Meeting Title	**Leicester, Leicestershire and Rutland (LLR) Integrated Care Board meeting** (meeting held in public)	**Date**	**Thursday, 12 October 2023**
Meeting no.	**11**	**Time**	**Meeting in public: 9:00am – 10:45am** **Confidential meeting: 10:50am – 11:30am**
Chair	**David Sissling** **Independent Chair, ICB**	**Venue / Location**	MSTeams

REF	AGENDA ITEM	ACTION	PRESENTER	PAPER	TIMING
ICB/23/108	Welcome and Introductions	To receive	David Sissling	**Verbal**	9:00am
ICB/23/109	Apologies for Absence: • Caroline Gregory (Spencer Gay deputising) • Richard Mitchell (Simon Barton deputising) • Angela Hillery (Jean Knight deputising) • Mike Sandys • Sir Mayur Lakhani • Prof Azhar Farooqi • Dr Nainesh Chotai	To receive	David Sissling	**Verbal**	9:00am
ICB/23/110	Notification of Any Other Business	To receive	David Sissling	**Verbal**	9:00am
ICB/23/111	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/23/112	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/23/113	• Minutes of the meeting held on 10 August 2023 • Minutes of the Annual General Meeting held 14 September 2023	To approve	David Sissling	**A1** **A2**	9:15am
ICB/23/114	Matters arising and actions for the meeting held on 10 August 2023	To receive	David Sissling	**B**	
ICB/23/115	Update from the Chair	To receive	David Sissling	**Verbal**	9:20am
ICB/23/116	Update from ICB, Acute Sector and Mental Health and Community Sector	To receive	Andy Williams /Jean Knight / Simon Barton	**Verbal**	9:25am
SHARING CASE STUDIES AND PATIENT STORIES					
ICB/23/117	Learning disability health checks	To receive	Rachna Vyas	**C** **presentation**	9:35am
STRATEGY AND SYSTEM PLANNING					
ICB/23/118	Feilding Palmer Pre-Consultation Business Case (PCBC) *(appendices to the PCBC available on the ICB website https://leicesterleicestershireandrutland.icb.nhs.uk/about/board-meetings/)*	To approve	Sarah Prema	**D**	9:45am

REF	AGENDA ITEM	ACTION	PRESENTER	PAPER	TIMING
ICB/23/119	Primary Care Access Recovery Plan - LLR System-level Access Improvement Plan	To approve	Rachna Vyas / Dr Nil Sanganee	**E**	9:55am
OPERATIONAL					
ICB/23/120	LLR Delivery Partnership – Delivery of the LLR one- and five-year plans	To receive	Rachna Vyas	**F**	10:05am
ICB/23/121	National Thematic Review - Maternity CQC Inspection (including S29a Warning Notice) Update	To approve	Caroline Trevithick / Julie Hogg	**G (a) and G (b)**	10:15am
ICB/23/122	LLR ICB Finance Report	To receive	Spencer Gay	**H**	10:25am
ASSURANCE					
ICB/23/123	Assurance report from the Finance Committee and terms of reference	To approve	Jeff Worrall	**I**	10:35am
ICB/23/124	Assurance report from the System Executive Committee	To receive	Andy Williams	**J**	
ICB/23/125	Assurance report from the Quality and Safety Committee	To receive	Pauline Tagg	**K**	
ICB/23/126	Assurance report from the Audit Committee	To receive	Darren Hickman	**L**	
ICB/23/127	Assurance report from the Health Equity Committee	To receive	Prof Azhar Farooqi	**M**	
ICB/23/128	Summary of the East Midlands Joint Committee held in August 2023	To receive	David Sissling	**N**	
GOVERNANCE					
ICB/23/129	Partnership and governance self-assessment and review	To receive	Sarah Prema	**O**	10:40am
FOR INFORMATION					
ICB/23/130	Specialised Services Pre-delegation Assessment Framework (PDAF)	To receive	For information	**P**	-
ANY OTHER BUSINESS					
ICB/23/131	Items of any other business and review of meeting	To receive	David Sissling	**Verbal**	10:45am

The next regular meeting of the LLR Integrated Care Board meeting will take place on **Thursday 14 December 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.*

A1

Minutes of the NHS LLR Integrated Care Board ("the ICB" or "the Board")
Held in Public, Thursday 10 August 2023
9:00am – 11:30am, via MSTeams

Members present:

Mr David Sissling	NHS LLR ICB Independent Chair and Chair of the meeting
Mr Andy Williams	Chief Executive, NHS LLR ICB
Dr Caroline Trevithick	Chief Nursing Officer, NHS LLR ICB
Dr Nil Sanganee	Chief Medical Officer, NHS LLR ICB
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 Jean Knight	Community/mental health sector representative (Managing Director / Chief Operating Officer, 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:

Dr Janet Underwood	Chair, Healthwatch Rutland
Ms Cathy Ellis	Chair of Leicestershire Partnership NHS Trust
Cllr Sarah Russell	Chair of Leicester City Health and Wellbeing Board
Cllr Diane Ellison	Chair of Rutland Health and Wellbeing Board
Cllr Louise Richardson	Chair of Leicestershire Health and Wellbeing Board

In attendance:

Mr Paul Gilbert	Community Pharmacy Clinical Lead, NHS LLR ICB (*for item ICB/23/94 only*)
Mr Vishal Mashru	Head of Medicines and Research, Cross Counties and North Blaby PCN (*for item ICB/23/94 only*)
Ms Caroline Goulding	Head of Primary Care Services (East Midlands), East Midlands Primary Care Team (*for item ICB/23/95 only*)
Mrs Daljit Bains	Head of Corporate Governance, NHS LLR ICB
Ms Charlotte Gormley	Corporate Governance Officer, NHS LLR ICB (minute taker)

Ten members of the public attended to observe the meeting.

ITEM		LEAD RESPONSIBLE
ICB/23/85	**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.	

ITEM		LEAD RESPONSIBLE
ICB/23/86	**Apologies for absence from Members and Participants:** • Ms Angela Hillery, Partner Member - community/mental health sector representative (Chief Executive, Leicestershire Partnership NHS Trust) • Ms Harsha Kotecha, Chair Healthwatch Leicester and Leicestershire • Mr Richard Henderson, Chief Executive, East Midlands Ambulance Service	
ICB/23/87	**Notification of Any Other Business** No additional items of business had been notified.	
ICB/23/88	**Declarations of Interest on Agenda Items** No specific declarations were noted on agenda items. The register of interests was published on the ICB website and reviewed on a regular basis.	
ICB/23/89	**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. The questions received, and the responses provided were as follows: <u>Question received from Anna Bland on behalf of the Leicester and Leicestershire Citizens Alliance campaign on discrimination in healthcare.</u> *1. Would the ICB consider varying some of the timings of their meetings to three evening meetings per year, in order to make it more accessible to the public?* Mr Andy Williams confirmed that the ICB was committed to openness and transparency and conducted the majority of its business within meetings held in public to enable members of the public to attend and observe. The timing of these meetings would continue to be considered. Mr Williams also reminded members of the public of alternative options to be involved in the work of the ICB, details for which are available on the ICB website. <u>Questions from Manohar Patel</u> *1. Why are Doctors still working from home as you cannot get a face-to-face appointment as the pre pandemic has finished. If more doctors were to be present in the Surgery, we might see the plan average increase to 90%.* *2. Cancer backlogs and the diagnostic waiting time ambition of 95% are they ever going to be achievable and same for 62 days and 28 days referral from GP and reduce the number of people waiting 62 days to start treatment: to February 2020 level.* *3. Diagnostics, Key Performance Indicator. Patients that receive a Diagnostic test within six weeks, Latest month, Apr 23, 59% and the Target 95% by March 2025. Is this going to be possible as it has been mentioned with NHS strikes budget deficits.* *4. UHL Chief operating officer John Melbourne said improvements to Hospitals' performance would further reduce waits for patients. The new Midlands Planned care Centre opened at Leicester General Hospital in June. Can the current waiting for the Cancer patients be treated at this new Centre.* *5. Are Cancer patients going to benefit from the private sector treatments. Cancer waiting times University of Leicester NHS Trust (ranks 124th out of 141 trusts in England) which is 83.6% against NHS target 96%.* *6. What are the contingency plans for further risk events for Covid.*	

ITEM		LEAD RESPONSIBLE
	In response to the first question, Mr Williams advised that general practices across LLR had implemented a triage process to manage demand. There were multiple ways to access care based on clinical needs, including by telephone, online, and face-to-face consultations. It was noted that 75% of all clinical appointments offered in the year to date had been face-to-face. This was above the NHS England average for the same period as well as the internal LLR benchmark of 70%, which was based on best practice evidence. LLR was performing just below the national average for same day appointments. In response to the second question, Mr Williams advised that the number of patients in the diagnostic backlog had fallen significantly since October 2022. The LLR System was on track to deliver the expectation of 85% of patients waiting less than 6 weeks by the end of March 2024, leading to 95% by March 2025 in the key 7 modalities listed in the operational plan. At the end of June, the plan for recovery in these 7 modalities was to be at 39%, however the actual performance was 29%. Reducing the 62-day cancer backlog was a key aim. At its peak in October 2022 the backlog was 863 patients. A huge amount of improvement work had taken place since then with the backlog at 469 as of 23 July 2023. Further improvements were planned. For the Cancer 28-day Faster Diagnosis Standard, performance had improved from 71% in May 2023 to 73% in June 2023. LLR expected to deliver against the 75% by year end. LLR would also invest c.£4m of additional cancer funds to focus further on pathway improvement, particularly in Urology, Lower GI and Skin. In response to the third question, Mr Williams advised that for all diagnostic tests as reported nationally each month, the performance at UHL for June 2023 was 65% of patients waiting less than 6 weeks. UHL continued to see improvement and expected to meet the 95% ask by March 2025. Additional capacity had been in place for imaging and echo since the start of the year. A modular unit for Endoscopy had been operational since 24 July 2023. In response to the fourth question, Mr Williams advised that Phase 1 of the East Midlands Planned Care Centre had established one theatre and a recovery area. Whilst this freed up some capacity on existing theatre lists for cancer patients it would not be until Phase 2, when the centre would be fully open, that additional outpatient capacity would further enable faster 2 week wait referral to treatment times. This would apply particularly to gynaecology and urology. In response to the fifth question, Mr Williams advised that LLR had seen an increase of 171% in independent sector activity in 2022 to 2023 compared to 2019 to 2020 levels. There was a plan for 2023 to 2024 activity levels to reach 185%. Independent sector capacity for cancer treatment was limited but the ICB would continue to explore all clinically appropriate options. In response to the sixth question, Mr Williams advised that plans for dealing efficiently and effectively with a COVID surge were based on learning from previous episodes. All surge plans across the health and care economy remained in place and responses would be delivered with strong Public Health leadership supported by multi-agency coordinating groups.	

ITEM		LEAD RESPONSIBLE
	Questions from Sally Ruane *1. When will the ICB clarify for the public how its plans for reconfigured hospital services compare with the proposals set out and approved in the Building Better Hospitals For the Future Decision Making Business Case in June 2021?* *2. Recently a child died following inaccurate advice and, it appears, inaccurate diagnoses by a physician associate whom the mother believed was a doctor. In addition, the physician associate appears to have prescribed medication without the oversight of a GP. How many physician associates are currently employed in surgeries within Leicester, Leicestershire and Rutland?* *3. What plans does the Board have to ensure that:* *(a) patients will always be aware of the professional identity of their carer?* *(b) carefully defined restricted roles will be enforced with regard to the assistant/associate roles being developed and that these role definitions will be accessible to the public?* *(c) general practitioner and nurse practitioner numbers will be increased before more physician and nurse associates are placed in general practices?* *(d) the training of associates in hospitals, for example with regard to exposure to medical procedures, will not be at the expense of junior doctors, as appears to be the case in some acute hospitals?* Mr Williams noted that a response to the first question would be provided via the LLR ICB enquiries route, as the question was not pertinent to the agenda. In response to the second question, Mr Williams advised that 36 physician associates were employed in surgeries within Leicester, Leicestershire, and Rutland at the current time. In response to the final question, Mr Williams advised that every organisation had a responsibility to ensure the implementation of good working practice, which included staff wearing identity badges and introducing themselves to the patient. He noted that clear definitions for each of the ARRS roles could be accessed from practices, and were available via the following link: https://www.england.nhs.uk/long-read/additional-roles-a-quick-reference-summary/ Furthermore, Mr Williams advised that all practices had a workforce plan which considered their population health needs, to understand what professional and clinical staffing was needed to meet those needs. As of April 2023, 524 GPs were in place with a planned increase of 16 by March 2024. For the same period, 289 nurses were in post with a planned increase to 292 by March 2024. Mr Williams confirmed that all training was undertaken under strict guidance and was compliant with the regulatory framework, in accordance with each profession. These roles were part of NHS England's response to the workforce challenge.	
ICB/23/90	**Minutes of the meeting held on 13 July 2023 (Papers A)** The minutes were confirmed as an accurate record. **It was RESOLVED to:** • **APPROVE** the minutes of the ICB Board meeting held on 13 July 2023.	
ICB/23/91	**Matters Arising and actions for the meeting held on 13 July 2023 (Paper B)**	

ITEM		LEAD RESPONSIBLE
	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/23/92	**Update from ICB Chair** Mr Sissling thanked members for contributing items to the agenda and encouraged members to continue shaping agendas for future meetings. Mr Sissling acknowledged the positive reflections within the annual assessment letter received from NHS England and thanked the Board members, staff and partners for their contributions to the progress made by the ICB. The letter would be published in due course. Furthermore, the recent Quarterly System Review Meeting (QSRM) with NHS England had been broadly positive, with finance highlighted as a key area of challenge. It was announced that the ICB's Annual General Meeting (AGM) would be held on Thursday 14 September 2023 at the Leicester Racecourse in Oadby. This would provide an opportunity to reflect on progress, challenges, and the ICB's ambitions for the future. Members of the public would be welcome to attend, and further details would be advertised over the coming weeks. Noting that this was Ms Cathy Ellis' last meeting, Mr Sissling expressed his thanks for her contributions as both the Chair of Leicester Partnership NHS Trust (LPT) and the chair of the LLR ICB's Finance Committee. **It was RESOLVED to:** • **RECEIVE** the update.	
ICB/23/93	**Update from ICB, Acute Sector and Mental Health and Community Sector** Mr Williams elaborated on the QSRM advising that the positive progress made by the ICB was acknowledged. However NHS England also emphasised the continued financial challenges and confirmed the requirement for responsive action at a system and an organisational level. An update on East Leicester Medical Practice (ELMP) highlighted that refurbishment and improvements to the building were progressing well to enable the building to reopen at the end of August 2023. The difficulties posed to staff and patients were acknowledged and thanks expressed for their forbearance. Mr Williams was pleased to advise that LLR ICB was rated fourth out of the 42 ICBs in England for digital maturity and progress continued to be made against the digital agenda. In addition, it was noted that LLR ICB had been shortlisted for an award in recognition of the approach to inclusivity in its Active Bystander programme. Mr Richard Mitchell also acknowledged the financial challenges and highlighted the importance of ensuring that focus on finance was not to the detriment of performance or quality. He advised that UHL's formal strategic relationships had enabled improvements to clinical services, urgent and emergency care,	

ITEM		LEAD RESPONSIBLE
	and planned care. Work continued with the seven Acute Trusts in the East Midland's Providers' Network. The Trust was actively building its relationship with the community. It was acknowledged that Leicester had been reported as the most ethnically diverse city in the UK. UHL celebrated its diverse workforce and provided cultural competence training, multi-lingual services, and initiatives reaching out to marginalised communities. The Trust was currently celebrating South Asian Heritage Month. Mr Mitchell drew attention to the ongoing industrial action, which would result in disruption to patients and staff. Ms Jean Knight advised that LPT had also placed focus on the diversity, equality, and inclusion agenda. The LPT Lead for the International Nurses Programme had been nominated for the nurse of the year award. The outcome of the joint area inspection led by Ofsted concluded that children in Rutland with special educational needs and disabilities were thriving. The highest possible grade had been awarded for local services, with recognition of partnership arrangements within the report. A right care at the right time workshop would take place in August 2023 in partnership with organisations such as the police. LPT's AGM would be held on Monday 11 September 2023 via MSTeams. This would provide an opportunity to reflect on achievements and the great work completed. Details were available on the Trust's website. The Celebrating Excellence Awards final for LPT staff would be held on 22 September 2023. Mr Sissling thanked members for their updates. **It was RESOLVED to:** • **RECEIVE** the updates.	
ICB/23/94	**Community Pharmacy (Paper C)** Dr Sanganee introduced the presentation, advising that over 2000 referrals had been made to Community Pharmacy Clinical Services, relieving pressure on general practice. He highlighted the importance of Community Pharmacy when considering access to health services for minor illnesses, long term conditions, vaccination programmes, and contraception. Mr Gilbert drew attention to the potential for Community Pharmacy Clinical Services to create capacity across the system through the treatment of minor ailments and by encouraging self-care. LLR was performing highest in the East Midlands region with 60% of practices referring patients to the service. Further growth was still to be realised and an action plan was in place. It was noted that the locum workforce in some areas had resulted in inconsistent delivery and difficulties in making referrals. Mr. Gilbert advised that a national programme was in place with the aim for all newly qualified pharmacists to be prescribing pharmacists from 2024.	

ITEM		LEAD RESPONSIBLE
	It was noted that medicines were the second highest budget cost after workforce. Community Pharmacy Clinical Services would create financial opportunities and increase access to care. There was some discussion regarding patient experience and involvement, particularly in terms of addressing a reluctance to access Community Pharmacy Clinical Services as an alternative to general practice. It was noted that education would be important in enabling patients to think 'pharmacy first'. Work was taking place to showcase the variety of services available within primary care, informing patients of the benefits which included increased access to services and expertise. It was confirmed that the number of 'bounce backs' to general practice would be monitored. In some cases, it would be appropriate for patients to be signposted back to their GP or urgent and emergency care. It was acknowledged that the volume of self-referrals would be challenging to capture however patient experience and feedback would continue to be reviewed. The Board received assurance that patients remained at the centre of the experience and that no issues regarding poor experience had been raised. It was confirmed that patients entitled to free prescriptions would not be charged for prescriptions written by community pharmacists. **It was RESOLVED to:** • **RECEIVE** the presentation.	
ICB/23/95	**Briefing on NHS Dentistry (Paper D)** Dr Sanganee introduced the item and provided an overview of NHS dental services across Leicester, Leicestershire and Rutland. He noted Pharmacy, Optometry and Dental services (PODs) had been delegated to ICBs as of April 2023. Hosted arrangements were in place and led by Nottingham and Nottinghamshire ICB on behalf of the five East Midlands ICBs. Ms Goulding acknowledged the national challenges regarding access to NHS dental services. She noted that a sufficient overall number of dentists were operating across LLR, however many were not working for the NHS. This was largely due to matters relating to terms and conditions as defined by national contracts. Ms Goulding, moreover, highlighted significant challenges in recruiting associated professionals such as technicians, hygienists, and receptionists. It was noted that the oral health need assessments would be refreshed to understand the impact of the pandemic and a national mandated recovery programme would be implemented. This programme was likely to include additional weekend access sessions and enhanced child services, with a focus on reducing waiting times and addressing unnecessary referrals to secondary care. It was noted that, whilst overall access to NHS dental services in LLR was recorded at 23.3%, access in Rutland was as low as 17%. A range of issues were raised by Board members including the affordability of private dental treatment and the difficulty in accessing emergency treatment.	

ITEM		LEAD RESPONSIBLE
	The Board received assurance that funding released by under delivery of contracted NHS dentistry services was re-invested to create additional capacity. Further plans to reprocure services would be considered following the refresh of the oral health needs assessment. It was highlighted that further work was required to address the specific needs of looked after children, noting the poor experiences of individuals in this vulnerable cohort. Due to the limited availability of access to NHS dental services, refreshed oral health needs assessments and public health data would inform the targeting of resources towards the most vulnerable groups. Information would also be collated regarding access to private practices and the level of patient movement to private practice on the closure of NHS services. Mr Sissling noted the challenges highlighted and the responsive work underway. He suggested that a longer session may be required to develop further insight into NHS dental services. The Board would receive periodic updates on relevant matters. **It was RESOLVED to:** • **RECEIVE and NOTE** for assurance the current position of NHS dental services (primary and secondary care) across Leicester, Leicestershire and Rutland.	
ICB/23/96	**NHS Long Term Workforce Plan (Paper E)** Ms McGee provided an overview of the national NHS Workforce Plan and described the relevant local approach to implementation. She advised that the workforce agenda would focus on the themes of training to increase capacity, enhancing retention, and transformation of the workforce. The approach would be implemented across health and social care as far as possible. The national Plan recognised the importance of talent management for succession planning and enabling greater inclusivity. Additional areas of focus included apprenticeships, career pathways, and anchor institutions. Locally, a workshop would take place in October 2023 to consider priority areas and what the plans would mean for LLR. Members were encouraged to register for the event. Board members emphasised the importance of accurate and relevant data- about recruitment and retention matters. It was also noted that staff surveys were an important means of collecting experiential information. Mr Sissling underlined the significance of the national plan and was encouraged by local progress. He invited periodic updates for the Board. **It was RESOLVED to:** • **RECEIVE and NOTE** the NHS Long Term Workforce Plan and the associated next steps for Leicester, Leicestershire and Rutland ICS	
ICB/23/97	**Winter Plan 2023/24 (Paper F)** Mr Mitchell advised that LLR had made significant progress in urgent and emergency care performance over the last 12 months, including improvement in ambulance handover times. To sustain improvements, focus would be	

ITEM		LEAD RESPONSIBLE
	placed on increasing capacity; growing workforce; accelerating hospital discharges; enhancing access to services; and providing care in the right place at the right time in accordance with national guidance. The Winter Plan was necessarily detailed and covered all key areas. There was a recognition that action would be required in all sectors. The pressures, for example, on primary care and social care were significant and presented risk to patient flow through the system. Ms Vyas advised that the Winter Plan would require a full partnership approach inclusive of local government, health partners, and Healthwatch. Over the following years, plans would focus on sustainability and surge planning rather than seasonal planning. New models of care would be introduced or extended at scale. It was noted, for example, that work was taking place across organisations to provide the best possible experience for patients in the areas of respiratory, cardiology, and frailty. Occupancy of virtual wards had increased to 60% and was on target to reach 80% by September 2023. Mr Mitchell emphasised the need to pay appropriate attention to quality and safety matters and balance these alongside access and financial priorities. The Board would receive periodic updates regarding the plan and its implementation. **It was RESOLVED to:** • **APPROVE** our winter plan for 2023/24	
ICB/23/98	**LLR Delivery Partnership Summary Report (ICB and system operational performance) (Paper G)** Ms Vyas introduced the report, advising that the LLR Delivery Partnership had been established to oversee the delivery of the Operational Plan and Five Year Plan. Reports from the Delivery Partnership would also provide a mechanism for escalation to the Board. Feedback on the format and content of the report had been received from committees of the Board. Future reports would continue to evolve in terms of content and format. Overall performance was rated as amber against 31 indicators with good progress being evidenced. Specific highlights included improvements for urgent care, planned care, cancer and diagnostics. There was also impressive progress in respect of aspects of primary care, out of area placements and access to talking therapies. Challenges remained evident in a number of areas including aspects of maternity and neonatal care. Ms Vyas clarified that the RAG ratings indicated progress against the agreed trajectory of the plan and not the overarching specific performance. Metrics had been determined in line with relevant national specifications and work had taken place to ensure consistency of reporting. It was confirmed that the report could also be broken down at neighbourhood level. The Board welcomed the report, which brought together a range of indicators and insights whilst celebrating progress and highlighting challenges simultaneously.	

ITEM		LEAD RESPONSIBLE
	It was RESOLVED to: • **RECEIVE AND NOTE** the full contents of the report, the escalations made to each committee of the Board and the revised framework being assessed for Q2.	
ICB/23/99	**LLR ICB Finance Report (Paper H)** Ms Gregory reminded the Board of key contextual matters and the way the financial position had developed over the last few months. It was noted that the LLR system was reporting a year-to-date deficit at month 3 of £25.7m which represented a £10.4m adverse variance to plan. UHL were reporting a £21.9m deficit and the ICB a £3.1m deficit. LPT were reporting a small year-to-date deficit The adverse variance is due predominately to unplanned inflationary pressures, industrial action and delayed delivery of some cost improvement programmes. Risks were being actively managed and early consideration of further additional measures to enable recovery was underway. Four key workstreams had been identified and overseen by the System Executive with engagement from partners. It was noted that a return would be prepared for NHS England regarding costs incurred as a result of industrial action. A forecast in line with the agreed system plan was being maintained but this was subject to increasing levels of risk. In September the Board would be asked to consider a range of options to mitigate the significant risks. The Board would be invited to consider these alongside relevant delivery, contractual and quality aspects. **It was RESOLVED 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.	
ICB/23/100	**Assurance report from the Finance Committee (Paper I)** Ms Ellis drew attention to UHL's prospects of exit from the recovery support programme which was rated amber due to improved governance and annual accounts being on track for 2022/23. Ms Ellis emphasised the increasing level of risk in relation to the delivery of the 2023/24 financial plans. The Committee had not been assured that all key risks had been successfully mitigated and that further work was necessary. The Committee was paying attention to the delegated commissioning functions. Relevant risks were being reviewed and reviewed with the east Midlands team. Ms Ellis confirmed that the Committee would be reviewing the medium-term financial plan in September 2023. **It was RESOLVED to:** • **RECEIVE** the report for assurance.	

ITEM		LEAD RESPONSIBLE
ICB/23/101	**Assurance report from the System Executive Committee (Paper J)** Mr Williams advised that there were no items for escalation to the Board. He highlighted that finance continued to be a key focus for the committee and that the report conveyed progress made against strategic plans. **It was RESOLVED to:** • **RECEIVE** the report for assurance.	
ICB/23/102	**Assurance report from the Quality and Safety Committee (Paper K)** Ms Tagg introduced the report which indicated appropriate levels of assurance for the service areas which had been considered. However there would be further focus on cancer, maternity, children and young people's services at future meetings. Dr Sanganee added that a Clinical Prioritisation Group had been established to consider the impact of unfunded business cases using equity and quality impact assessments and the outputs of the review would be considered by the System Executive Committee. **It was RESOLVED to:** • **RECEIVE** the report for assurance.	
ICB/23/103	**Assurance report from the Audit Committee (Paper L)** Mr Hickman drew attention to the generally positive assurances across all areas of review by the Committee. An amber rating was noted for the LLR ICB Internal Audit Report. The final Head of Internal Audit Opinion had provided a moderate opinion. This particularly reflected the starting position of the Board Assurance Framework (BAF), however, the report noted that positive progress had been made in developing the LLR ICB BAF. **It was RESOLVED to:** • **RECEIVE** the report for assurance.	
ICB/23/104	**Assurance report from the Health Equity Committee (Paper M)** Professor Farooqi advised that the Committee welcomed the outcome of the recent internal audit advisory review which had made some suggestions for improvements in the ICB's systems and processes. The health equity strategic risk continued to be one of the highest risks for the ICB and the Committee had reviewed the trajectory for reducing the exposure to the risk. A detailed discussion on this matter would take place at the September Development session. **It was RESOLVED to:** • **RECEIVE** the report for assurance.	
ICB/23/105	**Performance assurance briefings from UHL and LPT (Papers N1 and N2)** Mr Sissling introduced the reports, which provided a summary of assurance levels on key issues from partner Trusts. It was noted that reports would be requested periodically. **It was RESOLVED to:** • **RECEIVE** the reports for assurance.	

ITEM		LEAD RESPONSIBLE
ICB/23/106	**Summary of the East Midlands Joint Committee held in April and June 2023 (Paper O)** Mr Sissling introduced the report, which summarised the work of the East Midlands Joint Committee over the previous months. **It was RESOLVED to:** • **RECEIVE** the report for assurance.	
ICB/23/107	**Items of any other business and review of the meeting** Mr Samuels requested that confidential sessions of the Board be diarised alongside meetings held in public to address any items of confidential business if required. The point was noted. Ms Tagg queried whether the impact of the industrial action on operational performance and patient outcomes had been sufficiently captured within the Board Assurance Framework. **It was agreed that further consideration would be given by the Executive Management Team.** Sir Mayur Lakhani requested that policies regarding cancellation of important medical appointments, particularly during industrial action, be reviewed. He noted that postponement of appointments should be a clinical decision and patients should receive a definitive indication of when to expect further contact. Mr Sissling thanked members for their contributions and brought the meeting to a close. The meeting closed at 11:30am.	**Caroline Gregory**
Date and Time of next meeting: The next meeting of the NHS LLR Integrated Care Board would take place on **Thursday 12 October 2023,** 9:00m to 11:30am via MSTeams.		

A2

Minutes of the NHS LLR Integrated Care Board ("the ICB" or "the Board")
Annual General Meeting (AGM), Thursday 14 September 2023
1:00pm – 2:30pm,
Club Suite, Leicester Racecourse, Oadby, Leicester, LE2 4AL

Members present:

Mr David Sissling	NHS LLR ICB Independent Chair and Chair of the meeting
Mr Andy Williams	Chief Executive, NHS LLR ICB
Dr Caroline Trevithick	Chief Nursing Officer, NHS LLR ICB
Ms Caroline Gregory	Interim Chief Finance Officer, NHS LLR ICB
Ms Sarah Prema	Chief Strategy Officer, NHS LLR ICB
Dr Nil Sanganee	Chief Medical Officer, NHS LLR ICB
Ms Alice McGee	Chief People Officer, NHS LLR ICB
Ms Rachna Vyas	Chief Operating Officer, NHS LLR ICB
Professor Azhar Farooqi	Non-Executive Member – Inequalities, Public Engagement, Third Sector and Carers, NHS LLR ICB
Mr Darren Hickman	Non-Executive Member – Audit and Conflicts of Interest, NHS LLR ICB
Ms Simone Jordan	Non-Executive Member – Remuneration and People, NHS LLR ICB
Ms Pauline Tagg	Non-Executive Member – Safety, Performance and Transformation, NHS LLR ICB
Ms Angela Hillery	Partner Member - community/mental health sector representative (Chief Executive, Leicestershire Partnership NHS Trust)
Mr Mike Sandys	Partner Member – local authority sectoral representative (Director of Public Health, Leicestershire County Council)
Mr Mark Andrews	Partner Member – local authority sectoral representative (Chief Executive, Rutland County Council)
Ms Alison Greenhill	Chief Operating Officer, Leicester City Council (deputising for Mr Martin Samuels)
Sir Mayur Lakhani	Clinical Executive Lead, NHS LLR ICB

Participants:

Cllr Louise Richardson	Chair of Leicestershire Health and Wellbeing Board
Cllr Sarah Russell	Chair of Leicester City Health and Wellbeing Board
Cllr Diane Ellison	Chair of Rutland Health and Wellbeing Board
Ms Daljit Bains	Head of Corporate Governance, NHS LLR ICB
Ms Charlotte Gormley	Corporate Governance Officer, NHS LLR ICB

ITEM		LEAD RESPONSIBLE
1.	**Welcome and Introductions** Mr David Sissling welcomed members of the public to the first Annual General Meeting (AGM) of the LLR ICB which provided an opportunity to reflect on the achievements, successes and challenges since the ICB was established. Mr Sissling introduced the members of the Board and thanked them for their contributions, insight, and challenge over the previous year. He also extended thanks to all ICB staff.	
2.	**Introduction to LLR ICB and reflections on the last year** Mr Andy Williams outlined the responsibilities of the ICB in shaping and commissioning local healthcare services to meet the needs of the population at system, place and neighbourhood level. He reflected on key challenges experienced across the NHS over the last year, including extended urgent care waiting times, a backlog of appointments for elective care following the pandemic, significant financial pressures and industrial action. He emphasised the positive	

ITEM		LEAD RESPONSIBLE
	response which the ICB had made in response to these challenges and highlighted the significant improvements which had been delivered. This was very much a reflection of effective partnership working across LLR. Mr Williams was optimistic about the prospects for 2023/24 and future years although a number of significant challenges remained.	
3.	**Financial Review - 2022/23 for LLR CCGs and LLR ICB** Ms Caroline Gregory confirmed that the four sets of Annual Reports and Accounts had been audited and were published on the LLR ICB's website. Ms Gregory outlined the LLR ICB's financial position from 1 July 2022 and described how the funding received had been spent across various programmes and healthcare commissioning responsibilities. Financial challenges had reflected a range of factors including inflation, an increase in demand, and industrial action. The ICB had worked with NHS and Local Government partners to contain costs, introduce more efficient delivery models and pursue value for money options at all times. Ms Gregory confirmed that the LLR ICB had achieved its financial duties for 2022/23.	
4.	**Achievements and Successes** Dr Sanganee announced the launch of the Academy for Celebrating Excellence (ACE100), a digital platform to share, celebrate and learn from achievements across the local health and care system. Ms Vyas drew attention to specific examples of impressive achievement through the actions taken by the LLR ICB in conjunction with partner organisations, patient groups and local communities. Examples included improvements to; discharge services, urgent care pathways, elective wait times, access to primary care services, cancer screening services and enhanced services for those with learning disabilities. Furthermore, Ms Vyas highlighted that LLR ICB had been shortlisted for and achieved a number of Awards for the efficient use of resources, the management of risk, workforce, finance, and patient experience.	
5.	**The Year Ahead** Mr Williams concluded the presentations by expressing his optimism for the year ahead, whilst acknowledging that some of the challenges and pressures would continue. He advised that LLR ICB would pursue opportunities to improve patient experience through engagement with the public and clinicians on the front line. Reflecting on the position of the LLR Integrated Care System, Mr Williams noted that the system had faced many challenges in its first year but we should celebrate the impressive achievements which had been delivered. Mr Williams confirmed his forthcoming retirement in the near future after four and a half years in post. He advised that he had enjoyed his time in LLR and was proud of colleagues, partnerships formed, and progress made.	
6.	**Questions from the public** Mr Sissling thanked colleagues for their contributions and invited questions from the public, noting that some written questions had been received in advance of the meeting.	

ITEM		LEAD RESPONSIBLE

1. Written questions received from Councillor Ramsay Ross

- ***Question 1: Does a detailed plan exist that supports the 5 Year Plan (5YP) and when will this be made public?***

In response, Mr Williams confirmed that there was a supporting annex to the 5YP linked to each of the sub-sections within chapter 3. This sets out the interventions, actions, timeline, and intended impact. This was published with the LLR Integrated Care Board papers (meeting date 13 July 2023 – Appendix 2 of the Plan, pages 109 to 129). The 5YP was formally approved at that meeting.

In addition, it was confirmed that an outcomes framework had been developed (Appendix 3 of the Plan, pages 130 – 133). This outlined each of the pledges along with the national metrics, definitions, national targets (where available), baseline, data source, reasoning, and accountability.

- ***Question 2a: If a detailed plan exists have the various Health and Wellbeing Boards been consulted on this plan and their activities integrated within it?***

Mr Williams confirmed that formal consultation on the 5YP was not required. However, the LLR ICB had engaged widely with partners and stakeholders including the LLR Health and Wellbeing Boards. In line with the NHS England guidance published in December 2022, the Health and Wellbeing Boards were asked to provide a statement of opinion confirming that the Plan took proper account of each of the Joint Health and Wellbeing Strategies. Statements were duly received from the Health and Wellbeing Boards and were included within the Plan.

- ***Question 2b: Are cross-border service integration issues presently incorporated?***

Mr Williams confirmed that a comprehensive report had been produced ("Appendix 4 – Insights" contained within the Five-Year Plan available on the ICB website as mentioned earlier). Cross border issues were highlighted on pages 150 and 152 of the Plan. Work continues to try and resolve cross border issues, including discussions with Lincolnshire Integrated Care System, Rutland GP practices and Peterborough and Stamford Hospital. In addition, a comprehensive Digital Strategy was in place, setting out how the Fast Healthcare Interoperability Resource (FHIR) Release would support improvements in cross border data flows (page 28 of the Plan).

A link to the LLR ICB's Digital Strategy available via the following link: https://leicesterleicestershireandrutland.icb.nhs.uk/wp-content/uploads/2023/03/LLR-Digital-Strategy-v0.23-1.pdf

- ***Question 3: How will Board members know, in their process of review, that progress is being made in a timeous and efficient manner? Will any such supporting documentation be made public?***

Mr Williams confirmed that progress is reported to the Board through the reports from the LLR ICB's Delivery Partnership Group. Reports can be found on the LLR ICB website.

ITEM		LEAD RESPONSIBLE
	2. Verbal questions from Mr Kirit Mistry, Lead Health Inequalities, South Asian Health Action • ***Question 1: Does LLR ICB have a Health Equalities budget and if so, what does this look like?*** • ***Question 2: Are there opportunities for the voluntary sector to have more engagement in short-term or time-limited initiatives?*** • ***Question 3: How does LLR ICB intend to show more visible leadership in the community?*** In response to the above questions, Mr Williams confirmed that LLR ICB would review its level of engagement with voluntary organisations and communities, putting into place dedicated management and leadership time. He confirmed that a health inequalities support unit had been established to gather and process data and intelligence regarding health inequalities. Consideration was being given as to whether further investment would be made to expand the Unit. It was highlighted that health inequalities agenda influenced all areas of service and care and that equality impact assessment tools were key when commissioning and reviewing services. Regarding funding for voluntary organisations, Mr Williams advised that LLR ICB would explore opportunities to commit resources over longer periods of time. Mr Sissling confirmed that LLR ICB would welcome the opportunity to meet with voluntary organisations to enable more visibility. ***3. Written questions received from Mr Geoffrey Smith, member of the public.*** • ***Question 1: One of the ICB partners Leicestershire Partnership NHS Trust (LPT) is a leader in co-production of design, planning and implementation of services benefitting patients. How can the ICB ensure that all ICB partners learn from LPT and so make the whole of LLR a centre of excellence in co-production?*** Mr Williams acknowledged the benefits of operating as an ICB within a health and care system and the benefit of learning from partners regarding innovations and ways of working together to ensure best practice. He confirmed that it was an ambition of LLR ICB to become a centre of excellence for innovation, research and the adoption of evidence-based practice. The ACE100 platform was highlighted as a relevant initiative. Work was also underway with the East Midlands Academic Health Science Network to understand and learn how to best embed and share innovative programmes of work. ***4. Verbal questions from Ms Amy Mark and Mr Alex Charlesworth, Association of Colleges London*** Ms Mark and Mr Charlesworth advised that T-level qualifications were available in nursing, midwifery, and mental health. Technical qualifications were the equivalent of three A-levels and an offer of 45 placements was being made to young people. This would develop a pipeline of talent directly into the NHS. Ms McGee expressed thanks to Ms Mark and Mr Charlesworth for raising awareness. She noted that the qualifications available were in line with the wider agenda to support careers in the NHS and Local Authorities.	

ITEM		LEAD RESPONSIBLE
	5. Written questions received from Mr Gavin Brown, Chief Executive Officer, Trade Sexual Health ***Question 1: The recent census suggests that there are at least 2,200 people (aged over 16) across LLR who identify as trans or non-binary. As the local LGBT health charity, Trade Sexual Health have been receiving a growing number of enquiries and complaints from trans people across LLR who are dissatisfied with the care and support they are receiving from their GPs and other local NHS services. Will the ICB commit to working with the local LGBT community and relevant voluntary sector organisations to listen to these complaints and develop better guidance and training for local GPs and other NHS services about supporting trans individuals in inclusive and affirming ways?"*** Mr Williams confirmed that LLR ICB was committed to working with the local LGBT community and relevant voluntary sector organisations to hear and respond to feedback on the services provided across LLR. He advised that the LLR ICB would be looking to build on the previous work undertaken in the city to develop better guidance and training for local GPs and other NHS services. Ms McGee would make contact with Trade Sexual Health following the meeting. It was acknowledged that there were still examples of discrimination and inappropriate behaviour across the NHS. LLR ICB was working hard to change the culture and would encourage people affected or with relevant experience to report any concerns. ***6. Verbal questions from Sally Ruane, Director of Health Policy Research Unit, DeMontfort University*** • ***Question 1: How central is prevention to LLR ICB, what initiatives are in place, and what is the budget for primary prevention?*** Mr Williams advised that prevention is pivotal in decisions made by the ICB in respect of services which are commissioned. He referenced relevant example including the promotion of cancer screening and immunisation. He described the ICB's enthusiasm to work with partners to impact on the broader determinants of poor health which are outside the direct control of the NHS. Dr Sanganee further elaborated and highlighted the benefits of empowering the public wherever possible. He also advised that significant partnership working was proceeding focused on prevention in areas such as such as obesity, hypertension, and mental health. Primary Care was, moreover, well placed to advance the prevention agenda by taking an every-contact-counts approach. Dr Sanganee, finally, emphasised the priority given to a preventative approach for children and young people. ***7. Written questions received from Carol Hopkinson, member of the public*** • ***Question 1: When will a detailed Health Plan be published for Rutland, which sets out the future clinical provision in the County?*** Mr Williams confirmed that the Health Plan was presented to the Rutland Health and Wellbeing Board in July 2022. An updated Plan was expected to be submitted	

ITEM		LEAD RESPONSIBLE
	to the Health and Wellbeing Board in October 2023. These plans would detail proposed improvements in service provision and health outcomes for the residents of Rutland. ***8. Verbal questions from Mr Rob Hunter, member of the public*** • ***Question 1: Is there a whole-system approach to health and wellbeing and social prescribing?*** Ms Vyas advised that a group had been established to share best practice with a plan to establish management support from the Local Authorities and the NHS. Learning from social prescribing staff and patients would be applied across LLR. ***9. Verbal questions from a member of the public.*** • ***Question 1: What is the role of the Primary Care Networks (PCNs) for improving early diagnosis in primary care?*** Dr Sanganee noted the importance of work undertaken by PCNs at neighbourhood level enabling strong links to local communities. He advised that LLR had benchmarked well nationally in respect of primary medical care access, however patients continued to report problems in securing timely appointments. PCNs were playing a key role in addressing these concerns and in establishing extended access for services. A range of community diagnostics services were, moreover, commissioned through PCNs. ***10. Verbal questions from Rachel Hall, Falcon Support Services*** • ***Question 1: What are the future plans to improve health outcomes for the homeless population of LLR?*** Ms Vyas advised that learning from the pandemic had highlighted that a greater understanding was required of the needs of the homeless population and emphasised the requirement to have appropriate services in place. Feedback from the homeless population regarding access to services demonstrated a mismatch between the services offered and the services required by the homeless individual. Work was proceeding, much in partnership with other organisations, to improve service availability. ***11. Verbal questions from Xin Pan, PhD Researcher, University of Leicester*** • ***Question 1: What schemes or projects are in place for international students as temporary or long-term residents of LLR?*** Ms Vyas advised that GP Practices situated near the universities offered specific services. Information packs were provided to students on how to register for services, and the information was also available on respective university websites and at student health centres. ***12. Verbal questions from a member of a Patient Participation Group (PPG)*** • ***Question 1: What support is provided by LLR ICB to PPGs?***	

ITEM		LEAD RESPONSIBLE
	Ms McGee advised that a number of changes had been implemented over the previous 12 months with plans to go further. She noted that posters were used to advertise and encourage participation in PPGs. The LLR ICB received regular feedback and was liaising with practices as necessary. Attendees were encouraged to contact Ms McGee for support to establish a PPG if their local GP Practice did not have one established. ***13. Verbal questions from Salika Elyas, NHS Complaints Advocate, POhWER*** • ***Question 1: How does a virtual ward work, what are the timelines involved, and how do patients get in touch?*** Ms Vyas advised that virtual wards had been established in response to feedback from patients requesting treatment in their own homes. Virtual wards had proven successful over a number of pathways. Technology was easy to use, and patient groups received support with any literacy issues, as determined through clinical and social assessments. Patients had access to a helpline for direct access and immediate support without the need to contact 999. It was confirmed that 200 virtual ward bed were in place across various pathways. ***14. Verbal question received from a member of the public*** • ***Question 1: How will LLR ICB overcome the barriers to patients in accessing cancer screenings?*** Dr Sanganee emphasised the importance of encouraging and educating patients regarding the benefits of early diagnosis and the need to attend screening services. The importance of recognising our diverse population was critical with appropriate engagement and communication approaches now in place.	
7.	**Closing remarks** Mr Sissling concluded the meeting by expressing thanks to Mr Williams for his outstanding contributions to LLR ICB and wished him well for his retirement. He also expressed thanks, on behalf of the Board, to members of the public for their questions and interest in local care services. LLR ICB would continue to engage with the public and local communities regarding relevant issues. The next Annual General Meeting would take place in a year's time, to reflect on another year of care services in LLR. The meeting ended at 2:33pm.	

Date and Time of next meeting:
The next NHS LLR Integrated Care Board Annual General Meeting would take place in September 2024.

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 October 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 risk, a detailed review was undertaken at the Board development session in September 2023. **Action complete**	**Green**
ICB/23/107	10 August 2023	Items of any other business and review of the meeting	Caroline Gregory	To consider whether the impact of industrial action needs to be captured on the Board Assurance Framework (BAF).	October 2023	The Executive Management Team will be considering the impact at its meeting in mid October 2023 when the BAF is next reviewed.	**Amber**

C

NHS
Leicester, Leicestershire and Rutland
Integrated Care Board

Learning Disability Health Checks

Julie Gibson
LD Services Manager

A proud partner in the:

Leicester, Leicestershire and Rutland
Health and Wellbeing Partnership

National Context

- NHS Long Term Plan ambition: at least 75% of people aged 14 or over with a LD will have had an annual health check
- LDHC GP enhanced service £140

2023/24 - one of only 5 remaining IIF indicators

- IIF funding – 36 points, 60% (LT), 80% (UT)
- % of patients on the QOF LD register aged 14+, who have
  - received a learning disability Annual Health Check
  - completed Health Action Plan
  - a recording of ethnicity (new for this year)

Health conditions and LD

- The proportion of people with a condition is significantly higher in the LD population than the non-LD population for 9 conditions
- The proportion of people with a condition is significantly lower in the LD population than the non-LD population for 2 conditions (hypertension and COPD)
- There is no statistical difference in the proportion of LD and non-LD populations with 4 conditions

Confidence level	LD population		Non-LD population		
95.0%	No. (LD popn)	% (LD popn)	No. (non-LD)	% (non-LD)	Significance compared to NON LD pop
Whole population	4,925	100.0	1,152,220	100.0	
Bipolar	110	2.2	3,865	0.3	Higher
Depression	310	6.3	43,960	3.8	Higher
Obesity	220	4.5	34,725	3.0	Higher
Dementia	75	1.5	8,740	0.8	Higher
Heart failure	75	1.5	16,380	1.4	Similar
Hypertension	590	12.0	173,945	15.1	Lower
Lipid disorder	305	6.2	69,415	6.0	Similar
Asthma	775	15.7	138,595	12.0	Higher
COPD	50	1.0	20,330	1.8	Lower
Hypothyroid	400	8.1	40,600	3.5	Higher
Diabetes	550	11.2	82,230	7.1	Higher
Renal	150	3.0	36,805	3.2	Similar
Osteoporosis	80	1.6	18,270	1.6	Similar
ASD	235	4.8	2,030	0.2	Higher
SMI Register	335	6.8	9170	0.8	Higher

All counts are rounded to 5, numbers below 7 are suppressed. As such totals may not match.

Health conditions and LD (continued)

Most prevalent condition for people with LD

1. asthma (775 people, 15.7% of the LD population)
2. hypertension (590 people, 12.0%) and diabetes (550 people, 11.2%)

Conditions with the biggest difference between people with LD and those without are:

- Severe Mental Illness (SMI) where 6.8% of the LD population are on the SMI register compared to 0.8% of the non-LD population (this is very similar to the national difference)
- Hypothyroid (8.1% of the LD population and 3.5% of non-LD) which is exactly the same rate as a study of GP records nationally in 2017/18 for the LD population [PHE, Health inequalities, Thyroid disorders]
- ASD (4.8% of the LD population and 0.2% of the non-LD), nationally ASD was found for 30.7% of the LD population in 2021-22. [NHS digital, Health and care of people with LD, experimental stats 2021-22]

Deprivation and conditions

- Comparing the LD and non-LD populations and condition prevalence in the 20% most deprived areas, we see a significantly higher proportion of people with LD and a condition than those without LD and a condition
  - This is the case across all conditions apart from bipolar & ASD
- The difference is largest between the LD and non-LD populations living in the 20% most deprived areas for:
  - COPD – the LD population living in the most deprived areas are around two and a half times more likely to have COPD (40.0% of the LD population compared to 16.5% of the non-LD population)
  - Heart failure – the LD population living in the most deprived areas are more than twice as likely to have heart failure (33.3% of the LD population compared to 10.8% of the non-LD population)

Other risk categories

- 1,930 (39.2%) people with LD have 5 or more chronic conditions, 4 times as many as the non-LD population
  - This compares to 9.7% of the non-LD population and is a significantly higher rate in the LD population
- 300 people (6.1%) with LD are at a higher risk of emergency hospital admission, again, over 4 times as high as the non-LD population
  - This compares to 1.5% of the non-LD population and is a significantly higher risk in the LD population

In LLR in 2021/22, 40% of people with LD who died and whose life and death were reviewed in the LeDeR programme, had not had an Annual Healthcheck.

LLR Annual Health Check Pilot

LDA Collaborative funded LPT to deliver a LD health check pilot during 2022/23, which focused on

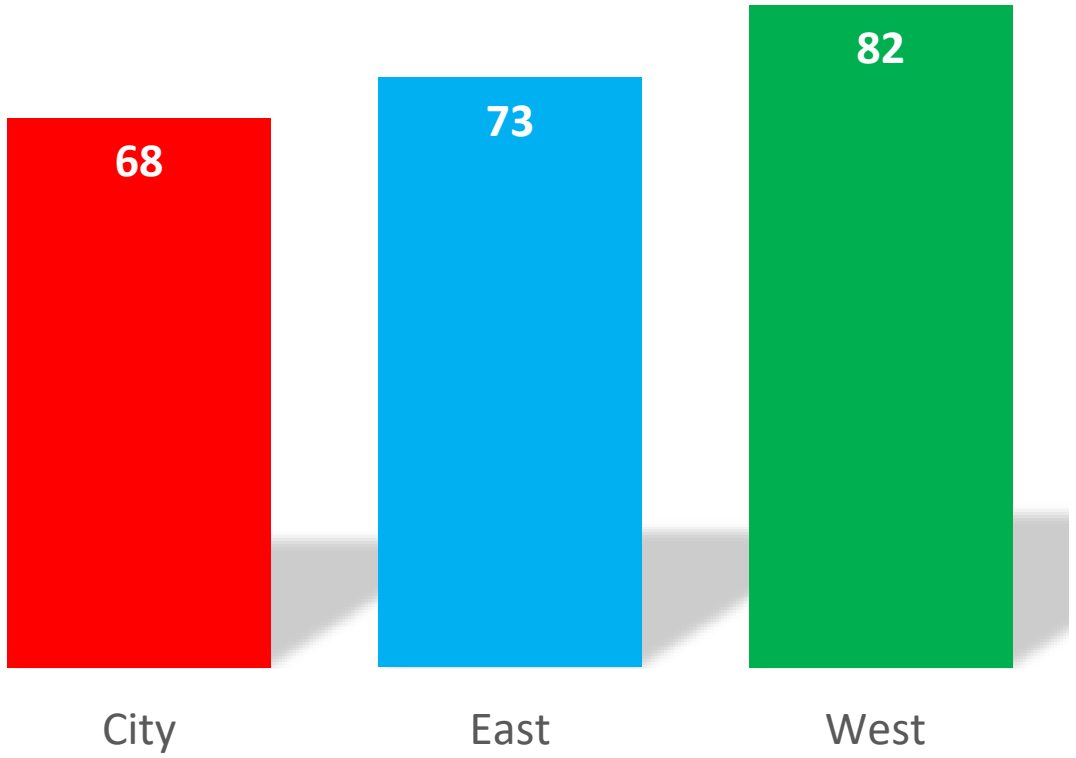
- People who have not had their annual health check in two years
- People with complex health needs requiring additional reasonable adjustments to access the check

- RNLD(s) with a high level of skill/experience of working with complex individuals with a LD -undertaking the health checks
- LD Care Co-ordinator (CCO)- Managing referrals, organising the health check, acting as a central point of contact for practices and families to promote continuity of care; ensuring the health action plan was sent out with additional information, following up any referrals to confirm that they had been completed.

Referrals received into the Pilot

The Pilot ran from September 2022 to March 2023

- GPs could refer people to the pilot
- 223 patients were referred in total
- Of those, 173 received a health check
  - 68 from City
  - 73 from East Leicestershire and Rutland
  - 82 from West Leicestershire



How we reached people

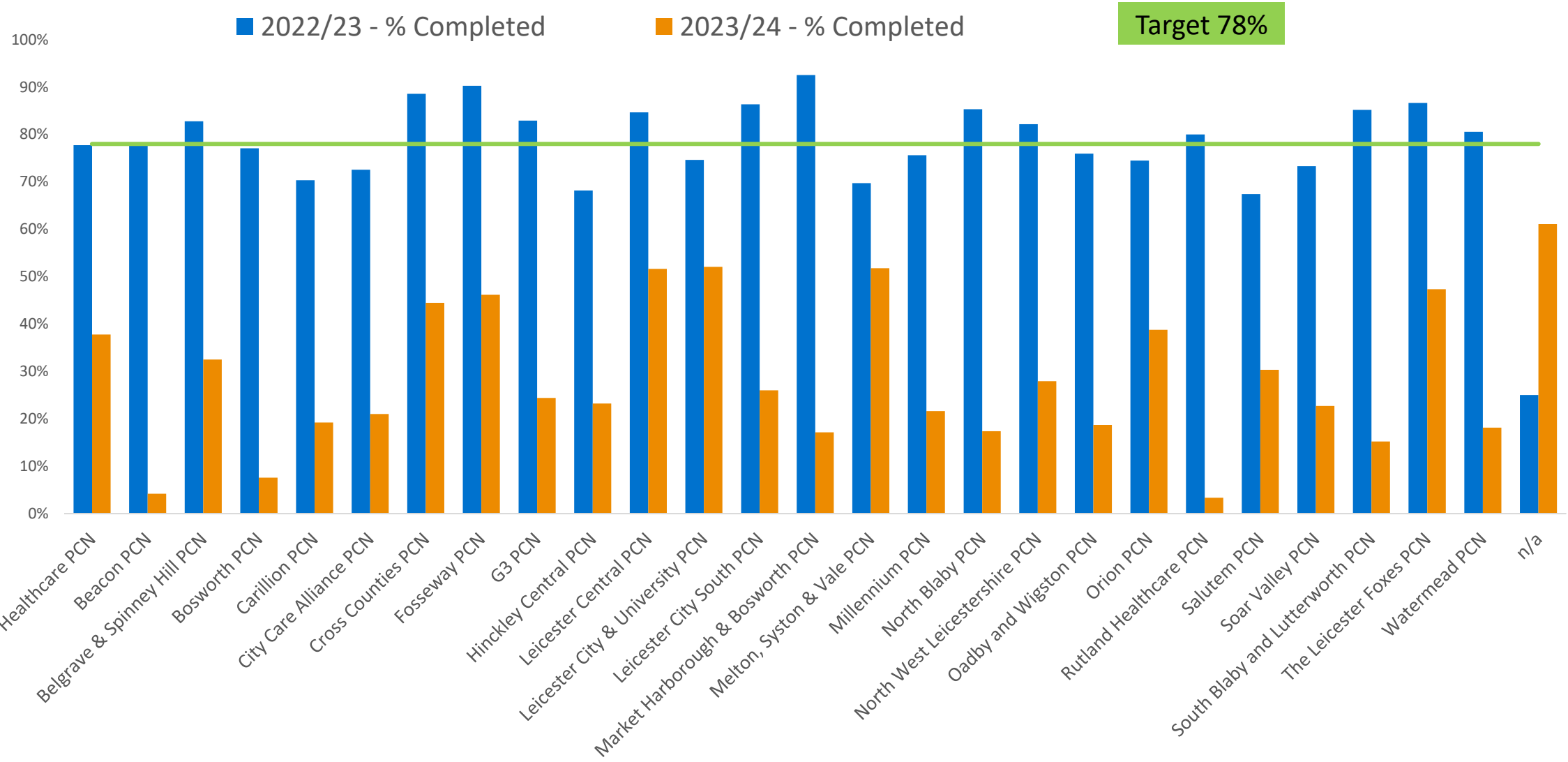
Some of the additional reasonable adjustments required included

- Visits ranging from accessing schools/day services and respite care
- Each patient on the pilot had on average 2-3 telephone calls to gain an understanding of the barriers they experience when accessing the primary services and to arrange their AHC.
- Where someone had more complex social circumstances, they received on average received 3-4 calls
- Unannounced visits were implemented where no response was received to telephone calls and accessible information being sent

Did it make a difference?

- LLR achieved 81.1% finishing 2nd regionally and in top 10 nationally
- Pilot extended until March 2024
- Some people with LD will always require additional reasonable adjustments over and above what a GP practice can offer
- People with treatable conditions were supported and referred to other relevant services where a need was identified
- The success of this pilot gives clear evidence of the need to support people who require additional reasonable adjustments to access their annual health check

LD Annual Health Checks at end of Q2, 2023/24



What next?

- Continue to reach people who have not had a check for a long time
- Aim to make this ‘business as usual’ to support people with those extra needs

D

Name of meeting:	**Leicester, Leicestershire and Rutland Integrated Care Board Meeting Public**		
Date:	**12 October 2023**	**Paper:**	**D**
Report title:	Feilding Palmer Pre-Consultation Business Case (PCBC)		
Presented by:	Sarah Prema, Chief Strategy Officer		
Report author:	Jo Clinton, Head of Strategy and Planning and Carrie Harris, Planning Manager		
Executive Sponsor:	Sarah Prema, Chief Strategy Officer		

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

Recommendations:

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

- **APPROVE** the PCBC for Feilding Palmer Community Hospital, Lutterworth.
- **APPROVE** the proposal to commence public consultation in line with the Consultation Document and the Communications and Engagement Plan available at the following https://leicesterleicestershireandrutland.icb.nhs.uk/about/board-meetings/

Purpose and summary of the report:

1. The PCBC for Feilding Palmer sets out the ICB's plans to make changes to the usage of Feilding Palmer Hospital in Lutterworth to maximise access to health services for the local community. The Executive Summary on pages 1-35 of the PCBC provides a detailed and comprehensive overview of the case, with the full PCBC from page 36 onwards providing more detail including supporting information. The supporting documents referenced within the PCBC can be found on the LLR ICB website at the following https://leicesterleicestershireandrutland.icb.nhs.uk/about/board-meetings/ .

2. The proposal is to permanently close the inpatient beds at Feilding Palmer and refurbish the space to provide an enhanced procedure suite and outpatient clinic rooms to increase the number of appointments for diagnosis or treatment. This means approximately 17,000 outpatient and diagnostic appointments would be provided each year in a refurbished Feilding Palmer Hospital. This would reduce the burden of people travelling a long way into places like Leicester and car parking would be easier. It is estimated that the number of miles travelled by people would reduce by 200,000 per year.

3. The Indicative Capital construction costs are estimated as £5.82m which will be funded from the ICS capital allocation. Revenue costs for the estates will be funded by the system and are estimated to be £0.5m, this is the additional cost to LPT for the refurbishment and is made up of:
    a. Depreciation costs
    b. PDC charges
    c. Running costs – staffing (cleaners, porters, reception), non staff costs (eg utilities, telephony, printing etc) and maintenance (eg grounds maintenance and building services)

4. Leadership of the programme has been through the Lutterworth Plan Steering Group, founded in June 2021. The group comprises of key stakeholders and was formed to work in partnership to develop a plan for Lutterworth to meet the future needs driven by the significant housing growth expected in the area.

5. The plan has the full support of local clinicians including those from local GP practices, Leicestershire Partnership NHS Trust, and University Hospitals of Leicester.

6. The proposal has been reviewed by the East Midlands Clinical Senate, comprising of independent clinicians and subject specialists. They have provided their assurance of the plan and have produced a report. A copy of this report can be found on the LLR ICB website at the following https://leicesterleicestershireandrutland.icb.nhs.uk/about/board-meetings/

7. The PCBC has been reviewed by NHSE via their strategic service change regional assurance panel was shared with their Regional Support Group on the 22nd September 2023.

8. A task and finish group was established in February 2023 to develop and design the public consultation and engagement process. Public consultation is planned to take place for 12 weeks from the 23rd of October 2023 until 14th January 2024. The consultation document and the communication and engagement strategy can be found on the LLR ICB website at the following https://leicesterleicestershireandrutland.icb.nhs.uk/about/board-meetings/

9. Once the consultation is complete, the data will be analysed and included in the development of a Decision-Making Business Case in Spring 2024.

Appendices:	Available on the LLR ICB website https://leicesterleicestershireandrutland.icb.nhs.uk/about/board-meetings/
Report history (date and committee / group the content has been discussed / reviewed prior to presenting to this meeting):	• System Executive: 2nd June 2023 • Integrated Care Board 13th July 2023 • System Executive: 22nd September 2023 • LPT Board Meeting: 26th September 2023

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.*		n/a
b) Does the report highlight any resource and financial implications? If so, provide which page / paragraph this can be found within the report.		Pages 146-154 .
c) Does the report highlight quality and patient safety implications? If so, provide which page / paragraph this is outlined in within the report.		Page 183 and 187.
d) Does the report demonstrate patient and public involvement? If so, provide which page / paragraph this is outlined in within the report.		Page 140-141 and pages 155-175.
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.		Page 191.

Feilding Palmer Pre-Consultation Business Case

12th October 2023

Introduction

1. The PCBC for Feilding Palmer sets out the ICB's plans to make changes to the usage of Feilding Palmer Hospital in Lutterworth to maximise access to health services for the local community.

Background

2. The NHS of the future will be fundamentally different from the NHS of today. This is partly due to the huge and existing possibilities for continuing advancement in medical treatments and better care outcomes for people.

3. It will also be due to the NHS response to the challenges we face. For example, people are currently waiting longer for a diagnosis and treatment. Access to services is sometimes difficult and the NHS is trying to ensure it can cover the cost of providing high quality services with a well-trained workforce.

4. In addition, the NHS is planning for population growth while making sure that people have equal access to services. This situation is very relevant to Lutterworth, as it is expected that the population will significantly increase in the near future.

5. We therefore need plans to tackle these current and future challenges. In response, the NHS proposes to increase the number of health services available to people in Lutterworth and join care up to improve patient experiences and improve the health and wellbeing of the local population.

Reasons for improvements

6. There are several key reasons why services need to change and improve:

7. The population's health and care needs are changing**.** Overall, people are living longer and there are fewer people dying from conditions such as cancer and heart disease. However, the number of people living with more than one health condition has increased and this puts pressure on health and social care services.

8. The population in Lutterworth is growing. There will be a significant growth in the population of Lutterworth in the next few years, with an estimated 2,750 homes being built. A younger population of families are expected to move to the area. They will require outpatient, diagnostic and GP services, rather than intensive treatment and rehabilitation provided in an inpatient bed, often required by older people.

9. Feilding Palmer is no longer fit for the 21st Century. Fielding Palmer Hospital is poorly laid out, with no single sex wards and shared bathrooms for males and females. Disability access is restricted in some areas and the building is not suitable for inpatient care. There is no

privacy and dignity for patients, and corridors are narrow and unsuitable for trollies and bed movements. The building does not meet the required infection prevention and control standards. There is also inadequate ventilation and internal damage to the roof.

10. Lower numbers of people from Lutterworth and immediate surrounding areas were using inpatient beds at Feilding Palmer Hospital. The inpatient beds were closed temporarily during the pandemic. They have not reopened as they do not meet Infection Prevention Control standards. The number of people using Feilding Palmer Hospital for overnight stays pre-pandemic had declined year on year since 2019. More residents of Lutterworth and South Blaby chose other community hospitals rather than Feilding Palmer. A higher number of people are also choosing to receive care at home.

11. Inpatient care at Feilding Palmer was expensive. With only 10 inpatient beds in the hospital, minimum staffing requirement still had to be met. This meant the nurse-to-patient ratio at the hospital was similar to that of an Intensive Treatment Unit.

12. More services are being provided at home or in the place people call home. Since the pandemic, more care has been provided at home or in a residential home. This is helping people regain some of their independence and avoiding the decline in physical abilities that can happen in hospital. Palliative care is also provided at home, in a care home or in a LOROS hospice. We would continue this service as it has allowed people to stay where they feel most comfortable, rather than in hospital.

13. There are long waits for diagnosis and treatment. We have longer waiting lists and people living in and around Lutterworth are travelling out of the area to receive a diagnosis and treatment. This could be done locally by changing the way we use Feilding Palmer Hospital. This would reduce the traumatic burden of travelling, reduce the carbon footprint and shorten waiting times.

14. Our community services are not joined up. People tell us that communications and relationships between services need to improve, particularly when people transfer from one service to another. More services at Feilding Palmer, which is next door to two GP practices and a pharmacist, would help with some of the communications problems that exist.

Proposed Improvements

15. To respond to the changing needs of people, we propose to significantly expand the number of health services available in Feilding Palmer Hospital by using the space in the hospital differently. We would permanently take out the inpatient beds and provide this care at home, in a care home, or another community hospital.

16. We would use the vacant space to increase the number of appointments for diagnosis or treatment of many conditions. This means approximately 17,000 outpatient and diagnostic appointments would be provided each year in a refurbished Feilding Palmer Hospital. This would reduce the burden of people travelling a long way into places like Leicester and car parking would be easier. It is estimated that the number of miles travelled by people would reduce by 200,000 per year.

17. Overtime, the healthcare improvements being made in Lutterworth would result in the creation of a Lutterworth Health Campus. Due to the population growth, there is a S106 allocation of £1.7m for primary care and the ICB is working with the practices to develop their plans. This means more services would be provided on the site on Gilmorton Road. Health and care teams from GP practices, social care, mental health teams, community teams will be working in very close proximity with each other. This will improve relationships and communications and join services up, which will benefit patients and services users.

Finance

18. The Indicative Capital construction costs are estimated as £5.82m which will be funded from the ICS capital allocation.
19. Revenue costs for the estates will be funded by the system and are estimated to be £0.5m which is the additional costs to LPT for the refurbishment. The £0.5m is made up of:
    a) Depreciation costs
    b) PDC charges
    c) Running costs – staffing (cleaners, porters, reception), non staff costs (eg utilities, telephony etc) and maintenance (eg grounds maintenance and building services)

20. For full financial breakdown please see pages 146-154 of the PCBC.

Consultation Activities

21. Leadership of the programme has been through the Lutterworth Plan Steering Group, founded in June 2021. The group comprises of key stakeholders and was formed to work in partnership to develop a plan for Lutterworth to meet the future needs driven by the significant housing growth expected in the area.

22. The group has co-designed the plan for Lutterworth and comprises of representatives from:
    - Local primary care
    - Lutterworth Town Council
    - Harborough District Council
    - Leicester Partnership Trust
    - Mary Guppy Group (Patient/Public representatives)
    - MPs office
    - Leicestershire County Council

23. The plan has the full support of local clinicians including those from local GP practices, from Leicestershire Partnership NHS Trust and from the University Hospitals of Leicester.

24. The plan has also been reviewed by the East Midlands Clinical Senate, comprising of independent clinicians and subject specialists. They have provided their assurance of the plan. A copy of this report can be found on the LLR ICB website at the following https://leicesterleicestershireandrutland.icb.nhs.uk/about/board-meetings/

25. A task and finish group was established in February 2023 to develop and design the public consultation and engagement process. The consultation document and the communication and engagement strategy can be found on the LLR ICB website at the following

https://leicesterleicestershireandrutland.icb.nhs.uk/about/board-meetings/. Public consultation is planned to take place for 12 weeks from the 23rd of October 2023 until 14th January 2024.

26. The consultation plan was presented to the Leicestershire Health and Overview Scrutiny Committee on the 13th September 2023, where there was support to proceed with consultation.

27. The PCBC was reviewed via the formal NHSE strategic service change process and was shared with their Regional Support Group (RSG) on the 22nd September 2023. The PCBC was also supported by the System Executive Meeting on the 22nd September 2023, and the Leicestershire Partnership Board meeting on the 26th September 2022. The supporting documents referenced within the PCBC can be found on the LLR ICB website at the following https://leicesterleicestershireandrutland.icb.nhs.uk/about/board-meetings/ .

28. Once the consultation is complete, the data will be analysed and included in the development of a Decision-Making Business Case in Spring 2024.

Next steps

29. Public consultation is planned to take place for 12 weeks from the 23rd of October 2023 until 14th January 2024.

Recommendations:

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

- **APPROVE** the PCBC for Feilding Palmer Community Hospital, Lutterworth.
- **APPROVE** the proposal to commence public consultation in line with the consultation document and the Communications and Engagement Plan available at the following https://leicesterleicestershireandrutland.icb.nhs.uk/about/board-meetings/

NHS

Leicester, Leicestershire and Rutland

Integrated Care Board

Lutterworth Feilding Palmer Hospital

Pre Consultation Business Case

'Maximising access to services for the local community'

V1.30

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Health and Wellbeing Partnership

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1 Executive summary

1.1 Introduction

1.1.1 Background and context

Lead commissioners are required to prepare a PCBC to inform NHSE's assessment of proposals for service changes against the government's four tests of service change. The tests are as follows:

- Strong public and patient engagement.
- Consistency with current and prospective need for patient choice.
- A clear clinical-evidence base.
- GP Commissioners' support for the proposals.

NHSE need comfort that proposals satisfy the government's four tests of service change, and the additional 'fifth test' (introduced in March 2017 in respect of justification for bed closures) and NHSE's own best practice checks, prior to views being sought from patients and members of the public who may be affected by the proposed changes. The PCBC also forms the starting point for any subsequent business case(s) as required by NHSE.

Pre-consultation seeks to build alignment between NHS commissioners and local authorities to:

- Make the case for change.
- Demonstrate that all options, benefits and impact on service users have been considered.
- Demonstrate that the planned consultation will seek the views of patients and members of the public who may potentially be impacted by the proposals.

Commissioners and providers must also give due consideration to potential impacts of any proposed service changes on the ability of the NHS to effectively plan for and/or respond to an emergency.

1.1.2 Scope of this PCBC

This PCBC considers the proposed changes to servicers provided at Leicestershire Partnership NHS Trust's (LPT's) Feilding Palmer Hospital in Lutterworth.

1.2 Strategic Context

1.2.1 Introduction

This section sets out the strategic context within which the proposals have been developed. This is considered at both a national level, in terms of government policy for health and social care, Department of Health and Social Care (DHSC), NHSE priorities and at a local

level in terms of the ICB and Trust strategies and the need to ***maximise access to services for the local community.***

1.2.2 The context

The context is explained in terms of:

- The national context:
  - NHS Long Term Plan.
  - Naylor Review – NHS Property and Estates.
  - Government's Response to the Naylor Review.
  - The vision for the future of Primary Care.
- The local context:
  - Leicester, Leicestershire and Rutland Integrated Care Board (ICB).
  - LLR Lutterworth Healthcare Plan.
  - University Hospitals of Leicester NHS Trust (UHL) strategy.
  - LPT Strategy.

1.2.3 Conclusion on the strategic context

The strategic context set out demonstrates that the proposals for Feilding Palmer Hospital are entirely consistent with health and social care strategies at both a national level, in terms of government policy for health and social care and DHSC and NHSE priorities. At the local level they are also consistent with the aims and objectives of the Leicester, Leicestershire and Rutland (LLR) Joint Forward Plan (JFP) and the relevant UHL and LPT strategies and support the aim of ***maximising access to services for the local community.***

1.3 Current service configuration and demographics

1.3.1 Introduction

This section provides on overview of the LLR Integrated Care System (ICS) and describes the current configuration of services provided in the Lutterworth area and provides details of the local population.

1.3.2 LLR ICS

Context

On 1 July 2022, 42 ICSs were established across England. Each ICS consists of an Integrated Care Partnership. The local Integrated Care Partnership is known as the Leicester, Leicestershire and Rutland Health and Wellbeing Partnership (LLR HWP). It is a statutory committee bringing together an alliance of partners who are concerned with improving the care, health and wellbeing of the local population. It is also responsible for producing an integrated care strategy on how to meet the health and wellbeing needs of the population in the ICS area.

The statutory partners are:

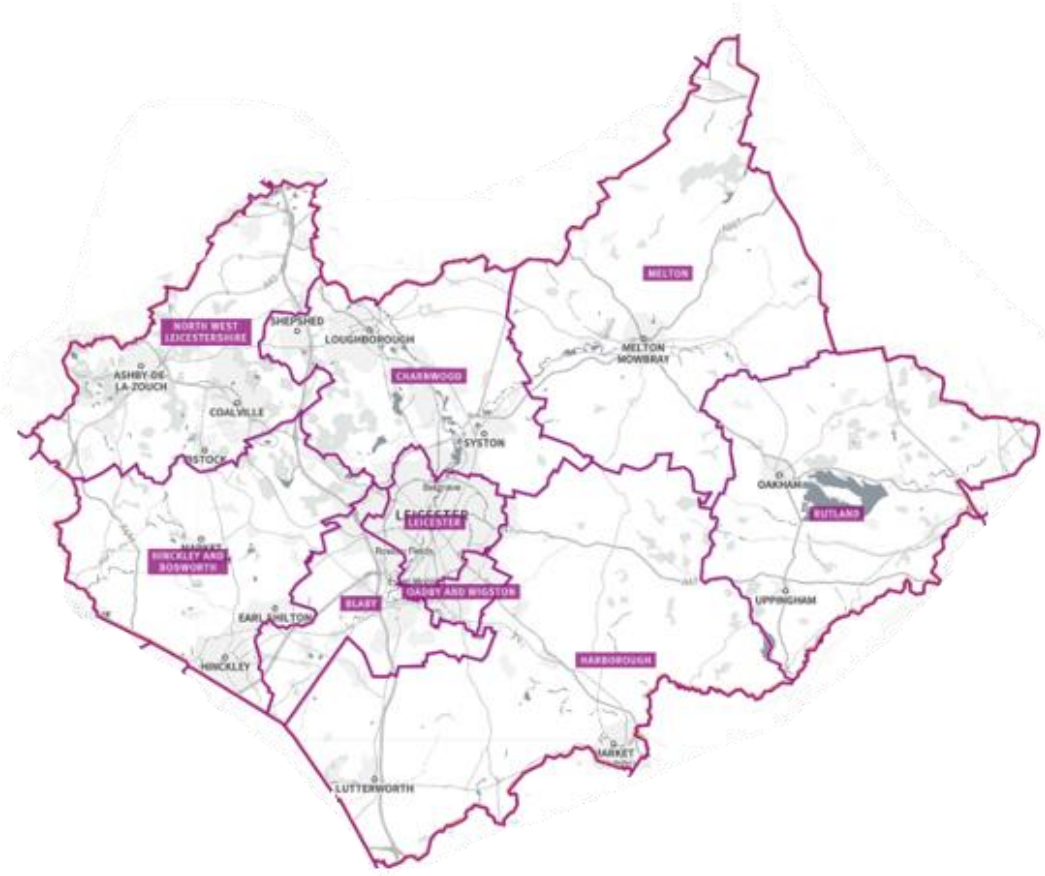
- NHS Leicester, Leicestershire and Rutland Integrated Care Board.
- University Hospitals of Leicester NHS Trust.
- Leicestershire Partnership NHS Trust.
- East Midlands Ambulance Service.
- Leicester City Council.
- Leicestershire County Council.
- Rutland County Council.

