributed to this programme as efficiencies are logged and counted within the LPT CIP.

Quality & equity

The Home First programme has raised **one** unmitigated quality concern and one currently being reviewed by SQG.

From a programme perspective 2 key quality issues have been highlighted, with the potential to impact on quality and outcomes:

Issue	Action to date	Escalation
Individuals subject to MM Judgement regulations cannot currently be discharged without virtual bed provision, of which		Solution being brokered regionally

LLR only has a solution for 2 out of 11 potential patients		
Urgent supply of end of life and specialist medicines - current service delivery model which ends September 23.	Currently being reviewed as per SQG meeting on the 15th June. Colleagues from HF and clinical quality and performance reviewing options including completion of QIA and EIA	Gap in service
Overall assessment	**Support required from Quality Committee to understand the risk to outcomes for these two areas**	

Successes to celebrate

Achievements	Outcome for our patients / colleagues
Intermediate Care transformation plan with 6 key recommendations to improve outcomes and patient experience taken to clinical executive and supported	This supports the ICB ambition of 'right patient, right place' and will support appropriate flow across the system in readiness for winter 2023/24
Consistently achieving the 70% 2-hour urgent community response (UCR) standard	Those patients who do not require acute care are supported by MDT's within the community, supporting admission avoidance and optimisation of care in a community setting
Independent assessments of complex discharge (KPMG and Newton Europe) have shown significant improvements and realisation of benefits: 1. 70% of patients on P1 being discharged within 24 hours compared to original baseline of 8%. 2. 70% of patients who go through the LPT RRR model go back to their place of residence compared to 66% remaining in residential care without RRR model	Each of these will: • Improve the patient journey and increase trust and relationships between teams • Improve relationships with other locality functions and staff satisfaction • Improve staff satisfaction • Improve understanding of each other's services • Improve communication with patients and families and carers
Redesign of discharge pathway for Charnwood has resulted in: • Reduced amount of ongoing need for ASC services by 50% • Reduced workload of both teams by half a day a week in reduced referral timescales • Reduced costs of ongoing care by 40% • Increased patient satisfaction scores	
Creation of MDT reablement approach at the LRI has resulted in: • Referral to discharge time on average 1 day post implementation • 70% of patients discharged within 24 hours of referral	

Urgent and Emergency Care Partnership

Performance against the Operational Plan

Standard	Plan	Actual	Status	Confidence in recovery / Year-end delivery
Improve A&E waiting times so that no less than 76% of patients are seen within 4 hours by March 24	76%	55% May 23		Medium Variability remains high and risk of destabilisation through winter
Improve cat 2 response times to an average of 30 mins across 23/24	30 mins	00:32.33 *May 23*		High
Reduce General and acute occupancy to 92% or below	92%	92% *May 23*		Medium Variability remains high and risk of destabilisation through winter
Overall assessment	**No escalations to system executive**			

Finance

Team	Scheme name	Rag Rating	Plan	Actual / Forecast	Var	Confidence in recovery / Year-end delivery
Acute	Contract / pathway changes		11,990	11,023	(967)	High
Overall assessment	*The gap against the CIP attributed to UEC remains under assessment and will be driven by the new UEC collaborative / Director. However, there is significant risk against this given M3 position* - **Support required from the Finance Committee to 'unlock' opportunities via a confirm and challenge process**					

Capital and revenue funding for additional bedded capacity at UHL and LPT has been released at regional level and will support additional capacity through winter 23/24.

No other CIP has been attributed to this programme as efficiencies are logged and counted within the UHL CIP.

Quality & equity

The UEC Partnership has raised no specific unmitigated quality concerns.

Successes to celebrate

Achievements	Outcome for our patients / colleagues
KPMG analysis shows LLR to be in the least challenged category for % population attending ED, conversion rate for ED and 7/14/21 day LOS	We know these will have a direct impact on patient experience of care and staff experience of delivering care. Improvements against these metrics support the ICB vision of right place, right time.
Continual improvement against the Cat 2 response time target	Our patients will be seen within the timeframes specified and this will further continue to improve as we work with EMAS and DHU to strengthen pre-hospital pathways of care
MOFD patients without a plan stood at a peak of 288 in May 22. Through Q1, this has stood at an average of 100.	Our patients are being discharged faster – and our readmission rates in the top quartile for our frail patients meaning our discharges are safe and timely

Mental health – delivered via our Mental Health Partnership

Performance against Operational Plan

Standard	Plan 23/24	Actual	Status	Confidence in recovery / Year-end delivery
Improve access to MH support for CYP	14,553	*No data*		High Plans in place, key risks understood
Increase the number of adults and older adults accessing IAPT	27,808	*No data*		High Plans in place, key risks understood
5% increase in the no of adults and older adults supported by community mental health services	6,456	*No data*		High Plans in place, key risks understood
Eliminate out of area placements	0	0 *May 23*		High Plans in place, key risks understood
Recover the dementia diagnosis rate to 66.7%	66.7%	63% *May 23*		High Plans in place, key risks understood
Improve access to perinatal mental health services	*Plan to be set*	*No data*		Unknown Action plan in place, significant risks
Overall assessment	**No escalations to System Executive**			

Significant issue with data sharing agreement between LPT and CSU, leading to a c 3-month time lag for reporting. Local reports are being produced in the interim, leading to duplication of work across teams.

Finance

Team	Scheme name	Plan	Actual / Forecast	Var	Rag	Confidence in recovery / Year-end delivery
Non acute	Contractual changes	2,988	2,988	0		High
Non acute	MHiS / SDF	No overspend planned; further efficiencies being assessed				High Slippage will support system baseline / further schemes
Overall assessment		**No escalations to Finance Committee**				

Quality & equity

The MH Partnership has raised no specific unmitigated quality concerns.

From a programme perspective 2 key quality issues have been highlighted, with the potential to impact on quality and outcomes:

Issue	Action to date	Escalation
The number of CYP mental health inpatients much higher than expected trajectory. Numbers of children with ASD and eating disorders in crisis has increased. Lack of appropriate community provision causing delayed discharges	Business case written for planning round	EIA and QIA undertaken to evidence impact on equity and quality
Venepuncture for individuals unable to have standard blood-taking after de-sensitisation and other non-invasive interventions – MH and LDA cohorts	Currently working on a new system pathway but requires adequate investment to sustain in the long term as currently ad hoc bespoke solutions cannot be maintained. This impacts on the ability to deliver on health checks in LDA and SMI	EIA and QIA undertaken to evidence impact on equity and quality
Overall assessment	**Support required from Quality Committee to understand the risk to outcomes for these areas**	

Successes to celebrate

Achievements	Outcome for our patients / colleagues
The Launch of the rebranded Crisis cafés to "Neighbourhood Mental Health Café" and expanded to 25 cafes across LLR. There has been a rolling programme of soft and big launches of the Cafes with and the first provider network event held.	Patient experience reports for the cafes are excellent, with patient reported outcomes showing a significant increase The spread of the Cafes provides better equity of access to communities and is in line with what our communities told us during the 'Step Up To Great' consultation
Dementia Diagnosis rate increased by 2% to 64.2% and the regional average is 62.5%.	Over 200 more patients were seen this month than last – meaning faster diagnosis for our patients
NHS Talking Therapies delivering in line with recovery plan and on target to achieve agreed performance by Oct '23. Three new pathways being developed for menopause, VCS provider staff and long waiters for physical health	These new pathways are based on patient and public feedback, particularly from Health watch and our primary care colleagues. Supporting people on these pathways also helps us reach under-served communities and widens access

treatment	per se
SMI Health Checks trajectory for Q4 showed LLR achieved 16% above Midland's average and 13.9% above national target	Evidence shows that health checks support optimisation of care, particularly for our vulnerable groups. More to do from an equity perspective but the focused work has supported our ICB ambition for equity of outcomes

Learning disability and Autism – delivered through out LDA Collaborative

Performance against Operational Plan

Standard	Plan 23/24	Actual	Status	Confidence in recovery / Year-end delivery
Ensure 75% of people aged over 14 on GP LD registers receive an annual health check and health action plan	4,284	*Awaiting data*		High Plans in place, key risks understood
Reduce reliance on inpatient care for adults	30	28 *May 23*		High Plans in place, key risks understood
Reduce reliance on inpatient care for under 18's	12-15	8 *May 23*		High Plans in place, key risks understood
Overall assessment	**No escalations to System Executive**			

Finance

Covered in SDF – no escalations to finance committee

Quality & equity

The LDA Collaborative has raised no specific unmitigated quality concerns.

From a programme perspective one key quality issues has been highlighted, with the potential to impact on quality and outcomes:

Issue	Action to date	Escalation
Long waiting times for autism assessments for both children and adults. The required level of investment needed to meet the demands is significant.	Currently a clinical prioritisation and risk assessment is being undertaken.	QIA and EIA have been completed and submitted for review. This does have a significant impact on patient outcomes. The outputs of the clinical prioritisation will go to Clinical Executive.
Overall assessment	**Support required from Quality Committee to understand the risk to outcomes for these areas**	

Successes to celebrate

Achievements	Outcome for our patients / colleagues
LeDeR 100% compliance for completed reviews within timescale since August 2022 with the highest quality audit result in the region	Learning from deaths has resulted in significant pathway changes; life expectancy in LLR for this population has increased from 59 to 62 years of

	age – this supports our ambition for equity of outcome and access as an ICB

From August 2023, this paper will include information from remaining partnerships.

Summary

7. This is the first attempt to triangulate the progress and issues across all programmes of work outlined in the LLR Operational Plan, against all facets of 'value'. It should be recognised that no programme of work outlined is being delivered by a single organisation – a full 'team of teams' approach has been adopted across health and care teams, with continuous improvement at the heart of each programme area. This may be an obvious point but speaks to the sustainability of some of the successes outlined in this paper, as well as the drive for further improvements through the rest of this year.

8. It is hoped that the escalations to system executive, finance committee and quality committee will support this drive, supporting system teams to unlock difficult, wicked issues, but also provide programme teams with a sense of support from each executive. Overall assessments are as follows:

a. **Performance** – Overall rating AMBER
In terms of performance, there remains fragility within the improvements made in urgent care and elective care and these will remain under close scrutiny. Cancer standards remain off track and are of primary concern.

b. Finance – Overall rating RED
The key risk to delivery overall remains a financial risk; significant variances noted in primary care, elective care and UEC across both ICB and individual provider cost improvement programmes. Support from the finance committee against these areas will be welcome.

c. **Quality and equity –** *Overall rating not yet agreed with Quality Committee*
In terms of quality, the key risks for the system remain in CYP, although not highlighted directly in this paper, the SQG is aware of and actively supporting these risks. Other system-wide areas of focus around equity remain within the major conditions workstream.

9. In August, this will be a full programme report from all areas and will provide each committee with a fuller picture of the LLR position. Equally, finance sections from each partnership will include relevant provider cost improvement programmes as well.

Next steps

10. The format of this report is being trialled at the System Executive, System Quality Committee and the System Finance Committee through July with the intention of taking a version of this paper to the public ICB in August, evidencing progress against our one- and five-year plans. The paper will be adapted as each committee requires.

11. A revised assurance framework is being assessed based on an 'alert, advise, assure' framework for presentation to the Board on a monthly basis.

12. This is the first delivery report from the LLR Delivery Partnership. Comments and feedback are welcome on the report, specifically on the following:

    a. Does the report provide sufficient level of oversight on the delivery work programme across the partnership/collaborative?
    b. Are there any areas of the Report that can be strengthened to provide the relevant information to the ICB?

    As the Partnership develops and starts to work through the programme this report will evolve and adapt as required.

Recommendations

System Executive is asked to:

- Note the full contents of the report
- Feedback on any areas of the report that require further improvements
- Feedback on any areas where SEC require further information

System Quality Committee is asked to:

- Note the full contents of the report
- Discuss and agree a way forward for the escalations to Quality Committee

System Finance committee is asked to:

- Note the full contents of the report
- Support a deep dive for Q1 for the programme areas most at risk of delivery – planned care, urgent care and primary care

The ICB is asked to:

- NOTE the full contents of the report, the escalations made to each sub-committee of the Board and the revised framework being assessed for Q2.

NHS
Leicester, Leicestershire and Rutland

LLR ICS System Executive Committee

NHS
Midlands and Lancashire
Commissioning Support Unit

National NHS Objectives 23/24 – 31 Metrics
July 2023

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

A proud partner in the:

Leicester, Leicestershire and Rutland
Health and Wellbeing Partnership

Executive Summary

The aim of this report is to provide a high-level overview of the LLR achievement of the 31 National NHS Objectives.

18 of the objectives are reported within this report. A further 8 are in development and will be available soon. We have been in touch with our local NHSE team regarding several indicators which are ambiguous or otherwise difficult to report

- We are stable on most indicators apart from the following:

    - 65+ weeks waits continues to improve
    - We have needed to send 3 Mental health patients out of area causing 75 OOA bed days (up from 0 last month
    - Urgent care indicators have reverted to norm from an unusual April

In addition, the LLR position within the NHS Oversight framework is reported on pages 22-23. This benchmarks ICBs against over 60 KPIs and includes the best ten and worst ten performance when LLR is compared to England as a whole.

31 Priorities Summary

Area	NATIONAL NHS OBJECTIVES 2023/24	LATEST PERFORMANCE		PREVIOUS PERIOD	VARIANCE PREVIOUS PERIOD
Urgent and emergency care Link	Improve A&E waiting times so that no less than 76% of patients are seen within 4 hours by March 2024 with further improvement in 2024/25	May-23 (UHL)	55.00%	59.00%	▼
	Improve category 2 ambulance response times to an average of 30 minutes across 2023/24, with further improvement towards pre-pandemic levels in 2024/25	May-23	32min33s	30min06s	▼
	Reduce adult general and acute (G&A) bed occupancy to 92% or below	May-23 (UHL)	92.0%	90.0%	▲
Community health services	Consistently meet or exceed the 70% 2-hour urgent community response (UCR) standard *In the Ops plan template commitment to achieve on numbers*				
	Reduce unnecessary GP appointments and improve patient experience by streamlining direct access and setting up local pathways for direct referrals				
Primary care	Make it easier for people to contact a GP practice, including by supporting general practice to ensure that everyone who needs an appointment with their GP practice gets one within two weeks and those who contact their practice urgently are assessed the same or next day according to clinical need	May-23	81.8%	81.5%	▲
	Continue on the trajectory to deliver 50 million more appointments in general practice by the end of March 2024	May-23	601,196	521,148	▲
	Continue to recruit 26,000 Additional Roles Reimbursement Scheme (ARRS) roles by the end of March 2024	Apr-23	101%		
Link	Recover dental activity, improving units of dental activity (UDAs) towards pre-pandemic levels				
Elective care	Eliminate waits of over 65 weeks for elective care by March 2024 (except where patients choose to wait longer or in specific specialties)	Apr-23	3,626	4201	▲
Link	Deliver the system - specific activity target (agreed through the operational planning process)	May-23	97% admitted 92% first OP		

31 Priorities Summary

Area	NATIONAL NHS OBJECTIVES 2023/24	LATEST PERFORMANCE		PREVIOUS PERIOD	VARIANCE PREVIOUS PERIOD
Cancer Link	Continue to reduce the number of patients waiting over 62 days	May-23	546	466	▼
	Meet the cancer faster diagnosis standard by March 2024 so that 75% of patients who have been urgently referred by their GP for suspected cancer are diagnosed or have cancer ruled out within 28 days	Apr-23	70.46%	73.23%	▼
	Increase the percentage of cancers diagnosed at stages 1 and 2 in line with the 75% early diagnosis ambition by 2028				
Diagnostics Link	Increase the percentage of patients that receive a diagnostic test within six weeks in line with the March 2025 ambition of 95%	Apr-23 (Performance across all tests)	59%	60%	▼
	Deliver diagnostic activity levels that support plans to address elective and cancer backlogs and the diagnostic waiting time ambition				
Maternity	Make progress towards the national safety ambition to reduce stillbirth, neonatal mortality, maternal mortality and serious intrapartum brain injury				
	Increase fill rates against funded establishment for maternity staff				
Use of resources Link	Deliver a balanced net system financial position for 2023/24	Forecast to achieve but currently £7m off plan			

31 Priorities Summary

Area	NATIONAL NHS OBJECTIVES 2023/24	LATEST PERFORMANCE		PREVIOUS PERIOD	VARIANCE PREVIOUS PERIOD
Workforce	Improve retention and staff attendance through a systematic focus on all elements of the NHS People Promise				
Mental health	Improve access to mental health support for children and young people in line with the national ambition for 345,000 additional individuals aged 0-25 accessing NHS funded services (compared to 2019) 12 mth rolling position reported for each month	Mar-23	13695	13400	▲
	Increase the number of adults and older adults accessing IAPT treatment	Mar-23	1590	1345	▲
	Achieve a 5% year on year increase in the number of adults and older adults supported by community mental health services	Mar-23	11810	11745	▲
	Work towards eliminating inappropriate adult acute out of area placements	Feb-23	75 bed days	0 bed days	▼
	Recover the dementia diagnosis rate to 66.7%	May-23	62.80%	64.20%	▼
Link	Improve access to perinatal mental health services				
People with a learning disability and/or autism Link	Ensure 75% of people aged over 14 on GP learning disability registers receive an annual health check and health action plan by March 2024	Apr-23	104	651	▼
	Number of adults with LD/Autsim in inpatient care	May-23	28	33	▲
	Number of children with LD/Autsim in inpatient care	May-23	8	7	▼
Prevention and health inequalities	Increase percentage of patients with hypertension treated to NICE guidance to 77% by March 2024				
	Increase the percentage of patients aged between 25 and 84 years with a CVD risk score greater than 20 percent on lipid lowering therapies to 60%				
	Continue to address health inequalities and deliver on the Core20PLUS5 approach				

Urgent Emergency Care

KPI	Latest month	Measure	Target	Assurance	Varriation
Percentage seen in A&E within 4 hoursMarch 24 Targe	May 23	55%			
Category 2 ambulance average response times	May 23	00:32:33	00:30:00		
Adult general and acute bed occupancy	May 23	92%	92%		

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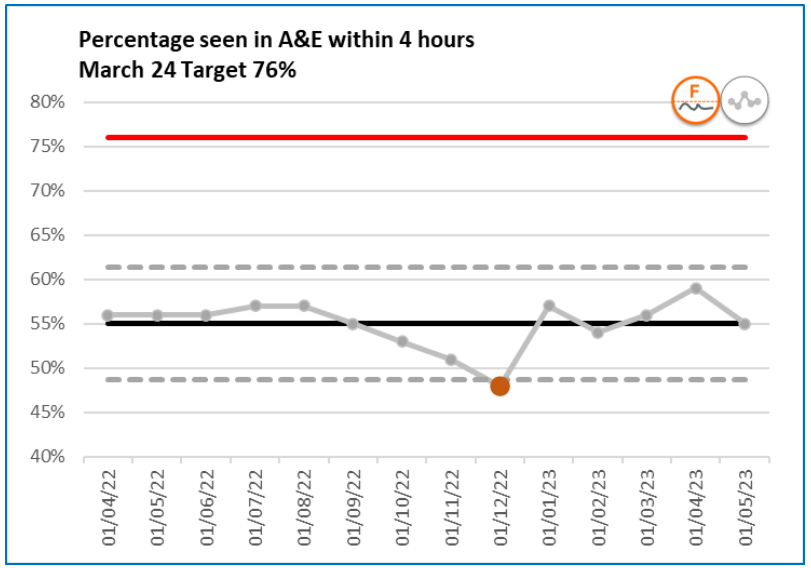
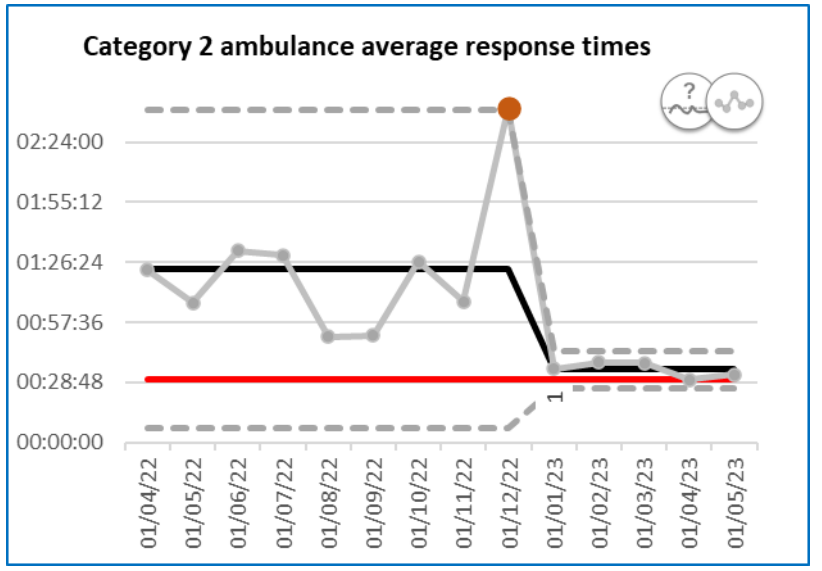
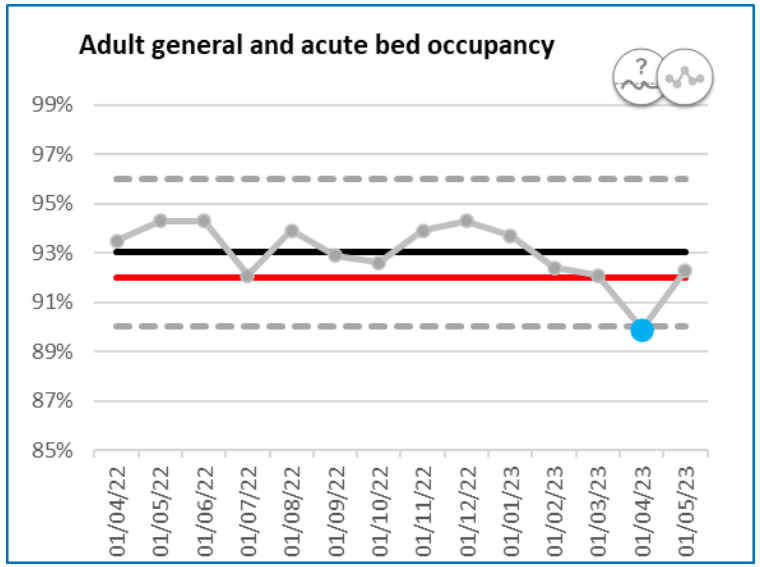
A&E 4hr target currently for May 55% against a 59% UHL local target. 76% national target to be achieved by March 2024.
ED continues to hold significant numbers of patients waiting for beds in the wider hospital, with improvements anticipated as the system intermediate care beds offer mobilises across July to September.
We are expecting to see significant improvement in February and March linked to the opening of additional bed capacity (Glenfield Hospital 2 x 28 beds plus 1 x 20 bed wards) in line with the planning round.