GPs, district councils, other health and care providers, Healthwatch and the voluntary and community sector are also important partners.

Geographical coverage

The geographical area covered by the LLR ICB/ICS is shown on the map below together with the local authority districts.

Figure 1-1 LLR ICB/ICS area including local authority districts



1.3.3 Current service configuration

Primary Care services

Primary Care health services are currently delivered from Lutterworth Medical Centre on Gilmorton Road. There are two practices within the medical centre: Wycliffe Medical Practice and The Masharani Practice. These are part of the wider South Blaby and Lutterworth Primary Care Network of 5 GP practices. The two Lutterworth practices serve just over 17,000 registered patients.

The practices hold a General Medical Services (GMS) contract which outlines the essential, additional and enhanced services that should be offered. The table below shows the appointment methods, digital services and enhanced services offered by the practices.

Table 1-1 Services offered by Lutterworth GP practices

Appointment Methods	Digital Services available through online internet access	Enhanced Primary Care Services
✓ Face to face. ✓ Telephone. ✓ Online.	✓ Booking appointments. ✓ Cancel appointments. ✓ Repeat prescriptions. ✓ Change nominated pharmacy. ✓ View test results. ✓ Access GP medical records. ✓ Complete questionnaires. ✓ View vaccination records. ✓ Change contact details. ✓ View NHS number.	✓ LD health check. ✓ Minor surgery. ✓ Home first. ✓ 24 hour blood pressure monitoring. ✓ 24 hour ECGs. ✓ Spirometry. ✓ ECG. ✓ FENO. ✓ Ear syringing. ✓ First contact physio. ✓ Mental health practitioner.

Community Health services

Community health services are currently delivered from a number of locations in Lutterworth including GP surgeries, the Feilding Palmer Hospital and within patient's own homes.

Prior to the COVID19 pandemic the following services were being delivered from Feilding Palmer Hospital:

- ECHO.
- Heart Failure.

- AAA screening.
- Dermatology.
- ADHD.
- Paediatrics.
- Psychiatrics.
- Psychiatric nurse.
- Dietician.
- Speech and Language Therapy – Adults.
- Speech and Language Therapy – Children.
- Parkinson.
- Stoma.
- Mental Health.
- Pulmonary and Cardio Rehab.
- Walking aid clinic.
- MSK Physio.
- Out of hours access.

COVID19 dramatically changed how outpatient care was delivered in health care settings this was to decrease the risk of transmitting the virus to either patients or health care workers. Providers deferred elective (non urgent) and preventative activity. As a result, the services in all community hospitals across LLR, including Feilding Palmer, were reduced. Those services that continued or commenced, during the COVID19 pandemic, in Feilding Palmer Hospital were:

- Physiotherapy.
- Out of hours access.
- Covid vaccination.

Community inpatient beds

Feilding Palmer Hospital is an LPT owned property built in 1899 with later extensions, and is one of 8 community hospitals in LLR to provide Sub Acute, Complex Rehabilitation and End of Life Care to patients transferred from major hospitals including the University Hospitals of Leicester or alternatively patients can be admitted via their GP from home.

Feilding Palmer Hospital has one ward consisting of 10 beds, one of which is a palliative care suite. At the beginning of the COVID19 pandemic, the beds at Feilding Palmer Hospital were forced to close due to the implications of the Infection Prevention and Control (IPC)

measures that were imposed nationally. As there are still IPC measures in place, albeit reduced, the beds remain closed. Patients across all of LLR are able to reside at any of the 8 community hospitals and this is often the case depending on bed availability at the time they are required.

1.3.4 Conclusion on the Current service configuration and demographics

LLR

Overall, the population of LLR in recent decades has seen an improvement in life expectancy and a reduction in mortality rates for the most prevalent conditions, such as cancer and cardiovascular diseases. However, given the growing and rapidly ageing and multi-morbid population, the outlook is for an increase rather than decrease in pressure on the health and social care system. In addition, health outcomes in LLR vary greatly owing to the large disparities in income and deprivation levels across the county.

From a health need perspective there is a marked variation in life expectancy across LLR with the main factors contributing to mortality being cardiovascular disease (CVD) and respiratory. Any plans for service improvement must respond to these challenges and make a significant contribution towards better outcomes.

Lutterworth

The health inequalities JSNA highlights populations and neighbourhoods of higher risk. Lutterworth is not one of the neighbourhoods of higher risk and although Market Harborough Central is (in the wider district), it is some distance from Lutterworth so is unlikely to impact upon the service offer to these people.

The Health Inequalities JSNA identifies population groups at high risk of inequality. The data shows that Lutterworth does not have high levels (comparatively to Leicestershire) of many of the at risk populations in the MSOA or district. The exceptions are Gypsy Irish Travellers (1.4% in Lutterworth, 0.2% in Harborough compared to 0.1% in Leicestershire), along with the LGBT+, disabled and Pakistani populations which are elevated, but not significant. These groups have been identified as a community of interest when the public engagement begins.

1.4 The case for change

1.4.1 Introduction

This section explains the current situation in terms of services provided at Feilding Palmer Hospital and the facilities available. It identifies the reasons why changes are needed to facilitate the ICB's Model of Care and to ***maximise access to services for the local community.***

1.4.2 Feilding Palmer Hospital

Overview

Feilding Palmer Hospital are freehold premises owned by LPT. Legal rights are reserved across part of the frontage and across the rear for the benefit of Lutterworth MC. Some key estates information is shown in the table below.

Table 1-2 Feilding Palmer Hospital key estates information

Build date	1899 (with later extensions)
Internal Floor area (m^2)	841
Total site area	0.2744 ha
Beds	10 (1 of which palliative care)
Backlog Maintenance	£1.554m to be spent over 10 years
Running Costs (2019/20)	£508.35 per m2 (v's £311.95 at Loughborough and £124.32 at St Lukes)

Admissions were suspended in the summer of 2020 due to the Covid-19 pandemic in response to a review against the national IPC guidance. The inpatient ward remains closed as the facilities do not meet IPC guidance and the layout of the building is not suitable to meet modern healthcare standards.

The poor condition of the current facilities is demonstrated in the photographs below.

Main entrance

Example of infrastructure in ward corridor

Corridor with W.C. shower facilities (male and female)

Ward area

Jack and Jill shower room

Dirty utility

Dirty utility only ventilation

Key challenges

The key challenges presented by the current facilities are summarised in the table below.

Table 1-3 Feilding Palmer Hospital key challenges

Area	Challenge
Estates	X Beds do not meet all regulatory requirements. X Site does not give the flexibility of modern health care. X Backlog maintenance - £1.544m over the next 10 year (75% of this within the next 4 years).
Clinical	X IPC standards cannot be met (bed spacing, sluice/dirty utility, handwashing and ward size). X Patient privacy and dignity due to the lack of single sex wards. X No X-ray, endoscopy or cystoscopy provided. X Keeping beds does not respond to the growing population healthcare need.
Workforce	X Not an attractive location for staff (lack of managerial support onsite). X Building and environment makes it an unsuitable place to deliver inpatient care. X Filling shifts on the inpatient ward was always a challenge. Workforce preferred to provide care in more modern facilities. X 2 RNs and HCAs for a 10 bedded unit is significant resource. This is against a system context of high turnover, retention of staff, carrying high vacancies.
Financial	X Inefficient workforce model: 2 RN's and 2 HCA's for 10 beds. X Running costs are high – disparity to other LLR facilities – not an effective use of tax payers money. ✓ Transformation of services is required.

Since the pandemic, when face to face activity was reduced due to social distancing and strict IPC measures, the services delivered from Lutterworth have reduced. This has had an

impact on outpatient appointments and the community hospital beds at Feilding Palmer. Patients are currently using other hospital sites within LLR and across the borders into Coventry and Warwickshire to receive their care. This deviates from the NHS vision of care closer to home. In addition, there will be further demands on services within Lutterworth once the Lutterworth East dwellings are populated resulting in Primary Care activity increase, demand for outpatient activity and an ageing population and therefore an increase of people with more complex care needs/conditions associated with ageing.

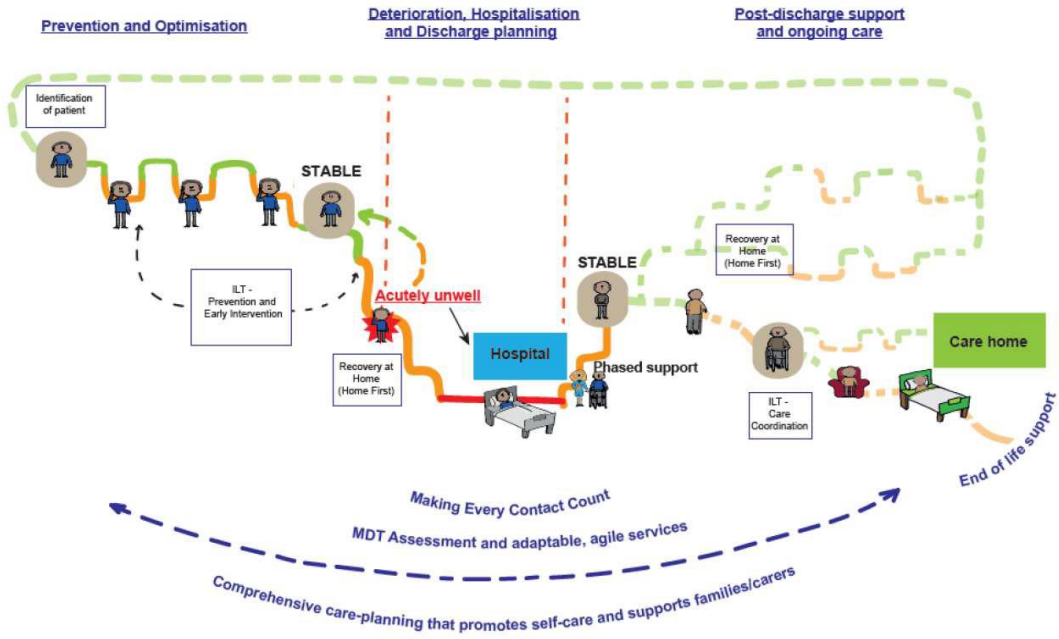
1.4.3 The developing Model of Care

A key priority for over the next few years is to redesign community services and transform Primary Care in order to reduce the acute footprint. To offer seven day services that connect with social care and to deliver the "left shift" in care, a model has been developed which places patients and their GP practice in the centre of care provision. A new layer of community delivered care with integrated services, organised, managed and funded by the ICB will be established. This Model of Care will enable practices, patients and communities to shape services that are coordinated and integrated at a local level to meet the needs of those communities.

The ICB is committed to improving outcomes for patients, supporting more people to live independently in their own homes and wrap support around patients to avoid unnecessary hospital admissions. This will help to reduce the number of sites from which services operate and consolidate community beds; this is part of a model that delivers good patient outcomes for fewer bed days and with less bed dependency. This vision is set out in the Keogh Settings of Care. A reduction in emergency hospital admissions will support the ability of ICB to provide additional community services.

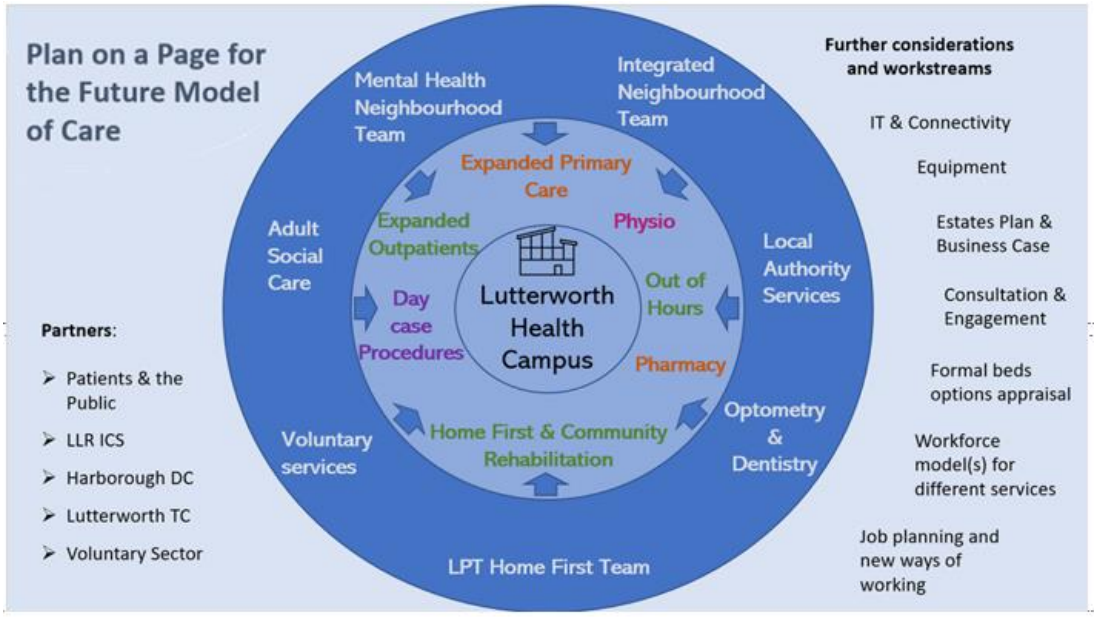
The emerging Model of Care is illustrated in the Figure below.

Figure 1-2 Model of care



What this means for residents of Lutterworth is that there will be a focus on preventable care, in particular for those people living with long term conditions, who will be actively supported to manage their own care and avoid acute exacerbations of disease wherever possible. Set out below is a summary of the proposed Model of Care to be provided in Lutterworth.

Figure 1-3 Plan on a Page for the future Model of Care in Lutterworth



The ICB will ensure that any solutions developed as part of this PCBC will deliver this required Model of Care and patient pathways for all the services within the scope of this project.

1.4.4 Conclusion on the case for change

The facilities from which community planned care across Lutterworth need to change to address:

- The poor state of the existing facilities at Feilding Palmer Hospital.
- The challenges presented by an increasing population.
- Increasing demand for community health services.
- Transformation of services in line with a modern healthcare system that is fit for the future.
- Deliver a financially stable health economy.

1.5 Options appraisal

1.5.1 Introduction

This section describes the process that the ICB has been through to evaluate the various options for the project and to identify a Preferred Option that meets the ICB's requirements and ***maximises access to services for the local community***.

1.5.2 Investment Objectives

The Investment Objectives for the project which have been developed by the ICB with key stakeholders are shown in the table below.

Table 1-4 Investment Objectives

Investment Objective Type	IO Ref	Investment Objectives	Measure	Time
Service provision - local population	1	Maximising access to services through developing existing services and/or provision of new services.	Improved access to effective care. Create access to increased service provision. Provide care closer to home. Reduce travel times from 40 minutes to 10 minutes	By autumn 2025 (measure in 26/27)
Clinical need - facilities	2	Modernise the environment and design facilities to suit clinical need. Also improves the working environment for staff.	Adherence to HBNs/HTMs	
Estates utilisation	3	Improve utilisation of space across the Trust with more effective use of resources	Co-location of services and increased integrated ways of working, maximising the use of financial, human and estates resources. Increase occupancy rates in current estate.	
System Benefits	4	Improved strategic fit of services	Service provision meet the requirements of the Lutterworth Healthcare Plan & the Joint Forward Plan.	
Estates - efficient use of resources	5	Reduced backlog maintenance and modernising infrastructure to support the net zero carbon objectives.	Estimated costs for backlog maintenance of c£1.5m over next 10 years (with 75% of spend in the first 4 yrs) to be addressed through the development and revised use.	

1.5.3 Constraints and dependencies

The constraints and dependencies for the project are shown in the table below.

Table 1-5 Constraints and dependencies

Reference	Description
Constraint 1	Need to maintain stakeholder support
Constraint 2	Physical constraints of site/building
Constraint 3	Funding
Dependency 1	May lead to temporary relocation of services when building works required

1.5.4 Options appraisal approach

The required approach to options appraisal in government is set out in the HM Treasury *'Green Book – Central Government Guidance on Appraisal and Evaluation'* (the Green Book).

The Green Book sets out an options appraisal framework (Strategic Options Framework Filter) to be used, which differs from the previous methodology undertaken in many NHS

schemes in recent years. The framework identifies the Critical Success Factors (CSFs) objectives and benefit criteria that need to be delivered by the relocation of services. The framework breaks a proposal down into a sequence of choices. These choices are presented as questions around the proposed scope, solution, delivery, implementation and funding. The framework considers these choices from the perspective of the public services delivering the project (see table below). The social value of assets is appraised according to how well they enable delivery of a service, as the public sector is generally concerned with the provision of goods and services, not asset ownership.

Table 1-6 Choices in the Strategic Options Framework Filter

Options	Description
Scope	Coverage of the service to be delivered
Solution	How this may be done
Delivery	Who is best placed to do this
Implementation	When and in what form can it be implemented
Funding	What will it cost and how will it be paid for

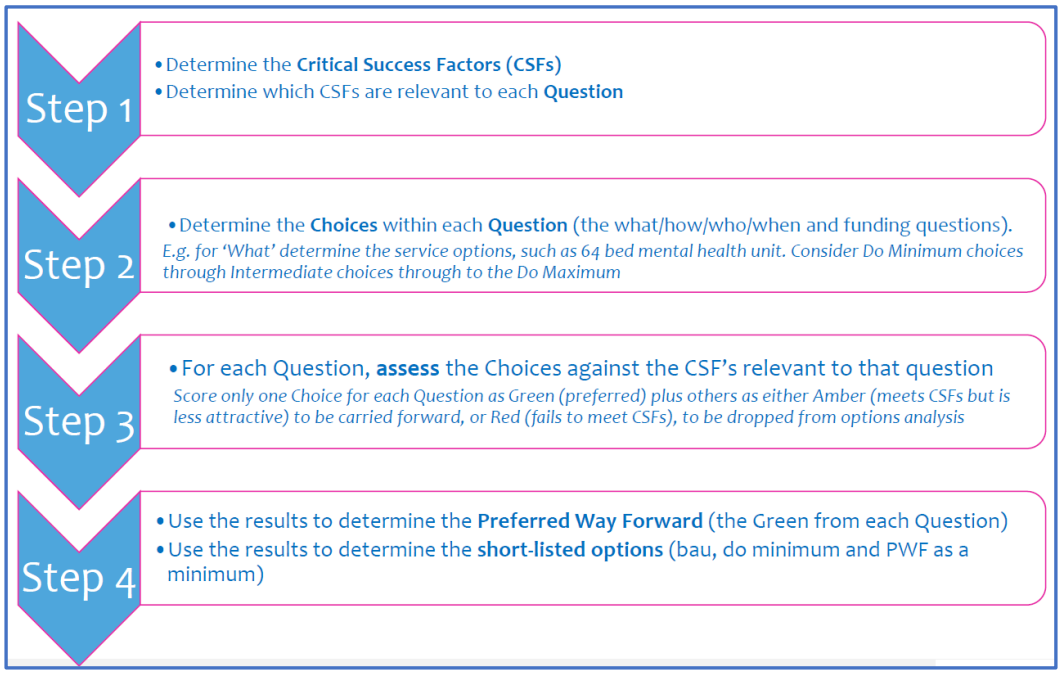
The Strategic Options Framework Filter identifies preferred choices and viable alternatives and rules out non-viable alternatives. The reasons for each decision are documented to support engagement with stakeholders on alternatives. The appraisal of the long list of options should clearly identify any trade-offs between CSFs. This approach has been found to improve the speed, effectiveness and efficiency of strategic analysis through a clear focus on key issues.

The Strategic Options Framework Filter as recommended in Annex 1 of the Green Book, has been used to carry out the appraisal and to:

- Identify the long list of options.
- Establish the Preferred Way Forward (PWF).

There is a four step process to establish the strategic options to be reviewed. These steps are shown are shown in the figure below.

Figure 1-4 Strategic Options Framework Filter appraisal process



1.5.5 Conclusion on the options appraisal

The above process has allowed the ICB to identify the PWF through an assessment against Critical Success Factors that allow the delivery of the Investment Objectives. The PWF, after assessing the five filters of the Strategic Options Framework Filter, is therefore as shown in the table below.

Table 1-7 Preferred Way Forward

Filter:	Preferred Way Forward
Scope	**Community Services Provision** Keep community beds at Feilding Palmer closed Provide services agreed in LLR healthcare plan: - Expand OP - Expand diagnostics - Provide access to pathways - Enable strategic alliances
Solution	**Feilding Palmer Refurbishment**
Delivery	**Public Sector P22 Framework**
Implementation	Single stage 12 month construction period starting January 2025

Filter:	Preferred Way Forward
Funding	System capital

1.5.6 Clinical assurance

Background

Clinical assurance is provided by a review of the proposals by a Clinical Senate. The core function of a Clinical Senate is to provide high quality, independent, evidence based strategic clinical advice and guidance. They provide important support by operating as impartial and advisory arm's length bodies, with access to a wide variety of experts, data and best practice to draw upon.

Clinical Senate

The Clinical Senate took place on 29th June 2023. The Review Panel consisted of 19 independent members from across the East Midlands. The Review Panel of experienced individuals, from a wide variety of specialised subject areas relevant to the review, was made up of a diverse group of multi-disciplinary, multi-professional individuals, as well as patient and public voice. Three weeks prior to their visit, the LLR system provided the Clinical Senate with a suite of information which had been requested.

On the day of the session, a presentation was given by the LLR senior team on the Feilding Palmer service change and revised clinical model, followed by a question and discussion session. The Senate panel also visited the Feilding Palmer Hospital and met with frontline clinicians and staff impacted by the changes.

Based on the information presented to them they provided a Senate Report with recommendations. The report is included in **Appendix F.** The report was reviewed by NHSE as part of the NHSE Stage 2 Assurance Checkpoint. The outcomes and feedback from the Clinical Senate support the clinical case for change within the PCBC.

1.5.7 Conclusion on the options appraisal

The ICB has undertaken an options appraisal in accordance with HM Treasury guidance which has identified the Preferred Way forward which ***maximises access to services for the local community*** as:

- Keeping community beds at Feilding Palmer closed.
- Providing services agreed in Lutterworth healthcare plan:
  - Expand outpatient services.
  - Expanding diagnostics services.
  - Providing access to pathways.
  - Enabling strategic alliances.

The Preferred Way Forward has been reviewed by the Clinical Senate and they have confirmed their support to redevelop the Feilding Palmer hospital to provide more outpatient services for the benefit of the Lutterworth and surrounding population.

1.6 The proposals

1.6.1 Introduction

This section summarises the services to be provided at Feilding Palmer Hospital and provides details of the proposed accommodation required for those services to ***maximise access to services for the local community.***

1.6.2 Proposed services

The proposal is for the following services to be provided from Feilding Palmer Hospital.

Table 1-8 Proposed services

Services	Sessions/clinics	Provider
Outpatient services (new services)		
Ophthalmology	6 per week	UHL
Trauma and orthopaedics	5 per week	UHL
General internal medicine	4 per week	UHL
Dermatology	3 per week	UHL
General surgery	3 per week	UHL
Urology	2 per week	UHL
Gynaecology	2 per week	UHL
Cardiology	2 per week	UHL
Rheumatology	2 per week	UHL
Respiratory medicine	2 per week	UHL
Enhanced procedure suite	10 per week	UHL
Community services (as currently provided)		
ECHO	2 every other week	LPT
Heart Failure	1 every other week	LPT
AAA screening	1 per month	LPT
Dermatology	1 per month	LPT
ADHD	2 every other week	LPT
Paediatrics	1 or 2 per week	LPT
Psychiatrics	1 per week	LPT
Psychiatric nurse	1 per week	LPT
Dietician	1 per month	LPT
Speech and Language Therapy – Adults	1 or 2 per week	LPT
Speech and Language Therapy – Children	3 or 4 per week	LPT
Parkinson	1 per month	LPT
Stoma	1 per month	LPT

Services	Sessions/clinics	Provider
Mental Health	1 every other week	LPT
Pulmonary and Cardio Rehab	4 per week	LPT
Walking aid clinic	2 per week	LPT
MSK Physio	Regular clinics	LPT
Out of Hours	Regular clinics	DHU

1.6.3 Conclusion on the proposals

The proposed services and the associated accommodation requirements have been developed with input from key stakeholders to ***maximise access to services for the local community*** and to ensure that they enable the ICB's Model of Care to be delivered in Lutterworth in accordance with the Lutterworth Healthcare Plan.

Once the work is complete and the services occupy the building there will be business continuity plans in place for the services implemented as part of the standard NHS contract. Engagement with the Local Health Resilience Partnership (LHRP) has commenced, and full details will be shared formally with them at their quarterly meeting in November 2023.

1.7 Public engagement to date

1.7.1 Introduction

This section summarises the engagement that has taken place so far, in respect of the proposed changes to services to be provided at Feilding Palmer Hospital, to ensure that proposals ***maximise access to services for the local community.***

1.7.2 Conclusion on public engagement to date

Engagement to date has been in the form of LLR wide engagement on a number of areas which impact on the residents of Lutterworth and the surrounding areas and specific engagement as part of the Lutterworth Steering Group, which has been specifically established to consider the proposals for Feilding Palmer Hospital. Feedback from this engagement has been incorporated into the proposals as they have been developed so far.

1.8 Impact of the proposals

1.8.1 Introduction

This section identifies the impact of the proposals in terms of the staffing, IT and premises requirements and the impact for patients in terms of quality of care and travel times which ***maximise access to services for the local community***. It also includes details of the Equality Impact Assessment that has been carried out.

1.8.2 Impact on staffing, premises and IT requirements

The impact of the proposals in terms of staffing, premises and IT requirements for LPT and

UHL are minimal. However, the greatest impacts are on patients in respect of quality of care and access to care.

1.8.3 Impact on patients

Quality of care

The fully refurbished accommodation will provide facilities that are developed specifically for the delivery of outpatient services and community services, which will be an effective and conducive environment for health care delivery, resulting in increased likelihood of desired health outcomes in the following ways:

- **Effective** – providing evidence based healthcare services to those who need them.
- **Safe** – avoiding harm to people for whom the care is intended.
- **People centred** – providing care that responds to individual preferences, needs and values.

To realise the benefits of quality health care, health services will be:

- **Timely** – reducing waiting times and sometimes harmful delays.
- **Equitable** – providing care that does not vary in quality on account of gender, ethnicity, geographic location, and socio-economic status.
- **Integrated –** providing care that makes available the full range of health services throughout the life course.
- **Efficient** – maximising the benefit of available resources and avoiding waste.

Access to care

Based on activity projections, the reduction in annual travel, in terms of miles and time saved, is shown in the table below, this is based on carrying out 50% of outpatient appointments for LE17 patients currently happening at alternative hospital locations being brought into Feilding Palmer.

Table 1-9 Reductions in travel times and distance

Specialty	Hours	Days	Miles
Ophthalmology	1,189	50	39,291
Trauma & Orthopaedics	1,153	48	38,104
General Internal Medicine	658	27	21,620
Dermatology	613	26	20,374
General surgery	603	25	20,182
Urology	365	15	12,165
Gynaecology	334	14	11,127
Cardiology	301	13	9,957
Rheumatology	293	12	9,708
Respiratory Medicine	298	12	9,968

Specialty	Hours	Days	Miles
Total	**11,224**	**468**	**377,492**

1.8.4 Conclusion on impact of the proposals

The impact of the proposals in terms of staffing, premises and IT requirements for LPT and UHL are minimal. However, the greatest impacts are on patients in respect of quality of care and access to care.

1.9 How the proposals meet the five NHS tests

1.9.1 Introduction

In 2010, the Government introduced four tests of service reconfiguration. These tests are "designed to build confidence within the service, with patients and communities". The organisations involved in developing service change proposals are responsible for working together to show that the evidence in each test is convincing, and thereby to reassure themselves and their communities.

The four tests are for the proposed service changes to demonstrate evidence of:

- Strong public and patient engagement.
- Consistency with current and prospective need for patient choice.
- A clear clinical-evidence base.
- GP Commissioner support for the proposals.

This section sets out the approach to assessing the Project against each of the four tests of reconfiguration for clinical assurance, and the additional 'fifth test', introduced in March 2017 in respect of justification for bed closures.

1.9.2 Test 1 - Strong public and patient engagement

The proposals have been the subject of strong public and patient engagement in that:

- The Lutterworth Steering Group was established in June 2021.
- The Steering Group has considered the options in response to the needs of the growing Lutterworth population and the future of Feilding Palmer using evidence based discussions. The meetings are attended by:
    - LLR ICS partners.
    - Local Authority partners.
    - Lutterworth GPs.
    - Lutterworth patient representatives/campaign group.
    - Harborough District Councillors.

- Lutterworth Town Councillors.

- The Lutterworth healthcare plan was approved at the steering group meeting in May 2022.
- Stakeholder briefings have been shared, after each Steering Group meeting, with:
  - Parish, Town and County Councillors.
  - Patient groups including:
    - Local Patient Participation Groups.
    - Voluntary Community Social Enterprise organisations.
    - MPs office.
    - Steering Group members.
    - Other key stakeholders.

1.9.3 Test 2 - Consistency with current and prospective need for patient choice

The proposed changes are consistent with the need for patient choice in that:

- The proposals create more patient choice as the population will be able to access diagnostic, outpatient and community services closer to home.
- The proposals will positively impact the ability to provide equitable access to services arising from the shift in provision of services from the acute hospital to the community setting closer to home.
- The facilities will be flexible to accommodate new services if the need is identified, which will increase choice for the patient.
- The proposal will positively impact more patients than retaining inpatient beds.

1.9.4 Test 3 - A clear clinical evidence base

The proposed changes are underpinned by clinical evidence in that:

- Activity data has been used to assess the need and types of services to be provided in Lutterworth. This has been assessed by clinicians who have confirmed which services could be provided from Feilding Palmer in the future.
- Evidence confirms that elderly patients who are supported in their home instead of hospital beds have better outcomes, and deconditioning is reduced.
- Bringing additional diagnostics to Feilding palmer would support management of patients in primary care which will reduce waiting times and unnecessary travel
- Patient flow is a key part of our end to end pathway redesign which is currently in progress in LLR.
- All changes will be measured against national guidance for procedures and specialties to ensure they are aligned to best practice (both prior to initiation and once in place).

1.9.5 Test 4 – GP Commissioners support for the proposals

The plans for the redevelopment have been shared across the LLR system, via the Steering Group as well as within PCN specific meetings, LPT's Executive Meetings, UHLs Clinical Management Group Meetings, and the LLR System Executive Meetings which have confirmed support. The proposed changes are supported fully by:

- Lutterworth GPs.
- South Blaby and Lutterworth Primary Care Network
- LLR ICB.
- UHL.
- LPT.

Letters of support have been received which confirm the following:

- The redevelopment would create a positive impact to LLR.
- The space previously occupied by the inpatient beds would allow for the expansion of community provision and support the ask of providing care closer to home.
- It would positively impact waiting times.
- It would positively impact health outcomes.
- It would provide additional capacity in the LLR system to respond to growth in population due to the Lutterworth East Housing development, creating long term sustainability.

1.9.6 Test 5 – bed closures

The proposed changes meet the required conditions for bed closures in that:

- Community capacity is available and has been tested due to temporary bed closures since June 2020 in response to Covid-19. The alternative provision is shown below:
    - Alternative bed based care (LLR community hospital bed, or a pathway 2 reablement bed for patients with lower medical needs).
    - HomeFirst (Urgent 2 hour response, falls crisis response, virtual wards, community nursing and therapy)
    - End of Life Care (EoL): Specialist Palliative Care in the Community, Hospice at Home, Hospice inpatient unit beds, care home beds, palliative/End of Life virtual ward)
- Our multi-disciplinary teams supporting HomeFirst enable needs to be looked at holistically and directs patients to the right service in a responsive manner. We have

continued to enhance our home first offer with the following being implemented in 23/24:

- Enhancement of our overnight response service (supporting EoL).
- Further investment in our integrated specialist palliative team supporting our 2 hour/same day response.
- Mobilisation of an additional 52 beds in our community hospitals, enabling us to enhance our intermediate care offer which will support reablement, rehabilitation and recovery.

- There is also the opportunity to consider 'care functions', new or optimised roles, that meet population needs, to support transformed care with a focus on right time, right place, right person Right care.

1.9.7 Conclusion on how the proposals meet the five NHS tests

The proposed changes meet the five NHS tests of service reconfiguration as demonstrated by the above analysis.

1.10 Financial implications

1.10.1 Introduction

This section sets out details of the estimated capital and revenue costs and cashflows to LPT associated with the proposed development of Feilding Palmer Hospital and demonstrates the extent to which the proposals are affordable within LPT's financial plan. It demonstrates how the plans are likely to be affordable in terms of both capital funding (cashflow) and ongoing sustainability (revenue). It also records the support of commissioners to the proposed investment and the resulting financial consequences.

1.10.2 Overview of capital costs and funding

The indicative capital construction costs of the preferred option for the Project are summarised in the table below based on the DHSC OB form format.

Table 1-10 Capital construction costs of the preferred option

Cost breakdown	Total (£)	VAT (£)	Total (incl VAT) (£)
Design development and construction	2,124,000	424,800	2,548,800
Abnormals	731,000	146,200	877,200
Overheads/oncosts	30,000	6,000	36,000
Total works cost	**2,885,000**	**577,000**	**3,462,000**
Fees (16% on works costs)	461,600	92,320	553,920
Equipment (15% on works costs)	432,750	86,550	519,300
Planning contingency (10% on works costs)	288,500	57,700	346,200
Total (at 2Q2023 price base)	**4,067,850**	**813,570**	**4,881,420**
Optimism Bias (20%)	813,570	162,714	976,284
Total including Optimism Bias (at 2Q2023)	**4,881,420**	**976,284**	**5,857,704**
Inflation (5.7%)	46,373	9,275	55,648
Total (at 2Q2025)	**4,927,793**	**985,559**	**5,913,352**
VAT reclaim			-92,320
Total outturn cost			**5,821,032**

The estimated capital costs of £5.8m will be funded from ICS capital allocation and not from LPT's specific allocation.

1.10.3 Incremental impact of the investment

The incremental impact of the investment on LPT's SoCI is shown in the table below.

Table 1-11 Incremental impact on SoCI

STATEMENT OF COMPREHENSIVE NET INCOME					
Incremental impact of scheme on the I&E of lead organisation					
	2024/25 £'000	**2025/26 £'000**	**2026/27 £'000**	**2027/28 - 2035/36 £'000**	**Total £'000**
Operating income from patient care activities	0	0	0	0	0
Other operating income	0	124	500	4,729	5,352
(Employee expenses)	0	(10)	(39)	(394)	(443)
(Operating expenses excluding employee expenses)	0	(76)	(305)	(2,634)	(3,015)
Less Cash Releasing Benefits	0	0	0	0	0
Operating surplus / (deficit)	**0**	**38**	**155**	**1,701**	**1,894**
Finance Income	0	0	0	0	0
(Finance Expense)	0	0	0	0	0
(PDC Dividends Payable)	(25)	(101)	(147)	(997)	(1,270)
Investment Revenue	0	0	0	0	0
Other Gains / (Losses) (including disposal of assets)	0	(1,455)	0	0	(1,455)
Gains / (Losses) on transfers by absorption	0	0	0	0	0
Retained surplus / (deficit)	**(25)**	**(1,518)**	**8**	**704**	**(831)**
Adjustments (including PPA, IFRIC 12 adjustment)	0	1,455	0	0	1,455
Adjusted financial performance retained surplus / (deficit)	**(25)**	**(63)**	**8**	**704**	**624**

1.10.5 Whole Trust position

The whole Trust SoCI including the impact of the investment is shown in the table below.

Table 1-12 Statement Of Comprehensive Income including the impact of the investment

STATEMENT OF COMPREHENSIVE NET INCOME					
Whole Trust Position including the Investment over the Appraisal Period					
	2024/25 £'000	**2025/26 £'000**	**2026/27 £'000**	**2027/28 - 2035/36 £'000**	**Total £'000**
Operating income from patient care activities	347,501	350,628	353,784	3,347,577	4,399,490
Other operating income	44,178	44,700	45,477	430,312	564,668
(Employee expenses)	(315,907)	(315,837)	(319,025)	(3,018,702)	(3,969,470)
(Operating expenses excluding employee expenses)	(76,606)	(76,587)	(77,484)	(741,854)	(972,531)
Less Cash Releasing Benefits	7,860	4,071	4,106	38,755	54,793
Operating surplus / (deficit)	**7,026**	**6,976**	**6,858**	**56,089**	**76,950**
Finance Income	360	360	360	3,240	4,320
(Finance Expense)	(1,488)	(1,488)	(1,488)	(13,392)	(17,856)
(PDC Dividends Payable)	(5,938)	(6,014)	(6,060)	(54,214)	(72,226)
Investment Revenue	0	0	0	0	0
Other Gains / (Losses) (including disposal of assets)	0	(1,455)	0	0	(1,455)
Gains / (Losses) on transfers by absorption	0	0	0	0	0
Retained surplus / (deficit)	**(40)**	**(1,622)**	**(330)**	**(8,277)**	**(10,268)**
Adjustments (including PPA, IFRIC 12 adjustment)	0	1,455	0	0	1,455
Adjusted financial performance retained surplus / (deficit)	**(40)**	**(166)**	**(330)**	**(8,277)**	**(8,813)**

1.10.6 Affordability of the investment and Commissioner support

The revenue implications of the proposed investment are affordable to LPT on the basis that the incremental costs of circa £500k per annum (in the first full year of operations which is 2026/27) are funded by the system and included in their medium term financial plan.

The proposals have commissioner support and will be approved by the ICB board in September.

1.10.7 Conclusion on financial implications

The proposed development at Feilding Palmer Hospital will be funded by LLR ICS capital of £5.8m. The incremental revenue cost to LPT of circa £0.5m will be funded by the system.

1.11 Delivering the proposals

1.11.1 Introduction

This section addresses how the consultation and proposals will be delivered. It demonstrates that Commissioners and LPT have the appropriate plans in place and the capacity and capability to deliver the proposals and to realise the benefits and ***maximise access to services for the local community.***

1.11.2 Consultation questions

The proposed consultation questions are shown below.

PROPOSAL 1. We would like to repurpose the current space in Feilding Palmer Hospital which currently houses 10 inpatient beds to provide outpatient and diagnostic services for hundreds of patients.

Q1. ***To what extent do you agree or disagree with this proposal?***

Please tick one box only

Strongly Agree □ Agree □ Neither agree nor disagree □

Disagree □ Strongly Disagree □

Q2. Please explain (in the space below) why you agree or disagree with this proposal. Please include any impacts (either negative or positive) that you feel this proposal may have on you, your family or any groups you represent.

PROPOSAL 2. We would like to provide a range of outpatient and diagnostic services in Lutterworth. Currently they include: Cardiology, General surgery,Gynecology, Physiotherapy, Out of hours access, Covid vaccination, Community Crisis response, Ophthalmology, Physiotherapy and Occupational therapy, Trauma and Orthopedics, General internal medicine, General surgery, Rheumatology, Respiratory Medicine, Rehabilitation, Community palliative care, Fall prevention and assessment, Dermatology, Low level diagnostics not provided at GP practice, General assessment, Gynecology, Audiology, Urology, Ear, Nose and Throat, Cardiology and Virtual Wards.

Q3. ***To what extent do you agree or disagree with this proposal?***

Please tick one box only

Strongly Agree □ Agree □ Neither agree nor disagree □

Disagree □ Strongly Disagree □

Q4. Please explain (in the space below) why you agree or disagree with this proposal. Please include any impacts (either negative or positive) that you feel this proposal may have on you, your family or any groups you represent.

Q5. ***What other outpatient or diagnostic services do you feel we should consider providing in Lutterworth?***

PROPOSAL 3: We are providing more care to people in their own home or in the place they call home. If there is a need for an inpatient bed, it would be provided in a care home facility near or close to Lutterworth or in a nearby community hospital but outside of Lutterworth.

Q6. If you have any specific comments about service provided at home or in a care home, please use this space to tell us?

PROPOSAL 4: We are providing more care in GP practices delivered by members of the practice team who are qualified and experienced to manage different conditions. A GP will always care for the most seriously ill patient and those who have more complicated illnesses.

Q7. If you have any specific comments about the services provided at your GP practice, please use this space to tell us?

Q8. If you have any further comments relating to issues access to services including travel and transport, the services, please explain these in the space below.

Q9. If you have any other specific comments about the proposals for community services in Lutterworth or if there are any alternative proposals that you think we should consider, please tell us and explain these in the space below.

1.11.3 Consultation risks

Risks and mitigations will be managed by the Executive Management Team and the ICB Board. Risks around communications and engagement will be fed into overall Risks log for the project. Communications and engagement risks will be identified and regularly reviewed and assessed throughout the consultation and mitigating actions put in place to respond to issues. The main risks and proposed mitigations are summarised in the table below.

Table 1-13 Risks and mitigations

Risk	Mitigation
Failure to engage with relevant stakeholders and meet statutory duties / stakeholders feel they have not been fully involved	Communications engagement plan developed identifying stakeholders and partners with detailed communications activity implemented during consultation period.
ICB do not engage with marginalised, disadvantaged and protected groups	Communications and Engagement plan identifies relevant groups and organisations that we will work with to access these groups and communities
Lack of response / “buy in”	Ensure adequate publicity and support. Ensure accessibility of activities and appropriate feedback mechanisms using a range of online and offline media. Implement mid-point review to assessment responses and modify communications and engagement activities accordingly
Proposal in consultation document perceived as already implemented or a ‘done deal’	Ensure through all communications that public are aware of changes made during the pandemic and have knowledge of the clear rational for the proposal for change

Risk	Mitigation
The consultation may be subject to challenge and the lack of options for the public to comment on may be criticised	Appropriate governance policies/standards will be put in place to ensure correct procedure, logging processes and equality analysis are maintained throughout the consultation and that public are fully aware of the engagement that led to the narrowing down of options to the proposal being consulted on
Campaign group(s) challenges proposals	Ensure co-design of proposals. Ensure that consultation documents outline how the proposals have been developed and how they will benefit service users by improving access to mental health services in a crisis or when the need is urgent. Ensure we are following due process and logging all engagement. Ensure that we are prepared through the processes in place to receive any petition

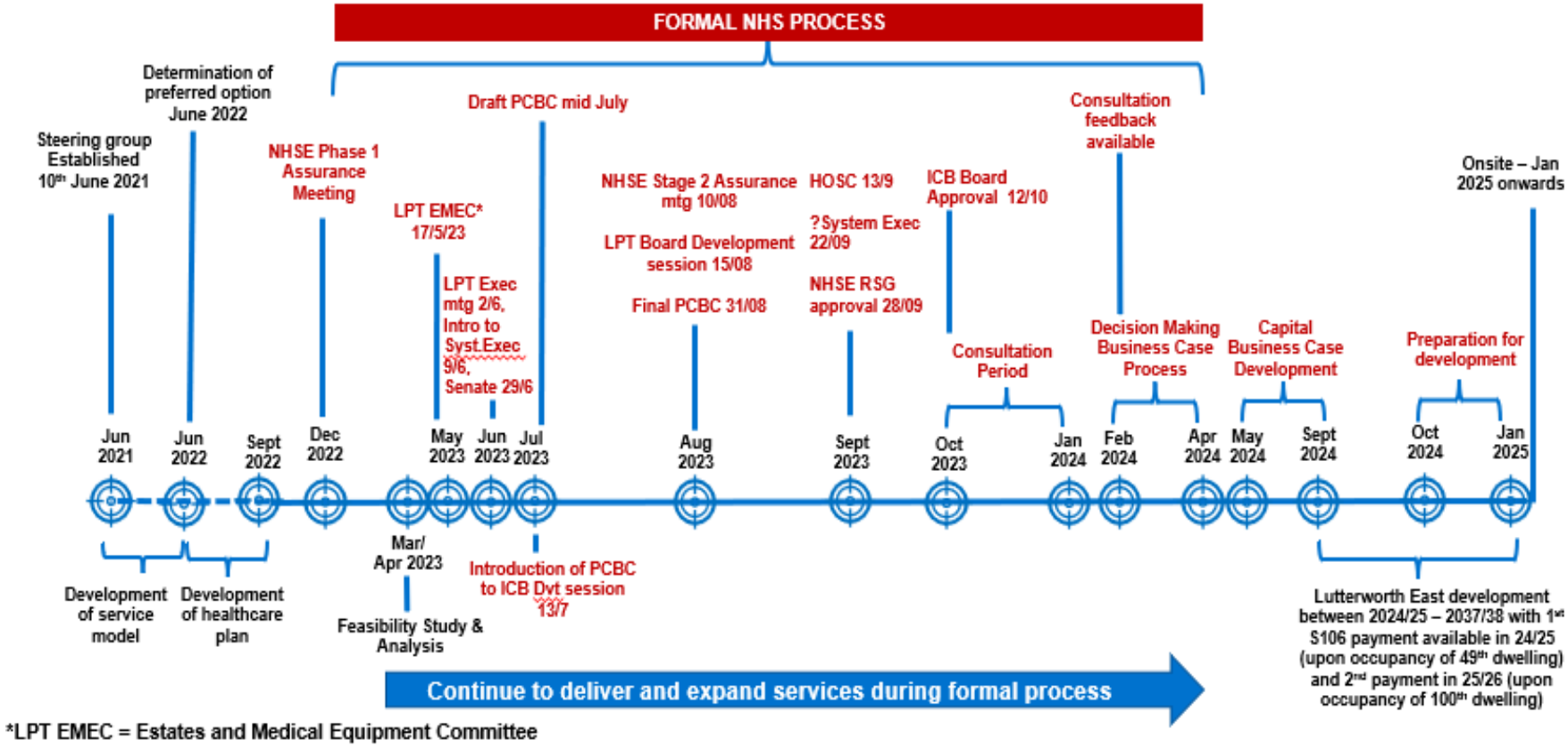
1.11.4 Consultation timeline

The final consultation document and process is subject to approval by the ICB Board and NHS England. The consultation plan assumes that the consultation will start when approval of the PCBC is known. The consultation will last for 12 weeks. There will be a period of deliberation and analysis of findings which will last 8 to 10 weeks, depending on the number of responses made to the survey. The ICB Board will then meet to make their decision on the outcome.

1.11.5 Project timetable

The project timeline for the consultation is shown in the figure below and the timeline for the Feilding Palmer Hospital capital development is shown in the table below.

Figure 1-5 Consultation timeline



*LPT EMEC = Estates and Medical Equipment Committee

Table 1-14 Feilding Palmer Hospital development timeline

	Target date
PCBC submission	July 23
PCBC approval	October 23
Consultation period start	October 23
Consultation period end	January 24
Consultation feedback available	February 24
DMBC completed	March 24
DMBC approval	April 24
P22 PSCP appointment complete	May 24
Capital business case submission	July 24
Capital business case approval	September 24
Construction contract signed	October 24
Construction start	January 2025
Construction complete	December 2025
Building occupation	January 2026
Post Project Evaluation	January 2027

1.11.6 Health Overview and Scrutiny Committee review

Early discussions have taken place with Leicestershire Health Overview and Scrutiny Committee (HOSC). The PCBC will be considered by HOSC at the 13 September 2023 meeting prior to public consultation commencing.

1.11.7 Outline arrangements for benefits realisation

Benefits realisation is a way of ensuring the intended benefits of the project are delivered. The intended benefits can be categorised as follows:

- Quality.
- Access.

- Financial.
- Workforce.
- Environmental.

By focusing on benefits planning, the ICS will track whether the intended benefits have been realised and sustained after the end of the project.

Table 1-15 Benefits realisation

Potential Benefit	
Quality of Care	
1	Improved health outcomes, better access to services, preventing illness and tackling health inequalities by providing local capacity enabling the local population to access a greater range of services.
2	Ensuring modern, fit for purpose facilities that enable the introduction of best practice and reduced infection risk.
Access to Care	
3	Providing flexible facilities to accommodate new services and models of care, including generic and flexible rooms.
4	Improving equity of access to services by providing them local within Feilding Palmer Hospital, thereby, improving access to services arising from a shift of outpatient services from acute hospital to a community setting.
5	Allowing planning of services based on the needs of the local population.
6	Ensuring fit for purpose facilities that meet relevant standards and guidance to deliver care close to home.
7	Opportunity to increase the provision of "one-stop shop" services, ensuring patients can be treated by multiple specialists on a single visit reduces risk of DNA.
Financial	
8	Maximising the use of Feilding Palmer Hospital and getting the most out of taxpayers' investment in the NHS.
Workforce	
9	Backing the NHS workforce by providing a pleasant working environment which permits the integration of services and collaboration which permits staff to deliver services to the levels they believe are necessary.
Estates	
10	Addressing existing estate issues at Feilding Palmer Hospital.
11	Enhanced community asset, which adds to sustainability of local community.
Environmental sustainability	
12	Reduced journeys for patients reducing carbon emissions.
13	Through the introduction of new plant equipment, providing greater energy efficiency, reduced carbon footprint and reduced estates running costs.

1.11.8 Conclusion on delivering the proposals

The above demonstrates that the Commissioners and LPT have the appropriate plans in place and the capacity and capability to deliver the project and to realise the benefits of ***maximising access to services for the local community.***

2 Introduction

2.1 Purpose and scope of this PCBC

2.1.1 Background

Lead commissioners are required to prepare a PCBC to inform NHSE's assessment of proposals for service changes against the government's four tests of service change. The tests are as follows:

- Strong public and patient engagement.
- Consistency with current and prospective need for patient choice.
- A clear clinical-evidence base.
- GP Commissioners' support for the proposals.

NHSE need comfort that proposals satisfy the government's four tests of service change, and the additional 'fifth test' (introduced in March 2017 in respect of justification for bed closures) and NHSE's own best practice checks, prior to views being sought from patients and members of the public who may be affected by the proposed changes. The PCBC also forms the starting point for any subsequent business case(s) as required by NHSE.

Pre-consultation seeks to build alignment between NHS commissioners and local authorities to:

- Make the case for change.
- Demonstrate that all options, benefits and impact on service users have been considered.
- Demonstrate that the planned consultation will seek the views of patients and members of the public who may potentially be impacted by the proposals.

Commissioners and providers must also give due consideration to potential impacts of any proposed service changes on the ability of the NHS to effectively plan for and/or respond to an emergency.

2.1.2 Scope of this PCBC

This PCBC considers the proposed changes to servicers provided at Leicester Partnership NHS Trust's (LPT's) Feilding Palmer Hospital in Lutterworth.

2.1.3 Compliance with guidance

This PCBC and the proposed changes described have been developed in accordance with NHSE guidance in terms of:

- *Planning, assuring and delivering service change for patients* (March 2018).
- *Major service change – an interactive handbook* (February 2022).

3 Strategic Context

3.1 Introduction

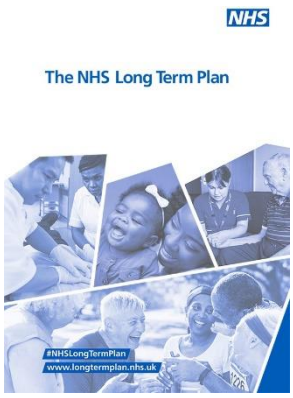
This section sets out the strategic context within which the proposals have been developed. This is considered at both a national level, in terms of government policy for health and social care, Department of Health and Social Care (DHSC), NHSE priorities and at a local level in terms of the ICB and Trust strategies and the need to ***maximise access to services for the local community.***

3.2 The national context

3.2.1 NHS Long Term Plan

Health and care leaders came together to develop a Long Term Plan to make the NHS fit for the future, and to get the most value for patients out of every pound of taxpayers' investment.

The plan was drawn up by those who know the NHS best, including frontline health and care staff, patient groups and other experts. And they have benefited from hearing a wide range of views, whether through the 200 events that have taken place, and or the 2,500 submissions we received from individuals and groups representing the opinions and interests of 3.5 million people.



What the NHS Long Term Plan will deliver for patients

Over the next ten years the NHS Long Term Plan aims to improve care for patients as set out in the table below.

Table 3-1 NHS Long Term Plan aims

Making sure everyone gets the best start in life	• Reducing stillbirths and mother and child deaths during birth by 50%. • Ensuring most women can benefit from continuity of carer through and beyond their pregnancy, targeted towards those who will benefit most. • Providing extra support for expectant mothers at risk of premature birth. • Expanding support for perinatal mental health conditions. • Taking further action on childhood obesity. • Increasing funding for children and young people's mental health. • Bringing down waiting times for autism assessments. • Providing the right care for children with a learning disability. • Delivering the best treatments available for children with cancer, including CAR-T and proton beam therapy.

Delivering world-class care for major health problems	• Preventing 150,000 heart attacks, strokes and dementia cases. • Providing education and exercise programmes to tens of thousands more patients with heart problems, preventing up to 14,000 premature deaths. • Saving 55,000 more lives a year by diagnosing more cancers early • Investing in spotting and treating lung conditions early to prevent 80,000 stays in hospital. • Spending at least £2.3bn more a year on mental health care. • Helping 380,000 more people get therapy for depression and anxiety by 2023/24. • Delivering community-based physical and mental care for 370,000 people with severe mental illness a year by 2023/24.
Supporting people to age well	• Increasing funding for primary and community care by at least £4.5bn. • Bringing together different professionals to coordinate care better. • Helping more people to live independently at home for longer. • Developing more rapid community response teams to prevent unnecessary hospital spells, and speed up discharges home. • Upgrading NHS staff support to people living in care homes. • Improving the recognition of carers and support they receive. • Making further progress on care for people with dementia. • Giving more people more say about the care they receive and where they receive it, particularly towards the end of their lives.

How the ambitions of the NHS Long Term Plan will be delivered

To ensure that the NHS can achieve the ambitious improvements for patients over the next ten years, the NHS Long Term Plan also sets out how the challenges that the NHS faces, such as staff shortages and growing demand for services, can be overcome by:

- **Doing things differently** - Giving people more control over their own health and the care they receive, encourage more collaboration between GPs, their teams and community services, as 'Primary Care networks', to increase the services they can provide jointly, and increase the focus on NHS organisations working with their local partners, as 'Integrated Care Systems', to plan and deliver services which meet the needs of their communities.

- **Preventing illness and tackling health inequalities -** Increasing the NHS's contribution to tackling some of the most significant causes of ill health, including new action to help people stop smoking, overcome drinking problems and avoid Type 2 diabetes, with a particular focus on the communities and groups of people most affected by these problems.

- **Backing our workforce -** Continuing to increase the NHS workforce, training and

recruiting more professionals including thousands more clinical placements for undergraduate nurses, hundreds more medical school places, and more routes into the NHS such as apprenticeships. We will also make the NHS a better place to work, so more staff stay in the NHS and feel able to make better use of their skills and experience for patients.

- **Making better use of data and digital technology -** Providing more convenient access to services and health information for patients, with the new NHS App as a digital 'front door', better access to digital tools and patient records for staff, and improvements to the planning and delivery of services based on the analysis of patient and population data.

- **Getting the most out of taxpayers' investment in the NHS -** Continuing working with doctors and other health professionals to identify ways to reduce duplication in how clinical services are delivered, make better use of the NHS' combined buying power to get commonly used products for cheaper, and reduce spend on administration.

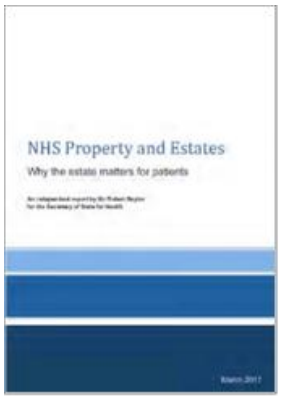
Delivering the NHS Long Term Plan at the local level

Integrated Care Systems (ICSs), have to develop and implement their own strategies for responding to the NHS Long Term Plan. These strategies must set out how they intend to take the ambitions that the NHS Long Term Plan and work together to turn them into local action to improve services and the health and wellbeing of the communities they serve, building on the work they have already been doing.

3.2.2 Naylor Review – NHS Property and Estates

In March 2017 an independent report by Sir Robert Naylor was published making 17 recommendations to the Secretary of State for Health and Social Care on the future of NHS property and estates.

These recommendations include:



- Proposals to improve capability and capacity to support national strategic planning and local delivery through the establishment of a new national NHS Property Board. The aim being to provide leadership to the centre and expertise and delivery support to the sustainability and transformation plans locally
- Encouraging and incentivising local action by enabling the reinvestment of sales receipts to support local plans and even offer additional incentive funding
- Prioritise land vacated by the NHS for development of residential homes, including prioritisation for use by NHS Staff.

The overarching drive of these recommendations is ensuring the NHS locally is supported at

a national level to develop robust, well evidenced estate plans that make best use of the capital available.

LLR's strategic ambitions are in line with the Naylor review principles in aspiring to deliver an estate which is safe, cost effective, meets the future requirements of clinical services and supports the aspirations of the ICP to transform services in HWE.

3.2.3 Government's Response to the Naylor Review

On 31st January 2018 the Government published its response to the Naylor Review and generally welcomes the review and its recommendations. They have confirmed that the recommendations will be implemented in conjunction with national partners and the NHS.

The review set out the progress needed on three key themes to transform the NHS estate, and the government has confirmed that they are taking action in response. The themes highlighted by the Review are:

- Leadership and capability.
- National planning and funding.
- Incentivising action locally.

Leadership and capacity

The response notes that a new NHS property boardhas been formed to bring together all the key national players and to act as a single point of leadership for the health system on estate matters.

Capability at a local level is being improved by creating a new national strategic estates planning and advisory service, to help the NHS move from planning to delivery. This team has evolved over the last year by bringing together all the local strategic estates advisers into a single team to provide expert advice to the NHS.

National planning and funding

The review gave a clear estimate of the level of funding required to enable the transformation of the estate to meet the vision of the Five Year Forward View. It recommended this could be found through government capital, private finance and proceeds from the disposal of surplus NHS land.

The Chancellor, in his 2018 Autumn Budget, announced an additional £10 billion package of capital investment over the course of this Parliament. The Government has committed over £3.9 billion of capital for the NHS. This will support the NHS to increase the proceeds from the sale of surplus land to £3.3 billion.

With this £10 billion package of capital investment, the Government would develop a pipeline of transformational STP projects over the next five years so that the NHS can deliver on the vision of the Five Year Forward View.

The government also confirmed that it would put forward £700 million to tackle critical maintenance issues and support turnaround plans in struggling trusts and put £200 million into support efficiency programmes, "allowing more time and money to be directed to patient care".

Incentivising action locally

Action is being taken to incentivise local NHS organisations to take a more strategic approach to estates planning and management.

Reassurance has been given to NHS organisations, confirmed that they will be able to retain receipts from land sales, so these can be reinvested in the NHS estate, to renew and replace outdated facilities and to address backlog maintenance, in line with local priorities and STP strategies. Where surplus land is developed for housing, NHS staff will be given the right of first refusal on any affordable homes built.

3.2.4 The vision for the future of Primary Care

Dr Claire Fuller's report, published in May 2022, on how integrated care system leaders can support Primary Care to work with other system partners to improve population health and reduce health inequalities. The report, commissioned by NHS chief executive Amanda Pritchard, provides recommendations for how newly formed ICSs can support integrating Primary Care with a focus on local population-based care.

Dr Fuller has set out a vision for the future of Primary Care, with practical actions that ICS and national leaders can take to work with Primary Care to make the changes needed to deliver this vision. The vision focuses on four main areas:

- Neighbourhood teams aligned to local communities.
- Streamlined and flexible access for people who require same-day urgent access.
- Proactive, personalised care with support from a multi-disciplinary team in neighbourhoods for people with more complex needs.
- More ambitious and joined-up approach to prevention at all levels.

Integrated neighbourhood teams

Systems should support Primary Care to build on the Primary Care network (PCN) structure by coming together with other health and care providers within a local community to develop integrated neighbourhood teams at the 30,000-50,000 population level. This will help to realign services and workforce to communities and drive a shift to a more holistic approach to care.

This means putting in place the appropriate infrastructure and support needed to build these multi-disciplinary teams, so they can proactively tailor care to meet the needs of particular communities and individuals in their local population, with a particular focus on the most deprived 20 per cent of their population (Core20PLUS5).

Streamlined access

To improve access, Primary Care should be supported to offer streamlined access to urgent, same-day care and advice from an expanded multi-disciplinary team and given the flexibility to adapt their service to local need. Data and digital technology should be optimised by systems to connect existing fragmented and siloed urgent same-day services, empowering Primary Care to build an access model for their community that gives patients with different needs access to the service that is right for them. This will also create resilience around GP practices by connecting patients to the practitioner who meets their need, rather than increasing GP referrals to additional services, increasing practices' capacity to deliver continuity of care.

Personalised care for those who need it

People should be able to access more proactive, personalised support from a named clinician working as part of a multi-professional team. To achieve this, development of neighbourhood teams providing joined-up holistic care to people who would most benefit from continuity of care in general practice (such as those with long-term conditions) should be supported and delivered in partnership with system partners and Primary Care.

This Model of Care should offer greater shared decision-making with patients and carers and maximise the role of non-medical care staff, such as social prescribers, so people get the care they need as close to home as possible.

Helping people to stay well for longer

There should be a more ambitious and joined-up approach to prevention for the whole of health and care with a focus on the communities that need it most. System partners should work collectively across neighbourhood and place to share expertise to understand what factors lead to poor health and wellbeing and agree how to work together proactively to tackle these.

This means building on what Primary Care is already doing well to improve local community health: working with communities, effective use of data, and relationships with local authorities while harnessing the wider Primary Care team including community pharmacy, dentistry, optometry and audiology, as well as non-clinical roles.

Creating the environment for change

The report also includes steps that can be taken to create the right environment for change.

Locally driven change

- Local decision-making should be maximised to enable the delivery of improved support at a local level. NHS England and NHS Improvement (NHSE) should consider what investment could be devolved to ICSs as part of the implementation of the wider recommendations.
- NHSE should also consider combining and simplifying central programme and transformation budgets for Primary Care.

Creating the capacity

Estates

- Estates that are not fit for purpose can impact how well providers can collaborate. Therefore, there needs to be greater weighting of capital investment to Primary Care estates, informed by a detailed review of physical space within systems to build a One Public Estate approach.
- NHSE and the Department of Health and Social Care should consider what flexibilities and permissions should be afforded to systems to build estates capability.

Data and digital

- Shared data and digital capabilities can play a big part in joining up services and help the whole health and care system to deliver care informed by local knowledge.
- A shared patient record, interoperability and system-level data analysis capabilities are essential to planning and delivering service in a coherent way.
- ICSs should develop coherent plans to data sharing and cross-system IT infrastructure, supported by NHSE.

Workforce

- Workforce capacity remains a huge pressure on Primary Care. There must be a continued focus on recruiting and retaining GPs and the wider Primary Care workforce, alongside optimising current capacity with a long-term, system-wide workforce strategy that includes Primary Care.
- The report welcomed progress made in recruitment through the Additional Roles Reimbursement Scheme (ARRS). However, it recognised there needs to be improvements in supervision, development and career progression. Systems and national leaders also need to support PCNs to deliver the ARRS offer post-2024.
- More work is also required to make Primary Care more attractive to staff by addressing work-life balance, parity with other NHS career paths, and making a portfolio career more accessible. Training and education to encourage career development should be rolled out across Primary Care, from clinical to managerial and reception roles.

3.3 The local context

3.3.1 Leicester, Leicestershire and Rutland Integrated Care Board (ICB)

Background to the ICB and ICS

NHS Leicester, Leicestershire and Rutland (LLR) is the Integrated Care Board (ICB) for LLR. The ICB began operating on 1 July 2022 and replaced the Leicester City, East Leicestershire and Rutland and West Leicestershire Clinical Commissioning Groups.

The ICB is part of the Integrated Care System (ICS) with partners in LLR and delivers a health and care system that tackles inequalities in health and improves the health, wellbeing and

life experiences of the local population. The role of ICB is to develop a plan to meet the health needs of the population and to arrange and manage the budget for the provision of NHS services in LLR.

Members of the ICB Board are the senior leaders from NHS organisations and local authorities in Leicester, Leicestershire and Rutland. The ICB Board has oversight of the whole health system, sets the strategic direction and working jointly with the Health and Wellbeing Partnership agrees what needs to be done to meet the priorities for the ICS.

LLR ICB Joint Forward Plan

Introduction

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

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

LLR face significant health and care challenges which are set out in Chapter 2 of the JFP Working with Councils and wider partners, the ICB have developed an Integrated Care Strategy that sets out the direction of travel to address these challenges for LLR. The LLR Councils have also worked with partners to develop Joint Health and Wellbeing Strategies (Leicester City Council JHWS; Rutland County Council JHWS; Leicestershire County Council JHWS) that focus on the specific challenges in each of their areas, as identified through their Joint Strategic Needs Assessments (JSNA) (Leicester City Council JSNA; Rutland County Council JSNA; Leicestershire County Council JSNA. Furthermore, the ICB is working with district councils to develop Community Health and Wellbeing Plans which are district level plans aligned to the Joint Health and Wellbeing Strategies to address housing growth, health inequalities and the wider determinants of healthcare at a local level.

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

LLR ICB priorities

The ICB worked closely with partners and stakeholders to develop a shared vision and principles that act as a 'golden thread' for how the ICB operate in LLR:

- How the ICB focus on a better future for local people.
- How the ICB transform and improve health and care.

- How the ICB interact with each other.

Our vision

- Working together for everyone in LLR to have healthy fulfilling lives.

Our Principles

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

Our Priorities

The ICB will focus on the first 1001 days of life to enable more equity in outcomes as we know this is critical to a child's life chances.

The ICB will support residents to live a healthy life and make healthy choices to maintain wellbeing and independence within their communities.

The ICB will focus on supporting those with multiple conditions and who are frail to manage their health and care needs and live independently.

The ICB will ensure people have a personalised, comfortable, and supported end of life with personalised support for carers and families.

3.3.2 LLR Lutterworth Healthcare Plan

The LLR ICB Vision and Plan for Local Healthcare in Lutterworth is included in **Appendix B**. This sets out the ICB's proposals for healthcare services in the Lutterworth area covering the ICB's aims in respect of:

- Primary Care transformation.
- Community Health and Social Care integration.
- Planned Care in the community.
- Mental Health.
- Access to pathways.
- Maternity and Children's.
- Enablers to fit for the future local healthcare.

The key aspects of each of these areas are set out below.

Primary Care transformation

- Pro active health inequalities focus.
- Technology and data enabled.
- New roles and ways of working.
- More operational space to deliver care.

Community Health and Social Care integration

- Technology and data enabled.
- Voluntary and community sector.
- Enhanced care in care homes.
- Integrated neighbourhood leadership.
- Anticipatory care.
- High risk focus.

Planned Care in the community

- Technology and data enabled.
- Care closer to home.
- Mobile provision.
- Wider delivery partners.
- Enhanced diagnostics.
- Better utilisation of Lutterworth estates.

Mental Health

- Local mental health pathway for Lutterworth.

- Pilot the 3 conversation approach to mental health aiming to eradicate organisational boundaries and reduce hand offs across the system.

Access to pathways

- Technology and data enabled.
- Enhance and strengthen models of access.
- Multi agency care planning.
- Same day provision.
- Increase utilisation of pathways.
- Minor illness provision.

Maternity and Children's

- Technology and data enabled.
- Integrated working.
- Increase utilisation of pathways.
- High risk focus.

Enablers to fit for the future local healthcare

- Long term infrastructure planning.
- Technology and data enabled teams and patients.
- Improve partnership working in and out of area.
- Model and understand population health impacts.

Not all of the developments above will be picked up through the pre-consultation business case, as they align to system level workstreams.

3.3.3 UHL strategy

UHL are currently in the process of refreshing their '*3 Year Quality Strategy & Priorities'*. The updated strategy is due to be completed in September 2023 and will build on the existing strategy which is included in **Appendix C**.

A key element of the strategy is to provide high quality, efficient integrated care by redesigning pathways in key clinical services to manage demand, improve use of resources and deliver financial improvement. UHL provide 66 different clinical services across the Trust, more if sub-specialties are included. In a perfect world UHL would have the time and resource to devote to improvement activity, pathway redesign and productivity in each service but the world is not perfect and therefore UHL have to focus their efforts where the opportunity is greatest.

Over the last year, using information from their own performance and quality metrics, supplemented by national peer comparisons from the likes of the 'Getting it Right First Time'

(GIRFT), programme, UHL has begun to focus on a number of services which in the round have the greatest potential for quality, performance and financial improvement. UHL call them the 'Vital Few'. It is important to recognise that in most if not all of UHL's services, activity is increasing whilst the ability to cope with the activity is not keeping pace. As a consequence, a key principle of the work on integrating and redesigning care pathways is that **patients should only be bought into UHL's hospitals for work that cannot be done safely and effectively elsewhere**. A genuinely Integrated Care System, means that services will need to be planned in such a way that the best interests of our patients continue to be served, but then elevate what is 'best for the system' over what is 'best for the Trust'.

The proposals to provide an enhanced procedure suite and outpatient clinics at Feilding Palmer Hospital directly support UHLs priority to provide services to patients out of the UHL hospital environment and closer to home.

3.3.4 LPT Strategy

The LPT Estates Strategy is currently being developed and is expected to be completed in September 2023, this will include the proposed development of Feilding Palmer Hospital. Feilding Palmer Hospital is LPT's only property in Lutterworth and as such is essential to the future delivery of community health, families and young persons, learning disability and mental health services in the town and wider area. The growth of the town in the coming years will only reinforce this need. Service delivery will reflect national and local drivers of providing care closer to home and creating neighbourhood hubs. These services will be delivered through GP practices (where possible), patients' homes, virtually when appropriate, but also in a clinical setting at Feilding Palmer Hospital, both individually and through group work.

3.1 Conclusion on the Strategic Context

The above demonstrates that the proposals for Feilding Palmer Hospital are entirely consistent with health and social care strategies at both a national level, in terms of government policy for health and social care and DHSC and NHSE priorities. At the local level they are also consistent with the aims and objectives of the LLR JFP and the relevant UHL and LPT strategies and support the aim of ***maximising access to services for the local community.***

4 Current service configuration and demographics

4.1 Introduction

This section provides on overview of the LLR ICS and describes the current configuration of services provided in the Lutterworth area. It also provides details of the local population.

4.2 Overview of the LLR ICS

4.2.1 Context

On 1 July 2022, 42 ICSs were established across England. Each ICS consists of an Integrated Care Partnership. The local Integrated Care Partnership is known as the Leicester, Leicestershire and Rutland Health and Wellbeing Partnership (LLR HWP). It is a statutory committee bringing together an alliance of partners who are concerned with improving the care, health and wellbeing of the local population. It is also responsible for producing an integrated care strategy on how to meet the health and wellbeing needs of the population in the ICS area.

The statutory partners are:

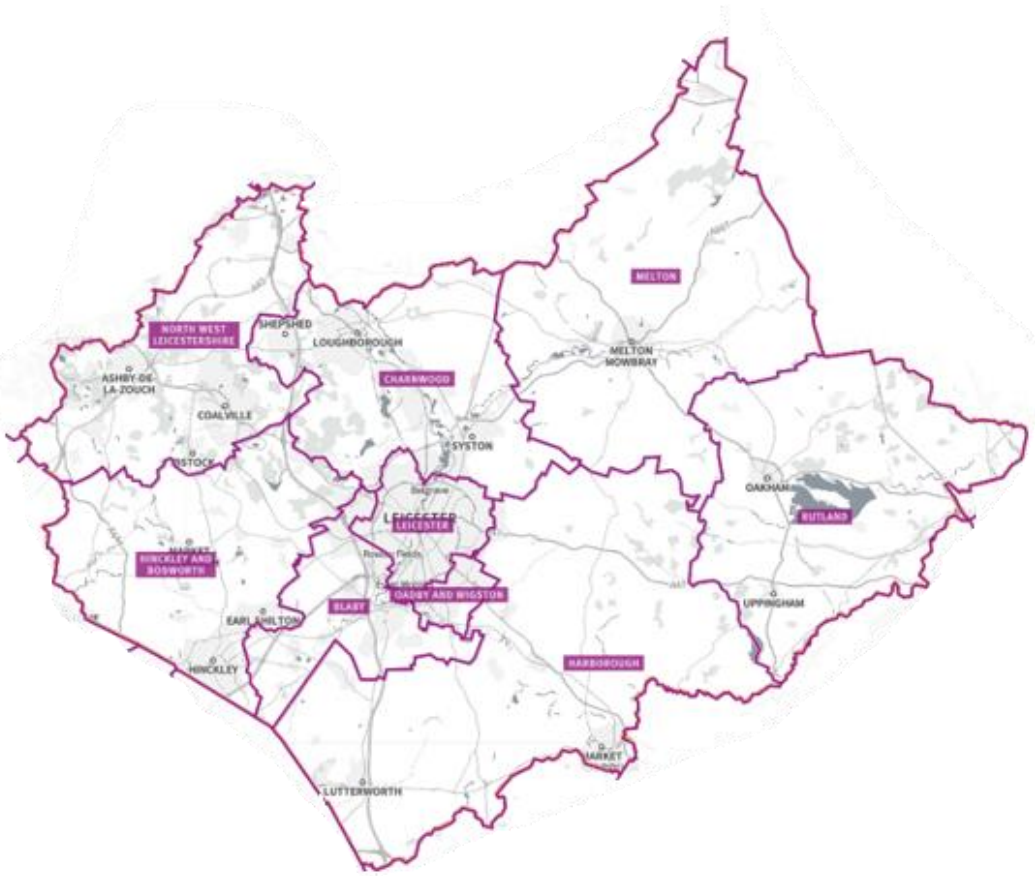
- NHS Leicester, Leicestershire and Rutland Integrated Care Board.
- University Hospitals of Leicester NHS Trust.
- Leicestershire Partnership NHS Trust.
- East Midlands Ambulance Service.
- Leicester City Council.
- Leicestershire County Council.
- Rutland County Council.

GPs, district councils, other health and care providers, Healthwatch and the voluntary and community sector are also important partners.

4.2.2 Geographical coverage

The geographical area covered by the LLR ICB/ICS is shown on the map below together with the local authority districts.

Figure 4-1 LLR ICB/ICS area including local authority districts



4.2.3 LLR NHS organisations

The LLR ICS includes the following NHS organisations and facilities:

- University Hospitals of Leicester NHS Trust (UHL) - acute services:
  - Glenfield Hospital.
  - Hinckley & District Hospital.
  - Leicester General Hospital.
  - Leicester Royal Infirmary.
  - Loughborough Hospital.
  - Melton Mowbray Hospital.
  - National Centre for Sports and Exercise Medicine.
  - St Lukes Hospital.
  - St Mary's Birth Centre (Melton Mowbray).

- Leicestershire Partnership NHS Trust (LPT) - community and mental health services:
  - Coalville Community Hospital.
  - Feilding Palmer Community Hospital.
  - Hinckley and Bosworth Community Hospital.
  - Loughborough Hospital.
  - Melton Mowbray Hospital.
  - Rutland Memorial Hospital.
  - St Luke's Hospital.
  - The Agnes Unit.
  - The Bradgate Mental Health Unit.
  - The Rise.
  - The Willows.
- East Midlands Ambulance Service

4.3 Current service configuration

4.3.1 Primary Care services

Primary Care health services are currently delivered from Lutterworth Medical Centre on Gilmorton Road. There are two practices within the medical centre: Wycliffe Medical Practice and The Masharani Practice. These are part of the wider South Blaby and Lutterworth Primary Care Network of 5 GP practices. The two Lutterworth practices serve just over 17,000 registered patients.

The practices hold a General Medical Services (GMS) contract which outlines the essential, additional and enhanced services that should be offered. The table below shows the appointment methods, digital services and enhanced services offered by the practices.

Table 4-1 Services offered by Lutterworth GP practices

Appointment Methods	Digital Services available through online internet access	Enhanced Primary Care Services
✓ Face to face. ✓ Telephone. ✓ Online.	✓ Booking appointments. ✓ Cancel appointments. ✓ Repeat prescriptions. ✓ Change nominated pharmacy. ✓ View test results. ✓ Access GP medical records. ✓ Complete questionnaires. ✓ View vaccination records. ✓ Change contact details. ✓ View NHS number.	✓ LD health check. ✓ Minor surgery. ✓ Home first. ✓ 24 hour blood pressure monitoring. ✓ 24 hour ECGs. ✓ Spirometry. ✓ ECG. ✓ FENO. ✓ Ear syringing. ✓ First contact physio. ✓ Mental health practitioner.

The catchment areas of the two GP practices are shown on the maps below.

Figure 4-2 Wycliffe Medical Practice catchment area

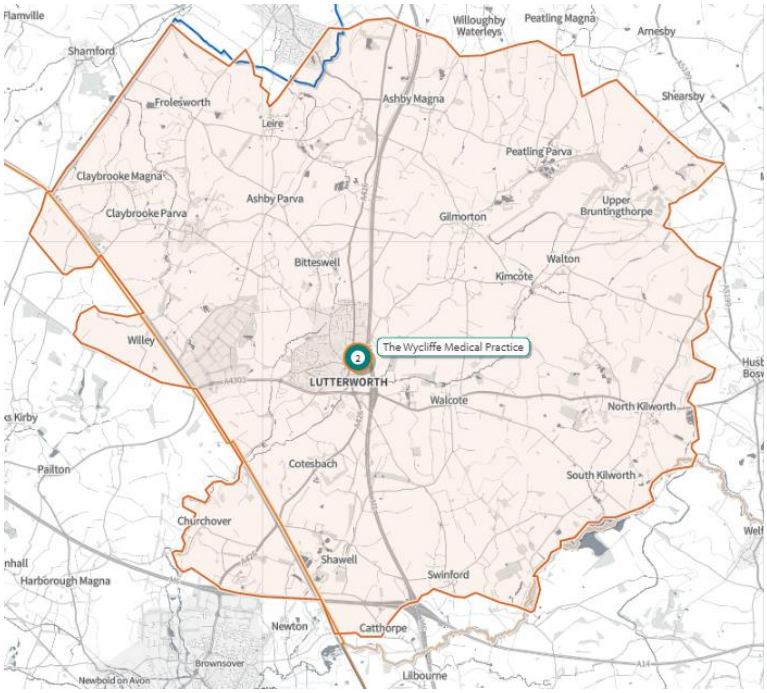
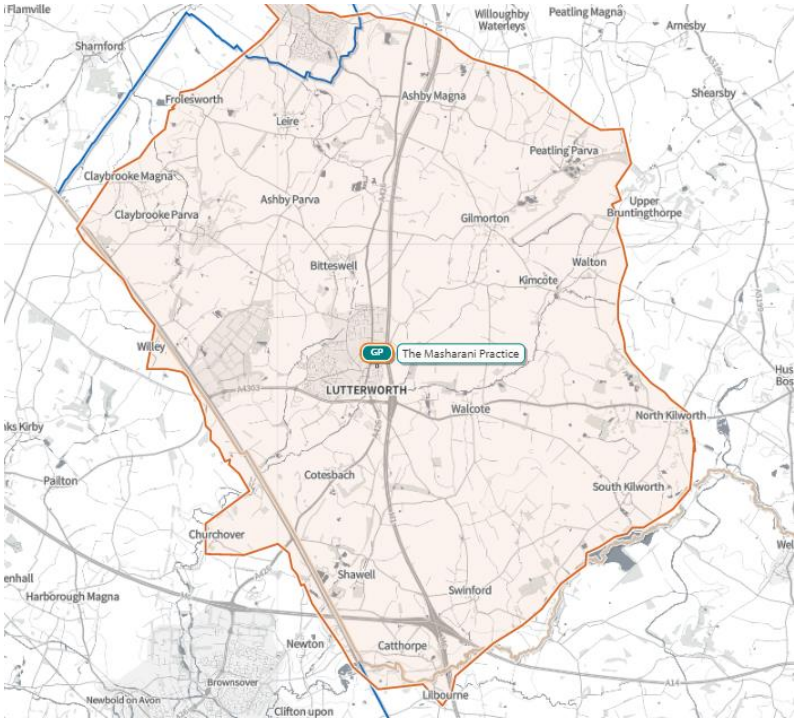


Figure 4-3 Masharani Practice catchment area



4.3.2 Community Health services

Community health services are currently delivered from a number of locations in Lutterworth including GP surgeries, the Feilding Palmer Hospital and within patient's own homes.

Prior to the COVID19 pandemic the following services were being delivered from Feilding Palmer Hospital:

- ECHO.
- Heart Failure.
- AAA screening.
- Dermatology.
- ADHD.
- Paediatrics.
- Psychiatrics.
- Psychiatric nurse.
- Dietician.
- Speech and Language Therapy – Adults.
- Speech and Language Therapy – Children.
- Parkinson.
- Stoma.

- Mental Health.
- Pulmonary and Cardio Rehab.
- Walking aid clinic.
- MSK Physio.
- Out of hours access.

COVID19 dramatically changed how outpatient care was delivered in health care settings this was to decrease the risk of transmitting the virus to either patients or health care workers. Providers deferred elective (non urgent) and preventative activity. As a result, the services in all community hospitals across LLR, including Feilding Palmer, were reduced. Those services that continued or commenced, during the COVID19 pandemic, in Feilding Palmer Hospital were:

- Physiotherapy.
- Out of hours access.
- Covid vaccination.

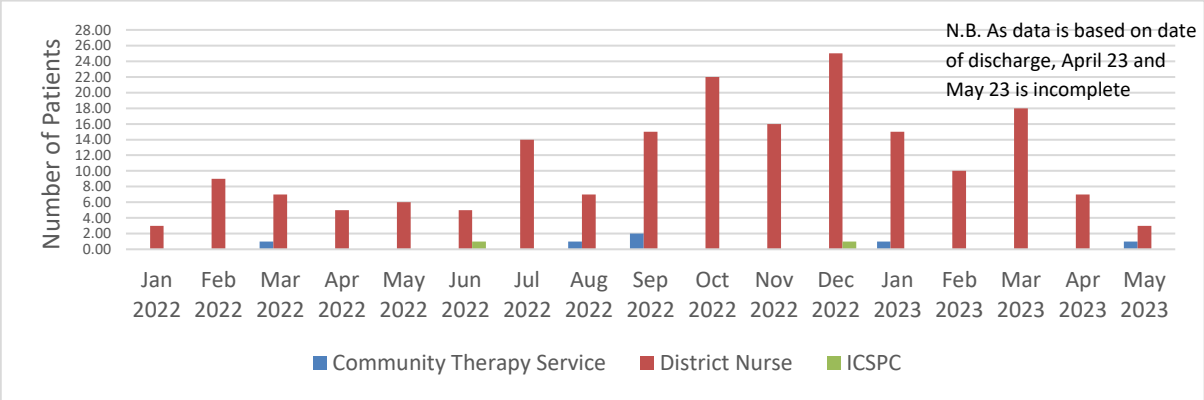
4.3.3 Community based care

Community based health services support patients in their homes in Lutterworth for patients requiring crisis response, reablement and end of life care. These are provided through the main services below:

- **Neighbourhood community nursing and therapy/Home First** - as part of integrated locality teams, which manage the majority of care of patients in the community, working closely with social care and Primary Care networks. Home First provides integrated health and social care crisis response and reablement services, which deliver intensive, short-term care for up to six weeks. Home First services are accessed via Locality Decision Units, with health and social care services working on the basis of trusted assessment and delivering co-ordinated packages of care.
- **Integrated Community Specialist Palliative Care (ICPSC)** – A team who look after patients with life-limiting illnesses, including cancer, who have complex palliative care needs, especially pain and symptom management, as well as patients who are in the last days of life.

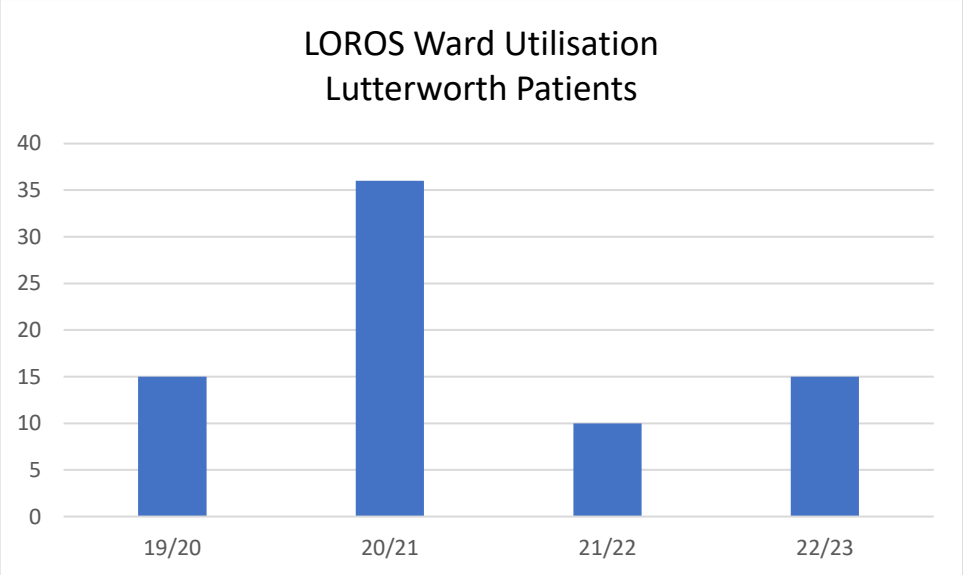
The utilisation of these services for Lutterworth patients is demonstrated in the chart below showing increasing utilisation over time.

Figure 4-4 Utilisation of community based care



- **Palliative Care Hospice (LOROS)** – LOROS provides end of life care to people living with life limiting conditions. It offers inpatient care as well as outreach support, support services, counselling and complimentary therapies. Patients in Lutterworth are eligible to access these services and the chart below shows the number of patients who have accessed inpatient care since pre-Covid**.**

Figure 4-5 LOROS ward utilisation for Lutterworth patients



- **Community Bed Based Care** - delivered either in community hospitals for patients requiring medical rehabilitation needing significant 24/7 nursing care and on-site therapies, and in 'Pathway 2' reablement beds for patients with lower medical needs requiring reablement and a degree of 24/7 support.

4.3.4 Community hospital inpatient beds

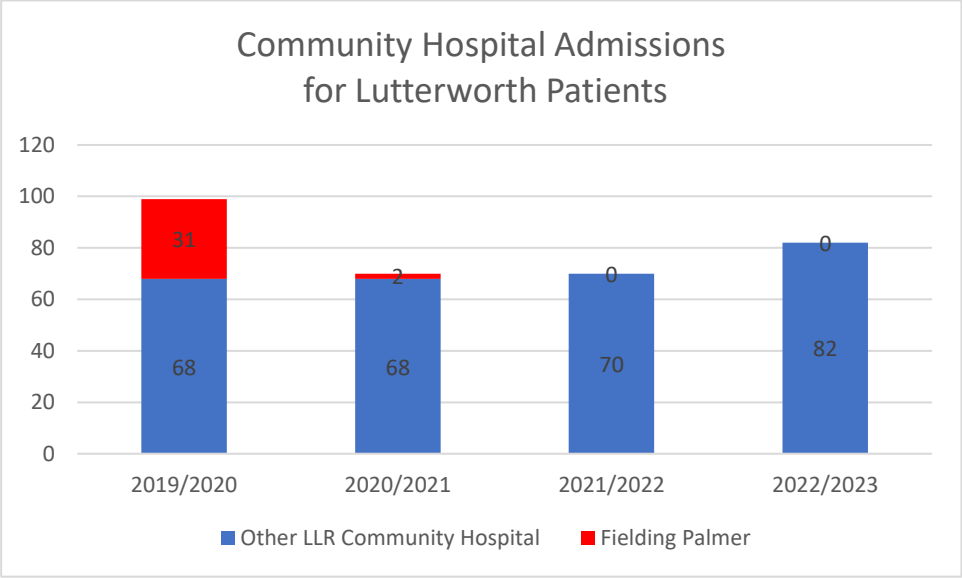
Feilding Palmer Hospital is an LPT owned property built in 1899 with later extensions and is one of 8 community hospitals in LLR to provide Sub Acute, Complex Rehabilitation and End of

Life Care to patients transferred from major hospitals including the University Hospitals of Leicester or alternatively patients can be admitted via their GP from home.

Feilding Palmer Hospital has one ward consisting of 10 beds, one of which is a palliative care suite. At the beginning of the COVID19 pandemic, the beds at Feilding Palmer Hospital were forced to close due to the implications of the Infection Prevention and Control (IPC) measures that were imposed nationally. As there are still IPC measures in place, albeit reduced, the beds remain closed. Patients across all of LLR are able to reside at any of the 8 community hospitals and this is often the case depending on bed availability at the time they are required.

The chart below shows which hospitals patients in South Blaby and Lutterworth use and shows Feilding Palmer Hospital compared to the other seven LLR community hospitals.

Figure 4-6 Annual bed usage for patients in South Blaby and Lutterworth



For Lutterworth patients, in 2019/20 there were 99 patients admitted into a community hospital; 31 patients admitted to Feilding Palmer Hospital, and 68 admitted to a different community hospital within LLR. In 2020/21 there were 70 admissions, with 2 admissions into Feilding Palmer and 68 into a different community hospital. The Feilding Palmer beds closed to admissions in May 2020. In 2021/22 and 2022/23 there were 70 and 82 admissions to an LLR community hospital respectively.

4.3.5 Social Care

Social Care providers in the area

There are a number of social care providers based in Lutterworth in terms of both Care Homes and providers of Home Care. These are:

- **Care Homes (Lutterworth):**

- Woodmarket House (42 beds).
- Lutterworth Country House Care Home (66 beds).
- Hunters Lodge (beds 17).
- Brook House Care Home (41 beds).

- **Home Care (Lutterworth):**
  - Home Instead Rugby.
  - Help At Home (St Marys House).
  - Helping Hands Market Harborough.

There are also social care providers in the neighbouring districts of Blaby and Harborough.

- **Care Homes (Blaby):**
  - Woodway House (32 beds)
- **Home Care (Blaby):**
  - Medacs Healthcare Leicester.
  - Carelink Healthcare Professionals Ltd.
- **Care Homes (Harborough):**
  - Herons Lodge (10 beds).
  - HF Trust - Cromwell Crescent (3 beds).
  - Lenthall House (40 beds).
- **Nursing Homes (Harborough):**
  - Peaker Park Care Village (137 beds).
  - The Willows Nursing and Residential Home (57 beds).
- **Home Care (Harborough):**
  - Carewatch (Harborough).
  - CT Care Ltd.
  - Freedom Support.
  - HF Trust - Leicestershire DCA.
  - New Horizon Care.
  - TML Care Solutions Ltd.
  - Welland Place.
  - Xcel Homes Ltd.
  - Yourlife (Market Harborough).

Leicestershire County Council services

Leicestershire County Council operate two main county wide services which therefore cover Lutterworth and surrounding areas.

Home Assessment and Reablement

Leicestershire County Council operate a Home Assessment and Reablement Team (HART) service which is a short term domiciliary care service designed to help people develop the confidence and skills they need to live as independently as they can at home. It supports people to do social care tasks for themselves, rather than doing it for them, including personal care (washing and dressing) and preparing food and drink. This service is available for people in the community as well as those who are being discharged from hospital.

Crisis Response

Leicestershire County Council's CRS (Crisis Response Service) is a short term service which supports citizens of Leicestershire who are experiencing a health or social care crisis within their own home and without which they may be admitted to hospital or a care home. The service is available 24 hours, 7 days a week helping people to remain independent and living at home. The service is short term and is only available for a maximum of 3 days. It is accessible to people aged 18+ undergoing a 'crisis' that requires urgent social care intervention. It is open not only to current and previously known individuals, but also to people who are not known to Adult Social Care.

The service will be available to people:

- Who require urgent personal care.
- Who have fallen but do not require hospital assessment or treatment, or who are at risk of further falls.
- Who require support with prescribed medication (in line with the Medication Policy and Guidelines).
- Who have become confused or distressed, requiring reassurance, personal care and support.
- Who require assistance with urgent nutritional needs.

Referrals can be made by:

- Adult Social Care's Customer Service Centre.
- Emergency Duty Team (EDT).
- Leicestershire Partnership NHS Trust.
- Urgent Care Centres.
- Health and Social Care Coordinators and Primary Care Coordinators based within the Accident and Emergency Department.
- The Elderly Frailty Unit, Acute Frailty Unit and Medical Assessment Unit.

- Out of hours GPs covering the County of Leicestershire.

4.4 Population profile and demographics

4.4.1 Lutterworth

2021 census data

Lutterworth has a population of 10,800. This is split between Lutterworth East and Lutterworth West 5,400 and 5,500 respectively and is shown in the tables below.

Table 4-2 Lutterworth population data

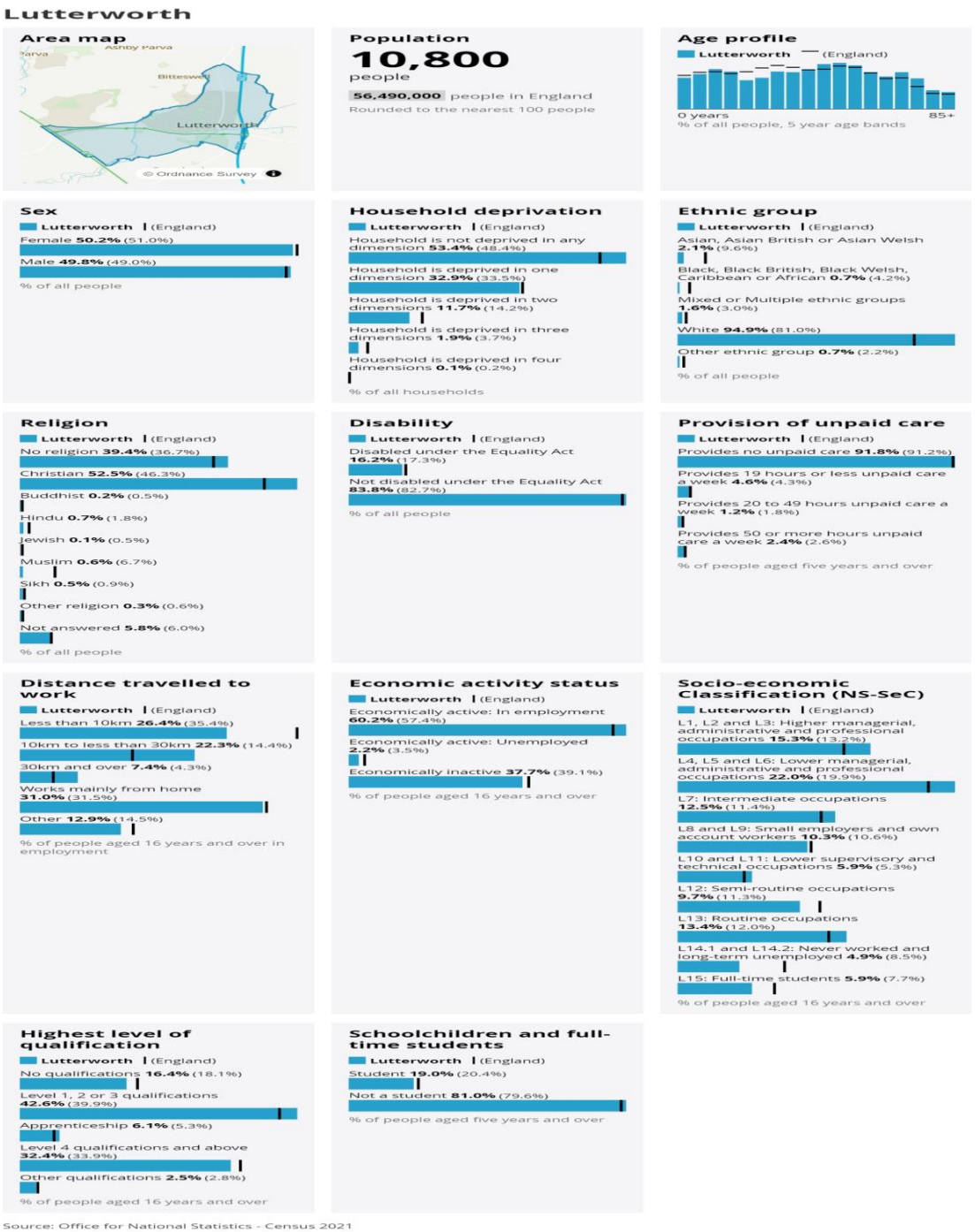
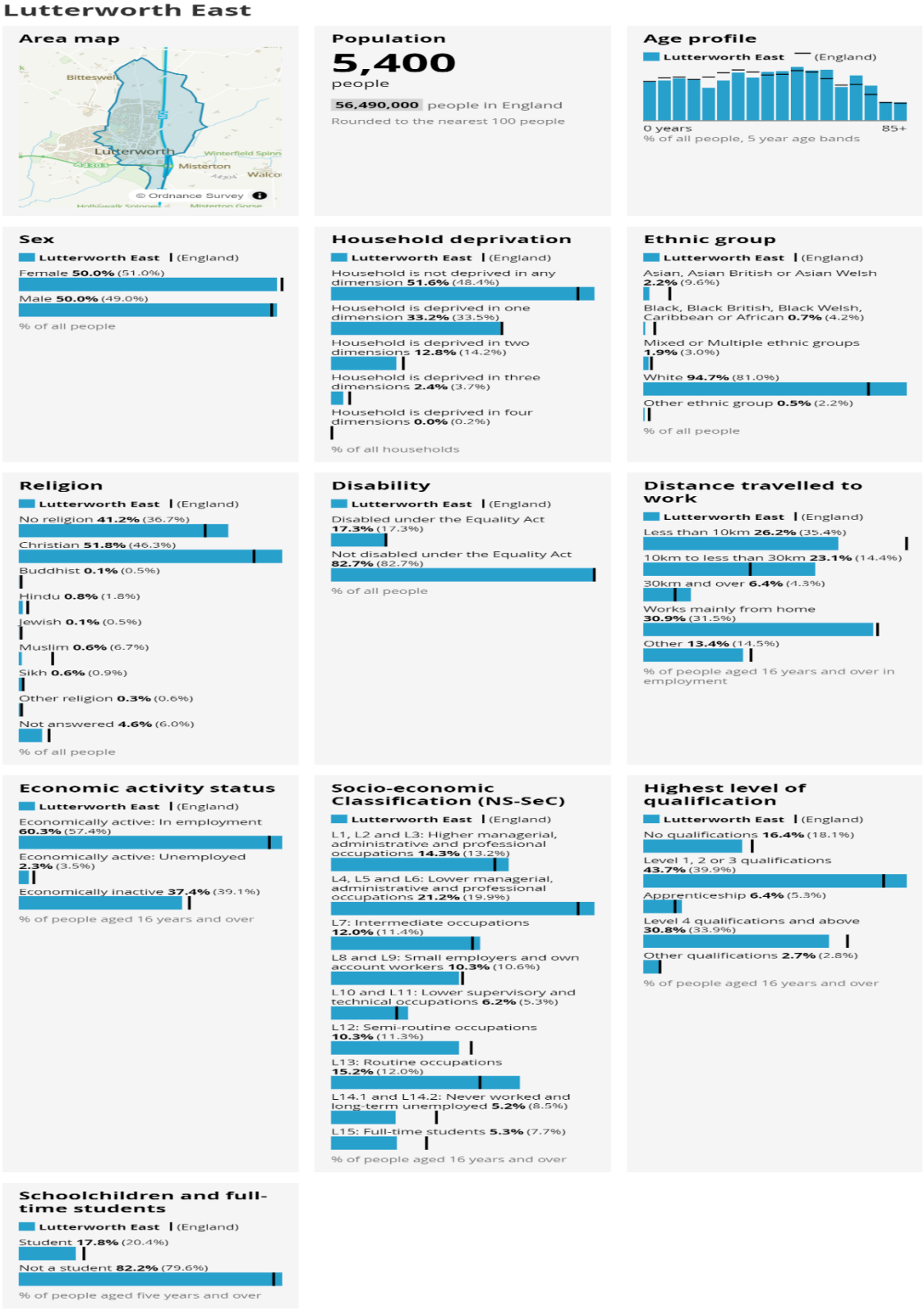
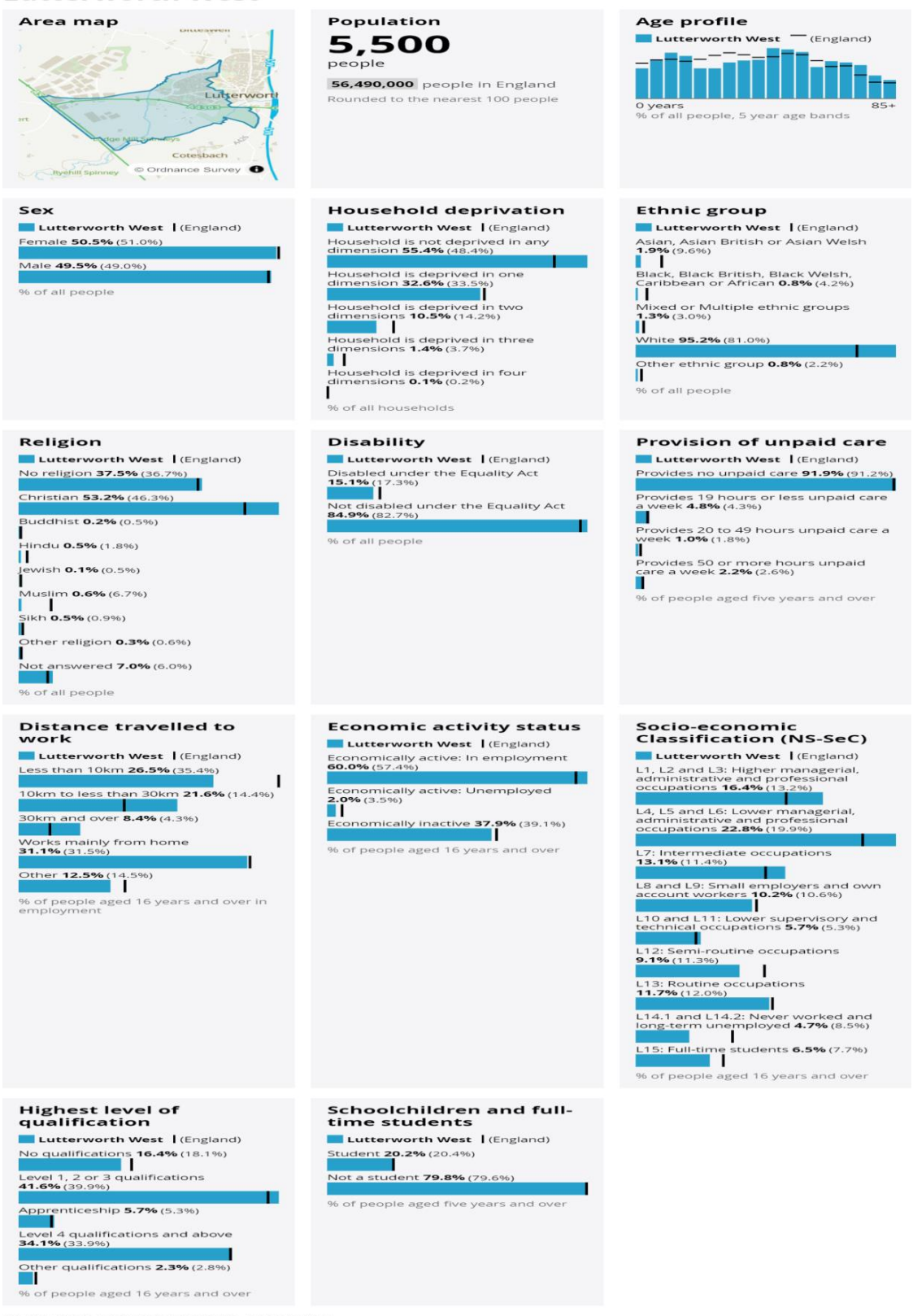


Table 4-3 Lutterworth East population data



Source: Office for National Statistics - Census 2021

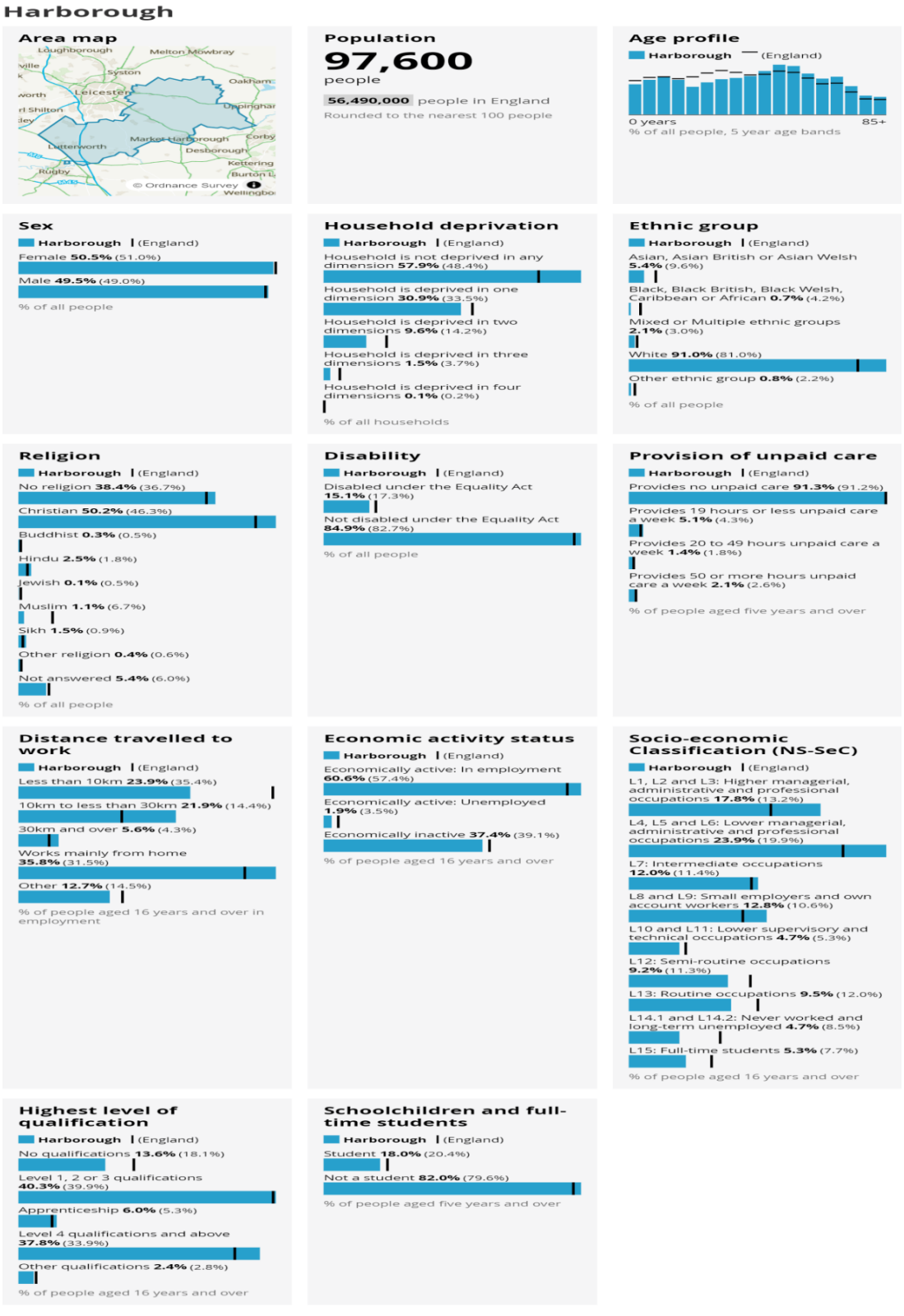
Table 4-4 Lutterworth West population data



Source: Office for National Statistics - Census 2021

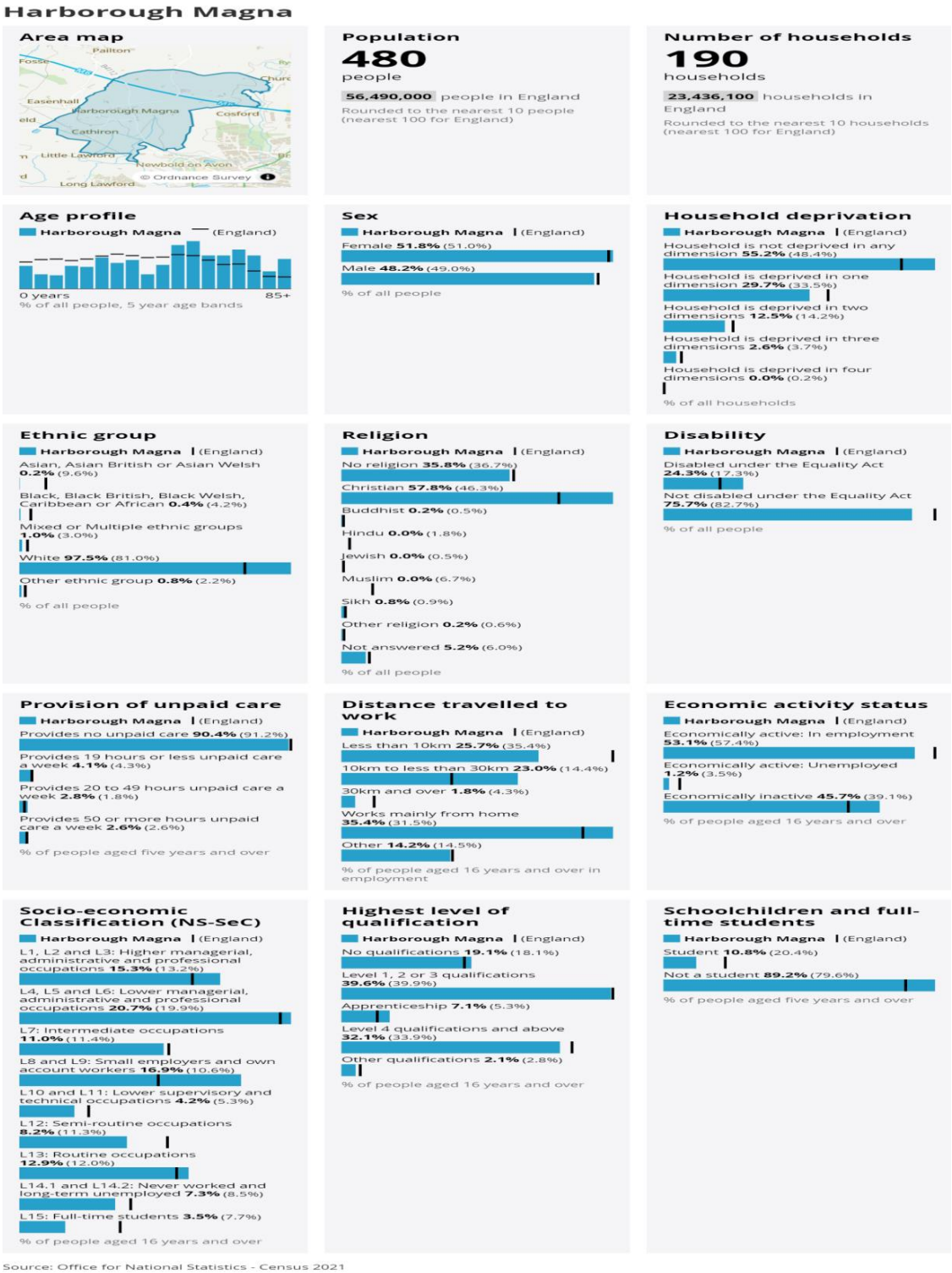
Population data for the surrounding areas of Harborough, Harborough Magna, and Brinklow, Wolvey and Churchover is shown in the tables below.

Table 4-5 Harborough population data



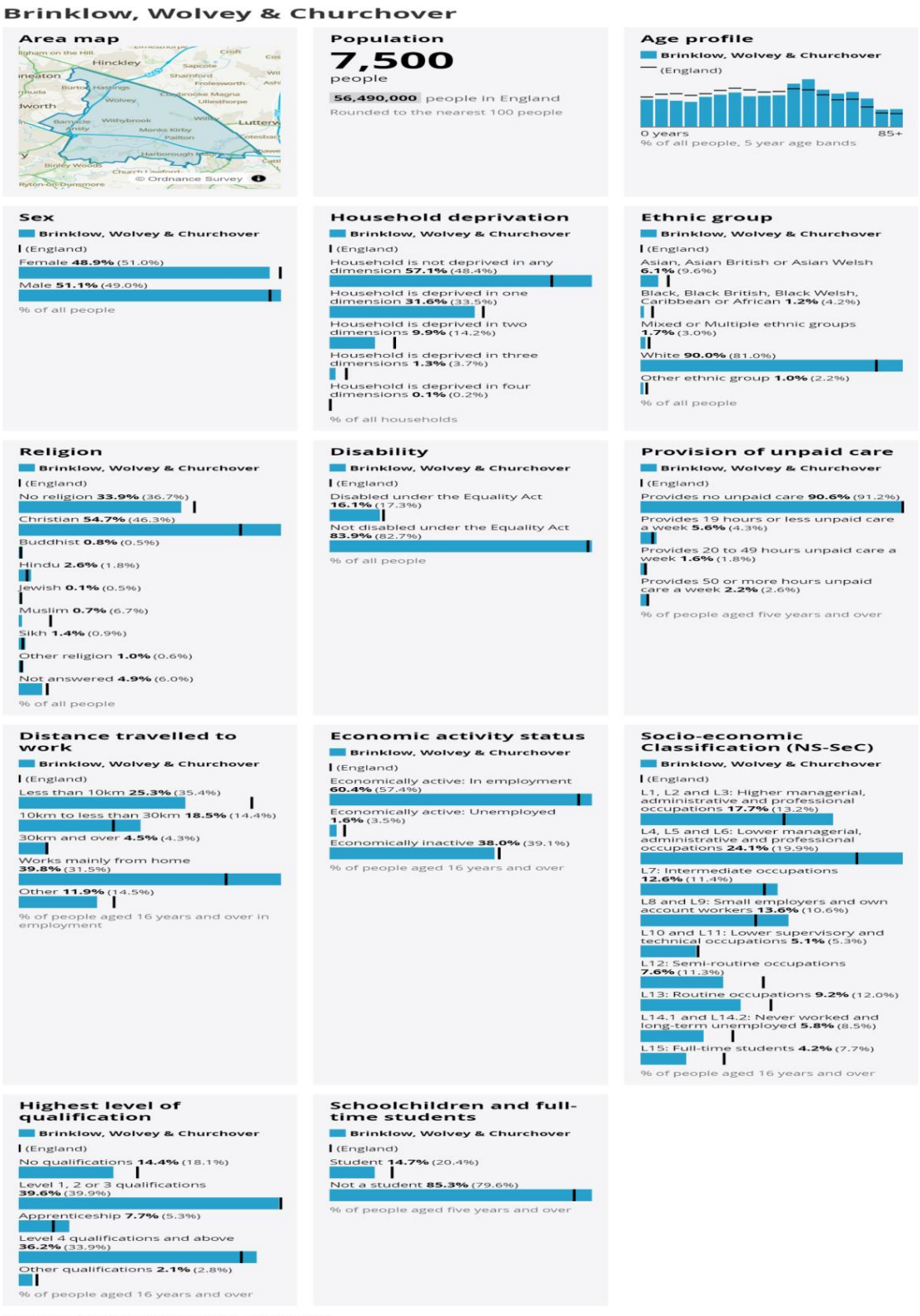
Source: Office for National Statistics - Census 2021

Table 4-6 Harborough Magna population data



Source: Office for National Statistics - Census 2021

Table 4-7 Brinklow, Wolvey and Churchover population data



Source: Office for National Statistics - Census 2021

Population Health Management data

LLR Population Health Management (PHM) data demonstrates the health profile of the population within Lutterworth, and South Blaby and Lutterworth Primary Care Network (PCN), the PCN in which Lutterworth sits. The results of the PHM risk segmentation analysis are included in **Appendix D**.

PHM enables commissioners to understand and look for the best solutions to people's needs, not just medically but also socially, including the wider determinants of peoples' health. The PHM risk segmentation tool enables segmentation of the population through data driven decision making, supported by Acorn classifications or through pre-set criteria aligned to locally or nationally defined priority areas or disease pathways. By segmentation, the local population can be grouped by what kind of care they need as well as how often they might need it.

The PHM risk segmentation tool has been used to show the breakdown of age and sex for patients registered to the two Lutterworth GP practices (The Wycliffe Medical Centre and The Masharani Practice).

There is an even split across the genders in the 35-64 age group, with slightly higher numbers of males in the younger age brackets, and higher numbers of females in the older age brackets. The PHM analysis shows the breakdown of long term conditions for patients registered to the same two Lutterworth GP practices. Hypertension is a condition that is most prominent in the cohort, followed by asthma, diabetes and depression.

Figure 4-7 Geodemographic map

PHM Segmentation Matrix

		Infants (0-5yrs)	Children (6-17yrs)	Working age adults (18-64yrs)	Older Adults (65+yrs)
Generally Well	Generally Well - Low Risk	582	1,355	2,809	220
	Generally Well - Higher Risk	164	318	1,062	71
	Generally Well - Other	44	83	426	34
Managed LTCs	Managed LTCs - Low Risk	62	355	2,796	689
	Managed LTCs - Higher Risk	22	116	777	179
	Managed LTCs - Other	5	22	396	96
Complex Health Issues	Complex Health Issues - Lower Risk	4	26	930	1,601
	Complex Health Issues - Higher Risk	2	15	368	554
	Complex Health Issues - Other		1	169	288

The geodemographic map above identifies where patients live who are registered to the two Lutterworth GP practices (The Masharani Practice and The Wycliffe Medical Centre). The majority of registrations are from within Lutterworth with fewer patients in the surrounding areas (indicated by the lighter shaded circles). This also shows that there are 16,641 patients registered to the two practices.

The PHM segmentation matrix demonstrates by life course (Infant, Children, Working age adults and Older adults), the number of patients who fall in to the following categories:

- Generally well (low risk/ higher risk/ other).
- Managed Long Term Conditions (low risk/ high risk/ other).
- Complex Health Issues (lower risk/ higher risk/ other).

It shows that:

- The largest cluster of patients, 7168, fall into the generally well category (4966 categorised a low risk, 1615 as higher risk, and 587 as other).
- 5515 patients fall into the managed LTC category (3902 low risk, 1094 higher risk and 519 as other).
- 3958 patients are identified as having complex health issues (2561 lower risk, 939 higher risk, 458 as other).

The Acorn Wellbeing Profiles segment the population into 4 groups (Health Challenges; At Risk; Caution; Healthy) and 25 types describing the health and wellbeing attributes of each postcode across Britain, and the Acorn Communities Profiles highlight type across a wide range of demographic, behavioural and attitudinal attributes. This information will be used to ensure that commissioners understand the needs of the population when designing the services for Lutterworth and enables commissioners to reach out to communities of interest, when public engagement begins, to help shape access to the future Model of Care. Details of the segmented engagement groups and methods of engagement are shown in Section 12.2.11 below.

4.4.2 Joint Strategic Needs Assessment (JSNA)

The Joint Strategic Needs Assessment analyse the health needs of populations. The purpose of the JSNA is to improve the health and wellbeing of the local community and reduce inequalities for all ages.

The Health and Wellbeing Board of Leicestershire publish the JSNA in subject specific chapters throughout a three year period. The following Leicestershire JSNA chapters are relevant to the proposed Lutterworth service developments:

- 2022-2025:
  - End of Life Care and Support.
  - Inequalities.
- 2018-2021:
  - Demography Report.
  - Multimorbidity and Frailty.
  - Sexual Health.
  - Loneliness.
  - Dementia.

Inequalities

The Inequalities JSNA identifies the groups as risk of facing health inequalities in Leicestershire are:

- People who identify as Lesbian, Gay, Bisexual or Transgender (LGBT).

- People with a disability, including **people with a learning disability**.
- People who are homeless.
- Victims of modern slavery.
- Sex workers.
- Vulnerable migrants.
- Carers.
- People with severe mental illness.
- Prisoners.
- People who have experienced trauma.
- Looked after children and care experienced adults.
- People living in poverty/deprivation.
- A complex picture was identified around race and ethnicity but evidence of health inequalities being most common for people who are Bangladeshi, Pakistani or **Gypsy or Irish Travellers**.

Those groups with a particularly high risk (evidence of years lost from their lives as a result) are identified in bold text in the list above. Whilst Lutterworth as a neighbourhood (Middle Super Output Area) has not been identified as a high risk area for health inequalities within Leicestershire it is important to understand that there will be smaller pockets of people who are affected which will enable us to ensure that we focus resource and efforts on prevention in order to reduce risk.

Frailty and multimorbidity, and loneliness

Multimorbidity is defined as having two or more chronic conditions, where at least one of these conditions is a physical health condition. Frailty is defined as a distinctive health state whose risk increases with age in which multiple body systems gradually lose their inbuilt reserves. The Leicestershire JSNA has made recommendations in relation to risk stratification, care coordination and social prescribing within local neighbourhood teams along with ensuring appropriate primary and secondary care services address these needs holistically, including self care management workstreams and the use of assisted technology. The loneliness JSNA also identifies how long term conditions can impact on loneliness and highlights the importance of the social prescribing model on these patients.

Dementia

Within the dementia chapter of the JSNA, the emergency hospital admission rates for people with dementia is suggested as a proxy for the provision of their care. Areas with higher admission rates may present as needing a change in the support available for dementia patients. Leicestershire in its entirety is significantly better than the national average.

Patients with dementia dying in the way that is in line with their needs and respects their

wishes in Leicestershire is significantly better than the national rate.

End of Life

The End of Life JSNA for Leicestershire states that most people reaching end of life in Leicestershire are over 75 years of age. Although the majority are older people, the end of life needs of children and younger people who often require a specific approach to their care are identified. Other population groups highlighted as sometimes requiring adjustment in care or approach to avoid poorer outcomes, experiences and health inequalities include:

- Those living in deprivation.
- Homeless people.
- LGBT people.
- People with learning disabilities.
- Ethnic minority groups.
- Non cancer diagnosis.
- Dementia.

Using the Office of Health and Disparity (OHID) data and the SHAPE atlas the demographics of the people in Lutterworth have been identified to highlight where there may be health inequality impact, extracts are shown below.

Lutterworth JSNA inequalities

Table 4-8 Indicator table – our community

Indicator table-Our community

District: Harborough

Fingertips Significance: Better | Not compared | Similar | Worse

	Percentage of households in Poverty 2013/14 (N/A)	Older people in poverty: Income deprivation affecting older people Index (IDA.. 2019 (P)	Modelled estimates of the proportion of households in fuel poverty (%) 2020 (N/A)	Index of Multiple Deprivation (IMD) Score 2019 (P)	Child Poverty, Income deprivation affecting children index (IDACI) 2019 (P)	Income deprivation, English Indices of Deprivation 2019 (P)	Unemployment (Percentage of the working age population claiming out of work benefit) 2021/22 (P)	Long-Term Unemployment-rate per 1,000 working age population 2021/22 (P)
Broughton Astley	10.5	6.0	7.0	4.5	5.7	4.4	2.0	0.0
Dunton Bassett, Claybrooke & Swinford	11.3	5.9	10.4	9.3	4.8	4.0	1.8	0.1
Fleckney, Kilworth & Foxton	10.9	7.3	11.0	8.6	4.6	5.1	2.4	0.7
Houghton, Thurby & Scraptoft	15.1	5.7	7.5	7.0	8.2	5.5	2.7	0.0
Kibworth & Great Glen	12.3	6.3	9.1	6.3	7.0	5.4	2.4	0.7
Lutterworth	14.2	8.7	8.7	8.5	7.4	6.8	3.0	0.8
Market Harborough Central	18.8	15.8	14.6	15.9	13.4	11.5	3.0	0.3
Market Harborough South & Little Bowden	11.8	7.1	8.9	5.9	6.3	5.1	1.9	0.0
Market Harborough West, Great Bowden & Lubenham	10.3	5.4	7.9	6.1	7.1	4.9	1.9	0.0
Tilton, Billesdon & Great Easton	14.9	5.5	13.0	11.1	4.7	4.1	2.1	0.0

Table 4-9 Indicator table – behavioural risk factors and child health

Indicator table-Behavioural risk factors & Child health

District: Harborough

Fingertips Significance: Better | Not compared | Similar | Worse

	Deliveries to teenage mothers	Emergency hospital admissions for injuries in 15 to 24 years old, crude rate	Emergency hospital admissions for injuries in under 5 years old, crude rate	Emergency hospital admissions for injuries in under 15 years old, crude rate	Emergency hospital admissions in under 5 years old, crude rate	General fertility rate: live births per 1,000 women aged 15-44 years. five year pooled	Reception: Prevalence of obesity (including severe obesity), 3-years data combined	Reception: Prevalence of overweight (including obesity), 3-years data combined	Year 6: Prevalence of obesity (including severe obesity), 3-years data combined	Year 6: Prevalence of overweight (including obesity), 3-years data combined
	2016/17 - 20/21	2016/17 - 20/21	2016/17 - 20/21	2016/17 - 20/21	2016/17 - 20/21	2016 - 20	2019/20 - 21/22	2019/20 - 21/22	2019/20 - 21/22	2019/20 - 21/22
Broughton Astley		98.3	109.4	70.1	121.2	49.7	7.5	22.6	16.7	34.8
Dunton Bassett, Claybrooke & Swinford		119.4	99.8	79.5	95.0	49.7	5.8	15.4	18.5	27.8
Fleckney, Kilworth & Foxton	0.0	104.4	88.3	77.9	105.1	51.5	5.2	19.0	19.6	28.6
Houghton, Thurby & Scraptoft		74.0	81.8	56.1	97.5	71.2	5.9	17.6	16.7	27.1
Kibworth & Great Glen		93.7	71.1	62.1	77.0	58.1	5.3	14.5	14.9	24.3
Lutterworth		97.0	113.8	96.4	105.1	56.5	6.5	21.0	17.6	27.9
Market Harborough Central		132.0	64.4	46.5	62.7	41.3	9.4	18.8	23.7	36.8
Market Harborough South & Little Bowden		115.3	69.6	66.0	101.0	61.8	6.7	18.3	10.6	25.8
Market Harborough West, Great Bowden & Lubenham		186.3	67.3	42.8	109.0	59.5	6.8	17.8	10.9	26.6
Tilton, Billesdon & Great Easton	0.0	105.2	82.9	50.9	49.1	44.8	7.4	22.2	9.1	21.2

Table 4-10 Indicator table – diseases and poor health

Indicator table-Diseases & Poor health

District: Harborough

Fingertips Significance: Better | Similar | Worse

	Emergency hospital admissions for all causes, all ages, standardised admission ratio 2016/17 - 20/21	Emergency hospital admissions for Chronic Obstructive Pulmonary Disease (COPD), standardised admission ratio 2016/17 - 20/21	Emergency hospital admissions for coronary heart disease, standardised admission ratio 2016/17 - 20/21	Emergency hospital admissions for hip fracture in persons 65 years and over, standardised admission ratio 2016/17 - 20/21	Emergency hospital admissions for intentional self harm, standardised admission ratio 2016/17 - 20/21	Emergency hospital admissions for Myocardial Infarction (heart attack), standardised admission ratio 2016/17 - 20/21	Emergency hospital admissions for stroke, standardised admission ratio 2016/17 - 20/21	Hospital admissions for alcohol attributable conditions, (Broad definition) 2016/17 - 20/21	Hospital admissions for alcohol attributable conditions, (Narrow definition) 2016/17 - 20/21
Broughton Astley	92.7	101.8	85.1	137.6	57.8	113.4	107.4	92.5	93.7
Dunton Bassett, Claybrooke & Swinford	81.0	60.8	75.4	85.6	64.6	69.5	89.9	74.0	79.6
Fleckney, Kilworth & Foxton	77.4	68.4	62.1	124.3	62.7	77.8	103.4	76.1	90.0
Houghton, Thurby & Scraptoft	86.9	52.7	83.6	131.6	63.0	98.3	85.1	65.0	73.4
Kibworth & Great Glen	76.0	32.3	64.4	121.5	61.3	77.7	95.8	66.6	75.2
Lutterworth	91.5	73.2	55.2	120.8	62.5	66.5	122.9	89.8	104.6
Market Harborough Central	85.8	134.3	56.1	106.4	114.1	69.4	85.1	98.6	111.3
Market Harborough South & Little Bowden	88.6	83.0	70.1	192.4	85.0	70.2	136.8	83.7	101.3
Market Harborough West, Great Bowden & Lubenham	72.8	50.1	68.5	92.8	132.1	80.7	100.1	68.2	80.9
Tilton, Billesdon & Great Easton	64.5	55.1	70.1	86.8	39.9	68.7	77.0	63.4	67.3

Table 4-11 Indicator table – cause of death and life expectancy

Indicator table-Cause of death & Life Expectancy

District

Harborough

Better Similar Worse

	Deaths from all cancer, all ages, standardised mortality ratio Persons 2016 - 20	Deaths from all cancer, under 75 years, standardised mortality ratio (SMR) Persons 2016 - 20	Deaths from all causes, all ages, standardised mortality ratio Persons 2016 - 20	Deaths from all causes, under 75 years, standardised mortality ratio Persons 2016 - 20	Deaths from causes considered preventable, under 75 years, standardised mortality rat.. 2016 - 20	Deaths from circulatory disease, all ages, standardised mortality ratio Persons 2016 - 20	Deaths from circulatory disease, under 75 years, standardised mortality ratio Persons 2016 - 20	Deaths from coronary heart disease, all ages, standardised mortality ratio Persons 2016 - 20	Deaths from respiratory diseases, all ages, standardised mortality ratio Persons 2016 - 20	Deaths from stroke, all ages, standardised mortality ratio Persons 2016 - 20	Life expectancy at birth, (upper age band 90 and over) Female 2016 - 20	Life expectancy at birth, (upper age band 90 and over) Male 2016 - 20
Broughton Astley	100.3	88.7	90.6	74.6	68.7	100.3	80.3	86.3	66.0	115.7	84.3	81.3
Dunton Bassett, Claybrooke & Swinford	91.0	94.1	79.5	72.7	77.4	78.7	76.9	87.3	50.2	47.9	85.9	82.5
Fleckney, Kilworth & Foxton	90.8	87.1	91.4	75.8	74.2	70.1	55.2	59.7	81.1	62.5	83.6	81.1
Houghton, Thurby & Scraptoft	79.7	69.1	74.0	54.5	48.1	77.9	50.3	83.2	68.2	80.8	86.6	84.1
Kibworth & Great Glen	93.2	71.1	85.9	63.3	53.4	78.4	71.6	78.5	53.8	65.5	86.0	81.1
Lutterworth	108.9	106.6	91.5	95.2	91.0	91.5	93.6	105.9	83.1	71.4	83.4	80.9
Market Harborough Central	92.2	120.3	85.7	125.4	130.4	80.5	115.9	83.6	91.4	56.8	84.2	78.5
Market Harborough South & Little Bowden	105.6	94.2	120.1	82.3	86.1	105.0	81.7	85.0	88.3	101.5	82.8	79.7
Market Harborough West, Great Bowden & Lubenham	74.1	68.3	70.8	66.6	55.4	74.1	63.0	67.9	54.3	89.6	85.5	83.1
Tilton, Billesdon & Great Easton	77.9	82.5	78.0	77.3	66.6	79.3	67.5	66.4	77.4	95.4	86.1	82.4

Lutterworth Demographics – ONS 2021 data

Table 4-12 MSOA mapping census indicators – Bangladeshi

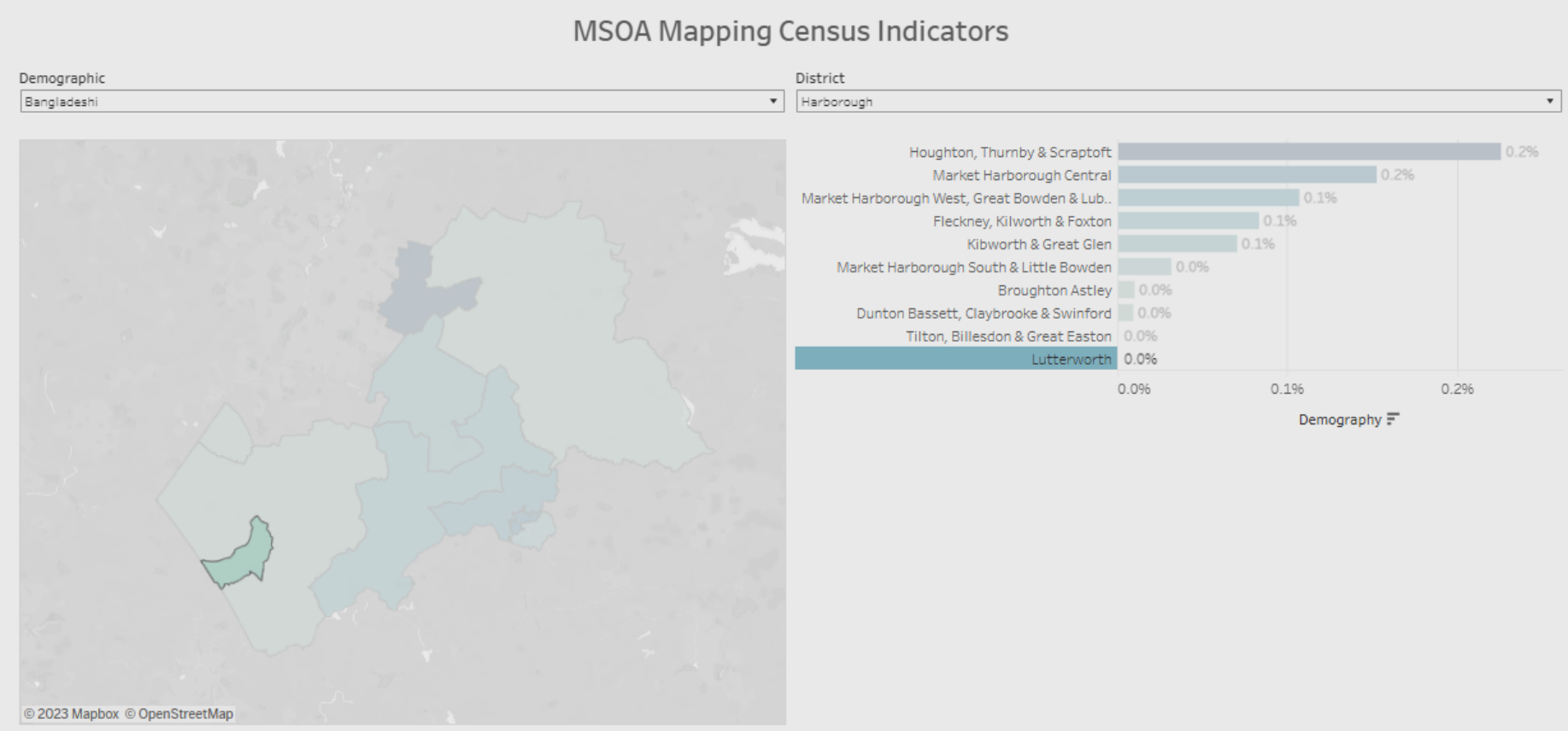


Table 4-13 MSOA mapping census indicators – Pakistani

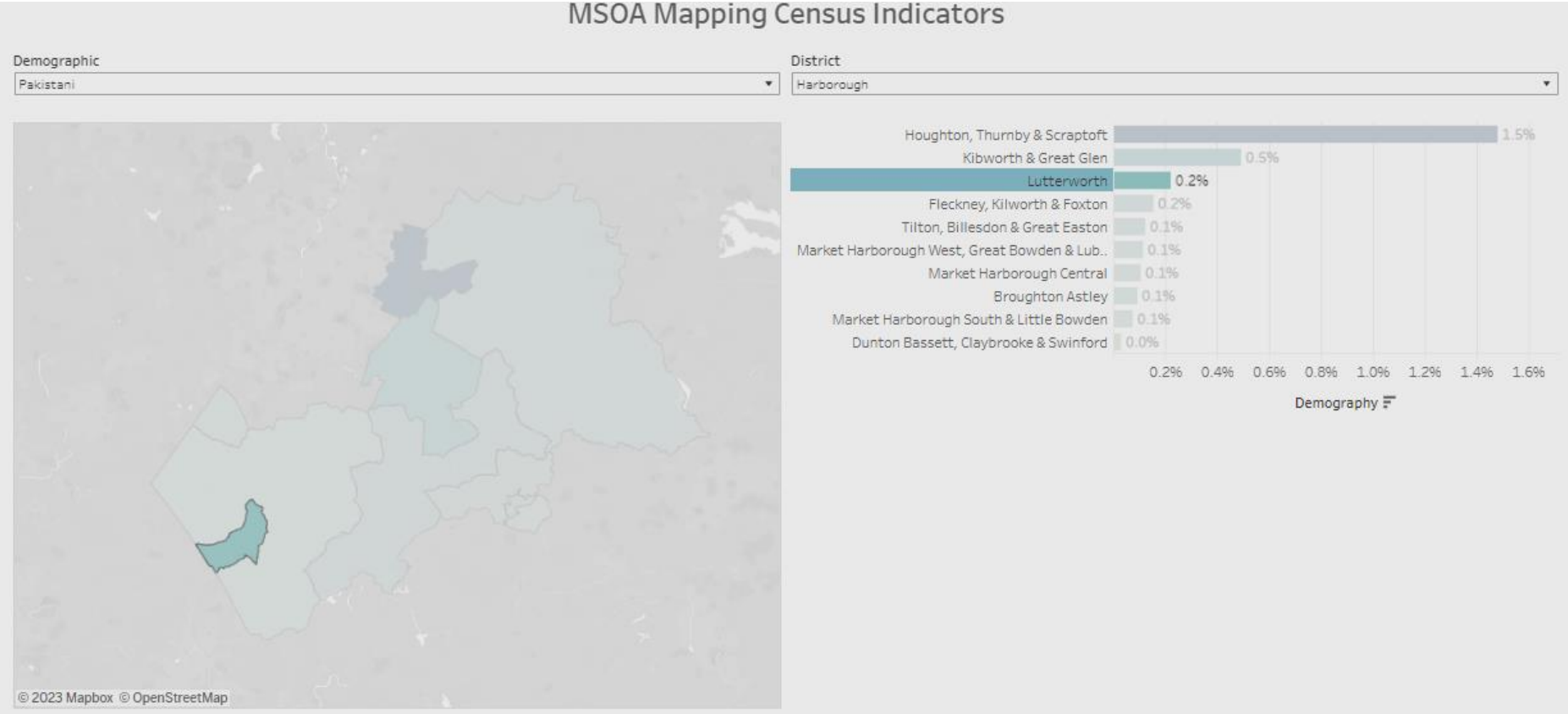


Table 4-14 MSOA mapping census indicators – disabled

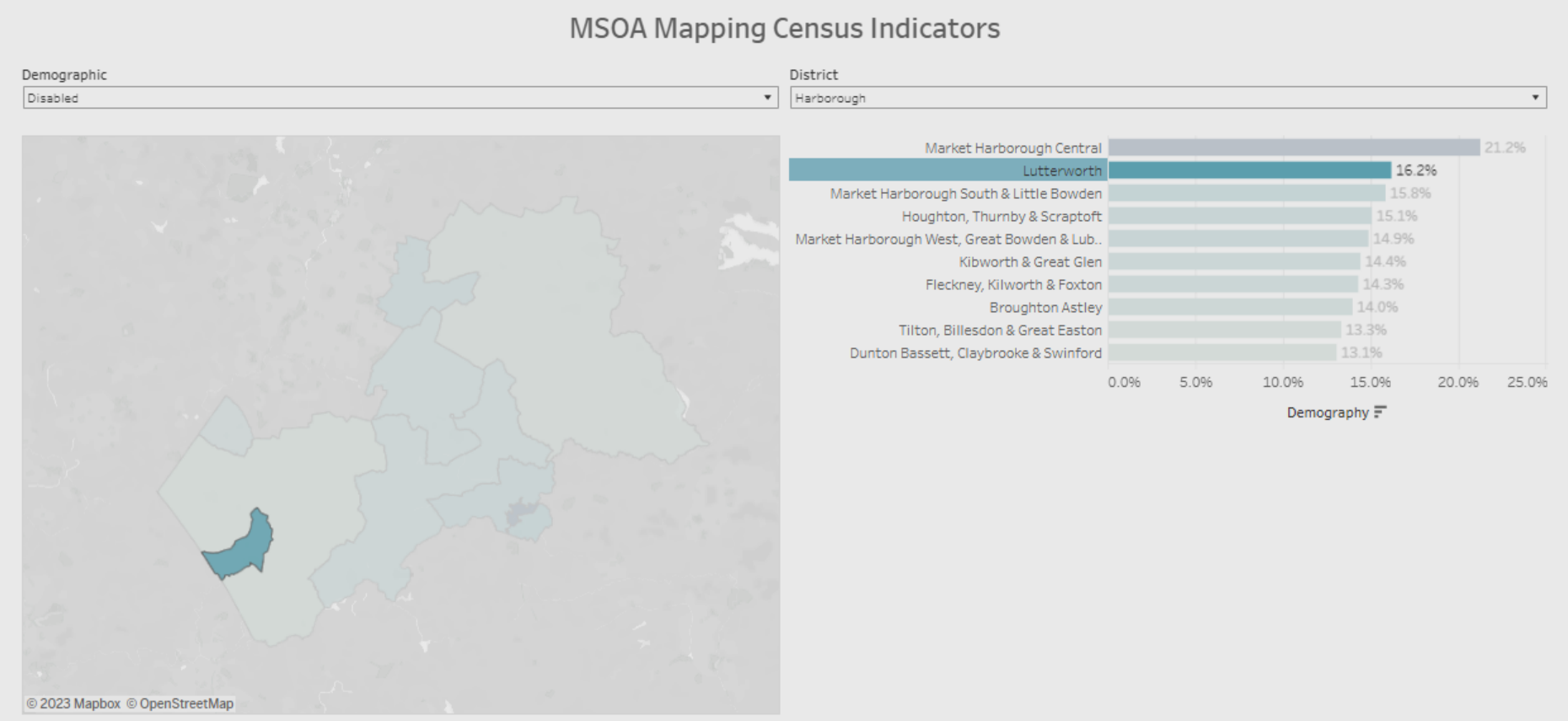


Table 4-15 MSOA mapping census indicators – gender different from birth

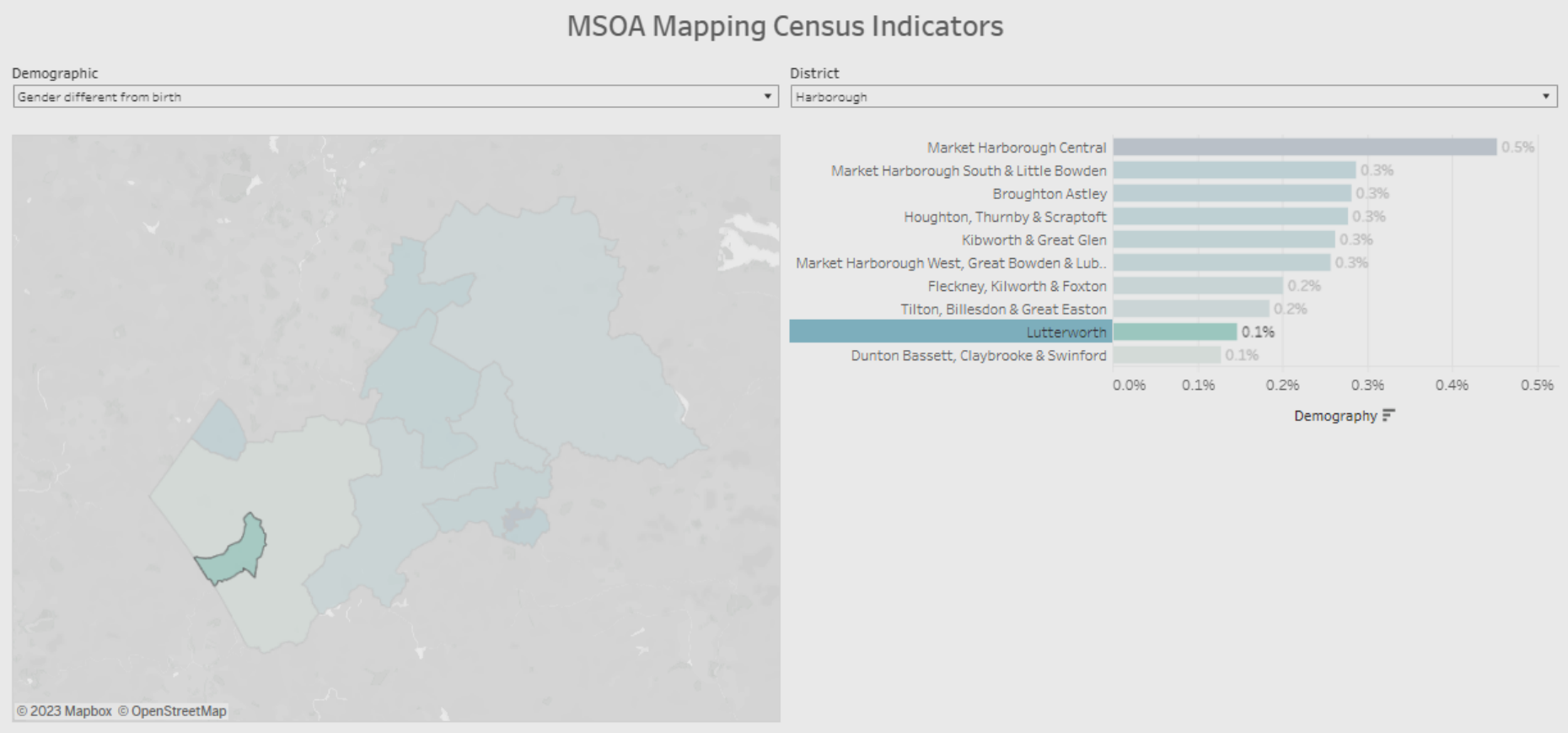


Table 4-16 MSOA mapping census indicators – gypsy/traveller

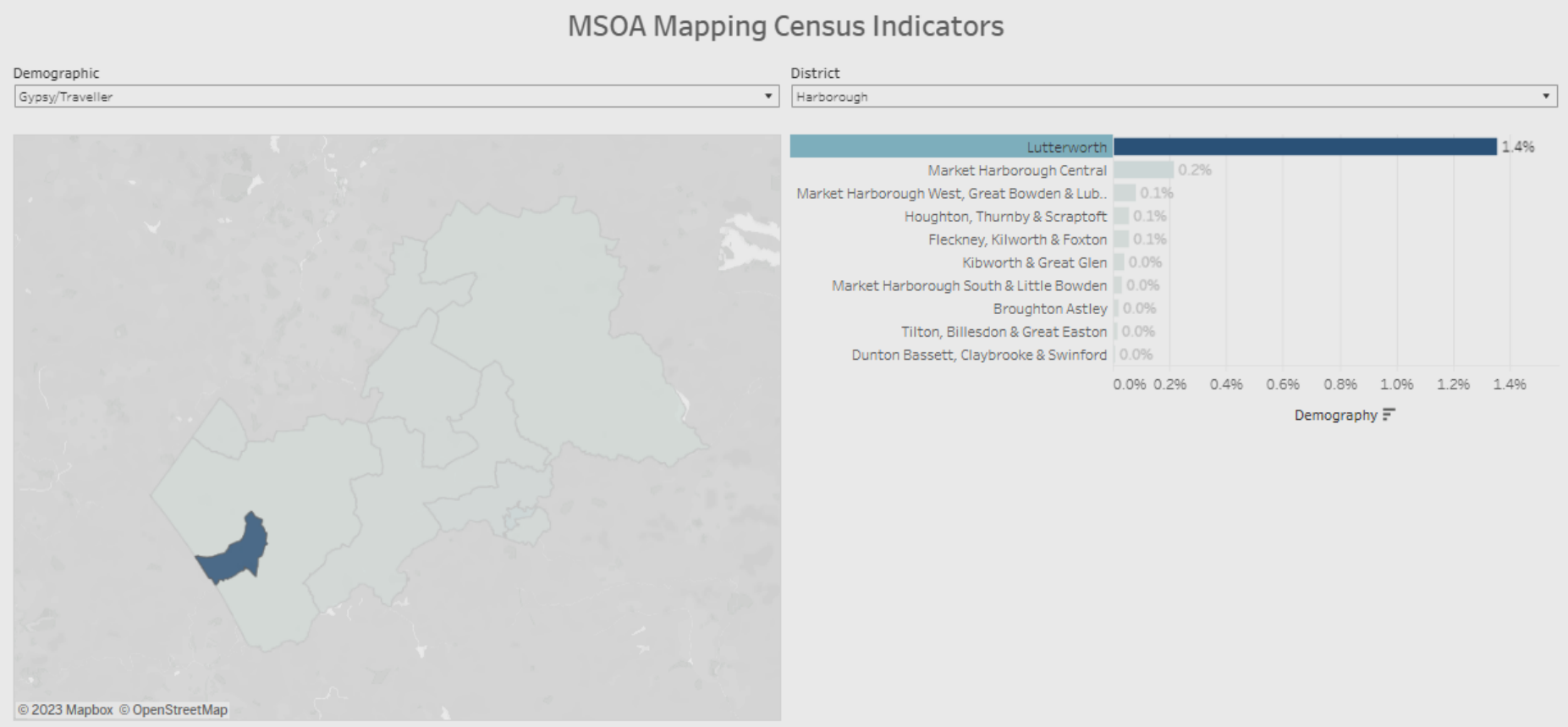
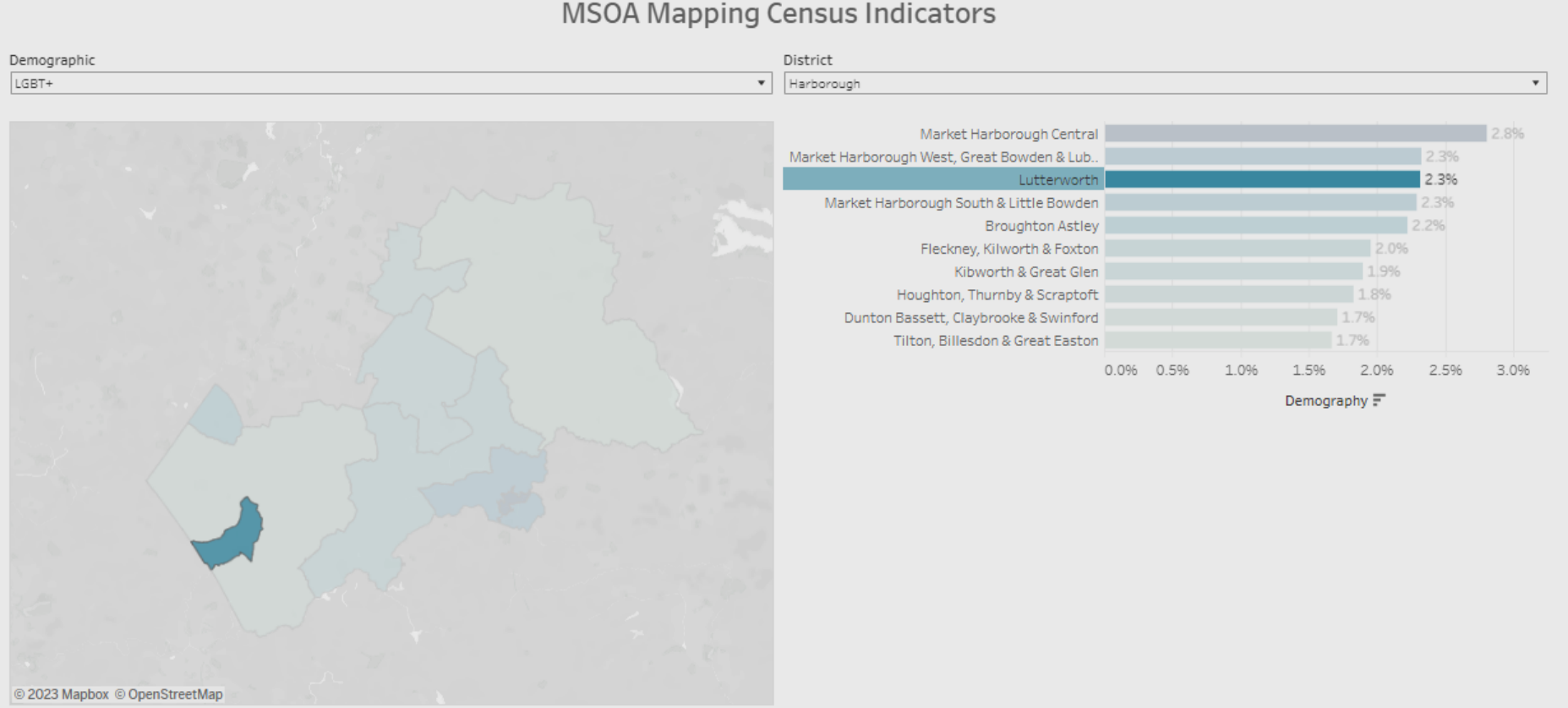


Table 4-17 MSOA mapping census indicators – LGBT+



Census 2021

The 2021 census provides some further insight to both the Lutterworth MSOA and the Harborough District.