Urgent and Emergency Care







1 – a change was introduced in UHL for ambulance handovers so the SPC controls have been reset from this point.

	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23
Percentage seen in A&E within 4 hours	56%	56%	56%	57%	57%	55%	53%	51%	48%	57%	54%	56%	59%	55%
Category 2 ambulance average response times	01:22:43	01:07:02	01:31:48	01:29:46	00:50:44	00:51:13	01:26:41	01:07:29	02:40:20	00:35:24	00:38:19	00:38:12	00:30:06	00:32:33
Adult general and acute bed occupancy	94%	94%	94%	92%	94%	93%	93%	94%	94%	94%	92%	92%	90%	92%

Primary Care

KPI	Latest month	Measure	Target	Assurance	Varriation
Percentage with a GP appointment within 2 weeks	May 23	82%			
Appointments in general practice	May 23	601196	658,865		

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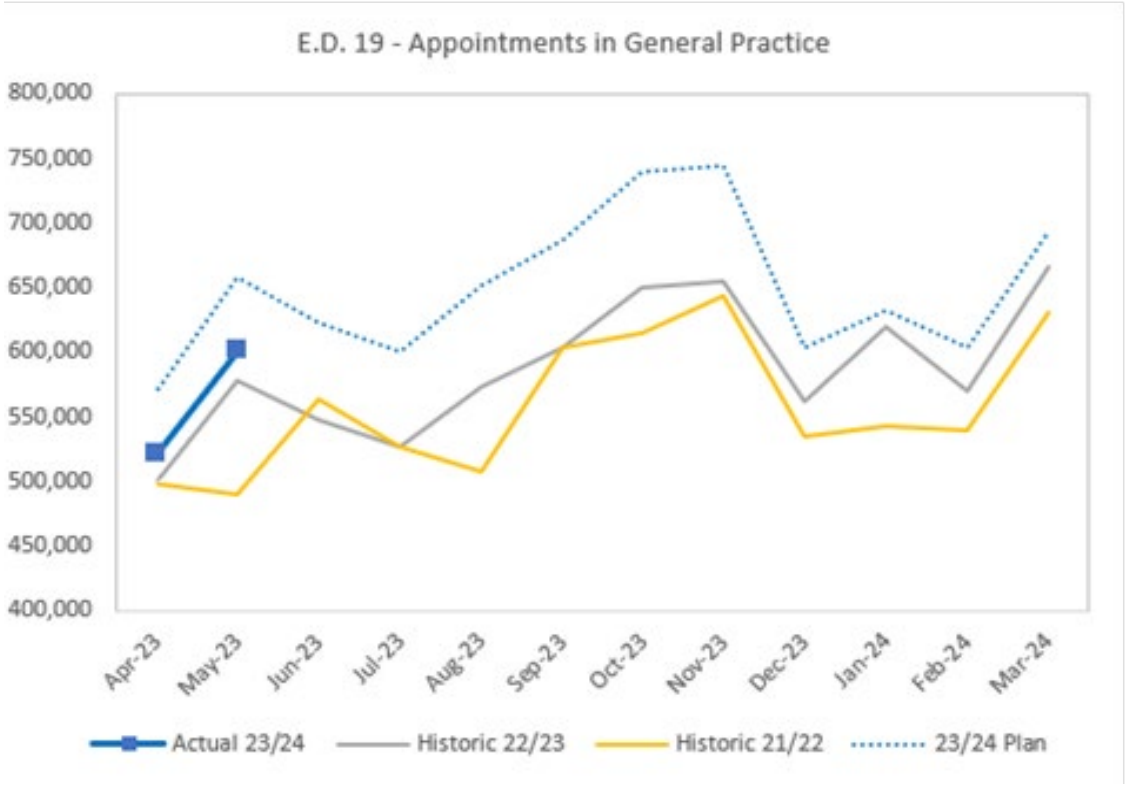
Percentage of appointments with a GP appointment within 2 weeks is being monitored through the Investment and Impact Fund (IIF). The IIF for 2023/24 has been redesigned to focus on a small number of key national clinical priorities, this metric is one of these priorities. There is specific thresholds against this measure, Lower = 85% and Upper = 90%.

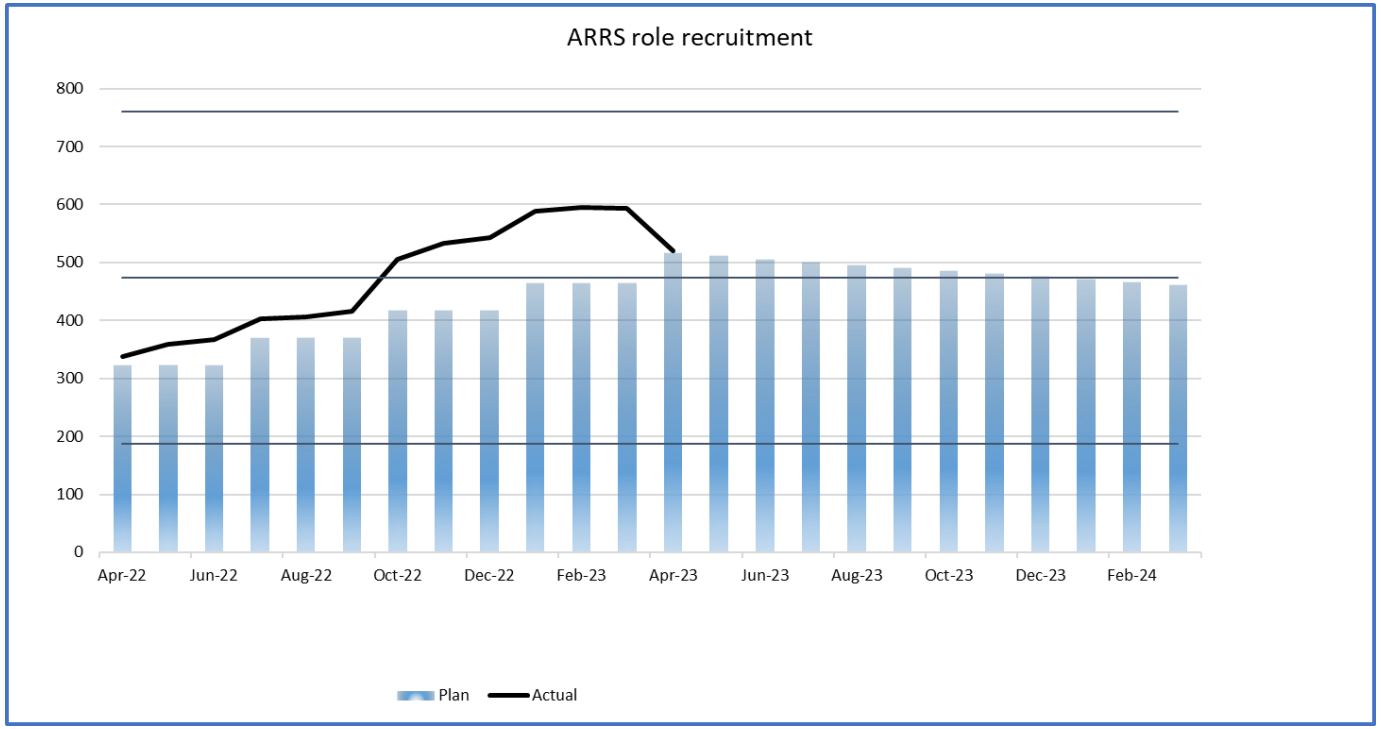
Workforce challenges reported through OPEL still remain and where possible workforce team are supporting. Appts will increase as the more ARRS roles are appointed. The lower activity will be linked to the increase in CPCS referrals which is positive for the system and patients requiring same day care. GP appointments target is part of wider System Access Recovery plan, which also includes increasing the number of self-referral pathways, implementing CPCS referral pathways and standardising Cloud Based Telephony systems.

Primary Care



	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23
Percentage with a GP appointment within 2 weeks													81.5%	81.8%
Appointments in general practice	502049	578737	547140	527692	573034	603319	650288	654370	562975	620230	570033	666861	521148	601196

Primary Care



Indicator: Continue to Recruit 26,000 (nationally) Additional Roles Reimbursement scheme by March 24

Currently LLR is over plan and looking to hold or reduce the number

April data may be underreported due to late submission of claims

	M1	M2	M3	M4	M5	M6	M7	M8	M9	M10	M11	M12
22/23	338	359	367	403	407	415	505	533	544	588	595	593
23/24	521	-	-	-	-	-	-	-	-	-	-	-

Elective Care

KPI	Latest month	Measure	Target	Assurance	Varriation
Number of 65+ week RTT waits March 24 Target 0	Apr 23	3626			
Deliver the system - specific activity target (agreed through the operational planning process)	May -23	97% admitted 92% first OP			

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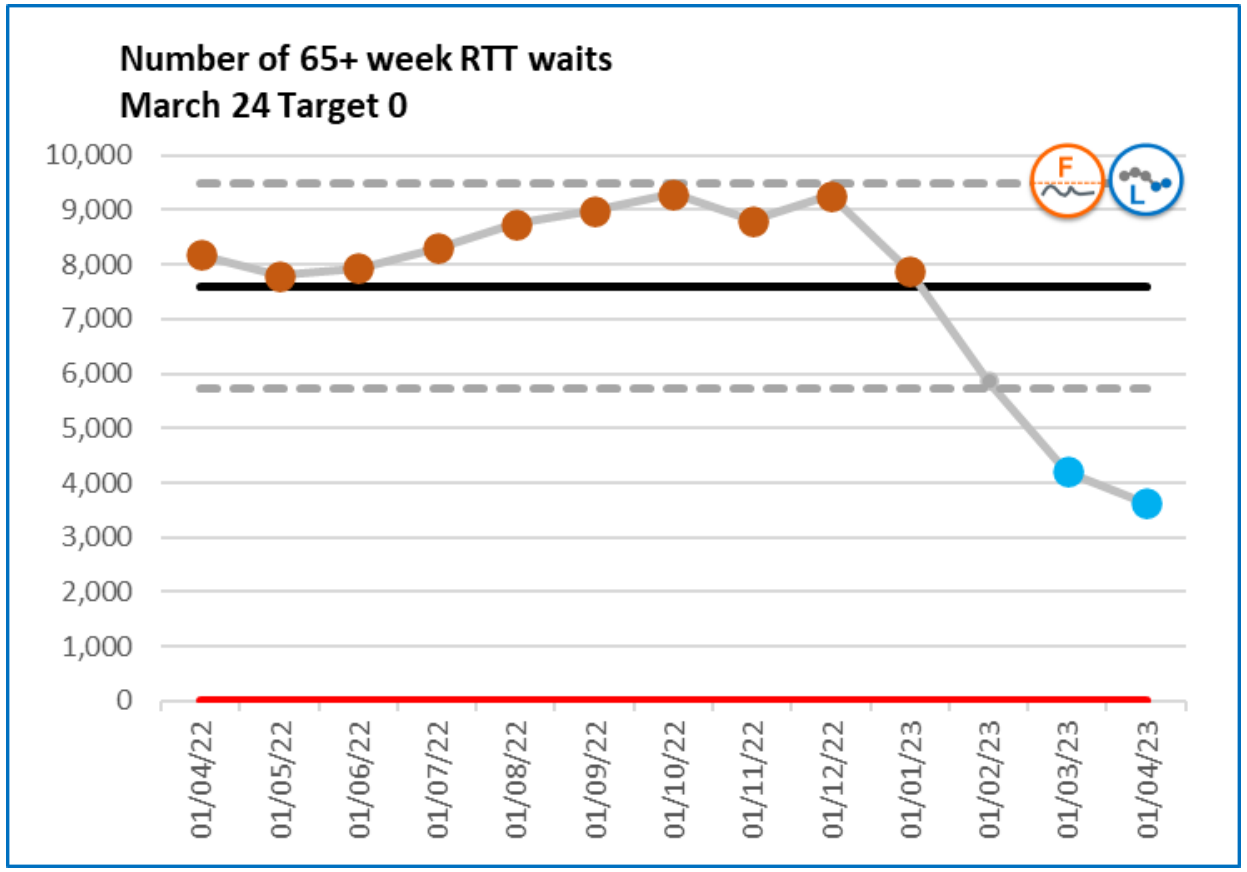
65+ week waits continue to fall
Elective activity close to achieving plan but still under for all PODs in May's data. Diagnostic activity is over plan.

Elective Care



	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23
Number of 65+ week RTT waits	8171	7801	7931	8305	8747	8993	9292	8799	9264	7867	5862	4201

Overview - Activity vs Plan vs 19/20

	LLR ICS - Elective Activity against Plan and 2019/20 activity																
	Variance % 22/23 vs 19/20												Current Month 23/24				
Point of Delivery	**April**	**May**	**June**	**July**	**August**	**September**	**October**	**November**	**December**	**January**	**February**	**March**	**May-23**	**Plan**	**Var Plan %**	**May 19/20**	**Var 19/20 %**
Total Elective	87.2%	92.6%	93.3%	87.8%	99.4%	101.3%	93.9%	100.4%	101.2%	99.7%	105.7%	154.6%	11,795	11,980	98.5%	12,147	97.1%
Daycase	87.4%	91.9%	92.3%	86.0%	98.5%	99.9%	94.5%	100.0%	101.1%	101.1%	105.9%	156.3%	10,352	10,419	99.4%	10,605	97.6%
Ordinary	85.7%	97.4%	100.1%	101.3%	105.5%	111.2%	90.3%	103.8%	101.6%	88.3%	104.8%	143.2%	1,443	1,561	92.4%	1,542	93.6%
Total Outpatient	78.2%	87.1%	85.0%	76.5%	91.2%	86.8%	76.5%	88.8%	84.1%	83.1%	85.2%	102.7%	66,449	68,763	96.6%	70,607	94.1%
Outpatient 1sts	81.1%	91.8%	91.0%	78.7%	93.3%	88.3%	80.4%	95.4%	89.1%	88.2%	97.5%	125.6%	23,662	24,908	95.0%	25,671	92.2%
Outpatient Follow-Ups	98.8%	108.5%	105.1%	97.6%	116.2%	109.3%	95.2%	108.5%	104.1%	102.5%	102.4%	120.1%	42,787	43,855	97.6%	44,936	95.2%

	LLR ICS Diagnostics Activity (DM01 Data) *																
	Variance % vs 19/20												Current Month				
Point of Delivery	**April**	**May**	**June**	**July**	**August**	**September**	**October**	**November**	**December**	**January**	**February**	**March**	**May-23**	**Plan**	**Var Plan %**	**May 19/20**	**Var 19/20 %**
MRI	102.4%	114.6%	113.1%	99.1%	105.6%	102.6%	107.6%	112.4%	105.4%	99.0%	94.6%	122.7%	6,131	5,618	109.1%	5,069	121.0%
CT Scan	101.4%	108.5%	107.4%	104.1%	115.7%	113.5%	111.2%	116.3%	106.2%	109.9%	108.5%	139.9%	11,089	9,814	113.0%	8,976	123.5%
Non-Obs Ultrasound	95.6%	91.0%	95.5%	79.9%	80.3%	84.6%	85.1%	103.1%	102.5%	102.1%	120.0%	162.2%	12,630	10,331	122.3%	10,074	125.4%
Colonoscopy	107.8%	108.9%	98.8%	93.5%	92.8%	104.2%	103.4%	115.2%	108.9%	103.1%	116.9%	199.5%	924	750	123.2%	507	182.2%
Flexi Sigmoidoscopy	101.7%	117.0%	115.9%	96.8%	94.3%	104.3%	85.6%	93.6%	88.4%	74.8%	99.8%	148.7%	420	663	63.3%	525	80.0%
Gastroscopy	113.4%	121.5%	102.2%	99.2%	103.3%	100.3%	99.7%	97.6%	102.7%	110.6%	121.4%	190.8%	1,092	1,230	88.8%	804	135.8%
Echocardiography	81.6%	88.4%	101.3%	94.2%	69.5%	68.7%	84.7%	108.1%	94.4%	119.4%	126.6%	172.4%	4694	3114	150.7%	3434	136.7%

* Please note this is Diagnostic ACTIVITY and not Diagnostic Waiting Times

Cancer

KPI	Latest month	Measure	Target	Assurance	Varriation
Number of patients waiting 63 or more days after referral from cancer PTL (UHL)	May 23	546			
Cancer 28 day waits (faster diagnosis standard) %	Apr 23	70%			

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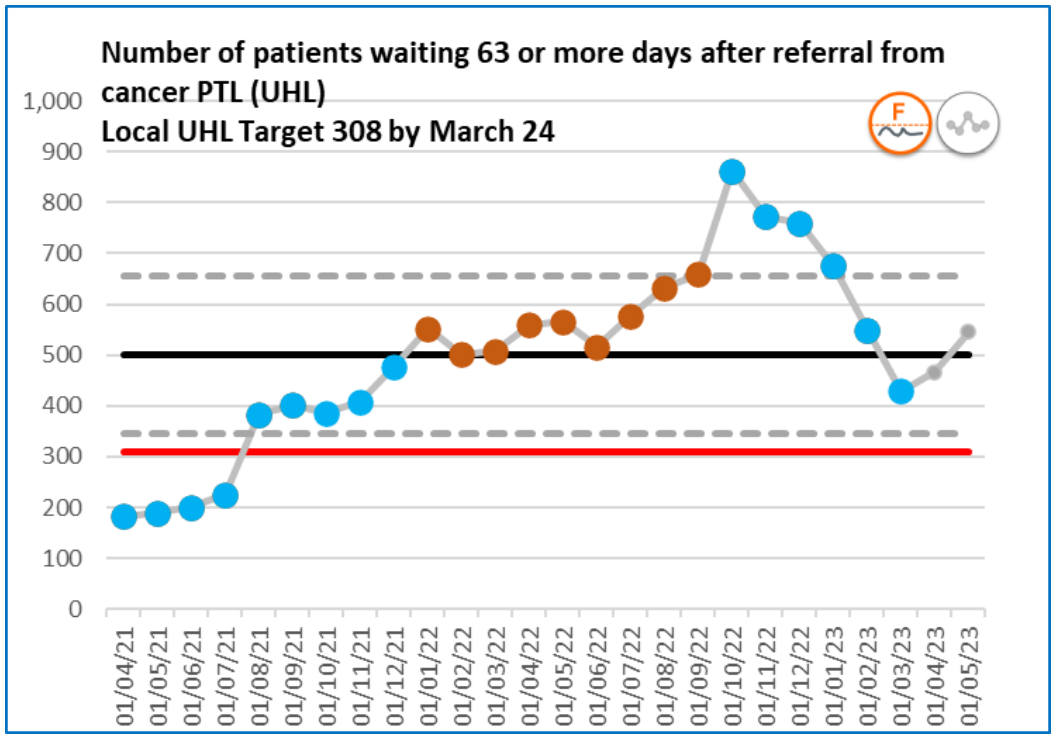
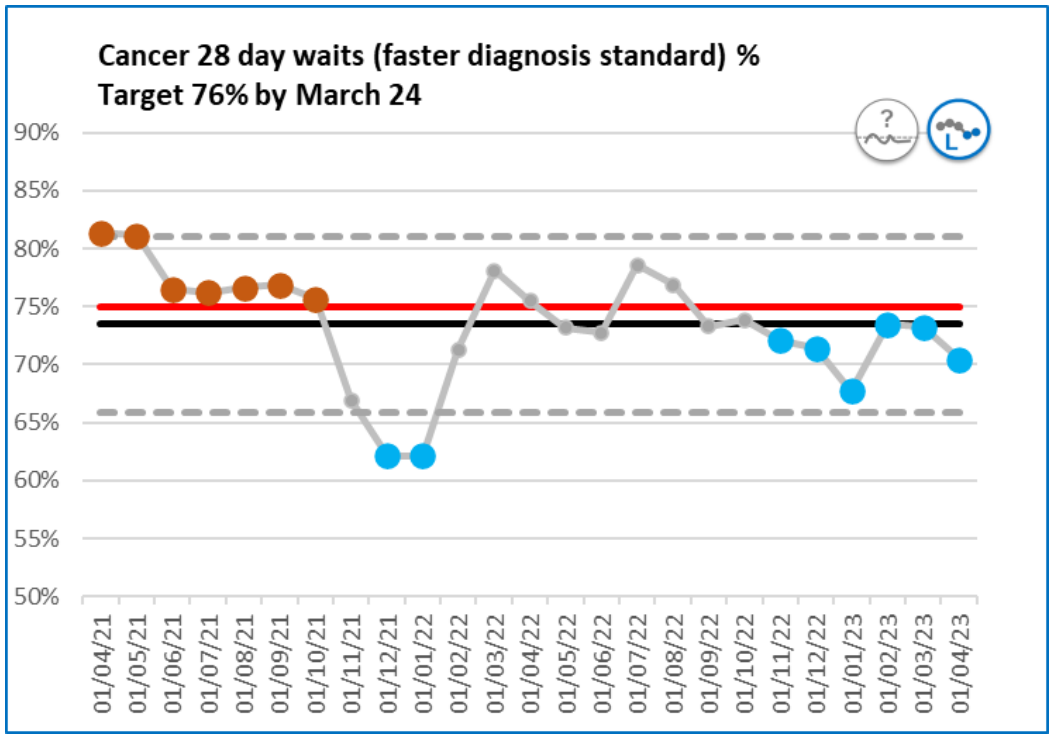
For the above measures the year end 23/24 targets have been added to the title on the graphs for information.
62 day has long been a challenge and was impacted further by COVID-19. NHS strikes further added to the disruption and you can see from the chart the start of the decline from December through to March. March however, reported the lowest quartile for all tumour sites which demonstrates the significant amount of work going on in the background to improve performance against waiting times standards.
There are various programmes in place to identify, diagnose and treat people who did not start treatment during the pandemic; reduce the number of people waiting 62 days to start treatment; to February 2020 level.

Cancer





	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23
Number of patients waiting 63 or more days after referral from cancer PTL (UHL)	560	566	517	577	633	659	863	772	760	676	550	429	466	546
Cancer 28 day waits (faster diagnosis standard) %	75%	73%	73%	79%	77%	73%	74%	72%	71%	68%	73%	73%	70%	

Diagnostics

KPI	Latest month	Measure	Target	Assurance	Varriation
Patients that receive a diagnostic test within six weeks	Apr 23	59%	95%		

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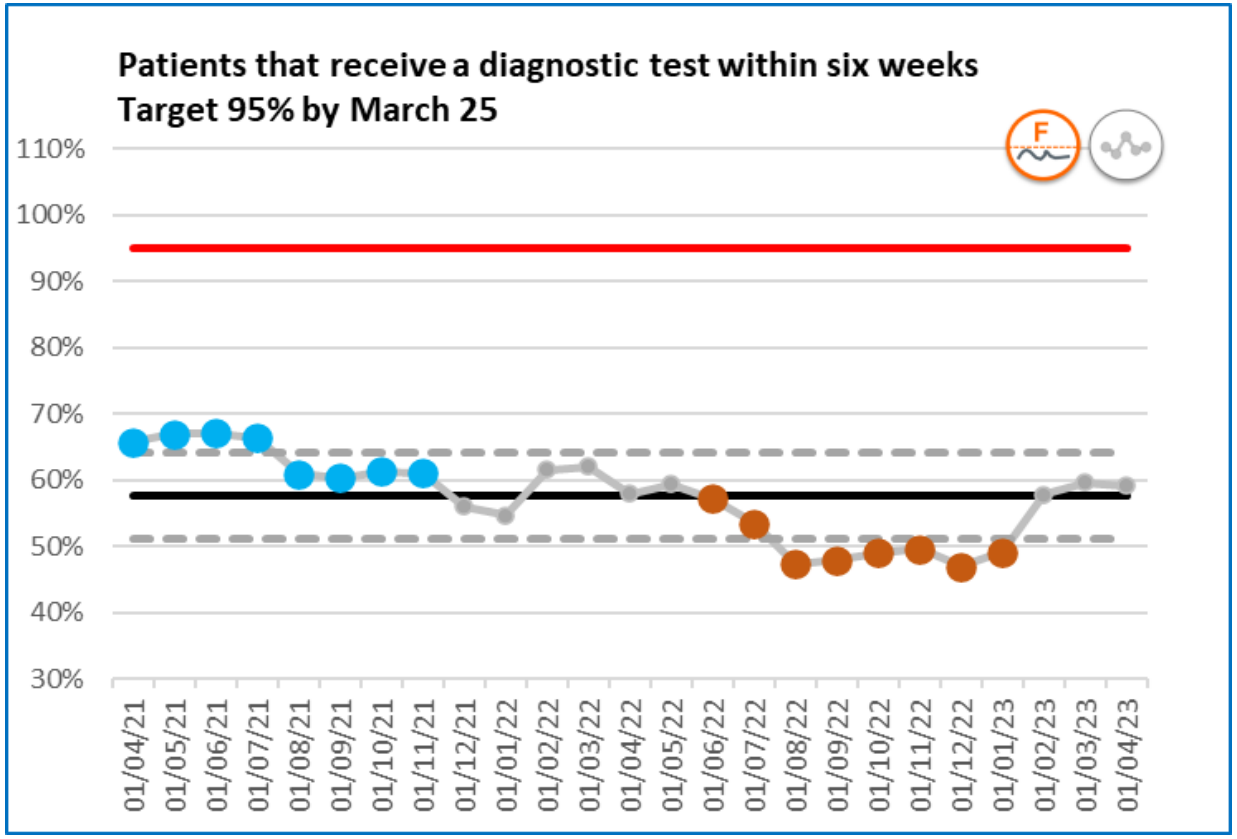
Target is 95% of patients by March 2025. We have trajectories to meet with target with an interim figure of 76% by March 2024 and are currently achieving in line with the operational plan.

Diagnostics



	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23
Patients that receive a diagnostic test within six weeks (%)	58%	59%	57%	53%	47%	48%	49%	50%	47%	49%	58%	60%	59%

Use Of Resources

System KPI Dashboard	YTD £'000			M1-12 £'000		
	Target	Actual	Rating	Target	FOT	Rating
System Delivery of planned surplus/(deficit)	(10,627)	(17,979)		(10,002)	(10,002)	
System Revenue expenditure not to exceed income	473,650	491,629		2,859,785	2,869,787	
System Capital expenditure not to exceed allocations	7,567	6,101		114,195	114,195	
System Operates within Cash Reserves	96,826	101,938		115,305	115,305	
ICB Running Costs Allocation not to be exceeded *(included within system position)*	3,398	2,853		20,385	14,385	
ICB Primary Care Co-Commissioning Allocation not to be exceeded *(included within system position)*	32,525	32,929		195,148	198,339	
ICB Newly Delegated Allocation not to be exceeded *(included within system position)*	15,034	16,073		91,398	91,398	
System CIP delivery	13,976	9,897		148,336	128,103	
System Better Payment Practice code % NHS invoices paid within target (£)	95%	96%		95%	96%	
System Better Payment Practice code % NHS invoices paid within target (number)	95%	92%		95%	92%	
System Agency spend within ceiling				45,392	55,555	
ICB MHIS spend requirement to meet target				185,518	185,582	
ICB Performance against ERF Allocation	6,849	4,924		53,953	53,953	

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Currently reporting to achieve our planned deficit of £10m by year end; this will require significant improvement from our YTD position of £17m deficit.

Currently LLR ICB is achieving 5/11 of the indicators

Mental Health

KPI	Latest month	Measure	Target	Assurance	Varriation
Age 0-18 accessing mental health support (12 month rolling) 23/24 Target 14,553	Mar 23	13695			
Adults accessing IAPT treatment 23/24 Target 27,808	Mar 23	1590			
Number of adults and older adults supported by community mental health services (12 month rolling) - 23/24 Target 6,456	Mar 23	11810			
Adult acute out of area placements (Bed days 3 months rolling) 0 Target	Feb 23	75	0		
Dementia diagnosis rate	May 23	63%			

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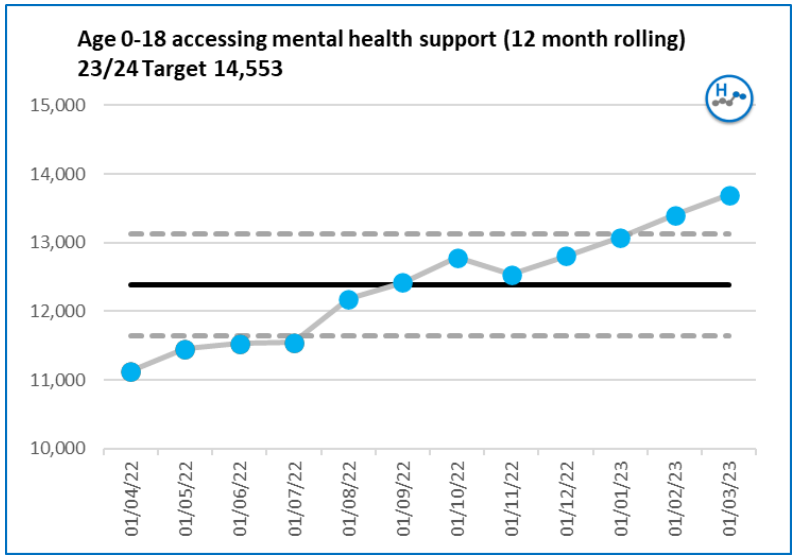
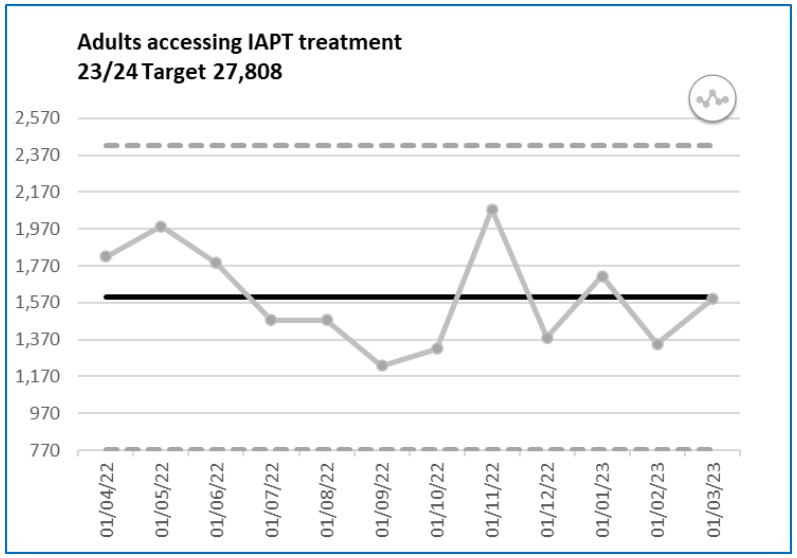
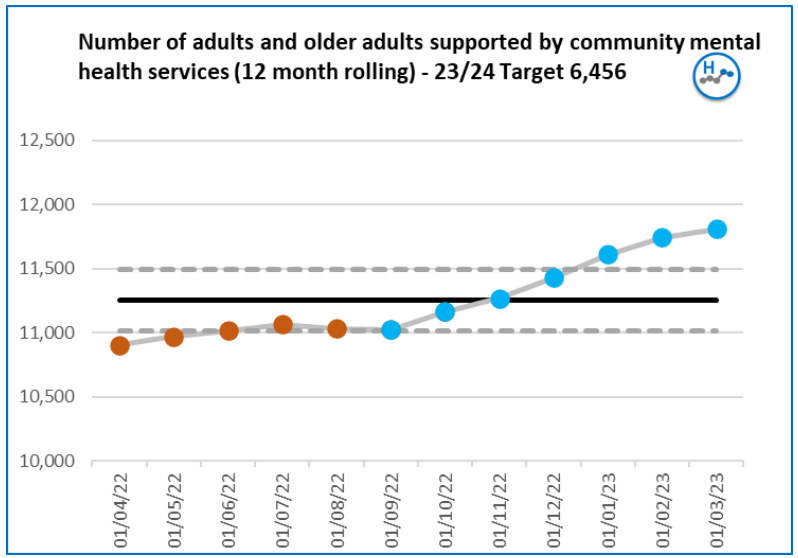
With the exception of out of area placements, the measures above do not have monthly trajectories against them. The year-end 23/24 targets are added to the titles on the graphs for information.
For the out of area patients from April this will show 0 as all patients were repatriated. NHSE were aware that we had to send 5 people out of area due to LPT having no beds and Opel4 for over 2 weeks.

Mental Health



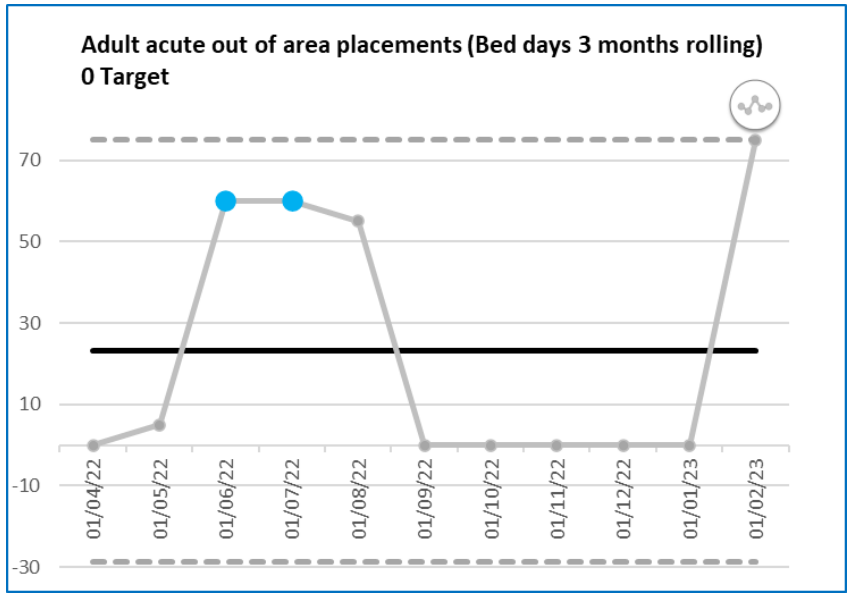


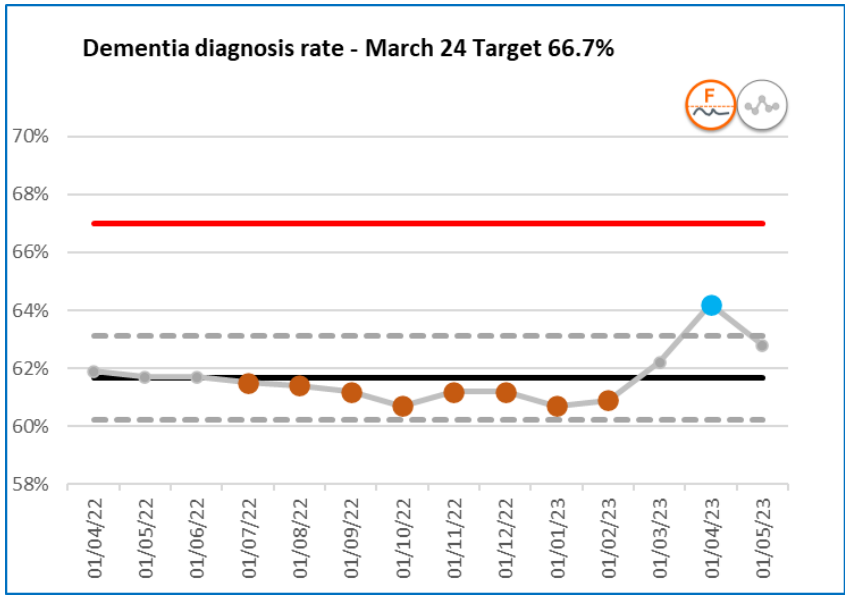


The national objective for the CYP MH access is to compare the current data to 2019 for 0-25. There is no data in 2019 for 18-25 year olds. The measure above compares to the Operational Plan for 23/24 (as a proxy measure).