Table 4-18 2021 census data

	Lutterworth MSOA	Harborough District	Leicestershire
Provides no unpaid care	Unavailable	91.7%	86.3%
Bangladeshi ethnicity	0%	0.1%	0.5%
Pakistani ethnicity	0.2%	0.3%	0.6%
Gypsy or Irish Travellers	1.4%	0.2%	0.1%
LGB+	2.32%	2.09%	2.4%
Gender different from birth	0.15%	0.24%	0.32%
Deprived in 4 dimensions	0.1%	0.1%	0.1%
Not disabled under the Equality Act	Unavailable	85.5%	83.4%
Under 15 years	18.3%	17.6%	16.4%
16-64 years	60.0%	60.4%	62.8%
Over 65 years	21.7%	22.0%	20.8%
Population size	Unavailable	97,625	712,366

4.5 Overall conclusions

LLR

Overall, the population of LLR in recent decades has seen an improvement in life expectancy and a reduction in mortality rates for the most prevalent conditions, such as cancer and cardiovascular diseases. However, given the growing and rapidly ageing and multi-morbid population, the outlook is for an increase rather than decrease in pressure on the health and social care system. In addition, health outcomes in LLR vary greatly owing to the large disparities in income and deprivation levels across the county.

From a health need perspective there is a marked variation in life expectancy across LLR with the main factors contributing to mortality being cardiovascular disease (CVD) and respiratory. Any plans for service improvement must respond to these challenges and make a significant contribution towards better outcomes.

Lutterworth

The health inequalities JSNA chapter highlights populations and neighbourhoods of higher risk. Lutterworth is not one of the neighbourhoods of higher risk and although Market Harborough Central is (in the wider district), it is some distance from Lutterworth so is unlikely to impact upon the service offer to these people.

The Health Inequalities JSNA identifies population groups at high risk of inequality. The data shows that Lutterworth does not have high levels (comparatively to Leicestershire) of many of the at risk populations in the MSOA or district. The exceptions are Gypsy Irish Travellers (1.4% in Lutterworth, 0.2% in Harborough compared to 0.1% in Leicestershire), along with the LGBT+, disabled and Pakistani populations which are elevated, but not significant, populations within Lutterworth These groups have been identified as a community of interest when the public engagement begins.

5 The case for change

5.1 Introduction

This section explains the current situation in terms of services provided at Feilding Palmer Hospital and the facilities available. It identifies the reasons why changes are needed to facilitate the ICB's Model of Care and to ***maximise access to services for the local community.***

5.2 Feilding Palmer Hospital

5.2.1 Overview

Feilding Palmer Hospital are freehold premises owned by LPT. Legal rights are reserved across part of the frontage and across the rear for the benefit of Lutterworth MC. Some key estates information is shown in the table below.

Table 5-1 Feilding Palmer Hospital key estates information

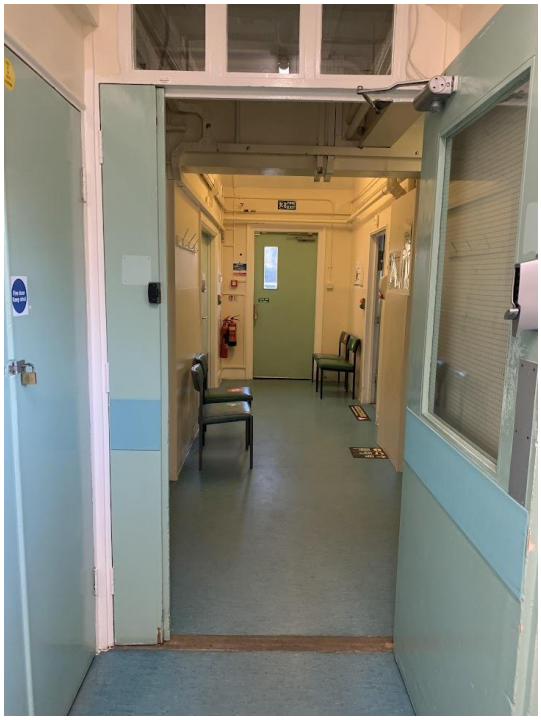
Build date	1899 (with later extensions)
Internal Floor area (m^2)	841
Total site area	0.2744 ha
Beds	10 (1 of which palliative care)
Backlog Maintenance	£1.554m to be spent over 10 years
Running Costs (2019/20)	£508.35 per m2 (v's £311.95 at Loughborough and £124.32 at St Lukes)

Admissions were suspended in the summer of 2020 due to the Covid-19 pandemic in response to a review against the national IPC guidance. The inpatient ward remains closed as the facilities do not meet IPC guidance and the layout of the building is not suitable to meet modern healthcare standards.

The poor condition of the current facilities is demonstrated in the photographs below.

Main entrance

Main reception waiting and ward circulation space



OPD entrance and waiting area

Example of infrastructure in ward corridor

Corridor with W.C. shower facilities (male and female)

Dayroom view straight into ward area

Linen store off the dining room

Ward area

Jack and Jill shower room

Dirty utility

Dirty utility only ventilation

Example of problematic roof and only fire exit

Example of roof issues

Internal damage from issues with pitched roof

First floor offices and staff welfare space

5.2.2 Key challenges

The key challenges presented by the current facilities are summarised in the table below.

Table 5-2 Feilding Palmer Hospital key challenges

Area	Challenge
Estates	X Beds do not meet all regulatory requirements. X Site does not give the flexibility of modern health care. X Backlog maintenance - £1.544m over the next 10 year (75% of this within the next 4 years).
Clinical	X IPC standards cannot be met (bed spacing, sluice/dirty utility, handwashing and ward size). X Patient privacy and dignity due to the lack of single sex wards. X No X-ray, endoscopy or cystoscopy provided. X Keeping beds does not respond to the growing population healthcare need.
Workforce	X Not an attractive location for staff (lack of managerial support onsite). X Building and environment makes it an unsuitable place to deliver inpatient care. X Filling shifts on the inpatient ward was always a challenge. Workforce preferred to provide care in more modern facilities. X 2 RNs and HCAs for a 10 bedded unit is significant resource. This is against a system context of high turnover, retention of staff, carrying high vacancies.
Financial	X Inefficient workforce model: 2 RN's and 2 HCA's for 10 beds. X Running costs are high – disparity to other LLR facilities – not an effective use of tax payers money. ✓ Transformation of services is required.

Background

Since the pandemic, when face to face activity was reduced due to social distancing and strict IPC measures, the services delivered from Lutterworth have reduced. This has had an

impact on outpatient appointments and the community hospital beds at Feilding Palmer. Patients are currently using other hospital sites within LLR and across the borders into Coventry and Warwickshire to receive their care. This deviates from the NHS vision of care closer to home. In addition, there will be further demands on services within Lutterworth once the Lutterworth East dwellings are populated resulting in Primary Care activity increase, demand for outpatient activity and an ageing population and therefore an increase of people with more complex care needs/conditions associated with ageing.

Estate challenges

There are a number of estate challenges in respect of the services being provided in Lutterworth:

- The facilities at Feilding Palmer Hospital do not meet all regulatory requirements. The Victorian Cottage Hospital still retains much of the feel of an historic building which does not give the flexibility of modern health care.
- Backlog maintenance.
- The Lutterworth Health Centre has limited space for expansion in its current location.

Clinical challenges

There are a number of clinical challenges in respect of the services being provided in Lutterworth:

- Increasing population resulting in increased demand for Primary Care services.
- IPC guidelines affect the ability to meet current standards on space and ward size thus affecting bed availability at Feilding Palmer Hospital. The building presents issues to patient privacy and dignity due to the lack of single sex wards. Undertaking the backlog of maintenance will have no effect on current standards (space and ward size) or on the cross infection risk.
- Feilding Palmer Hospital does not have diagnostics such as xray, endoscopy or cystoscopy.

Workforce Challenges

There are significant workforce shortages within health and social care. To maximise activity and reduce waiting lists activity is being consolidated at alternative sites as there are insufficient nurses and doctors to run clinics that are not at full capacity.

Financial challenges

Financial balance and sustaining financial health is a priority for the LLR ICB. The NHS faces increasing pressure on resources and continued transformation of services and joint working across both health and social care services, will be required to deliver a financially stable health economy over the coming years.

5.3 Strategic service change required

The ICB and ICS are committed to delivering and expanding planned and urgent care in local

communities where is it safe and viable to do so. The aims in the Lutterworth area are to:

- Transform local Primary Care through:
  - Expansion of additional roles within the Primary Care Network (PCN).
  - Improved and quicker access to Primary Care diagnostics.
  - Ensuring access to Primary Care professions using face to face and non-face to face appointment methods.
  - Enhanced access to appointments.
- Integrate Community Health and Social Care:
  - Develop an integrated neighbourhood leadership team.
  - Increase frailty identification.
  - Create quality care plans for vulnerable patients.
  - Review and develop rehabilitation models.
  - Care coordination with joined up working between health and adult social care.
- Bring planned care closer to home:
  - Mobilisation of falls crisis response.
  - Implement ageing well urgent crisis response.
  - Expand virtual ward models.
  - Support sustainable increase in referrals to community pharmacy.
- Improve mental health support:
  - Deliver a local mental health pathway.
  - Co-ordination of services between voluntary, health and local authority mental health services.
- Improve access to local pathways:
  - Including enhanced access model to support same day appointments.
  - Review minor injury service provision and urgent treatment centres across LLR to support reduced need for ED.
  - Expand the number of clinical pharmacists working locally who can treat minor illnesses.
  - Strengthen the community palliative and end of life care offer.
  - Support more people to die in their place of choice.
- Improve services for children and maternity:

  - Reviewing strategies for young persons health and wellbeing.
  - Develop an integrated workforce across the system to deliver improved outcomes for LD/SEND patients.
  - Continue with midwifery continuity of carer rollout.
  - Working to improve uptake of covid and flu vaccination rates, especially those most at risk and strengthen perinatal mental health services and referral rates.

- Develop a 'fit for the future' local healthcare offer:
  - Strategic estates review of local health estates.
  - Develop shared care records between health and local authority staff.
  - Remote monitoring of patients.
  - Maximise S106/CIL contributions.
  - Develop plans with neighbouring ICS's.

Not all of the developments above will be picked up through the pre-consultation business case, as they align to system level workstreams.

5.4 Model of Care

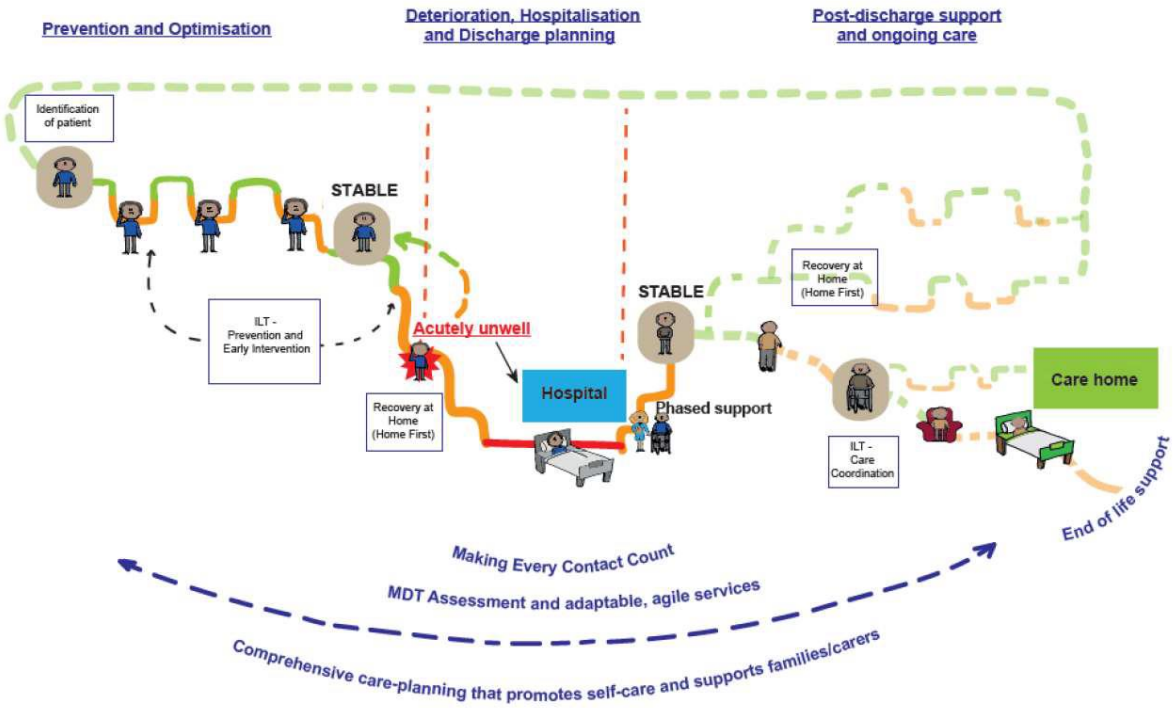
5.4.1 Introduction

A key priority for over the next few years is to redesign community services and transform Primary Care in order to reduce the acute footprint. To offer seven day services that connect with social care and to deliver the "left shift" in care, a model has been developed which places patients and their GP practice in the centre of care provision. A new layer of community delivered care with integrated services, organised, managed and funded by the ICB will be established. This Model of Care will enable practices, patients and communities to shape services that are coordinated and integrated at a local level to meet the needs of those communities.

The ICB is committed to improving outcomes for patients, supporting more people to live independently in their own homes and wrap support around patients to avoid unnecessary hospital admissions. This will help to reduce the number of sites from which services operate and consolidate community beds; this is part of a model that delivers good patient outcomes for fewer bed days and with less bed dependency. This vision is set out in the Keogh Settings of Care. A reduction in emergency hospital admissions will support the ability of ICB to provide additional community services.

The emerging Model of Care is illustrated in the Figure below.

Figure 5-1 Model of care



What this means for residents of Lutterworth is that there will be a focus on preventable care, in particular for those people living with long term conditions, who will be actively supported to manage their own care and avoid acute exacerbations of disease wherever possible.

When there is a requirement for an urgent and immediate response this will be delivered by skilled specialists either through outreach services into the patient's home or a community location. Where there is a need for an acute hospital stay people will be returned home where possible or into a community facility where they will be rehabilitated to optimise their recovery and independence. The journey for patients needs to be seamless and easy to navigate and discharges from services need to be co-ordinated and well communicated. To achieve this vision both the shape of community services and the workforce delivering them needs to change.

To deliver the new Model of Care with a focus on care in the community and more investment in the prevention agenda requires a different type of workforce. The ICB plans include the development of multi skilled care workers that can work across the boundaries of health and social care. New roles will be developed as patient needs demand. Third sector services will be used to support the Model of Care. The model lends itself to harnessing skills of other professional groups for example community pharmacists to undertake medication reviews.

The principles of the integrated community services strategy are:

- Provide equitable health care in all localities. Some localities will develop specialist services to meet the needs of a wider population, using local community assets to enhance the care provided both now and in the future.
- Engage local communities in the co-design and production of local health services, involving them in the decisions taken about where their care is delivered and ensuring that local people are empowered to access the right care, in the right place and at the right time.
- Retain control of all non-urgent and emergency care at a local level, working with the right people to ensure that health and social care services are integrated. Should people require access to emergency care, the ICB will ensure that they are kept safe and do not suffer delayed access to an acute hospital.
- Maximise the use of information technology, using it to ensure that all the health care needs of patients are managed effectively. The care of patients and carers will be led by local doctors working through their Primary Care Networks, enhancing the patient journey, making it more responsive to meeting health needs and supporting the carer to do a good job.

5.4.2 Developing the Model of Care

The ICB's vision for integration is to create community based health and social care teams clustered around groups of GP practices.

The proposed new model is based around the following main services:

- **Neighbourhood community nursing** - as part of integrated locality teams, which would manage the majority of care of patients in the community, working closely with social care and Primary Care networks.
- **Home First services** - integrated health and social care crisis response and reablement services, which would deliver intensive, short-term care for up to six weeks. Home First services would be accessed via Locality Decision Units, with health and social care services working on the basis of trusted assessment and delivering co-ordinated packages of care.
- **Community bed based care** - delivered either in community hospitals for patients requiring medical rehabilitation needing significant 24/7 nursing care and on-site therapies, and in 'Pathway 2' reablement beds for patients with lower medical needs requiring reablement and a degree of 24/7 support.
- **Integrated Community Specialist Palliative Care** – an integrated team of nurses and health care assistants from LPT and LOROS who look after patients with life-limiting illnesses, including cancer, who have complex palliative care needs in the community. Working in partnership with other professions, including community nurses, GPs, palliative care medical teams and social services.

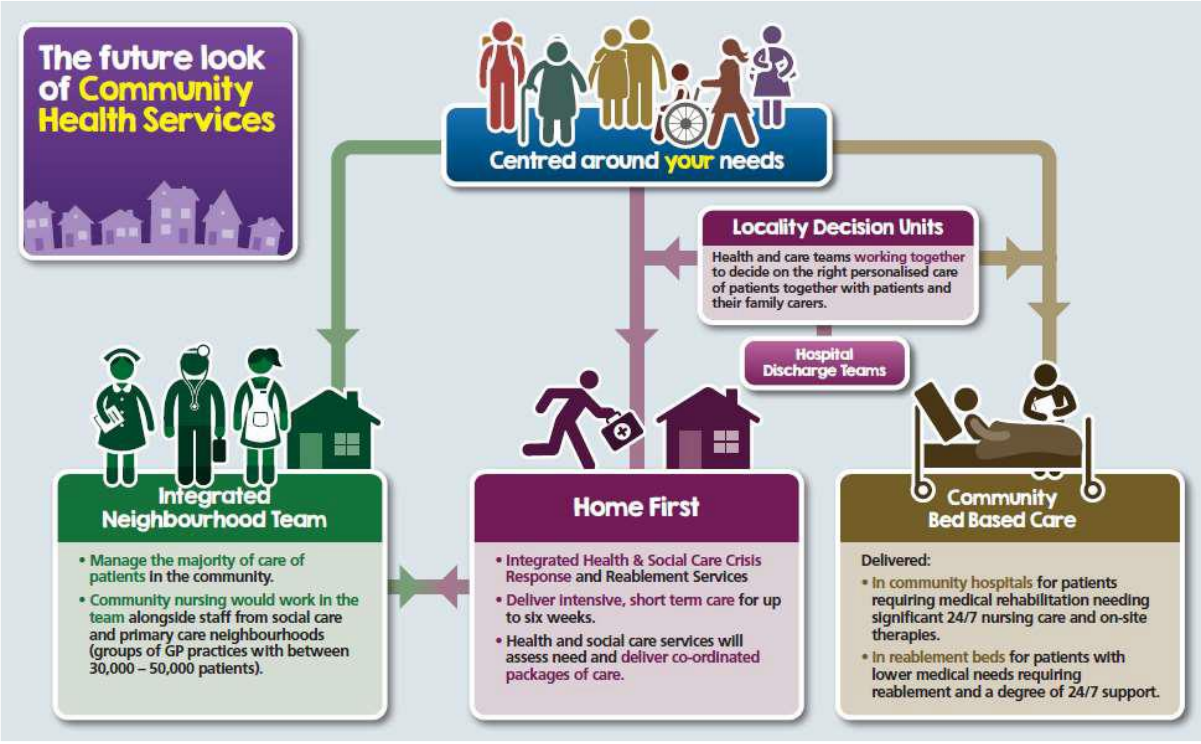
Key features of the model include improvements in:

- Co-ordinated Care.

- Integrated team working.
- Preventative care, support for self-care.
- Pro-active approach to identifying patients who need co-ordinated care.
- Focus on the frail and 'multi-morbid' patients.
- Trusted assessment – where agencies trust the assessments made by those outside their organisation reducing duplication in assessment.
- 'Discharge to Assess' – ensuring people leave hospital when medically fit.
- Delivery of the 'Home First' principles.
- Capacity in community nursing and development of a sustainable workforce.

It is important to note, that the evidence review suggests if the community model described were further developed and had sufficient capacity in the home-based teams and reablement beds, there could be reduced utilisation of community hospital inpatient beds in future. This could create a shift towards using community hospital beds predominantly for patients who on discharge from an acute hospital and continue to need 24 hour care with on-site therapies.

Figure 5-2 The future look of community health services



The ICB's ambition is to place a high priority on prevention and on maintenance of independent living. This matches most closely the aspirations of the registered population, improves overall clinical safety and effectiveness, and frees resources for more specialised care when it is needed.

As a result, the ICB will develop patients as partners in care to support health, well being and independence, using the resources and assets on their doorstep, while placing less reliance on statutory services.

The community services provided by Leicester Partnership NHS Trust will be reconfigured around the hubs to provide services for frail and vulnerable patients.

The following services will be required:

- Community Crisis response.
- Physiotherapy and Occupational therapy.
- Rehabilitation.
- Community palliative care.
- Falls prevention and assessment.

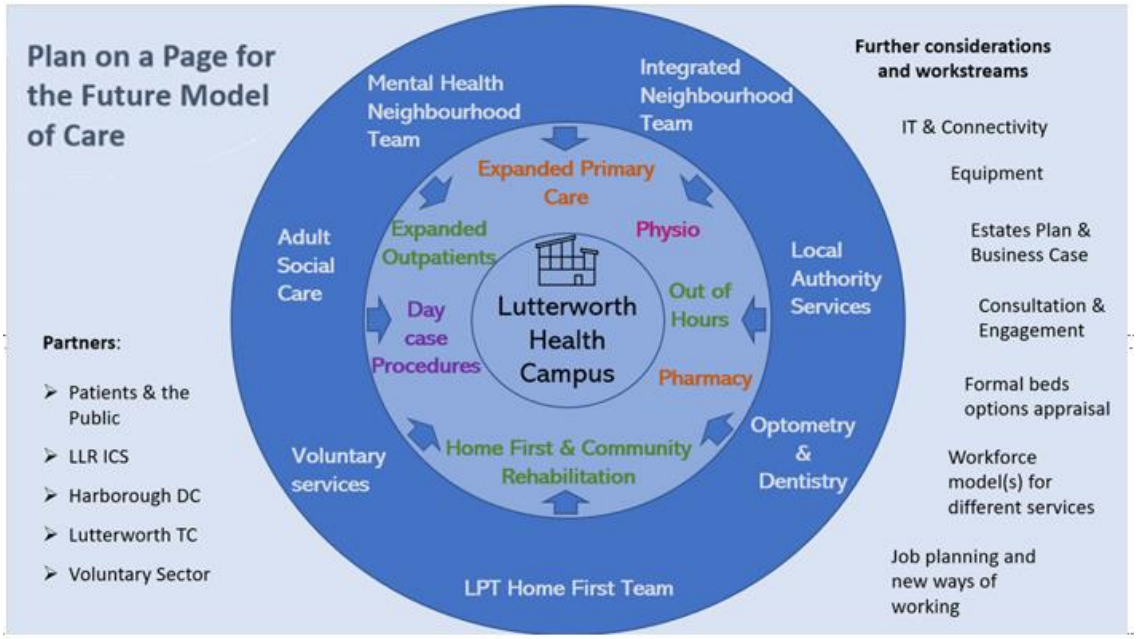
Analysis of outpatient activity not currently taking place suggests that it would be beneficial for the following to be carried out from a community site in Lutterworth:

- Ophthalmology.
- Trauma and orthopaedics.
- General internal medicine.
- Dermatology.
- General surgery.
- Urology.
- Gynaecology.
- Cardiology.
- Rheumatology.
- Respiratory medicine.
- Virtual Wards.

These services will as far as possible work as a 'one-stop shop' to reduce the number of times a patient has to attend appointments. Where they are not already provided, these services will be developed with local providers to ensure appropriate provision for patients within the locality.

Set out below is a summary of the proposed Model of Care to be provided.

Figure 5-3 Plan on a Page for the future Model of Care in Lutterworth



The ICB will ensure that any solutions developed as part of this PCBC will deliver this required Model of Care and patient pathways for all the services within the scope of this project.

5.5 Demand for services

5.5.1 Activity modelling

The projected activity that would be carried out in the new facility is shown in the table below. Activity growth is based on standard assumptions between now and the time the facilities will be operational.

Table 5-3 Feilding Palmer Hospital projected activity

50% repatriation	Annual Activity for Repatriation	Number appts per week	Number sessions per week
Ophthalmology	2,793	66	7
Trauma & Orthopaedics	2,722	65	6
General Internal Medicine	1,571	37	4
Dermatology	1,439	34	3
General surgery	1,406	33	3
Urology	847	20	2
Gynaecology	780	19	2
Cardiology	717	17	2
Rheumatology	695	17	2
Respiratory Medicine	675	16	2
Total	**13,644**	**325**	**32**

The table below demonstrates the site that the patient would previously have been referred

to.

Table 5-4 Feilding Palmer Hospital repatriation of patients

Repatriated from	Number
UHL	9440
University Hospitals Coventry & Warwickshire NHS Trust	2128
LLR Alliance	618
George Eliot Hospital NHS Trust	192
Spire Leicester Hospital	142
University Hospitals of Derby & Burton NHS Foundation Trust	95
Leicestershire Partnership NHS Trust	87
Kettering General Hospital NHS Foundation Trust	68
Nuffield Health, Leicester Hospital	66
New Medical Systems Limited	55
Nottingham University Hospitals NHS Trust	41
North West Anglia NHS Foundation Trust	30
Northampton General Hospital NHS Trust	18
Cambridge University Hospitals NHS Foundation Trust	6
United Lincolnshire Hospitals NHS Trust	5
Other Providers	654
Grand Total	**13644**

The activity projections are based on 50% repatriation of existing activity using the following assumptions:

- 42 weeks of the year.
- 10 sessions per week.
- 2 sessions per day (Monday to Friday).
- 4 hr sessions.
- An average of 10 patients per session.

The projected activity that would take place in the enhance procedures suit is shown in the table below.

Table 5-5 Feilding Palmer Hospital projected activity in enhanced procedures suite

Primary Procedure	Number
C794 - Injection into vitreous body NEC	458
M459 - Unspecified diagnostic endoscopic examination of bladder	248
Q181 - Diagnostic endoscopic examination of uterus and biopsy of lesion of uterus	174
Q554 - Colposcopy of cervix	138
Q555 - Transvaginal ultrasound examination of female genital tract	120

Primary Procedure	Number
S571 - Debridement of skin NEC	111
S065 - Excision of lesion of skin of head or neck NEC	88
W903 - Injection of therapeutic substance into joint	77
E253 - Diagnostic endoscopic examination of nasopharynx NEC	69
S151 - Biopsy of lesion of skin of head or neck NEC	66
Q171 - Endoscopic resection of lesion of uterus	65
Q034 - Punch biopsy of cervix uteri	64
Q553 - Papanicolau smear NEC	53
P273 - Colposcopy of vagina	37
Q014 - Large loop excision of transformation zone	35
B371 - Aspiration of lesion of breast	28
C893 - Injection of therapeutic substance into posterior segment of eye NEC	24
W904 - Injection into joint NEC	23
C734 - Capsulotomy of lens NEC	17
E259 - Unspecified diagnostic endoscopic examination of pharynx	17
P091 - Biopsy of lesion of vulva	13
M703 - Rectal needle biopsy of prostate	12
C733 - Capsulotomy of posterior lens capsule	8
S561 - Debridement of skin of head or neck NEC	8
A735 - Injection of therapeutic substance around peripheral nerve	6
H524 - Rubber band ligation of haemorrhoid	6
Q021 - Avulsion of lesion of cervix uteri	6
H626 - Proctoscopy	5
S102 - Cryotherapy to lesion of skin of head or neck	5
T744 - Injection of therapeutic substance into tendon NEC	5
C224 - Injection into eyelid	4
M494 - Introduction of therapeutic substance into bladder	4
S152 - Biopsy of lesion of skin NEC	2
S532 - Injection of therapeutic substance into skin	2
T872 - Excision or biopsy of cervical lymph node NEC	2
S069 - Unspecified other excision of lesion of skin	1
X551 - Biopsy of lesion of unspecified organ	1
Total	**2,002**

The projected activity would be repatriated from the following Trusts.

Table 5-6 Feilding Palmer Hospital repatriation of primary procedures

Primary Procedure Repatriated From	Number
UHL	1,587
University Hospitals Coventry & Warwickshire NHS Trust	295
LLR Alliance	37
George Eliot Hospital NHS Trust	8
Spire Leicester Hospital	8
New Medical Systems Limited	4
Nottingham University Hospitals NHS Trust	2
University Hospitals of Derby & Burton NHS Foundation Trust	1
Kettering General Hospital NHS Foundation Trust	1
Northampton General Hospital NHS Trust	1
Other Providers	56
Grand Total	**2,002**

5.6 Conclusion on the case for change

The above demonstrates why the facilities from which community planned care across Lutterworth need to change to address:

- The poor state of the existing facilities at Feilding Palmer Hospital.
- The challenges presented by an increasing population.
- Increasing demand for community health services.
- Transformation services in line with a modern healthcare system that is fit for the future.
- Deliver a financially stable health economy.

6 Options appraisal

6.1 Introduction

This section describes the process that the ICB has been through to evaluate the various options for the project and to identify a Preferred Option that meets the ICB's requirements and ***maximises access to services for the local community***.

6.2 Investment Objectives

The Investment Objectives for the project which have been developed by the ICB with key stakeholders are shown in the table below.

Table 6-1 Investment Objectives

Investment Objective Type	IO Ref	Investment Objectives	Measure	Time
Service provision - local population	1	Maximising access to services through developing existing services and/or provision of new services.	Improved access to effective care. Create access to increased service provision. Provide care closer to home. Reduce travel times from 40 minutes to 10 minutes	By autumn 2025 (measure in 26/27)
Clinical need - facilities	2	Modernise the environment and design facilities to suit clinical need. Also improves the working environment for staff.	Adherence to HBNs/HTMs	
Estates utilisation	3	Improve utilisation of space across the Trust with more effective use of resources	Co-location of services and increased integrated ways of working, maximising the use of financial, human and estates resources. Increase occupancy rates in current estate.	
System Benefits	4	Improved strategic fit of services	Service provision meet the requirements of the Lutterworth Healthcare Plan & the Joint Forward Plan.	
Estates - efficient use of resources	5	Reduced backlog maintenance and modernising infrastructure to support the net zero carbon objectives.	Estimated costs for backlog maintenance of c£1.5m over next 10 years (with 75% of spend in the first 4 yrs) to be addressed through the development and revised use.	

6.3 Constraints and dependencies

The constraints and dependencies for the project are shown in the table below.

Table 6-2 Constraints and dependencies

Reference	Description
Constraint 1	Need to maintain stakeholder support
Constraint 2	Physical constraints of site/building
Constraint 3	Funding
Dependency 1	May lead to temporary relocation of services when building works required

6.4 Options appraisal approach

The required approach to options appraisal in government is set out in the HM Treasury *'Green Book – Central Government Guidance on Appraisal and Evaluation'* (the Green Book).

The Green Book sets out an options appraisal framework (Strategic Options Framework Filter) to be used, which differs from the previous methodology undertaken in many NHS schemes in recent years. The framework identifies the Critical Success Factors (CSFs) objectives and benefit criteria that need to be delivered by the relocation of services. The framework breaks a proposal down into a sequence of choices. These choices are presented as questions around the proposed scope, solution, delivery, implementation and funding. The framework considers these choices from the perspective of the public services delivering the project (see table below). The social value of assets is appraised according to how well they enable delivery of a service, as the public sector is generally concerned with the provision of goods and services, not asset ownership.

Table 6-3 Choices in the Strategic Options Framework Filter

Options	Description
Scope	Coverage of the service to be delivered
Solution	How this may be done
Delivery	Who is best placed to do this
Implementation	When and in what form can it be implemented
Funding	What will it cost and how will it be paid for

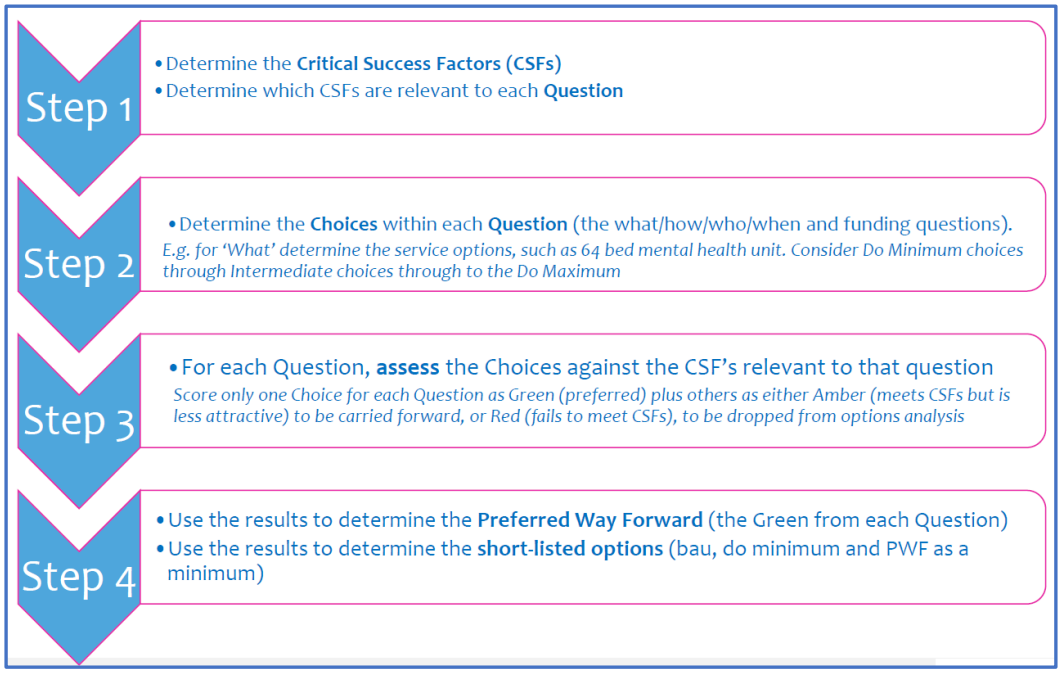
The Strategic Options Framework Filter identifies preferred choices and viable alternatives and rules out non-viable alternatives. The reasons for each decision are documented to support engagement with stakeholders on alternatives. The appraisal of the long list of options should clearly identify any trade-offs between CSFs. This approach has been found to improve the speed, effectiveness and efficiency of strategic analysis through a clear focus on key issues.

The Strategic Options Framework Filter as recommended in Annex 1 of the Green Book, has been used to carry out the appraisal and to:

- Identify the long list of options.
- Establish the Preferred Way Forward (PWF).

There is a four step process to establish the strategic options to be reviewed. These steps are shown are shown in the figure below.

Figure 6-1 Strategic Options Framework Filter appraisal process



Set out below is how the ICB has gone through the process to identify the PWF.

6.5 Options appraisal process

6.5.1 Workshop

A workshop was held on 29th March 2023 with attendees from key stakeholder organisations, to review the first two choices, being Service Scope and Service Solution. The investment objectives (Table 6-1) and dependencies/constraints (

Table 6-2) described above and the key Critical Success Factors (CSFs) (Table 6-4) were also agreed. The results of the workshop can be seen in **Appendix E** and are summarised below. These were also shared with the LLR System Executive Board for review/comments and sign off.

6.5.2 Step 1: Critical Success Factors (CSFs)

Critical Success Factors (CSFs) are a small number of criteria used at the long list stage to make strategic choices about options. The ICB has used the five key CSFs that are recommended by The Green Book and added two further project specific CSFs, as shown in the table below.

Table 6-4 Critical Success Factors

CSF1: Strategy	CSF2: Economic	CSF3: Commercial	CSF4: Financial	CSF5: Management	CSF6: Access	CSF7: Quality & Safety
Compulsory (per Green Book)					Project Specific	
Strategic fit and meets business needs	Potential VfM/benefits optimisation	Supplier capacity and capability	Potential affordability	Potential achievability	Access	Quality & Safety Standards
(i) Meets the investment objectives	(i) VfM modelling	(i) Matches the ability of potential suppliers to deliver the required services	(i) Can be financed from available funds	(i) Needs to be achievable within required timescales and constraints	(i) Improves access to effective care	(i) High quality accom provided within HBN and HTM standards
(ii) Ensure the services provided meet the needs of the local population, taking into account the increased population in the Lutterworth East region	(ii) Optimises social value (maximises societal benefits including most effective use of financial, human and estates resources)	(ii) Appeals to the supply side	(ii) Aligns with strategy of the funders	(ii) Deliverability of the required permitted development rights/ planning permission	(ii) Reduces unplanned admissions to hospital	(ii) Provides services in a location that are linked to local commissioning plans and local estates strategy of ICS
	(iii) Meets tne requirements for energy efficiency, reduces carbon footprint and estates running costs	(iii) Enables construction/ refurbishment, dealing with site constraints and planning risk	(iii) Minimises capital and revenue costs exposure to LLR	(iii) Matches the level of available skills for successful delivery	(iii) Creates a community hub, where both patients and professionals can access a wide range of community care	
	(iv) Provides flexibility for the future, adaptable to future healthcare delivery patterns	(iv) Limits phasing and timeframe of the build/refurbishment	(iv) Aligns with resourcing constraints and minimises risk of a termination in funding			

These CSFs are used to evaluate the choices within the questions set out in Step 2 below. Only the CSF's relevant to each question are used as illustrated in the table below.

6.5.3 Step 2: Determining the Choices

The workshop looked into the Scope and Solution questions as outlined in Table 6-3 above, with the remaining questions then assessed post workshop with the appropriate technical subject matter experts (covered by the Commercial, Management and Financial cases below).

The workshop attendees discussed and agreed the CSFs in Table 6-4 above and then assigned the CSFs to the questions as shown in the table below the green sections indicate assigned

CSFs).

Table 6-5 Assigning CSFs to the filters

			Workshop		Post Workshop		
			What	How/Where	Who	When	Funding
Ref.	Type	Description	Service scope	Service solution: location(s)	Delivery: How to be delivered?	Timing options	Funding options
CSF 1	Strategic	Strategic fit and meets business needs	■			■	
CSF2	Economic	Potential VfM/benefits optimisation		■			
CSF 3	Commercial	Supplier capacity and capability		■	■	■	
CSF 4	Fianncial	Potential affordability		■			■
CSF 5	Management	Potential achievability		■	■	■	
CSF 6	Access	Access		■			
CSF 7	Quality/Safety	Quality & Safety Standards	■				

For example, for the service cope filter relating to what service is required, CSF 1 (Strategic fit) and CSF 7 (Quality and Safety Standards) were considered the appropriate CSFs to apply to this question.

6.5.4 Step 3: Assessing the Choices against the CSF's

Filter 1: Scope (what?)

The workshop attendees first established 'What' the service required was and assessed against the CSFs in line with the assessment choices above. The analysis can be seen in **Appendix E** and in Table 6-6 below.

Table 6-6 Filter 1: Scope assessment (what?)

		Critical Success Factors					
		CSF1: Strategy		CSF7: Quality & Safety			
1) SERVICE SCOPE: WHAT?		Strategic fit and meets business needs		Quality & Safety Standards			
Choice reference:	*Further Explanation*	*(i) Meets the investment objectives (ii) Ensure the services provided meet the needs of the local population, taking into account the increased population in the Lutterworth East region*		*(i) High quality accom provided within HBN and HTM standards (ii) Provides services in a location that are linked to local commissioning plans and local estates strategy of ICS*		*Assessment Result (only one choice to be identified as Green)*	
What are the services to be delivered?							
0. Business as Usual Keep community beds closed	**Business As Usual** Service provision remains limited	- No benefit to population - Does not meet needs of local population - Limited access to services	✗	Services not in location that link with local commissioning plans and local estates strategy of ICS	✗	Carry forward - BAU	Not fit for purpose, but c/fwd as the benchmark. **C/fwd as benchmark.**
1. No services required	**Close Local Hospital** Close community hospital for inpatient and outpatient services	- No benefit to patients - Local community hospital beds are not available - Does not respond to current and growing population needs - No access to service - Benefits of keeping patients at home is reduced	✗	- Vacant building - Does not respond to current and growing population needs	✗	Discounted	Does not meet strategic aims. **Reject.**
2. .Community Services Provision	**Provide Community Services** Keep community beds closed Provide services agreed in LLR healthcare plan: **- Expand OP** **- Expand diagnostics** **- Provide access to pathways** **- Enable strategic alliances**	- Meets needs of local population and provides services agreed in Lutterworth Healthcare Plan	✓ ✓ ✓	Provides refurbished accommodation meeting HBN/HTM standards and first with local estates strategy	✓ ✓ ✓	Preferred Way Forward	Substantially meets strategic CSFs and correctly managed is deliverable, subject to site constraints. **Prefered Way Forward.**
3. Re-open Community Beds	**10 Community Beds** Re-open the community beds for Lutterworth area	- Provides IP community palliative care - Expensive model of care - Does not respond to needs of growing pop of Lutterworth East development	✓	- Hospital layout ineffective for modern healthcare -Ward does not meet regulatory requirements and is not cost effective for small number of beds (plus training/skills development is low for staff)	✗	Discounted	Does not sufficiently meet CSFs **Reject.**
4. New larger hospital	**New IP community beds + LLR healthcare plan services provision**	- Number of Lutteroworth patients requiring IP beds is small - Not aligned to Lutterworth Healthcare Plan - Not a cost effective solution - Benefits of keeping patients at home is reduced	✓	- Would provide high quality estate, but at a cost	✗	Discounted	Does not sufficiently meet CSFs **Reject.**

The following table adds a narrative to the findings in Table 6-6 above.

Table 6-7 Filter 1: Scope assessment (what?) - narrative

Ref.	Options	Findings	Assess.
0.	**Current (BAU)**	The temporary services provided (a short-term solution) remain. The accommodation is not fit for purpose (unused wards reprovisioned). Backlog maintenance currently c£1.5m would still need to be addressed. Does not cater for services required in the growing Lutterworth East area. This solution does not meet the appropriate CSFs and would be rejected but carry forward as a benchmark, in accordance with HM Treasury guidelines.	Carry forward as a comparator
1.	**No services required (Do minimum)**	This option assumes that there is no demand or requirement for services to be delivered in the Lutterworth area, meaning that the Feilding Palmer site would be vacated, and no new service provision is required. This does not meet the requirements of the LLR strategy or the Lutterworth Healthcare Plan and does not fit with current demand and supply. This solution does not meet the appropriate CSFs.	Reject
2.	**Community Services Provision**	This option provides community services in the local Lutterworth area, with the provision of outpatient services and diagnostics. This also provides access to pathways and enables strategic alliances with appropriate organisations/partners, all in a community setting (releasing pressure from acute services and providing services nearer to home). This is consistent with the LLR strategy and the Lutterworth Healthcare Plan. This solution meets the appropriate CSF and was considered the solution that best met the criteria.	Preferred Way Forward

Ref.	Options	Findings	Assess.
3.	**Re-open Community beds**	This option reopens the 10 community beds to make Feilding Palmer a community inpatient bed site. However, the accommodation is not fit for purpose and is not consistent with national policy where there is a preference to provide more community provision in the patient's home. Also, the ability to keep the beds occupied at the required 93% (to provide the most cost effective solution and best practice) means that the service would need to be offered to patients from further afield in LLR. As a result, this would increase (not decrease) travel times. Having relatively small sites also creates staffing issues, with recruitment, cover, training and education particularly difficult (e.g. lack of mix of patients to develop nursing skills). The LLR ICS considers that the best solution is to work with the third party organisations, such as those who have raised funds for local investment of palliative care beds. This solution does not meet the appropriate CSFs.	Reject
4.	**New larger hospital (Do maximum)**	This option combines options 2 and 3 above and represents the 'do maximum' option. Again, the reasons against the provision of 10 community beds outlined in 3 above also apply in this option. This is also a far more costly solution. It was felt that this would be beyond the scope of this project and would not represent best value for money. This does not meet the appropriate CSFs.	Reject

The PWF from the first filter is therefore as shown in the table below.

Table 6-8 Preferred Way Forward after the first filter

Filter:	Preferred Way Forward
Scope	**Community Services Provision** Keep community beds at Feilding Palmer Hospital closed Provide services agreed in Lutterworth healthcare plan: - Expanded outpatient services - Expanded diagnostic services - Provide access to pathways - Enable strategic alliances
Solution	To follow
Delivery	To follow
Implementation	To follow
Funding	To follow

Filter 2: Solution (how?)

The Strategic Options Framework Filter then takes the PWF as identified in the Service Scope above (i.e. Expanding the Community Service Provision) and asks how this may be delivered.

The workshop considered the various options for 'How' the facilities could deliver the required services and scored them against CSFs 2,3,4,5 and 6 as follow (see also **Appendix E** for a larger print).

Table 6-9 Filter 2: Solution assessment (how?)

2) SERVICE SOLUTION: HOW? WHERE?															
Ref		CSF2: Economic		CSF3: Commercial		CSF4: Financial		CSF5: Management		CSF6: Access		CSF7: Quality & Safety		Assessment Result (only one choice to be identified as Green)	
		Potential VfM/benefits optimisation		Supplier capacity and capability		Potential affordability		Potential achievability		Access		Quality & Safety Standards			
How are the services to be delivered?		*(i) VfM modelling (ii) Optimises social value (maximises societal benefits including most effective use of financial, human and estates resources) (iii) Meets tne requirements for energy efficiency, reduces carbon footprint and estates running costs (iv) Provides flexibility for the future, adaptable to future healthcare delivery patterns*		*(i) Matches the ability of potential suppliers to deliver the required services (ii) Appeals to the supply side (iii) Enables construction/ refurbishment, dealing with site constraints and planning risk (iv) Limits phasing and timeframe of the build/refurbishment*		*(i) Can be financed from available funds (ii) Aligns with strategy of the funders (iii) Minimises capital and revenue costs exposure to LLR (iv) Aligns with resourcing constraints and minimises risk of a termination in funding*		*(i) Needs to be achievable within required timescales and constraints (ii) Deliverability of the required permitted development rights/ planning permission (iii) Matches the level of available skills for successful delivery*		*(i) Improves access to effective care (ii) Reduces unplanned admissions to hospital (iii) Creates a community hub, where both patients and professionals can access a wide range of community care*		*(i) High quality accom provided within HBN and HTM standards (ii) Provides services in a location that are linked to local commissioning plans and local estates strategy of ICS*			
Current (Business as Usual)	Use existing site without refurbishment	Very few benefits as services can't be configured correctly to benefit patients/staff/professionals.	✗	N/A - no building works		Backlog maintenance still needs to be applied.	✓		✓	Limitations due to ward spaces . Would not be able to offer expanded services	✗	Limitations due to ward spaces . Would not be able to offer expanded services	✗	**Discounted**	Ther required servces cannot be delviered from the existing site without significant spend/refurbishment. **Reject.**
Feilding Palmer Refurbishment	Refurbish Feilding Palmer to meet current needs and provide flexible accommodation for future healthcare needs	Provides the best solution for patients and staff, allowing fit for purpose facilities for the local population with a cost effective solution, nearer to home.	✓ ✓ ✓	Supplier capacity and capability not expected to be a problem. Few planning risks.	✓ ✓ ✓	Limited capital funding available	✓ ✓	Internal management experienced in capital programme delivery, with use of external subject matter experts where required.	✓ ✓ ✓	Meets all the requirements of the access CSFs	✓ ✓ ✓	Refurbishment will be carried out within the necessary HBN and HTM standards	✓ ✓ ✓	**Preferred Way Forward**	Substantially meets the various CSFs and provides the best service deliver option. Various sub-options required for variations within FP to deliver the required services (to be assessed separately) **Preferred Way Forward.**
Expand to out of area existing sites	Provides services in fit for purpose locations, but outside of local provision	Limited social value as requires patients to travel further afield.	✗	Supplier capacity and capability not expected to be a problem. May have planning risks, depending on site.	✓ ✓	Limited capital funding available	✓ ✓	Internal management experienced in capital programme delivery, with use of external subject matter experts where required.	✓ ✓ ✓	Out of local area means that the access CSFs are not met, increasing time/travel/inconvenience and delivering healthcare further from home,	✗	Whilst adherence to HTMs/HBNs may be achieved (depending on site), providing the service outside the local commissioning plans and local estates strategy of the ICS means that this CSF is largely not met.	✗	**Discounted**	Does not meet the required standards, particularly around local provision. **Reject.**
Lutterworth Medical Centre	Refurbish/extend the Lutterworth Medical Centre ,adjacent to the current Feilding Palmer site	Won't provide VfM to same level as Feilding Palmer due to site constraints	✓	Supplier capacity and capability not expected to be a problem.	✓ ✓ ✓	Limited capital funding available	✓ ✓	Conflicting requirements of existing/expanding primary care service make this an unviable option	✗	Not sufficient space to allow this CSF to be achieved	✓	Location good (next door to Feilding Palmer) but not enough space. Current need for expansion for existing primary care means not a viable option	✗	**Discounted**	Does not sufficiently meet CSFs **Reject.**

Table 6-10 Filter 2: Solution assessment (how?) - narrative

Ref.	Options	Findings	Assess.
0.	**Current (BAU)**	This solution assumes that the proposed community services can be provided from the current Feilding Palmer Hospital, without refurbishment. This is not considered to be possible given the limitations of the current ward spaces. It was felt that the expanded service provision would not be possible. This does not meet the appropriate CSFs.	Carry Forward as a comparator
1.	**Feilding Palmer Refurbishment**	This solution allows the current Feilding Palmer Hospital to be refurbished to meet the required building standards and provide fit for purpose, flexible space, ensuring any service provision is flexible and adaptable for future needs. Importantly, this maintains a 'health campus' approach, with healthcare services provided from Feilding Palmer Hospital and the adjacent Lutterworth Medical Centre (and its resident 2x GP practices and supporting services). This would also significantly address/resolve any backlog maintenance issues in the current building. This solution meets the appropriate CSF and was considered the solution that best met the criteria.	Preferred Way Forward
2.	**Out of area sites**	The provision of services could be provided in out of area NHS (or alternative) locations. This is not consistent with LLR strategy or the Lutterworth Healthcare Plan. This solution does not meet the appropriate CSFs.	Reject

Ref.	Options	Findings	Assess.
3.	**Lutterworth Medical Centre**	This medical centre, adjacent to Feilding Palmer, was considered but rejected, as space is currently at a premium and there are already considerable conflicting pressures on space, especially given the residential developments that are leading to an increase in population in the east of Lutterworth. This solution does not meet the appropriate CSFs.	Reject

The PWF, after assessing the first two filters of the Strategic Options Framework Filter, is therefore as shown in the table below.

Table 6-11 Preferred Way Forward after the second filter

Filter:	Preferred Way Forward
Scope	**Community Services Provision** Keep community beds at Feilding Palmer Hospital closed Provide services agreed in Lutterworth healthcare plan: - Expanded outpatient services - Expanded diagnostic services - Provide access to pathways - Enable strategic alliances
Solution	**Feilding Palmer Refurbishment**
Delivery	To follow
Implementation	To follow
Funding	To follow

The next step is to consider who is best to deliver.

Filter 3: Delivery (who?)

This section reviews the various alternatives in reviewing the procurement route to deliver the proposed development of Feilding Palmer Hospital.

The procurement options were scored against CSFs 3 (commercial) and 5 (management) as shown in Table 6-13 overleaf. The narrative supporting the assessment is shown in the table below.

Table 6-12 Filter 3: Delivery (who?) - narrative

Ref.	Options	Findings	Assess.
1.	**Traditional Procurement**	This solution involves the Trust Design team completing the full design, before inviting tenders. It was felt that this would cause delay and therefore would mean that the key CSFs around deliverability would not be met. The Trust is not in a position to take on the design risk and given the potential time delay too, this does not meet the appropriate CSFs.	Reject
2.	**Design and Build (single stage, OJEU)**	This solution sees the contractor take on the design and construction risks, but the time delays in the process mean that this too, although a good option, would not meet the required timescales and constraints.	Reject
3.	**Public Sector P22 Framework**	Trust led requirements set out and framework Contractor appointed. Works are design and build for single or multiple schemes for an agreed maximum price on an open book, partnering basis.	Preferred Way Forward

Table 6-13 Filter 3: Delivery assessment (who?)

3) DELIVERY: WHO?								
			CSF3: Commercial		CSF5: Management			
			Supplier capacity and capability		Potential achievability			
Who is best placed to deliver the required works?			*(i) Matches the ability of potential suppliers to deliver the required services (ii) Appeals to the supply side (iii) Enables construction/ refurbishment, dealing with site constraints and planning risk (iv) Limits phasing and timeframe of the build/refurbishment*		*(i) Needs to be achievable within required timescales and constraints (ii) Deliverability of the required permitted development rights/ planning permission (iii) Matches the level of available skills for successful delivery*		*Assessment Result (only one choice to be identified as Green)*	
Traditional Procurement	**Delivery 1**	**The Trust's Design Team complete full design and coordination prior to inviting tenders. There is a full tender process to select a contractor for an agreed lump-sum price. Design risk stays with trust.**	Trust takes on the design risk, which is not preferred.	✓	Achievable, but likely to cause delay and be expensive for such a small scheme.	✓	**Discounted**	Trust takes on the design risk, which is not preferred. **Reject.**
Design and build (single stage, OJEU)	**Delivery 2**	**Trust led requirements set out and tendered. Constructor responsible for undertaking both the design and construction work for an agreed lump sum price.**	Available to wide set of contractors, but the quality of the build asset can be subject to commercial pressures. Likely to take longer as length of construction programme incorporates elements of risk transfer.	✓	Contractor assumes risk and responsibility for design and construction. Requires OJEU, which is time consuming. Not limited to top tier contractors, single point responsibility for design and construction, fixed contract sum provision. Likely to be expensive for such a small scheme.	✓ ✓	**Discounted**	Good option but the risk on time delays mean that this option would not meet the required timescales and constraints. **Reject.**
Public Sector Procure22 Framework	**Delivery 3**	**Trust led requirements set out and framework Contractor appointed. Works are design and build for single or multiple schemes for an agreed maximum price on an open book, partnering basis.**	LPT already have a P22 PSCP in place. The relatively small size of the project will easlity be deliverable by the selected PSCP.	✓ ✓ ✓	Preferred procurement route supported by DHSC, NHSE, and HM Treasury. LPT already have a P22 PSCP in place, so likley to be the quickest.	✓ ✓	**Preferred Way Forward**	"Best meets the CSFs. Preferred Way Forward."

The PWF, after assessing the first three filters of the Strategic Options Framework Filter, is therefore as shown in the table below.

Table 6-14 Preferred Way Forward after the third filter

Filter:	Preferred Way Forward
Scope	**Community Services Provision** Keep community beds at Feilding Palmer Hospital closed Provide services agreed in Lutterworth healthcare plan: - Expanded outpatient services - Expanded diagnostic services - Provide access to pathways - Enable strategic alliances
Solution	**Feilding Palmer Refurbishment**
Delivery	**Public Sector P22 Framework**
Implementation	To follow
Funding	To follow

The next filter looks at implementation.

Filter 4: Implementation (when?)

This section of the filter looks at the choices around implementation. e.g. whether the project to deliver the above could be carried out in stages/phases. Due to the small scale of the project and the likely build period the only practical solution is to deliver the project in a single stage.

This was scored against the appropriate CSFs 1 (strategy), 3 (commercial) and 5 (management) as shown in the table below.

Table 6-15 Filter 4: Implementation assessment (when?)

4) IMPLEMENTATION: WHEN?										
			CSF1: Strategy		CSF3: Commercial		CSF5: Management			
			Strategic fit and meets business needs		Supplier capacity and capability		Potential achievability			
When will the proposal be delivered by?			*(i) Meets the investment objectives (ii) Ensure the services provided meet the needs of the local population, taking into account the increased population in the Lutterworth East region*		*(i) Matches the ability of potential suppliers to deliver the required services (ii) Appeals to the supply side (iii) Enables construction/ refurbishment, dealing with site constraints and planning risk (iv) Limits phasing and timeframe of the build/refurbishment*		*(i) Needs to be achievable within required timescales and constraints (ii) Deliverability of the required permitted development rights/ planning permission (iii) Matches the level of available skills for successful delivery*		*Assessment Result (only one choice to be identified as Green)*	
pletion 2025/26	Imp. 1	**Deliverd over a 12 month construction period starting in January 2025**	Meets strategic investment objectives. Allows the commissioning of the newly refurbished acommodation to be achieved within the required timescales	✔ ✔ ✔	Likley to be delivered and acceptable to the P22 PSCP	✔ ✔ ✔	Fully meets required CSF.	✔ ✔ ✔	**Preferred Way Forward**	Delivers programe within the desired timescales. **Preferred Way Forward.**

The PWF, after assessing the first four filters of the Strategic Options Framework Filter, is therefore as shown in the table below.

Table 6-16 Preferred Way Forward after the fourth filter

Filter:	Preferred Way Forward
Scope	**Community Services Provision** Keep community beds at Feilding Palmer Hospital closed Provide services agreed in Lutterworth healthcare plan: - Expanded outpatient services - Expanded diagnostic services - Provide access to pathways - Enable strategic alliances
Solution	**Feilding Palmer Refurbishment**
Delivery	**Public Sector Framework**
Implementation	Single stage 12 month construction period starting January 2025
Funding	To follow

The final filter looks at the funding choices.

Filter 5: Funding

The final filter in the Strategic Options Framework Filter is to identify what the likely cost will be and how it will be funded. The assessment was based on an approximation build cost for the PWF of c£5.8m.

The long list of options were scored against CSF 4 (financial) as shown in Table 6-17 below.

Table 6-17 Filter 5: Funding assessment

5) FUNDING £££s						
			CSF4: Financial			
			Potential affordability			
What will it cost and how will it be funded?			*(i) Can be financed from available funds (ii) Aligns with strategy of the funders (iii) Minimises capital and revenue costs exposure to LLR*		*Assessment Result (only one choice to be identified as Green)*	
ICS capital	**Funding 1**	Funding from LLR ICS capital	System capital available and consistent with ICB strategy	✔ ✔ ✔	**Preferred Way Forward**	Achievable funding route. **Preferred Way Forward.**
LPT capital allocation	**Funding 2**	Fundeing from LPT's existing capital allocation	Dependant on sufficient capital being available given other demands on LPT's capital allocation	✘	**Discounted**	Not a viable option. Reject.
Private funding	**Funding 3**	Funded by sources outside the public sector.	NHS current requirements do not allow private funding initiatives.	✘	**Discounted**	Not a viable option. **Reject.**

The PWF, after assessing the final filter of the Strategic Options Framework Filter, is therefore as shown in the table below.

Table 6-18 Preferred Way Forward after the final filter

Filter:	Preferred Way Forward
Scope	**Community Services Provision** Keep community beds at Feilding Palmer Hospital closed Provide services agreed in Lutterworth healthcare plan: - Expanded outpatient services - Expanded diagnostic services - Provide access to pathways - Enable strategic alliances
Solution	**Feilding Palmer Refurbishment**
Delivery	**Public Sector P22 Framework**
Implementation	Single stage 12 month construction period starting January 2025
Funding	System capital

6.5.5 Step 4: Preferred Way Forward

The above process has therefore allowed the ICB to identify the PWF through an assessment against Critical Success Factors that allow the delivery of the Investment Objectives.

6.6 Clinical assurance

6.6.1 Background

Clinical assurance is provided by a review of the proposals by a Clinical Senate. The core function of a Clinical Senate is to provide high quality, independent, evidence based strategic clinical advice and guidance. They provide important support by operating as impartial and advisory arm's length bodies, with access to a wide variety of experts, data and best practice to draw upon.

6.6.2 Clinical Senate

Introduction

The Clinical Senate took place on 29th June 2023. The Review Panel consisted of 19 independent members from across the East Midlands. The Review Panel of experienced

individuals, from a wide variety of specialised subject areas relevant to the review, was made up of a diverse group of multi-disciplinary, multi-professional individuals, as well as patient and public voice. Three weeks prior to their visit, the LLR system provided the Clinical Senate with a suite of information which had been requested. On the day of the session, a presentation was given by the LLR senior team on the Feilding Palmer service change and revised clinical model, followed by a question and discussion session. The Senate panel also visited the Feilding Palmer Hospital and met with frontline clinicians and staff impacted by the changes.

Based on the information presented to them they provided a Senate Report with recommendations. The report is included in **Appendix F**. The report was reviewed by NHSE as part of the NHSE Stage 2 Assurance Checkpoint. The outcomes and feedback from the Clinical Senate support the clinical case for change within the PCBC.

Response to Clinical Senate findings

The recommendations arising from the Clinical Senate are shown in the table below together with the ICB's proposed responses to the recommendations.

Table 6-19 Clinical Senate recommendations and ICB responses

Recommendation No.	Recommendation details	ICB response
1: Bed Closures	The panel recommend that the inpatient facility on the Feilding Palmer site remains closed permanently and that future plans for community service provision in Lutterworth do not include inpatient facilities (based on current evidence of provision and population need).	
2: Volume of Services, finance, infrastructure, demand and adjacencies	The panel recommend that the system reflect on the volume of potential services planned for delivery from the Feilding Palmer site; to take a future view, working through each service and consider all aspects from finance, infrastructure, patient demand and volume, required adjacencies and implications to patient experience and need. The outcome should determine what is viable, cost effective and sensible for the present and future of community services. This should consider the national steers and best practice.	A review of the services and planned procedures has been carried out. Although the activity in PCBC is the activity that is planned, initially the focus will be on the top 5 specialties for repatriation, but retaining all clinical space as flexible for demand changes. The top 5 specialties are shown below: • Ophthalmology.* • T&O. • Dermatology.* • Urology.* • Gynae.* (*Denotes demand for procedure room)

Recommendation No.	Recommendation details	ICB response
		The intention for diagnostics is that only simple tests will be completed at Lutterworth. Therefore, there is no expectation for further significant diagnostic investment. As this will be repatriated activity to enable the population to receive their care closer to home, in line with the national direction, the revenue costs are in the ICB's existing financial plans. The need for this activity has been assessed taking into account all other LLR system plans, including the Glenfield Planned Care Centre and the Clinical Diagnostic Centre in the neighbouring district. There remains evidence of need for this activity in Lutterworth now and as the population grows, taking into account the type of patients moving into the area as a result of the Lutterworth East development. The proposed refurbishment has been designed with patient experience embedded in the plans which will provide the patients with a modern healthcare facility whilst retaining the external character of the building. Refurbishment costs of the building have been prioritised within the LLR system.
3: PHM	The panel suggest that the system refreshes an analysis of the local population health data to look at the present and future population modelling to understand the nuances in less visible population health needs and health inequalities. This should inform decisions regarding patient needs and service provision to ensure no future plans unintentionally widen the health inequalities gap.	The ICB, along with ICS partners, is committed to delivering a heatlh and care system that meets the needs of the present and future population which tackles health inequalities in health and improves health, wellbeing and life experiences of the people it serves. An indepth analysis was carried out to understand the population in Lutterworth and the surrounding area for the PCBC, and this will

Recommendation No.	Recommendation details	ICB response
		be refreshed as the decision making business case is produced to ensure that there are no changes to the population.
4: Clear proposals relevant to Lutterworth	The panel recommend that the system ensure that the data and narrative presented in the business case and consultation documents is highly detailed, covering both the wider LLR geography but very specifically the Lutterworth patient population. This should provide a significant degree of clarity for patients to understand the impact on them as individuals and for all involved in the project to have a robust understanding of what is proposed.	The ICB has included local data relevant to Lutterworth and the surrounding area within this PCBC to demonstrate where patients are currently going for their care. This has identified an opportunity to repatriate over 13,000 patients who are currently going to other hospitals for their outpatient appointments and over 2000 patients who are currently going elsewhere for their outpatient procedures. The data in section 4.3.3 of this PCBC provides local information in relation to community based care since the temporary closure due to Covid-19 of the Feilding Palmer inpatient beds. The ICB has carried out a review of the consultation documents to ensure that they provid clear and thorough information to enable the respondents to be well informed of the proposals.
5: Workforce	The panel suggest that workforce development considerations are expanded to include the impact on the wider system of repatriation of staff into Lutterworth (with particular reference to the acute provider) and mitigation for potential ongoing unwillingness to work at the Feilding Palmer site post refurbishment.	The proposals to include outpatient appointments and enhanced procedures that are not currently being delivered from Lutterworth will be supported by workforce from across a range of providers. Once the confirmed list of services is confirmed, following public consultation, the ICB will confirm with UHL and alternative providers (OOC/GPSI's) which services they will be supporting.

Recommendation No.	Recommendation details	ICB response
		Where staff from UHL are supporting the activity in Lutterworth, the ICB will triangulate the impact that this may have within the system which will be detailed within the Decision Making Business Case.

6.7 Conclusion on the options appraisal

The ICB has undertaken an options appraisal in accordance with HM Treasury guidance which has identified the Preferred Way forward which ***maximises access to services for the local community*** as:

- Keeping community beds at Feilding Palmer closed.
- Providing services agreed in Lutterworth healthcare plan:
  - Expand outpatient services.
  - Expanding diagnostics services.
  - Providing access to pathways.
  - Enabling strategic alliances.

The Preferred Way Forward has been reviewed by the Clinical Senate and they have confirmed their support to redevelop the Feilding Palmer hospital to provide more outpatient services for the benefit of the Lutterworth and surrounding population.

7 The proposals

7.1 Introduction

This section summarises the services to be provided at Feilding Palmer Hospital and provides details of the proposed accommodation required for those services to ***maximise access to services for the local community.***

7.2 Proposed services

The proposal is for the following services to be provided from Feilding Palmer Hospital.

Table 7-1 Proposed services

Services	Sessions/clinics	Provider
Outpatient services (new services)		
Ophthalmology	6 per week	UHL
Trauma and orthopaedics	5 per week	UHL
General internal medicine	4 per week	UHL
Dermatology	3 per week	UHL
General surgery	3 per week	UHL
Urology	2 per week	UHL
Gynaecology	2 per week	UHL
Cardiology	2 per week	UHL
Rheumatology	2 per week	UHL
Respiratory medicine	2 per week	UHL
Enhanced procedure suite	10 per week	UHL
Community services (as currently provided)		
ECHO	2 every other week	LPT
Heart Failure	1 every other week	LPT
AAA screening	1 per month	LPT
Dermatology CHELLIAH	1 per month	LPT
ADHD	2 every other week	LPT
Paediatrics	1 or 2 per week	LPT
Psychiatrics	1 per week	LPT
Psychiatric nurse	1 per week	LPT
Dietician	1 per month	LPT
Speech and Language Therapy – Adults	1 or 2 per week	LPT
Speech and Language Therapy – Children	3 or 4 per week	LPT
Parkinson	1 per month	LPT
Stoma	1 per month	LPT
Mental Health	1 every other week	LPT
Pulmonary and Cardio Rehab	4 per week	LPT
Walking aid clinic	2 per week	LPT

Services	Sessions/clinics	Provider
MSK Physio	Regular clinics	LPT
Out of Hours Access	Regular clinics	DHU

Initially the clinical space will be used for the following 5 high volume specialties.

Table 7-2 Initial specialties to be included

50% repatriation	Annual Activity for Repatriation	Number appts per week	Number sessions per week
Ophthalmology	2,793	66	7
Trauma & Orthopaedics	2,722	65	6
Dermatology	1,439	34	3
Urology	847	20	2
Gynaecology	780	19	2
Total	**8581**	**204**	**20**

The associated enhanced procedure suite activity is shown in the table below.

Table 7-3 Enhance procedure suite activities

Specialty/Procedure	Volume
Gynaecology	**705**
Q181 - Diagnostic endoscopic examination of uterus and biopsy of lesion of uterus	174
Q554 - Colposcopy of cervix	138
Q555 - Transvaginal ultrasound examination of female genital tract	120
Q171 - Endoscopic resection of lesion of uterus	65
Q553 - Papanicolau smear NEC	53
P273 - Colposcopy of vagina	37
P091 - Biopsy of lesion of vulva	13
Q021 - Avulsion of lesion of cervix uteri	6
Ophthalmology	**511**
C794 - Injection into vitreous body NEC	458
C893 - Injection of therapeutic substance into posterior segment of eye NEC	24
C734 - Capsulotomy of lens NEC	17
C224 - Injection into eyelid	4
Urology	**264**
M459 - Unspecified diagnostic endoscopic examination of bladder	248
M494 - Introduction of therapeutic substance into bladder	4
Dermatology	**237**
S065 - Excision of lesion of skin of head or neck NEC	88
S069 - Unspecified other excision of lesion of skin	1

Specialty/Procedure	Volume
S571 - Debridement of skin NEC	111
T&O, Rheumatology	28
W904 - Injection into joint NEC	23
S561 - Debridement of skin of head or neck NEC	8
E259 - Unspecified diagnostic endoscopic examination of pharynx	17
B371 - Aspiration of lesion of breast	28
H524 - Rubber band ligation of haemorrhoid	6
H626 - Proctoscopy	5
Grand Total	**1717**

Clinical space will be kept flexible for changes in demand.

The appropriate infection prevention and control measures would be implemented to allow for the enhanced procedure suite to be used for multiple specialities, along with flow of patients around the site to enable safe practices to be in place.

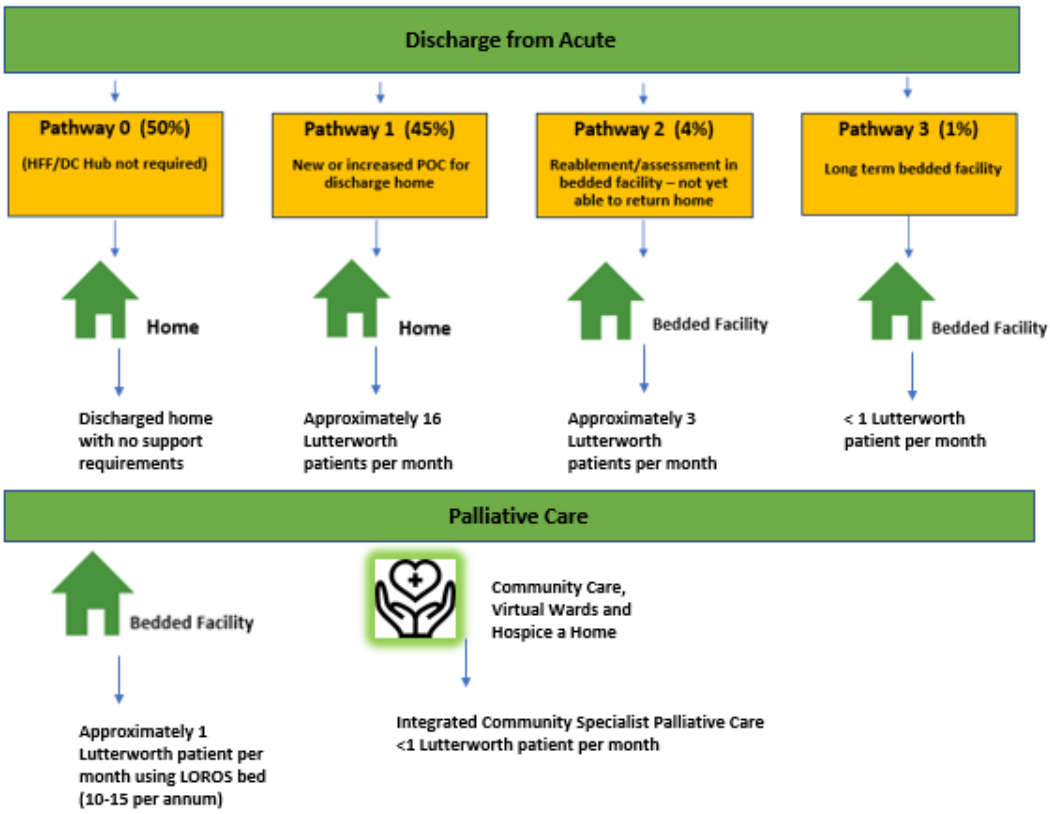
The intention regarding diagnostics is that only simple tests will be completed at Lutterworth therefore there is no expectation for further significant diagnostic investment and will not be duplicating the work of the Clinical Diagnostic Centre in Hinckley. There will be specific equipment needs for each of the specialties which will be worked up in the subsequent business case for Lutterworth with the provider(s) of the service.

7.3 Alternative provision of inpatient beds

Prior to the Feilding Palmer bed closures, if a Lutterworth patient required a bedded facility they were admitted to either the Feilding Palmer Community Hospital, or an alternative Community Hospital Bed in LLR if there wasn't one available locally. As the Feilding Palmer beds were used for all LLR patients, it was often the case that the beds were fully occupied and so the patient was placed outside Lutterworth. On average, there were 2 or 3 Lutterworth patients requiring an inpatient bed at any one time.

The proposed model has been in place since the temporary closure of the beds, and the diagram below outlines the need for Lutterworth patients aligned to the Discharge to Assess pathways.

Figure 7-1 Discharge access to pathways



7.4 Accommodation requirements

In order to identify the potential costs of the proposed development of Feilding Palmer Hospital some indicative plans have been developed of the accommodation requirements to deliver the proposed services. At this stage these plans are only indicative and will be subject to review and update following the conclusion of the public consultation and consideration of the results of the consultation.

7.4.1 Indicative Schedule of Accommodation

The indicative Schedule of Accommodation is shown in the table below.

Table 7-4 Indicative Schedule of Accommodation

Generic Suites			Version 2				
Strategic Content	**Proposed Function**	**Comments**	**Area Derived From**	**Proposed Unit Area (sqm)**	**Quantum**	**Total Area (sqm)**	**Sub Totals (sqm)**
Entrance/Reception	Reception, 2 positions		HBN	11.00	1	11.00	
	Office: 2-person		HBN	12.00	1	12.00	
	Waiting Area		HBN	1.85	21	38.85	
	WC: Semi-ambulant		HBN	2.50	2	5.00	
	WC: Independent wheelchair		HBN	4.50	1	4.50	
	Sub Total (Net)						**71.35**
Group Room	Group room: multi-purpose		Project	24.00	1	24.00	
	Store: general	8m2 per multi-purpose group room for flexibility in use	HBN	8.00	1	8.00	
	Sub Total (Net)						**32.00**
Generic Outpatients	Consulting/Examination room: double-sided couch access		HBN	16.00	3	48.00	
	Treatment Room: double-sided couch access		HBN	16.00	2	32.00	
	Interview Room: 4 places (including 1 wheelchair place)		HBN	8.00	1	8.00	
	Sub Total (Net)						**88.00**
Procedure Suite	Enhanced Procedures Room	including scrub sink	Project	32.00	1	32.00	
	Changing Cubicle (1) - accessible	Pass through	HBN	4.50	1	4.50	
	Sub Total (Net)						**36.50**
Recovery	Staff Touchdown		Project	2.00	1	2.00	
	Recovery - Stage 2 (per person)	Trolley	Project	7.00	1	7.00	
	Discharge lounge	Chaired recovery	Project	2.50	2	5.00	
	Beverage Bay - With HRB		HBN	5.00	1	5.00	
	WC: Independent wheelchair		HBN	4.50	1	4.50	
	Sub Total (Net)						**23.50**

Generic Suites			Version 2				
Strategic Content	**Proposed Function**	**Comments**	**Area Derived From**	**Proposed Unit Area (sqm)**	**Quantum**	**Total Area (sqm)**	**Sub Totals (sqm)**
Support Facilities	Clean Utility Room Without Controlled Drugs Cupboard		HBN	8.00	1	8.00	
	Dirty Utility With Macerator		HBN	12.00	1	12.00	
	Parking bay: resuscitation trolley		HBN	2.00	1	2.00	
	Store: clinical equipment		Project	12.00	1	12.00	
	Store: Linen		HBN	2.00	1	2.00	
	Disposal Hold: 1700 litres	Use of existing	HBN	8.00	0	0.00	
	Cleaners' Room		HBN	8.00	1	8.00	
	Sub Total (Net)						**44.00**
Staff Support Facilities	WC: Semi-ambulant		HBN	2.50	2	5.00	
	Staff Rest		HBN	1.80	10	18.00	
	Staff - Shower	Ambulant	HBN	2.50	2	5.00	
	Staff Changing		HBN	1.40	8	11.20	
	Office - Open plan - Mobile	Clinical Hot Desking	Adcuris	4.00	4	16.00	
	Sub Total (Net)						**55.20**

Exclusively for enhanced procedures	**Net Departmental Area**		**350.55**
Shared	Planning Allowance	5.0%	17.53
Not relating to enhanced procedures	**Sub Total**		**368.08**
	Engineering Allowance	3.0%	11.04
	Circulation Allowance	25.0%	92.02
	Gross Departmental Area		**471.14**

7.4.2 Floor plans

The indicative floor plans are shown below.

Figure 7-2 Indicative ground floor plan

Figure 7-3 Indicative first floor plan

7.5 Conclusion on the proposals

The proposed services and the associated accommodation requirements have been developed with input from key stakeholders to ***maximise access to services for the local community*** and to ensure that they enable the ICB's Model of Care to be delivered in Lutterworth in accordance with the Lutterworth Healthcare Plan.

Once the work is complete and the services occupy the building there will be business continuity plans in place for the services implemented as part of the standard NHS contract. Engagement with the Local Health Resilience Partnership (LHRP) has commenced, and full details will be shared formally with them at their quarterly meeting in November 2023.

8 Public engagement to date

8.1 Introduction

This section summarises the engagement that has taken place so far, in respect of the proposed changes to services to be provided at Feilding Palmer Hospital, to ensure that proposals ***maximise access to services for the local community.***

8.2 Early engagement

A significant amount of engagement has been undertaken over the last 18 months to involve the population across LLR. Key projects have seen qualitative information gained from patients, service users, staff and carers, including work with communities including those with protected characteristics. Engagement has included, but not been exclusive to the following.

Table 8-1 Engagement to date

Consultation	Total no of responses (LLR)	Total responses from 7 Lutterworth wards	Respondents who didn't provide geographical data
Building Better Hospitals	5,675	108 (2.3%)	2,377 (42%)
Step up to Great MH	6,650	106 (2.6%)	3,171 (48%)
Covid-19 vaccine hesitancy	4,094	32 (0.8%)	1,109 (27%)
Primary Care local survey	5,483	163 (3%)	N/A*
Primary Care national survey	14,426	228 ((.158%)	N/A*

8.3 Specific engagement

A local community campaign group attends each Steering Group meeting and a stakeholder briefing has been provided following each meeting which has been shared with Parish, Town

and County Councillors, patient groups including local Patient Participation Groups, VCSE, MPs office, Steering Group members and other key stakeholders.

8.4 Conclusion on engagement to date

Engagement to date has been in the form of LLR wide engagement on a number of areas which impact on the residents of Lutterworth and the surrounding areas and specific engagement as part of the Lutterworth Steering Group, which has been specifically established to consider the proposals for Feilding Palmer Hospital. Feedback from this engagement has been incorporated into the proposals as they have been developed so far.

9 Impact of the proposals

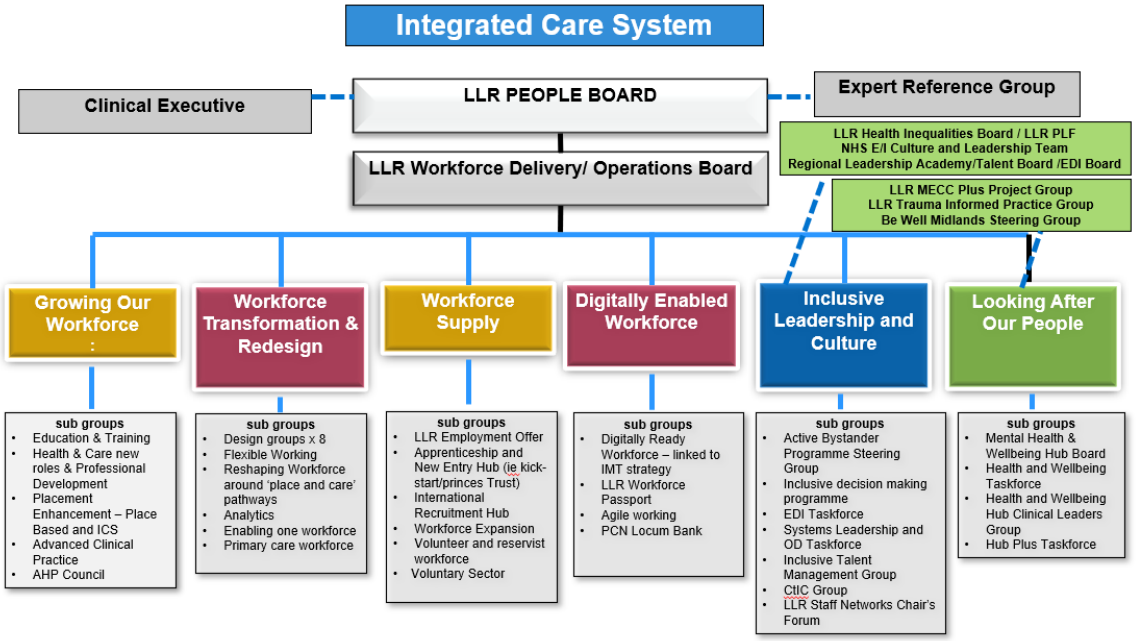
9.1 Introduction

This section identifies the impact of the proposals in terms of the staffing, premises and IT requirements and the impact for patients in terms of quality of care and travel times which ***maximise access to services for the local community***. It also includes details of the Equality Impact Assessment that has been carried out.

9.2 Staffing implications and workforce planning

The ICB's LLR People and Culture Board, which has representation from across the ICB's partners, oversees the people intervention programmes and operational workforce planning submissions, which are summarised in the diagram below.

Figure 9-1 LLR People and Culture Board



People are the ICB's greatest asset and the ICB has seen 7.7% growth in employed NHS staff in the last 3 years. However, the ICB know there are workforce challenges both locally and nationally. In response to these, the People Strategy is delivering intervention programmes to enable attraction, recruitment, retention and supply of people. At the heart of the ICB's plans is ensuring the ICB is looking after people's health and wellbeing, as well as creating a compassionate and thriving culture.

The services to be provided under the proposals will primarily be provided by staff from UHL and LPT. The implications for each organisation are summarised below.

9.2.1 UHL

UHL already provide some limited outpatient services at Feilding Palmer Hospital, these include administration and nursing services with visiting Doctors. These staff would transfer into the 'new' accommodation. In addition to this, for the proposed additional outpatient clinics and for the 'new' clean room facility additional staff will be required.

Pre Covid levels of workforce were limited to staffing the existing outpatient rooms on a part time basis. From a nursing point of view this was a part time healthcare assistant and part time registered nursing, supported by part time administration. These staff were a shared resource with one of our other community elective sites at Market Harborough. Scaling up the FP facility will therefore require scaling up the staffing model to support this activity, both in outpatients and the clean room. This will include:

- Recruiting additional nursing and administrative staff.
- Approaching individual specialities for additional medical sessional cover.

The table below shows potential additional staff for the day to day running of the outpatient, diagnostic and enhanced procedure services. This is based on the activity projections which include standard growth assumptions.

Table 9-1 Potential additional UHL staff

Band	Job Description	WTE
6	Registered nurse	2
2	HCA	2
2	Prepper	1
2	Receptionist	1
	DR - Clean Room	1.5
	DR - Consulting room	4.5
	Total Staff	**12**

9.2.2 LPT

LPT already provide services at Feilding Palmer Hospital, Lutterworth and the surrounding area. These services will continue to be provided and as such staffing arrangements will be unchanged.

9.3 Premises implications

9.3.1 Accommodation standards

The fully refurbished accommodation, providing facilities specifically designed for the outpatient and community services will comply with up to date healthcare standards. Retaining the external character of the building will allow the local area to retain its charm and history, whilst also increasing its ability to provide safe and effective modern healthcare. The redevelopment of the building will enable utilisation to be increased by providing additional facilities to provide care.

9.3.2 East Midlands Ambulance Service

Feilding Palmer is an existing NHS asset and is part of the LLR system. It is included as a named site with the provider of patient transport services when this is required. As the hospital is not an acute site, there is no direct impact on EMAS. However, should there be a need for a 999 call out to attend a patient, then EMAS would respond in line with their contract.

9.4 IT implications

LLR has the vision for an integrated health and care system that has all the data and information it needs, delivered in an accessible and timely way, to enable it to support health and care services to achieve the best possible outcomes for the population. The ICS continues to achieve this through the overarching digital strategy in LLR. For this project, to care for the local population, the ICS will continue to follow the LLR approach and will ensure that there are sufficient IT resources available to allow staff to work effectively from the site, introducing this in the new consulting rooms, enhanced procedure suite and other areas where required.

9.5 Impact on quality of care

The fully refurbished accommodation will provide facilities that are developed specifically for the delivery of outpatient services and community services, which will be an effective and conducive environment for health care delivery, resulting in increased likelihood of desired health outcomes in the following ways:

- **Effective** – providing evidence based healthcare services to those who need them.
- **Safe** – avoiding harm to people for whom the care is intended.
- **People centred** – providing care that responds to individual preferences, needs and values.

To realise the benefits of quality health care, health services will be:

- **Timely** – reducing waiting times and sometimes harmful delays.
- **Equitable** – providing care that does not vary in quality on account of gender, ethnicity, geographic location, and socio-economic status.
- **Integrated –** providing care that makes available the full range of health services throughout the life course.
- **Efficient** – maximising the benefit of available resources and avoiding waste.

These will be monitored as set out in the table below.

Table 9-2 Monitoring of benefits

For assessment	Description	Method	Due
Low clinical value treatment policies	Review treatments options to ensure they are in line with latest treatment policies to ensure they are in line with robust clinical evidence and national guidance	Audit	Prior to initiation of Enhanced Procedure and annually thereafter.
National guidance for procedures and specialities	Review national guidance for the procedures and specialities carried out at the Feilding Palmer to ensure they are in line with current guidance.	Audit	Prior to initiation of Enhanced Procedure and annually thereafter.
Clinical outcomes	Audit patient clinical outcomes to monitor the effectiveness of the enhanced procedure suite (infection rates, complication rates and readmission rates) Review Patient Reported Outcome Measures (PROM)	Audit	Prior to initiation of Enhanced Procedure and annually thereafter.
Waiting times	Analyse waiting times data to assess the impact of the enhanced procedure suite on the local population and the system	Performance monitoring	Prior to initiation of Enhanced Procedure and monthly thereafter.
New to follow up ratios	Monitor new to follow up ratios to ensure they are in line with local targets	Performance monitoring	Prior to initiation of Enhanced Procedure and monthly thereafter.
Monitoring issues raised by patients	Monitoring issues raised by patients who would have historically used the inpatients beds from the surrounding areas, going elsewhere.	Patient complaints	Monthly

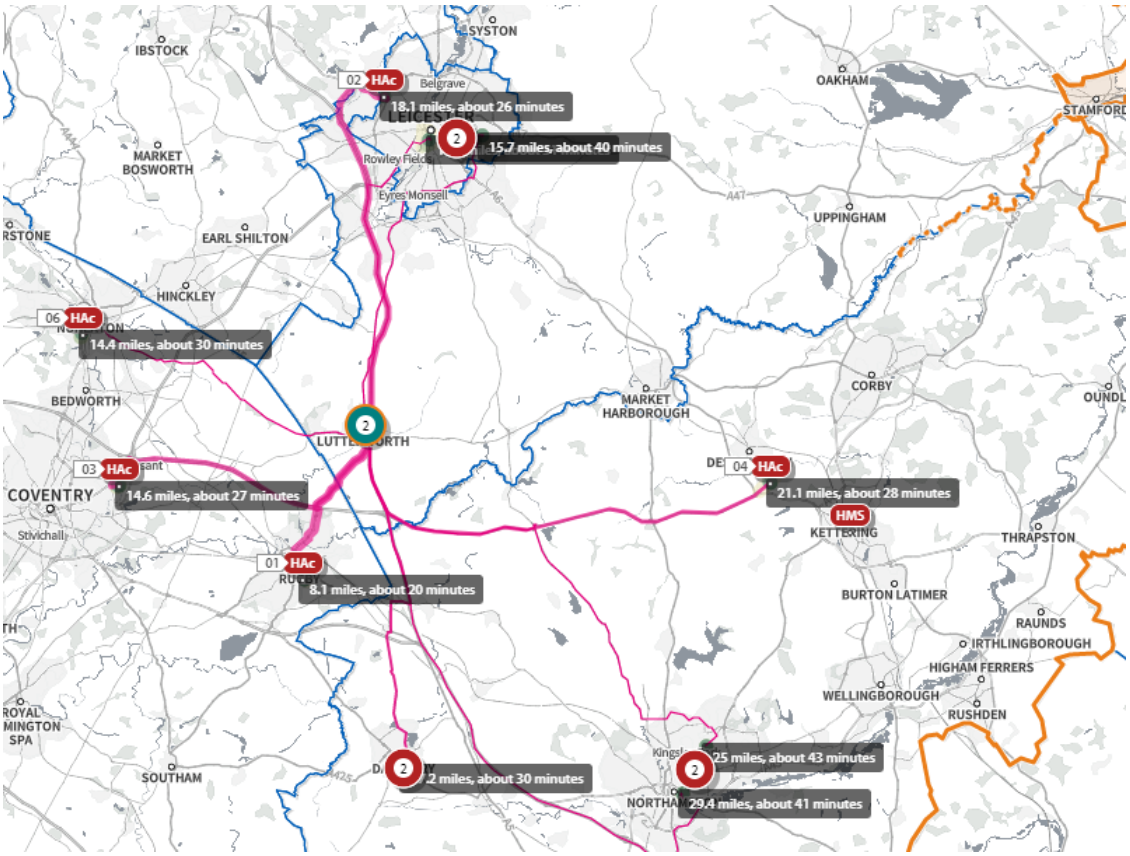
9.7 Impact on patients

9.7.1 Travel Impact Assessment

Travel times and distances

The map below shows the travel times for patients in the Lutterworth area to the main acute sites where they are currently required to travel for outpatient/daycase services.

Figure 9-2 Travel times from Lutterworth



The main acute sites where outpatient/daycase services for Lutterworth patients are:

- Leicester (LRI) – travel time 40 minutes.
- Rugby (Hospital of St Cross) – travel time 20 minutes.
- Coventry (UHC&W) – travel time 27 Minutes.

Based on the activity projections in section 5.5.1 above, the reduction in annual travel, in terms of miles and time saved, is shown in the table below. This is based on carrying out 50% of outpatient appointments for LE17 patients currently happening at alternative hospital locations being brought into Feilding Palmer.

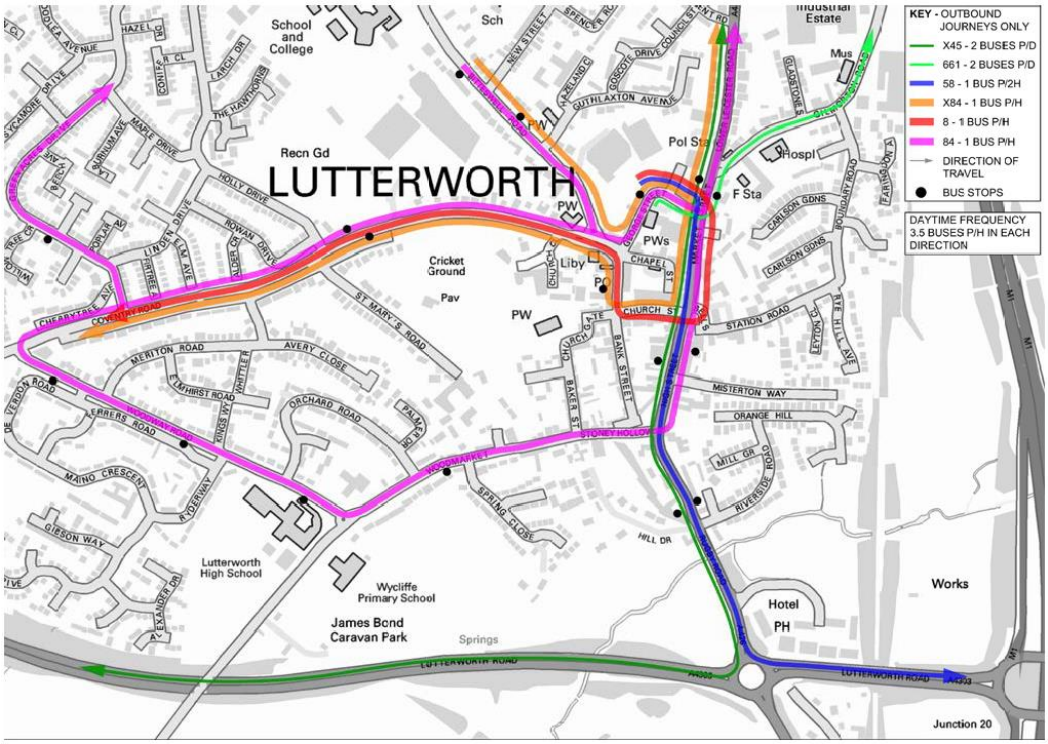
Table 9-3 Reductions in travel times and distance

Specialty	Hours	Days	Miles
Ophthalmology	1,189	50	39,291
Trauma & Orthopaedics	1,153	48	38,104
General Internal Medicine	658	27	21,620
Dermatology	613	26	20,374
General surgery	603	25	20,182
Urology	365	15	12,165
Gynaecology	334	14	11,127
Cardiology	301	13	9,957
Rheumatology	293	12	9,708
Respiratory Medicine	298	12	9,968
Total	**11,224**	**468**	**377,492**

Public transport

Lutterworth is served by 6 core bus routes with connectivity to Hinckley, Leicester, Market Harborough and Rugby. There are a maximum of 3.5 buses per hour in each direction during weekdays, but bus services are more limited during evenings and weekends. The bus routes are shown below.

Figure 9-3 Bus routes



Whilst there are buses to Leicester, they take a very circuitous route and take approximately

1 hour 20 minutes, making a return journey time of 2 hours 40 minutes. There are no direct public transport links to Glenfield Hospital, Leicester General Hospital or Walsgrave and bus services are very limited to anywhere after 7pm.

9.7.2 Equality Impact Assessment

The Equality Impact Assessment is included in **Appendix G**.

9.8 Conclusion on the impact of the proposals

The impact of the proposals in terms of staffing, premises and IT requirements for LPT and UHL are minimal. However, the greatest impacts are on patients in respect of quality of care and access to care.

10 How the proposals meet the five NHS tests

10.1 Introduction

In 2010, the Government introduced four tests of service reconfiguration. These tests are "designed to build confidence within the service, with patients and communities". The organisations involved in developing service change proposals are responsible for working together to show that the evidence in each test is convincing, and thereby to reassure themselves and their communities.

The four tests are for the proposed service changes to demonstrate evidence of:

- Strong public and patient engagement.
- Consistency with current and prospective need for patient choice.
- A clear clinical-evidence base.
- GP Commissioner support for the proposals.

Set out below is the approach to assessing the Project against each of the four tests of reconfiguration for clinical assurance, and the additional 'fifth test', introduced in March 2017 in respect of justification for bed closures.

The five tests have been applied throughout the pre-consultation phase and will continue through the consultation and post-consultation phases of this Project. The following sections describe how the ICB has engaged with a broad range of stakeholders to meet the five tests. Each section describes:

- The guidance.
- Conclusions.
- Future planned activities.

10.2 Test 1 - Strong public and patient engagement

10.2.1 Guidance

Under the NHS Act 2006 (as amended by the Health and Social Care Act 2012), CCGs and NHSE must make arrangements to ensure that people who use, or may use, services are properly involved in the following:

- Planning the provision of services.
- Developing and considering proposals for change in the way those services are provided.
- Considering the NHS organisation's decisions affecting the operation of services.

Providers of NHS-funded services have a separate but similar legal duty, under Section 242 of the NHS Act 2016, to involve service users.

Guidance in "Planning and delivering service change for patients" states that engagement activity should be proactive and should reach out to local populations, engaging them in ways that are accessible and convenient for them. The approach should take account of the differing information and communication needs of the audiences, and their differing preferences. Communities should be actively involved as partners rather than as passive recipients.

10.2.2 Conclusion

The proposals have been the subject of strong public and patient engagement in that:

- The Lutterworth Steering Group was established in June 2021.
- The Steering Group has considered the options in response to the needs of the growing Lutterworth population and the future of Feilding Palmer using evidence based discussions. The meetings are attended by:
    - LLR ICS partners.
    - Local Authority partners.
    - Lutterworth GPs.
    - Lutterworth patient representatives/campaign group.
    - Harborough District Councillors.
    - Lutterworth Town Councillors.
- The Lutterworth healthcare plan was approved at the steering group meeting in May 2022.
- Stakeholder briefings have been shared, after each Steering Group meeting, with:
    - Parish, Town and County Councillors.
    - Patient groups including:
        - Local Patient Participation Groups.
        - Voluntary Community Social Enterprise organisations.
        - MPs office.
        - Steering Group members.
        - Other key stakeholders.

10.3 Test 2 - Consistency with current and prospective need for patient choice

10.3.1 Guidance

The NHS Constitution outlines the right to informed choice on the following elements:

- The right to choose your GP practice.
- The right to express a preference for seeing a particular doctor within your GP practice.
- The right to make choices about your NHS care and to information to support these choices.
- The right to choose the organisation that provides your NHS care when you are referred for your first outpatient appointments with a service led by a consultant.

The Health and Social Care Act 2012 requires commissioners to ensure good practice and to promote and protect patient choice. Choice and competition are effective tools that a commissioner can use to improve services for patients.

In March 2013, NHSE and Monitor published a joint statement on choice and competition in commissioning clinical services in the NHS. According to the statement, it is for commissioners to decide how best to use choice and competition to improve the quality and efficiency of services, beyond the rights in the NHS Constitution. Commissioners need to make balanced judgments on a variety of factors, such as delivering care in a more integrated way, ensuring service sustainability, and determining whether there is a range of suitable providers.

10.3.2 Conclusion

The proposed changes are consistent with the need for patient choice in that:

- The proposals create more patient choice as the population will be able to access diagnostic, outpatient and community services closer to home.
- The proposals will positively impact the ability to provide equitable access to services arising from the shift in provision of services from the acute hospital to the community setting closer to home.
- The facilities will be flexible to accommodate new services if the need is identified, which will increase choice for the patient.
- The proposal will positively impact more patients than retaining inpatient beds.

10.4 Test 3 - A clear clinical evidence base

10.4.1 Guidance

The objective of this test is to ensure that the service change proposals are underpinned by a clear clinical evidence base and align with up to date clinical guidelines and best practices.

10.4.2 Conclusion

The proposed changes are underpinned by clinical evidence in that:

- Activity data has been used to assess the need and types of services to be provided in Lutterworth. This has assessed by clinicians who have confirmed which services could be provided from Feilding Palmer in the future.

- Evidence confirms that elderly patients who are supported in their home instead of hospital beds have better outcomes, and deconditioning is reduced.
- Bringing additional diagnostics to Feilding palmer would support management of patients in primary care which will reduce waiting times and unnecessary travel
- Patient flow is a key part of our end to end pathway redesign which is currently in progress in LLR.
- All changes will be measured against national guidance for procedures and specialties to ensure they are aligned to best practice (both prior to initiation and once in place).

10.5 Test 4 – GP Commissioners support for the proposals

10.5.1 Guidance

All service change needs GP Commissioner ownership, support and leadership (even if change is initiated by a provider or other organisation).

Commissioners have a duty to ensure that proposals meet certain conditions, including that they:

- Align with commissioning intentions and expenditure plans.
- Will meet the current and future healthcare needs of the patient.
- Will deliver high-quality care.
- Will install services that have long-term sustainability.

10.5.2 Conclusion

The plans for the redevelopment have been shared across the LLR system, via the Steering Group as well as within PCN specific meetings, LPT's Executive Meetings, UHLs Clinical Management Group Meetings, and the LLR System Executive Meetings which have confirmed support. The proposed changes are supported fully by:

- Lutterworth GPs.
- South Blaby and Lutterworth Primary Care Network
- LLR ICB.
- UHL.
- LPT.
- Local MP.

Letters of support have been received which confirm the following:

- The redevelopment would create a positive impact to LLR.
- The space previously occupied by the inpatient beds would allow for the expansion of community provision and support the ask of providing care closer to home.

- It would positively impact waiting times.
- It would positively impact health outcomes.
- It would provide additional capacity in the LLR system to respond to growth in population due to the Lutterworth East Housing development, creating long term sustainability.

10.6 Test 5 – bed closures

10.6.1 Guidance

In March 2017, NHSE published "Next Steps on the NHS Five Year Forward View", which introduced a 'fifth test' for proposed service reconfiguration:

From 1 April 2017, NHS organisations also have to show that proposals for significant bed closures, requiring formal public consultation, can meet one of three common sense conditions:

- That sufficient alternative provision, such as increased GP or community services, is being put in place alongside or ahead of bed closures, and that the new workforce will be there to deliver it.
- That specific new treatments or therapies, such as new anti-coagulation drugs used to treat strokes, will reduce specific categories of admissions.
- Where a hospital has been using beds less efficiently than the national average, that it has a credible plan to improve performance without affecting patient care.

10.6.2 Conclusion

The proposed changes meet the required conditions for bed closures in that:

- Community capacity is available and has been tested due to temporary bed closures since June 2020 in response to Covid-19. The alternative provision is shown below:
    - Alternative bed based care (LLR community hospital bed, or a pathway 2 reablement bed for patients with lower medical needs).
    - HomeFirst (Urgent 2 hour response, falls crisis response, virtual wards, community nursing and therapy)
    - End of Life Care (EoL): Specialist Palliative Care in the Community, Hospice at Home, Hospice inpatient unit beds, care home beds, palliative/End of Life virtual ward)
- Our multi-disciplinary teams supporting HomeFirst enable needs to be looked at holistically and directs patients to the right service in a responsive manner. We have continued to enhance our home first offer with the following being implemented in 23/24:
    - Enhancement of our overnight response service (supporting EoL)

- Further investment in our integrated specialist palliative team supporting our 2 hour/same day response
- Mobilisation of an additional 52 beds in our community hospitals, enabling us to enhance our intermediate care offer which will support reablement, rehabilitation and recovery

- There is also the opportunity to consider 'care functions', new or optimised roles, that meet population needs, to support transformed care with a focus on right time, right place, right person Right care.

10.7 Conclusion on the five NHS tests

The proposed changes meet the five NHS tests of service reconfiguration as demonstrated by the above analysis.

11 Financial implications

11.1 Introduction

This section sets out details of the estimated capital and revenue costs and cashflows to LPT associated with the proposed development of Feilding Palmer Hospital and demonstrates the extent to which the proposals are affordable within LPT's financial plan. It demonstrates how the plans are likely to be affordable in terms of both capital funding (cashflow) and ongoing sustainability (revenue). It also records the support of commissioners to the proposed investment and the resulting financial consequences.

11.2 Capital costs

This section sets out details of the indicative capital costs of the preferred option and how these will be funded. The affordability of the proposals in terms of the associated revenue implications and impact on the LPT's financial statements are set out in section 11.3.

11.2.1 Overview of capital costs

The indicative capital construction costs of the preferred option for the Project are summarised in the table below based on the DHSC OB form format.

Table 11-1 Capital construction costs of the preferred option

Cost breakdown	Total	VAT	Total (incl VAT)
	(£)	(£)	(£)
Design development and construction	2,124,000	424,800	2,548,800
Abnormals	731,000	146,200	877,200
Overheads/oncosts	30,000	6,000	36,000
Total works cost	**2,885,000**	**577,000**	**3,462,000**
Fees (16% on works costs)	461,600	92,320	553,920
Equipment (15% on works costs)	432,750	86,550	519,300
Planning contingency (10% on works costs)	288,500	57,700	346,200
Total (at 2Q2023 price base)	**4,067,850**	**813,570**	**4,881,420**
Optimism Bias (20%)	813,570	162,714	976,284
Total including Optimism Bias (at 2Q2023)	**4,881,420**	**976,284**	**5,857,704**
Inflation (5.7%)	46,373	9,275	55,648
Total (at 2Q2025)	**4,927,793**	**985,559**	**5,913,352**
VAT reclaim			-92,320
Total outturn cost			**5,821,032**

Underlying assumptions

The above cost estimates are based on the following assumptions:

- Works costs are at current prices i.e. 2Q2023.
- Abnormals relate to allowances to reflect potential additional structural/extension works and additional M&E works outside the footprint of the building.
- Overheads and oncosts relate to planning fees, building regulation fees and site investigations/surveys.
- Fees allowance 16% of works costs.
- Equipment allowance 15% of works costs.
- Planning contingency is included at 10% of works costs.
- Optimism Bias of 20% has been included to reflect the early stage of development of the proposals.
- Inflation to midpoint of construction, 2Q2025 (based on PUBSEC indices) assumed at 5.7%.
- VAT will be recoverable on professional fees only in accordance with usual NHS practice.

11.2.2 Capital funding

The estimated capital costs of £5.8m will be funded from ICS capital allocation and not from LPT's specific allocation.

11.2.3 Potential procurement route for capital developments

For the procurement for this scheme LPT will utilise its established Procure 22 (P22) delivery framework. The initial high level draft design developed from the PCBC enabled the preparation of the high level cost estimates. This work will be refined and developed for a Short Form Business Case submission with support from the LPT's P22 Principal Supply Chain Partner (PSCP) and Cost Advisor.

P22 is a construction procurement framework administrated by the DHSC for the rapid development and delivery of NHS and Social Care major capital schemes in England. It is structured contractually to support Trusts through the individual business case stages and final construction stage. It is consistent with the requirements of Government Policy including:

- The Productivity and Efficiency agenda.
- MMC.
- Government Construction Strategy.

- Public Contracts Regulations 2015.
- National Audit Office guidance on use of centralised frameworks.
- Cabinet Office Common Minimum Standards for procurement of the Built Environment in the Public Sector.

P22 represents the third iteration of the DH Framework providing Design and Construction Services for use by the NHS and Social Care organisations for a range of works and services. P22 continues to build on the principles of its predecessors to streamline the procurement process and create an environment in which clients, PSCPs and their supply chains develop stronger partnerships through extended relationships to drive increased efficiency and productivity whilst supporting enhanced clinical outputs for patients and improved environments for staff and visitors. The next iteration of the framework (P23) is available but not yet adopted by LPT.

The existing appointment of the P22 PSCP gives LPT the flexibility to draw on their resources as and when required to assist in working up business cases and to undertake any enabling works and surveys required to assist in this process. To date the framework has successfully delivered the LPTs Beacon Unit, Dormitory Eradication programme and minor block capital programme.

11.2.4 Demonstrating Value For Money from procurement

In conjunction with the LPT's P22 PSCP, Tilbury Douglas, the Short Form Business Case preferred option will be developed to a FBC level, producing a Guaranteed Maximum Price (GMP) offer.

This GMP will be derived from a market testing exercise carried out by Tilbury Douglas. This informed by site survey work, Client briefing workshops and support from the Trusts P22 PSCP design team and LPT's appointed Cost Advisor. The detailed design packages are tendered (market tested) by the PSCP to generate the GMP. This is an open book process with predetermined overhead and profit margins already agreed within the DHSC framework for the PSCP. The process is audited by LPT's appointed Cost Advisor.

11.3 Revenue implications

11.3.1 Introduction

The section demonstrates the affordability of the proposals in terms of the associated revenue implications of the capital costs and funding and the impact on LPT's financial position as shown in the Statement of Comprehensive Income (SoCI). It sets out the Business As Usual (BAU) scenario, the incremental impact of the investment on LPT's SoCI and the whole Trust position including the impact of the investment.

11.3.2 Business As Usual (BAU) scenario

The LPT BAU scenario (without the impact of the proposed investment) is shown in the table

below.

Table 11-2 BAU scenario

STATEMENT OF COMPREHENSIVE NET INCOME					
Whole Trust Business As Usual scenario					
	2024/25 £'000	**2025/26 £'000**	**2026/27 £'000**	**2027/28 - 2035/36 £'000**	**Total £'000**
Operating income from patient care activities	347,501	350,628	353,784	3,347,577	4,399,490
Other operating income	44,178	44,576	44,977	425,584	559,315
(Employee expenses)	(315,907)	(315,827)	(318,985)	(3,018,308)	(3,969,027)
(Operating expenses excluding employee expenses)	(76,606)	(76,511)	(77,179)	(739,220)	(969,516)
Less Cash Releasing Benefits	7,860	4,071	4,106	38,755	54,793
Operating surplus / (deficit)	**7,026**	**6,937**	**6,703**	**54,388**	**75,055**
Finance Income	360	360	360	3,240	4,320
(Finance Expense)	(1,488)	(1,488)	(1,488)	(13,392)	(17,856)
(PDC Dividends Payable)	(5,913)	(5,913)	(5,913)	(53,217)	(70,956)
Investment Revenue	0	0	0	0	0
Other Gains / (Losses) (including disposal of assets)	0	0	0	0	0
Gains / (Losses) on transfers by absorption	0	0	0	0	0
Retained surplus / (deficit)	**(15)**	**(104)**	**(338)**	**(8,981)**	**(9,437)**
Adjustments (including PPA, IFRIC 12 adjustment)	0	0	0	0	0
Adjusted financial performance retained surplus / (deficit)	**(15)**	**(104)**	**(338)**	**(8,981)**	**(9,437)**

Assumptions

The main assumptions underpinning the above are as follows:

- The baseline position has been derived using the latest 2023/24 planning submission figures, then forecasting forward for 2024/25 and future years based on inflation rates and adjusting for any non-recurrent items in the baseline.
    - Assumed £3.7m non-recurrent to give a normalised £3.7m underlying deficit in 2024/25 (assumed £9.265m non-recurrent income will continue to be funded).
- No growth assumed.
- Depreciation assumed to continue at 2023/24 baseline level.
- Underlying deficit mitigated by recurrent CIP in 2023/24 of 2.15% (1.05% above the national efficiency requirement of 1.1%).
- Inflation rates have been applied using the 2023/24 tariff guidance as a starting point then adjusting for local factors.

The inflation assumptions are set out in the table below.

Table 11-3 Inflation assumptions

Inflation assumptions	23/24	24/25	25/26	26/27	27/28	28/29	29/30	30/31	31/32	32/33	33/34	34/35	35/36	36/37
Tariff Income	1.80%	1.00%	0.90%	0.90%	1.00%	1.00%	1.00%	1.00%	1.00%	1.00%	1.00%	1.00%	1.00%	1.00%
Other Income	0.00%	1.00%	0.90%	0.90%	1.00%	1.00%	1.00%	1.00%	1.00%	1.00%	1.00%	1.00%	1.00%	1.00%
High Cost Drugs	1.30%	1.30%	1.30%	1.30%	1.30%	1.30%	1.30%	1.30%	1.30%	1.30%	1.30%	1.30%	1.30%	1.30%
Pay	2.10%	2.10%	2.10%	2.10%	2.10%	2.10%	2.10%	2.10%	2.10%	2.10%	2.10%	2.10%	2.10%	2.10%
Other Drugs	1.30%	1.30%	1.30%	1.30%	1.30%	1.30%	1.30%	1.30%	1.30%	1.30%	1.30%	1.30%	1.30%	1.30%
CNST	1.50%	1.50%	1.50%	1.50%	1.50%	1.50%	1.50%	1.50%	1.50%	1.50%	1.50%	1.50%	1.50%	1.50%
PFI	8.90%	3.40%	1.60%	1.60%	1.60%	1.60%	1.60%	1.60%	1.60%	1.60%	1.60%	1.60%	1.60%	1.60%
Other Non Pay	5.50%	1.57%	0.96%	1.20%	1.65%	1.65%	1.65%	1.65%	1.65%	1.65%	1.65%	1.65%	1.65%	1.65%
Capital	4.00%	4.00%	4.00%	4.00%	4.00%	4.00%	4.00%	4.00%	4.00%	4.00%	4.00%	4.00%	4.00%	4.00%
Efficiencies	1.10%	2.15%	1.10%	1.10%	1.10%	1.10%	1.10%	1.10%	1.10%	1.10%	1.10%	1.10%	1.10%	1.10%

11.3.3 Incremental impact of the investment

The incremental impact of the investment on LPT's SoCI is shown in the table below.

Table 11-4 Incremental impact on SoCI

STATEMENT OF COMPREHENSIVE NET INCOME					
Incremental impact of scheme on the I&E of lead organisation					
	2024/25	**2025/26**	**2026/27**	**2027/28 - 2035/36**	**Total**
	£'000	**£'000**	**£'000**	**£'000**	**£'000**
Operating income from patient care activities	0	0	0	0	0
Other operating income	0	124	500	4,729	5,352
(Employee expenses)	0	(10)	(39)	(394)	(443)
(Operating expenses excluding employee expenses)	0	(76)	(305)	(2,634)	(3,015)
Less Cash Releasing Benefits	0	0	0	0	0
Operating surplus / (deficit)	**0**	**38**	**155**	**1,701**	**1,894**
Finance Income	0	0	0	0	0
(Finance Expense)	0	0	0	0	0
(PDC Dividends Payable)	(25)	(101)	(147)	(997)	(1,270)
Investment Revenue	0	0	0	0	0
Other Gains / (Losses) (including disposal of assets)	0	(1,455)	0	0	(1,455)
Gains / (Losses) on transfers by absorption	0	0	0	0	0
Retained surplus / (deficit)	**(25)**	**(1,518)**	**8**	**704**	**(831)**
Adjustments (including PPA, IFRIC 12 adjustment)	0	1,455	0	0	1,455
Adjusted financial performance retained surplus / (deficit)	**(25)**	**(63)**	**8**	**704**	**624**

Assumptions

The main assumptions underpinning the above are as follows:

- Capital expenditure is assumed at £5.8m as per the OB forms.
- Depreciation is calculated based on an estimated useful life of the buildings of 25 years and equipment of 7 years.
- Impairment on the capital value of the newly refurbished asset is assumed at 25%.
- Dividends payable on PDC are calculated at 3.5%.
- Incremental/additional costs and income have been assumed as follows:
    - Staffing costs (cleaners, porters and reception/admin) - £37k per annum (at current prices).
    - Non staff costs - £53k per annum (at current prices).
    - Maintenance costs - £34k per annum (at current prices).
    - Revenue cost £486k per annum (at current prices) funded by the LLR system (including depreciation and PDC).

11.3.4 Whole Trust position

The whole Trust SoCI including the impact of the investment is shown in the table below.

Table 11-5 Statement Of Comprehensive Income including the impact of the investment

STATEMENT OF COMPREHENSIVE NET INCOME					
Whole Trust Position including the Investment over the Appraisal Period					
	2024/25 **£'000**	**2025/26** **£'000**	**2026/27** **£'000**	**2027/28 - 2035/36** **£'000**	**Total** **£'000**
Operating income from patient care activities	347,501	350,628	353,784	3,347,577	4,399,490
Other operating income	44,178	44,700	45,477	430,312	564,668
(Employee expenses)	(315,907)	(315,837)	(319,025)	(3,018,702)	(3,969,470)
(Operating expenses excluding employee expenses)	(76,606)	(76,587)	(77,484)	(741,854)	(972,531)
Less Cash Releasing Benefits	7,860	4,071	4,106	38,755	54,793
Operating surplus / (deficit)	**7,026**	**6,976**	**6,858**	**56,089**	**76,950**
Finance Income	360	360	360	3,240	4,320
(Finance Expense)	(1,488)	(1,488)	(1,488)	(13,392)	(17,856)
(PDC Dividends Payable)	(5,938)	(6,014)	(6,060)	(54,214)	(72,226)
Investment Revenue	0	0	0	0	0
Other Gains / (Losses) (including disposal of assets)	0	(1,455)	0	0	(1,455)
Gains / (Losses) on transfers by absorption	0	0	0	0	0
Retained surplus / (deficit)	**(40)**	**(1,622)**	**(330)**	**(8,277)**	**(10,268)**
Adjustments (including PPA, IFRIC 12 adjustment)	0	1,455	0	0	1,455
Adjusted financial performance retained surplus / (deficit)	**(40)**	**(166)**	**(330)**	**(8,277)**	**(8,813)**

11.3.5 Affordability of the investment and Commissioner support

The revenue implications of the proposed investment are affordable to LPT on the basis that the incremental costs of circa £500k per annum (in the first full year of operations which is 2026/27) are funded by rental charges from UHL of a corresponding amount.

The proposals have commissioner support and will be approved by the ICB board in September.

11.4 Conclusion on financial implications

The proposed development at Feilding Palmer Hospital will be funded by LLR ICS capital of £5.8m. The incremental revenue cost to LPT of circa £0.5m will be funded the system and included in their medium term financial plan.

12 Delivering the proposals

12.1 Introduction

This section addresses how the consultation and the proposals will be delivered. It demonstrates that Commissioners and LPT have the appropriate plans in place and the capacity and capability to deliver the proposals and to realise the benefits and ***maximise access to services for the local community.***

12.2 Public engagement

12.2.1 Background and the legal framework

The law requires NHS bodies to engage with members of the public before making decisions on changes to health services. Currently, separate sections of the NHS Act apply to CCGs and to other organisations.

CCGs are governed by Section 14Z2 of the NHS Act 2006, which states:

(1) This section applies in relation to any health services which are, or are to be, provided pursuant to arrangements made by a clinical commissioning group in the exercise of its functions ("commissioning arrangements").

(2) The clinical commissioning group must make arrangements to secure that individuals to whom the services are being or may be provided are involved (whether by being consulted or provided with information or in other ways):

(a) In the planning of the commissioning arrangements by the group.

(b) In the development and consideration of proposals by the group for changes in the commissioning arrangements where the implementation of the proposals would have an impact on the manner in which the services are delivered to the individuals or the range of health services available to them.

(c) In decisions of the group affecting the operation of the commissioning arrangements where the implementation of the decisions would (if made) have such an impact.

There are two other relevant aspects to Section 14Z2. Subsection 3 requires all CCGs to include in their constitution a description of their public engagement arrangements and a statement of the principles that they will follow in when implementing them. Subsection 4 empowers NHSE to publish guidance on compliance with this section, which CCGs must have regard to. This was published in September 2013 – see below for more details.

Section 13Q of the Act applies to NHSE and contains effectively identical provisions to Section 14Z2. Section 242 of the Act contains the same obligations for NHS Trusts and Foundation Trusts. Any NHS body considering changing the services it commissions or provides must be aware of the obligations discussed in this note.

In summary, any significant commissioning decision or reconfiguration is caught by these statutory requirements. The statute does not insist on "consultation", but seeks to make sure that service users are "involved". In practice, for any significant proposed change to services, some form of consultation exercise will be required to comply with this duty.

12.2.2 Proposed engagement

The approach to the consultation is explained below and the draft consultation document is included in **Appendix G.**

12.2.3 Aims and objectives of consultation

The aim of the consultation exercise is:

- To inform people about how the proposals have been developed.
- To describe and explain the proposals for improving community health services in Lutterworth.
- To engage with people currently using services and their carers to understand their lived experience what the proposals will mean to them.
- To seek people's views and understand the impact of the proposals on them.
- To ensure that a wide range of voices are heard which reflect the socio-demographics of the area, particularly the most vulnerable and those with protected characteristics.
- To give people the opportunity to sign up for further co-design services post-consultation.
- To understand the responses made in reply to our proposals and take them into account in decision making.
- To respond to the feedback received.
- To ensure that the consultation process maximises community engagement and complies with our legal requirements and duties.

12.2.4 The role of consultation in the review process

Public consultation is essential in the development of NHS services. It provides people with an opportunity to be involved and shape proposals for change and improvement and to comment on those proposals before any final decisions are made. This includes those who use services, their carers and advocates; the voluntary, community and social enterprise sector, local government; community leaders and stakeholders, NHS partners and NHS staff.

Public consultation is one of a number of methods used by the NHS to develop better care and better services.

12.2.5 Public Consultation with patients, carers and public

Introduction

The length of time recommended for a consultation in determined by a number of factors. The length of a public consultation should be proportionate and realistic to allow people sufficient time to provide a considered response to proposals. For a programme of work that has some potentially contentious proposals to change the Model of Care for inpatient services, although also improving and increasing the provision of diagnostic and other community services within a local community hospital, 12 weeks is appropriate to allow the impact of the proposals to be understood.

The timetable leading to the start of consultation takes on the learning of other consultations locally and nationally. It outlines the minimum number of weeks necessary to prepare for a consultation.

It is clear that public bodies need to exercise their functions for the benefit of those they serve and that the NHS needs to adopt a multi-channel approach to ensure that people have the opportunity to participate in the conversation if they wish. The mechanisms that will be put in place for the public consultation are proven in a range of recent consultations and will allow engagement with a more diverse range of people. Technology that a high proportion of people use on a day-to-day basis will be used to reach a wide range of people. This will be balanced with a range of offline communications using traditional media. The ICB will work in partnership with Leicestershire Partnership NHS Trust and University Hospitals of Leicester to involve patients across all services. The ICB will also work with the local community, through the Task and Finish Group, and with a range of voluntary and community sector organisations who will support the ICB to reach people with protected characteristics.

These routes to involve and consult the public allow the ICB to operate effectively, efficiently and economically. The outcomes from the consultation will allow the ICB to make decisions which will have a positive impact on patient and public outcomes and accessibility to an improved range of services. Equally as important, the ICB need to publicly consult on proposals in a safe, inclusive and responsible manner, so the ICB can understand and improve the health services received by communities.

The ICB has also developed a Consultation Document that describes simply and specifically the proposals for improvement. The document includes questions that ask people their views of the proposals and request that they share what the impact of the change is on them, their family and/or carer. It also asks them to identify things that they feel we haven't considered and should.

Stakeholder Analysis and Segmentation

To make sure that the consultation effectively captures views and feedback from the local population, two approaches have been taken to stakeholder analysis and segmentation. The first, codesigned with the Task and Finish Group, identifies the target audiences that

need to be consulted with and prioritises and ranks them. This will be used as a basis on which to consult based on their involvement, the impact on them or their interest.

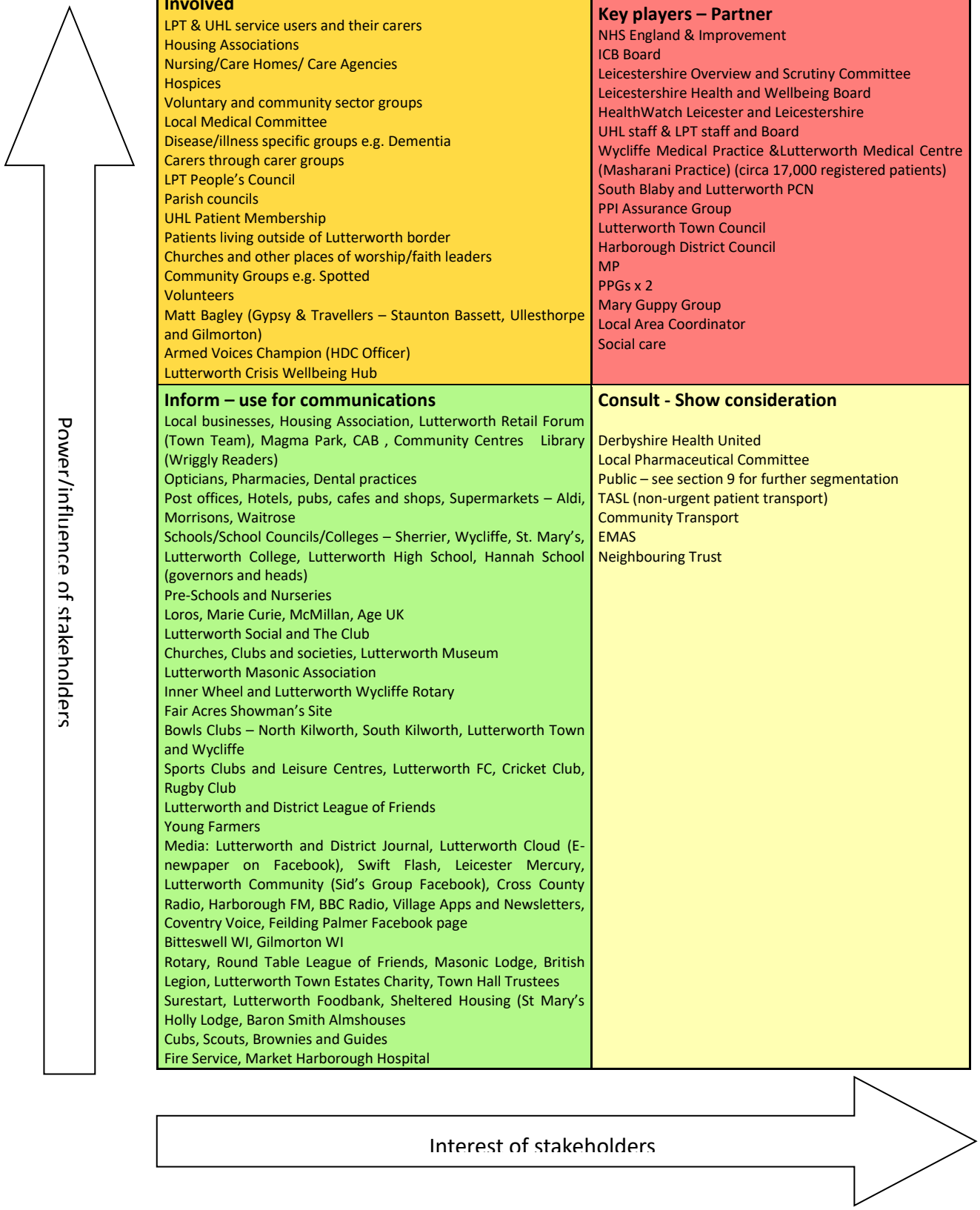
They will all be contacted and their views sought during the consultation period. In addition, all organisations and groups will be asked to act as conduits and to actively help the ICB to promote the consultation (via their communication channels) to any relevant stakeholders in addition to those sitting on the Task and Finish Group.

Demographic information will also support the ICB to plan the consultation work and target communities. It will also allow the ICB, post consultation to, identify whether a statistically representative number of the population have been consulted.

In addition, the ICB will also allocate grant funding to some key voluntary and community organisations to help with more in depth engagement with their communities using a variety of communication methods. This approach will support the ICB to engage with vulnerable communities and those representing people with protected characteristics particularly where communications support is required e.g. deaf community.

The figure below shows the high level segmentation of the target audiences, completed by the Task and Finish Group. Communities have also been analysed on the basis of how it may be possible to reach them. There may be a wide range of reasons why people don't want to take part in the consultation. The challenge is to think about these groups and how their involvement might be triggered. Table 12-1 looks at these communities and methods for engagement which are not mutually exclusive.

Figure 12-1 Target audiences



12.2.7 Key messages

Overarching messages will be used through the duration of the consultation process which convey the ICB's vision, values and commitment. In addition, specific messages in relation to the proposals for will be developed and conveyed in relation to:

- About this consultation – the context and case for change:
  - The need to make it easier for people to access the right support with a 'no wrong door' policy in place, adding value with every contact.
  - Increase planned care in the local community (planned care is the name given to health services and treatments that aren't due to an accident or emergency, but necessary following a referral from a GP or other health professional).
  - Improve waiting times and access for diagnostics, planned care and treatment.
  - A new way of providing community bed-based care including palliative care.
  - Provide more care close to home.
  - Deliver care and treatment in line with best practice and improve the experience of care ensuring that people report positive outcomes and experiences.
  - Ensure that staff delivering care and treatment report positive experiences.
  - Address clinical challenges.
  - Set in context of system improvements.
  - The importance of people having their say on the proposals.
- The consultation mandate:
  - Describes the purpose of the consultation.
  - What the ICB wishes to achieve through consultation.
  - The specific areas we are seeking to understand what the impact of proposals will be.
  - How the ICB will respond to inform their decision and respond to the feedback received.
- The proposal(s):
  - Description of the proposal.
  - Benefits of proposals.
  - Within the proposal highlight the need to understand the impact on service users, patients, carers, staff and public.
  - Set out clearly what can be influenced, what can't.
  - Set out clearly the independencies with other transformation projects.

- Include all changes needed to implement the proposals.
- Set out Funding/financial implications.

- How the proposals were developed:
  - Ongoing engagement and involvement.
  - How the engagement and involvement has influenced the proposals.
  - Show how the proposal meets financial, clinical objectives.
  - Explain what community services in Lutterworth will look like in the future.

- Details of the ways that people can get involved in the consultation:
  - Events.
  - Outreach.
  - Online.
  - Offline.

The ICB will endeavour to recognise the motivation of each of its communities and tailor the approaches to what matters most to them. The ICB will also acknowledge that some people will need to be persuaded to participate which will involve using interesting and creative ways to make the consultation relevant to them.

12.2.8 Testing views

A number of questions will be asked through the consultation providing the public with the opportunity to provide views about the proposals. A full equality monitoring form will also be included, to enable the ICB to understand who has participated in the consultation and assess gaps. Postcode data will also be collected.

The questions will also be tested in advance with the Task and Finish Group for Lutterworth and the ICB Public and Patient Involvement Assurance Group, which is the system wide group established as part of the governance that assures the plans, outcomes and outputs. It comprises of patients and service users, independently recruited from across LLR.

In addition, prior to the launch of the consultation the ICB will engage with LPT's People's Council (which is an independent advisory group) and UHL's membership. The groups comprise of patients and carers with lived experiences of services.

12.2.9 Consultation document and materials

A consultation briefing document will be developed which will convey the key messages outlined above.

The ICB will ensure that the main consultation document is relevant to people who currently use and are likely to use services in Lutterworth in the future.

The document will be discussed with Healthwatch Leicester and Leicestershire, the Public

and Patient Involvement Assurance Group and the LPT People's Council and UHL's membership. The document will explain why change is needed, what the proposals are and what benefits they will bring for people, as well as how the proposals, if agreed, might be implemented.

It will also clearly explains how people can participate, feedback comments and asks for further information by post, email, social media, website and telephone.

The ICB will produce an online and a hard copy questionnaire (including an equalities monitoring form) including an easy read version.

People involved in the engagement will be from a variety of backgrounds, therefore there will be a need to ensure that the consultation document is made available in different formats e.g. easy read. With the ability to produce in BSL on request. It will also be provided online in a Word format at 20 point font to ensure that people experiencing sight difficulty can read the document. The ICB will also explore the translation of the document into other languages spoken locally working in partnership with other organisations. A summary document will also be produced to provide people with a quick overview of the proposals which will be circulated to key outlets e.g. libraries and community venues.

All information produced as part of the consultation will be written in a language that can be easily understood. Technical phrases and acronyms will be avoided, and information will be produced in other formats as required to reflect population needs.

All the consultation documents will be available on a dedicated section on the ICB website and linked from all partner websites. The sites will be promoted via all media including social media channels such as Facebook, Twitter, Linked In, Instagram and YouTube.

Posters and flyers will also be produced for distribution, along with displays and stands for use in public places. A video in plain English with subtitles will also be produced to explain the proposals in an audio format, and support understanding, especially for those with low levels of literacy. These can be easily shared on Whatsapp and social media channels and sent out via community groups and networks. This will also be supported by a proactive media campaign to drive traffic to find out more, using key NHS figure heads and community leaders.

A telephone interview service will be offered, recommended by the Consultation Institute, to support those who may need it to ensure that they are able to understand the information contained within the documents and to ensure that all participants in the consultation have enough information and are able to give informed feedback in a telephone call. If translation is required then this can be arranged.

12.2.10 Planned activities

Learning from the last three years has shown how technology can be used to involve and engage the public on a range of issues. The use of technology to hold meetings, share information and, recordings of meetings, and enable a wider reach across communities has

provided additional methods and opportunities to consult or provide information to individuals to whom the services are being or may be provided. This is in addition to offline communications and engagement activities essential for a meaningful consultation that reaches people who may not be digitally enabled or active or those that simply aren't comfortable with technology.

In order to support people who may not be digitally enabled to take part in meetings there will be the functionality for people to dial in via telephone should they so wish. This is essential from an accessibility perspective.

A web platform will be set up to contain information and full details of the consultation including the PCBC and supporting document (clinical, financial). In addition, arrangements will be made to enable people to feed back their views. This will include an online option via secure software as well as telephone and postal options. Information will be provided in different formats and in appropriate languages.

A multi-faceted approach to communications and engagement will be implemented using market segmentation that enables the ICB to understand, in advance of consultation, what a representative response to the consultation would look like. Using this data, a variety of both online and offline tools and techniques to communicate with the people of LLR have been developed.

Outlined below is a summary of the planned activities to be used. The process will be monitored and evaluated consistently to ensure that all activities are meeting the requirements of a robust consultation. A mid consultation review wil be carried out to assess whether all communities are being reached. If gaps are found the plan will be adjusted to ensure that feedback is being invited from all communities.

Table 12-1 outlines a further stakeholder analysis including specific communities and methods to reach them.

Existing mechanism

There are a number of mechanisms that ICB partners already have in place which help to provide information and communicate with a range of stakeholders. These mechanisms will be utilised during the consultation process:

- MP through face-to-face (video) and written briefings.
- LPT staff – through a number of methods including briefings, newsletters, presentations at Heads of Meetings etc.
- Local councillors updated through discussions at scrutiny and Health and Wellbeing Boards and through briefings at committee meetings.
- Monthly System Engagement meetings with Healthwatch, providers, Public and Patient Involvement Group Chair and ICB.
- Voluntary, Community and Social Enterprise Alliance via online platform, newsletter and quarter meetings.

- Local media including TV, radio and newspapers.
- Patient groups and members including LPT service users and UHL service users.
- Online Citizens' Panel.
- ICB Five on Friday (online newsletter).
- LLR Connect (ICB staff newsletter).
- LPT and UHL Membership.
- LPT People's Council.
- LPT Youth Advisory Board.
- Twitter, Facebook, Instagram, LinkedIN and Youtube.
- LPT and UHL stakeholder newsletters.
- LPTs Patient Experience and Involvement Newsletter (monthly).
- LPT and UHL staff Facebook group.
- LPT staff support group networks.
- LPT and UHL website and associated websites (healthforkids.co.uk, healthforteens.co.uk, healthforunder5s.co.uk).

Working with voluntary and community sector

Under the Equality Act 2010, the ICB has a duty to consider potential impacts of service change on people with protected characteristics. In order to help understand these potential impacts in detail, the ICB will directly commission a number voluntary and community organisations to reach out to seldom heard and often overlooked communities to encourage and support them to participate (with a focus vulnerable, carers and protected characteristics of age, race, disability, pregnancy/maternity, sexual orientation). The identification of these organisations will be driven by the findings of the Equality Impact Assessment and market segmentation. This approach has been used in a previous consultation and supported the involvement of a true representation of the populations.

A toolkit of collateral will be produced to support the voluntary and community sector, who undertake outreach and events at a hyperlocal level within communities including Food Banks and community centres.

The ICB will also work with our full database of voluntary and community organisations, who whilst not commissioned to host events and undertake outreach, will articulate messages to the relevant communities that services in Lutterworth serve.

Work with patients

The two Lutterworth practices (The Masharani Practice and Wycliffe Medical Practice) serve circa 17,000 registered patients. They are part of South Blaby and Lutterworth Primary Care Network comprising of 5 practices (also including Countesthorpe Health Centre, Hazelmere Medical Centre and Northfield Medical Centre). In addition, Market Harborough

and Bosworth PCN and Cross Counties PCN along PCNs in East of the Coventry and Warwickshire ICB area will be patients within an interest in proposals in Lutterworth. These patients have valuable insights and experiences of current services. The ICB will work with the practices and their Patient Participation Groups to reach their patients to promote the consultation in order to understand how change will impact them and their family carers.

Deliberative events

Over the last three years, there has been a decline in the attendance at deliberative online and face to face events. People prefer the localised face to face outreach and the use of digital.

What the ICB has found beneficial is the coordination, at the onset of the consultation, online briefings with key stakeholder groups e.g. voluntary and community sector stakeholders and parish councils. They are able to share their views and provide an understanding of the impact of proposals on them and the people they may represent, at an early stage. They are also able to amplify the consultation to wider audiences.

During the consultation two drop in events will be coordinated in different parts of Lutterworth. The drop in sessions will be over an afternoon and evening to allow for people who both work or don't work to attend. The days of the week will be varied. NHS staff will be on hand to discuss the proposals individually or as a small group. There will also be the facility for people to fill in the survey on and offline.

Digital methods of engagement increase greatly the number of people we can engage. To ensure people who work and those that don't are catered for, three online events will be held at differing times, both daytime, evening and weekends throughout the consultation.

All feedback from the events will be captured and the key themes and points of any discussions recorded along with the attendance in terms of equality and diversity requirements. These records will form part of the evidence to inform the final decision making process. The ICB will also capture any questions and draw up a question and answer section on the ICB's websites, so that answers can be viewed by everyone.

Displays and posters

Displays will be situated in prominent areas where there is a high footfall to engage with the public providing leaflets, a poster or pop up banners and signpost them to further information. This includes sites such as libraries, supermarkets, community centres, pub, cafes etc.

Briefings

Online briefings will be held with key stakeholders, including Healthwatch Leicester and Leicestershire, the Public and Patient Involvement Assurance Group (PPIAG), local authorities (previously mentioned) and any other key interest groups. These briefings will be held early on in the consultation period to enable these stakeholders to cascade information to their membership and contacts and support engagement.

Networks and contacts

We will work with the network of contacts identified in the Stakeholder Analysis empowering them to publicise the consultation and signpost people to our website and response form. We will also share with them a toolkit, containing articles, social media posting and web copy to support their communications.

Communications activities

Awareness of the consultation, associated engagement activities and call to action will be raised through a range of communication channels including media, social media, websites, consultation newsletter, stakeholder communications channels and by distributing a range of communications materials.

The ICB will work with the local media identified in the stakeholder analysis. Key clinical and non clinical spokespeople will be identified, trained enabling them to be called upon to undertaken TV, radio and newspaper interviews. They will also need to lead and answer questions at online events. Sufficient time will need to be allocated by these representatives in order to run a successful, but intensive consultation.

Digital

A variety of digital techniques will be used to raise awareness of the consultation including:

- Search engine optimisation to ensure the website is visible to existing and new content.
- Broadcast media including radio and TV.
- Remarketing campaign.
- SMS text messaging.
- Placement of content on local community websites covering areas, towns and villages e.g. Spotted.
- Email marketing using ICB, LPT and UHL email lists and sharing of key messages with residents by local authority via their own email lists.
- E-Briefing and/or letter to the MP and councillors (district, town and parish) providing information about the proposals, the consultation, and asking for any support in dissemination within their community.
- Email marketing to voluntary and community sector groups, schools and key business across in Leicester, Leicestershire and Rutland.

Advertising

Only where appropriate and not possible through public relations, the ICB will use offline advertising to reach key areas of the community including niche groups. Advertorials across local newspapers, community magazines and newsletters

Staff engagement

There will be staff briefings and written communications will be shared with staff UHL, DHU, EMAS, LPT and local authorities. There will also be online and off line events for staff directly impacted to understand their views and what matters most just prior to consultation. Given the fact that the inpatient beds have been closed for the last 3 years there is minimal impact on staff currently working at the facility.

12.2.11 Reaching different communities

In addition to the main stakeholder analysis, the target communities have been further segmented and outlined below are methods of engaging them. It also considers the format of information e.g. different languages, braille, video, Online BrowseAloud and Easy Read.

Table 12-1 Engaging with different communities

Who	Methods of engagement
People who live in rural communities	Local display in village stores and other local businesses Libraries Young Farmers Through parish councils Social media e.g. Spotted and Neighbourhood Facebook pages Church and community newsletters, magazines
People who live in urban communities	Local display in library, supermarkets and other business indicated in stakeholder analysis Social media pertinent to communities social connections, Whatapp Voluntary and community groups indicated in stakeholder analysis
Homeless	Work with voluntary bodies, LPT and local authorities – district, town and parishes
Areas of deprivation	Local support workers – e.g. Local Area Coordinator Through - district, town and parishes Social media Community leaders Voluntary and community organisations
Housebound	Work with district nurses, health visitors, volunteers to raise awareness
Younger people	Use of online social networks Schools and colleges indicated on stakeholder analysis Voluntary and community organisations Young peoples' forums including the LPT's Youth Advisory Board, Young Farmers, Cubs, Scouts etc. Healthforteens.co.uk – an LPT specific website for young people and @Healthforteens twitter and Instagram account associated to this

Who	Methods of engagement
Older people	Voluntary sector groups e.g. Age UK Older peoples' forum and similar groups Social care via Homefirst LPT Carer Forums LPT Older Children Forum
Long distance commuters and people living over the LLR boundary	Ensure good online methods are in place via email, website, e-newsletters, online fora, social networks Engage with media over the borders Ensure timing of some events in evening
People with an agenda/campaign groups	Develop the relationships already established through engagement and coordinate online discuss at their community meetings
People without transport	Ensure good online methods are in place via email, website, e-newsletters, online fora, social networks
People who work	Ensure good online methods are in place via email, website, e-newsletters, online fora, social networks Ensure timing of some events are in evening Engage local businesses/employers e.g. Magna Park
People who don't work	Continue to use social groups and networks online and offline e.g. WI, SureStart, Mumsnet, Job Centre and Benefits providers
People with learning disabilities	Through schools and voluntary sector Learning Disability Partnership Boards Ensure Easy Read capability on main website and use of video and illustrations Use of LPT's Learning Disabilities services – direct easy read mail and the Talk and Listen Group and other LPT run groups.
People with physical disability or with a sensory impairment	Through voluntary sector (grant support)and NHS provider organisations Local community groups e
People with long term mental health problems	Through voluntary sector and NHS providers. Existing LPT service users across mental health services LPT's recovery college and recovery networks IAPT networks Veterans Support Groups
People who are pregnant, have babies and young children or have used neonatal services	Maternity and Neonatal Voices Partnership Women and Toddler groups Surestart LPT's perinatal mental health service Social media e.g. Mumsnet Healthforunder5s.co.uk – LPT's website for new mums in LLR Health visiting and midwifery services Breastfeeding peer supporters

Who	Methods of engagement
Lesbian, Gay, Bisexual and Transgender	Through Leicestershire LGBT
Migrant workers and refugees	Through employers – displays and collateral Through voluntary organisations
BAME	Through voluntary and community sector
Adult carers	Through carer groups and organisations including the local authority through their carers passport scheme and LPT Carer Forums, Carers Association, VASL etc.
Child carers	Through carer groups and organisations LPT Young Carer Forums
Travelling communities	Through local authorities and GP practices with registered patients
Walking well	Through local organisations and business e.g. local authority and large businesses. Fair Acres Showman's Site Social media
Staff	Utilising existing newsletters, staff forums, team and staff briefings Engage with Head of Service providing materials to enable them to deliver regular messages at their regular team meetings Outreach and displays LPT website Staff events and outreach

12.2.12 Providing support during the consultation

The ICB is very conscious of the difficult and challenging times that people are living in. This consultation may create demand for services and people may be encountered who need support. The ICB will ensure that online information is provided and signposting to points of access for both physical and mental health services should anyone require support.

12.2.13 Equalities considerations

As a legal requirement and moral requirement we will ensure that the consultation process reaches out to all those who have an interest in the proposals and that they are empowered to take part in the consultation. An equality impact assessment has been undertaken to ensure that the process for consultation and decision making is fully compliant with the ICB's legal duties under the 2010 Equality Act and the NHS Act and that people's protected characteristics are taken account of.

An Equality Risk Assessment will also be undertaken to highlight key areas of concern or issues and identify mitigating actions.

As outlined previously, consultation information will be made available to all communities in various formats appropriate to the community e.g. Easy Read. Videos have proved particularly successful and can be easily overlaid in various languages.

For all methods of feedback whether online or offline the ICB will ensure that people have

been asked to provide socio-demographic and equalities information. This information will be aggregated as part of the consultation to enable the ICB to assess the impact and views from groups that differ from the general population e.g. LGBT, younger people, people living in deprived area. This will be done halfway through the consultation to assess any gaps, which can then be mitigated against. It will also be done at the end of the consultation.

12.2.14 Capturing consultation responses

The ICB will secure the services of an independent organisation to handle the consultation data and report the findings to the ICB. The organisation would provide guidance on the development of the questionnaire. The consultation responses from the various online and offline responses will be logged, analysed and evaluated and an independent report of the consultation written. Interim findings will be produced internally halfway through the consultation to ensure that responses are representative of our population. This plan will be adjusted if required to target under-represented communities.

Depending on the number of responses received the ICB would expect the its Board to receive the report within circa 8 weeks of the closure of the consultation.

People will be asked to answer, on a voluntary basis as part of their consultation response, specific equality monitoring questions. This will enable responses to be analysed by segmented communities to ensure that we have been inclusive. This analysis will be done throughout the consultation period enabling modifications to be made to the consultation plans if it is found that the consultation is not reaching and providing opportunities to the entire communities. This will be identified through a half point assessment.

After carefully considering all of the feedback received and a period of reflection, the ICB Board will make a final decision at their public meeting(s), which will be promoted. After a decision has been made this will be widely communicated back to the public to ensure they are well informed of the decision.

12.2.15 Assurance and evaluation

The consultation plan and consultation materials will be informed by insights gained through the engagement process and through the Task and Finish Group will be discussed and approved by the ICB.

Statutory scrutiny during the consultation will be provided by the Leicestershire Health Overview and Scrutiny Committees, the ICB Board and the Public and Patients Involvement Assurance Group.

The consultation will comply with the law which requires NHS bodies to engage with members of the public before making decisions on changes to health services.

The consultation will also comply with the Gunning Principles on fairness. These have been established by case law which describe the principles that should underpin consultation as follows:

- Consultation must take place when the proposal is still at a formative stage.
- Sufficient reasons must be put forward for the proposal to allow for intelligent consideration and response.
- Adequate time must be given for consideration and response.
- The product of consultation must be conscientiously taken into account.

The consultation plan has been designed using the Cabinet Office principles for public consultation (updated January 2016) and to comply with the NHS England guidance 'Planning, assuring and delivering service change of patients (published in November 2015).

12.2.16 Impact of consultation outcomes

After the consultation the feedback will be used to help commissioners decide on the final outcome.

This decision making process will comply with the NHS England guidance 'Planning and Delivering Service Changes for Patients'. It will use the outcome of the consultation as part of the evidence to be considered, alongside clinical benefits of the options put forward and the sustainability and transformation of service.

At the close of consultation, the ICB will publish a report setting out the major themes emerging from the consultation, a summary of the responses to the proposal, an overview of the process, an explanation of how the final decisions will be taken (including dates of meetings in public) and the timeline for implementing the recommended option, should this be adopted. This report will draw on the independent evaluation report, which will also contain full equality monitoring data. It will be available in hard copy and online. A detailed communications and media plan will set out the actions for commissioners to communicate the decision to patients, carers, staff, local people, partner organisations, stakeholders and the media.

The Leicestershire Health Overview and Scrutiny Committees will also be informed of the outcome.

12.2.17 Consultation timetable

The final consultation document and process is subject to approval by the ICB Board and NHS England. The consultation plan assumes that the consultation will start when approval of the PCBC is known. The consultation will last 12 weeks. There will be a period of deliberation and analysis of findings which will last 8 to 10 weeks, depending on the number of responses made to the survey. The ICB Board will then meet to make their decision on the outcome.

An outline plan of the proposed consultation activities is included in **Appendix I**.

12.2.18 Consultation risks

Risks and mitigations will be managed by the Executive Management Team and the ICB

Board. Risks around communications and engagement will be fed into overall Risks log for the project. Communications and engagement risks will be identified and regularly reviewed and assessed throughout the consultation and mitigating actions put in place to respond to issues. The main risks and proposed mitigations are summarised in the table below.

Table 12-2 Risks and mitigations

Risk	Mitigation
Failure to engage with relevant stakeholders and meet statutory duties / stakeholders feel they have not been fully involved	Communications engagement plan developed identifying stakeholders and partners with detailed communications activity implemented during consultation period.
ICB do not engage with marginalised, disadvantaged and protected groups	Communications and Engagement plan identifies relevant groups and organisations that we will work with to access these groups and communities
Lack of response / "buy in"	Ensure adequate publicity and support. Ensure accessibility of activities and appropriate feedback mechanisms using a range of online and offline media. Implement mid-point review to assessment responses and modify communications and engagement activities accordingly
Proposal in consultation document perceived as already implemented or a 'done deal'	Ensure through all communications that public are aware of changes made during the pandemic and have knowledge of the clear rational for the proposal for change
The consultation may be subject to challenge and the lack of options for the public to comment on may be criticised	Appropriate governance policies/standards will be put in place to ensure correct procedure, logging processes and equality analysis are maintained throughout the consultation and that public are fully aware of the engagement that led to the narrowing down of options to the proposal being consulted on
Campaign group(s) challenges proposals	Ensure co-design of proposals. Ensure that consultation documents outline how the proposals have been developed and how they will benefit service users by improving access to mental health services in a crisis or when the need is urgent. Ensure we are following due process and logging all engagement. Ensure that we are prepared

Risk	Mitigation
	through the processes in place to receive any petition

12.2.19 Consultation questions

The proposed consultation questions are shown in the consultation document which is found in the executive summary in section 1.11.2, and also in appendix H.