	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23
Age 0-18 accessing mental health support (12 month rolling)	11133	11454	11534	11545	12180	12420	12785	12535	12805	13075	13400	13695
Adults accessing IAPT treatment	1820	1985	1785	1475	1475	1230	1320	2075	1380	1715	1345	1590
Number of adults and older adults supported by community mental health services (12 month rolling)	10904	10973	11018	11065	11035	11025	11165	11270	11430	11610	11745	11810

Mental Health





	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23
Adult acute out of area placements (Bed days 3 months rolling)	0	5	60	60	55	0	0	0	0	0	75			
Dementia diagnosis rate	62%	62%	62%	62%	61%	61%	61%	61%	61%	61%	61%	62%	64%	63%

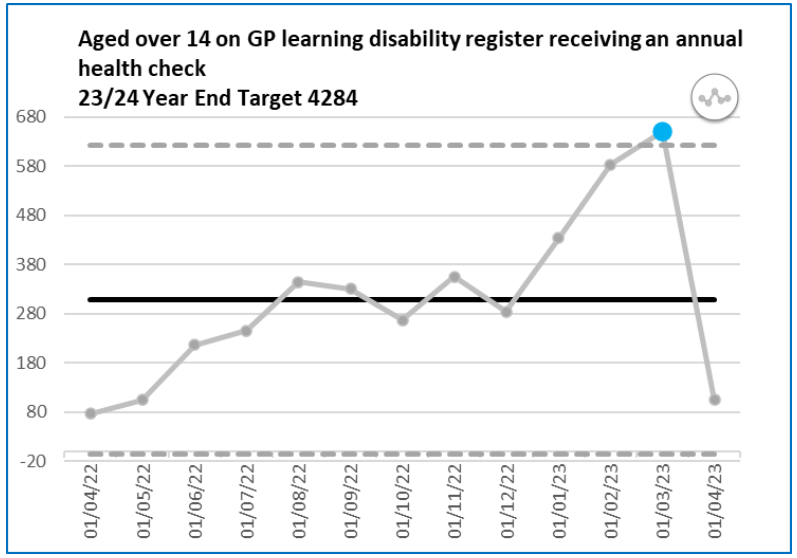
People with a Learning Disability and/or Autism

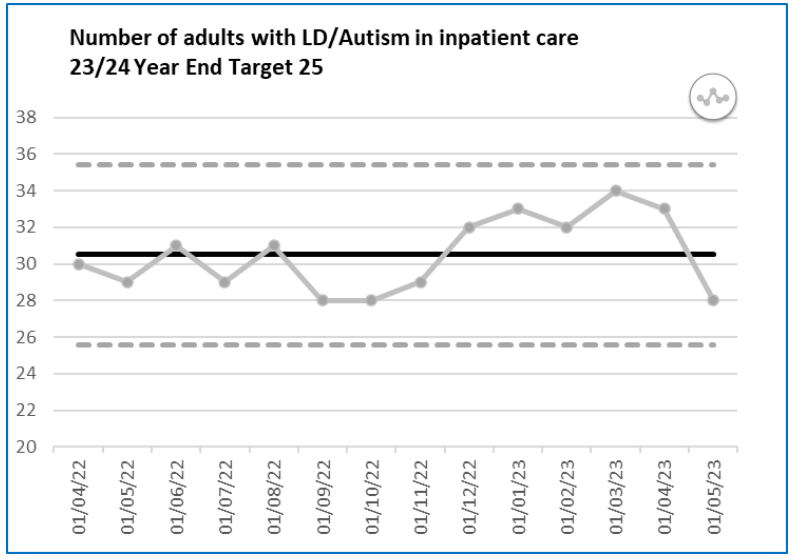
KPI	Latest month	Measure	Target	Assurance	Varriation
Aged over 14 on GP leaming disability register receiving an annual health check	Apr 23	104			
Number of adults with LD/Autism in inpatient unit	May 23	28			
Number of children with LD/Autism in inpatient unit	May 23	8			

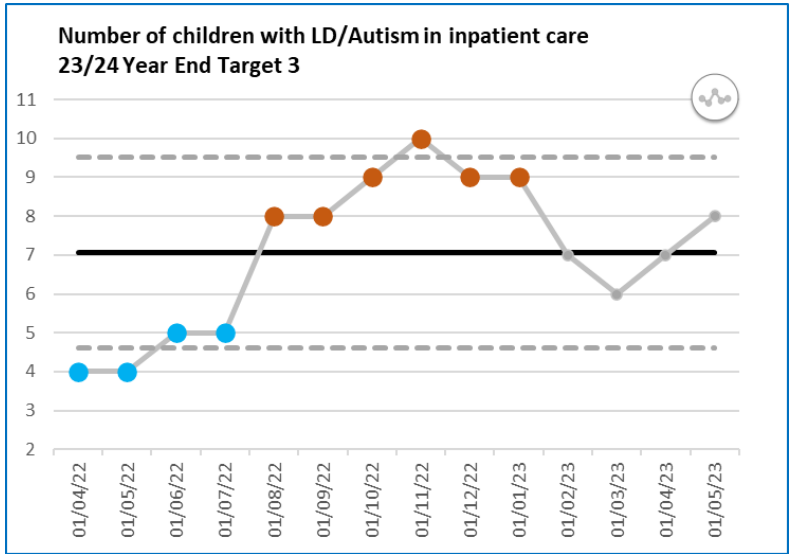
Return to contents

The LD measures do not have monthly trajectories against them. The year-end 23/24 targets are added to the titles on the graphs for information. There is a trend where LD health checks are driven towards the end of the financial year, hence the peak in data towards year end. Prior to April 21 the data was reported nationally on a quarter basis.

People with a Learning Disability and/or Autism







	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23
Aged over 14 on GP learning disability register re	77	105	216	245	344	330	267	355	284	434	583	651	104	
Number of adults with LD/Autism in inpatient un	30	29	31	29	31	28	28	29	32	33	32	34	33	28
Number of children with LD/Autism in inpatient u	4	4	5	5	8	8	9	10	9	9	7	6	7	8

NHS System Oversight Framework

In Jan 22 NHSE/I provided an update on performance data for a number of key metrics from the 22/23 NHS System Oversight Framework (SOF). For LLR ICB the following table provides the Highest 10 rank positions against all reporting ICB's, according to the nationally produced dataset.

Region	Organisation Type	Organisation	Categories	Apply colour coding for National Averages
Midlands	ICB	Leicester, Leicestershire & Rutland ICB	All	No

	Indicator	Aggregation Source	Latest Period	Previous	Latest		Target / Nat Ave*	National Value	Rank
S063c	Proportion of staff who say they have personally experienced harassment, bullying or abuse at work from patients/service users, ...	ICB	2022	22.8%	23.1%	↗			1/42
S116a	Proportion of adult inpatient settings offering tobacco dependence services	ICB	2023 03	100.0%	100.0%		100%	28.1%	1/42
S053a	% of atrial fibrillation patients with a record of a CHA2DS2-VASc score of 2 or more who are treated with anticoagulation drug th...	SubICB	2021-22	91.3%	92.1%	↗	90%	89.0%	2/42
S074a	FTE doctors in General Practice per 10,000 weighted patients	ICB	2023 04	6.6	6.6	↗	5.7*	5.7	3/42
S084a	Number of children and young people accessing mental health services as a % LTP indicative trajectory	ICB	2023 03	118.2%	121.4%	↗	100%		3/42
S110a	Access rates to community mental health services for adult and older adults with severe mental illness	ICB	2023 03	336.2%	336.6%	↗	100%		4/42
S108a	Number of Completed Referrals to Community Pharmacist Consultation Service (CPCS) from a general practice	ICB	2023 02	150.9	150.8	↘	86.2*	86.3	5/42
S085a	People with severe mental illness receiving a full annual physical health check and follow-up interventions as a % of LTP indicativ...	ICB	2023 03	94.5%	104.4%	↗	100%	91.3%	6/42
S013c	Diagnostic activity levels: Endoscopy	SubICB	2023 03	112.7%	110.2%	↘	120%	92.6%	7/42
S053b	% of hypertension patients who are treated to target as per NICE guidance	SubICB	2021-22	50.0%	62.9%	↗	80%	60.4%	7/42

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NHS System Oversight Framework

For LLR ICB the following table provides the Lowest 10 rank positions against all reporting ICB's, according to the nationally produced dataset.

	Indicator	Aggregation Source	Latest Period	Previous	Latest		Target / Nat Ave*	National Value	Rank
S041a	Clostridium difficile infection rate	Provider	2023 04	144.1%	155.4%	↗	100%	129.1%	38/42
S042a	E. coli bloodstream infection rate	Provider	2023 04	132.4%	139.5%	↗	100%	122.1%	38/42
S081a	Access rate for IAPT services	ICB	2023 03	60.6%	57.6%	↘	100%		38/42
S044b	Antimicrobial resistance: proportion of broad-spectrum antibiotic prescribing in primary care	SubICB	Apr 2022 - Mar 2023	9.3%	9.2%	↘	10%	7.8%	39/42
S009b	Total patients waiting more than 78 weeks to start consultant led treatment	Provider	2023 04	837	584	↘	261.4*	10,979	40/42
S009b	Total patients waiting more than 78 weeks to start consultant led treatment	SubICB	2023 04	840	601	↘	263.1*	11,051	40/42
S104a	Neonatal deaths per 1,000 total live births	ICB	2021	1.52	2.41	↗	1.6*	1.6	40/42
S010a	Total patients treated for cancer compared with the same point in 2019/20	ICB	2023 03	105.2%	81.8%	↘	100%		41/42
S022a	Stillbirths per 1,000 total births	ICB	2021	4.1	5.05	↗	3.5*	3.52	42/42
S041a	Clostridium difficile infection rate	SubICB	2023 04	161.4%	169.1%	↗	100%	116.8%	42/42

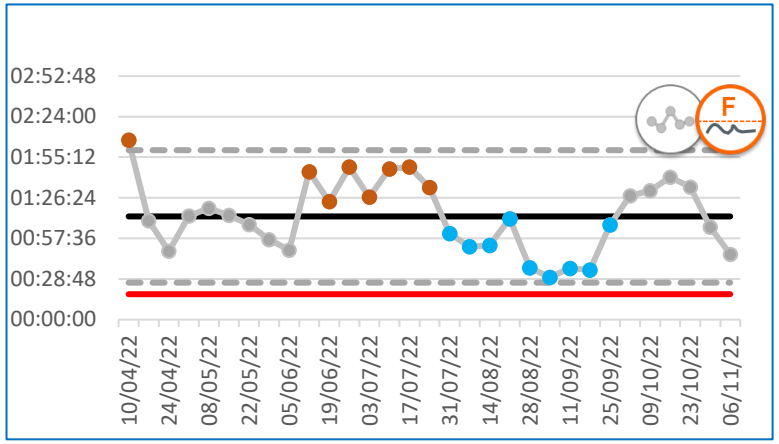
LLR benchmarks high on a number of infection indicators. However, we are under our local trajectories and these figures have been discussed with our regional IPC lead who has raised no concerns. There is an ongoing programme to improve these.

Whilst we have seen a gradual reduction in the number of stillbirths towards our baseline in 2018-2019, we currently have a higher number of neonatal deaths compared to previous years. A review of the deaths from 2020 has been undertaken and has not identified any worrying theme within the PMRT reports. Following on from that UHL have sought advice from the MBRRACE-UK team on next steps and have a comprehensive plan in place to reduce

Making Data Count Approach

The Making Data Count (MDC) approach uses Statistical Process Control (SPC) charts along with rules and icons to provide a more effective summary of performance. Further details can be found: https://www.england.nhs.uk/publication/making-data-count/

How to read the chart



SPC charts will only work when there is an annual target, therefore some measures are shown as a standard line graph.

The charts show:

- data over time
- against a target
- with a median
- upper and lower control limits

The individual data points colour can indicate:

- special cause variation of particular concern
- special cause variation indicating improvement
- no significant change (common cause variation)

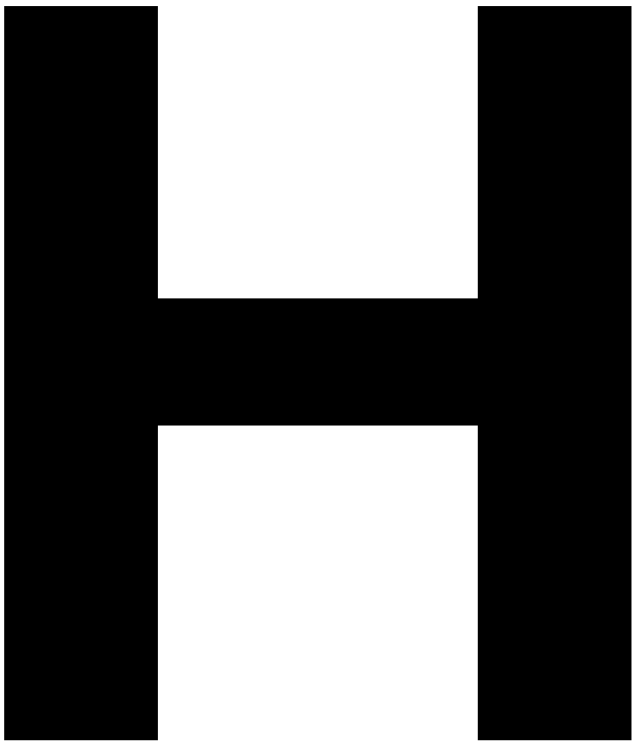
The symbols are based on the last 6 data points and show:

Variation (direction of travel):

- concerning special cause
- improving special cause
- no special cause

Assurance (capability):

- failing process
- capable process
- unreliable process (flip flop)



Name of meeting:	**Leicester, Leicestershire and Rutland Integrated Care Board**		
Date:	**Thursday 10 August 2023**	**Paper:**	**H**
Report title:	**LLR ICB Finance Report**		
Presented by:	Caroline Gregory, Chief Finance Officer, LLR ICB		
Report author:	Caroline Gregory, Chief Finance Officer, LLR ICB		
Executive Sponsor:	Andy Williams, Chief Executive, LLR ICB		

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

Recommendations:

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

NOTE this update to the report presented at the last Board meeting, on the work that is progressing to address the financial challenges and risks which have materialised across the LLR system in 2023/24.

Purpose and summary of the report:

1) The purpose of this paper is to build on the last update provided to the Board in July. It describes the financial challenges manifesting themselves across the system based on the latest month 03 information.

2) It provides an update on the system position and outlines the actions which are taking place to get back on track to deliver to the financial target by year end.

3) Four priority areas have been agreed through System Executive; these were shared with the Board last month and have now been assessed to determine the level of financial opportunity.

4) Further consideration is being given to additional measures to enable the ICB to develop a balanced plan for 2023/24.

Appendices:	• Appendix 1- Finance Report for Month 03
Report history (date and committee / group the content has been discussed / reviewed prior to presenting to this meeting):	Input and steer have been sought at the following meetings: • EMT/ODG 26 June 2023 • System Executive 30 June, 14 July and 28 July 2023

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

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

Implications:	
a) Does the report provide assurance against a corporate risk(s) e.g. risk aligned to the Board Assurance Framework, risk register etc? *If so, state which risk and also detail if any new risks are identified.*	Impact of financial challenges on BAF risk and risk register aligned to Financial Sustainability as overseen through Finance Committee
b) Does the report highlight any resource and financial implications? If so, provide which page / paragraph this can be found within the report.	Yes, the report focuses on the financial situation in 2023/24 and resource implications associated with addressing risks and pressures
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.	Not in the context of this paper.
e) Has due regard been given to the Public Sector Equality Duty? If so, how and what the outcome was, provide which page / paragraph this is outlined in within the report.	Not in the context of this paper.

2023/24 LLR Financial Challenges

31 July 2023

Introduction and Background

1. The purpose of this paper is to provide an update to the LLR ICB Board on the financial position based on the month 03 financial report and reflecting further known risks.

2. To recap, LLR submitted a financial plan with a financial deficit of £10m at the end of March. The level of CIP required to achieve this was over 6%; twice what the system had delivered in the prior year.

3. At month 02 we reported an adverse variance to plan of £7.4m, which was shared with the Board at its July meeting; this has increased at month 03 to £10.4m (UHL £7.2m, ICB £3.1m, LPT £0.1m).

4. Given the challenges/risks present in our plans, all organisations have stepped up financial recovery programmes to ensure plans are enacted and efficiency delivery is maximised. These include: identifying focused resources to lead financial recovery, enhanced recovery workstreams and programmes, clear governance to support delivery and the implementation and embedding of NHSE financial controls.

5. We have recognised the need to go further to identify collective opportunities across the system which could start to yield cost reductions and benefits in year. At the July Board meeting members were informed of four areas which were being urgently reviewed: planned care, urgent care, workforce and medicines management. The aim was to determine the scale of financial opportunity to mitigate the financial pressures being experienced across the system and return to the planned deficit of £10m.

6. **ICB position**

7. The ICB is currently reporting a year-to-date deficit of £3.1m at the end of month 03 due predominately to under delivery against its cost improvement programme (CIP).

8. It has identified a range of risks against its CIP and the Executive Management Team reviewed these prior to the July Board meeting to establish which schemes would not deliver, those that were actively being managed and were deemed difficult to achieve and those that we were getting back on track.

9. In July, the ICB Board recognised the pressures arising from the schemes which would no longer deliver and requested alternative areas be pursued to identify opportunities to address the shortfall.

10. Early consideration of further additional measures to enable recovery is underway. These include phased or part year expenditure in relevant areas (with a risk assessment of impact) and containment of spend. Further work will be undertaken to understand feasibility and a proposed break-even plan will be submitted for consideration by the Board in September.

11. It is worth acknowledging that the ICB has strengthened the governance arrangements in place to ensure that tight controls are in place:

    a. Executive Management Team considered the NHSE financial controls at its meeting on the 10 July to ensure they are all in place.
    b. As part of its 20% Running Cost reduction, the Executive Team revisited its vacancy panel process to ensure a range of alternative options are considered before replacing on a like for like basis.
    c. Updated ICB CIP scorecard and frequency of reporting through to Executive Team.
    d. Enhanced role of Partnerships/Collaboratives reporting through to Delivery Partnership on achievement of operational plan targets, including delivery of associated CIP.
    e. Robust process for reviewing and approving business cases to ensure a range of criteria are considering covering clinical, workforce and financial aspects.

12. **LPT and UHL positions**

13. UHL year-to-date position at month 03 is a £21.9m deficit, £7.2m worse than plan. They have identified that the most significant factor impacting on this adverse variance is the cost of the industrial action, the remainder being predominately due to excess inflationary pressures.

14. LPT is reporting a year-to-date slight deficit of £0.1m and is working to its financial target of break even.

15. Both organisations are refocusing on their recovery actions to mitigate risk and deliver to plan, with an emphasis on delivering existing CIPs and, in particular, workforce aspects.

16. **Strengthened Workstreams.**

17. The Board were informed in July that further system -wide recovery across LLR would focus on improving productivity, reducing cost base, and avoiding duplication across areas of ‘overlap’ between sectors and organisations. This additional systemwide programme covers four areas where evidence indicates significant opportunity for gain:

    a. UEC/Urgent care- efficient and effective use of bedded capacity.
    b. Planned care- decreasing backlog and streamlining follow ups.
    c. Medicines management- reducing waste and focusing on up front treatment.
    d. Workforce- reducing reliance on agency and improving productivity.

18. The expectation was these schemes would deliver savings to cover materialising risks. The impact of these workstreams is detailed below:

19. **Medicines Management.**

20. A presentation was given at System Executive on the 14 July which outlined the current level of saving targets across each organisation for 2023/24, the progress being made and options to deliver more.

21. The approach to additional savings covered: benchmarking with other systems/trusts on overall spend, use of drugs, review of electronic tools, discussions with regional leads, Lead Pharmacists, review of performance and pace of existing schemes for opportunities to extend.

22. The overall opportunity has been scoped for 2023/24 but this may be reduced if it is deemed clinically appropriate to invest in other areas. Additional support from the ICB has been identified to support this workstream.

23. NHSE have identified significant variation in both the forecast and observed medicines efficiency savings and will shortly be releasing guidance with tailored information for each ICB which describes medicines optimisation opportunities for the NHS in 2023/24, and signposts to resources to help with their implementation.

24. **Workforce**

25. System Executives on the 14 July reviewed the current workforce position across LLR to determine the additional cost-out opportunities for workforce and specifically considered accelerated action relating to agency cost reduction.

26. The magnitude of the financial opportunity from this workstream will be derived from two main areas:
    a. Strengthened planning and management controls to enable costs to be contained within the LLR agency cap.
    b. Stopping agency procurement outside of agreed frameworks.

27. System Executive were asked at their meeting on 28 July to consider opportunity for additional savings by undertaking a root-cause analysis of over-expenditure on workforce pay bill and by assessing associated options to reduce cost. Partners felt this could be best served by ensuring actions as described above were being taken forward with robust processes and controls in place.

28. **Planned Care**

29. The opportunity across Planned Care as discussed at the System Executive meeting on the 14 July is very much focused on ensuring best practice productivity whilst continuing to reduce waiting lists. There will be enhanced clinical and operational oversight to maximise opportunities to enhance ERF income and to optimise the impact of new delivery arrangements including patient initiated follow ups.

30. **Urgent Care**

31. As part of the 2023/24 planning round collaborative urgent care arrangements were agreed enabling a joint focus on all key operational, clinical, and financial aspects. In the context of the current financial position three areas are the subject of particular attention:

    a. Productivity- ensuring optimal use of current capacity, making sure it is being used appropriately, enabled in part by timely discharge arrangements.
    b. Value- ensuring best value can be demonstrated through benchmarking the cost of beds and shifting away from non-recurrent to recurrent models and savings.

c. Utilisation-ensuring maximum utilisation of available beds.

32. **Conclusion**

33. The recent review undertaken to explore additional financial benefits across four workstreams has been extremely positive. However, the likelihood of finding significant savings beyond the current CIP programmes is limited. The impact of these workstreams is therefore to strengthen the prospects of delivering the existing CIP programmes.

34. As we head into August ongoing work is in train focusing on:

    a. articulating in more granular detail the nature of the financial pressures being felt across the system. These pressures need to be described in the context of the many positive areas of delivery, but we need to be clear about areas where we should strengthen our planning and implementation processes. We also need to be clear about the factors which are causing pressure and are significantly outside of our control such as inflationary pressures and industrial strikes,
    b. ensuring all NHSE financial controls are embedded and working effectively enabling robust performance monitoring and escalation,
    c. consistent understanding and appreciation of risk appetite across the system,
    d. reviewing run rate and approach to forecasting,
    e. road testing impact of medium-term financial plan to delivery to sustainable financial position.

35. The System Prioritisation Group will be convening in August to work through the Equality and Quality Impact Assessments and Clinical Prioritisation of unfunded business cases, and it is likely that there will be clinical risk that is not fully mitigated due to the decisions not to invest made as part of the planning round. Clinically, these risks are materialising and are being reviewed by System Quality Group and Clinical Executive discuss. There is a significant probability of a need to invest in some pathways and this will offset the size of any savings achieved.

36. The role of the Finance Committee in providing oversight and assurance is pivotal and a stocktake on Q1 was held in July reviewing progress being made across Delivery Partnership.

37. Nationally any movement away from our year forecast position must adhere to national guidance. It is likely that we will be asked to self-assess ourselves against defined protocols.

Recommendations:

NOTE the financial challenges and risks across LLR system for 2023/24 and the actions which are being put in place to address these to ensure organisation and system financial targets are delivered by year end. Detailed proposals to mitigate ICB risks will be taken to a September ICB Board meeting for consideration.

Appendix 1

Finance Report Month 03 2023/24

10th August 2023

Month 3 System Financial Position

1. Dashboard:

The system dashboard is shown below:

System KPI Dashboard	YTD £'000			M1-12 £'000		
	Target	Actual	Rating	Target	FOT	Rating
System Delivery of planned surplus/(deficit)	(15,249)	(25,672)		(10,002)	(10,002)	
System Revenue expenditure not to exceed income	720,386	746,058		2,858,680	2,868,682	
System Capital expenditure not to exceed allocations	16,714	10,889		114,195	105,940	
System Operates within Cash Reserves	86,497	114,931		115,305	117,240	
ICB Running Costs Allocation not to be exceeded *(included within system position)*	5,096	3,399		20,385	16,262	
ICB Primary Care Co-Commissioning Allocation not to be exceeded *(included within system position)*	48,985	49,582		195,941	199,091	
ICB Newly Delegated Allocation not to be exceeded *(included within system position)*	23,138	23,487		91,565	91,565	
System CIP delivery	21,411	15,439		154,520	134,927	
System Better Payment Practice code % NHS invoices paid within target (£)	95%	95%		95%	95%	
System Better Payment Practice code % NHS invoices paid within target (number)	95%	90%		95%	90%	
System Agency spend within ceiling				45,392	54,582	
ICB MHIS spend requirement to meet target				190,473	190,473	
ICB Performance against ERF Allocation	9,362	8,681		50,282	48,162	

Revenue

2. The system is reporting a year-to-date deficit of £25.7m which is £10.4m worse than plan, (UHL £7.3m adverse variance and ICB £3.1m variance against plan). The position reflects pressures relating to industrial actions, unfunded inflation, the inability to release costs from the emergency pathway and efficiency delivery lower than plan.

3. The system is forecasting a £10.0m deficit year end position, UHL are reporting a £10.0m deficit as per their 23/24 plan. All system partners are taking action to mitigate risks to be able to deliver the planned total of £10.0m deficit year-end position.

4. The system has planned efficiencies of £154.5m, of which we are currently forecasting £134.9m delivery (£15.4m achieved year to date).

Capital

5. Operating capital spend is currently below plan by £2.9m with a year to date actual spend of £7.4m. The system is forecasting an underspend of £8.3m against national schemes as funding has been withdrawn, the target will be reduced in future months to reflect the new position.

Other Indicators of note

6. Agency spend remains above target. The position has been impacted by additional costs with Emergency and Specialist Medicine and Nursing vacancies across a number of specialties.

7. Better Payments Policy expectation across all public sector organisations is to pay creditors in a timely manner. ICB are achieving the cumulative standard of 95% of invoices (both in value and volume) paid within 30 days, UHL is cumulatively at 85% in relation to the numbers of NHS invoices paid within 30 days (non NHS at 96%) and LPT is cumulatively at 86% in relation to the numbers of NHS invoices paid within 30 days (non NHS at 98%).

8. NHS partners within LLR are expected to manage their cash position proactively in line with plans and cash draw-down limits. The current financial deficit position will impact on cash usage across all partners. There is no system for transferring cash between partners without the raising of invoices. UHL and LPT are currently holding above plan cash balances and are expected to be in line with planned cash reserves by the end of the year. The ICB is maintaining a minimal end-of-month cash balance as required.

9. The ICB receives funding for specific elements of spend within its allocation. Better Care Fund, Primary Care Co-Commissioning, Mental Health Investment and Running Costs are examples of these. The ICB has committed funds in line with allocations in all these areas and is forecasting to spend more in relation to Primary Care Co-commissioning and Mental Health Investment and underspend against Running Costs.

Conclusion

10. As a system at month 3, we have reported an in-year deficit of £25.7m against revenue budgets and forecast a £10m year-end deficit.

11. Capital spend is currently below plan and forecasting a breakeven position.

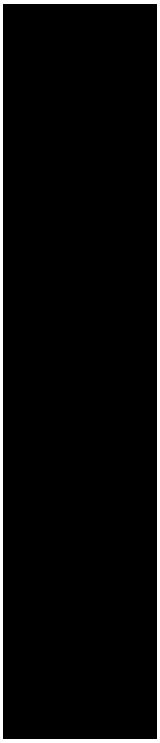
12. The ICB are declaring achievement of the Mental Health Investment Standard and Running Costs targets.

13. Cash position remains positive across the system.

Recommendations:

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

- **RECEIVE and NOTE** the financial position as at month 3 and the forecast performance.
- **RECEIVE** for assurance.



Name of meeting:	**Leicester, Leicestershire and Rutland Integrated Care Board meeting**		
Date:	**10 August 2023**	**Paper:**	**I**
Report title:	**Assurance Report from the ICB Finance Committee**		
Presented by:	Cathy Ellis, Chair of ICB Finance Committee		
Report author:	Tamara McCabe, Corporate Governance Officer Imran Asif, Corporate Governance Officer Cathy Ellis, Chair of ICB Finance Committee		
Sponsor:	Caroline Gregory, Chief Financial Officer (Interim)		

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

Recommendations:

The LLR Integrated Care Board is asked to:

- **RECEIVE** the report for assurance.

Purpose and summary of the report:

1. This report provides a summary of the key areas of discussion and outcomes following the meeting of the **ICB Finance Committee** held on the **28 June 2023** and **26 July 2023**. The report also covers items for escalation and consideration by the Board ensuring that the Board is alerted to emerging risks and issues.

2. A summary of the level of assurance provided by the Committee is detailed below.

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

The report is helping to deliver the following strategic objective(s) – *please tick all that apply*:

1. 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.	No conflicts of interests were identified in relation to this report.
☐	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 strategic risk(s) e.g. risk aligned to the Board Assurance Framework, risk register etc? *If so, state which risk and also detail if any new risks are identified.*	Aligned to BAF financial sustainability risk.
b) Does the report highlight any resource and financial implications? If so, provide which page / paragraph this can be found within the report.	Revenue and Capital risks highlighted for 2023/2024.
c) Does the report highlight quality and patient safety implications? If so, provide which page / paragraph this is outlined in within the report.	None specifically in relation to this report.
d) Does the report demonstrate patient and public involvement? If so, provide which page / paragraph this is outlined in within the report.	None specifically in relation to this report.
e) Has due regard been given to the Public Sector Equality Duty? If so, how and what the outcome was, provide which page / paragraph this is outlined in within the report.	Not specifically in relation to this report, however, the principles are contained with the Constitution and governance arrangements.

Assurance Report from the ICB Finance Committee

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

Key area discussed at the Committee meeting	Level of assurance (RAG)	Rationale for level of assurance	Risk(s) / issue(s) to escalate where required
1. ICS System Financial Report for Month 3 2023/24 – Revenue, capital, efficiency schemes and POD	**RED**	The Finance Committee received M03 ICS system financial position including an update on revenue, capital, efficiency schemes and the Pharmacy, Ophthalmology and Dentistry (POD) delegation. The Finance Committee were not assured because of the emerging risks and overall YTD deficit of £25.7m reported, the system partner control totals are listed below with narrative on key drivers: - • UHL – £21.9m deficit (Industrial action and inflation) • ICB - £3.1m deficit (Cost Improvement Plans not delivering) • LPT - £0.6m deficit (Estates/Facilities costs)	There is a significant risk of the LLR system not achieving the year end forecast outturn.
2. ICB Finance Report Month 3 2023/24	**RED**	The Finance Committee received the M03 ICB financial position which was a deficit of £3.1m. Detail was provided around the financial position and risks highlighted within the efficiency plan.	There is a significant risk of the ICB not achieving the year end forecast outturn.
3. UHL Exit from Recovery Support Programme, status at Month 2	**AMBER**	The Finance Committee received an update from UHL with regards to their Exit from the Recovery Support Programme. UHL advised their annual accounts for 2022.23 were on track. The organisation remained focused on delivering the 2023/24 plan and medium-term plan. A meeting would take place with the national team to discuss their progress. The Finance Committee were partially assured as UHL were making progress, but no defined exit route was determined.	The medium-term plan is key to driving UHL's financial sustainability.
4. Pharmacy, Optometry and Dentistry (POD) Finance update Month 3	**RED**	The LLR ICB overall year to date position was reported to be an overspend of £349k. **Dental –** There is a ring-fenced budget, the year-to-date position was reported to be an underspend of £119k. There is an expectation of non-recurrent slippage in year. **Ophthalmology-** There is a year to date overspend of £328k, LLR ICB are investigating the impact to end of year reporting. **Pharmacy –** data from the BSA is received two months in arrears, ICB Finance Committee to receive an update in Month 4 reporting.	There is a risk that the ICB will report an overspend for PODs delegated services at the end of year
5. System Capital Update Report	**RED**	The capital budget is set at £121.4m, which comprises £63.4m from system business as usual capital allocations, £42.9m from national funded	There is a risk that there will be insufficient capital to

		schemes and £15.1m for capital implications of entering leases. The year-to-date capital expenditure was reported at £2.8m underspend for Month 3. The System Capital Planning Group has been formally established and have met on two occasions; the Terms of Reference were shared. The Committee were informed that the focus of the group will be to assess the 3-year capital plan and develop a prioritisation process for assessing investments.	fund strategic estates projects. There is a further risk of sub-optimal allocation of capital for backlog maintenance, equipment and digital.
6. Medium Term Financial	**RED**	The medium-term financial plan focused on the desire to address the adverse variance to plan reported in the M3 position for future sustainability of the LLR system. The Committee were informed that four system wide programmes have been identified to reduce the financial deficit in 2023/2024 and impact planning for 2024/2025: - • UEC/ Urgent Care (use of bedded capacity) • Planned Care (reduce elective backlog/ streamline follow ups) • Medicines Management (reduce waste/focus on treatment) • Workforce (reduce agency costs) It was noted that clinical input and insight will be paramount to achieving a balanced approach to ensure quality and safety is taken into consideration whilst achieving financial objectives.	There is s risk that the LLR system will not achieve a sustainable financial balance by the end of 2024/25
7. LLR System Delivery Partnership Month 3 Report	**RED**	The first iteration of the integrated quality, operational and finance LLR System Delivery Partnership M03 Report was presented. This contained details of achievements and challenges. It was acknowledged that the report would be further enhanced for M04 and include additional areas of transformation and whole system view of CIPs. The Committee requested the report to include narrative on the barriers that are preventing achievement of transformation, to enable the Finance Committee members to consider solutions in supporting Executives.	The Delivery Partnerships are working on transformational projects, but there is a risk that operating costs will not be reduced.
8. ICB Board Assurance Framework 2023/2024 update	**N/A**	The Committee noted progress in the 'actions being taken to address gaps in controls and/or assurance'.	

9. System risks and issues Log Month 3	**N/A**	The Committee agreed to update the below risks on the committee system risks and issue logs, following the discussions held in the meeting for each item: - • Transformation risk • 2023/24 Financial risks • Capital • Pharmacy, Ophthalmology, Dentistry	

Key for level of assurance:

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

Recommendations

The LLR Integrated Care Board is asked to:

- **RECEIVE** the report for assurance.

J

Name of meeting:	**Leicester, Leicestershire and Rutland Integrated Care Board**		
Date:	10 August 2023	**Paper:**	**J**
Report title:	**Assurance Report from the System Executive**		
Presented by:	Andy Williams, Chief Executive LLR ICB and Chair of the System Executive		
Report author:	Charlotte Gormley, Corporate Governance Officer		
Sponsor:	Andy Williams, Chief Executive LLR ICB and Chair of the System Executive		

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

Recommendations:

The LLR Integrated Care Board is asked to:

- **RECEIVE** the report for assurance.

Purpose and summary of the report:

1. This report provides a summary of the key areas of discussion and outcomes following the meetings of the System Executive Committee held on 23 June 2023, 30 June 2023, and 28 July 2023. The report also covers items for escalation and consideration by the Board ensuring that the Board is alerted to emerging risks and issues.

2. A summary of the level of assurance provided by the Committee is detailed in paragraph 17.

Appendices:	• Appendix 1 – Committee effectiveness review and annual report
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. 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.*	The focus is on mitigating strategic risks as identified in the BAF and to identify and evaluate risks on an ongoing basis.
b) Does the report highlight any resource and financial implications? If so, provide which page / paragraph this can be found within the report.	Assurances received in relation to the financial plan.
c) Does the report highlight quality and patient safety implications? If so, provide which page / paragraph this is outlined in within the report.	None specifically in relation to this report.
d) Does the report demonstrate patient and public involvement? If so, provide which page / paragraph this is outlined in within the report.	None specifically in relation to this report.
e) Has due regard been given to the Public Sector Equality Duty? If so, how and what the outcome was, provide which page / paragraph this is outlined in within the report.	Not specifically in relation to this report, however due regard is considered within reports presented to the Committee.

Assurance Report from the System Executive

Introduction

1. This report aims to provide assurance to the Board and a summary of the key updates, decisions, and outcomes, aligned to the Committee's delegated authority, following the meetings of the System Executive Committee held on 23 June 2023, 30 June 2023, and 28 July 2023. The report also covers items for escalation and consideration by the Board ensuring that it is alerted to emerging risks or issues.

Strategy and Planning

2. The System Executive received the **LLR ICS Digital Strategy – Annual Update**. This included updates on some recent regional and national asks which superseded the Strategy's approval in May 2022. Positive progress was noted along with the introduction of a single app for all NHS digital interactions, which would be tested live in September 2023. The success of LLR's virtual wards and recognition at the HSJ awards was also highlighted. It was acknowledged that the digital workforce continued to be under pressure due to a lack of trained staff and change fatigue.

3. The **System Capital Update** highlighted the current capital position for the system and the risks associated with availability of capital funding. There were a number of areas where costs had grown in excess of the national funding allocation and schemes were emerging without an identified source of funding. In response, a forum had been established to consider appropriate allocation of capital and to prioritise programmes against strategic schemes.

Operational performance assurance

4. An **Update on the ICB 2023/24 Financial Position at month 2 (May 2023)** identified that the system year to date (YTD) deficit at month 2 was £18m, which was an adverse variance from plan of £7.4m. The report also highlighted the ambitious Cost Improvement Programme (CIP) target of 6%.

5. An update on workforce at month 2 identified a variance of 0.1% from plan. Substantive nursing appointments were 150 below plan however projections were above plan in terms of agency spend, medical staffing and infrastructure.

6. An **Update on the ICB 2023/24 Financial Position at month 3 (June 2023)** identified that the system year to date (YTD) deficit at month 3 was £25.7m, which was an adverse variance from plan of £10.4m. The system was forecasting a deficit of £10m at year end, in line with the plan submitted on 4 May 2023.

7. **LLR ICS Financial Recovery –** Four key workstreams were identified across the system which could yield additional cost reductions and benefits in-year. Programmes would be progressed through existing groups wherever possible, with continual oversight through System Executive.

8. The **Leicester, Leicestershire and Rutland System Performance Update** introduced the newly developed performance report to be presented to the System Executive and LLR System Delivery Partnership. The Committee supported the systemised approach and agreed to stand-down the previous reporting style. Partnerships and Collaboratives would work in conjunction to produce a single pack of reports and reduce duplication.

9. The Committee received the first report on the **Delivery of the LLR Operational Plan 2023/24** in its new format. This included a progress update against each programme areas detailed within the Operational Plan and the Five-Year Plan. Concerns remain regarding cancer and

maternity and the trajectory evidenced progress. Information regarding planned care, urgent care and medicines optimisation would be triangulated in future reports. Activity would also be reported against from month 4.

10. The **Leicester, Leicestershire and Rutland System 2023/24 Quarter One Provider Segmentation Scores** – Members acknowledged that the responsibility for scoring Trusts transferred from NHS England to ICBs as of September 2022. A segmentation decision, in accordance with the national guidance indicates the scale and general nature of support needs, from no specific support needs (segment 1) to a requirement for mandated intensive support (segment 4). LPT remained at NOF level 2 and UHL remained at NOF level 4.

11. An update on the **Urgent and Emergency Care Collaborative (UEC)** highlighted discussions regarding the job description for UEC Director, for which expressions of interest would be requested once finalised. The UEC plan was not yet fully agreed and the vision for the collaborative would be established to determine its principles and anticipated benefits. Further updates would be provided to the System Executive in due course.

Governance arrangements

12. **Committee effectiveness review and annual report –** the Committees of the Board are required to review their own effectiveness on an annual basis to enable changes and improvements to be made. The System Executive reflected on the value of regularly engaging with clinical leaders and the monthly development sessions which took place in addition to formal meetings. It was agreed for the current arrangements to continue.

13. The Committee effectiveness review and annual report is appended for information at **Appendix 1.**

Other decisions including business cases, procurements and contracts:

14. Committee members considered and supported a number of decisions, all of which fall within the delegated authority of the Committee:

    a. **Hinckley Day Case Short Form Business Case (SFBC) –** existing day-case facilities present a risk of cross-contamination and require separate male and female sessions due to poor layout. A new build is proposed to improve recruitment and efficiency. The System Executive approved the request to delegate authority to sign off the SFBC for Hinckley Day Cases to the LLR ICB Chief Executive and LLR ICB Interim Finance Officer.

    b. The **East Midlands ICBs Management of Assisted Fertility Policy Review** was being undertaken by Arden and Greater East Midlands Commissioning Support Unit (AGEM CSU). The review aimed to address inconsistencies across LLR would focus on a number of areas including same sex couples, previous children, and the number of cycles. A progress update would be provided in Autumn 2023.

    c. **Direct Award Proposal for ICB Framework Pathway 2 Nursing Home Beds –** the contracts for Discharge to Assess (D2A) beds on the ICB framework ended on 30 June 2023. The System Executive approved the request to retain the current 8 framework providers under existing terms to enable a review of the framework over the next 9 months.

    d. **Social Prescribing Platform Contract Award –** the System Executive approved the recommendation to award a direct contract to Pungo Ltd (Joy App) for 2 years plus the option of an addition 12 + 12 months.

15. Regular assurance reports are received from the Strategic Commissioning Group (with delegated authority from the Board for primary care commissioning and sub-group of the System Executive Committee) and the Clinical Executive Group. A query was highlighted regarding the Continuous Glucose Monitoring (CGM) business case, which did not receive funding in the previous planning round. Patient cohorts at risk of no longer being able to access CGM were identified through the clinical prioritisation tool. Further consideration would be given by the Executive Management Team (EMT).

16. The **ICB Board Assurance Framework 2023/2024 update** was received for assurance and the System Executive reviewed strategic risks. Emergency preparedness, resilience and response (EPRR) and the clinical impact of financial decisions made in the 2023/24 planning round linked to not approving business cases were highlighted for further consideration.