12.3 Stakeholder support

The proposals have the full support of a range of local stakeholders and Letters of Support are included in **Appendix J** from the following:

- UHL.
- LPT.
- The Masharani Practice.
- South Blaby and Lutterworth PCN.
- George Eliot Hospital NHS Trust.
- University Hospitals of Coventry and Warwickshire

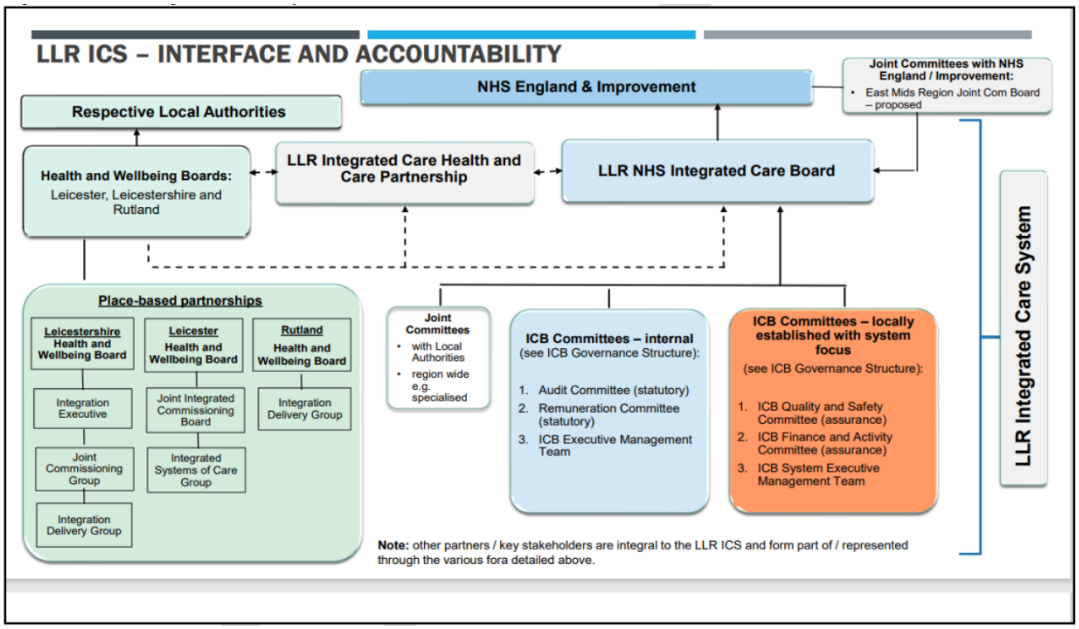
It should be noted that there are no specialised services included the proposals.

12.4 Project governance

12.4.1 ICS governance arrangements

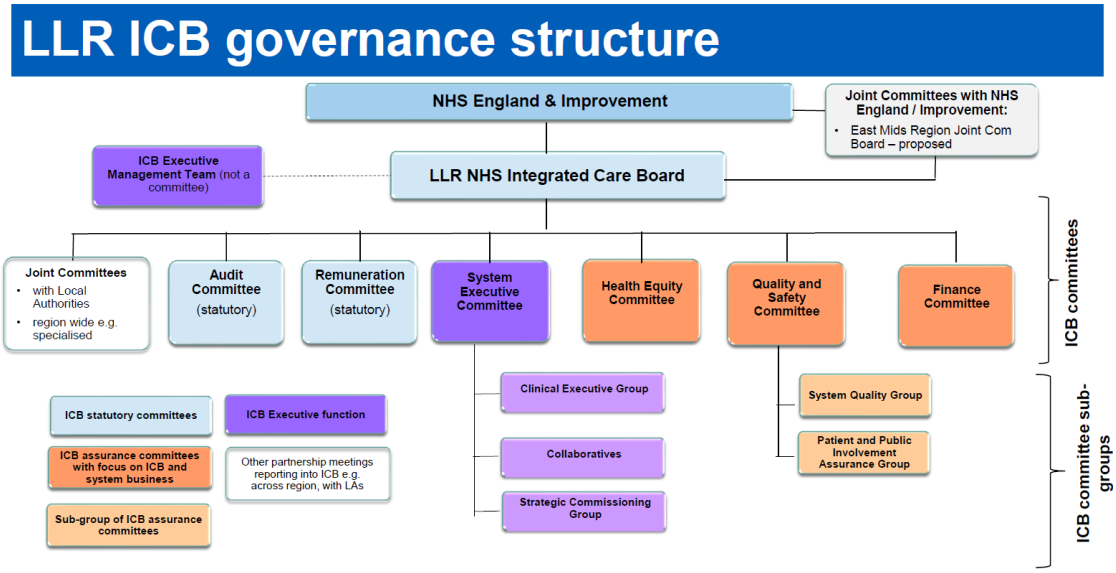
The structure for the ICS Governance arrangements is shown below. The Senior Leadership Team for the ICS, comprising of senior representatives from NHS commissioning and provider organisations along with the three local authorities is dually accountable to the boards and governing bodies of NHS organisations in LLR. Also, to the executives of its members as well as to the Health and Wellbeing Board. It makes recommendations to the individual Boards, Governing Bodies and Executives upon specific issues, to ensure local decisions e.g. capital investment projects, are informed by system views and priorities.

Figure 12-2 LLR ICS interface and accountability framework



A further breakdown of the ICB governance structure, along with ICB committee sub-groups is shown below.

Figure 12-3 ICB governance structure



12.4.2 PCBC Project governance arrangements

Delivery of the PCBC has been managed by a steering group drawn from all key stakeholders, which was established at the inception of the project, meeting every 6 weeks.

Day-to-day management of the project sits with the Head of Strategy and Planning, LLR ICB answering to the steering group which is chaired by the Chief Strategy and Planning Manager, LLR ICB. Beaumaris Consulting provides appropriate project management support to the development of the Pre Consultation Business Case.

12.4.3 PCBC approval

Subject to NHSE approval, the following stakeholders are expected to obtain formal approval of the PCBC report prior to commencement of the public consultation:

- ICB (as commissioner).
- LPT Board (as provider and landlord).

Alongside this, the Health Overview and Scrutiny committee will receive the report prior to public consultation.

12.5 ICB project management

12.5.1 Background

Robust project management arrangements are vital to ensure effective control is maintained over the subsequent development and delivery of the Project, not least to address the following matters:

- Adoption of the general principles in managing the activities and outputs of the project, for example the use of PRojects IN Controlled Environments (PRINCE) 2.

- Appliance of relevant guidance, for example Infrastructure Investment Guidance.
- The use of NHS standard documentation or otherwise.
- Specialist professional and technical advisers support.

The intention of effective project management is to:

- Deliver the project on time and to budget.
- Ensure effective and proactive lines of accountability and responsibility for the project deliverables.
- Establish user involvement at all stages of the project.

12.5.2 ICB Project management structure

The project management structure for both the Decision Making Business Case (DMBC) and the capital business case will be developed to reflect the views of the key stakeholders, with clinical leadership central to that development. Furthermore, the critical role of LPT as landlords of the site, will be clearly reflected during both stages.

Whilst it is expected that the ICB will have overall project management oversight via a Project Board, there will be a requirement for workstreams/delivery groups sitting within this, and that LPT will lead on project delivery of the construction of the scheme, sitting alongside other workstreams including workforce, service delivery and quality.

12.6 LPT project management

12.6.1 Background

Management of the capital project will be overseen by a specific LPT scheme Project Board, with an appointed Senior Responsible Owner (SRO) and Project Manager. The capital construction element of the project will be overseen by LPT's Estates and Facilities Capital Team, formal monthly updates being submitted to the Project Board and Estates and Medical Equipment Committee (EMEC).

On approval to progress this scheme LPT will engage the P22 delivery framework which will manage the detailed design process and market testing leading to GMP for the project. This incorporates risk monies (for Trust and Contractor), Building Regulation and any Local Authority Planning application requirements. On acceptance of the GMP by the Trust the PSCP will be formally engaged to carry out the work.

A construction strategy and programme will be planned by the P22 PSCP to minimise impact to LPT's services, neighbours and construction working practice will be undertaken in a responsible manner. This will form part of the GMP.

In line with the P22 framework and the requirements for CDM the following appointments will need to be made within the PSCP domain:

- The Principal Designer.

- The Principal Contractor.

12.6.2 Change management control

Once within the P22 framework structure the change control procedure will be managed by the named Trust appointed Project Manager using the contractual P22 proformas and will form part of the formal monthly report from the Project Manager to the Estates and Medical Equipment Committee.

Under the P22 framework the Project Manager will be the only contractually named individual with the authority to issue an instruction to change Works Information.

12.6.3 Compensation Events

In the event of a potential change to the stage 4 contract, post GMP either party will raise a Compensation Event, early agreement of variations will be managed through the P22 process with clear contractual timescales. The named Project Manager will be the only person with contractual authority to approve a Compensation Event.

Compensation Event s will form an item of the formal monthly report. The contract will include a variation to the standard Compensation Event timescale to allow the Project Manager to seek formal approval for significant Compensation Event s from the scheme Project Board, prior to implementation.

12.6.4 Programme

As part of the early engagement of the PSCP for stage 3 and generation of a GMP, a stage 3 and construction programme will be submitted. The final programme forms part of the contractual commitment of the GMP.

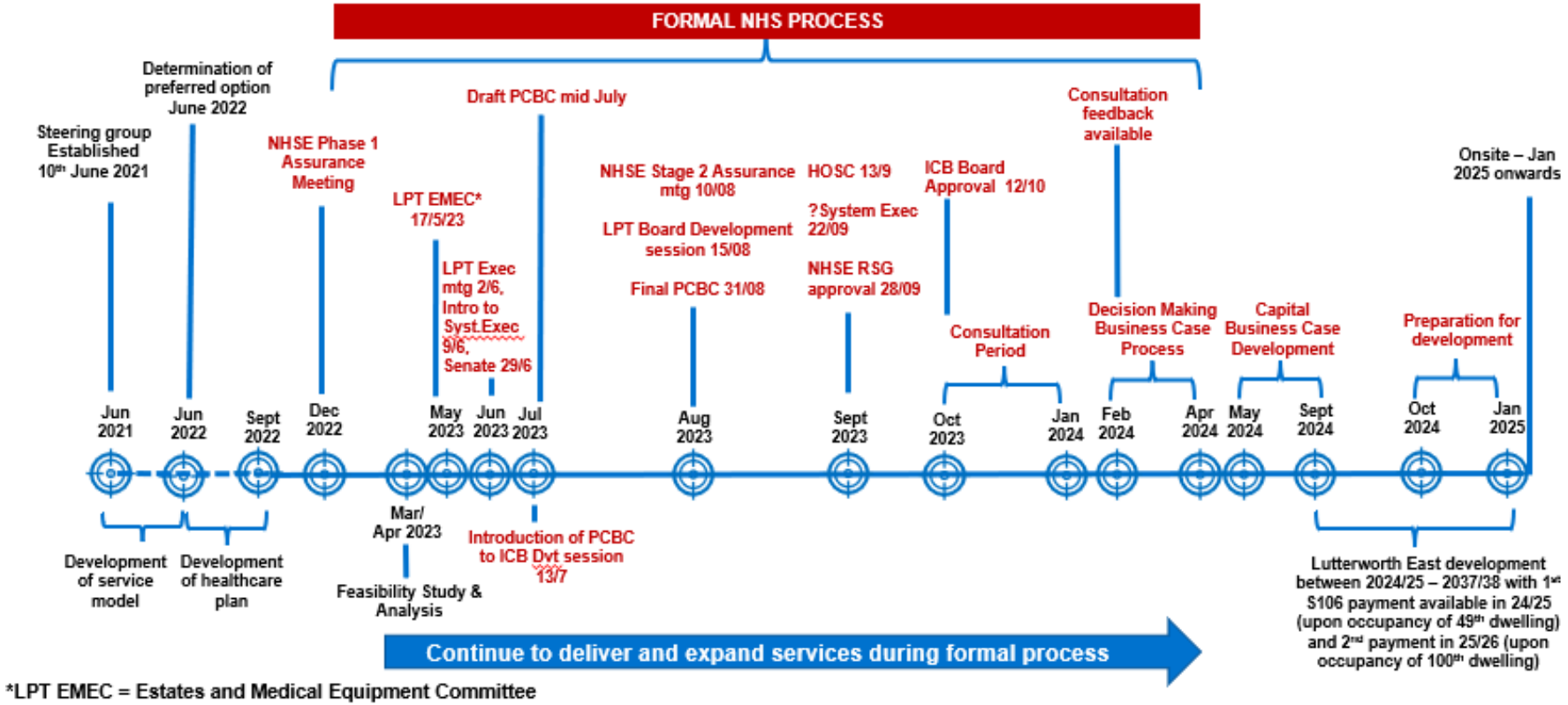
Once engaged the PSCP will provide a monthly formal report to the Project Manager which will include the status of project against programme, this programme will be the benchmark for contract completion and any resulting Liquidated Ascertained Damages. This will be issued by the Project Manager on the monthly report.

12.7 Project timetable

12.7.1 Consultation timeline

The project timeline for the consultation is shown in the figure below. the timeline for the Feilding Palmer Hospital capital development is shown in the table below.

Figure 12-4 Consultation timeline



12.7.2 Capital development timeline

The timeline for the Feilding Palmer Hospital capital development is shown in the table below.

Table 12-3 Feilding Palmer Hospital development timeline

	Target date
PCBC submission	July 23
PCBC approval	October 23
Consultation period start	October 23
Consultation period end	January 24
Consultation feedback available	February 24
DMBC completed	March 24
DMBC approval	April 24
P22 PSCP appointment complete	May 24
Capital business case submission	July 24
Capital business case approval	September 24
Construction contract signed	October 24
Construction start	January 2025
Construction complete	December 2025
Building occupation	January 2026
Post Project Evaluation	January 2027

12.7.3 Health Overview and Scrutiny Committee review

Early discussions have taken place with Leicestershire Health Overview and Scrutiny Committee (HOSC). The PCBC will be considered by HOSC at the 13 September 2023 meeting prior to public consultation commencing.

12.8 Risk management

The Project Board will hold a high level scheme risk register, this will initially be developed from the PCBC stage.

A construction risk register and issues log will be created for review throughout the scheme period and updated periodically for the monthly report. A standard risk schedule is incorporated within the P22 framework. LPT will hold an element of risk (and associated finances) within the cost plan as will the PSCP within the final contract GMP. The PSCP may release any unspent risk funds during the life time of the scheme. Risk owners will provide regular updates to the register.

Within the P22 process all parties will raise an Early Warning (EW) as soon as they become aware of any event that could affect time, quality or cost. This is then managed within the P22 framework which defines the process and actions required to move to a decision. EW Schedules will form part of the project meetings and formal monthly report. The EW process is integral to the risk management of the project, escalated EW s will be included in the construction risk register.

12.9 Post project review and benefits realisation

12.9.1 Outline Arrangements for Post Project Evaluation

LPT has established arrangements for Post Project Evaluation (PPE) in accordance with best practice. LPT is committed to ensuring that a thorough and robust PPE is undertaken at key stages in the process to ensure positive lessons can be learned from projects that can inform processes and future projects undertaken.

The diagram below outlines the framework and example timescales that is adopted in the undertaking of PPE associated with each project.

Figure 12-5 Framework for delivering Post Project Evaluation

Post Project Evaluation: Framework for Delivery									
NHS Standard project & business case planning		FBC	Construction Phase	Post Project Evaluation Stage					
					← PER →				
				POE		PIR			
				3 month	6 month	1 year	2 year	5 year	
Post Project Evaluation		Review previous PPE for lessons learned							
Stage 1: Evaluation Plan		✓							
Stage 2: Project Delivery				✓					
Stage 3: Initial PPE						✓			
Stage 4: Follow up PPE							✓	✓	
A	NHS Improvement - Project Completion Report				✓				
B	Design Quality Indicator appraisal (DQI for Health)	Stage 3 Detailed design		Stage 4 Ready for Occupation		Stage 5 In Use			
C	Building Research Establishment Environmental Assessment Model (BREEAM)	Interim Certificate		Post Construction Assessment		Final Cert			
D	Project Gateway Review (Internal or External)	Gateway 3 Investment Decision	Gateway 4 Readiness for service	Gateway 5 Benefits Evaluation					
E	Building Information Modelling (BIM)	Data Exchange Construction Information Model	Data Exchange Operation & Maintenance Information Model	Data Exchange Post Occupation Validation Information & on-going operation & management					
F	NEC 3 Construction Contract (where applicable)			Post construction assessment					
G	Government Soft Landings (GSL) Environmental, Financial, Performance, Functionality & Effectiveness	GSL 4.0 Design	GSL 5.0 Build & Construction	GSL 6.0 Handover	GSL 7.0 POE.1	GSL 8.0 POE.2	GSL 9.0 POE.3		

Post-Occupancy Evaluation

Post Occupancy Evaluation (POE) is the process of obtaining feedback on a building's performance once in use. POE is valuable, particularly in healthcare environments, where poor building performance will impact on running costs, occupant well-being and business efficiency.

POE will:

- Highlight any immediate teething problems that can be addressed and solved.
- Identify any gaps in communication and understanding that impact on the building operation.
- Provide lessons that can be used to improve design and procurement on future projects.
- Act as a benchmarking aid to compare across projects and over time.

Post Implementation Review (PIR)

PIR will ascertain whether the anticipated benefits have been delivered and will take place 12 months following the delivery of the project and will be monitored on an annual basis is

subsequent years.

12.9.2 Outline arrangements for benefits realisation

Benefits realisation is a way of ensuring the intended benefits of the project are delivered. The intended benefits can be categorised as follows:

- Quality.
- Access.
- Financial.
- Workforce.
- Environmental.

By focusing on benefits planning, the ICS will track whether the intended benefits have been realised and sustained after the end of the project.

Table 12-4 Benefits realisation

Potential Benefit	
Quality of Care	
1	Improved health outcomes, better access to services, preventing illness and tackling health inequalities by providing local capacity enabling the local population to access a greater range of services.
2	Ensuring modern, fit for purpose facilities that enable the introduction of best practice and reduced infection risk.
Access to Care	
3	Providing flexible facilities to accommodate new services and models of care, including generic and flexible rooms.
4	Improving equity of access to services by providing them local within Feilding Palmer Hospital, thereby, improving access to services arising from a shift of outpatient services from acute hospital to a community setting.
5	Allowing planning of services based on the needs of the local population.
6	Ensuring fit for purpose facilities that meet relevant standards and guidance to deliver care close to home.
7	Opportunity to increase the provision of "one-stop shop" services, ensuring patients can be treated by multiple specialists on a single visit reduces risk of DNA.
Financial	
8	Maximising the use of Feilding Palmer Hospital and getting the most out of taxpayers' investment in the NHS.
Workforce	
9	Backing the NHS workforce by providing a pleasant working environment which permits the integration of services and collaboration which permits staff to deliver services to the levels they believe are necessary.

Potential Benefit	
Estates	
10	Addressing existing estate issues at Feilding Palmer Hospital.
11	Enhanced community asset, which adds to sustainability of local community.
Environmental sustainability	
12	Reduced journeys for patients reducing carbon emissions.
13	Through the introduction of new plant equipment, providing greater energy efficiency, reduced carbon footprint and reduced estates running costs.

12.10 Conclusion on delivering the proposals

The above demonstrates that the Commissioners and LPT have the appropriate plans in place and the capacity and capability to deliver the project and to realise the benefits of ***maximising access to services for the local community.***

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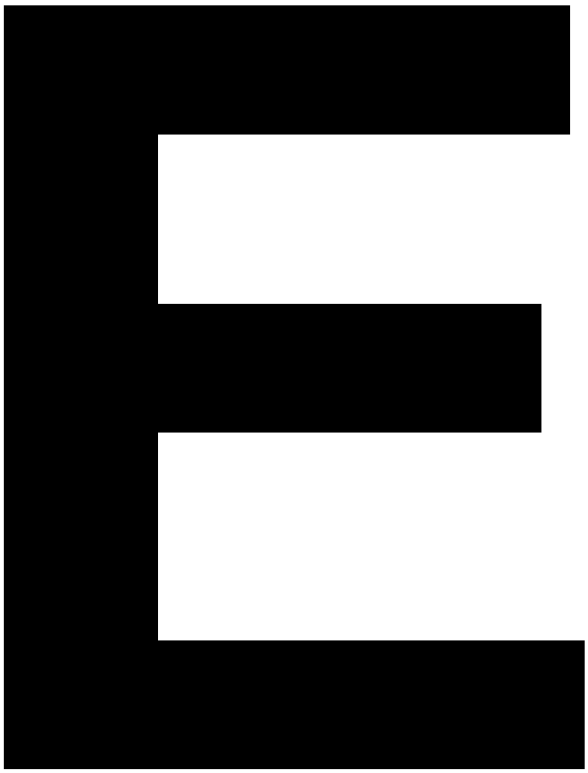


Name of meeting:	**Leicester, Leicestershire and Rutland Integrated Care Board** – meeting in public		
Date:	12 October 2023	**Paper:**	**E**
Report title:	**Primary Care Access Recovery Plan – LLR System-level Access Improvement Plan**		
Presented by:	Dr Nilesh Sanganee – Chief Medical Officer Rachna Vyas – Chief Operating Officer		
Report author:	David Muir – Senior I&T Manager Mayur Patel – Head of Transformation Dr Sulaxni Nainani – Deputy Medical Chief Officer		
Executive Sponsor:	Dr Nilesh Sanganee – Chief Medical Officer Rachna Vyas – Chief Operating Officer		

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

Recommendations:

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

- **RECEIVE** this report that describes the key components of the LLR System-level Access Improvement Plan and outlines how the ICB intends to deliver its key actions and priorities.
- **APPROVE** the DRAFT LLR System Level Access Improvement Plan for Primary Care with a progress report to come to the Board in March 2024.

Purpose and summary of the report:

Following the publication of the Delivery plan for recovering access to primary care in May 2023, integrated care boards (ICBs) are required to develop system-level access improvement plans for primary care.

In July 2023, NHSE published a briefing note to support the development by ICBs of their system-level access improvement plans. This referenced “checklists”, published June 2023, which detailed expected actions for both ICBs and PCNs to achieve primary care access recovery. These “checklists” were update by NHSE September 2023.

The purpose of this report is to provide Board with an overview of the NHSE Primary Care Recovery Plan (PCARP) and the commitments to patients therein, and provide assurance to Board that, through the development and implementation of LLR ICB’s “System-level Access Improvement Plan”, (SLAIP), we will deliver on these commitments for the people of LLR by: -

- Tackling the 8 am rush - make it easier and quicker for patients to get the help they need from Primary Care
- Enabling “Continuity of Care”
- Reducing Bureaucracy

The report will describe work already undertaken, work to be progressed, and the methodology for monitoring and assuring delivery.

Appendices:	• Appendix 1 – LLR SYSTEM-LEVEL ACCESS IMPROVEMENT PLAN – NHSE Guidance and Recommendation • Appendix 2 – LLR PCARP Workforce Plan Summary • Appendix 3 – Delivery Plan for Recovering Access to Primary Care – Assurance Trackers • Appendix 4 – Winter 2023/2024 – Adult and Paediatric ARI Hubs – LLR Response • Appendix 5 – Respiratory Winter Plan for 2023/24

Report history (date and committee / group the content has been discussed / reviewed prior to presenting to this meeting):	An outline of the ICB's requirement for, and approach to developing and implementing a "System-level Access Improvement Plan" was presented to Joint HOSC 18th September 2023.

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	Executive Sponsor is a GP working in LLR
☐	Conflict noted, conflicted party can participate in discussion but not in decision	
☐	Conflict noted, conflicted party can remain in meeting but not participate in discussion or decision.	
☐	Conflict noted, conflicted party to be excluded from the meeting.	

Implications:	
a) Does the report provide assurance against a corporate risk(s) e.g., risk aligned to the Board Assurance Framework, risk register etc? *If so, state which risk and also detail if any new risks are identified.*	Yes – BAF 2 Health Inequalities, BAF 3 Demand and Capacity, BAF 8 Workforce
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 Capacity and Access Improvement Payment (CAIP) which is 30% of the DES Capacity and Access Payment which is to be determined by ICBs – SDF funding which maybe used to support winter surge management
c) Does the report highlight quality and patient safety implications? If so, provide which page / paragraph this is outlined in within the report.	Yes - Report outlines expectation for ICB to improve access to and quality of care.
d) Does the report demonstrate patient and public involvement? If so, provide which page / paragraph this is outlined in within the report.	Yes – in regard to LLR General Practice Experience Survey (GPES) results and the Primary Care Network Capacity and Access Improvement Payment Plans (CAIP)
e) Has due regard been given to the Public Sector Equality Duty? If so, how and what the outcome was, provide which page / paragraph this is outlined in within the report.	Yes

NHSE Primary Care Recovery Plan

Leicester, Leicestershire and Rutland "System-level Access Improvement Plan"

12 October 2023

Introduction

1. This report will provide Board with an overview of the NHSE Primary Care Recovery Plan (PCARP) and the commitments to patients therein, and provide assurance to Board that, through the development and implementation of LLR ICB's "System-level Access Improvement Plan", we will "make good" on those commitments for the people of LLR.

2. It describes the current general practice access position in LLR, the improvements we intend to make, and the actions required to deliver those improvements. Appendix 1 describes the national guidance and recommendation received from NHSE that has shaped and is reflected in our Plan for LLR.

Background

3. General Practice, like many parts of the NHS, is under tremendous pressure – nationally one in five people report they did not get through or get a reply when they last attempted to contact their practice. The Fuller Stocktake stated, "there are real signs of growing discontent with primary care – both from the public who use it and the professionals who work within it". The Fuller Stocktake also provides valuable insights on the preferences of people waiting for and choosing appointments:

> *People waiting for an appointment with their GP prioritise different things. Some need to be seen straightaway while others are happy to get an appointment in a week's time. Some people – often, but certainly not always, patients with more chronic long-term conditions – need or want continuity of care, while others are happy to be seen by any appropriate clinician, as long as they can be seen quickly. Equally, for some patients it is important to be seen face to face while others want faster, more convenient ways of accessing treatment and there is emerging evidence of a growing appetite (even before COVID-19) for patients to access care digitally.*

4. The NHSE "Delivery Plan for Recovering Access to Primary Care" (NHSE May 2023) has two central ambitions:

    a) To tackle the 8am rush and reduce the number of people struggling to contact their practice. Patients should no longer be asked to call back another day to book an appointment, and we will invest in general practice to enable this.

    b) For patients to know on the day they contact their practice how their request will be managed.

        i. If their need is clinically urgent it should be assessed on the same day by a telephone or face-to-face appointment. If the patient contacts their practice in the afternoon they may be assessed on the next day, where clinically appropriate.
        ii. If their need is not urgent, but it requires a telephone or face-to-face appointment, this should be scheduled within two weeks.
        iii. Where appropriate, patients will be signposted to self-care or other local services (e.g., community pharmacy or self-referral services).

5. The Recovery Plan seeks to support recovery by focusing on four areas:
    i. Empower patients to manage their own health including using the NHS App, self-referral pathways and through more services offered from community pharmacy.
    ii. Implement Modern General Practice Access to tackle the 8am rush, provide rapid assessment and response, and avoid asking patients to ring back another day to book an appointment. The 2023/24 contract requires practices to assess patient requests on the day.
    iii. Build capacity to deliver more appointments from more staff than ever before and add flexibility to the types of staff recruited and how they are deployed.
    iv. Cut bureaucracy and reduce the workload across the interface between primary and secondary care, and the burden of medical evidence requests so practices have more time to meet the clinical needs of their patients.

Why do we need a Recovery Plan in LLR?

The "National Problem" – Pressures in Primary Care and the Problems for Patients – and what it means in LLR

6. In 2022/23:
    - LLR general practices provided 360,807 more appointments than in 2022
    - On average, 75% of LLR practices recovered to their 19/20 appts levels
    - Overall, LLR practices exceeded LLR target of 70% of available appointments being "Face to Face" – monthly average 74%
    - Overall, LLR practices exceeded LLR target of 75/1000 practice population clinical contacts – monthly average 93%

7. However, we know "access"- getting through to a practices, and then being "seen" in a "timely manner" - are major concerns for our LLR population.

8. Like many parts of the NHS, general practice is under intense pressure. Where demand is greater than capacity it means general practice cannot always be effective, and patient experience and access are negatively impacted. It also means that stresses appear in other parts of the health system as patients seek alternative routes to get NHS care. One key driver of growth in demand is the ageing population. Most of those over 70 live with one or more long-term condition and have five times more GP appointments on average than teenagers.

9. Nationally, overall general practice staffing is 27% higher and the number of staff delivering direct patient care is 44% higher than March 2019. However, nationally, the pandemic has changed the nature of demand. Patient contacts with general practices are estimated to have grown faster than demographic pressures, at between 20% and 40% since pre-pandemic, in part as COVID-19 backlogs have increased workload.

10. Practice surveys conducted by NHSE suggest that administrative tasks outside a consultation, measured by entries to medical records, are up 50% since 2019. Locally, and nationally, Practices report that they have never been as busy. Nationally, over the same period, NHSE reports that the growth in the number of GPs has lagged behind that of total practice staff employed.

11. Importantly, the pressure in general practice is felt strongly by these experienced GPs, who today are managing larger practices, with more patients, and supervising more doctors in GP training, more practice staff, and more clinical roles, yet remain critical to assessing the on-the-day urgent clinical need.

12. Overall growth in the LLR Primary Care workforce is at 0.9%, which is below expectation. However, separately both City and County, (including Rutland), have seen growth. County largely outgrew City in 22/23. Based on plans submitted by the LLR Primary Care Networks to NHSEI, increase in practice staff through the "Additional Roles Reimbursement Scheme", (ARRS), is on plan in LLR and has seen substantial growth in all staff groups.

13. Our LLR SLAIP describes the workforce strategies and initiatives – recruitment, retention, and development - through which we will optimise our most valuable workforce resource. A particular focus for Leicester City will be on the level of Social Prescriber Link Worker, (one of the ARRS roles key to enabling effective clinical navigation and sign-posting).

14. The national picture is that as demand rises, many practices are struggling to meet all the needs of their patients. Difficulties with access were also highlighted in the DHSC pulse-check survey, (December 2022), where one in five of the public said they either did not get through or get a reply when they last tried to contact their practice.

15. Good access is central to general practice being effective at meeting the reasonable needs of patients. As demand rises, the number of calls is challenging for reception staff. For those practices still on analogue lines, patients find repeated engaged tones frustrating. Retaining staff in this environment can be difficult.

16. The recently released General Practice Experience Survey, (GPES), results has allowed us to compare LLR practices performance on the Care Quality Commission (CQC) NHS GP Practice Indicators for 2023 to national performance.

17. Nationally and within the LLR ICS, performance on all indicators was lower in 2022 than in 2021. However, in 2023, average performance in LLR improved in 7 out of the 11 indicators (and 6 out of 11 nationally).

18. As in 2021 and 2022, in 2023 the worst scoring questions relate to access to GP services – GPES Q1 – *Ease of getting through to…,* LLR 2023 score down 3.29%, LLR practice score variation 11% - 97%: GPES Q2 – *How helpful was the receptionist*…, LLR 2023 score up, but LLR practice score variation 52% - 99%.

19. This is followed by *Overall experience of GP practice*…, LLR 2023 score down 0.54%, LLR practice score variation 33% - 96%.

20. Improvement initiatives will focus on addressing this variation, learning from "high" scoring practices/PCNs, and supporting "lower" scoring practices/PCNs to design, implement, and sustain improvements.

21. The results show some "positives" to <u>learn from and build on</u>:
    - The majority of respondents had positive perceptions of their care and felt their needs were met during their last GP appointment.
    - Confidence and trust in healthcare professionals is high (93%) among respondents.
    - 90% of respondents feel their needs were met during their last GP appointment.
    - 90% of respondents feel they are involved in decisions about their care and treatment.

22. GPES 2023 also provided useful insights into "online" usage in LLR:
    - Both nationally and in LLR, respondents reported an increase in booking appointments, ordering repeat prescriptions, and accessing medical records online from 2022 – 2023.

    - In 2021, 22 and 23, the most used online service was ordering repeat prescriptions (in 2023, 33% both nationally and in LLR).

- In 2023, the second most used online service, nationally and in LLR, was booking appointments online (23% of patients nationally and 18% of patients in LLR).

23. We have ranked top, middle, and bottom performing practices for each indicator to identify examples of good and poor performance and to get a deeper sense of performance across the system for each indicator.

24. Our 2023 GPES data will be, shared with practices and PCNs and data can be aggregated to PCN level to further nuance and support the implementation of the PCN Capacity and Access Improvement Payment plans - a key and integral component of our LLR SLAIP - to drive improvement in the experience of accessing general practice and general practice services.

25. Addressing variation in experience will continue through existing Access, Resilience, and Quality committees and processes.

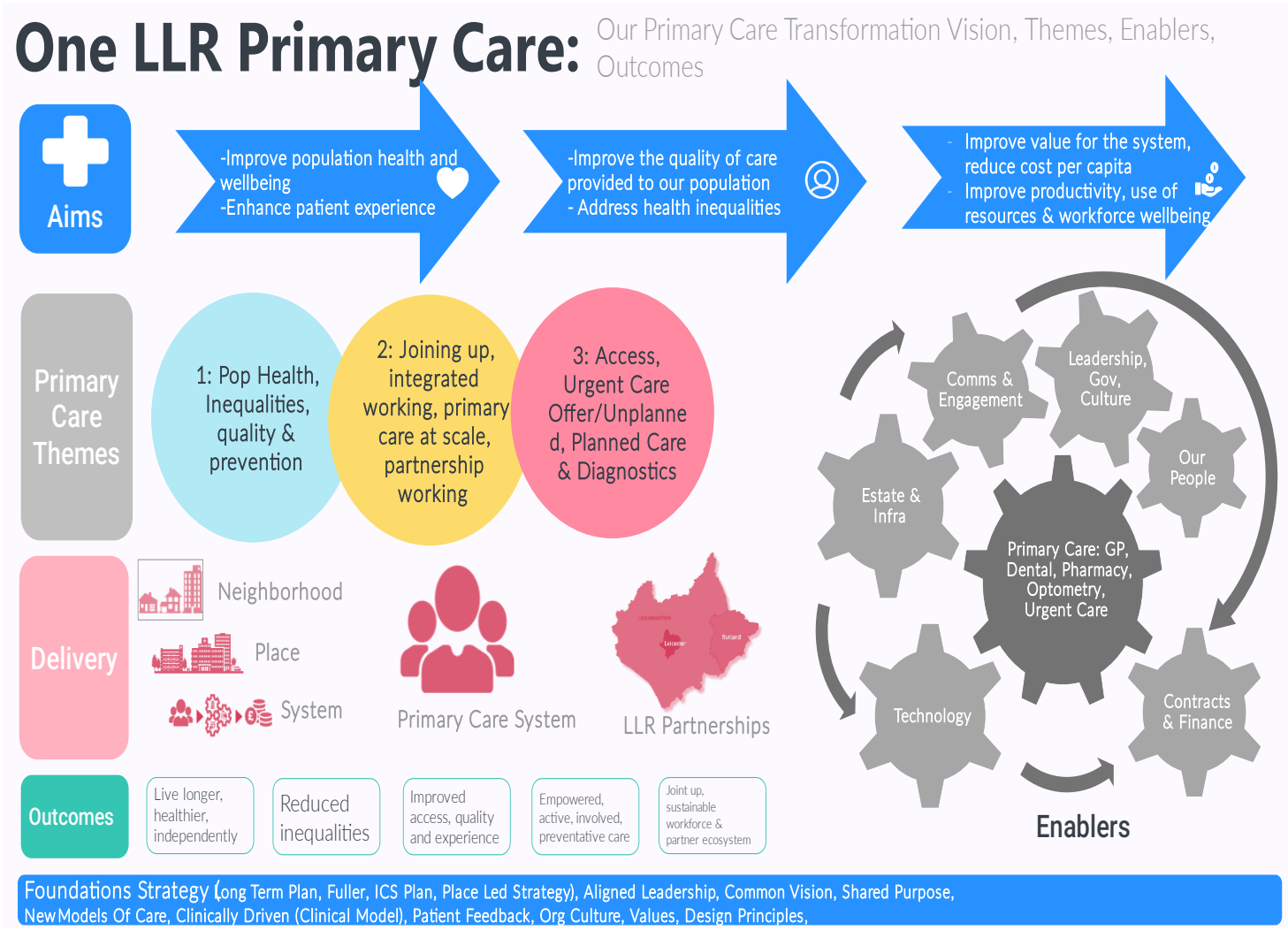
The Local strategic context

Our Primary Care Strategy

26. In Leicester, Leicestershire & Rutland, we are committed to putting primary care at the centre of our integrated care system. We recognise the benefits of strong primary care. The vision outlined in our LLR Primary Care Strategy states:

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

27. This is summarised in the figure below: - *Figure 1 LLR Primary care Strategy*



28. This flows into and under-pins our vision for "Place Based Access and (Primary Care) Integration" in LLR, illustrated in *Figure 2* below: -

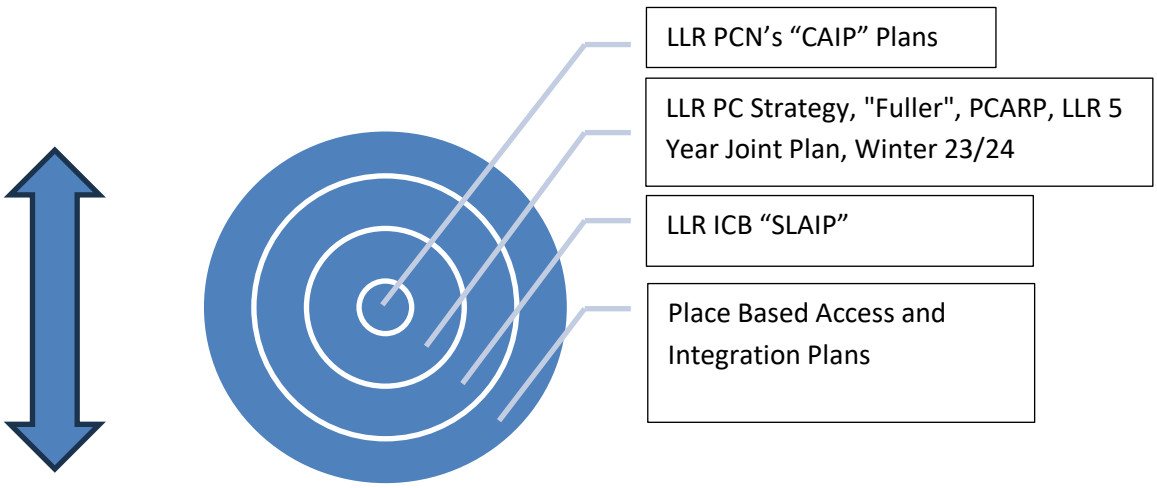


Figure 2 – Place Based Access and Integration Vision

What is in our System-Level Access Improvement Plan

29. Although titled as a plan for recovering access to Primary Care, successful delivery of the **Delivery Plan for Recovering Access to Primary Care** will require concerted and not insignificant response and action from nearly all ICS Partners and ICB Teams in LLR.

30. To enable and assure this system level response, LLR ICB has developed and implemented an approach to delivery based around 3 central aims. These are: -
    - To tackle the 8 am rush - make it easier and quicker for patients to get the help they need from Primary Care
    - To enable "Continuity of Care"
    - To reduce Bureaucracy

31. These LLR aims reflect and will in turn be enabled by the four key commitments of the Primary Care Access Recovery Plan, (PCARP): -
    - Empowering Patients
    - Implementing "Modern General Practice Access"
    - Building Capacity
    - Cutting Bureaucracy

32. This relationship, and the delivery areas within our SLAIP are shown in *Figure 3 – LLR System-level Access and Improvement Plan* – below: -

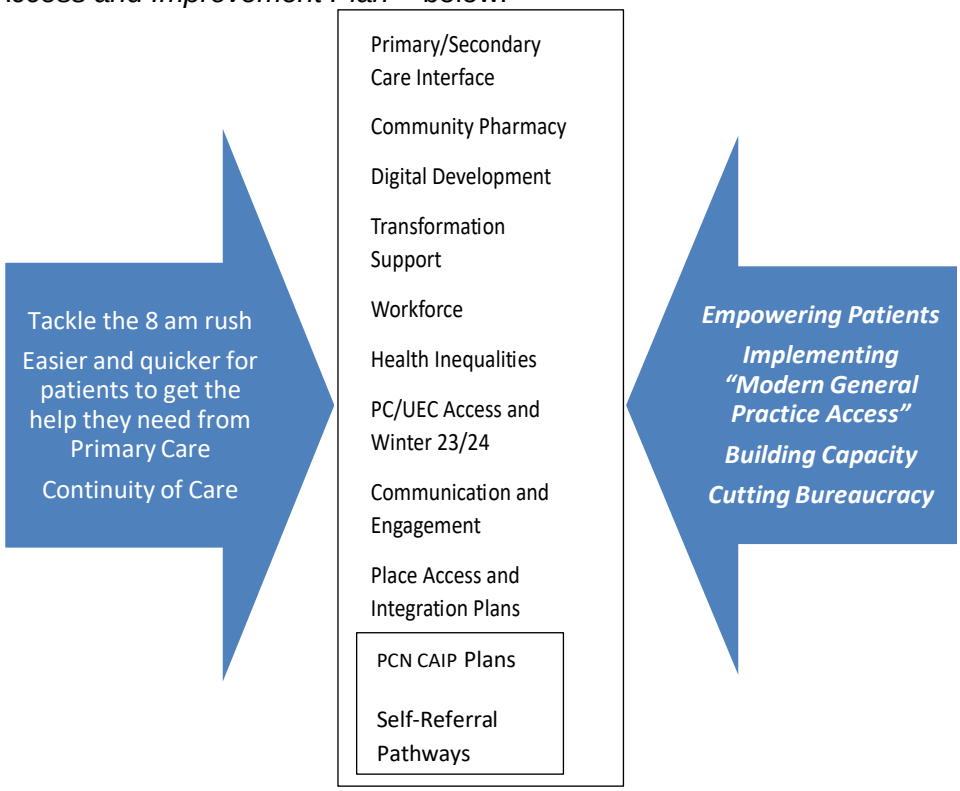


Figure 3 – LLR System-level Access Improvement Plan

Primary-secondary Care Interface

33. In the NHS, there's a growing demand amidst limited resources. To optimise patient journeys and experiences, it's crucial for healthcare professionals in primary and secondary care to collaborate effectively. However, the complex systems, varying IT systems, cultures, and priorities often hinder seamless communication and interconnection. The advent of Integrated Care Systems (ICS) represents a shared vision, where organisations partner to plan and deliver unified healthcare services for local communities. This includes delivering patient care within ICS and progressively across multiple ICS.

34. The true success lies in transitioning from 'I' to 'we.' It's not about adding to the burden on services or shifting bottlenecks within the care continuum. Instead, it's about working collectively across the primary-secondary care interface to provide the best care at the right time and place for each patient when they need it most. Patient-centred care, delivered at the right time and by the appropriate professionals, is fundamental. Effective communication is vital in interface working, as many issues stem from suboptimal communication practices. Given the pressures of workloads, waiting lists, service delays, and patient demands, healthcare professionals operate at maximum capacity. It's easy to be absorbed in one's own pressures and overlook colleagues facing their unique challenges. Improved patient outcomes and experiences are the goals. This approach not only reduces medical errors but also curtails healthcare costs and enhances overall efficiency in service delivery. It benefits patients and ensures the healthcare system's sustainability and effectiveness.

35. This approach is closely linked to the challenges outlined in our Primary Care Strategy and aligns with the themes designed to address these challenges. A significant aspect of the access challenge stems from the increasing workload, particularly for seasoned GPs, which risks overwhelming them and leaving less time available for patients. The pressure originates from the escalating number of patient contacts, which practices report to have surged by 20% to 40% since the pre-pandemic period.

36. Primary-secondary Care Interface -Progress so far within LLR:

- TCS(Transferring Care Safely) established since 2016. We were one of the first nationally to set up a group to resolve ongoing interface issues.

- C2C policy which reflects previous principles and has evolved i.e., initially consultant to consultant now clinician to clinician.

- TCS Handbook created in 2017 with the purpose of offering comprehensive guidelines to healthcare providers regarding the best practices for effective interface collaboration.

- **New Interface document for LLR (2023)** embedding the 10 principles to improve effective communication and behaviours. The document provides a detailed framework and principles for seamless communication, coordination, and cooperation across different levels of care. It serves as a valuable tool for healthcare professionals striving to improve the quality of care and patient outcomes by fostering better collaboration among various providers across LLR (*signed off by SE on 22/9)*
- Pathway revisions, fit note policies, 2ww changes and various other issues as highlighted through TCS.

37. There are opportunities to reduce this workload by:

    i. improving the primary-secondary care interface

    ii. building on the “Bureaucracy Busting Concordat”

38. The existing system-level LLR Transferring Care Safely Group (TCS) is taking the lead on this and has reached a consensus on the primary areas of focus for delivery partners in the upcoming 6-9 months. These are shown in the table below:

Delivery Partner	Focus Actions
University Hospitals, Leicester	Embedding and improving the approach to providing Medical Fit Notes on discharge. Further embedding the use of Consultant Connect across the organisation. Delivery of an options appraisal for the development of a centralised contact point for those on the waiting list.
Leicestershire Partnership Trust	Provide easy access to the GP team for secondary care clinicians via non-public phone numbers and shared email mailboxes. Make 'fit note' more accessible on inpatient wards and in outpatient clinics and produce guidance for secondary care clinicians on their use. Standardise outpatient clinical letters where possible (placing particular emphasis on concise GP recommendations)
Primary Care	Prereferral work - This is mainly to look at pathways where investigations are being requested above and beyond what should be done in Primary Care (based on NICE guidance). Ensuring referrals have got all the relevant information needed. “Advice & Guidance” to get converted to referrals if deemed necessary if all the relevant information is available Build on consultant connect-currently few practices signed up, to ensure more practices sign up to allow good communication between primary and secondary care.

39. DHSC also developed the Bureaucracy Busting Concordat, setting out seven principles to reduce unnecessary bureaucracy in general practice in consultation with RCGP and the British Medical Association.

40. Continue to reduce medical evidence requests and increase self-certification; examples include:
    a. Working with the aviation industry to encourage clear, proportionate, and pragmatic processes.
    b. Working with His Majesty’s Courts and Tribunals Service to amend guidance to staff and correspondence with jurors, so people summoned for jury service do not seek a note from a GP as evidence of illness unless they are asked to by the court service. These changes will be made by September 2023.
    c. Exploring opportunities to improve efficiencies for both GPs and local authorities regarding the medical needs of people wishing to access social housing.

41. Measuring the outcomes of our approach is a vital aspect of our strategy. It's essential to understand that culture change doesn't happen overnight, and its effects can be challenging to quantify. However, by adhering to the principles outlined in this concordat, we anticipate witnessing the benefits gradually emerge over time. It's crucial to recognise that this initiative

is just one component of a broader, more comprehensive strategy aimed at enhancing healthcare services. By committing to implement these foundational principles, we aim to reduce unnecessary workload and streamline pathways, ultimately benefiting patients and their healthcare journeys. One anticipated outcome is an increase in the capacity of healthcare professionals beyond GPs to handle work and requests efficiently. This shift towards broader involvement can lead to a more effective healthcare system.

42. Furthermore, a positive response from general practice is expected as bureaucratic burdens are reduced. This reduction can contribute to a more streamlined and efficient workflow in primary care. TCS will continue to monitor progress in these key areas with agreed KPI's and consider looking at new indicators in a years' time.

Community Pharmacy - Common Conditions Service and Community Pharmacy Consultation Service

43. One of the key priorities identified within our Primary Care strategy to deliver our LLR vision is to redesign care pathways. The role Community Pharmacies have in this space is crucial.

44. As per PCARP, the ICB will support the transitioning of pharmacies participating in the regional extended care services to the proposed common conditions service where the two services overlap. We will work with our community pharmacy network and system stakeholders, including Community Pharmacy Leicestershire & Rutland to drive engagement and participation with the common conditions service, with the ambition that over 50% of the network are actively participating within 6 months of launch.

45. We will build on work already underway with regards to the Community Pharmacist Consultation Service to promote community pharmacy capacity as a viable and reliable option for patients with wider stakeholders including general practice and primary care networks.

46. Working with national colleagues we are developing an interactive map showing the services available from local pharmacies. We are still in the testing stage, but it is envisaged that this tool will help other primary care colleagues, particularly GP patient services teams and care navigators, identify pharmacies that patients can be referred to thus freeing up practice capacity and providing quicker, needs appropriate access to care in the most appropriate setting.

Community Pharmacy - Blood Pressure and Oral Contraceptive services

47. Targeted support has been provided to several practices and PCNs to engage with local community pharmacies to integrate the community pharmacy blood pressure checks service. We continue to see growth in referrals and pharmacy identified checks for both one off clinic checks and ambulatory blood pressure monitoring (ABPM). The LPC are working with contractors to increase confidence on the use of ABPM machines and are trialling in innovative IT platform to send data back directly into GP practices.

48. Whilst national level negotiations continue, in LLR there has been significant interest from contractors in providing the service, and several neighbourhood level meetings are planned. The latest month we have data for is June - 12 contractors have delivered a total of 63 consultations.

Digital Development

49. Another of our priorities within the Primary Care Strategy is the "Digital First" approach. This includes enabling and promoting digital innovation and a "digital by default" approach to the

design and delivery of care, including patient and staff education, whilst ensuring digital inclusion and avoiding un-intended digital discrimination.

50. Revised guidance for delivering the recovery plan was received from NHSE mid-September 2023, with 3 revisions specific to our digital development:

- **Cloud-based telephony** – National support to enable 1,000 practices to transition to digital telephony by December 2023. Expectation is that all remaining analogue practices move to digital telephony by March 2024. We will be actively monitoring progress, working alongside the national procurement hub, and following further national guidance and support expected soon, we will review the quality of cloud-based telephony already in place with a view to improve this where necessary.

  In LLR, 102 practices already have digital telephony platforms. Twenty, 20, LLR practices, supported by national funding, are in the process of migrating to a Cloud Based Telephony system. Five, 5, LLR practices are also migrating independently of national support. We will work with those practices that have not yet described their plan to migrate.

- **NHS App** – Data shows that all our LLR practices have patients registered to use the NHS App and have patients making and cancelling appointments and ordering repeat prescriptions via the NHS App. The same data shows significant variation in relative levels between practices, and across the year within practices. We will work with practices to understand this variation and support the sharing of learning and best practice to address.

  We will continue to leverage the core functions of the NHS App, to empower patients and enable them to self-serve to address appropriate. We will liaise with practices to ensure that each practice has a plan for each patient to receive prospective record access, (unless exceptions apply), from 31 October.

- **Digital pathways framework** – Whilst national level engagement with the market continues, and the timeline for the launch of the framework is confirmed, we will work with practices to fully understand the contracting position for their online consultation, messaging and booking solutions currently in use. We expect to receive guidance and information on what to expect from the framework from our Regional Team so we can begin preparatory work.

<u>Primary Care Transformation and Transformation Support</u>

<u>General Practice Improvement Programme (GPiP)</u>

51. This national programme includes Universal, Intermediate, Intensive and Local levels of support. Programmes focuses on implementing 'modern general practice' operating models and introduces the Support Level Framework (SLF) tool.

52. The table below, *Table 1 – GPiP uptake in LLR,* shows the uptake of these offers by LLR practices, relative to our ICB allocation of places.

Table 1 – GPiP Uptake in LLR

Offer type	Confirmed Spaces utilised in LLR	Unconfirmed Spaces utilised in LLR	LLR Total	LLR Proportionate 'Allocation'
Practice Intensive	5	4	9	15
Practice Intermediate	1	4	5	8
PCN Intermediate	0	0	0	2
Local Improvement	25	0	25	19

53. Within the Midlands region, LLR currently have the second-highest utilisation across all offers. We will continue to proactively identify practices that would potentially benefit from participating in GPiP programmes or by accessing other support offers.

54. Utilising a SLF approach triangulated with outputs from local quality and resilience surveillance processes we have identified **32** practices we will prioritise and then work with to gain assurance/identify improvement opportunities and challenges.

Workforce

55. One of the key enablers, outlined within the Primary Care Strategy to achieve the needed transformation, is our workforce. The performance of any health and care system ultimately depends on its people.

56. We have described the LLR workforce position earlier in the report, and we are committed to addressing workforce issues through retaining our existing workforce whilst supporting, optimising new roles, and making LLR an attractive place to train and work.

57. Reflecting the NHSE "People Plan", and the expectations of PCARP, the ICB's Workforce Team has developed robust plans in place to support and build the workforce. Please see Appendix 2 – *LLR PCARP Workforce Plan Summary* – for examples of the initiatives to be actioned.

Health Inequalities

58. Improving Health Equity by identifying and addressing health inequalities is one of the ICS's key pledges within its "Five Year Joint Plan", and "tackling inequalities in outcomes, experiences, and access" is one of the plans quintuple aims.

59. This is under-pinned and enabled by our "Life Course" and "Population Health Management" approaches that run through the LLR Primary Care Strategy and all our operational and delivery plans.

60. In their CAIP Plan development and submissions, LLR PCNs have been asked how they will identify and address health inequalities in their strategies for improving patient experience and access. This will build on the work and plans our PCNs have undertaken as part of the Network DES Contract – to develop a "Tackling Health Inequalities Plan", and "Personalised Care Plans" for patients identified through risk stratification.

61. Quality and Equality Impact Assessments will be undertaken - as standard practice and process – for any service change proposals within the emerging Place Based Access and Integration Plans.

Primary Care/Urgent and Emergency Care Access and Winter 23/24

62. Although not an explicit "NHSE requirement" for our SLAIP, we are including how we intend to enhance system wide access and capacity to manage winter surge demand from Acute Respiratory Infections, (ARIs), identified as one of the "High Impact Actions" for Winter 23/24. (See Appendix 4 - Winter 2023/2024 – Adult and Paediatric ARI Hubs – LLR Response).

Place Based Access and Integration Plans

63. Again, although not an explicit "NHSE requirement", our SLAIP plan references our "Place Based Access and (Primary Care) Integration Plans" as these are the 'strategic conclusion' of our access improvement work and are symbiotic with our Integrated Neighbourhood Teams development.

64. Reflecting nationally, the Fuller Recommendations, the development and implementation of "Modern General Practice Access" through the "Primary Care Access Recovery Plan" and the Network Contract DES Capacity and Access payments; and locally the LLR ICS Joint Five Year Plan and LLR Integrated Neighbourhood Team evolution; Place based "Access and Primary Care Integration Plans" are being developed for the 3 LLR "Places" – Leicester, Leicestershire, and Rutland.

65. This work is being led by the ICB Place Clinical Leads, supported by ICB Place managerial leads, (the Place Team), with them working collaboratively with the place PCNs, Federations, and Practices and relevant Integrated Neighbourhood Teams.

66. The key 'asks' and aims of the "Place Access and Primary Care Integration Plans are: -
    - to design – now - and implement - by 1st April 2025 - integrated systems, processes, and or services that provide and sustain same day access to general practice services, whilst ensuring and maintaining continuity of care for those practice patients who need it
    - That the required capacity for both "same day access" and "continuity of care" is determined by the identified "7/7", "365" access to health care needs of the local population(s)

67. In developing the Plans, the Place Teams will: -
    - Proactively engage with all stakeholders potentially impacted by the plan and or plan
    - development
    - Review and consider the demographics and needs of the relevant local population(s)
    - Review and consider current service configuration and utilisation
    - Use this intelligence to determine the "case for change" and, therefore, the scope of their Place Plan, and the integrated model of care required to best achieve the access aims for the relevant local population(s)
    - Contribute and support to any Public Consultation required because of changes to services within the emerging and final Place Plans

68. The Place Access and Primary Care Integration Plans will all describe a degree of service change. Depending on the significance of this change, a Place-level Public Consultation maybe required.

Communication and Engagement – and the "Patient Voice"

69. The delivery plan commits to a national communications campaign to increase public understanding of the changes to primary care services, the benefits they bring, and how and what services they can access.

70. We will align national messaging, (and materials), with LLR "system" and "local" messaging, materials, and methodologies, using learning from previous major campaigns, such as "Get in the Know" and "Talk before you Walk", and from how we have identified and addressed immunisation inequity. We will also harness the insights gleaned from local and national patient surveys, such as "GPES" and our local Enhanced Access design surveys.

71. Three main focus areas have been identified for our campaign: -

    I. "The Wider Practice Team" - to increase service users' knowledge of and confidence in the primary care triage process and the wider multi-disciplinary team of clinicians and health and wellbeing workers that are available in general practice and in local communities.
    II. "Digital Access" - to increase awareness, understanding, and uptake of the digital routes for accessing general practice services.
    III. "The Wider Care Available" – to increase awareness, understanding, and utilisation of services and access routes such as NHS 111 (to increase the number of people with a perceived urgent care need to access the NHS 111 service so that they can be triaged and directed to the most appropriate local service), Community Pharmacy Common Conditions Service, and those services with "self-referral" pathways.

72. As well as delivering ourselves, we will utilise community assets and networks to ensure "the message" gets to those populations and communities that need it the most, and we will support our practices so they themselves can engage with and empower their patients, again ensuing inclusion for all their patients. We have specifically asked PCNs to consider and plan for this in their CAIP plans.

PCN Capacity and Access Improvement Payment (CAIP) Plans

73. The national requirements, under the Capacity and Access Guidance for 2023/24, for the development of our PCN's CAIP Plans is shown in Appendix 1.

74. All 26 LLR PCNs submitted plans to the ICB as per the national deadline, and all 26 plans were accepted by the ICB. It is expected that these plan will be iterative and there will be opportunities, formal and informal, throughout the year to guide and support further development and implementation. Our proposed process to allocate CAIP funding to our PCNs is described later in the paper.

75. Whilst all 26 PCNs have described how they will address/achieve the core CAIP requirements, a number of themes emerged from the submitted plans. (See *Table 2 – LLR CAIP Plan Themes* below). These have been shared with all PCNs to share ideas and spread innovation.

Table 2 – LLR "CAIP" Plan Themes

Ideas shared	Themes from Plans
• Addressing 8am rush • Empowering pts – Modern General Practice options (NHS App, Online Consultation, CPCS, use of ARRS, etc) • Active Signposting Training • Use of CBT triangulation data • Maintain project / delivery plan to monitor progress • Collaboration with partners and voluntary organisations to deliver the plan • Linked to the H&W / Place Plans	• Collaboration with PPGs • Develop bespoke in-house surveys to engage with pts, e.g., use text/ QR • Employ Digital Lead, Care Coordinator to support with capacity and demand/ empower pts • Promoting ARRS, CPCS services • T&D of staff; Active Signposting • Update website- self-help options, improve content and online consultation • Segmentation of population • Triangulation of CBT / Online consultation data – addressing demand/capacity and staff management • Integrated working with partners / voluntary organisation • Website review and redesign / social media and use of QR codes

Self-referral Pathway Development

76. The clinically led development, and then the subsequent promotion of, to professionals and service users, of self-referral pathways for services identified in the 2023/24 Planning Guidance, is key to managing demand on, and preserving access to general practice in LLR. They will mean patients do not need to contact their practice, and or will provide another, clinically appropriate, alternative care option.

77. We have under-taken an initial national self-assessment, with a second self-assessment to be completed imminently. This will allow us to make a local decision, based on best judgement, whether self-referral routes are in place, and, where routes are not in place inform the clinical reasons as to why not.

78. We are awaiting illustrative targets from the national team outlining the levels of self-referrals that that we will be expected to achieve.

79. Empowering patients to safely utilise self-referral pathways, and supporting our practices to so empower their patients, is a key strand of our Recovery Plan Communications strategy.

Assuring Delivery of our LLR System-level Access Improvement Plan

80. The figure below, *Figure 4 – LLR System-level Access Improvement Plan Assurance,* shows the assurance components within our system-level plan.

81. This is also included in Appendix 1, which details the guidance and recommendation for the scope and development of ICB SLAIPs received from NHSE.

Figure 4 - LLR System-level Access Improvement Plan Assurance

82. *Appendix 3 - Delivery Plan for Recovering Access to Primary Care – Assurance Trackers* - details the dashboards and trackers, reflecting this guidance and recommendation, we have developed, with metrics and trajectories when/where appropriate, to monitor and inform delivery of the LLR SLAIP.

83. The table below, *Table 3 – LLR System-level Access Improvement Plan Governance,* shows the assurance and governance route for each of the assurance components reflected in our SLAIP.

Table 3 – LLR System-level Access Improvement Plan Governance

System-level plan component	Reports to…	Escalation to…
PCN CAIP Plans	CAIP Steering Group	Strategic Commissioning Group and Primary Care Transformation Board
PCARP PCN Actions	Primary Care Transformation Board	TBC
PCARP ICB Actions	Primary Care Transformation Board	TBC
PC/UEC Access Actions	PC/UEC Access Ops Group	Primary Care Transformation Board or Acute Care Collaborative

PCN Capacity Access Improvement Payment Plan Assurance

84. The NHSE CAP guidance states that for PCNs to receive the 30% CAIP funding, the ICBs will make an assessment based on the local improvement across the three key areas detailed in the guidance. A paper is due to be submitted to the ICB Strategic Commissioning Group in October to seek approval of the proposed local review and assessment process the ICB will undertake when final CAIP plans are received after 31 March 2024 in order to determine if full or part payment of the CAIP is offered to PCNs.

85. The ICB I&T Team and relevant clinical leads, have developed a dashboard based on national and any local indicators available and listed below: -
    a. Patient Experience GP Survey Results (July 22)

b. Friends and Family Test when published.
c. NHS App enablement and utilisation
d. Online Consultation
e. Practices on CBT
f. Practices on analogue but migrating to CBT and signed up to a supplier from the national cloud-based telephony framework
g. GPAD data on appointment slots; % unmapped or unknown
h. CPCS referrals
i. ARRS current and proposed recruitment – ARRS Workforce plans
j. Active signposting training

86. This will be shared with PCNs and used to assess each PCN's progress throughout the year, with "issues" being raised and addressed at each PCN's mid-year review.

87. This proposed CAIP Assessment process has been shared with LMC and Place Leads for views and recommendations. If the proposed assessment process is agreed, this will be presented to PCNs as part of the CAIP webinars from October onwards. The ICB will continue to support PCNs during the year with their delivery plans with the expectation that they work towards improving their baseline position.

88. The LLR ICB Strategic Commissioning Group will continue to receive:
    - a mid-year update on how PCNs are progressing on implementing their CAIP plans
    - Assurance against the actions outlined in the Delivery Plan Checklist
    - Any updates published by NHSE which will support PCNs with assessing the final CAIP plans

Recommendations:

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

RECEIVE this report that describes the key components of the LLR System-level Access Improvement Plan and outlines how the ICB intends to deliver its key actions and priorities.

APPROVE the draft LLR System-level Improvement Plan for Primary Care with a progress report to come to the Board in March 2024.

APPENDIX 1

LLR SYSTEM-LEVEL ACCESS IMPROVEMENT PLAN – NHSE Guidance and Recommendation

This appendix summarises the guidance and recommendation from NHSE to all ICBs regarding to the scope and development of their own "System-level Access Improvement Plans (SLAIP), and illustrates how this guidance and recommendation has been incorporated into our SLAIP.

What is in our System-Level Access Improvement Plan

Vision and Improvement Approach

The diagram below – Figure 1: LLR System-level improvement access plan – shows the components within our system-level plan reflecting the guidance and recommendation received from NHSE

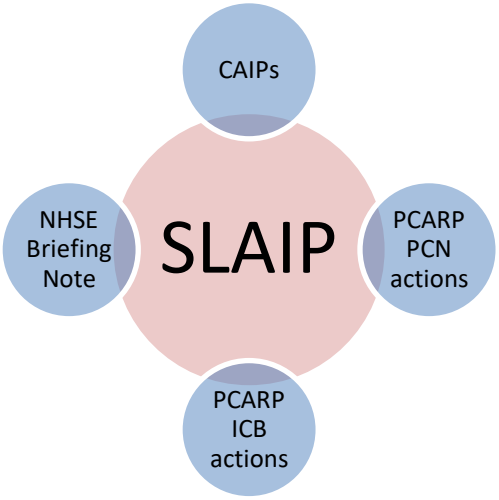


Figure 1 LLR System-level improvement access plan components

The ambitions and actions described in the full report reflect those described for each component in the NHSE guidance and recommendation.

PCN Capacity Access Improvement Payment Plans (CAIPs)

In June and August 2023, the Strategic Commissioning Group were presented with a report outlining the national requirements under the Capacity and Access Guidance for 2023/24 which was distinguished in two-part payments as outlined below:

- **Capacity and Access Support Payment** calculated at 70% payment made unconditionally to PCNs in 12 equal allocations over the 2023-24 financial year.

- **Capacity and Access Improvement Payment** at 30% payment which will be paid in full, or in part, to PCNs following delivery of an improvement plan at the end of March 2024 and paid before August 2024.

From April 23 onwards, the ICB have been working closely to support PCNs in the development of their Capacity and Access Improvement Payment (CAIP) plan by providing baseline data and a range of on-going support to consider how they will make improvements in the following **three key areas** outlined in the guidance:

- **Patient experience of contact** - through surveys, PCN analysis of data and friends and family tests to patients including engagement

- **Ease of access and demand management** - Cloud based telephony, effective use of online consultation systems including appointment making and support.

- **Accuracy of recording of appointments** by complying with the categorisation guidance (GPAD)

In addition, the ICB have encouraged PCNs to incorporate within their plans the requirements outlined within the **Delivery Plan for recovering Access to primary care**; through *empowering patients*, *modernising general practice, build capacity and cut bureaucracy*.

In July 2023, NHSE published a briefing note to support the development by ICBs of their system-level access improvement plans. This referenced a "checklist", published June 2023, which detailed expected actions for both ICBs and PCNs to achieve primary care access recovery.

Primary Care Access Recovery Plan – PCN Actions

PCN actions detailed in the June checklist are shown as Appendix . As per the July briefing note, LLR ICB will ensure that it's system-level plan will include:

- An overview of PCN CAIPs and assurance that all required PCN actions have been included/covered in system-level plan
- Delivery confidence for all aspects of the recovery plan, i.e., empowering patients; implementing modern general practice access (MGPA); building capacity; cutting bureaucracy
- Description of support and training offers, and details of individual practice/PCN up-take of those offers
- Consideration of the key challenges and risks identified by PCNs, and their mitigations

Primary care Access Recovery Plan – ICB Actions

ICB actions detailed in the June checklist are shown as Appendix. Asper the July briefing note, LLR ICB will ensure that it's system-level plan will include:

- All ICB actions from the delivery plan checklist
- The delivery approach for all aspects of the delivery plan for recovering access to primary care, i.e., empowering patients; implementing MGPA; building capacity; cutting bureaucracy
- The actions the ICB will take to improve the primary-secondary care interface, including the four key areas set out in the recovery plan with clear leadership responsibility at Board level
- The LLR plan to support signup and implementation of the pharmacy Common Conditions Service, including reviewing of existing locally commissioned services to ensure strategic fit
- That "scaling opportunities" and a coordinated approach to procurement has been considered for digital offers/platforms, and that the business change required for the implementation of digital tools has been considered
- How the Support Level Framework has been used with practices and PCNs to identify support needs

- What local support is being provided/funded

- How the ICB is leveraging and ensuring maximum uptake of national transformation support and training offers, including ensuring participation from PCN/practices that need support the most

- ICB plans to support and build workforce in LLR, including supporting PCNs to use their full ARRS budget, delivering GP retention schemes and promoting national health and wellbeing offers

- How the ICB is building improvement capability and capacity within and across the system, including sharing learning across the system?

- How the ICB will assure delivery

The guidance and recommendation received from NHSE also identifies and highlights key elements and inter-dependencies that are again reflected in and incorporated into our LLR SLAIP. These are shown in the diagram below – Figure 2: LLR System-level improvement access plan elements – shows the elements of, and inter-dependencies for our system-level plan.

Figure 2: LLR System-level improvement access plan elements

Appendix 2

LLR PCARP Workforce Plan Summary

- Continuation of the thriving GP Fellowship as it enters a third year and welcomes cohort 3 of GP fellows with a range of CPD and support offers as they settle in to new roles in practice
- Development of a Fellowship+ and mid/wise years offer to support GPs looking to diversify and to retain their skillset and capacity – including coaching, mentoring, GPs with a Special Interest (GPwSI) development, wellbeing, PCN integration, leadership development and continued peer support, plus full access to the LLRTH CPD events calendar
- Introduction of an IMG GP Ambassador and Fellowship Ambassador to support integration in to primary care
- Strengthening of current relationship with Leicester Medical School to ensure greater involvement and connectivity with ST1, 2 and 3s to promote primary care in LLR as the preferred career choice
- Funding provision for the continuation of the Next Generation GP programme across LLR and the East Midlands geography, linking closely with the fellowship and enhancing education and support opportunities
- Continuation of GP Mentoring – supporting newly qualified and new to area GPs to settle in to practice and thrive, whilst also bolstering mentoring capacity with a formal training programme for new and existing GP mentors seeking to pursue this aspect of their career
- Further development of outreach programmes with HEIs, colleges and schools to ensure equitable access to medical education and subsequent careers in primary care
- Further development of the new to practice nursing programme, including expansion of capacity on the GPN Fundamentals Programme at DMU, protected time for study and implementation of learning, leadership development, access to the Shapes Toolkit™ , CARE Programme and fully funded access to CPD events as relevant from the LLRTH CPD event calendar
- Development of practice nurse preceptorship to support greater integration and support in primary care
- Support with practice nurse recruitment – development of pertinent advertising, job descriptions, person specifications and interview questions, plus information pertaining to the local area
- Support for newly qualified or new to area nurses in their search for a new role in general practice – process being developed to ensure that recruiting practices are connected to candidates and support through the recruitment journey
- Support for PCNs to develop colleagues in primary care recruited to ARRS roles, maximising preceptorship offers, grant funding to support development
- Continuation of the established Communities of Practice for ARRS and well established primary care roles, offering opportunity to network, protect time for sharing good practice and overcoming barriers to progress, education opportunities and support
- Continuation and expansion of the LLRTH designed ARRS/New to Primary Care Induction programme (cohort 3 commencing in October 23), supporting colleagues new to primary care with essentials (orientation, systems, coding, MDT teamworking, remote consulting and triage, management of common and emergency presentations) and enhanced induction modules (introduction to long term conditions – asthma, heart failure, COPD, Diabetes) – with an opportunity for colleagues in primary care to influence the agenda
- Introduction of group video clinics for PCN teams – fully funded training provided to support teams to utilise VGC to maximise clinical time and provide greater support to patients
- Support to introduce new clinical and non-clinical apprenticeships in to PCNs, ensuring the appropriate levy funds and governance is in place, and course capacity is secured at local HEIs
- Increase in the number of clinical placements in primary care, supporting greater exposure to general practice and an opportunity to attract people in to the workforce

- Increased local funding to support placement provision in primary care – a local top up tariff is in place for student nurses and a pilot programme will launch in the autumn for student paramedics and nursing associates
- Provision of non-clinical training programmes to support rapid upskilling for colleagues new to primary care administrative roles
- Continuation of interprofessional education sessions delivered for both undergraduate and postgraduate students, supporting the workforce to understand the differing roles in practice
- Annual Training Needs Analysis to support local commissioning intentions pertaining to training and education for primary care colleagues (at practice and PCN level)
- Full engagement with the METIP planning and submission process to ensure future education, training and development capacity secured for the primary care workforce

Appendix 3 **Delivery Plan for Recovering Access to Primary Care – PCN/Practice Check-list Tracker – NHS App and Engagement**

Commitment	Description	1st Level Metric	1st Level Timeline	2nd Level Metric	2nd Level Timeline
Empowering Patients	Prospective online record access	Y/N		100%	November 23
Empowering Patients	Directly bookable online appointments available	Y/N Plan Y/N	August 23	# of registrations for & appointments made via NHS App	
Empowering Patients	NHS secure messaging in place*	Y/N	ongoing	Plan Y/N	ongoing
Empowering Patients	Repeat meds ordered via NHS App	Y/N	ongoing	# of repeat meds via NHS App	ongoing
Capacity	Submit ARRs WF Plan	5 PCNs submitted	September 23	Budget spend	
Capacity	Review and uptake local offers for retention	Y/N	ongoing	WF data, fewer leavers	ongoing
Reducing Bureaucracy	Feedback to ICB re Primary/Secondary Care interface	Y/N			

Delivery Plan for Recovering Access to Primary Care – ICB Check-List Tracker

Commitment	Description	1st Level Metric	1st Level Timeline	2nd Level Metric	2nd Level Timeline	Data Source
Empowering Patients	Establish self-referral pathways	Y/N	October 23	Self- referral rates	N/A	Service Hosts
Empowering Patients	Optometrist to Opthalmology direct referral pathways	Y/N	October 23	Referral rates Referral quality	N/A	ECT
MGPA	111 diversion process	Y/N	April 24	"Breeches"	N/A	PC OPEL NHSE 111
Reducing Bureaucracy	Progress with PC/SC Interface	Focus Area progress	Public Board Oct 23	Practice feedback	Public Board Spring 24	TCS
MGPA	Sign up practices, analogue to digital	# to move	July 23	#/% completed move	ongoing	IM&T
MGPA	Digital tools from DPF	Y/N	September 23	Y/N	ongoing	IM&T
MGPA	Nominations for national transformation support	List	ongoing	List	April 25	PCT
MGPA	Provide local hands-on support	Y/N	April 24			PCT
MGPA	Agree/distribute transition cover and transformation funding	# practices received	ongoing	Actual funding allocation against planned	ongoing	PCT
MGPA	Co-ordinate nominations & allocations to CN training, PCN TL training	50% of allocation nominated	August 23	100% of allocation nominated	ongoing	PCT
MGPA	CAIP baseline sign off	Y/N	July 23	N/A	N/A	CAIP SG
MGPA	Agree practice/PCN support needs	Y/N	15th July 23	N/A	N/A	PCT

Commitment	Description	1st Level Metric	1st Level Timeline	2nd Level Metric	2nd Level Timeline	Data Source
MGPA	Sign off CAIPs	% of plans signed off	August 23	N/A	N/A	CAIP SG
MGPA	Pay CAIP	% PCNs paid	6th August 24	% of ICB budget allocated	6th August 24	CAIP SG
MGPA	Develop SLAIP	Y/N	Oct/Nov 23	Progress report	Spring 24	
Capacity	Full use of ARRs	PCN Y/N	ongoing	PCN spend against allocation	April 24	PCN Dev Grp
Enabler	System Coms		ongoing		April 24	
Enabler	Up to date DoS	Training webinar Y/N	ongoing		April 24	

Delivery Plan for Recovering Access to Primary Care – Briefing Note Actions

Commitment	Description	1st Level Metric	1st Level Timeline	2nd Level Metric	2nd Level Timeline	Data Source
All	DP Checklist	Y/N	November 23	Y/N	Spring 24	Board Paper(s)
All	RP 3 key areas	Y/N	November 23	Y/N	Spring 24	Board Paper(s)
Reducing Bureaucracy	4 key areas of PC/SC interface	Y/N	November 23	Progress in Focus Areas	Spring 24	TCS
MGPA	Pharmacy CCS	Y/N	November 23	Progress	Spring 24	CP Liaison Group
	Review of AMR processes	Y/N	November 23	Impact	Spring 24	MOT
MGPA/Empowering Patients	Scaling of digital procurement	Y/N	November 23	Update	Spring 24	IM&T
MGPA/Empowering Patients	Digital tool implementation BC	Y/N	November 23	Update	Spring 24	IM&T
MGPA	SLF used to identify development needs	Y/N	November 23	Update	Spring 24	PCT
MGPA	Local Support	what	November 23	Update	Spring 24	PCT
MGPA	Maximising uptake of national transformation support	How	November 23		Spring 24	PCT
Capacity	Building WF support	ARRS budget R&R data H&WB offers	November 23	Update	Spring 24	WFT
	Building improvement capacity	How	November 23	Update	Spring 24	I&T

Appendix 4
Winter 2023/2024 – Adult and Paediatric ARI Hubs – LLR Response

Adults

1. BACKGROUND
• NHS England and UK Health Security Agency (UKHSA) reports from 2020-2022 show that acute respiratory infections are among the most common reasons for emergency attendance and admission. Scenarios for COVID-19, combined with those for flu, suggest that even in optimistic scenarios, high numbers of appointments and beds will be needed for respiratory patients during Winter.
• Primary care, secondary care, and NHS111 will need to work together to prevent large numbers of children and older patients with breathing difficulties from being triaged with the outcome of an emergency ambulance, as many of these patients do not need to be admitted and can be looked after in the community.
• In the NHSE Winter Letter published in July 2023, Acute Respiratory Infection Hubs are listed as one of the ten high-impact interventions for Winter 2023/2024. They should "support consistent roll-out of services, prioritising acute respiratory infection, to provide same day urgent assessment with the benefit of releasing capacity in ED and general practice to support system pressures."