Summary of assurance from the Committee

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

Key area	Level of assurance	Rationale for level of assurance	Risk(s) to escalate where required
1. Strategy and planning	**Amber**	• Progress has been made against the LLR ICS Digital Strategy 2022-24, particularly the introduction of a single NHS app and virtual wards. • Pressures remain in terms of the digital workforce due to a lack of trained staff and change fatigue. • System Capital presented a risk in areas where costs had grown in excess of the national funding allocation and schemes emerging without an identified source of funding. A forum had been established to consider mitigations.	N/A
2. Operational performance assurance	**Amber**	• At month 2 the system was reporting an adverse variance against plan of £7.4m, and an adverse variance of £10.4m at month 3. • Four key workstreams were identified across the system which could yield cost reductions and benefits in-year.	N/A
3. Governance arrangements	**Green**	• The meetings were considered to be of value and the membership appropriate, particularly the inclusion of clinical leads. It was agreed for the current schedule of monthly development sessions and formal meetings to continue.	N/A
4. Other decisions including business cases, procurements and contracts	**Amber**	• A review of the ICB Framework Pathway 2 Nursing Home Beds may take longer than 9 months and require a further extension to existing providers on the framework. • A review of the East Midlands ICBs Assisted Fertility Policy may result in changes to the policy that require funding in order to meet NICE guidance.	N/A
5. Information only	**Amber**	• Assurance reports from sub-groups are regularly received, and issues and risks identified along with mitigations. • A particular concern was raised regarding the unfunded business case for Continuous Glucose Monitoring (CGM). Affected cohorts	N/A

		were identified through the clinical prioritisation tool and further consideration would be given by EMT.	

Key for level of assurance:

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

Recommendations

The LLR Integrated Care Board is asked to:

- **RECEIVE** the report for assurance.

Appendix 1

NHS Leicester, Leicestershire and Rutland Integrated Care Board

Committee self-assessment checklists
(DKB v1, May 2023)

In line with good practice, committees of the Board should assess their effectiveness annually. A variety of assessment tools are available to facilitate this process, and the exercise can be carried out through facilitated workshops or short questionnaires. The following checklists (sections one and two) have been derived from the key questions detailed in the *HFMA NHS Audit Committee Handbook,* condensed to generate a series of prompts that the ICB committees can use to help assess their effectiveness.

SECTION ONE: Committee administration checklist

This can be completed by the Chair with the assistance of the committee's administration officer or Head of Corporate Governance. The results can be reported to the Committee and where the response of 'no' is given this issues(s) could be discussed further at the Committee meeting to determine if any further action is required. The action / comments column could detail further actions required to build effectiveness where the Committee believe they are not performing effectively.

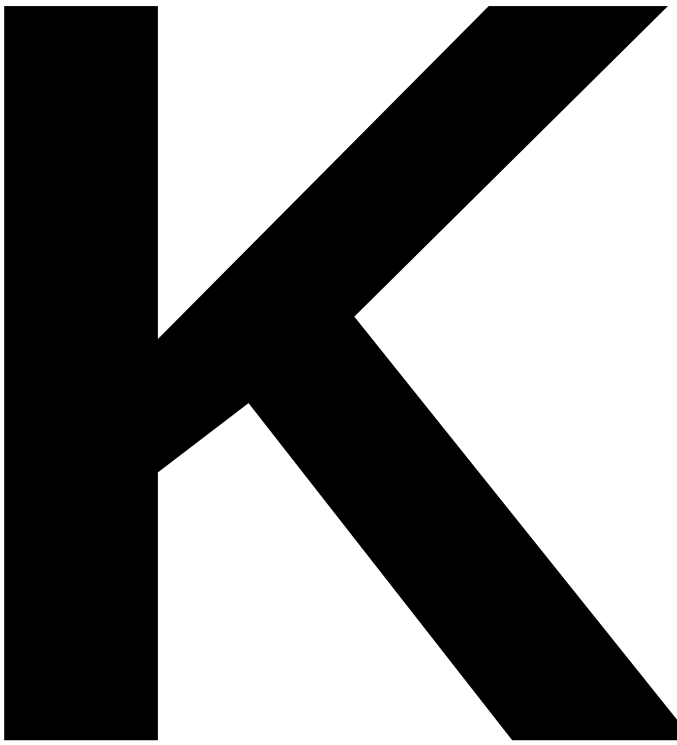
Area / Question	Yes	No	Comments / action (System Executive Committee, July 2023)
a) Composition, establishment and duties			
Does the committee have written terms of reference and have they been approved by the Board?	✓		
Are the terms of reference reviewed annually?	✓		
Has the committee formally considered how it integrates with other committees that are reviewing risks?	✓		
Are the committee members independent of the management team?		X	The Executive Members are the members of this Committee in line with the terms of reference approved by the Board.
Are the outcomes of each meeting and any internal control issues reported to the next Board meeting?	✓		
Does the committee prepare an annual report on its work and performance for the Board?	✓		This is by way of this effectiveness review. The Committee also produces regular assurance reports for the Board.
Has the committee established a plan of matters to be dealt with across the year?	✓		Work programme in place.
Are committee papers distributed in sufficient time for members to give them due consideration?	✓		
Has the committee been quorate for each meeting this year?	✓		
b) Internal Control and Risk Management			
Has the committee reviewed the strategic risks within the Board Assurance Framework aligned to the committee?	✓		
Does the committee receive and review the evidence required to demonstrate compliance with regulatory requirements?	✓		

SECTION TWO: Committee Effectiveness

This checklist is designed to gauge the committee's effectiveness by taking the views of committee members across a number of themes. It is suggested that every member of the audit committee complete the checklist and the chair and the Head of Corporate Governance and / or the Executive Lead review the results and use their judgement to recommend any further actions required. Alternatively, the committee may decide to work through the checklist collectively.

Statement	Agree	Disagree	Don't know	Comments / actions (System Executive Committee, July 2023)
1. Committee Focus				
The Committee has set itself a series of objectives for the year.	✓			By way of the terms of reference and work programme.
The committee has made a conscious decision about the information it would like to receive.	✓			
Committee members contribute regularly to the issues discussed.	✓			
The committee is aware of the key sources of assurance and who provides them.	✓			This includes reviewing assurances presented through the Board Assurance Framework.
The committee receives assurances from third parties who deliver key functions to the organisation – for example NHS Shared Business Services.	✓			Assurances received through partners / providers of services e.g. delivery through the partnerships / collaboratives.
Equal prominence is given to both quality and financial assurance.	✓			
2. Committee team working				
The committee has the right balance of experience, knowledge and skills to fulfil its role.	✓			
The committee has structured its agenda to cover quality, data quality, performance targets and financial control.	✓			The Committee also ensures appropriate interface with the Quality and Safety Committee which has responsibility for providing assurance in respect of quality and safety matters.
The committee ensures that the relevant executive director attends meetings to enable it to understand the reports and information it receives.	✓			
Management fully briefs the committee on key risk and any gaps in control.	✓			
The committee environment enables people to express their views, doubts and opinions.	✓			
Decisions and actions are implemented in line with the timescale set down.	✓			

Statement	Agree	Disagree	Don't know	Comments / actions (System Executive Committee, July 2023)
3. Committee effectiveness				
The quality of committee papers received allows committee members to perform their roles effectively.	✓			
Members provide real and genuine challenge – they do not just seek clarification and / or reassurance.	✓			
Debate is allowed to flow, and conclusions reached without being cut short or stifled.	✓			
Each agenda item is 'closed off' appropriately so that the committee is clear on the conclusion, who is doing what, when and how, and how it is being monitored.	✓			
At the end of each meeting the committee discuss the outcomes and reflect on decisions made and what worked well, and not so well etc.	✓			
The committee provides a written summary report of its meetings to the Board.	✓			
The Board challenges and understands the reporting from this committee.	✓			
There is a formal appraisal of the committee's effectiveness each year.	✓			
4. Committee engagement				
The committee challenges management and other assurance providers to gain a clear understanding of their findings.	✓			This is a management led Committee.
The committee is clear about its role in relationship to other committees that play a role in relation to clinical governance, quality and risk management.	✓			
The committee receives clear and timely reports from sub-groups which set out the assurances they have received and their impact (either positive or not) on the organisation's assurance framework.	✓			
5. Committee leadership				
The committee chair has a positive impact on the performance of the committee.	✓			Committee members provided positive feedback in respect of all of these areas at the July 2023 meeting.
Committee meetings are chaired effectively.	✓			
The committee chair is visible within the organisation and is considered approachable.	✓			
The committee chair allows debate to flow freely and does not assert his / her own views too strongly.	✓			
The committee chair provides clear and concise information to the Board on committee activities and gaps in control.	✓			



Name of meeting:	**Leicester, Leicestershire and Rutland Integrated Care Board meeting**		
Date:	10 August 2023	**Paper:**	**K**
Report title:	**Assurance Report from the ICB Quality and Safety Committee**		
Presented by:	Pauline Tagg, Non-Executive Member - Quality, Safety and Transformation		
Report author:	Charlotte Gormley, Corporate Governance Officer		
Sponsor:	Dr Caroline Trevithick, Chief Nursing Officer/Deputy CEO		

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

Recommendations:

The LLR Integrated Care Board is asked to:

- **RECEIVE** the report for assurance.

Purpose and summary of the report:

1. This report provides a summary of the key areas of discussion and outcomes following the meeting of the ICB Quality and Safety Committee held on 6 July 2023. The report also covers items for escalation and consideration by the Board ensuring that the Board is alerted to emerging risks and issues.

2. A summary of the level of assurance provided by the Committee is detailed below.

Appendices:	• Appendix 1 – Committee effectiveness review
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. 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 strategic risk(s) e.g. risk aligned to the Board Assurance Framework, risk register etc? *If so, state which risk and also detail if any new risks are identified.*		Yes, assurance at pathway and provider level supporting improvements and input against the current risks of LLR BAF 05. This Committee will review risks associated with quality at design group / collaborative level on a quarterly basis.
b) Does the report highlight any resource and financial implications? If so, provide which page / paragraph this can be found within the report.		No.
c) Does the report highlight quality and patient safety implications? If so, provide which page / paragraph this is outlined in within the report.		Yes. Quality and safety risks considered in the CNO/CMO Quality Assurance report and GP Quality report.
d) Does the report demonstrate patient and public involvement? If so, provide which page / paragraph this is outlined in within the report.		Report from Chairman of PPIAG.
e) Has due regard been given to the Public Sector Equality Duty? If so, how and what the outcome was, provide which page / paragraph this is outlined in within the report.		N/A

Assurance Report from the ICB Quality and Safety Committee

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

Key area discussed at the Committee meeting	Level of assurance (RAG)	Rationale for level of assurance	Risk(s) / issue(s) to escalate where required
Draft effectiveness review of the governance arrangements	**GREEN**	The Committee approved the draft effectiveness review of governance arrangements (attached at Appendix 1). It was agreed that assurance reports would highlight gaps in control to enable engagement and challenge from the Board. A proposal was discussed to remove provider non-executive directors and the Chair of the PPIAG from the membership of formal assurance meetings. Provider non-executive directors and the Chair of the PPIAG would continue to attend development sessions and deep dives. It was however considered that the experience and scrutiny provided by these members added value to the assurance-led committee. It was agreed that agenda setting would instead be reviewed to ensure a valuable and useful meeting experience. Changes to the formal committee membership would be discussed further prior to a decision being taken.	N/A
ICB Chief Nursing Officer / Chief Medical Officer Quality Assurance Report	**AMBER**	**Alerts –** • **Unfunded Business Cases -** The System Quality Risk Log was updated with a risk on the challenges around unfunded business cases. Further information was required to determine the level of risk. A deep dive would be held at the earliest opportunity to provide clarity. • **Maternity** – MBBRACE data indicated that perinatal mortality in UHL was more than 5% higher than that of its peer group. UHL were undertaking actions and seeking peer support. A deep dive on Maternity services is planned for August. • **Cancer** - UHL performance in some specialities and FIT are new risks added to the system quality risk register. • **Learning Disabilities & Autism (Care Homes)** - A number of care homes had been rated "Inadequate" or "Requires Improvement" by the CQC. Work was underway to address the risks identified in local care homes.	Sufficient assurance was not received regarding the impact of unfunded business cases on patient services. A deep dive session would be held with a focus on this area.
	GREEN	**Assure** – positive assurances were received across the following areas in particular: • **Youth Voice** – Engagement work with Children and Young People provided feedback on remote consultations with General Practice. Resultant actions were being shared with GPs. A wider piece of system work would follow. • **Received Quality Accounts for UHL, LPT, EMAS, DHU and Rainbows** - All were satisfactory reflections of their position and ambitions for the future. • **Learning Disabilities / Autism Collaborative** - Improvements were made in performance and quality, with an approach being taken from an equity	

Key area discussed at the Committee meeting	Level of assurance (RAG)	Rationale for level of assurance	Risk(s) / issue(s) to escalate where required
		perspective. Partnership working had been demonstrated through engagement.	
System Quality Provider Updates	**GREEN**	**UHL** - there were no additional items / updates / risks to be provided on this occasion. **LPT** – The system was taking part in the Daisy Foundation Award for exceptional nursing care. Policy work was ongoing to ensure patients received the right care at the right time. Pressures remained regarding workforce and staffing. Positive work detailed within the annual report for research and development was highlighted. **EMAS** – Significant research and development work was taking place. Hospital handover times had improved with further work required to achieve the target time of 18 minutes. It was anticipated that new NHS pathways would be running by October 2023 in time for winter preparedness. **GP Quality Report** – Seven practices were recorded on the risk log for the Quarter and four CQC reports had been published. One practice had improved from a rating of inadequate to good; two practices had improved from a rating of inadequate to requires improvement; and one practice remained at a rating of inadequate. Within primary care, quality initiatives included the launce of the Quality Assurance Tool.	N/A
Children and Young People Summit presentation	**AMBER**	The Committee noted that significant challenges remained from a culture and finance perspective. Concerns were raised regarding long waiting times and lack of investment into neurodevelopmental pathways and community therapies. This was linked to the issue of non-funded business cases.	
Cancer Summit presentation	**AMBER**	The Committee were alerted to challenges, performance issues, and actions per specialty. UHL performance and FIT had been identified as key areas of risk and had been escalated to System Quality Risk Register. SQG would consider where the risks would be owned and logged, as these would no longer be held by the Committee.	N/A
Workforce Assurance Report	**AMBER**	Agency and bank staff usage remained over plan, however the Committee received assurance that a national programme was in place to reduce agency staff and cost whilst increasing quality and efficiencies. Consideration was being given to the recently published Workforce Plan. The Committee would hold a deep dive session with a focus on maternity and obstetrics which would provide clarity on workforce in these areas.	N/A
Update from Public and Patient Involvement	**GREEN**	The Committee received assurance regarding the following:	N/A

Key area discussed at the Committee meeting	Level of assurance (RAG)	Rationale for level of assurance	Risk(s) / issue(s) to escalate where required
Assurance Group (PPIAG)		• Maternity and Neo-Natal Voices Partnership – contracted for a 12-months to Leicester Mamas. The plan is to be modified to include more inclusive language. • Communities' consultation review – the approach to engagement was appropriate and in line with equality and consultation duties. • 5 Year Forward Plan – the initial draft was informed by engagement with staff, carers, and patients. Further engagement and consideration of implementation would be worked through by the Strategy and Planning Team.	
ICB Board Assurance Framework 2023/2024 update and LLR QSC System Quality Risk Log	**AMBER**	The BAF assigned risk 5 to the Committee for oversight. On review, the Committee identified a gap in control regarding assurance received from care homes and out of county providers. Mitigations would be considered by SQG to address this. A further gap was identified regarding PODs and triangulation from other areas with complex commissioning arrangements. The Committee was assured of the process to transition risks from the risk log to the appropriate committee/sub-committee. Evidence would be shared to demonstrate the transition and to ensure no risks were lost.	N/A
LLR ICB System Quality Group Minutes	**N/A**	The SQG minutes of the meetings held on 18 May 2023 and 15 June 2023 were presented for information.	N/A
Quality Governance Audit Phase 2 report	**N/A**	The report was received for information.	N/A

Key for level of assurance:

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

Recommendations

The LLR Integrated Care Board is asked to:

- **RECEIVE** the report for assurance.

Appendix 1

NHS Leicester, Leicestershire and Rutland Integrated Care Board

Committee self-assessment checklists
(DKB v1, May 2023)

In line with good practice, committees of the Board should assess their effectiveness annually. A variety of assessment tools are available to facilitate this process, and the exercise can be carried out through facilitated workshops or short questionnaires. The following checklists (sections one and two) have been derived from the key questions detailed in the *HFMA NHS Audit Committee Handbook,* condensed to generate a series of prompts that the ICB committees can use to help assess their effectiveness.

SECTION ONE: Committee administration checklist

This can be completed by the Chair with the assistance of the committee's administration officer or Head of Corporate Governance. The results can be reported to the Committee and where the response of 'no' is given this issues(s) could be discussed further at the Committee meeting to determine if any further action is required. The action / comments column could detail further actions required to build effectiveness where the Committee believe they are not performing effectively.

Area / Question	Yes	No	Comments / action
a) Composition, establishment and duties			
Does the committee have written terms of reference and have they been approved by the Board?	X		
Are the terms of reference reviewed annually?	X		
Has the committee formally considered how it integrates with other committees that are reviewing risks?	X		The committee has considered risk relating to workforce and financial decision-making
Are the committee members independent of the management team?	?		
Are the outcomes of each meeting and any internal control issues reported to the next Board meeting?	X		
Does the committee prepare an annual report on its work and performance for the Board?	X		The Committee has approved the Quality Framework Implementation Plan and will receive quarterly reports regarding progress. The Q4 report will form the Annual report
Has the committee established a plan of matters to be dealt with across the year?	X		
Are committee papers distributed in sufficient time for members to give them due consideration?	X		
Has the committee been quorate for each meeting this year?	X		
b) Internal Control and Risk Management			
Has the committee reviewed the strategic risks within the Board Assurance Framework aligned to the committee?	X		QSC to receive a Board Assurance Report update from July 2023.

Area / Question	Yes	No	Comments / action
Does the committee receive and review the evidence required to demonstrate compliance with regulatory requirements?	X		The committee receives updates relating to statutory responsibilities. E.g., Quality assurance, SEND, Safeguarding, LAC, Domestic violence/MARAC, medicine's safety

SECTION TWO: Committee Effectiveness

This checklist is designed to gauge the committee's effectiveness by taking the views of committee members across a number of themes. It is suggested that every member of the audit committee complete the checklist and the chair and the Head of Corporate Governance and / or the Executive Lead review the results and use their judgement to recommend any further actions required. Alternatively, the committee may decide to work through the checklist collectively.

Statement	Agree	Disagree	Don't know	Comments / actions
1. Committee Focus				
The Committee has set itself a series of objectives for the year.	X			The Committee has approved the 23/24 Quality Framework implementation plan that sets out the objectives for the year The work programme is regularly reviewed to reflect the requirements of the committee The committee has deep dives planned for the year based on the risk log & work programme
The committee has made a conscious decision about the information it would like to receive.	X			
Committee members contribute regularly to the issues discussed.	X			
The committee is aware of the key sources of assurance and who provides them.	X			
The committee receives assurances from third parties who delivery key functions to the organisation – for example NHS Shared Business Services.	X			Assurance regarding responsibilities delegated to M&LCSU for CHC/CC/FNC/S117 through personalisation elements in CNO/CMO report

Statement	Agree	Disagree	Don't know	Comments / actions
Equal prominence is given to both quality and financial assurance.	X			QSC has reviewed the impact of financial planning on quality & safety
2. Committee team working				
The committee has the right balance of experience, knowledge and skills to fulfil its role.	X			
The committee has structured its agenda to cover quality, data quality, performance targets and financial control.		X		The committee agenda is constructed to meet the ToR
The committee ensures that the relevant executive director attends meetings to enable it to understand the reports and information it receives.	X			
Management fully briefs the committee on key risk and any gaps in control.		X		The committee has received risk log reports, but this area is still developing in line with the BAF development
The committee environment enables people to express their views, doubts and opinions.	X			
Decisions and actions are implemented in line with the timescale set down.	X			
3. Committee effectiveness				
The quality of committee papers received allows committees members to perform their roles effectively.		X		Executive to ensure that papers identify the risk, mitigations and any gaps in assurance to inform the appropriate discussion
Members provide real and genuine challenge – they do not just seek clarification and / or reassurance.	X			
Debate is allowed to flow, and conclusions reached without being cut short or stifled.	X			
Each agenda item is 'closed off' appropriately so that the committee is clear on the conclusion, who is doing what, when and how, and how it is being monitored.		X		QSC to review each agenda item and assign an assurance rating.
At the end of each meeting the committee discuss the outcomes and reflect on decisions made and what worked well, and not so well etc.		X		Plan to add a reflection of the meeting to the agenda
The committee provides a written summary report of its meetings to the Board.	X			
The Board challenges and understands the reporting from this committee.		X		Development plan to be developed for the Committee and the ICB

Statement	Agree	Disagree	Don't know	Comments / actions
				relating to Statutory responsibilities for Quality & Safety
There is a formal appraisal of the committee's effectiveness each year.	X			This is undertaken through this report and the 360 Internal Audit report
4. Committee engagement				
The committee challenges management and other assurance providers to gain a clear understanding of their findings.	X			
The committee is clear about its role in relationship to other committees that play a role in relation to clinical governance, quality and risk management.	X			
The committee receives clear and timely reports from sub-groups which set out the assurances they have received and their impact (either positive or not) on the organisation's assurance framework.	X			
5. Committee leadership				
The committee chair has a positive impact on the performance of the committee.	X			
Committee meetings are chaired effectively.	X			
The committee chair is visible within the organisation and is considered approachable.	X			
The committee chair allows debate to flow freely and does not assert his / her own views too strongly.	X			
The committee chair provides clear and concise information to the Board on committee activities and gaps in control.	X			

Name of meeting:	**Leicester, Leicestershire and Rutland Integrated Care Board**		
Date:	**10 August 2023**	**Paper:**	**L**
Report title:	**Assurance Report from the ICB Audit Committee**		
Presented by:	Darren Hickman, Non-Executive Member and Chair of Audit Committee		
Report author:	Tamara McCabe, Corporate Governance Officer		
Sponsor:	Darren Hickman, Non-Executive Member and Chair of Audit Committee		

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

Recommendations:

The LLR Integrated Care Board is asked to:

- **RECEIVE** the report for assurance.