2. LAST YEAR – WINTER 2022/2023
• By the end of Winter 2022/23, we had 8 ARI hubs, one of which was paediatrics only, and the others were for both paeds and adults. The hubs saw an additional 4341 adults between January and the end of March. Around 1.6% were sent to ED/A&E after assessment.
• 61% of adults were discharged home, which might indicate that the majority of these people could have been managed by pharmacy/111/CNH or over the phone instead of having a face-to-face ARI appointment.
This was also evident in the presenting conditions and diagnoses. However, all our data is free text (due to implementation speed), so it can't be relied upon fully. And we didn't have robust patient triage in place.
• Additionally, many patients were seen for more chronic presentations of the allowed criteria, for example, coughs lasting longer than 4 weeks or sinus problems over several months.
• When compared to other systems, our average price per available appointment was quite expensive: £73. And because only 72% of our appointments were utilised, the average cost per utilised appointment was £102.

3. CAPACITY & DEMAND
• We cannot know the adult ARI demand over a given winter – at the moment, our primary care data doesn't allow us to know how many people will get an acute respiratory infection and want to be seen.
• However, using the data we have, there is an undeniable surge in acute respiratory infections in LLR, as well as an increase in related emergency admissions and A&E attendances between October and February.
• Nationally, it is understood that 73% of ED attendees are discharged on the same day of arrival. (GIRFT – Emergency Medicine) For LLR, between April 2022 and March 2023, 58% of those patients coded with a complaint of "airway/breathing" in A&E were not admitted. In many cases, it would be more appropriate for these patients to be seen in the community.
• There are generally two types of adult patients who will require a service to manage their acute respiratory infection:

1.) Patients with no known respiratory conditions who get an ARI and need low-level care, reassurance and perhaps some medicine such as over-the-counter products or antibiotics. Some of these patients might legitimately require urgent treatment from secondary care services, which is appropriate.
2.) Patients with known respiratory conditions who are more at risk from getting an ARI and are more likely to have adverse effects, more likely leading to treatment from secondary care services and are at risk of a longer length of stay.

4. PROPOSAL

• For Cohort 1, who don't require secondary care treatment, there are additional services/improvements in the system which have/will be set up to manage this kind of demand. They are:

- Maximising Community Pharmacy use (including CPCS) – *suitable complaints include coughs, flu symptoms, sore throat, blocked or runny nose, earache, etc.*
- Minor Injuries and Minor Illness Unit (MIaMI)
- Better access to GP services through Enhanced Access and the Capacity & Access Improvement Plans (CAIP)
- Redirecting appropriate patients from ED to Type 3 Urgent Treatment Centres such as Oadby/Merlyn Vaz.
- Increase walk-in capacity at UTCs instead of booked appointments. See ARI patients as a priority.
- Increase use of NHS App – advice and reassurance.
- Growth of 111 and Clinical Navigation Hub, including retired clinicians – As part of LLR Delivery Plan to recover UEC services, May 2023
- Targeted immunisation programmes such as flu/COVID – increasing uptake will reduce the incidence of ARI.

Based on our estimated data on ARI Hubs from last year, the majority of the surge in ARI demand for cohort 1 (who do not require urgent secondary care treatment) will be captured by one or more of these services.

All of these services are designed to meet our objective: to support the ARI demand in primary care and ED and ease system pressures.

There is already a tremendous amount of work happening to improve or implement these services ready for this Winter, and it is proposed that we don't add any more services to an already busy and complicated system.

However, all these services will be continually monitored through the UEC programme and the associated dashboard.

Finally, the ICB comms and engagement teams are implementing a targeted communications plan to ensure that patients know where to go and what to do over Winter. This is called "Get in the Know."

• For Cohort 2, more work is needed to help our known respiratory patients in case of ARI. There are two types of interventions:

- Proactively monitoring appropriate patients to spot signs of deterioration earlier, likely using technology. This can also be known as 'remote monitoring.'
- Proactively optimising known respiratory patients so that in case of exacerbation or ARI, they and their clinicians are more prepared, de-escalation will be quicker, and in case of a hospital

stay, length of stay may be reduced. This will also help to support flow through UHL, including pressures on the front door.

There is already a service in place to remotely monitor some COPD patients. Spirit Health provide the technology, and the platform is called Clinitouch Vie. It would be beneficial to expand this kind of "telehealth"; however, there isn't currently any additional funding to do this. A review of this service is now underway to evaluate its effectiveness, and we can ensure it is maximised, even without any additional funding.

A lot of the work for proactively optimising patients at risk of ARI has been scoped by the Integrated Respiratory Team for Winter, and the 12-point plan can be found at Appendix 5.

There is a potential opportunity to involve General Practices, incentivising using the Primary Care SDF funding. Before population weighting, this would equate to £19,230 for each PCN to help them work with partners and ensure our higher-risk respiratory patients are as prepared as possible for Winter and potential ARIs.

Paediatrics

Proposal to consider:

- Improved communications about existing provision and how to access
- Expand capacity at Minor Injuries & Minor Illness unit (MIaMI) to deal with paediatric infections
- Possibility of a Community Hub
- Increased access to Consultant Connect
- Provision of 48 hour reviews
- Creation of a Paediatric virtual ward (respiratory)

What is our Respiratory Winter plan for 2023/24?

This is a system-led plan with participation from LLR ICB, UHL, LPT, Pharmacy and General Practice. It is coordinated through the existing Integrated Respiratory Team.

A. **Update both the UHL DOS (Directory of Services) for Respiratory and the local DOS to help ensure existing respiratory patients are seen in the right place**

B. **Re-open 'hot' clinics or slots with the Respiratory Team in UHL**

C. **Ensure that PCNs align with the LPT Community Respiratory team to support reviews and hold clinics for higher-risk patients. Particularly those PCNs with high rates of emergency admissions/attendances**

D. **Send blanket communications (e.g., AccuRx text) from General Practice and UHL to all high-risk known respiratory pts; with preparedness information/advice**

E. **Develop and add QR Codes to the bottom of Respiratory Consultant letters and appointment letters for patients to access preparedness information/advice**

F. **Write a SOP for Rescue Packs and ensure all system services can prescribe where appropriate (with consideration to stepping-down again)**

G. **Run an educational 'Teams Live' event for known respiratory patients that can be recorded and shared**

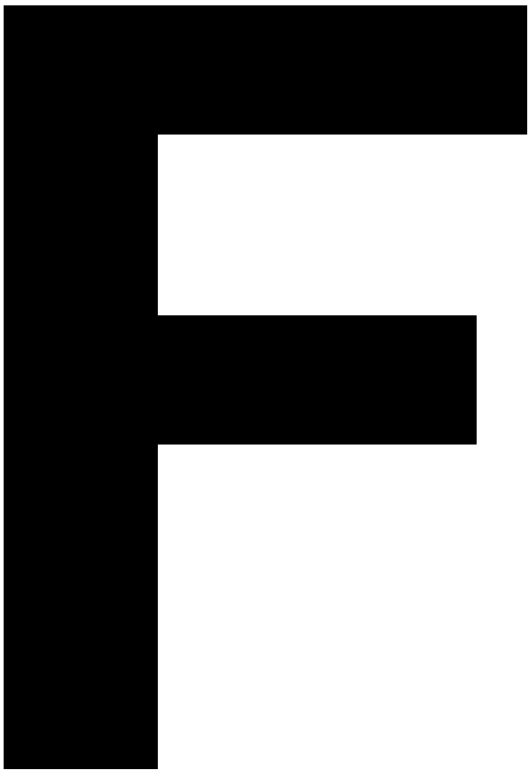
H. **Hold webinars for Primary Care staff including items such as managing exacerbations, rescue packs and pulmonary rehabilitation**

I. **Pilot and then develop in-reach onboarding for the COPD Virtual Ward from the Emergency Department**

J. **Where possible, expand the current remote monitoring (Telehealth) offer and evaluate its effectiveness**

K. **Create short information videos for respiratory patients to help them understand their conditions**

L. **Expand SDEC to include a new separate Chest Pain pathway to allow more respiratory patients to be seen**



Name of meeting:	**Leicester, Leicestershire and Rutland Integrated Care Board Meeting Public**		
Date:	**12 October 2023**	**Paper:**	**F**
Report title:	**LLR Delivery Partnership – Delivery of the LLR one- and five-year plans**		
Presented by:	Rachna Vyas, Chief Operating Officer, NHS LLR ICB		
Report author:	Serena Pook, System PMO		
Executive Sponsor:	Andy Williams, Chief Executive, 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 ICB is asked to:

- **NOTE** the full contents of the report, the progress outlined against both the one- and five-year plans and the escalations made to each sub-committee.

Purpose and summary of the report:

1. This paper highlights progress against each facet of the LLR operational plan as part of the LLR five-year plan, on behalf of all system Partnerships. In this report, progress against delivery of 12/13 pledges in the five-year plan is outlined; pledge 13 (our people) is integral to the delivery of pledges one to twelve and is reported through the people and communities plan. Work to triangulate this within this report is underway.

2. Assessments against each facet of the plan are recommended as follows:

   a. **Performance** – Overall rating AMBER
      In terms of performance, Cancer standards remain off track and are of primary concern. Whilst monthly trajectories are off plan for some metrics, most are within tolerance levels against the planned positions at M5 and confidence remains high within Partnerships to recover the position by year-end.
   b. **Finance** – Overall rating RED
      The key risk to delivery overall remains a financial risk; at M5, the financial position has deteriorated, with a significant portion of this position assessed as due to external factors. The teams remain focused on delivering the agreed Cost improvement plans at organisational and system level, with a further focus on assessing benchmarking information across each Partnership.
   c. **Quality & transformation** – Overall rating - AMBER
      In terms of quality, there are no new risks identified this month; focus remains on the CYP and maternity portfolios. The Quality Assessment Framework has been distributed to all Partnerships to strengthen the governance between Partnerships and the System Quality Group. Transformative plans continue to progress as planned, with progress reflected in performance metrics across the system.
   d. **Equity –** Position not yet agreed with committee, likely AMBER
      Each of the transformation programmes highlighted have been rooted in our knowledge of inequity – the examples provided through the paper demonstrate how the information we hold as a system is being used to tackle systemic inequity. Links have now been

made with the Health inequalities Support Unit to ensure flow of information to and from each Partnership. 3. Progress continues to be made across the month of August 2023; despite industrial action preparation, system teams have remained focussed on delivery of both one- and five-year plans.	
Appendices:	
Report history (date and committee / group the content has been discussed / reviewed prior to presenting to this meeting):	• Various partnerships

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 01 - Quality of care provided by acute providers. BAF 02 - Quality of care provided by non-acute providers. BAF 03 – Quality of care and service provided by emergency patient transport services. BAF 04 - Quality of care provided by non-emergency patient transport services BAF 07 - EPRR arrangements.

b) Does the report highlight any resource and financial implications? If so, provide which page / paragraph this can be found within the report.	No new funding requests
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.	Yes, throughout 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.	Any new services / service changes will be made with due regard to the Inclusive Decision-Making Framework and the PSED

LLR Delivery Partnership – Delivery of the LLR one- and five-year plans

Background

1. This is the third, integrated delivery report from the LLR Delivery Partnership, covering progress against the LLR Operational Plan and the LLR five-year plan made at Month 5 of 2023/24. The key aims of this paper are to highlight areas of challenge and concern across the various partnerships /collaboratives, highlight areas of good practice, and seek specific support where required from the system executive, system finance committee, system equity committee and the system quality committee or their respective sub-groups.

Overall status against Operational Plan

2. 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.

3. Assessments against each facet of the plan are recommended as follows:

   a. **Performance** – Overall rating AMBER
   In terms of performance, Cancer standards remain off track and are of primary concern. Whilst monthly trajectories are off plan for some metrics, most are within tolerance levels against the planned positions at M5 and confidence remains high within Partnerships to recover the position by year-end.
   b. **Finance** – Overall rating RED
   The key risk to delivery overall remains a financial risk; at M5, the financial position has deteriorated, with a significant portion of this position assessed as due to external factors. The teams remain focused on delivering the agreed Cost improvement plans at organisational and system level, with a further focus on assessing benchmarking information across each Partnership.
   c. **Quality & transformation** – Overall rating - AMBER
   In terms of quality, there are no new risks identified this month; focus remains on the CYP and maternity portfolios. The Quality Assessment Framework has been distributed to all Partnerships to strengthen the governance between Partnerships and the System Quality Group. Transformative plans continue to progress as planned, with progress reflected in performance metrics across the system.
   d. **Equity –** Position not yet agreed with committee, likely RED
   Each of the transformation programmes highlighted have been rooted in our knowledge of inequity – the examples provided through the paper demonstrate how the information we hold as a system is being used to tackle systemic inequity. Links have now been made with the Health inequalities Support Unit to ensure flow of information to and from each Partnership.

4. Progress continues to be made across the month of August 2023; despite industrial action preparation, system teams have remained focussed on delivery of both one- and five-year plans.

Look ahead to the next report

5. Teams are assessing how to combine the reporting of the five-year joint plan and that of the one-year operational plan.
6. A revised assurance framework is being assessed based on an 'alert, advise, assure' framework – the Delivery Partnership will receive this framework in August, with a view to implementation in October 2023, as requested through the Quality Committee.
7. Specific application of the data and intelligence from the Health inequalities support unit will start to be evidenced, as requested through discussions with Chair of the Health Equity committee
8. Further detail on the opportunities for financial recovery will be summarised, as requested by the Finance Committee.

Recommendations

System Executive is asked to:

- Receive & Note the full contents of the report

System Quality Committee is asked to:

- Receive & Note the full contents of the report, including the progress of the transformative schemes showcased
- Note that the System Quality Group has cross-checked quality risks highlighted in this report with either risk registers or for discussion through quality governance

System Finance committee is asked to:

- Receive & Note the full contents of the report

System Health Equity committee is asked to:

- Receive & Note the full contents of the report
- Support identification of areas of focus for Partnerships in preparation for planning 24/25

The ICB is asked to:

- NOTE the full contents of the report, the progress outlined against both the one- and five-year plans and the escalations made to each sub-committee

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

Transformation of primary care continues at pace, delivering **pledge four** of the LLR five-year plan to improve access to routine general practice appointments. Year one of the five-year plan includes actions to increase the 'additional roles' recruitment across LLR, the total number of appointments and streamlining access to a wider range of primary care services, such as community pharmacy pathways. Progress against these is on track and evidenced in aligned performance metrics below.

Performance against Operational Plan

Standard	Plan	Actual	RAG	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	82.4% July 23	Within 5% tolerance	High All 26 PCN's have submitted high quality capacity plans, on track to deliver. Year on year analysis shows that summer months tend to have a dip in appts.
Continue on trajectory to deliver more appts in general practice by March 2024	600,753	577,585 July 23	Within 5% tolerance	
Continue on trajectory to recruit additional roles (ARRS) by end of March 2024	502	526.7 July 23	Met	Updated figure from last month as all claims received
Recover dental activity towards pre-pandemic levels	Data not yet available			
Overall Assessment	**No escalations to System Executive**			

Finance

Team	Scheme Name	Rag Rating	Plan	Actual / Forecast	Var	Confidence in delivery/mitigation
Primary Care	Review of associated budgets (based on outturn)		5,841	1,041	(4,800)	Low overall
Overall Assessment		**Recommended removed from CIP and closed**				

Quality & Equity

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

From a programme perspective 3 key quality issues have been highlighted, with the potential to impact on quality and outcomes:

Issue	Escalation
Respiratory surge has highlighted the need for all age respiratory pathways to support system flow as BAU and not just specific to winter	ALERT - Risk to services understood – risk on quality outcomes/equity has been assessed No escalation
Phlebotomy in General Practice – a new delivery model is required across the system for primary and secondary care-initiated bloods.	ALERT - Risk understood by ODG and options for in year support are being considered with wider partners. No escalation

Procurement of Sexual Health services and impact on patients and General Practice	ADVISE - Equity of access and risk of greater health inequalities to specific patient cohorts being determined via internal EIA / QIA System Quality Group should be aware of potential risks to patients, including inequity of access
Increase in the number of Asylum Seekers placed in contingency hotels, specifically in Leicester City.	ADVISE - Concerns re funding and timeliness of sharing information re new arrivals to be raised at NHSE Regional Primary Care Board on 15/09. To be agreed post urgent meeting SQG should be aware that additional practices in the City may need to register these patients if Assist are not renumerated accordingly.
Overall Assessment	**Support is required from System Quality Group to understand the risk to outcomes for these areas**

Transformation

Achievements (aligned to Step 4 NHS Impact programme)	Outcome for our patients / colleagues
As of July 2023, **50,473** Enhanced Access appointments have been delivered in LLR since October 2022 by 26 PCNs. This is in addition to the appointments delivered at practice level. Many of these appointments have supported delivery of LD health checks, screening services, management of LTCs and other preventative services.	One of the pledges in our five-year plan is to ensure preventative services are upscaled across LLR. By using the enhanced access additional appointments to focus on preventative services, we can ensure general practice core capacity is available for those who need an on-the-day or planned service.
Following a flash flooding on 22nd June 2023, East Leicester Medical Practice suffered extensive damage which required the practice to shut with immediate effect. It was anticipated it would take a minimum of 3 months to get the practice to a safe standard, however through collaborative working across the system and support with interim arrangements, the patients were welcomed back on 29th August, just under 10 weeks following the incident.	Due to the partnership approach employed, patients of the practice suffered minimal disruption to services and our practice teams were well supported through the incident. As an ICB we work with our wider partners to collaboratively support General Practice and ensure they are resilient, sustainable, safe and able to deliver optimal quality of care to our population.
Continual improvement in CPCS (Community Pharmacy Consultation Scheme). LLR ICB were the highest performing system in the Midlands region for June and July. Slight dip in August referrals, however this is mirrored across the region and over 50% higher than last August.	Our engagement tells us that our patients want easy access to the right clinician at the right time for primary care type requirements. This service supports patients who may not have been able to or need to access GP support on the day – they can now access pharmacy support instead where appropriate. Supports practices to release GP/practice time for those who need this acuity of appointment.
Belgrave and Spinney PCN are focussing on improving health outcomes for target cohorts identified through risk stratification, this includes LD pts with long term conditions, Bowel Screening and Women' Health.	Taking a population health management approach is a key objective of the ICB and is supported by worldwide evidence. The Leicester City Health and Wellbeing plan recognises there are cohorts of the population

<table>
<tr><td>The PCN have delivered additional clinics with longer appts on Saturday and Sundays to meet the needs of their pts. Not only will this improve outcomes for patients but also supports the delivery of the City Health and Wellbeing Plan.</td><td>not accessing services and we have a responsibility to ‘find’ these patients and make our services equitable and accessible to meet their needs.

The work in Belgrave and Spinney is a great example of delivery of pledge one of the five year plan – to tackle health inequity</td></tr>
<tr><td>GP Access variation and resilience support work continues; all LLR practices now have an individual allocated ‘next step’ where appropriate for resilience interventions or to gain further assurance. This is a collaborative approach between I&T, Quality and Contracting.</td><td rowspan="4">Our general practice surveys indicate that LLR practices benchmark well in the ‘quality of care’ domains, but improvements are required in access domains.

Tackling variation in access is supporting our ICB ambition to have equitable access to general practice services across LLR and supports our practices to show improvement against national metrics</td></tr>
<tr><td>89% of practices delivering against the benchmark of 75/1000 clinical contacts against a plan of 75% (July 23)</td></tr>
<tr><td>42% of same day appointments delivered against an England average of 42% (July 23)</td></tr>
<tr><td>74% of face-to-face appointments delivered against a plan of 70% (July 23)</td></tr>
</table>

Major Conditions including Prevention and Health Inequalities – *delivered through the LTC Steering Group*

Our major conditions workstream continues to work across the key disease areas impacting on our population across LLR with actions. Actions taken through this area will support delivery of **pledge two and pledge three** of the LLR five-year plan to spend more money on preventing ill health and to identify the frailest in our community and wrap support around them.

Year one of the five-year plan includes actions to re-launch the 'proactive care' programme, driving up primary care identification of diseases to expected prevalence levels and to relaunch the 'complex care' programme, to improve disease management for frail and multi-morbid patients. Progress against these is on track. Whilst some progress can be evidenced in the aligned performance metrics below, outcomes for this programme will take time to evidence. Input measures, however, are on track and measured at the programme level.

Performance against Operational Plan

Standard	Plan	Actual	RAG	Confidence in recovery / Year-end delivery
Increase % of patients with hypertension treated to NICE guidance to 77% by March 24	77% 23/24	71% =79 years & below 80% = 80 years & below	Met	High Plan in place, with further focus on under-served groups
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	59.96% = 18 years & above	Met	High Plan in place, with further focus on under-served groups
Continue to address health inequalities and deliver on the CORE20PLUS5 approach	Part of each Partnerships plans – will be strengthen through link to Health Inequalities Support Unit			
Overall Assessment	**No escalations to System Executive**			

Finance

There are no schemes specifically for long term 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. Since M4 reporting, colleagues from the Health Inequalities Support Unit have agreed to design a 'return on investment' tool to provide an evidence base for these kinds of innovations. This is expected to be ready in October 2023 and will be ratified by CFO's, in readiness for the 24/25 planning round.

Quality & Equity

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

Issue	Escalation

The provider of our type 2 diabetes structured education and behaviour change programme, Oviva, are overperforming on capacity commissioned.	ALERT - Gap in service
Unlikely to achieve full practice sign up to the Diabetes Enhanced Service by 31 August 2023	ALERT - Any resulting inequity in service provision across LLR will need to be understood, with mitigations in place
Provider has withdrawn from the Early Onset Type 2 Diabetic Service	ALERT - Potential delay in service offer, risk to long term patient outcome will need to be understood, with mitigations in place
Delays in recruitment for the Familial Hypercholesterolaemia service, as well as reduced staffing model as 1 ICB has withdrawn	ALERT - Potential reduction in service offer
Tier 2 Weight Management Service in Leicester City	ADVISE - To note risk and potential implications Any resulting inequity in service provision across LLR will need to be understood, with mitigations in place
Overall Assessment	**Support required from System quality group to understand the risk to outcomes for these areas**

Transformation

Achievements (aligned to Step 4 NHS Impact programme)	Outcome for our patients / colleagues
In line with NICE guidance, **Continuous Glucose Monitoring** for diabetics approved through Clinical System Prioritisation for 4 high risk groups	Part of our work on equity, this programme will support better management of 4 priority diabetic cohorts to reduce HbA1c levels leading to reduce admissions and complications. It will make it easier for people to check their blood sugar levels and better manage their diabetes control
Type 2 Diabetes Pathway to Remission Programme (Low Calorie Diet) is on track to 'go live' on 13th September	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. The programme will support type 2 diabetics who are obese or overweight, establish healthy eating and activity habits which can lead to remission of type 2 diabetes, and is a positive example of delivery of **pledge one** of the five year plan – to tackle health inequity
Over 30% of practices are now trained to offer a **Diabetes Enhanced Service** from 1st September	Part of our work on equity, this programme will enable the management of complex patients in the community, to meet their diabetic treatment targets and enable medication initiation/titration
The **Integrated Chronic Disease programme** (pilot) has • Launched 8 patient educational videos • Shortlisted for a HSJ award • The projects patient representative has been shortlisted for UHL volunteer of the year award • LUCID clinics set up for 8 PCNs	Part of our work to deliver **pledge one** of five-year plan to tackle inequity, this programme means that by primary care and secondary care clinicians working in a more integrated way, people at risk of kidney disease will be detected and treated earlier to delay/ prevent disease progression in this population, impacting on their long-term health outcomes
Successful bid (£156k non recurrent) to help care for **early onset type 2 diabetics** (under 40 years)	Part of our work to deliver **pledge one** of five-year plan to tackle inequity, this programme will improve adherence to NICE-recommended care processes, particularly for people from ethnic minorities (especially people with South Asian ethnicity) and people living in the most socio-economically deprived areas, impacting on their long-term health outcomes
Successful bid (£60k non recurrent) to recruit LTC Champions to support earlier detection and diagnosis of **heart failure** in community settings	Part of our work on early diagnosis, this programme will support early detection, timely diagnosis and subsequent rapid access to virtual specialist input, impacting on long-term health outcomes
In readiness for winter, 200 patients who have previously declined **pulmonary rehabilitation**, have been invited to a focus group to explore their reasons for non-attendance to improve access.	Part of our work to deliver **pledge one** of five-year plan to tackle inequity, this programme aims to improve access to pulmonary rehabilitation to help people better understand their condition and symptoms to empower people to manage their condition with confidence.

Community health services – *delivered via our Community Care Partnership*

The integration of health and care services, delivered via a single team approach, is essential to delivery of **pledge seven** of the five-year plan; to provide more joined up, holistic and person-centred care delivered closer to home. Our community health and well-being plans continue to progress at pace, aligned with our three Health and Wellbeing Board delivery plans.

Place based approaches to delivery of care are on track, with strong performance against the national metrics below. Local metrics to evidence progress against this pledge are under development in each place.

Performance against Operational Plan

Standard	Plan	Actual	RAG	Confidence in recovery / Year-end delivery
Consistently meet or exceed the 70% 2-hour community response standard	70%	94% *August*	Met	High
Meet 80% occupancy for virtual ward by September 2023	70%	70% *August*	Met	High
Reduce unnecessary GP appts by streamlining direct access pathways*	Metric under assessment, national guidance now received- working on a plan			
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.

Finance

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

Team	Scheme Name	Rag Rating	Plan	Actual / Forecast	Var	Confidence in delivery/mitigation
Non acute	Contract changes		600	600	0	High
Non acute	BCF, discharge funding, community SDF		No overspend planned			High
Overall Assessment		**No escalations to Finance Committee**				

Quality & Equity

The Home First programme has raised one quality concern which has now been reviewed by the clinical prioritisation group and resolved.

Issue	Escalation
Urgent supply of end of life and specialist medicines - current service delivery model which ends September 23	ASSURE - mitigation identified with support from System Quality Group and the clinical prioritisation process.
Overall Assessment	**No escalations to System Quality Group**

Transformation

Achievements (aligned to Step 4 NHS Impact programme)	Outcome for our patients / colleagues
Equitable urgent falls response service across LLR- Enhancement to service to now include a response to all residential and nursing homes	Supports utilisation of alternative care pathways, reducing EMAS calls and ED attends. Reduces long lays and deterioration in health and well-being. Positive patient and family feedback.
Increase in Virtual Ward occupancy to from 30% in April 23 to 80% in Sept 23 with an increase in patients admitted onto Virtual Ward (step up/down), supporting earlier discharge and avoiding acute admission	Patient engagement event demonstrated positive patient experience. Increased confidence within clinical teams and those accessing the service.
As part of our joint carers strategy a pilot commenced to discover and support carers. 7000 carers have been identified with support being offered.	Carers have been able to access the right support at the right time. Supporting them to live fulfilled life's while still being able to care for their loved ones.
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
The unscheduled care hub continues to optimise holistic patient care by taking patients off the EMAS stack and providing services through an integrated model of community care. Over 3500 patients have now been through this service. The service has been shortlisted in the HSJ awards under the category of 'provider collaboration'	Patient feedback from this service shows an exemplary model of care is in place, with all balancing quality measures also positive. Patients are largely treated in their usual place of residence for the immediate issue at hand but are also referred onto partner services for preventative care – this includes carer's assessments, falls assessment and aligned public sector referrals such as fire alarm checks by Leicestershire Fire and Rescue.
Consistently achieving the 70% 2-hour urgent community response (UCR) standard – now at 94%.	The patient engagement undertaken as part of the Home First programme locally has consistently shown our patients want to be treated in their normal place of residence and only transported to hospital where clinically needed. These services enable this to happen, constantly and consistently, with positive patient feedback. 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

Urgent and Emergency Care Partnership

The UEC Partnership supports delivery of **pledges five and six** of the five-year plan; to reduce category two response times and to reduce waiting times in the Emergency Department. Actions taken to support both of these pledges have yielded remarkable improvement, evidenced in the performance metrics below.

Performance against Operational Plan

Standard	Plan	Actual	RAG	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	57% July 23	61% *July 23*	Met	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	00:29.49 *July 23*	Met	Medium Variability remains high and risk of destabilisation through winter
Reduce General and acute occupancy to 92% or below	92%	85.9% *July 23*	Met	Medium Variability remains high and risk of destabilisation through winter
Overall Assessment	**System executive to note the variability of performance and interlink with financial position**			

Finance

Team	Scheme Name	Rag Rating	Plan	Actual / Forecast	Var	Confidence in delivery/mitigation
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 interim UEC Director. However, there is significant risk against this given M5 position, with further improvements needed in the second half of the year. Escalated to Chief Finance Officers for support					

Quality & Equity

Two unmitigated issues has been raised through the Clinical Executive which may impact on quality and outcomes:

Issue	Escalation
Regional dashboard shows a high number of 12 hour waits; plan and improvement trajectory required	ADVISE – System Quality Group to support review of actions and trajectory, with clinical support provided as needed

Revised process to discharge are causing increasing delays for some patients	ADVISE - Increased in length of stay and delayed discharges noted during initial stages of pilot. Additional pressure to upcoming industrial action. Discussed at Intermediate Care Steering group and escalated to UEC partnership. Chief nurses to confirm and challenge the impact of process change as per UEC partnership agreement.
Overall Assessment	**System Quality Group to support both concerns raised**

Mental health – *delivered via our Mental Health Shadow Collaborative*

The actions being progressed through the MH collaborative align to **pledge ten** of the five-year plan, to reduce inequity in access to mental health services. The performance section describes the impact of these local actions with each of the key metrics on track for delivery. As noted below, formal reporting is three months behind – using local data sources, the collaborative can evidence progress through the targeted interventions in place, including the neighbourhood-based development of mental health and wellbeing hubs (formally known as crisis cafes).

Performance against Operational Plan

Standard	Plan	Actual	RAG	Confidence in recovery / Year-end delivery
Improve access to MH support for CYP	14,553 Target by Q4	13,680 *May 23*	On track	High Plans in place, key risks understood
Increase the number of adults and older adults accessing IAPT	27,808 Target by Q4	18505 *May-23 (12 month rolling)*	Within 5% tolerance	High Plans in place, key risks understood
5% increase in the know of adults and older adults supported by community mental health services	6,456 Target by Q4	*May-23 12665*	Met	High Plans in place, key risks understood
Eliminate out of area placements	0 Monthly Target	May-23 3 months rolling 140 (Bed days)		High Plans in place, key risks understood
Recover the dementia diagnosis rate to 66.7%	66.7% Target by Q4	July-23 64%	Within 5% tolerance	High Plans in place, key risks understood
Improve access to perinatal mental health services	1259 Target by Q4	*May-23 975 (rolling 12 months)*	On track	High Plans in place, key risks understood
Overall Assessment	**No performance escalations to System Executive** Noted improvement in Perinatal performance. Data source (MHSDS) has c 3-month time lag for reporting. Request gone to LPT for agreement to use their current performance data. Medium term plan for business intelligence to receive data from LPT directly as its submitted to MHSDS.			

Finance

Team	Scheme Name	Plan	Actual / Forecast	Var	RAG	Confidence in delivery/mitigation
Non acute	Contractual changes	3,121	3,121	0		High

Non acute	23/24 MHIS funding / 23/24 SDF	18,626	18,626	0		High
Overall Assessment		**No escalations to Finance Committee**				

Quality & Equity

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

Issue	Escalation
The waiting time CYP and adults waiting for an ADHD or ASD diagnosis is growing significantly. This is due to a surge in referrals and a lack of qualified resource to manage this increase. This remains our top issue and has been raised regionally with NHSE. LLR waiting times (c2yrs) are lower than many in the region	ALERT - EIA and QIA and clinical prioritisation undertaken. Monthly escalation to NHSE.
As reported last month: Venepuncture for individuals unable to have standard blood-taking after de-sensitisation and other non-invasive interventions – specific to Mental Health and neuro-diverse cohorts	ADVISE - EIA and QIA undertaken to evidence impact on equity and quality
Overall Assessment	**Support required from System Quality Group to continue to monitor the risk to outcomes for these areas**

Transformation

Achievements (aligned to Step 4 NHS Impact programme)	Outcome for our patients / colleagues
The LLR MH Shadow Collaborative received positive feedback from each of the 3 place-based MH groups. Each are now getting into the detail of MH in their places, and what needs to happen to make improvements. They reported active engagement from a broad range of stakeholders and linking of agendas across all ages. The Dementia Programme Board has also requested a standing item on the agenda to feed in updates of their progress and work.	This will deliver better outcomes for the local populations and ensure that the offers are tailors to the needs of those communities. The place-based approach to MH within these groups identify, and works towards addressing, health inequalities and CORE20+5 as per pledges **one and ten** of the five-year plan Each place-based group is a sub-group of their respective Health and Wellbeing Board, further raising the profile of Mental Health and creating parity with other needs.
Advancing MH Equalities: *Loneliness & Isolation* – an action group is in place in Charnwood with primary care, local authority and VCS partners involved. The group has so far delivered two successful events; "Picnic on the Green" held during National Loneliness Week, and a Men's BBQ was held in August at Fearon Hall, Loughborough.	Part of our work to deliver **pledge one** of five-year plan to tackle inequity - Both events have engaged with over 50 men who have been identified as isolated and having mental health challenges, for example asylum seekers staying at the Cedars and Ramada Jarvis accommodation attended the event. One attender commented *"It is amazing to see people from different walks of life chatting who normally would just walk by each other on the street and make no contact".* The events have been an opportunity to signpost and navigate people to support that might help them.
Mental Health Networks – there have been a number of local mental health networks set up within the Charnwood area, bringing together key	The benefit of the smaller networks is that it has created a forum to consider very local priorities and understand local needs, an example, partners seeking to develop a

partners from primary, secondary care, VCS and local authority. As well as an overarching Charnwood network, there have also been smaller networks set up within Syston, Sileby and Shepshed.	dementia one-stop shop in Syston. Moving to a neighbourhood approach is increasing the understanding and awareness of offers between partners and stimulating more joined up approaches to deliver the right support people need.
The ARMs – (At Risk Mental State) service has been locally renamed 'PAUSE' (psychological Awareness of Unusual Sensory Experiences) and is launching on the 1st October within City East initially and will then rollout across LLR within 6 months.	PAUSE will support 14 – 35-year-old people who are high risk of developing psychosis. This is an early support service to help prevent deterioration and potential hospitalisation.
Getting Help in Neighbourhoods: There are 54 projects being delivered by the VCS between April '22 and June '23. The schemes cover a huge range of support including reducing loneliness and isolation, debt support, recovery coaching, engaging those who do not engage with statutory services, and tackling health inequalities. To date they have supported 6,729 people, delivered 22,835 one to one or group sessions, and 59,675 people have participated in activities.	Case study: P approached Headstrong Wellbeing CIC seeking therapy as he was struggling to cope, feeling financially strained and feeling a sense of shame at not being as financially secure. He reported needing some reprieve from his partner, who has mental health needs and is supported by adult crisis and community mental health teams. Utilising therapeutic approaches, P was then able to start to recognise his sense of being overwhelmed at an earlier stage. P has also expressed that he's not quite ready to go back to volunteering and attend community activities. But he does feel more hopeful he can and is starting to plan for this.

Learning Disability & Autism Collaborative

Pledge nine of the five-year plan outlines our commitment to increasing the percentage of our learning disability population who have had a health check and have a health action plan in place. Whilst currently off-track, LLR has a proud tradition of achieving this metric and full recovery of the position is expected through the year. This programme also includes our commitment to reducing adult and child inpatient numbers through regular review of plans, with system escalation for individuals with a delayed discharge now in place, supporting our ambitions.

Performance against Operational Plan

Standard	Plan		Actual	RAG	Confidence in recovery / Year-end delivery
Ensure 75% of people aged 14 or over on GP LD registers receive an annual health check and health action plan	5044	24.29%	Not achieving		High Plans in place, key risks understood
Reduce reliance on inpatient care for adults	30		27 (August data)	Met	High Plans in place, key risks understood
Reduce reliance on inpatient care for under 18's	3		5	Within 5% tolerance	High Plans in place, key risks understood
Overall Assessment	**No escalations to System Executive**				

Finance

Team	Scheme Name		Plan	Actual / Forecast	Var	RAG	Confidence in delivery/mitigation
Non-acute	SDF - LDA	2,450	2,450	0		High Schemes already in delivery	
Overall Assessment							

The Transforming Care Programme is funded by LDA Service Development Funding and it is on track to deliver as planned.

Quality & Equity

The LDA Collaborative has raised no specific unmitigated quality risks.

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

Issue	Escalation
Long waiting times for autism assessments for both children and adults. The required level of investment needed to meet the demands is significant.	ADVISE - 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.

Late referral to the Dynamic Support Pathway: individuals referred for crisis management rather than crisis avoidance.	ALERT – plan in place
Overall Assessment	**Mitigations in place, no escalations to System Quality Group**

Transformation

Achievements (aligned to step 4 of the NHS Impact framework)	Outcome for our patients / colleagues
LD Annual Health Check performance ahead of same time last year, with further support for improvement being pursued. 1279 LD people across LLR did not have their LD health check for 1-2 years and we know this has a direct impact on outcomes and life expectancy for this cohort. Using our population health management tools, our practices were asked to refer patients in who they thought would come forward with a bit of extra help. 233 referrals received since pilot was launched and 231 of these patients have now had a health check, with majority saying they would not have come forward if not approached. Pilot extended to find another set of people from the original 1279.	More people having their checks in a timely way, with a greater potential for prevention of illness/deterioration We also know that a detailed health check can support increase of life expectancy for this cohort of patients and that this supports parents / carers/ families in their own mental and physical health. This delivers **pledge one** of the five-year plan.

Women's Partnership

Our women's partnership will support the delivery of **pledge twelve** of the five-year plan. Whilst this programme is in its infancy, progress has been made in the canvassing of views on the scope, depth and breadth of the partnership across local partners. A planned Women's Health summit in October will seek the views of our local women and girls from across LLR before the work of the Partnership is recommended for approval. Our plans for launching women's health hubs are also on track.

Performance against Operational Plan

There are no metrics for Women's health in the 31 standards of the NHS Operational Plan; however, the women's partnership is working toward delivery of Women's health hub's across LLR, supporting the ICB vision of better access and outcomes for this we serve.

Standard	Plan	Actual	RAG	Confidence in recovery / Year-end delivery
Establish a Women's Health Partnership	October 23	October 23	In progress	High – confirmation to be sought by SRO
To build relationships with women's groups ensuring that we understand their needs and they have a voice in planning services across health care.	October 23	October 23	In progress	High
Improving access to NHS fertility treatment for all couples including female same-sex couples and assessing the use of non-clinical access criteria locally	Sept/Jan 24	Sept/Jan 24	In progress	High – Awaiting EM policy review outcome
Work with system leaders to agree local models for implementation of women's health hub across LLR, to provide social, emotional and health support including sexual health, menopause, and social prescribing	March 24	March 24	In progress	High – EOI process in place
Overall Assessment	**No escalations to System Executive**			

The 'standards' listed above are not related to the deliverables set out in the 2023/24 Operational Plan. Instead, these are related to the deliverables set-out in line with the 5-year-plan.

Finance

LLR ICB has received £198,000 in M6 to deliver the women's health hub agenda. Finance model to be completed by end of M6 (September 2023).

Quality & Equity

From a programme perspective no key quality issues have been highlighted, with the potential to impact on quality and outcomes. Further work to be undertaken with the Health Inequality Support Unit to assess the metrics associated with women's health hubs.

Further work to be completed on equity in each place as part of planning for the health hubs.

Transformation

Achievements (aligned to step 4 of the NHS Impact framework)	Outcome for our patients / colleagues

LLR Women's Programme 'launch' • Operational Delivery Group • Women's Health Week • Women's Health Summit • Women's health hub's programme	Women's Health Summit to officially launch the programme for LLR All women will have access to at least 1 Women's Hub including a core offer of menopause, screening and sexual health - improving the care and experience for women across LLR.

Maternity, Neonatal and Perinatal Mental Health Partnership

Our Local Maternity and neonatal services Board oversees the metrics behind pledge twelve. Our specific pledge is to engage with, listen to, empower and co-produce services with women and girls; progress against this pledge is measured through the Maternity 'friends and family test'. This is not a direct metric in the operational plan and therefore has not yet been reported through this partnership report. Once triangulated, it will be included.

Performance against Operational Plan

Standard	Plan	Actual	RAG	Confidence in recovery / Year-end delivery
Make progress towards national safety ambition to reduce stillbirth, neonatal mortality, maternal mortality and serious intrapartum brain injury	TBC – reporting being aligned. Working with CSU colleagues with a view to start reporting from next month			
Increase fill rates against funded establishment for maternity staff				
Delivery of Ockenden	Year 4 NHS Maternity Incentive Scheme (MIS)-We are currently non-compliant in 4/10 Safety Actions , 5/10 - Safety Actions are progressing and 1/10 we are fully compliant. We remain non-compliant with1/5 standards of Saving Babies Lives Care Bundle V2. We will now be monitored on SBLCBV3 which has an extra element Diabetes Care. For now, we will continue to report on implementation of V2 care bundle.			
Overall Assessment	**System oversight continued via LMNS**			

Finance

The programme is on track to spend our allocation.

Quality & Equity

From a programme perspective we have identified a number of issues that will impact on quality, safety and outcomes with workforce challenges across the service areas being a critical factor. For the purpose of this section below we have highlighted four key quality issues with the potential to impact on quality and outcomes, with all being managed through the LMNS governance infrastructure:

Issue	Escalation
Perinatal Mortality: Aug 23: Neonatal Mortality rates remain more than 5% higher than peer group. Babies of non-white ethnicity are overrepresented. This reflects the national picture.	ALERT – managed through LMNS
Implementation of NCCR: Workforce remains a challenge. Currently working on meeting transitional care requirements for the benefit of mother and baby (ies).	ALERT – managed through LMNS
CQC maternity inspection Feb- 2023: Currently working through KLOE following initial warning notice. Representation/challenge made back to CQC in respect of CQC report. Awaiting outcome.	ALERT – managed through LMNS
Delivery of Ockenden 7IEA's , MIS, SBLCB: Currently **f**alling short of full compliance against SBLCBv2 and MIS	ALERT – managed through LMNS
Perinatal mental health: Whilst access targets are improving (slow pace) – the activity levels for perinatal mental health do not reflect the expected prevalence (ethnicity) for our population.	ALERT – managed through LMNS

Overall Assessment	For noting as indicated – SQG fully appraised and supporting mitigating actions

Transformation

Achievements (aligned to Step 4 of NHS Impact framework)	Outcome for our patients / colleagues
LLR Maternity and Neonatal Voice Partnership now in place	Co production of services. Independent Voice/influence within the Local Maternity and Neonatal System on behalf of the birthing person, babies / families to help improve maternity and perinatal outcomes for birthing people and babies

Medicines Optimisation Partnership

Performance against Operational Plan

There are no metrics for Medicines Optimisation directly in the 31 standards of the NHS Operational Plan.

Finance – overall system position

System requirement	Annual Spend Plan	Forecast outturn year end	RAG	Confidence in recovery / Year-end delivery
Break even or underspend at March 24 on prescribing budget	£184million	£194 million		Low
Overall Assessment	**No further escalation**			

Quality & Equity

Issue	Escalation
Progress against operational plan at risk due to pharmacy work force pressures against all sectors.	ALERT - Through individual organisations
Overall Assessment	**System Quality Group to support escalations above**

Transformation

A separate paper will be presented around the LLR response to the National medicine optimisation opportunities 2023/24. This guidance describes the 16 national medicines optimisation opportunities for the NHS in 2023/24. It is recommended that integrated care boards (ICBs) choose at least five medicines optimisation opportunities to focus and deliver on alongside their local medicine optimisation priorities. System support will be required to deliver these.

Achievements (aligned to Step 4 of the NHS Impact framework)	Outcome for our patients / colleagues
NHSE support for community pharmacy Independent prescribing pilot	The independent prescribing pilot from Nov 23 will support respiratory and CPCS+ in four community pharmacies leading to improved access to care
Highest CPCS referral rate from GP practices in midlands region	As detailed in primary care section
Agreement for the Existing Community Pharmacy service for the supply of urgent End of Life Medications and specialist medications to be rolled over until March 24 to enable full review to be undertaken and business case development.	As detailed in the Community Care section
Primary care Green Plan finalised and ready for implementation.	Transition towards net zero.

Children and Young People's Partnership

Our work to improve access, experience and outcomes for children and young people across LLR is reflected in **pledge eleven** of the five-year plan. Whilst progress has been made through 2324, capacity issues and the financial position have hampered progress. Mitigations are now in place, with the urgent care, elective care and mental health/LD portfolios all requested to cover children and young people as part of the partnership approach from September 2023. Further progress will be reported in coming months.

Performance against Operational Plan

There are a range metrics for CYP but no standalone metrics within the 31 standards of the NHS Operational Plan.

These are local system standards:

Standard	Plan	Actual	RAG	Confidence in recovery / Year-end delivery
Improve and strengthen CYP Partnership Group and embedding CYP objectives within the other Collaboratives and Partnerships.	Nov 23	Nov 23	On track	Medium Plans in place, risks are understood, CYP workforce constraints. CYP Partnership Development session early Nov.
Implement and monitor critical action plans against the CYP Partnership priorities: CYP UEC, CYP Elective Care & Paediatric Critical Care, *CYP Neurodevelopment*, *CYP MH*, SEND EHCP & service waiting times.	October 23	October 23	Complete	
Implement and drive change through the CYP Transformation programme against NHSE set metrics and objectives (as per Long term plan).	Sept/Jan 24	Sept/Jan 24	On track	Medium- workforce constraints affect delivery but plans remain in place and key risks are understood
Ensure co-production of all CYP services, delivering care and services with the voice of the CYP as the main driver.	Ongoing through year			High Plans in place
Overall Assessment	**No escalations to System Executive**			

Finance

Team	Scheme Name	Rag Rating	Plan	Actual / Forecast	Var	Confidence in delivery/mitigation
CYP	Community Paediatric Continence		209k	tbc	209k	Requires re-profiling. Partial recruitment has completed.
CYP	Paediatric Outpatient parenteral antibiotic therapy		382k	Tbc	382k	Requires re-profiling. Partial recruitment completed. Nursing recruitment failed at first appointment.

CYP	CYP Transformation programme		121k	121k	0	Funds allocated and on track; some subject to recruitment
Overall Assessment		**No escalation to Finance Committee**				

Quality & Equity

Issue	Escalation
Paediatric oversight of providers for continuing care through Mids and Lancs CSU	ADVISE: M&L CSU do not currently hold contract management service - this is being reviewed with the contracts teams to mitigate this risk. M&L CSU are liaising with those 3 providers to review care plans and risk assessments to mitigate the current risk.
Review and assessment of all System CYP Clinical Risks	ALERT - For noting
Palliative care services	ALERT - Business case in development
CEW Tier Plus 2 (Obesity services)	ALERT - Business case in development and re-analysing the CYP Transformation financial bundles; logging issues on System risk register
Paediatric ARI / ED/ UTC Winter Surge planning	ALERT - Paediatric Winter Surge drafted and workshop completed considering patient flows. Proposal to increase lower acuity appts in place
Overall Assessment	**All escalations being managed through System Quality Group**

Transformation

Achievements (aligned to Step 4 of the NHS Impact framework)	Outcome for our patients / colleagues
Epilepsy: Recruitment continues into the Epilepsy nurse service. B7 1 WTE has been appointed, awaiting start date. Advert for 1 WTE B8a has now closed and interviews are scheduled for September.	Epilepsy clinics have commenced in September for patients to access. PRISM form in creation to enable appropriate referrals. Neurology nursing team is supporting with cross-cover of these clinics whilst recruitment continues.
Obesity: CEW: Evaluation of pilot has shown positive outcomes for CYP and provides recommendations for ongoing work into health inequalities and socio-economic support from non-health support services. There is a need for ongoing work to understand the support requirements for those CYP with LD&A and mental health conditions who over-present to CEW clinics. Tier2+: Work continues to plan the extension of this pilot. CEW Tier 3 cannot manage operational pressures without Tier2+ as a measured system.	An increase of patients have received effective multidisciplinary support in order to manage their weight condition. Tier 2+ and Tier 3 are working collaboratively to provide patients with early identification and timely support. The findings from tier 2+ shows proven effective reversal of co-morbidities such as type 2 diabetes and fatty liver disease which will improve their long-term health and reduce costs on adult services within the NHS.
Diabetes: Bridge the gap pilot has been operational since November	Using targeted intervention, a cohort of CYP who haven't previously been able to access health

2022 and completes in September 2023. The aim of this pilot is to provide provision and accessibility to those CYP who cannot access health technology to manage their diabetic condition as a result of a wide variety of factors.	technology to manage their diabetes condition, received education, support and advice in an accessible environment, which enabled empowerment and better management of their condition. This has been achieved through co-production with CYP to ensure barriers were identified and addressed and supports delivery of **pledge one** of the five-year plan.
Asthma: Diagnostic hub for primary care referrals in UHL funding secured and work underway to establish hub with focus on establishing PRISM primary care referral pathway.	CYP awaiting an asthma diagnosis receiving timely, appropriate care from speciality trained professionals.
Palliative Care: CYP team are involved in regional work review of palliative care services, utilising specialist workforce across the East Midlands to support equity in provision and efficiency of resource.	Patients will be empowered and supported to receive quality care in their chosen setting, with a standardised approach to ensure equity.
SEND Language and Living: Project continues to move with pace, cohort 2 commenced for September with good levels of participation.	CYP and families requiring help and support with speech and language therapy can access this through school provision, reducing the demand on therapy waiting lists. Discussions about how SEND L& L fits, merges together with LLR Regional Early Years Language Speech and Communication programme.

Elective care, cancer and diagnostics

Our planned care Partnership delivers **pledge eight** of the five-year plan to reduce waiting times for consultant led treatment. Thus far, the system has negated patients waiting over 104 weeks as at the end July and are confident that position can be maintained. Our 78-week position continues to reduce, with the trajectory for achieving zero now amended to October 23, primarily due to the cumulative impact of ongoing Industrial Action. There has been a steady decline in the number of 65+ waiters, demonstrating the impact of validation and other actions and the 65+ position is ahead of trajectory for most specialties and on track to hit national target of clearance by March 2024.

The cancer programme also supports **pledge two**, preventing illness through cancer screening and diagnostics. Progress against the Cancer action plan continues, with further work being undertaken with regional and national colleagues. Diagnostics centres plan remains on track and will support delivery of this pledge at scale across LLR.

Performance against Operational Plan

Standard	Plan	Actual	RAG	Confidence in recovery / Year-end delivery
Eliminate waits of over 65 weeks for elective care by March 2024	3,546	2,533 *July 23*	Met	Confidence in delivery remains high – Main risk is the on-going impact of IA. Monitored via NHSE Tiering Plans in place, key risks understood
Deliver the system specific activity target		*98% admitted; 98% first outpatient at M4*	Within 5% tolerance	
Continue to reduce the number of 62 days waits for cancer	308 July 23	467 July 23	Target not met	Confidence in recovery to fair shares and FDS delivery remains high – Main risk is the on-going impact of IA. Monitored via NHSE Tiering
Meet the faster diagnosis standard of 75%	76.02% June 23	*72.5% June 23*	Within 5% tolerance	
Increase the % of cancers diagnosed at stages 1 and 2 by 2028	*TBC*	*TBC*		*TBC*
Increase % of patients receiving diagnostic tests within six weeks to 95% by March 2025 (85% by March 24)	63%	71% July 23	Met	Confidence in delivery of 85% by end of March remains high. Monitored via NHSE Tiering
Deliver diagnostic activity levels that support plans to address elective and cancer backlogs and the waiting time ambition	30,996	34,610	Met	Confidence in delivery is high. Activity in month at 111.7% of plan
Overall Assessment	**No escalations to System Executive**			

Finance

Team	Scheme Name	Rag Rating	Plan	Actual / Forecast	Var	Confidence in delivery/mitigation
PC	Use of EMCA for FIT tests		200	0	200k	Low – no regional support
PC	Access to care thresholds		900	44	856k	Low – scheme cancelled

PC	OOC payments via ERF		6,529	tbc	tbc	Low – no regional support but will be partially mitigated by additional ERF
PC	ERF income		11,951	tbc	tbc	High – will overperform
PC	Cataract contract		392	0	392k	Low – scheme cancelled
Overall Assessment		**Further opportunities continually assessed including PIFU and OP. Clinical executive providing clinical oversight and support for implementation to drive improvement**				

Quality & Equity

The measures of quality in planned care will be established over the next 4 weeks. These will likely centre on RCA and Harm reviews for cancer and long waits plus any other known risks to services.

From an equity perspective, over the last quarter there has been the formation of new outreach relationship between UHL and The Centre Project (Leicester). Two public engagement events around national cancer screening programme uptake delivered. Other cancer screening events at Afro-Caribbean Football tournament and Loughborough Mela. Prostate cancer screening programme for Black men launched with Spinney Hill practice (EMCA/ICB/City Council). Finally, an Inclusion Healthcare subgroup has been set up - process for UHL sharing of OPD invites with Inclusion to enable pre-appointment prompting by Inclusion and UHL. Each of these supports delivery of **pledge one** of the five-year plan.

There are no known immediate issues or risks to escalate.

Transformation

Achievements (aligned to Step 4 of the NHS Impact framework)	Outcome for our patients / colleagues
Good progress continues to be maintained in the reduction of long waits with UHL and LLR now at zero 104+ waits. This is a significant milestone in the recovery plan for elective care. 78+ waits have been reducing month on month and the plan to deliver zero 65+ waits by the end of March 2024 is on track. 52+ waits are also reducing	The numbers of patients waiting for elective care for long periods of time is steadily reducing, meaning that patients are being seen faster. Much more to do but steady improvement is positive, despite industrial action etc
An increase in theatre productivity seen from 74.7% in April 23 to 76.4% in June. On average theatre utilisation has increased by 1% each month since Jan 2023. Cancellations on the day at 7% in June, the lowest it has been in 2023. May and June day case activity higher than plan.	Productive theatres supports our ambitions above – more patients can be treated at optimal levels if theatres are run efficiently and effectively
Phase 1 East Midlands Planned Care Centre open June 2023, Hinckley CDC additional £10.25m approved. Total capital £24m. Endoscopy Business Case approved by NHSE Panel. Total capital £16m. £100k to support breathlessness and paediatric asthma pathway	Patients will have access to diagnostics faster and closer to home, both pledges in our one- and five-year plans and fully in line with what our patients have told us

Name of meeting:	**NHS Leicester, Leicestershire and Rutland Integrated Care Board meeting**		
Date:	12 October 2022	**Paper:**	**G(a)**
Report title:	**Assurance and oversight of the UHL Maternity CQC response**		
Presented by:	Caroline Trevithick – LLR ICB Chief Nursing Officer/Deputy Chief Executive		
Report author:	Caroline Trevithick – LLR ICB Chief Nursing Officer/Deputy Chief Executive		
Executive Sponsor:	Caroline Trevithick – LLR ICB Chief Nursing Officer/Deputy Chief Executive		

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

Recommendations:

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

- **RECEIVE** the governance for oversight of the UHL Maternity CQC response

Purpose and summary of the report:

The CQC carried out announced inspections into each of University Hospitals of Leicester maternity service locations (the Leicester Royal Infirmary, the Leicester General and St Mary's birth centre) in February and March this year, as part of their new national inspection regime for maternity. The inspections looked specifically at the 'safe' and 'well-led' domains. The CQC has rated maternity services at UHL as 'Requires Improvement' overall. Services at the Leicester General and Leicester Royal Infirmary have both been rated 'Inadequate' for safe, and 'Requires Improvement' for well-led. St Mary's remains rated as 'Good' overall.

Current governance arrangements in place are through the LMNS Board, ICB attendance in the Trust Maternity Assurance Committee and Trust Quality Committee, Insight visits, in conjunction with the regional midwifery team.

Plans are already in place in the Trust to address the concerns identified by the CQC and these have been reported through the Maternity Assurance Committee. Discussions have been had between the ICB CNO and Regional Chief Midwife regarding the process for escalation following the publication of the CQC report in September.

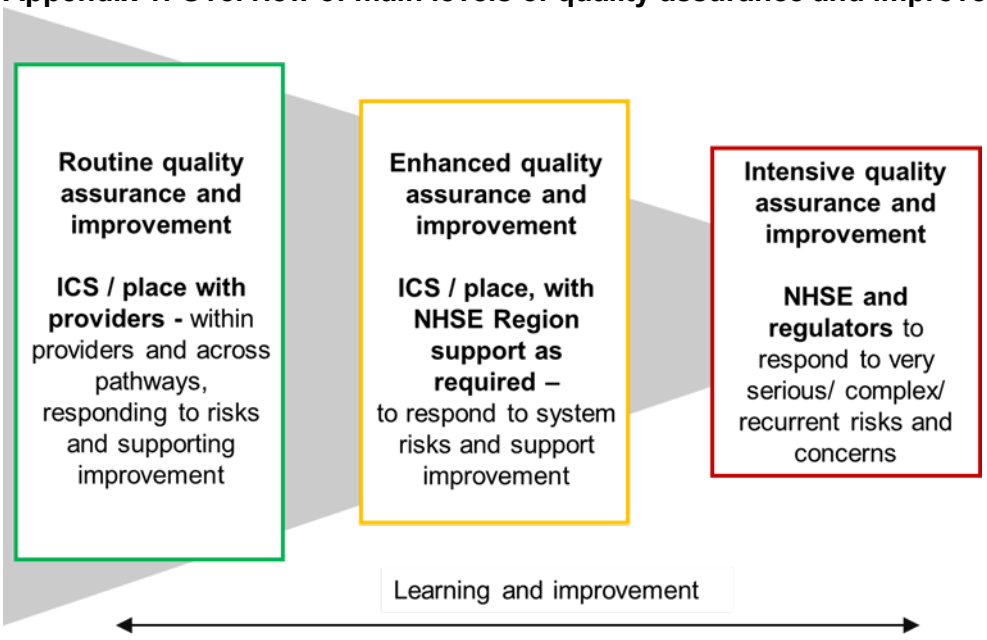
In line with the National Quality Board Guidance: National Guidance on Quality Risk Response and Escalation in Integrated Care Systems, the ICB has agreed with NHSE to move from routine quality assurance and improvement to enhanced quality assurance and improvement and establish a Rapid Quality Review meeting as an oversight group to monitor the progress and sustainability of the improvement plans in place

Membership of the Rapid Quality Review meeting includes:

- ICB CNO – Chair
- Regional Chief Midwife
- ICB Maternity Lead
- ICB CMO
- UHL CNO, MD and Director of Midwifery
- MNVP Chair
- Public Health
- Regional Workforce & Education Team
- University Leads – DMU & Leicester University
- CQC
- To be considered – ICB NED, UHL NED

Meetings will commence in October 2023.

Appendix 1: Overview of main levels of quality assurance and improvement



Name of meeting:	**Leicester, Leicestershire and Rutland Integrated Care Board meeting in public**		
Date:	12 October 2023	**Paper:**	**G (b)**
Report title:	**National Thematic Review - Maternity CQC Inspection (including S29a Warning Notice) Update**		
Presented by:	Julie Hogg, Chief Nurse, University Hospitals of Leicester NHS Trust		
Report author:	Danni Burnett, Director of Midwifery, University Hospitals of Leicester NHS Trust Julie Hogg, Chief Nurse, University Hospitals of Leicester NHS Trust		
Executive Sponsor:	Dr Caroline Trevithick, Chief Nursing Officer, LLR ICB		

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

Recommendations:

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

- **RECEIVE and NOTE** the feedback from CQC and confirmation of S29a and final reports.
- To be **ASSURED** by the significant progress to date.
- To be **ASSURED** by the maternity & neonatal improvement plan that has been developed.
- To **APPROVE** Maternity assurance committee as the lead committee providing oversight of the necessary actions to address the s29a with a plan to update Quality Committee and Board accordingly.

Purpose and summary of the report:

The purpose of this paper is to brief the board of directors on the outcome of the CQC inspection of maternity services. The inspection formed part of a national thematic review of maternity services.

Appendices:	• Appendix 1 – UHL Maternity and Neonatal Improvement Programme Q1 2023
Report history (date and committee / group the content has been discussed / reviewed prior to presenting to this meeting):	•

The report is helping to deliver the following strategic objective(s) – *please tick all that apply*:		
1. 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 report provides assurance against BAF 5 – Quality and Safety and BAF 8 – Workforce
b) Does the report highlight any resource and financial implications? If so, provide which page / paragraph this can be found within the report.	Yes – page 4
c) Does the report highlight quality and patient safety implications? If so, provide which page / paragraph this is outlined in within the report.	Yes – pages 1-7
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.	

Meeting title:	Board of Directors - Public					
Date of the meeting:	12th October 2023					
Title:	National Thematic Review - Maternity CQC Inspection (including S29a Warning Notice) Update					
Report presented by:	Julie Hogg, Chief Nurse					
Report written by:	Danni Burnett, Director of Midwifery & Julie Hogg, Chief Nurse					
Attachments	None					
Action – this paper is for:	Decision/Approval		Assurance	X	Update	X
Where this report has been discussed previously	Patient Safety Committee Quality Committee					

Purpose of the Report

The purpose of this paper is to brief the board of directors on the outcome of the CQC inspection of maternity services. The inspection formed part of a national thematic review of maternity services.

Summary

The CQC carried out focussed inspections of UHL's maternity services in February and March 2023, looking at the 'safe' and 'well-led' domains.

The CQC published its findings on 20 September, rating the overall service as 'Requires Improvement', a move down from 'Good'. Services at the LGH and LRI were rated inadequate for the 'safe' domain.

We take the report and its findings very seriously and will use them to drive further improvements for women and families.

While the service is not yet at the standard we want or need it to be, we had already identified many of the challenges raised prior to the CQC visits, with plans in place to tackle them. These changes – including a significant strengthening of our maternity leadership and staffing - are now embedding.

Not having enough people to safely staff our units is the golden thread running through the CQC's report – and it's a challenge we share with Trusts across the country. We have made real improvements on this over the last 12 – 18 months and are working hard to attract and retain the colleagues we need to provide an exceptional service in the future.

Since April last year, 35 new neonatal nurses have joined us, with 25 new midwives joining us from January. Another 24 midwives will join us in November, and we have strengthened the maternity leadership team, bringing in a new Director of Midwifery this year. The CQC report notes the progress we have made in this area.

We have also made a number of improvements to the way the service is run, to reduce delays and improve safety. This includes improvements to our triage systems, daily safety checking of our equipment, and progressing plans to separate the theatre space we use for planned and emergency caesareans at the Leicester General.

Overall, we are in a very different place today than we were in February and March and have invited the CQC back to see the impact of the changes we have made.

We are encouraged by the positives in the report, not least recognition for our dedicated maternity staff who continue to put the needs of women and birthing people at the centre of everything they do.

Leicester remains a safe place for people to give birth, and anyone with concerns is encouraged to raise them – we promise to listen to you and take your concerns seriously.

The Inspection and Outcome

The CQC conducted a planned inspection to maternity services; the visit excluded Gynaecology, Termination of Pregnancy Services, and Neonatal Services and was as follows:

- Leicester General Hospital 28 February 2023 (team of 8)
- Leicester Royal Infirmary 1 March 2023 (team of 8)
- St Mary's Birth Centre 2 March 2023 (team of 4)

In line with normal practice, we received immediate feedback on 3 areas for improvement and 3 areas of good practice. These were as follows:

1. 3 improvement areas which require attention:
    a. Staffing medical and midwifery
    b. Triage – staffing and processes
    c. Oversight of systems and processes
2. 3 areas of good practice
    a. Development of the JANAM app
    b. Empowering Voices programme
    c. Leadership - receptive and responsive to concerns raised by the CQC team during the visit

On 12th June 2023 the Trust was notified that the CQC had formed the view that the quality of health care provided by the maternity services required significant improvement and a regulation 29A (warning notice) was issued to UHL. The warning notice covered the following areas:

a. Governance systems are not operating effectively to ensure risk and performance issues are identified, escalated appropriately, and addressed with timely action. *Significant Improvement Required by 30 September 2023*
b. Delays in treatment including induction of labour were evident. This meant some service users experienced delayed inductions and some did not receive induction of labour as planned for clinical reasons. *Significant Improvement Required by 30 November 2023*
c. There were not enough midwives to provide safe care and treatment to service users. *Significant Improvement Required by 30 November 2023*
d. Some equipment, safety checks, and documentation were out-of-date or not fit for purpose, and daily checks were not always completed. *Significant Improvement Required by 31 July 2023*
e. Staff did not adequately document and respond to ongoing risks to the safety of service users, in line with national guidance *Significant Improvement Required by 30 September 2023*

The final report was published on 20th September 2023 the overall rating for UHL remains at requires improvement. The overall rating for maternity reduced to requires improvement with site breakdown as follows:

	Safe	Effective	Caring	Responsive	Well-led	Overall
LRI	Good 2019	Good 2019	Good 2019	Good 2019	Good 2019	Good 2019
	Inadequate 2023	Domain Not Inspected			Requires Improvement 2023	Requires Improvement 2023
LGH	Requires Improvement 2017	Good 2017	Good 2017	Good 2017	Good 2017	Good 2017
	Inadequate 2023	Domain Not Inspected			Requires Improvement 2023	Requires Improvement 2023
St Mary's	Good 2017	Good 2017	Good 2017	Good 2017	Good 2017	Good 2017
	Good 2023	Domain Not Inspected			Requires Improvement 2023	Good 2023

Response - progress made to date

Progress has been over the last 7 months and whilst we have more to do it is important to recognise the significant improvements so far, these include:

1. Improving access to Maternity Assessment Unit (MAU) services:
    a. Separation of MAU and telephone triage helpline, now known as single point of contact (SPOC)
    b. Implementation of NetCall digital, which diverts unanswered calls to the MAU to a new Telephone Triage team, with protected staff to answer calls.
    c. Monitoring of call volume in place including average time to answer and number of abandoned calls, to ensure adequate cover is in place, managed via eRostering.
    d. A crib sheet has been developed with a pathway showing to whom external calls should be diverted.
    e. Daily tactical Women's and Maternity Calls to include SPOC and MAU activity are in place, with checks to confirm that the MAU / TT is discussed three times per day.
    f. Development of NerveCentre reports into the Daily Tactical calls and the Trust has fully implemented BSOTS and conducted subsequent audits to check it remains embedded.

2. Effective governance systems.
    a. Maternity & Neonatal Improvement Programme Launched September 2023 supported by new Quality Improvement team including 2 New Lead Midwives for Quality Improvement commencing August 2023
    b. Executive-Led Maternity Assurance Committee (MAC) in place May 2023
    c. Perinatal Mortality Deep Dive & Peer Review (NHSE Public Health input August 2023)
    d. External Independent Review of Governance arrangements commissioned May 2023; Governance Team Development Session June 2023 & September 2023
    e. Plans in place to transition complaint function to Corporate Team (October 2023) and increase capacity for PMRT
    f. Obstetric Consultant job plan review to ensure dedicated input into quality and safety (August 2023)
    g. Audit Programme refreshed and approved August 2023
    h. Implementation of 2x Daily Tactical Operational Calls (7 Days a Week)

i. Refreshed Daily SitReps to encompasses all parts of the service
j. Implementation of refreshed Escalation Policy to improve oversight of risks and performance
k. New Perinatal Surveillance Scorecard
l. Safe Staffing Policy updated March 2023
m. 3 New Safety Champions recruited (July 2023)
n. Quality Improvement Projects- Post-partum Haemorrhage / Perineal Trauma / Induction of Labour (IOL) Working Group re-established
o. Introduction of Surgical Site surveillance programme
p. Utilisation of Microsoft Forms for ultrasound scan referrals

3. Safer staffing
    a. Workforce Plan focused on recruitment, retention, and wellbeing
    b. Safe Staffing Matron in post
    c. Recruitment, Retention, and Pastoral Midwives x 3 in post, and 1 for Maternity Support Workers, International Recruit Pastoral Midwife in post to support onboarding
    d. Staffing Summit (December 2022 and June 2023)
    e. Leadership Development Opportunities –e.g., LEO, Connect, RCN Leadership, Chief Nurse Fellowships
    f. Recognition –e.g., Long Service, Daisy Award
    g. Launch of the Microsite to support recruitment
    h. BirthRatePlus Awareness and Education
    i. Twice-Weekly Skill-Mix Reviews led by Heads of Midwifery
    j. Launch of Self Rostering Pilot
    k. Incentive Schemes
    l. Collaboration with Universities to improve conversion rate and support packages
    m. Empowering Voices Culture Programme
    n. RCM/RCOG Professional Behaviour & Safety Pilot
    o. Strengths & Motivators Profiling for Labour suite Coordinators
    p. Preceptorship programme for Band 2-8 and updated Career pathways

4. Reduce delays to the induction of labour pathway
    a. Induction of Labour (IOL) Working Group re-established
    b. Manager on Call (MoC) onsite presence 7 days per week
    c. Recruitment to increase the number of Labour Suite / Maternity Coordinators 24/7
    d. Change in process in relation to communication with women on day of IOL
    e. IOL prioritisation tool developed for use within unit and on tactical huddles
    f. Decision made to book IOLs using gestational ranges; notable increase in the number of IOLs during July and August 2023 in response to a change in guidance for Post Dates IOL following HSIB recommendations
    g. New QI Lead Midwife initiated IOL project (August 2023) working with Regional QI NHSE Team - sharing of resources, tools and guidance in relation to successful IOL QI projects across the region
    h. Working with Birmingham Womens Hospital to gain insight regarding successful IOL service project
    i. Engagement - Walkarounds completed across both sites to gain staff insight and feedback including meeting with delivery suite coordinators. Meeting held with MNVP (23 August) to discuss IOL project and to gain service user involvement. Patient feedback survey relating to IOL developed in multiple languages and UHL's

Engagement Officer has commenced daily walk-arounds at both sites (from 11/09/23) to collate completed surveys

j. Formal review of the current IT systems used for monitoring IOL referrals, bookings and on-going IOLs has taken place. Online digital prioritisation tool developed
k. Audit of all IOLs performed in July 2023, to create a baseline for improvement
l. Review of the IOL pathway coordinator role providing recommendations to improve effectiveness and flow
m. Draft SOP in development in relation to delayed IOL to enable knowledge of clear process/escalation routes to provide safety and effectiveness
n. Pop-up' DAU in place since June 2023 to ensure safety and monitoring of delayed IOLs

5. Improve equipment, safety checks and documentation
    a. Daily Assurance Ward Checks integrated into Tactical Calls
    b. Scoped automated and digital solutions for ward level checks, interim solution in development
    c. Matron Weekly Spot checks
    d. A customised Microsoft Power App developed (30 August 2023) currently undergoing testing in live environments, specifically the Maternity Assessment unit at the Leicester Royal Infirmary and the neonatal service. Aim is for go live by 1 November 2023
    e. Trust-Wide scoping audit tools for potential purchase and implementation across the entire organisation to support the ward Exemplar programme and consistent safety checks
    f. Communication Campaigns with teams
    g. Head of Clinical Engineering work programme to service all equipment, 100% compliance achieved by 31 July 2023 with future plan under development for monitoring
    h. Invested in new IT equipment (laptops, IPads and phones) for staff working in the community and upgraded IT systems and processes
    i. Maternity EPR Options Appraisal complete and funding identified
    j. Immediate attention and resolution of all equipment issues / concerns identified by CQC

6. Responding and documenting ongoing risks
    a. Mobile phones delivered to both sites and are in use, NerveCentre alerting is built and in LIVE environment and alerts in place for Medical Baton phones
    b. NerveCentre permissions adjusted (30 August) to allow midwifery sign off of results; live dynamic blood results lists in place for ward areas
    c. Neonatal observations: Audit proforma designed, plans to integrate as part of the ATAIN program. Latest evidence reviewed and unit decision made to move to the latest tool - new guideline being produced with plans to adopt NEWTT2 with appropriate training to support
    d. Maternal observations Observations collected in NerveCentre for >18 months in Maternity, tracker developed. Digital system has been implemented, optimisation is key
    e. UHL Fetal Monitoring in Labour Guidelines (May 2021) suggests where stickers are not available all elements of pneumonic DRCBRAVADO are used and completed - Deep Dive Audit commenced around fresh eyes/ classification and embedding of the stickers in practice. Spot check audit from yearly fetal monitoring audit currently ongoing to monitor baseline.

f. Sepsis: eAssessments Live (July 2023), amendment to rules requested, data extraction underway, once testing has been produced this will provide a daily report. SBAR Maternity Sepsis Action Tool disseminated 31 May 2023
g. Review & Update of Guidelines: Latent Phase, Caesarean Section, Fetal Monitoring, Water Birth (particular focus on evacuation), and a SOP for babies who are not medically fit for discharge
h. Plans to increase infrastructure to support guidelines and audit team – greater scrutiny around derogations and best practice

Response – governance structure, workstreams and action plan

The maternity and neonatal improvement programme has been developed and is included in appendix 1. The bring together compliance actions for CQC, Maternity Incentive Scheme, Ockenden immediate and essential actions and the NHS England 3 year plan.

A 'three lines of defence' assurance process is being established within the CMG to ensure actions are delivered, embedded and checked robustly. The first line of defence is workstream level; these meet weekly for planning as well as confirm and challenge sessions. These report to the programme group (second line of defence), which examines the completion evidence and decides whether the action has been delivered or assured or needs further work. Those that pass scrutiny are presented to the Maternity Assurance Committee, which has final say on whether the action has been delivered and assured to an acceptable level.