Purpose and summary of the report:

1. This report provides a summary of the key areas of discussion and outcomes following the meeting of the **ICB Audit Committee (extraordinary)** held on **20 June 2023.** The report also covers items for escalation and consideration by ICB Integrated Care Board ensuring that it is alerted to emerging risks and issues.

Appendices:	• Appendix 1 - Audit Committee effectiveness review
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. 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.	No conflict identified in relation to this report.
☐	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 strategic risk(s) e.g. risk aligned to the Board Assurance Framework, risk register etc? *If so, state which risk and also detail if any new risks are identified.*	The remit of the Audit Committee is to provide assurance in respect of the ICB's risk management arrangements including the BAF.
b) Does the report highlight any resource and financial implications? If so, provide which page / paragraph this can be found within the report.	Not 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.	Not 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.	Not 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 in relation to this report.

Assurance Report from the ICB Audit Committee

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

Key area discussed at the Committee meeting	Level of assurance (RAG)	Rationale for level of assurance	Risk(s) / issue(s) to escalate where required
1. Committee effectiveness review / annual review	**GREEN**	The Audit Committee approved the committee effectiveness review and checklist noting the positive outcome and supported a standing agenda item at every meeting to reflect on its effectiveness. See Appendix 1.	**None.**
2. Service Auditor Reports	**GREEN**	The Audit Committee received the Service Auditor Reports and were assured of the mitigations to performance risks.	**None.**
3. Counter Fraud Annual Report	**GREEN**	The Counter Fraud, Bribery and Corruption 2022/23 Annual Report was received by the Audit Committee. The report highlighted the ICB's compliance with the Government Functional Standards for Counter Fraud.	**None.**
4. Final Head of Internal Audit Opinion 2022/23 for CCGs	**GREEN**	The Head of Internal Audit Opinion was received containing the final opinion and a summary of the delivery of internal audit services for the period 1 April to 30 June 2022 for the three predecessor CCGs. An opinion of significant assurance was given. The Audit Committee supported the final opinion.	**None.**
5. LLR Integrated Care Board Internal Audit Report and Final Head of Internal Audit Opinion	**AMBER**	The Internal Audit Annual Report 2022/23 and Final Head of Internal Audit Opinion for the LLR ICB 1 July 2022 to 31 March 2023 was provided. The Annual Report set out the service delivery by internal audit and noted the significant changes that were made since August 2022. An Opinion of moderate assurance was given. The Audit Committee supported the Internal Audit Report and Final Head of Internal Audit Opinion for LLR ICB and acknowledged this to be a positive position for the first nine months of the organisation.	**None.**
6. Internal Audit Report - Quality Governance Framework Phase 2	**GREEN**	The Internal Audit Report for Quality Governance Framework (Phase 2) was given an opinion of significant assurance.	**None.**
7. Internal Audit Report – Governance Phase 2	**GREEN**	The Internal Audit Report for Governance (Phase 2) was given an opinion of significant assurance.	**None.**
8. Internal Audit – Risk Management Phase 2	**GREEN**	The Internal Audit Report for Risk Management (Phase 2) was given an opinion of significant assurance.	**None.**
9. External Audit Findings 2022/23 for CCGs	**GREEN**	The External Audit Findings for the three CCGs 2022/23 were provided. No significant weaknesses were identified in the CCGs' arrangements for securing value for money. The Audit Committee approved of the findings.	**None.**
10. External Audit Report 2022/23 for CCGs	**GREEN**	The External Audit Report for the three CCGs 2022/23 were provided. No significant weaknesses were identified and no improvement recommendations made.	**None.**

Key area discussed at the Committee meeting	Level of assurance (RAG)	Rationale for level of assurance	Risk(s) / issue(s) to escalate where required
		All risks from the previous year were followed up and actioned, and external audit were satisfied that the issues for 2022/23 were addressed. The Audit Committee approved of the External Audit Annual Report 2022/23 for the three CCGs.	
11. Audit Findings and External Audit Report for LLR ICB	**GREEN**	A summary of External Audit findings and the External Audit Report for the LLR ICB was provided with a summary of findings given prior to the final report being received in August 2023. No significant weaknesses were identified, and only minor improvement recommendations made. The Audit Committee approved of the findings and noted the final report would be reissued in August 2023.	**None.**
12. Letters of Representation	**GREEN**	The Letters of Representation were approved as part of receiving the external audit findings for the three CCGs and LLR ICB. The Letters of Representation would be signed the Accountable Officer prior to submission to NHS England.	**None.**
13. Statement by Accountable Officer and Annual Governance Statement for 2022/23 for CCGs and LLR ICB	**GREEN**	The Audit Committee approved the Accountable Officer Statements contained within the 2022/23 Annual Reports for LLR CCGs and the LLR ICB, and also approved the Annual Governance Statements for the LLR CCGs and LLR ICB.	**None.**
14. The Annual Reports for 2022/23 for CCGs and LLR ICB	**GREEN**	The Audit Committee approved the Annual Reports 2022/23 for the three LLR CCGs and LLR ICB.	**None.**
15. The Annual Accounts 2022/23 for CCGs and LLR ICB	**GREEN**	The Audit Committee approved the Annual Accounts 2022/23 for the three LLR CCGs and LLR ICB.	**None.**

Key for level of assurance:

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

Recommendations

The LLR Integrated Care Board is asked to:

- **RECEIVE** the report for assurance.

Appendix 1

NHS Leicester, Leicestershire and Rutland Integrated Care Board

Audit Committee self-assessment checklists
(v1, May 2023)

In line with good practice, the Audit Committee and other committees of the Board should assess their effectiveness annually. A variety of assessment tools are available to facilitate this process, and the exercise can be carried out through facilitated workshops or short questionnaires. The following checklists (sections one and two) have been derived from the key questions detailed in the *HFMA NHS Audit Committee Handbook,* condensed to generate a series of prompts that Committees can use to help assess their effectiveness.

SECTION ONE: Committee administration checklist

This can be completed by the Chair with the assistance of the committee's administration officer or Head of Corporate Governance. The results can be reported to the Audit Committee and where the response of 'no' is given this issues(s) could be discussed further at the Audit Committee meeting to determine if any further action is required. The action / comments column could detail further actions required to build effectiveness where the Committee believe they are not performing effectively.

Area / Question	Yes	No	Comments / action (Audit Committee, June 2023)
a) Composition, establishment and duties			
Does the audit committee have written terms of reference and have they been approved by the Board?	Y		
Are the terms of reference reviewed annually?	Y		
Has the committee formally considered how it integrates with other committees that are reviewing risks?	Y		Still evolving
Are the committee members independent of the management team?	Y		
Are the outcomes of each meeting and any internal control issues reported to the next Board meeting?	Y		
Does the committee prepare an annual report on its work and performance for the Board?	Y		This effectiveness review forms the Annual Report.
Has the committee established a plan of matters to be dealt with across the year?	Y		
Are committee papers distributed in sufficient time for members to give them due consideration?	Y		
Has the committee been quorate for each meeting this year?	Y		
b) Internal Control and Risk Management			
Has the committee reviewed the effectiveness of the organisation's assurance framework?	Y		Through governance statement and Head of Internal Audit Opinion.
Does the committee receive and review the evidence required to demonstrate compliance with regulatory requirements?	Y		This is undertaken through the internal and external audit reviews. In addition, the Committee considered:

Area / Question	Yes	No	Comments / action (Audit Committee, June 2023)
			- compliance with the data protection legislation including cyber security (through the information governance report) - conflicts of interest compliance with legal framework - personalisation deep dive which included legal duties in respect of continuing healthcare and quality.
Has the committee reviewed the accuracy of the draft annual governance statement?	Y		Scheduled for June 2023.
c) Annual Report and Accounts and disclosure statements			
Does the committee receive and review a draft of the organisation's annual report and accounts?	Y		Undertaken as informal meeting with draft Annual Reports and Accounts circulated.
Does the committee specifically review: - The going concern assessment - Changes in accounting policies - Changes in accounting practice due to changes in accounting standards - Changes in estimation techniques - Significant judgements made in preparing the accounts - Significant adjustments resulting from the audit - Explanations for any significant variances?	Y		Scheduled for June and informal/formal meetings.
Is the committee meeting scheduled to discuss any proposed adjustments to the accounts and audit issues?	Y		
Does the committee ensure it receives explanations for any unadjusted errors in the accounts found by the external auditors?	Y		Scheduled for June 023.
Internal audit			
Is there a formal charter or terms of reference, defining internal audit's objectives and responsibilities?	Y		
Does the committee review and approve the internal audit plan, and any changes to the plan?	Y		
Is the committee confident that the audit plan is derived from the clear risk assessment process?	Y		
Does the committee receive periodic progress reports from the head of internal audit?	Y		
Does the committee effectively monitor the implementation of management actions arising from internal audit reports?	Y		

Area / Question	Yes	No	Comments / action (Audit Committee, June 2023)
Does the head of internal audit have a right of access to the committee and its chair at any time?	Y		Monthly meetings held with Internal audit. And time given at end of committee meetings
Is the committee confident that internal audit is free of any scope restrictions, or operational responsibilities?	Y		
Has the committee evaluated whether internal audit complies with the *Public Sector Internal Audit Standards?*	Y		Included within auditors' progress reports and Annual Reports.
Does the committee receive and review the head of internal audit's annual opinion?	Y		Draft is review and the final is scheduled for review in June 2023.
External Audit			
Do the external auditors present their audit plan to the committee for agreement and approval?	Y		
Does the committee review the external auditor's ISA 260 report (the report to those charged with governance)?	Y		Yes, scheduled for June 2023.
Does the committee review the external auditor's value for money conclusion?	Y		
Does the committee hold periodic private discussions with the external auditors?	Y		Provision at the end of each meeting.
Does the committee assess the performance of external audit?	Y		To be scheduled
Does the committee require assurance from external audit about its policies for ensuring independence?	Y		
Has the committee approved a policy to govern the value and nature of non-audit work carried out by the external auditors?	N		No specific policy, however if non-audit work is undertaken this will be reviewed and agreed with the Audit Committee.
Counter Fraud			
Does the committee review and approve the counter fraud work plans, and any changes to the plans?	Y		
Is the committee satisfied that the work plan is derived from an appropriate risk assessment and that coverage is adequate?	Y		
Does the audit committee receive periodic reports about counter fraud activity?	Y		
Does the committee effectively monitor the implementation of management actions arising from counter fraud reports?	Y		
Do those working on counter fraud activity have a right of direct access to the committee and its chair?	Y		
Does the committee receive and review an annual report on counter fraud activity?	Y		Scheduled in June.
Does the committee receive and discuss reports arising from quality inspections by the NHS Counter Fraud Authority?	Y		Benchmarking and case studies requested.

SECTION TWO: Committee Effectiveness

This checklist is designed to gauge the committee's effectiveness by taking the views of committee members across a number of themes. It is suggested that every member of the audit committee complete the checklist and the chair and the Head of Corporate Governance and / or the Executive Lead review the results and use their judgement to recommend any further actions required. Alternatively, the committee may decide to work through the checklist collectively.

Statement	Agree	Disagree	Don't know	Comments / actions (Audit Committee, June 2023)
1. Committee Focus				
The Committee has set itself a series of objectives for the year.	Y			
The committee has made a conscious decision about the information it would like to receive.	Y			
Committee members contribute regularly to the issues discussed.	Y			
The committee is aware of the key sources of assurance and who provides them.	Y			
The committee receives assurances from third parties who delivery key functions to the organisation – for example NHS Shared Business Services.	Y			Service Auditor Reports expected to be received in June 2023.
Equal prominence is given to both quality and financial assurance.	Y			
Committee team working				
The committee has the right balance of experience, knowledge and skills to fulfil its role.	Y			
The committee has structured its agenda to cover quality, data quality, performance targets and financial control.	Y			
The committee ensures that the relevant executive director attends meetings to enable it to understand the reports and information it receives.	Y			
Management fully briefs the committee on key risk and any gaps in control.	Y			
Other committee provide timely information in support of the audit committee.	Y			
The committee environment enables people to express their views, doubts and opinions.	Y			
Committee members understand the messages being given by external audit, internal audit and counter fraud specialists.	Y			
Internal audit contributes to the debate across the range of the agenda.	Y			
Members hold their assurance providers to account for late or missing assurances.	Y			
Decisions and actions are implemented in line with the timescale set down.	Y			

Statement	Agree	Disagree	Don't know	Comments / actions (Audit Committee, June 2023)
3. Committee effectiveness				
The quality of committee papers received allows committees members to perform their roles effectively.	Y			
Members provide real and genuine challenge – they do not just seek clarification and / or reassurance.	Y			
Debate is allowed to flow, and conclusions reached without being cut short or stifled.	Y			
Each agenda item is 'closed off' appropriately so that the committee is clear on the conclusion, who is doing what, when and how, and how it is being monitored.	Y			
At the end of each meeting the committee discuss the outcomes and reflect on decisions made and what worked well, and not so well etc.		N		The Committee will consider doing this going forward.
The committee provides a written summary report of its meetings to the Board.	Y			
The Board challenges and understands the reporting from this committee.	Y			
There is a formal appraisal of the committee's effectiveness each year.	Y			
4. Committee engagement				
The committee challenges management and other assurance providers to gain a clear understanding of their findings.	Y			
The committee is clear about its role in relationship to other committees that play a role in relation to clinical governance, quality and risk management.	Y			
The committee receives clear and timely reports from other Board committees which set out the assurances they have received and their impact (either positive or not) on the organisation's assurance framework.	Y			Will receive annual reports / effectiveness reviews.
5. Committee leadership				
The committee chair has a positive impact on the performance of the committee.	Y			
Committee meetings are chaired effectively.	Y			
The committee chair is visible within the organisation and is considered approachable.	Y			
The committee chair allows debate to flow freely and does not assert his / her own views too strongly.	Y			
The committee chair provides clear and concise information to the Board on committee activities and gaps in control.	Y			

M

Name of meeting:	**Leicester, Leicestershire and Rutland Integrated Care Board meeting**		
Date:	10 August 2023	**Paper:**	**M**
Report title:	**Assurance Report from the ICB Health Equity Committee**		
Presented by:	Professor Azhar Farooqi, Non-Executive Member		
Report author:	Imran Asif, Corporate Governance Officer Daljit Bains, Head of Corporate Governance		
Sponsor:	Sarah Prema, Chief Strategy Officer		

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

Recommendations:

The LLR Integrated Care Board is asked to:

- **RECEIVE** the report for assurance.

Purpose and summary of the report:

1. This report provides a summary of the key areas of discussion and outcomes following the meeting of the ICB Health Equity Committee held on 20 June 2023. The report also covers items for escalation and consideration by the Board ensuring that the Board is alerted to emerging risks and issues.
2. A summary of the level of assurance provided by the Committee is detailed below.

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

The report is helping to deliver the following strategic objective(s) – *please tick all that apply***:**

1. 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 strategic risk(s) e.g. risk aligned to the Board Assurance Framework, risk register etc? *If so, state which risk and also detail if any new risks are identified.*	The Committee has oversight for the health inequalities risk on the Board Assurance Framework 2023/24.
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 due regard is integral to the remit of the Committee and is considered within reports presented to the Committee.

Assurance Report from the ICB Health Equity Committee

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

Key area discussed at the Committee meeting	Level of assurance (RAG)	Rationale for level of assurance	Risk(s) / issue(s) to escalate where required
1. ICB Board Assurance Framework	**RED**	The Committee reviewed the ICB Board Assurance Framework (BAF) risk 2 and proposed a minor amendment to the risk description: "*Failure to adequately address health inequalities due to a lack of investment* ***and / or*** *lack of* ~~*collaboration and*~~ *partnership working, therefore unable to improve health equity and outcomes for the population of LLR."* The current / residual risk score indicated further mitigations are required. Additional controls were identified by Committee members offering further assurance. The aspiration is to reduce the residual risk score within the next six months. The assurance level reflects the need to review the controls and assurance further. Further consideration may need to be given to the risk appetite score of 15.	The Board has subsequently approved the amendment to the risk description.
2. Maternity Health Equity and Equality Co-Designed Actions Plans	**GREEN**	Positive assurance was received in relation to the Maternity Health Equity and Equality Co-Designed Actions Plans against the following five domains: • Priority 1: Restore NHS services inclusively. • Priority 2: Mitigate against digital exclusion. • Priority 3: Ensure datasets are complete and timely. • Priority 4: Accelerate preventative programmes that engage those at greatest risk of poor health outcomes. • Priority 5: Strengthen leadership and accountability.	
3. Equality Delivery Scheme 2023/2023	**AMBER**	Positive progress was being made to publish data under the Equality Act, using the Equality Delivery Scheme (EDS). Further progress would be reported to the Committee in January 2024 prior to ICB Board approval being sought in February 2024.	
4. Overview and update from LPT	**GREEN**	An overview was provided demonstrating the breadth of work underway in LPT to challenge racism and health inequalities, create greater inclusivity and promote a culture of "enquiring minds" across the workforce, communities, and service users.	
5. Health Inequality Support Unit Update	**AMBER**	The deep dives into childhood immunisation uptake and ethnicity data indicated a correlation between lower vaccination uptake rates and Practices with a higher level of deprivation and / or higher rate of ethnic minority population. Proposal for targeted support for GP Practices was considered to aid improvement in childhood	A targeted approach is required to reduce the health inequalities for childhood immunisation.

Key area discussed at the Committee meeting	Level of assurance (RAG)	Rationale for level of assurance	Risk(s) / issue(s) to escalate where required
		vaccination uptake, and consideration was given to obtaining data and intelligence.	
6. Items for escalation / report to the Board	**AMBER**	• ICB BAF risk 2: risk description to be amended and additional controls to be identified (the Board has subsequently approved the amended risk description in July 2023 as proposed). • The Committee proposed targeting GP Practices that require support to improve the uptake of childhood immunisation and vaccinations.	

Key for level of assurance:

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

Recommendations

The LLR Integrated Care Board is asked to:

- **RECEIVE** the report for assurance.

N1

Meeting title:	LLR Integrated Care Board					
Date of the meeting:	10 August 2023					
Title:	Performance Assurance report - UHL					
Report presented by:	Richard Mitchell, UHL CEO					
Report written by:	Becky Cassidy, UHL Director of Corporate and Legal Affairs					
Action – this paper is for:	Decision/Approval		Assurance	x	Update	
Where this report has been discussed previously	UHL Trust Board – July 2023					

Purpose of the Report

At the request of the ICB, this report provides the key assurances in relation to performance at UHL. There is no reference to Finance and Quality as these are provided through alternative assurance structures.

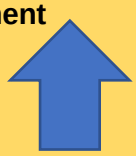
Recommendation

The ICB should receive the report noting the assurances provided.

Main report detail

Summary of UHL Performance: May 2023

Arrow Indication indicates the direction of performance. Colour is a subjective assessment of performance against standards and expectations.