The CMG plans to introduce a 'reverse RAG' (red, amber, green) method to ensure that the CQC actions have been delivered and assured in full. All CQC recommendations have been marked as 'not yet delivered' (red) by default, until sufficient evidence has been produced to prove otherwise. Once concrete action has been taken to deliver the recommendation, and evidence

Typical delivery evidence might be the installation of new software or processes, an update to an SOP, or co-produced information improvements made in partnership with the MNVP. Typical assurance evidence would be audit or survey findings which prove (to pre-agreed parameters) that the changes are having the desired effect and are resulting in significant improvement.

The forum that takes the decision as to whether an action has been delivered and then assured is the Maternity Assurance Committee. This group will also provide guidance and direction for follow-up audits (sample size, regulatory of repetition and standards to be achieved) to ensure that the standard remains embedded.

The CMG has set up a fully resourced QI team who will be responsible for updating the CQC response plan. The CMG is also forming the four workstreams mentioned above, each of which have clinical leadership and triumvirate representation and are assigned specific tasks from the plan.

Response - Next Steps

- Progress Actions to address Significant Improvement Requirements as per S29A Warning Notice
- Action Plan being developed to address Must & Should Do's from the CQC findings aligning with MNIP / MIS / 3 Year Plan / Ockenden / Empowering Voices
- Proactive Engagement & Staff Support as part of publication
- Engage in Post-Inspection Survey

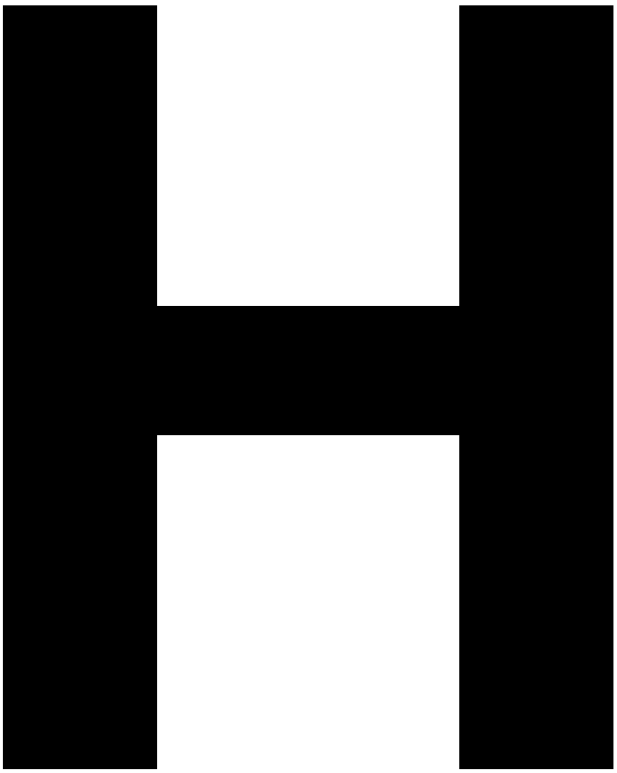
Recommendation

The board of directors are asked to:

1. Receive and note the feedback from CQC and confirmation of S29a and final reports
2. To be assured by the significant progress to date
3. To be assured by the maternity & neonatal improvement plan that has been developed
4. To approve Maternity assurance committee as the lead committee providing oversight of the necessary actions to address the s29a with a plan to update Quality Committee and Trust Board accordingly

Appendix 1


UHL MATERNITY AND NEONATAL IMPROVEMENT PROGRAMME Q1 2023
Governance
Rebekah Calledine
Frances Hills
Robust risk management
Appropriate Datix/Incident reporting
Audit
HSIB & PMRT
Duty of Candour processes
Investigative processes
Governance team function, support and development
Risk review process
Governance structure & reporting
Floor to board reporting
Family liaison and engagement
Clinical effectiveness & guidelines
Training and education
Sharing of learning
Board level safety champions
Saving Babies Lives Care Bundle v2
CQC Well-Led, Safe, Effective & 2023 Must-Dos
Ockenden 1,2,3,4,5,9,14,18.
CNST: 1,3,4,5,6, 7,8,9,10
Saving Babies Lives v2
Priority Actions for Q1
Focus on PMRT reports & process improvements
Improve Risk Register review process
Improve on lessons learnt from incidents amongst staff
Improve timelines of responses to complaints
Improve accuracy and analysis of audit information
Review of guidelines and policy process
Quality & Safety
Rebekah Calledine
Frances Hills
Head of Service (Neonates)
Clarity & visibility of Maternity and Neonatal Outcome Measures
Safety Culture
Maternal record Management
Capacity and demand matching
Digital transformation
Continuity of Carer
Perinatal mental & pelvic health
Personalised Care Plans
Risk assessments
Continuous Glucose Monitoring
Safety Training
Neonatal collapse
Huddles and Handovers
Emergency Equipment
Infection prevention and control
Prescription of medication
Care of the deteriorating patient
Kirkup 2022
HSIB/Other
CQC Well-Led, Safe, Effective, Responsive & 2023 Must-Dos
Ockenden all actions
CNST: 1,6,7,9
Priority Actions for Q1
Auditing and improving risk assessments & shared decision making
Improve safety training compliance
Improve monitoring of outcomes of care
Undertake regulatory audits
Improve infection control monitoring
Improve epidural waiting times and consultant availability
Reduce delays to induction of Labour
Compliance with prescribing processes
All workstreams aim to review and improve or implement the themes described.
Priority Actions include CQC must-dos & are updated Quarterly
Leadership & Culture
Jonathan Cusack
Danni Burnett
Head of Operations
Roles & responsibilities of the Senior Midwifery Team
Effective appraisal processes
Development packs for all Band 7 and above midwives
Leadership Development – coaching and leadership training
Triumvirate Leadership development
Improved meeting and communication
Development of UHL maternity website
Equality, Diversity, & Inclusion
PROUD Behaviours
Improvement culture
Culture of Compassion
Excellence in team working and shared aims, perspectives & trust
CNST: 3,4,5,8,9
Kirkup 2022
HSIB/Other
CQC Well-Led
Priority Actions for Q1
Development of Improvement Hubs in conjunction with Staff Engagement work
Consultant led Maternity Improvement programmes workstream monthly updates to be introduced
Maternity Service Manager action plan and on-going recruitment.
Workforce & Staffing
McParland Penelope
Kerry Williams
Head of Service (Neonates)
Midwifery Establishment
Midwifery rotations between clinical areas & locations
Monitoring, reporting and escalations of Midwifery establishment
Forward facing Midwifery establishment planning
Neonatal workforce
Medical workforce
MDT training - technical & relational
Workforce well-being
Sickness absence management and support
Retention planning
Talent management and succession planning
Kirkup 2022
CQC Safe, Effective & 2023 Must-Dos
Ockenden 1,3,7
HSIB/Other
Priority Actions for Q1
Agree future Maternity establishment
Continue with recruitment programme
Improve training and performance appraisals in line with national guidance
Sickness absence prevention and support action planning with new Maternity HR Business Partner
Improve agency staff induction process
Complete Core Competency Framework Training Needs Analysis
Partnerships & Engagement
Rebekah Calledine
Natasha Archer
Head of Service (Neonates)
Maternity Voices Partnership working
Effective staff engagement & ensuring staff feel they have a voice
Working in partnership with our LMNS
ICB Mutual Aid
Development of Professional
Midwifery Advocate role
Development of OGN SharePoint site
Improving our estate
Maternity Star Awards
Communication strategy
Cultural development work – NHSE/I Civility & Respect Toolkit
Psychological safety
Kirkup 2022
HSIB/Other
Ockenden 1,3,7
CNST: 7,8
Priority Actions for Q1
Spread of accessible and interesting OGN SharePoint site
2022 Maternity Survey action plan to be signed off and incorporated into MIP
Wider engagement activities planned to include community staff
Q4 focus on well-being launch



Name of meeting:	**Leicester, Leicestershire and Rutland ICB Finance Committee**		
Date:	12 October 2023	**Paper:**	**H**
Report title:	**Finance Report Month 5 2023/24**		
Presented by:	Spencer Gay, Deputy Director of Finance (System).		
Report author:	Spencer Gay, Deputy Director of Finance (System).		
Executive Sponsor:	Caroline Gregory, Executive Director of Finance, Contracting and Corporate Governance.		

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

Recommendations:

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

- **RECEIVE and NOTE** the financial position as at month 5 and the forecast performance.
- **RECEIVE for assurance.**

Purpose and summary of the report:

The overall year-to-date (YTD) system position is a deficit of £51.6m which is a £31.8m adverse variance against plan.

UHL have reported a YTD deficit of £36m (£17m adverse variance to plan), LPT have reported a YTD deficit of £0.8m (in line with plan), whilst the ICB have reported a £14.8m YTD deficit (£14.8m adverse variance to plan).

The system has declared a deficit forecast of £10.0m (UHL £10.0m deficit, LPT breakeven and ICB breakeven) which is in line with the final agreed plan for the year.

All system partners are taking action to mitigate risks, strengthening financial controls and delivering increasing levels of financial efficiency as the year progresses. Given the financial pressures being experienced related to inflation, industrial action, demand and prescribing costs, there is a risk that the ICS may be unable to achieve the £10m planned deficit.

Appendices:	• Appendix 1
Report history (date and committee / group the content has been discussed / reviewed prior to presenting to this meeting):	• CFOs • Finance Committee • System Execs

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.*	This aligns to the financial sustainability risk
b) Does the report highlight any resource and financial implications? If so, provide which page / paragraph this can be found within the report.	Yes as the report focuses on the financial position
c) Does the report highlight quality and patient safety implications? If so, provide which page / paragraph this is outlined in within the report.	N/A
d) Does the report demonstrate patient and public involvement? If so, provide which page / paragraph this is outlined in within the report.	N/A
e) Has due regard been given to the Public Sector Equality Duty? If so, how and what the outcome was, provide which page / paragraph this is outlined in within the report.	N/A

Finance Report Month 5 2023/24

12 October 2023

Month 5 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)	(19,799)	(51,596)		(10,002)	(10,002)	
System Revenue expenditure not to exceed income	2,190,485	2,242,081		5,237,766	5,247,768	
System Capital expenditure not to exceed allocations	32,844	17,521		121,649	121,365	
System Operates within Cash Reserves	91,621	83,469		115,305	114,506	
ICB Running Costs Allocation not to be exceeded *(included within system position)*	8,494	6,836		20,385	17,129	
ICB Primary Care Co-Commissioning Allocation not to be exceeded *(included within system position)*	81,642	82,802		195,941	199,713	
ICB Newly Delegated Allocation not to be exceeded *(included within system position)*	8,994	8,955		23,086	23,086	
System CIP delivery	42,639	31,478		142,569	125,034	
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	54,456	
ICB MHIS spend requirement to meet target				188,276	188,327	

Revenue

2. **The system is reporting a year-to-date deficit of £51.6m which is £31.8m worse than plan**, (UHL £17m adverse variance and ICB £14.8m variance against plan). The position reflects pressures relating to industrial actions, unfunded inflation, prescribing growth and efficiency delivery lower than plan.

3. There has been a significant deterioration in the ICB year-to-date deficit this month linked to growth in prescribing costs. We now have data relating to the first three months of the year (and have estimated months 4 and 5 based on this) – prescribing costs have grown by 13.4% compared to the same period last year, this is largely related to price increases rather than volume (8.3% price increase, 4.7% more items). This pressure appears to be impacting all systems, the growth average for the midlands for month 3 is 14.4%.

4. **The system is forecasting a £10.0m deficit year end position**, UHL are reporting a £10.0m deficit as per their 23/24 plan whilst the ICB and LPT are forecasting delivery of planned breakeven positions.

5. All system partners are taking action to mitigate risks, strengthening financial controls and delivering increasing levels of financial efficiency as the year progresses. Given the financial pressures being experienced related to inflation, industrial action, demand and prescribing costs, there is a risk that the ICS may be unable to achieve the £10m planned deficit.

6. The system has planned **efficiencies** of £142.6m, of which we are currently forecasting £125m delivery (£31.5m achieved year to date).

Capital

7. Operating capital spend is currently below plan by £7.5m with a year to date actual spend of £11.6m, however the system is anticipating full spend by year end.

8. The plan against national schemes has been adjusted to reflect £8.5m of UEC schemes which will now not be received by the system. The end of year forecast variance for national schemes is a £0.3m underspend.

Other Indicators of note

9. **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.

10. **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 86% in relation to the numbers of NHS invoices paid within 30 days (non NHS at 96%) and LPT is cumulatively at 90% in relation to the numbers of NHS invoices paid within 30 days (non NHS at 97%).

11. 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. 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, while UHL are slightly below plan on both accounts. The ICB is maintaining a minimal end-of-month cash balance as required.

12. The ICB receives funding for specific elements of spend within its allocation. **Better Care Fund, Primary Care Co-Commissioning, Mental Health Investment**, **Running Costs** and the newly delegated **Pharmacy, Ophthalmic & Dental** 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

13. As a system at month 5, we have reported an in-year deficit of £51.6m against revenue budgets and forecast a £10m year-end deficit.

14. Operational capital spend is currently below plan and forecasting a breakeven position.

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

16. The cash position remains largely positive across the system, there is some concern that cash could become a problem if financial recovery and mitigation plans do not deliver as expected in the second half of the year – this will be monitored closely, particularly at UHL.

17. All system partners are taking action to mitigate risks, strengthening financial controls and delivering increasing levels of financial efficiency as the year progresses. Given the financial pressures being experienced related to inflation, industrial action, demand and prescribing costs, there is a risk that the ICS may be unable to achieve the £10m planned deficit.

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

- **RECEIVE and NOTE** the financial position as at month 5 and the forecast performance.
- **RECEIVE for assurance.**

Name of meeting:	**Leicester, Leicestershire and Rutland Integrated Care Board meeting**		
Date:	**12 October 2023**	**Paper:**	**I**
Report title:	**Assurance Report from the ICB Finance Committee**		
Presented by:	Jeffrey Worrall, Non-Executive Director from University Hospitals of Leicester NHS Trust		
Report author:	Imran Asif, Corporate Governance Officer, LLR ICB Simone Jordan, (Vice Chair) Non-Executive Member – Remuneration and People, LLR ICB Jeffrey Worrall, Non-Executive Director from University Hospitals of Leicester NHS Trust		
Sponsor:	Caroline Gregory, Chief Financial Officer (Interim), 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 LLR Integrated Care Board is asked to:

- **RECEIVE** the report for assurance.
- **APPROVE** the amendments to the Committee terms of reference (Appendix 1).

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 **30 August 2023** and **27 September 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. The terms of reference are appended to the report for approval following the change in the Committee chairing arrangements.

Appendices:	• Appendix 1 - LLR ICB Finance Committee Terms of Reference
Report history (date and committee / group the content has been discussed / reviewed prior to presenting to this meeting):	• N/A

The report is helping to deliver the following strategic objective(s) – *please tick all that apply***:**		
1. 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. Terms of Reference – Amendment to membership	**N/A**	The Finance Committee members supported the amendments to the membership section of the Terms of Reference, noting one minor amendment to the Chairs title to read: • Non-Executive Director, University Hospitals of Leicester NHS Trust	The ICB are requested to approve the minor amendments to the Terms of Reference.
2. ICS System Financial Report for Month 5 2023/24 – Revenue, capital, efficiency schemes and POD	**RED**	The Finance Committee received M05 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 £51.6m reported, the system partner control totals are listed below with narrative on key drivers: - • UHL – £36m deficit; (Industrial action, unfunded inflation, and emergency pathway) • ICB - £14.8m deficit; (Continuing Healthcare (CHC) and prescribing) • LPT - £0.8m deficit; (Estates services).	There is a significant risk of the LLR system not achieving the year end forecast outturn.
3. ICB Finance Report Month 5 2023/24	**RED**	The Finance Committee received the M05 ICB financial position which was a deficit of £14.8m. Detail was provided around the financial position and risks highlighted within the efficiency plan with further detail provided in the LLR Financial Recovery and 5-Year Financial Strategy Updates.	There is a significant risk of the ICB not achieving the year end forecast outturn.
4. Pharmacy, Optometry and Dentistry (POD) Finance update Month 5	**RED**	The LLR ICB overall year to date position was reported to be an underspend of £114k, with insufficient information to determine an accurate year end forecast. **Dental –** There is a ring-fenced budget, the year-to-date position was reported to be an underspend of £2.5m. There is an expectation of non-recurrent slippage in year. **Ophthalmology-** There is a year to date overspend of £1m, LLR ICB are investigating the impact to end of year reporting. **Pharmacy –** The year-to-date position was reported to be an underspend of £39k which includes three months accruals. The Committee raised concerns on its lack of ability to influence financial spend and noted the complexity of the governance arrangements in	There is a risk that the ICB will report an overspend for PODs delegated services at the end of year.

		place to manage the delegated services and requested they were escalated to the attention of the Chair of the ICB.	
5. LLR Financial Recovery Update	**RED**	The Committee were presented with the LLR financial recovery update which detailed the increasing financial pressures from M02 to M05, year to date deficit of £51.6m. Assurance was provided that the Executive Management Team at the ICB have undertaken all necessary steps to analyse financial schemes, however, no further efficiency opportunities have been identified. The ICB have conducted a deep dive at M04 and note the likely forecast outturn position to be £22.9m deficit of which £13.4m *'will not deliver'* and £9.5m *'will be actively managed/difficult to achieve'*. If pressures continue at their current level, the current risk-based assessment at M05 across the system is a projected £89.8m deficit at year end (ICB £40.7m, UHL £43.2m and LPT £5.9m); a £79.8m deterioration against plan. Factors driving the financial challenge were noted as: - **External** • Unfunded inflationary pressures • Industrial action • UEC pressures • Operational pressures **Internal** • Non delivery of CIP programme (linked to running costs and stretching targets) A list of 'high risk' opportunities were put forward to the Committee that were considered risky because of their contractual, clinical and safety implications and impact on operational targets. The Committee discussed that it may be prudent to aggregate financial reductions across all schemes rather than targeting high-risk areas only. The LLR system have provided an update against the 88 financial controls to NHSE on the 5 September. The Committee supported an internal audit review by 360 Assurance to assess key controls which could deliver the greatest financial impact. The Committee emphasised the need to ensure the scope and terms of reference for this piece of work is concise and be taken from the current internal audit plan allocation.	The LLR system is facing unprecedented financial difficulties and there is a risk that the agreed financial plan 2023/2024 will not be achieved.
6. LLR System Delivery	**RED**	The Committee were pleased to receive the LLR System Delivery Partnership report and noted	The Delivery Partnerships are working on

	Partnership Month 5 Report		better integrated reporting for finance, quality, and health inequality. It was noted that the report did not highlight significant financial transformation or scale of savings to provide sufficient assurance. The Committee considered that additional opportunities for transformation could be realised for improved estates management across the LLR system, including a better understanding of population health management data.	transformational projects, but there is a risk that operating costs will not be reduced.
7.	**5 Year Financial Strategy Update**	**RED**	The Committee were provided with an update on progress against the 5-Year Financial Strategy, it was noted that the system level financial model has been refreshed following guidance from NHSE regional teams. The Committee were informed that the financial gap continues to worsen and a 4.3% efficiency target will need to be delivered for the LLR system to achieve a balanced position by 2027/2028. Further work is to be undertaken and the Committee will receive an update at the next meeting.	
8.	**ICB Board Assurance Framework 2023/2024 update**	**N/A**	The Committee discussed the BAF risk score of 20 and debated if this should be increased to 25 due to the financial difficulties being faced in 2023/2024. It was agreed that the risk score should remain at 20 because executives had reviewed all options and decided not to implement higher risk strategies which could impact quality.	
9.	**System risks and issues Log Month 5**	**N/A**	The Committee noted the following changes to the system risk and issues log for M04 and M05: - **<u>Changes to risk score</u>** Risk 3 (Financial Plan Delivery) – 16 to 20 Risk 6 (POD Delegation Risk) – 16 to 20 Risk 7 (Transformation and Efficiency Schemes) – 12 to 16 Risk 8 (3-Year Capital Plan) – 6 to 9 **<u>Closed risk</u>** Risk 2 (Elective Care Backlog) has been closed as the risk score (6) had reduced below the risk appetite score of (12). The Committee were notified that all actions from the previous meeting had been completed.	
10.	**Internal Audit of Financial Controls (across the Integrated Care System)**	**N/A**	The Finance Committee members received Terms of Reference for the internal controls audit to be conducted by 360 Assurance.	

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.

NHS Leicester, Leicestershire and Rutland Integrated Care Board

Finance Committee
Terms of Reference (v3, March 2023)

1. CONSTITUTION

The Finance Committee (the Committee) is established by the NHS Leicester, Leicestershire and Rutland Integrated Care Board (the Board or ICB) as a Committee of the Board in accordance with its Constitution.

These terms of reference set out the membership, the remit, responsibilities and reporting arrangements of the Committee and may only be changed with the approval of the Board.

The Committee will be chaired by a Non-Executive Director from either the ICB or from a NHS partner organisation, it is a committee of the Board and its members are bound by the Standing Orders and other policies of the ICB.

2. PURPOSE OF THE COMMITTEE

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

The Committee will provide regular assurance updates to the ICB in relation to activities and items within its remit.

3. DELEGATED AUTHORITY

The Committee is a formal committee of the ICB. The Board has delegated authority to the Committee as set out in the Scheme of Reservation and Delegation and may be amended from time to time.

The Committee holds only those powers as delegated in these Terms of Reference as determined by the ICB Board.

4. MEMBERSHIP AND ATTENDANCE

Membership

The Committee members shall be appointed by the Board in accordance with the ICB Constitution.

The Board will appoint no fewer than four members of the Committee including two who are Non-Executive Members (one of whom will be from the ICB). Other attendees of the Committee need not be members of the Board, but they may be.

When determining the membership of the Committee, active consideration will be made to equality, diversity and inclusion.

The Chair may ask any or all of those who normally attend, but who are not members, to withdraw to facilitate open and frank discussion of particular matters.

Members

- Non-Executive Director (from NHS partner organisation) – Associate Non-Executive Director from University Hospitals of Leicester NHS Trust (Chair)
- Non-Executive Director – Remuneration and People (ICB) (vice Chair)
- Chief Finance Officer (ICB) or nominated deputy
- Chief Nursing Officer or the Chief Medical Officer or their respective deputies (ICB)
- Non-Executive Director from University Hospitals of Leicester NHS Trust (UHL)
- Chief Finance Officer from University Hospitals of Leicester NHS Trust (UHL) or nominated deputy
- Non-Executive Director from Leicestershire Partnership NHS Trust (LPT)
- Chief Finance Officer from Leicestershire Partnership NHS Trust (LPT) or nominated deputy

Only members of the Committee have the right to attend committee meetings. Other individuals may be invited to attend all or part of any meeting as and when appropriate. The following individuals may be asked to attend on a regular basis, however they would not form part of the membership and therefore do not have voting rights:

- Deputy Director of Finance (for system) (ICB)
- Non-Executive Member – Audit (ICB)
- Representative from East Midlands Ambulance Service
- NHS England / Improvement representative

Chair and vice chair

In accordance with the Constitution, the Committee will be chaired by a Non-Executive Member ~~of the Board~~ and the second Non-Executive Member (a member of the ICB Board) will be the vice Chair of the Committee.

The Committee shall satisfy itself that the ICB's policy, systems and processes for the management of conflicts, (including gifts and hospitality and bribery) are effective including receiving reports relating to non-compliance with the ICB policy and procedures relating to conflicts of interest.

If the Committee Chair has a conflict of interest then the vice chair or, if necessary, another member of the Committee will be responsible for deciding the appropriate course of action.

5. MEETING QUORACY AND DECISIONS

The Finance Committee shall meet on a monthly basis. Additional meetings may be convened on an exceptional basis at the discretion of the Committee Chair.

Quoracy

For a meeting to be quorate a minimum of four members will be required with either the Chair or the vice Chair present, plus the Chief Finance Officer (ICB) plus a member from UHL and a member from LPT.

If any member of the Committee has been disqualified from participating in an item on the agenda, by reason of a declaration of conflicts of interest, then that individual shall no longer count towards the quorum.

Where members are unable to attend they should ensure that a named and briefed deputy is in attendance who is able to participate on their behalf.

If the quorum has not been reached, then the meeting may proceed if those attending agree, but no decisions may be taken.

Decision making and voting

Decisions will be taken in accordance with the Standing Orders. The Committee will ordinarily reach conclusions by consensus. When this is not possible the Chair may call a vote.

Only members of the Committee may vote. Each member is allowed one vote and a majority will be conclusive on any matter.

Where there is a split vote, with no clear majority, the Chair of the Committee will hold the casting vote. The result of the vote will be recorded in the minutes.

If a decision is needed which cannot wait for the next scheduled meeting, the Chair may conduct business on a 'virtual' basis through the use of telephone, email or other electronic communication.

6. RESPONSIBILITIES OF THE COMMITTEE

The responsibilities of the Committee will be authorised by the ICB Board. It is expected that the Committee will:

- Gain assurance from the executive functions and provide assurance to the Board that there are robust processes in place for the effective management of:
    - financial strategy;
    - financial planning and management;

  - financial performance, activity and control;
  - capital expenditure and schemes; and
  - financial risk management.

- Oversee and monitor delivery of the ICB key statutory requirements.

- Ensure that suitable policies and procedures are in place to comply with relevant regulatory, legal and code of conduct requirements.

- Have oversight of the Terms of Reference and work programmes for the groups reporting into the Finance Committee.

Financial Strategy

- Provide oversight of the financial strategy
- Receive and evaluate recommendations from the Executive Finance officers for the key financial priorities that are included within the ICB strategy/ annual plan, including priorities to address variation/ inequalities in care
- Oversight of payment policy reform and impact of commissioning reforms such as place based allocations
- Oversight of provider collaboration and impact on finance.

Financial planning

- Oversight of the development of system financial management information systems and processes, forming recommendations to the Board on the model of financial planning to be adopted and the contractual frameworks to be operated within the system.
- Provide assurance on the development and delivery of the continuous improvement and efficiency agenda

Financial performance and controls

- Have oversight of the monthly financial performance of the system and provide the Board with an accurate understanding of the system's current and forecast financial position and the development and oversight of the system's financial strategy/ recovery plans to address any underlying challenge.
- To review exception reports on any material in-year overspends against delegated budgets, including adequacy of any proposed remedial action plans
- Receive assurance that appropriate arrangements are in place to ensure robust system financial control.
- Consider proposals for the system financial architecture and financial controls required to ensure the system is able to meet the value for money criteria and ensure financial sustainability.

Capital

- Oversight of the system capital plans including robust in year monitoring and forecasting to provide the Board with an accurate understanding of the system's current and forecast position.

- Ensure capital plans are aligned to LLR strategic, clinical, operational and innovation priorities.

Financial risk management

- To have oversight of strategic financial risks on the Board Assurance Framework and high-risk operational risks and oversight of associated mitigations. Ensure the ICB is kept informed of significant risks and mitigation plans, in a timely manner

7. ACCOUNTABILITY and REPORTING ARRANGEMENTS

The Finance Committee is directly accountable to the ICB. The minutes of meetings shall be formally recorded. The Chair of the Committee shall report to the Board (public session) after each meeting and provide a report on assurances received, escalating any concerns where necessary.

The Committee will advise the Audit Committee on the adequacy of assurances available and contribute to the Annual Governance Statement

The Committee will receive scheduled assurance report from its delegated groups. Any delegated groups would need to be agreed by the ICB Board.

8. BEHAVIOURS AND CONDUCT

ICB values

Members will be expected to conduct business in line with the ICB values and objectives. Members of, and those attending, the Committee shall behave in accordance with the ICB's Constitution, Standing Orders, and Standards of Business Conduct / Conflicts of Interest Policy.

Equality and diversity

Members must demonstrably consider the equality and diversity implications of decisions they make.

9. DECLARATIONS OF INTEREST

All members and those in attendance must declare any actual or potential conflicts of interest which will be recorded in the minutes. Anyone with a relevant or material interest in a matter under consideration will be excluded from the discussion at the discretion of the Committee Chair.

10. SECRETARIAT AND ADMINISTRATION

The Committee shall be supported by the Corporate Governance Team this will include ensuring that:

- The agenda and papers are prepared and distributed in accordance with the Standing Orders having been agreed by the Chair with the support of the relevant executive lead;
- Attendance of those invited to each meeting is monitored and highlighting to the Chair those that do not meet the minimum requirements;
- Records of members' appointments and renewal dates and the Board is prompted to renew membership and identify new members where necessary;
- Good quality minutes are taken in accordance with the standing orders and agreed with the chair and that a record of matters arising, action points and issues to be carried forward are kept;
- The Chair is supported to prepare and deliver reports to the Board;
- The Committee is updated on pertinent issues/ areas of interest/ policy developments;
- Action points are taken forward between meetings and progress against those actions is monitored.

11. REVIEW

The Committee will review its effectiveness at least annually and complete an annual report submitted to the Board.

These terms of reference will be reviewed at least annually and more frequently if required. Any proposed amendments to the terms of reference will be submitted to the Board for approval.

The Committee will utilise a continuous improvement approach in its delegation and all members will be encouraged to review the effectiveness of the meeting at each sitting.

Date of approval: 13 April 2023 by the Board of the LLR ICB

Date of review: April 2024

J

Name of meeting:	**Leicester, Leicestershire and Rutland Integrated Care Board**		
Date:	12 October 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 11 August 2023, 25 August 2023, and 22 September 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 16.

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 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 11 August 2023, 25 August 2023, and 22 September 2023. The report also covers items for escalation and consideration by the Board ensuring that it is alerted to emerging risks or issues.

Governance Arrangements

2. An **ICB Board Assurance Framework 2023/24 update** was provided following a review by the Board in July 2023. The residual risk score of BAF 6 (Emergency Preparedness, Resilience and Response) had reduced from a red score of 16 to an amber score of 8. BAF 2 (Health Inequalities) and BAF 4 (Finance) remained the joint highest risks with red residual risk scores of 20. A series of actions is being developed to reduce the risk score of BAF 2 over a 6-month period.

Strategy and Planning

3. The **Approach for the 2024/25 Operational Planning Round** was discussed. The LLR ICB had produced a 5 Year Plan and Annual Plan which incorporated a significant financial ask, increased performance requirements, and national mandates for 2023/24. A medium-term financial plan would be developed with an in-year efficiency target of 3-6%. Decisions regarding disinvestment and reallocation of resources would be informed by principles developed at the System Prioritisation Group. The System Executive approved the System Planning Parameters and System Investment Approach.

4. The role of partnerships and collaboratives was further explored at the System Executive development session on 8 September 2023. The partnerships and collaboratives would assist with the development of a planning narrative as in the previous year. Efficiency Programmes and Cost Improvement Programmes (CIP) would also be developed with partnerships and collaboratives where appropriate.

5. **Leicester, Leicestershire and Rutland System 2023/24 Quarter Two 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). Leicestershire Partnership NHS Trust (LPT) remained at NOF level 2 and University Hospitals of Leicester NHS Trust (UHL) remained at NOF level 4.

6. The System Executive received an update on the **LLR ICS Infrastructure Strategy**, to be developed by April 2024 as required by NHS England. A draft Strategy would be presented to the System Executive for review in January 2024. Workshops for the development of the Strategy would include a wide range of representation including Estates Leads.

7. The **Blaby District and Melton Community Health and Wellbeing Plans** were received. The local priorities identified within the plans would be developed into workstreams for collective action. Key themes would also be identified from the plans developed by each of the seven districts within Leicestershire. It was agreed that Health and Wellbeing Plans for the City would be received for consideration by the System Executive.

Operational performance assurance

8. The **Outcome Letter from Quarter One Review Meeting (QSRM)** outlined the key areas of discussion. Positive improvements had been evidenced in many areas whilst challenges remained regarding the financial position and quality of care in some service areas. Segmentation scores for the ICB, UHL and LPT were confirmed.

9. The **LLR Delivery Partnership – August briefing** reported on the progress made against the Operational Plan at month 4 (July 2023). Overall ratings for Performance, Quality and Transformation were amber. Finance received a red rating due to the forecast delivery against the Cost Improvement Programme (CIP) and further pressures which had materialised in year. An overall rating was not available for Health Equity however this was highlighted as a key consideration within each transformation programme.

10. The **LLR Delivery Partnership – September briefing** reported on the progress made against the Operational Plan at month 5 (August 2023). Overall ratings for Performance, Quality and Transformation remained as amber. Finance remained at a red rating as the financial position had deteriorated since the month prior. Delivery of CIP remained a key focus. Health Equity received an overall rating of red however it was acknowledged that the LLR ICS was performing comparatively well, and the position would be reviewed.

11. An **Update on the ICB 2023/24 Financial Position at month 4 (July 2023)** identified that the system year to date (YTD) deficit at month 4 was £34.7m, which was an adverse variance from plan of £17.5m. The System Executive discussed financial recovery, governance, and controls in detail. It was agreed that financial outturn was not on course with original projections and further financial mitigations should be explored. Assurances would be provided to NHS England that enhanced financial controls were in place and working effectively.

12. An **Update on the ICB 2023/24 Financial Position at month 5 (August 2023)** identified that the system year to date (YTD) deficit at month 5 was £51.6m, which was an adverse variance from plan of £31.8m. The ICB would provide assurance to NHS England regarding contained workforce costs and improved productivity at the next QSRM on 20 October 2023.

13. The **Month 3 Workforce Dashboard** identified that the system YTD position at month 4 was an overspend of £22.2m against planned staffing. Overall, there had been an increase in bank staff usage compared to agency. A deep dive session would be held by LPT, and assurances returned to the System Executive.

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. The System Executive approved the **Endoscopy Short Form Business Case (SFBC)**, noting that the national Endoscopy Transformation Team had committed to capital funding of £16.7 million for a new endoscopy build at the Leicester General site. The staged approach outlined in the SFBC was appropriate and in line with the system approach to improving cancer and elective services overall.

    b. **East Midlands Assisted Fertility Policy Review Update –** a review was being undertaken by Arden and Greater East Midlands Commissioning Support Unit (AGEM CSU) on behalf of the five East Midlands ICBs to ensure a standardised approach and to incorporate NICE guidance. A report would be returned in October

2023 detailing the options for changes to the policy and any associated financial impact. A recommendation would then be made to the Board.

c. The System Executive approved the **Proposed S256 agreements to retain Harmless CIC community self-harm intervention service across Leicester, Leicestershire and Rutland (LLR)**. Current contracts, hosted by the Local Authorities and jointly funded through the NHS, were due to expire on 31 August 2023 with no alternative service in place. It was agreed to extend the contracts from 1 September 2023 - 31 March 2024. Funding was available within the 2023/24 Mental Health Investment Standard.

d. The System Executive approved the **Continuation of the Urgent Supply of Palliative Care and Specialised Medicines Service - Direct Award.** The service would continue to be provided by 19 community pharmacies under a new contract from the 1 October 2023 to 31 March 2024.

e. **Implementation of previously approved Mental Health Financial Plan Spend 2023-2024 – enhanced services for First Steps Eating Disorder Service and Community Early Intervention Service** – The System Executive approved the implementation of funding as per the Mental Health Financial Plan 2023-2024.

f. The System Executive supported the **Feilding Palmer Pre-Consultation Business Case (PCBC)** for onward approval by the Board.

g. The System Executive received the **Hinckley Community Diagnostic Centre (CDC) Programme Update.** Assurance was provided that demand and capacity assessments would be completed.

h. Vanguard Theatre Decommissioning Paper (UHL) – The System Executive received assurance that the decision to decommission the Vanguard Theatre from September 2023 would not adversely impact elective recovery and that a viable exit strategy was in place.

i. Protecting and Expanding Elective Capacity – UHL Assurance Response to NHSE letter August 2023 – It was confirmed that assurance could be given on 7 of the 12 asks within the letter. The remaining 5 were partially assured due to the size of the ask and the significant work being undertaken on outpatient transformation.

j. The System Executive approved the **Primary Secondary Care – LLR ICS Interface document 2023.** The document had been developed to support clinicians in delivering patient centred care at the right place, right time and by the right health professional. Collaborative working would continue with a specific focus on the Recovery Plan for Primary Care.

k. The System Executive received an update on the **Local Resilience Forum (LRF) Funding Review.** It was noted that a change to the funding formula would likely increase contributions by each individual health agency in 2024/25.

15. Regular assurance reports were received from the Strategic Commissioning Group and the Clinical Executive Group. The System Executive received the first assurance report from the System Prioritisation Group, including a review of unfunded business cases and the investment approach. The Neurodevelopmental Pathway was highlighted for prioritisation in the 2024/25 planning round or as part of the Medium-Term Financial Plan investment timeframe.

Summary of assurance from the Committee

16. 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. Governance Arrangements	**Amber**	• Health Inequalities and Finance remained the highest risk areas, both with a red residual risk score of 20. • A series of actions was agreed to reduce the risk score for Health Inequalities over a six-month period.	N/A
2. Strategy and planning	**Amber**	• Initial discussions regarding the approach to the 2024/25 Operational Planning Round commenced. Work would continue to develop a medium-term financial plan. • The System Planning Parameters and Investment Approach were approved. • Collaboratives and partnerships would develop a planning narrative and be involved in the development of cost improvement plans where appropriate.	N/A
3. Operational performance assurance	**Amber**	• The financial position of the LLR ICB was highlighted as a challenge. • Finance and Health Equity risks were rated as red overall in the LLR Delivery Partnership September briefing. • Financial challenges reviewed in detail. • The workforce position at month 4 was an overspend of £22.2m against planned staffing.	N/A
4. Other decisions including business cases, procurements and contracts	**Amber**	• East Midlands ICBs Assisted Fertility Policy is under review. • Underspend on the CDC Programme may be redistributed by NHS England outside of LLR. • There is a risk that UHL will not achieve the 90% validation target for waiting lists by October 2023.	N/A
5. Information only	**Green**	• Assurance reports from sub-groups are regularly received, and issues and risks identified along with mitigations.	N/A

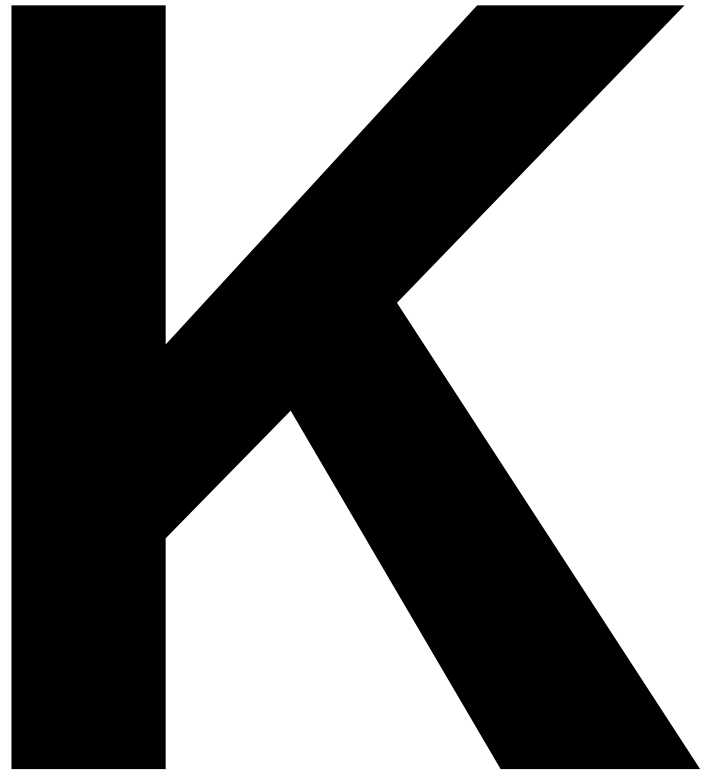
Key for level of assurance:

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

Recommendations

The LLR Integrated Care Board is asked to:

- **RECEIVE** the report for assurance.



Name of meeting:	**Leicester, Leicestershire and Rutland Integrated Care Board meeting**		
Date:	12 October 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:	Imran Asif, 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 7 September 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.*		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
ICB Chief Nursing Officer / Chief Medical Officer Quality Assurance Report	**GREEN**	**Assure** • The Committee were assured that satisfactory Quality Accounts had been received for system providers.	
	RED	**Alerts** • **System Quality Risk Log** a new issue relating to neurodevelopmental assessment and treatment waiting times had been identified by the sub-group. It was reported that there is a significant backlog in the neurodevelopment pathway, which is a national issue. A regional approach is being taken to assess how patients could be triaged. • **Special Educational Needs and Disability (SEND) concerns** The CNO expressed concerns for the fragility of services for SEND. The ICB are working with LPT to provide a collaborative workforce approach as a form of mitigation. • **Delegated Healthcare Tasks training** An emerging risk was acknowledged in relation to delegated healthcare tasks that are managed by Local Authorities. Due to operational pressures, as Local Authorities reassess their priorities, they may potentially stop providing these services.	
Delivery Partnerships Report	**GREEN**	The committee received the Delivery Partnership Report and supported the quality and transformation overall rating of amber.	N/A
Quality Strategy Implementation Plan	**GREEN**	A progress update for Q2 was provided on the 2023/2024 Quality Strategy Implementation Plan. The committee were pleased to note significant assurance was provided against key areas of focus within the plan.	N/A
Health Equity Update	**GREEN**	The impact of health equity on quality and safety was recognised. Assurance was provided that the ICB has made progress on challenging health inequity, however there is much more to achieve. The forthcoming ICB Board development session on health equity was welcomed.	N/A
Unfunded Business Cases Report	**GREEN**	The committee was assured that the six unfunded business cases had been through a comprehensive clinical prioritisation process. Assurance was provided that all six business cases had completed an equality and quality impact assessment and presented no clinical risk to the LLR system.	N/A
Update from Public and Patient		Assurance was received from the PPIAG sub-group highlighting progress made in relation to the engagement	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
Involvement Assurance Group (PPIAG)	**GREEN**	and involvement workstreams. The key highlights included: maternity and neonatal voices partnership enabling patients and staff to be heard at all stages of the process; and extensive public engagement reported in respect of the Hinckley Community Services Review however the review has taken longer than anticipated and local residents concerned about the delay in making improvements.	
ICB Board Assurance Framework 2023/2024 update and LLR System Quality Risk Log	**AMBER**	The Committee were assured that controls and assurances were in place to mitigate the BAF risk 5 (quality and safety). Interdependencies with other strategic risks within the BAF was acknowledged. A detailed review of BAF risk 5 will be undertaken through a deep dive session at a future meeting. Assurance was received in relation to the transition of the operational risks, the oversight of which would form part of the remit of the System Quality Group.	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.

Name of meeting:	**Leicester, Leicestershire and Rutland Integrated Care Board**		
Date:	**12 October 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:	Imran Asif, Corporate Governance Officer Daljit Bains, Head of Corporate Governance		
Sponsor:	Darren Hickman, Non-Executive Member and Chair of Audit Committee		

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

Recommendations:

The LLR Integrated Care Board is asked to:

- **RECEIVE** the report for assurance.

Purpose and summary of the report:

1. This report provides a summary of the key areas of discussion and outcomes following the meeting of the **ICB Audit Committee** held on **15 August 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:	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 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. External Audit Update	**GREEN**	The Audit Committee were informed that the Value for Money review has been completed and a draft version of the external auditor's report to management has identified several improvement recommendations for consideration.	**None.**
2. Internal Audit Progress Report	**GREEN**	Audit plan was on track and the Committee approved some changes to timing of specific audit reviews acknowledging that some reviews would be best undertaken in quarter 3 or quarter 4 as opposed to early in the year.	**None.**
3. 2022/23 Health Inequalities Final Report	**GREEN**	The Audit Committee received the Health Inequalities Audit report noting that this was an advisory review as governance and control arrangements for health inequalities are still emerging and were unable to provide an assurance opinion at this stage.	**None.**
4. 2023/24 Data Security & Protection Toolkit Final Report	**GREEN**	"Substantial assurance" opinion had been received for the Data Security and Protection Toolkit (DSPT) which is the framework for information governance and information security standards.	**None.**
5. 2023/24 Head of Internal Audit Opinion Annual Work Programme Terms of Reference	**GREEN**	The Committee noted and received the 2023/2024 Head of Internal Audit Opinion Annual Work Programme and terms of reference.	**None.**
6. Internal Audit Follow-up Report	**GREEN**	Positive progress was noted in respect of the follow-up and implementation of internal audit actions.	**None.**
7. ICB Risk Management arrangements and BAF update	**GREEN**	The update report highlighted the progress made with the Board Assurance Framework content and the alignment of the Board Assurance Framework (BAF) and the Five Year Plan, including the ICB strategic objectives. The Committee was also assured by the regular review of the BAF by committees of the Board.	**None.**
8. Financial Sustainability Self-Assessment – Completed actions and final sign-off	**GREEN**	Assurance was received in relation to actions that were outstanding in relation to the self-assessment review, highlighting an improved control environment.	**None**.
9. Information Governance Assurance Report	**GREEN**	Assurance was received that the outstanding actions relating to the LLR ICB 2022/2023 Data Security and Protection Toolkit (DSPT) were all implemented ahead of the national submission of the self-assessment on 29 June 2023. This position confirmed 100% compliance with the information governance and information security standards as within the DSPT.	**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
10. Losses and Special Payments	**GREEN**	There have been no losses or special payments incurred during quarter one of 2023/2024.	**None.**
11. Waiver of Standing Orders report	**GREEN**	The waivers report was noted.	**None.**
12. Delegation of NHS England functions to ICBs	**AMBER**	The deep dive outlined the regional and local governance arrangements for the delegation of Pharmacy, Optometry and Dentistry services from NHS England. The Committee recognised that there was a risk that the ICB may fail to implement delegated functions adequately due to a lack of clear, accountable, and effective governance processes in place across the region. The Committee requested further clarity through examples of scenarios to fully understand the accountability and respective roles of NHS England, the ICB and the host organisation.	Risk of complex regional governance arrangements and clarity in respect of accountability.
13. Partnerships Self-Assessment	**GREEN**	Received the briefing on partnerships self-assessment for information.	**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.

M

Name of meeting:	**Leicester, Leicestershire and Rutland Integrated Care Board meeting**		
Date:	12 October 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 15 August 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. Committee Effectiveness Review	**Green**	The Committee reviewed and considered the Committee Effectiveness checklist including the member attendance record. Members feedback and discussion at the meeting assisted in identifying areas of improvement, for example it was proposed that place-based reporting be strengthened.	**None.**
2. Overview and Update from University Hospitals of Leicester NHS Trust Report	**Green**	UHL outlined significant progress being made in addressing the health equity agenda across the organisation, although acknowledged areas of further development.	**None.**
3. Health Inequality Dashboard Report	**Amber**	The committee acknowledged that the data presented showcased areas where health inequalities existed against the Core20plus5 metrics. The members requested that where possible data be presented on a granular scale to include Place and neighbourhood level reporting.	**None.**
4. Health Inequality Support Unit Update Report (Childhood Immunisation)	**Amber**	The deep dive into childhood immunisation uptake was useful in identifying areas of inequalities and how these were being addressed. There was a recognition that investment in the services was key.	**None.**
5. Workforce Assurance Report	**Amber**	The committee were provided with an update on the NHS long term strategic workforce plan which was published in June 2023. The three key themes were detailed as: - • Train (Increase education and training) • Retain (Improve culture and leadership to retain staff) • Reform (Improve productivity of staff through training)	**None.**
6. Health Inequalities Internal Audit Report	**Amber**	The audit report was received for information. This report provided an advisory note and areas for further consideration that management would wish to take forward and build on.	**None.**
7. ICB Board Assurance Framework Update Report	**Amber**	Focusing on BAF risk 2 (health inequalities) the committee reviewed the detail and acknowledged the actions required to enable the residual risk score to be reduced.	**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.

N

Briefing Summary of the Meetings of the East Midlands Joint Committee Meetings Held on Friday 25 August 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 Friday 25 August 2023.

2. NHS East Midlands Joint Committee for Specialised Services

2.1 2023/24 Month 4 Finance & Contracting Update

The Committee were provided with an update on the finance and contracting position for Specialised Services across the East Midlands Integrated Care Boards through which they received assurance on the forecast breakeven position and the agreement of contracts, noting the ongoing discussion on Elective Recovery Funding (ERF) and the impact this may have. The Committee noted the work that remains ongoing with regard to the development of a needs-based allocation formula (for 2025, with limited implementation in 2024). Given the transition period the Committee are to allocate time in upcoming meetings to drill further into funding arrangements.

2.2 Delegated Commissioning Group and Joint Committees Update

The Committee were provided with an update on progress made at a national and regional level with regard to delegation of services from 2024 and 2025. Whilst it was accepted that guidance was still in development if was noted NHSE and ICB CEOs were to meet on the 6 September, by which time it was anticipated a clear understanding of proposals would be known. The Committee noted the update and requested an updated position statement and recommendations are be provided at the next meeting, supporting the analysis future risk and the best resulting short, medium and longer-term mitigating actions.

2.3 Midlands Specialised Services Strategy

The Committee received a paper outlining the proposed approach to development of the Midlands Specialised Services Strategy for the next five to ten years. The Committee sought assurance on the proposed approach and encouraged triangulation with other complimentary strategies/ plans being developed at national, regional and local (ICB) level. The Committee endorsed the proposals in terms of outline structure, scope and methodology, subject to alignment of the joint forward plans as agreed.

2.4 Midlands Specialised Commissioning (Acute and Pharmacy) Health Inequalities Strategy (2023-25)

The Committee received the Midlands Specialised Commissioning Health Inequalities Strategy for approval. Received assurance on the process of development including the breadth of engagement undertaken across the region, and its alignment to national programmes and local commissioning priorities. The Committee highlighted the need to triangulate this work with other national/ regional/ local strategies/ plans, inclusive of key enablers such as data, digital and IT. The Committee approved the strategy and agreed for progress and impact to be presented into future meetings.

2.5 Midlands Acute Specialised Commissioning Group (MASCG) Assurance Report

The Committee were provided with a highlight summary of key matters from the MASCG meetings held on 17 July and 14 August and at which each ICB has attendance. The Committee noted the level of detail and assurance it provided.

2.6 Quality Governance and Reporting to Joint Committee

The Committee received a paper setting out the proposal by which the future reporting of the quality agenda for specialised services that are jointly commissioned and those deemed as suitable for delegation in the future (inclusive of how this may triangulate between NHSE, the Joint Committee and ICBs leads) would be undertaken. The paper also sought to provide assurance on the work being undertaken to transition toward delegation and by exception the assessed quality of commissioned services. The Committee welcomed the approach being taken on all matters, approved the proposed approach to reporting and requested the exception report be presented as a standing item for meetings going forward.

2.7 Deep Dives

2.7.1 Adult Critical Care

In line with the approved schedule of deep dives the Committee received detailed on the provision of Adult Critical Care services including current service provision and the vision for services in the future. The Committee noted the breadth of content and agreed a range of next steps with regard to engagement, capacity planning, workforce, and associated services.

2.7.2 Feedback on Neonatal Care Report

The Committee noted additional work being undertaken by NHSE with regard to enhance oversight of care in light of recent legal case.

3. <u>NHS East Midlands Integrated Care Boards Joint Committee</u>

*3.*1 Primary Care Finance and Assurance Report

The report provided the Committee with an update for assurance from the Tier 2 Group on the latest finance, performance, quality, and commissioning status in respect of Pharmacy, Optometry and Dental services (PODs) in the East Midlands. The Committee sought additional assurance on dental access and the utilisation of underperformance investment to support plans for recovery with consideration of the link to in year ICB financial plans and NHSE expectation.

3.2 East Midlands IMOS Procurement Briefing Update

The Committee received a further update with regard to the procurement of Intermediate Minor Oral Surgery and were asked to approve a proposed direction of travel informed by engagement with ICB leads and legal support. Following discussion the Committee approved for the cessation of the current procurement, the continuation of current services and undertaking of a further procurement exercise.

3.3 Midlands NHS111 Procurement Outcome Report

Through the presentation of the paper the Committee were asked to approve the award of contract. The Committee considered the Procurement Outcome Report as presented, seeking assurance of the process undertaken. The Committee noted that, subject to approval, significant work would still be required to mobilise the service and that this would be lead through a mobilisation project and oversight group. The Committee also noted that the West Midlands Joint Committee are to receive the same paper, but that the decisions of each region are being made independently. The Committee determined to approve the award as proposed and to establish the Mobilisation Project and Oversight Group.

3.4 East Midlands Collaborative Programme Office Update

The Committee received a further paper with regard to the proposal to establish an East Midlands Collaborative Programme Office. The Committee discussed the proposals made and how these triangulated with the current work being led/undertaken by ICBs on behalf of partners and the challenges faced with running cost allowances. Following careful consideration, the Committee concluded that the proposal should be amended in light of the discussion and represented for approval by the CEO meeting on the 11 September 2023, with the outcome reported to the meeting in October.

3.5 East Midlands Cancer Alliance Report

Through the presentation of the paper the Committee were asked to consider a proposed outline approach for delivery of the East Midlands Cancer Alliance from 1 April 2024; inclusive of geography, operational and governance. The discussion had supported the further shaping of a proposal with broad agreement for the maintenance of an East Midlands footprint and a hosted model with links to each ICB. Agreement was reached for a further proposal to be received and tested through the Committee.

o

Name of meeting:	**Leicester, Leicestershire and Rutland ICB Board meeting** – meeting in public		
Date:	12 October 2023	**Paper:**	**O**
Report title:	**Partnership and Governance Self-Assessment and Review**		
Presented by:	Sarah Prema, Chief Strategy Officer		
Report author:	Daljit K. Bains, Head of Corporate Governance		
Executive Sponsor:	Caroline Gregory, Chief Finance Officer Andy Williams, Chief Executive		

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

Recommendations:

The LLR ICB Board is requested to:

- **RECEIVE** the report for assurance.

Purpose and summary of the report:

At establishment the expectation was set that Integrated Care Boards (ICBs) would undertake a self-assessment of their own decision-making arrangements after the first year. This self-assessment would include a review of how partners could inform the ICB's decision-making.

An "ICB Partnership Governance Self-assessment and Development" support pack was developed by NHS England for use by ICBs to complement their own Board development programmes and to be used to support strengthening partnership governance arrangements.

The pack outlines four areas of development that senior ICB leaders nationally have identified are likely to be of most interest to ICB Chairs and Boards in considering how best to include partners in the ICB decision-making. These four areas are:

- The role and functioning of the ICB board itself – what should be its future focus and what should it delegate.
- Assignment of decision-making to Place and System-level, including providers / provider collaboratives taking on greater responsibilities.
- Commissioning decision-making, achieving system goals and implementing the Provider Selection Regime.
- NHS system management – how the ICB and its partner trusts will make decisions together to meet their shared financial statutory duties (system financial balance and capital planning) and to undertake system risk management (finance, quality and performance); including the relationship between organisational and system accountabilities.

ICBs have the choice of completing one or more modules. In conjunction with NHS England, it has been agreed that for this first year LLR ICB would focus on the *ICB role and functioning and ICB Board Composition* module. The following key areas of focus within this module have been used to assess the ICB's progress and conduct its self-assessment:

a) Purpose of Board meetings in public
b) Level of maturity of the Board
c) Board members making substantive and well-informed contributions

d) Effectiveness of the committee structure and delegated authority
e) Alignment of Board arrangements with wider Integrated Care System partnership.

The slides at Appendix 1 demonstrate the activities and actions taken over the last year to support the Board's own development, maturity and self-assessment.

Appendices:	• Appendix 1 – Self-assessment and 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 corporate risk(s) e.g. risk aligned to the Board Assurance Framework, risk register etc? *If so, state which risk and also detail if any new risks are identified.*	Not having the fundamental governance and risk management arrangements could result in non-compliance with legal and statutory requirements.
b) Does the report highlight any resource and financial implications? If so, provide which page / paragraph this can be found within the report.	None specifically in relation to this report.
c) Does the report highlight quality and patient safety implications? If so, provide which page / paragraph this is outlined in within the report.	None specifically in relation to this report.
d) Does the report demonstrate patient and public involvement? If so, provide which page / paragraph this is outlined in within the report.	None specifically in relation to this report.

e) Has due regard been given to the Public Sector Equality Duty? If so, how and what the outcome was, provide which page / paragraph this is outlined in within the report.	Not specifically in relation to this report, however the principles are contained with the Constitution and governance arrangements.

NHS
Leicester, Leicestershire and Rutland

LLR ICB Board – Partnership and Governance Self-Assessment and review

12 October 2023

Introduction

- At establishment the expectation was set that ICBs would undertake a self-assessment of their own decision-making arrangements after the first year.
- This self-assessment would include a review of how partners could inform ICB decision-making effectively.
- A suite of supporting documents and case studies was made available from NHS England to complement the Board's own development programme.
- This year the ICB is focusing on one of the four modules: the *ICB role and functioning and ICB Board Composition* module. The following key areas of focus within this module have been used to assess the ICB's progress:
    a) Purpose of Board meetings in public
    b) Level of maturity of the Board
    c) Board members making substantive and well-informed contributions
    d) Effectiveness of the committee structure and delegated authority
    e) Alignment of Board arrangements with wider Integrated Care System partnership.
- Reflections and feedback from Board members and wider partners have been incorporated into this review.
- The following slides demonstrate the activities and actions taken over the last year to support its own development, maturity and self-assessment.

a) Purpose of board meetings in public

- The **principal purpose of Board meetings in public** is understood by Board members, recognising the requirement to be open, transparent and being held to account by the public.
- As the Board has collectively matured and developed over the last year, the focus of Board meeting agendas have also shifted through the year.
- At establishment the focus was on assurance and operational matters, whereas in the last 6 – 8 months the focus has progressed to strategy and future planning, understanding the impact of strategic risks, balanced with operational oversight and assurance. The *Good Governance Institute* also recognised this shift in focus as per their feedback in January / February 2023 following a review of Board agendas.
- The **purpose of private Board meetings and Board development sessions** is also well understood.
- Board development sessions have provided the opportunity to build relationships, pursue in-depth discussions on 'wicked' issues and to learn and enhance our collective knowledge and understanding across a variety of strategic and operational matters.
- Topics of discussion in the development sessions have included, patient safety and quality, finance, Board Assurance Framework and risk management (including session facilitated by the *Good Governance Institute*, strategy and operational planning, and workforce.
- Overall, the role of the Board has become progressively clearer, primarily focused on NHS statutory functions but with greater opportunity for direct contribution from partner organisations and opportunity for focus on strategic integration and joint working between NHS and social care.

b) Level of maturity of the Board
c) Board makes substantive and well-informed contributions

- The **Board has developed and matured during the year** to enable it to become an effective unitary Board. This is evident through for instance:
  - The high-quality debate and challenge that takes place during meetings in public, in private sessions and in development sessions.
  - The trust and confidence in the governance arrangements established enabling delegated authority and oversight to be assigned to committees and the executive where appropriate.
  - The relationship and interface with the LLR Health and Wellbeing Partnership and the Chairs of the respective Health and Wellbeing Boards.
  - The recognition and importance of participants, including representatives from local Healthwatch organisations, and how they support and inform Board discussion and debate.
- Attendance at Board meetings is positive with all **Board members making substantive and well-informed contributions** to discussions and debate to enable the Board to make informed decisions.
- The Board will continue to evolve and develop through self-reflection and in response to external reviews and feedback from NHS England.

b) Level of maturity of the Board
c) Board makes substantive and well-informed contributions *continued…*

- **In March 2023**, the ICB Chair led a process whereby the Partner Members on the Board were invited to provide their reflections on how the ICB and the Board were progressing. Reflections were provided across four themes, a high-level summary provided below:
  - **Initial establishment and early days:**
    - Transition from CCGs to ICB was smooth.
    - Board membership and appointments were strong with high level of trust amongst members.
  - **Board meetings:**
    - Board discussions generally of high quality with good debate and challenge.
    - Length of agenda, timeliness and quality of papers needed improvement.
    - Potential for co-designing agendas with partner members and aligning agenda content to the aims of an ICB / ICS.
  - **Role of the ICB and work practices:**
    - Clarity required on how the ICB adds value, although ICB role becoming clearer allowing for opportunities for the LLR HWP to become more clearer.
    - There had been insufficient focus on strategic integration and on root cause of issues.
    - Lack of clarity on approach to transformation.
    - Showcase examples of joint working.
  - **Role of Health and Wellbeing Partnership:**
    - Greater clarity of ICB role will assist with understanding the role of the HWP.
    - Its roles is complementary to the Health and Wellbeing Boards.
    - Consider thematic approach to joint working e.g. consider children and young people.

b) Level of maturity of the Board
c) Board makes substantive and well-informed contributions *continued…*

- Following the discussion with Partner Members in March 2023, the Chair discussed the key themes with all Board Members, participants and the Chairs of the Health and Wellbeing Boards at an ICB Board development session in March 2023.
- **Changes have subsequently been made including:**
  - Development sessions have continued to strengthen trust and relationships amongst Board members and participants, with a standing invitation to the three Chairs of the Health and Wellbeing Boards.
  - The length of Board meeting agendas, timeliness and quality of papers has continued to be reviewed and some improvements have been made.
  - Board meeting agendas are being co-designed with partner members where possible.
  - The role of the ICB has become clearer and strategic objectives have been approved in addition to the 5 Year Plan and the strategic risks associated with the Plan.
  - The Board agenda now includes a section on case studies and patient stories to showcase examples of collaborative working, stories and experiences of our patients, improvements in services etc.
  - The role of the Health and Wellbeing Partnership is becoming clearer as its work programme has been reviewed and aligned to the Integrated Care Strategy, and a thematic approach to joint working, e.g. consider children and young people, has been agreed.

d) Effectiveness of the committee structure and delegated authority

- Robust governance arrangements were established from 1 July 2022 and continue to work effectively allowing the Board to fulfil its role and statutory duties.
- Throughout the year the corporate governance arrangements and committee structure have been reviewed, enabling them to evolve as the Board has matured.
- In June 2023, the Board reviewed the ICB Constitution, Board composition, ICB Schemes of Reservation and Delegation (SORD) and the rest of the components of the Governance Handbook. The changes included further delegations to the Strategic Commissioning Group (sub-group of the System Executive Committee) to enable appropriate oversight of the pharmacy, optometry and dental delegated functions from NHS England.
- Each of the Board committees provide an assurance report outlining the assurances in place to manage strategic risks, actions proposed in response to issues identified, and decisions taken in line with delegated authority.
- Each of the committees of the Board carried out an effectiveness review between June 2023 – August 2023, including a review of committee terms of reference, to ensure the committees continue to be effective and remain fit for purpose. The outcomes of the committee effectiveness reviews were incorporated within the respective committee assurance reports to the Board.
- Internal Auditors have also reviewed the ICB's governance and risk management arrangements and provided an opinion of significant assurance indicating that robust and effective governance arrangements are in place.

e) Alignment of Board arrangements with wider Integrated Care System partnership

- The role of the ICB and the ICB Board has become progressively clearer - primarily focused on NHS statutory functions and duties with greater opportunity for contribution from partner organisations.
- The establishment of the Learning Disability & Autism Collaborative and partnerships across key workstreams and pathways has enabled a collaborative approach in designing and transforming of service pathways. Progress and performance from the Collaborative / partnerships are reported through the new LLR Delivery Partnership Group. This then enables a single report to the Board providing assurance on performance and delivery against the ICB's Operational Plan and the LLR Five Year Plan.
- The relationship and interface with the LLR Health and Wellbeing Partnership (HWP) and the Chairs of the respective Health and Wellbeing Boards has enabled opportunities for more collaborative approach to addressing key priorities and issues across health and care. A key milestone was the approval of the LLR Integrated Care Strategy by the LLR HWP in September 2023.

Conclusion

- The ICB's self-assessment against the five key areas within the *ICB Board Composition* document and having taken on board feedback from Board members and wider partners it is clear that the ICB Board has evolved and matured in its approach.

- The interface between the ICB and the LLR HWP is evolving and being strengthened to enable partners both NHS and care to inform decision-making and inform ICB decision-making effectively.

- The Board will build on the progress it has made to date and continue to evolve and develop through self-reflection and collective development, improvements in data and insights, in response to internal / external reviews and feedback from NHS England.

P

Name of meeting:	**Leicester, Leicestershire and Rutland Integrated Care Board** (public)		
Date:	**12 October 2023**	**Paper:**	**P**
Report title:	**Specialised Services Pre-delegation Assessment Framework (PDAF)**		
Presented by:	Sarah Prema, Chief Strategy Officer		
Report author:	Jo Grizzell, Senior Planning Manager		
Executive Sponsor:	Sarah Prema, Chief Strategy Officer		

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

Recommendations:

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

- **RECEIVE** the report for assurance and note the list of specialised services to be delegated with effect from 1 April 2024 (appendix 1) subject to NHS England approval.

Purpose and summary of the report:

The ICB Board is asked to receive the report and be assured by the process undertaken to complete the East Midlands multi-ICB Specialised Services Pre-Delegation Assessment Framework (PDAF). The LLR ICB Executive Management Team approved the PDAF at its meeting on 18 September 2023. It was subsequently submitted to NHS England on 20 September 2023, in advance of the deadline of 25 September 2023, for onward moderation and approval.

Appendices:	• Appendix 1 – List of specialised services for delegation from April 2024.
Report history (date and committee / group the content has been discussed / reviewed prior to presenting to this meeting):	• Not applicable

The report is helping to deliver the following strategic objective(s) – *please tick all that apply*:		
1. 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.*	NHS England has produced an overarching risk register which identifies risks to safe delegation. The three highest operational risks are closely monitored via the Operating Model Group established to oversee the delegation process.
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 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 the context of 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 the context of 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 required at this stage.

Specialised Services Pre-Delegation Assessment Framework

12 October 2023

Introduction

1. In preparation for the delegation of specialised services from 1 April 2024, ICBs across the East Midlands were asked to complete a Pre-Delegation Assessment Framework (PDAF) detailing their level of readiness. For the five ICBs across the East Midlands the delegation involves 59 of the 177 specialised service lines as detailed in Appendix 1.

Process for completion of the PDAF

2. The five ICBs across the East Midlands and NHS England Midlands collectively co-authored the multi-ICBs' response to the PDAF. This involved the formation of working groups across six domains with members drawn from across the five ICBs:

    i. Health & Care Geography
    ii. Transformation
    iii. Governance
    iv. Finance
    v. Workforce
    vi. Data, Reporting & Analytical Infrastructure.

3. Responses across each of the domains were collated and reviewed by the Operating Model Group, consisting of senior leaders from the 11 Midlands ICBs and NHS England.

Submission of the PDAF

4. Each of the five ICBs across the Midlands were responsible for the approval and submission of the PDAF in line with respective internal governance arrangements.

5. For LLR ICB the Executive Management Team reviewed and approved the PDAF prior to submission on 20 September 2023. The deadline for submission to the NHS England national moderation panel was 25 September 2023.

6. The PDAF submission is expected to be moderated during October and November prior to final approval by the NHS England Board on 7 December 2023.

7. Subject to approval by the NHS England Board, the PDAF submission by the East Midlands ICBs will fall into one of the following three categories listed in the table below. The East Midlands ICBs have all confirmed readiness for full delegated commissioning responsibility from April 2024 (i.e. category 1) within the PDAF submission, subject to NHS England approval.

Category	Description
Category 1 (delegation)	The (multi-)ICB is ready for full delegated commissioning responsibility from April 2024.
Category 2 (delegation with conditions)	The (multi-)ICB is ready for delegated commissioning responsibility from April 24 subject to developmental conditions being attached.
Category 3 (intensive support required)	Where the (multi-)ICB is not yet ready for full delegated commissioning responsibility from April 24 and needs an additional year of development and support through more intensive conditions being attached to the arrangement.

8. The LLR ICB Board will be provided with the outcome of NHS England's decision in due course.

Recommendations:

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

- **RECEIVE** the report for assurance and note the list of specialised services to be delegated with effect from 1 April 2024 (appendix 1) subject to NHS England approval.

APPENDIX 1

SCHEDULE 3: JOINT SPECIALISED SERVICES

The following are the Specialised Services that NHS England has determined as being suitable and ready for greater ICB involvement:

PSS Manual Line	PSS Manual Line Description	Service Line Code	Service Line Description
2	Adult congenital heart disease services	13X	Adult congenital heart disease services (non-surgical)
		13Y	Adult congenital heart disease services (surgical)
3	Adult specialist pain management services	31Z	Adult specialist pain management services
4	Adult specialist respiratory services	29M	Interstitial lung disease
		29S	Severe asthma
5	Adult specialist rheumatology services	26Z	Adult specialist rheumatology services
7	Adult Specialist Cardiac Services	13A	Complex device therapy
		13B	Cardiac electrophysiology & ablation
		13C	Inherited cardiac conditions
		13E	Cardiac surgery (inpatient)
		13F	PPCI for ST- elevation myocardial infarction
		13H	Cardiac magnetic resonance imaging
		13T	Transcatheter Aortic Valve Replacement (TAVI)
		13Z	Cardiac surgery (outpatient)
9	Adult specialist endocrinology services	27E	Adrenal Cancer
		27Z	Adult specialist endocrinology services
11	Adult specialist neurosciences services	08E	Neurosurgery - Low Volume Procedures (National)
		08F	Neurosurgery - Low Volume Procedures (Regional)
		08G	Neurosurgery - Low Volume Procedures (Neuroscience Centres)
		08O	Neurology
		08P	Neurophysiology
		08R	Neuroradiology
		08S	Neurosurgery
		08T	Mechanical Thrombectomy
12	Adult specialist ophthalmology services	37C	Artificial Eye Service
		37Z	Adult specialist ophthalmology services
13	Adult specialist orthopaedic services	34A	Orthopaedic surgery
		34R	Orthopaedic revision
15	Adult specialist renal services	11B	Renal dialysis
		11C	Access for renal dialysis
16	Adult specialist services for people living with HIV	14A	Adult specialised services for people living with HIV
17	Adult specialist vascular services	30Z	Adult specialist vascular services
18	Adult thoracic surgery services	29B	Complex thoracic surgery
		29Z	Adult thoracic surgery services: outpatients
30	Bone conduction hearing implant services (adults and children)	32B	Bone anchored hearing aids service
		32D	Middle ear implantable hearing aids service
35	Cleft lip and palate services (adults and children)	15Z	Cleft lip and palate services
36	Cochlear implantation services (adults and children)	32A	Cochlear implantation services
40	Complex spinal surgery services (adults and children)	06Z	Complex spinal surgery services
54	Fetal medicine services (adults and adolescents)	04C	Fetal medicine services

PSS Manual Line	PSS Manual Line Description	Service Line Code	Service Line Description
58	Specialist adult gynaecological surgery and urinary surgery services for females	04A	Severe Endometriosis
		04D	Complex urinary incontinence and genital prolapse
58A	Specialist adult urological surgery services for men	41P	Penile implants
		41S	Surgical sperm removal
		41U	Urethral reconstruction
59	Specialist allergy services (adults and children)	17Z	Specialist allergy services
61	Specialist dermatology services (adults and children)	24Z	Specialist dermatology services
62	Specialist metabolic disorder services (adults and children)	36Z	Specialist metabolic disorder services
63	Specialist pain management services for children	23Y	Specialist pain management services for children
64	Specialist palliative care services for children and young adults	E23	Specialist palliative care services for children and young adults
65	Specialist services for adults with infectious diseases	18A	Specialist services for adults with infectious diseases
		18E	Specialist Bone and Joint Infection
72	Major trauma services (adults and children)	34T	Major trauma services
78	Neuropsychiatry services (adults and children)	08Y	Neuropsychiatry services
83	Paediatric cardiac services	23B	Paediatric cardiac services
94	Radiotherapy services (adults and children)	01R	Radiotherapy services (Adults)
		51R	Radiotherapy services (Children)
		01S	Stereotactic Radiosurgery / radiotherapy
105	Specialist cancer services (adults)	01C	Chemotherapy
		01J	Anal cancer
		01K	Malignant mesothelioma
		01M	Head and neck cancer
		01N	Kidney, bladder and prostate cancer
		01Q	Rare brain and CNS cancer
		01U	Oesophageal and gastric cancer
		01V	Biliary tract cancer
		01W	Liver cancer
		01Y	Cancer Outpatients
		01Z	Testicular cancer
		04F	Gynaecological cancer
		19V	Pancreatic cancer
		24Y	Skin cancer
106	Specialist cancer services for children and young adults	01T	Teenage and young adult cancer
		23A	Children's cancer
106A	Specialist colorectal surgery services (adults)	33A	Complex surgery for faecal incontinence
		33B	Complex inflammatory bowel disease
		33C	Transanal endoscopic microsurgery
		33D	Distal sacrectomy for advanced and recurrent rectal cancer
107	Specialist dentistry services for children	23P	Specialist dentistry services for children
108	Specialist ear, nose and throat services for children	23D	Specialist ear, nose and throat services for children
109	Specialist endocrinology services for children	23E	Specialist endocrinology and diabetes services for children
110	Specialist gastroenterology, hepatology and nutritional support services for children	23F	Specialist gastroenterology, hepatology and nutritional support services for children
112	Specialist gynaecology services for children	23X(b)	Specialist paediatric surgery services - Gynaecology
113	Specialist haematology services for children	23H	Specialist haematology services for children

PSS Manual Line	PSS Manual Line Description	Service Line Code	Service Line Description
115B	Specialist maternity care for adults diagnosed with abnormally invasive placenta	04G	Specialist maternity care for women diagnosed with abnormally invasive placenta
118	Neonatal critical care services	NIC	Specialist neonatal care services
119	Specialist neuroscience services for children	23M	Specialist neuroscience services for children
		07Y	Paediatric neurorehabilitation
		08J	Selective dorsal rhizotomy
120	Specialist ophthalmology services for children	23N	Specialist ophthalmology services for children
121	Specialist orthopaedic services for children	23Q	Specialist orthopaedic services for children
122	Paediatric critical care services	PIC	Specialist paediatric intensive care services
125	Specialist plastic surgery services for children	23R	Specialist plastic surgery services for children
126	Specialist rehabilitation services for patients with highly complex needs (adults and children)	07Z	Specialist rehabilitation services for patients with highly complex needs
127	Specialist renal services for children	23S	Specialist renal services for children
128	Specialist respiratory services for children	23T	Specialist respiratory services for children
129	Specialist rheumatology services for children	23W	Specialist rheumatology services for children
130	Specialist services for children with infectious diseases	18C	Specialist services for children with infectious diseases
131	Specialist services for complex liver, biliary and pancreatic diseases in adults	19L	Specialist services for complex liver diseases in adults
		19P	Specialist services for complex pancreatic diseases in adults
		19Z	Specialist services for complex liver, biliary and pancreatic diseases in adults
132	Specialist services for haemophilia and other related bleeding disorders (adults and children)	03X	Specialist services for haemophilia and other related bleeding disorders (Adults)
		03Y	Specialist services for haemophilia and other related bleeding disorders (Children)
134	Specialist services to support patients with complex physical disabilities (excluding wheelchair services) (adults and children)	05P	Prosthetics
135	Specialist paediatric surgery services	23X(a)	Specialist paediatric surgery services - General Surgery
136	Specialist paediatric urology services	23Z	Specialist paediatric urology services
139A	Specialist morbid obesity services for children	35Z	Specialist morbid obesity services for children
139AA	Termination services for patients with medical complexity and or significant co-morbidities requiring treatment in a specialist hospital	04P	Complex termination of pregnancy
ACC	Adult Critical Care	ACC	Adult critical care