Emergency Care 	May 2023 saw an increase in overall ED attendances (Types 1 to 3) with 4,069 more attendances than the previous month. Type 1 & Type 3 attendances saw the largest proportional increase (+13%) with Type 2 & seeing a slightly lower increase (+11%), 4 hour performance UHL ranked 80th out of 111 Acute Trusts. The National average in England was 74.0 %. Only 1 out of the 111 Acute Trusts achieved the target. UHL ranked 10th out of 16 trusts in its peer group. The best value out of the Peer Trusts was 79.9% and the worst value was 67.7%. , LRI monthly ambulance handovers over 60 minutes were at 5.8% (279 out of 4,792 handovers) which is a slight deterioration compared to April 2023 when LRI was 4.6% (202 out of 4,369 handovers).
Referral to Treatment 	Elective recovery remains challenged and total waiting list is large, but our focus remains on achieving the best possible position for 78 weeks plus breaches by the end of June 23. Our revised forecast position agreed with NHSE, taking into account the impact of June industrial action is 166. Whilst this is not at zero, there continues to be a month-on-month reduction in the longest waiters. We are actively monitoring our 65 ww March 24 cohort and working closely with the specialties who have the biggest challenge. This month UHL has joined the NHSE 'Further Faster' programme, taking part in the challenge of improving the elective recovery position sooner than the March 25 ambition of zero 52-week waiters. Improving productivity across the board in both theatres and outpatients remains a key priority and are starting to see some green shoots in improvement.

Outpatient Transformation 	The Outpatients Board in June agreed a clear strategy for Outpatients Transformation with 7 underlying work streams, to be progressed at pace. The delivery will focus initially on 5 key clinical specialties with quantifiable opportunities, whilst maintaining a focus on broad application of validation, PIFU, DNA and Clinic Utilisation. The Outpatient follow up reduction will be driven by: • Increase in PIFU: a relaunch with specialties is underway with support from the transformation team to reinvigorate the approach and share best practice • Digital solutions to overdue follow ups, validating the list and moving patients to PIFU where possible – which has already removed over 10,500 pathways • The introduction of GPSIs in the Gynae pathways, to move more activity to primary care and other pathway and triage approaches to increase the rate of discharge at first appointment.
Cancer 	After the improved landing for 2022/23 with a range of cancer metrics, led by the patients waiting over 62 days (>62ds) measure, this financial year has seen a subsequent deterioration due to the cumulative effects of industrial actions interspersed around Easter and Bank holidays which has been seen across multiple providers, both regionally and nationally. UHL is starting to see a recovery in the >62 days metric, our key lead measure. 28 day FDS and other measures are expected to follow the pattern seen within >62ds through April & May with improvements being tracked within June. A key focus on our now fortnightly meetings with NHSE/I has been the 62 day backlog position, with the Trust reaching 952 patients waiting at the beginning of November. As tumour site recovery plans, centred around daily monitoring of backlog levels, have taken affect, and as of 16th June this is now down to 529 from a second lesser peak of 598 on 25th May. June Industrial Action is expected to impact our cancer performance to a lesser degree, due to the absence of other special causes within the immediate vicinity, although risk remains.
Activity 	Elective Admissions between April 2023 and May 2023 were 622 over plan (3.2%); Day Case activity was 775 over plan (4.8%) and Inpatient activity was 153 under plan (-4.9%). Non-Elective Admissions between April 2023 and May 2023 were 74 over plan (0.4%); Emergency activity was 239 over plan (1.5%) and Non-Elective activity was 165 under plan (-4.4%). Outpatient activity between April 2023 and May 2023 was 7,067 under plan (-4.2%). Total ED activity between April 2023 and May 2023 was 636 under plan (-1.5%); Emergency Department (Type 1) activity was 841 under plan (-2.1%) and Eye Casualty (Type 2) activity was 205 over plan (5.9%).
Workforce 	There is an improved vacancy position for the majority of our KPIs. The exception is midwifery but the change from February to March is minimal. Recruitment and retention continues to be a key focus across all areas of the Trust and recruitment approaches and activities are being tailored to support the needs of the Trust, our services and the local community. Traditional recruitment activities are now complemented with large scale recruitment campaigns and events and a range of in reach activities which are tailored to the needs of local communities. Over the previous months events have focused on catering, pharmacy and healthcare support workers. Retention remains a priority with key work streams underway across the organisation which focus on elements linked to our Staff Survey priority areas (recognition, inclusivity, support and equipped). The Trust's turnover rate for May 2023 has de-creased by 0.4% and within the Trusts target of 10%. Staff absence has also shown a decrease of 0.5%, however is above the Trust target of 3%.

	The percentage of staff who have received an annual appraisal has increased by 1.6% and staff compliant with mandatory training topics has remained static outside of the 95% target. KPIs continue to be monitored through Trust Performance Review meetings.


N2

Name of meeting:	**Leicester, Leicestershire and Rutland Integrated Care Board** (public)		
Date:	10 August 2023	**Paper:**	**N2**
Report title:	LPT performance summary and escalations report July 2023		
Presented by:	Angela Hillery, Trust sector - community / mental health sector representative (Chief Executive Officer, Leicestershire Partnership NHS Trust)		
Report author:	Kate Dyer, Acting Director of Corporate Governance – LPT		
Executive Sponsor:	Richard Mitchell, Acute Trust Sector Representative (Chief Executive Officer, University Hospitals Leicester NHS Trust) Angela Hillery, Trust sector - community / mental health sector representative (Chief Executive Officer, Leicestershire Partnership NHS Trust)		

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

Recommendations:

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

- **RECEIVE for information.**

Purpose and summary of the report:

To share the outcome from the LPT July 2023 Accountability Framework Meeting where performance is discussed in full. This is based on an alert, advise and assure format to provide a summary of items discussed and the key messages (both positive and negative).

Appendices:	• None
Report history (date and committee / group the content has been discussed / reviewed prior to presenting to this meeting):	• None. This is the first report – the Board may wish to provide feedback on the suitability of format and content

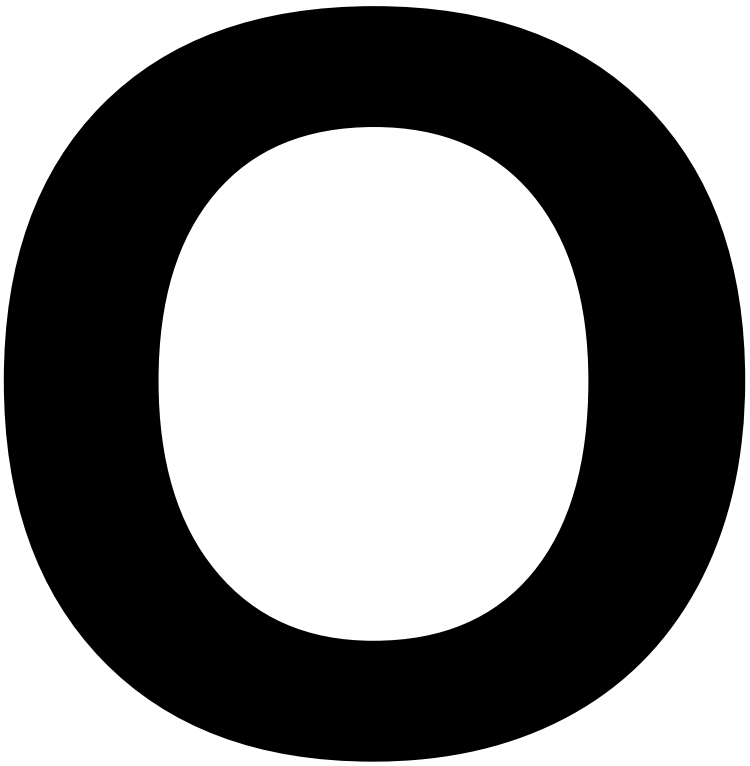
The report is helping to deliver the following strategic objective(s) – *please tick all that apply*:		
1. Improve outcomes	Improve outcomes in population health and healthcare.	☒
2. Health inequalities	Tackle inequalities in outcomes, experience and access.	☒
3. Value for money	Enhance productivity 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.*		NA
b) Does the report highlight any resource and financial implications? If so, provide which page / paragraph this can be found within the report.		NA
c) Does the report highlight quality and patient safety implications? If so, provide which page / paragraph this is outlined in within the report.		NA
d) Does the report demonstrate patient and public involvement? If so, provide which page / paragraph this is outlined in within the report.		NA
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.		NA

Leicestershire Partnership NHS Trust

Accountability Framework Meeting - Performance Summary & Escalations Report to the ICB: Accountability Framework Meeting – 21st July 2023			
AFM Agenda Item:	**AFM Reference:**	**Lead:**	**Description:**
ALERT: Alert to matters that need the ICB's attention or action, e.g. an area of non-compliance, safety or a threat to the Trust's strategy			
Directorate Accountability Framework Reports - DMH	AFM/23/069	Tanya Hibbert	ADHD – area of challenge, not subject to MIS funding and complicated by the private sector
Directorate Accountability Framework Reports - DMH	AFM/23/069	Tanya Hibbert	CAP – performance call answering – some data quality issues – work ongoing on this to support a live dashboard. Phone system supporting improvement. Front end review will be complete by September 2023 to support retendering process.
Directorate Accountability Framework Reports - FYPCLD	AFM/23/071	Helen Thompson	Neurodevelopmental & paediatrics – wait list is growing.
ADVISE: Advise the ICB of areas subject to on-going monitoring or development or where there is negative assurance			
Directorate Accountability Framework Reports - DMH	AFM/23/069	Tanya Hibbert	Adult Psychiatry - wait time stable; CMHT vacancies & waits – largest transformation focus; Memory Service – waiting list initiatives to support reducing wait times; TSPPD - trusted assessment process has reduced waiting times but waits remain lengthy – 4 years;
Directorate Accountability Framework Reports - CHS	AFM/23/070	Sam Leak	CHS waiting lists – all targets on a trajectory to compliance – more positive picture moving forward – this was completed as a clinical review to support pathways.
Performance Dashboard Report	AFM/23/074	Sharon Murphy	Special cause/concern areas – memory clinic, ADHD & CAMHS
ASSURE: Inform the ICB where positive assurance has been received			
Directorate Accountability Framework Reports - DMH	AFM/23/069	Tanya Hibbert	Casework management reviews process – successful progress & national award received
Directorate Accountability Framework Reports - DMH	AFM/23/069	Tanya Hibbert	Mental Health Best Practice Groups set up

Directorate Accountability Framework Reports - DMH	AFM/23/069	Tanya Hibbert	CBT – wait time reduction – nothing over 52 weeks; Inpatient 72 hour follow up – new addition – 72 hour follow up – supporting quality & safety. April achieved 85%, May 84%.
Directorate Accountability Framework Reports - FYPCLD	AFM/23/071	Helen Thompson	3 business cases approved – working out the governance framework for these: good recruitment around CAMHS access and paediatrics; complex CYP escalation tool – route mapping – positive piece of work.
RISK: Advise the ICB which risks were discussed and any new risks identified			
All	All	All	All relevant risks both directorate & organisational discussed as appropriate – no new risks identified.
CELEBRATING OUTSTANDING: Share any practice, innovation or action that the Trust considers to be outstanding			
Directorate Accountability Framework Reports -All	AFM/23/various	All	Finance position at month 4
Directorate Accountability Framework Reports - Finance	AFM/23/072	Sharon Murphy	Unqualified opinion from accounts;
Directorate Accountability Framework Reports - Estates	AFM/23/073	Paul Sheldon	Estates - achieving national cleaning standards now; Medical devices improvement over the last 12 months - QI process being used – now 98% compliance



Briefing Summary of the April Meetings of the East Midlands Joint Committee Meetings Held on Tuesday 18 April 2023

1. Purpose

1.1. This **ADVISORY** report is presented to provide a summary with a summary of the East Midlands Joint Committee meetings held on Tuesday 18 April 2023.

2. NHS East Midlands Joint Committee for Specialised Services

2.1. Formalisation of the Joint Committee

The committee adopted the Terms of Reference, confirmed the appointments to the membership of the committee and approved the appointment of David Sissling (Chair of NHS Leicester, Leicestershire, and Rutland Integrated Care Board [ICB]) as the Chair of the committee. The committee discussed the current requirement for the Chair to be taken from the Core Membership what resulted in a Non-Executive carrying the vote for an ICB rather than an Executive. An action was taken to approach NHS England (NHSE) to explore the proposal for the Chair to be taken from the broader discretionary (non-voting) membership and for this to be fed back into the committee meeting in June.

2.2. Proposal for Development of Future Commissioning Arrangements

The committee received an outline proposal for how NHSE and the ICBs will work to support future commissioning arrangements with alignment to the delegation of services from April 2024. The committee approved the proposed approach noting the role the committee will have in this work.

2.3. Midlands Acute Specialised Commissioning Groups Update

The committee noted the update presented on the meeting held on 13 March 2023. The committee requested that future reports provide a focus on the highest priority issues for services and for this approach to be tested at the next meeting.

2.4. 2023/24 Operational Plan for NHSE Directly Commissioned Services Including Pharmacy, Ophthalmic and Dental (POD) Services

The report noted that NHSE have taken steps to work collaboratively with ICBs to develop a plan that focused deliver of the triple aim of better health, better care, and lower costs, and the identification of priority pathways which addressed national and regional transformation priorities. The committee noted the plan presented by NHSE and discussed the need to develop the process of enhancing collective insight to shape future plans.

2.5. 2023/24 Financial Plan for NHSE Directly Commissioned Services

The committee noted the plan presented by NHSE with regard to Directly Commissioned Services.

3. NHS East Midlands Integrated Care Boards Joint Committee

3.1. Formalisation of the Joint Committee

The committee adopted the Terms of Reference, confirmed the appointments to the membership of the committee and approved the appointment of David Sissling (Chair of NHS Leicester, Leicestershire, and Rutland Integrated Care Board [ICB]) as the Chair of the committee.

3.2. Primary Care Delegation POD Governance Arrangements

The committee received a proposal for the Governance Framework for Tier 2 and below with regard to POD services, Inclusive of examples of the enaction of decision-making processes. It was agreed that a review would be undertaken to learn from the reality of operating after a few months of operating the committee/ groups. The associated Standard Operating framework and Hosting Agreements are in development and will be present to the meeting in June. The committee approved the Tier 2 and 3 Terms of Reference, noted the arrangement for review and the documents to be present to the June meeting.

3.3. 2023/23 Financial Plan for PODs

The committee approved the proposal for the 2023/24 Financial Plan for POD services, noting that a duly established collaborative Finance group would maintain overview of deliver against the wider plan, and would operate with the intent of exploring opportunities to ensure monies are allocated in the most appropriate manner in terms of efficiency and equity.

3.4. NHS Midlands 111 Procurement Update

The committee received an update on the Midlands 111 procurement process. It was noted that this was the first time such an update had been presented to a joint meeting. The committee sought assurance on the process being undertaken and requested that a more detailed update be provided to the meeting in June.

3.5. NHS 999/11 Update – Governance and Oversight

The committee received an update on the proposed collaborative governance and oversight arrangements for NHS 999/111 services in 2023/24 and discussed the potential for linking the existing work to the Joint Committee arrangements, inclusive of the benefit of collaborative discussion whilst maintaining local engagement. It was agreed that options should be explored outside of the meeting with the aim of presenting an informed options appraisal to the meeting in June.

4. Recommendation

4.1. This briefing summary is provided for information to be noted.

Briefing Summary of the Meetings of the East Midlands Joint Committee Meetings Held on Tuesday 20 June 2023

1. Purpose

1.1. This **ADVISORY** report is presented to provide a summary with a summary of the East Midlands Joint Committee meetings held on Tuesday 20 June 2023.

2. NHS East Midlands Joint Committee for Specialised Services

2.1. Formalisation of the Joint Committee

The committee confirmed the revised appointments to the core (Executive) and discretionary (Non-Executive) membership of the committee and noted the continued appointment of David Sissling (Chair of NHS Leicester, Leicestershire, and Rutland Integrated Care Board [ICB]) as the Chair of the committee. The committee discussed the opportunity of extending standing invitations to further NHS England colleagues in support of the committees' duties and agree an action to explore this further outside of the meeting and in advance of the meeting in August.

2.2. Specialised Services (Developing Future Commissioning Arrangements, Clinical Engagement, Priority Setting)

The committee received an update of how NHSE and the ICBs will work to support the development of future commissioning arrangements, clinical engagement, and the setting of commissioning priorities through the establishment of a multi-year plan. Focus was placed on effective engagement inclusive of early clinical leadership. The committee noted the update.

2.3. Midlands Acute Specialised Commissioning Groups Update

The committee received an update on the work being undertaken through the Group and the draft Terms of Reference for the Group. With regard to the Terms of Reference, these were approved in principle with a request to further define trigger points for escalation between the Group and Committee. The Committee noted the update and requested the next update provided a focus on quality management and strategic risk.

2.4. Neonatal Services in the East Midlands: Regional Priority Overview

The Committee received this report as the first in its schedule of Deep Dives aimed at strengthening the knowledge and understanding of the Committee. Neonatal Critical Care being one of four key priority pathways in the Midlands. The Committee noted the report. The report noted that NHSE have taken steps to work collaboratively with ICBs to develop a plan that focused deliver of the triple aim of better health, better care, and lower costs, and the identification of priority pathways which addressed national and regional transformation priorities. The committee noted the plan presented by NHSE and discussed the need to develop the process of enhancing collective insight to shape future plans.

2.5. Midlands Acute Specialised Commissioning: Schedule of Deep Dives

The Committee received a proposal for the schedule of Deep Dives. This proposal is based upon the Priority Pathways agreed as part of the Regional Commissioning Planning processes. The Committee approved the schedule as proposed.

2.6. AoB; Role of Delegated Commissioning Group and Joint Committees

The Committee received a presentation on the role of the National Delegated Commissioning Group and its alignment to the Regional Joint Committees. The Committee agreed for Matt Day (NHS England Regional Director Specialised Commissioning, Health and Justice to be the interim East Midlands representative to allow for further understanding of the ask.

3. NHS East Midlands Integrated Care Boards Joint Committee

3.1. Primary Care Assurance Report

The Committee received a report for assurance from the Tier 2 Committee meeting held on 11 May 2023. Key matters for escalation were presented via following papers. The Committee consider specific challenges around Dental access and Community Pharmacy provision, and the approach to financial risk sharing across the Region. The Committee noted and were assured by the content of the paper.

3.2. Primary Care Delegated Services Financial Plan 2023/24

The committee received the proposed Plan for 2023/24. The Committee agreed that the plan provided a pragmatic approach to this year but that future years should be focused upon mitigating inequalities in provision/ access, noting the risk share proposal that would see funds aligned to committed/ anticipated expenditure within the East Midlands and the wider Midlands region. The Committee approved the plan.

3.3. East Midlands Intermediate Minor Oral Surgery Procurement

The Committee received a proposal with regard to the procurement of Intermediate Minor Oral Surgery services. The proposal had been developed by the Tier 2 Group and escalated to the Committee for approval. The Committee sought assurance with regard to process, quality, outcomes, and the proposed next steps. An included options appraisal and associated risk profile had been informed by legal opinion. The Committee were not assured and so did not approve the proposal, requesting further consideration by Tier 2 and for a refined proposal to be brought back to a subsequent meeting. The Committee asked for Tier 2 to undertake a lessons learnt appraisal.

3.4. NHS Midlands 111 Procurement and Contract Award

The Committee received an update on the Midlands 111 procurement process and contract award. The Committee were asked to consider the proposed role it would play in decision making and the aligned asks of the individua ICBs. The committee took assurance of the processes being undertaken and supported the intention for it to receive delegated authority from the ICB Boards.

3.5. NHS 999/11 Update – Governance and Oversight Arrangements

The Committee received an update on the proposed collaborative governance and oversight arrangements for NHS 999/111 services in 2023/24 and discussed the potential for linking the existing work to the Joint Committee arrangements. It was agreed that a full options appraisal should be presented to the next meeting in August.

3.6. Developing the East Midlands Office

The Committee received an outline proposal for the establishment of an East Midlands Office whose role would be to co-ordinate and drive forward both sub-regional and regional collaboration. The Committee approved the proposal in principle, requesting further work be done in defining the roles and responsibilities and how it added value to collaboration, linkages between it and existing resource working across systems and the consideration of communications.

4. Recommendation

4.1. This briefing summary is provided for information to be noted.