Meeting Title	**Leicester, Leicestershire and Rutland (LLR) Integrated Care Board meeting** (meeting held in public)	**Date**	**Thursday, 14 December 2023**
Meeting no.	**12**	**Time**	**Meeting in public: 9:00am – 11:05am** **Confidential meeting: 11:10am – 11:30am**
Chair	**David Sissling** **Chair, ICB**	**Venue / Location**	MSTeams

REF	AGENDA ITEM	ACTION	PRESENTER	PAPER	TIMING
ICB/23/132	Welcome and Introductions	To receive	David Sissling (Chair)	**Verbal**	9:00am
ICB/23/133	Apologies for Absence: • Dr Nil Sanganee *(Dr Sulaxni Nainani deputising)*	To receive	David Sissling (Chair)	**Verbal**	9:00am
ICB/23/134	Notification of Any Other Business	To receive	David Sissling (Chair)	**Verbal**	9:00am
ICB/23/135	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 (Chair)	**Verbal**	9:00am
ICB/23/136	To consider **written questions received in advance** from the Public in relation to items on the agenda	To receive	David Sissling (Chair)	**Verbal**	9:05am
ICB/23/137	Minutes of the meeting held on 12 October 2023	To approve	David Sissling (Chair)	**A**	9:15am
ICB/23/138	Matters arising and actions for the meeting held on 12 October 2023	To receive	David Sissling (Chair)	**B**	
ICB/23/139	Update from the Chair	To receive	David Sissling (Chair)	**Verbal**	9:20am
ICB/23/140	Update from ICB, Acute Sector and Mental Health and Community Sector	To receive	Caroline Trevithick (ICB CEO) / Angela Hillery (LPT CEO) / Richard Mitchell (UHL CEO)	**Verbal**	9:25am
SHARING CASE STUDIES AND PATIENT STORIES					
ICB/23/141	Maternity and neo-natal voices partnership	To receive	Mel Thwaites and Sue Venables	**C** **presentation**	9:35am
STRATEGY AND SYSTEM PLANNING					
ICB/23/142	Operational Planning 2024/25 update	To receive	Sarah Prema (ICB Chief Strategy Officer)	**D**	9:50am
OPERATIONAL					
ICB/23/143	LLR ICB Workforce Race Equality Standard (WRES) and LLR ICB Workforce Disability Standard (WDES) (2022-2023)	To approve	Alice McGee (ICB Chief People Officer)	**E**	10:05am

REF	AGENDA ITEM	ACTION	PRESENTER	PAPER	TIMING
ICB/23/144	LLR Delivery Partnership – Delivery of the LLR one- and five-year plans	To receive	Rachna Vyas (ICB Chief Operating Officer)	**F**	10:15am
ICB/23/145	LLR ICB Finance Report	To receive	Robert Toole (ICB Chief Finance Officer)	**G**	10:30am
ASSURANCE					
ICB/23/146	Assurance report from the Finance Committee	To receive	Jeff Worrall (ICB Finance Committee Chair)	**H**	10:40am
ICB/23/147	Assurance report from the System Executive Committee	To receive	Caroline Trevithick (ICB CEO)	**I**	
ICB/23/148	Assurance report from the Quality and Safety Committee	To receive	Pauline Tagg (ICB Non-Executive Member)	**J**	
ICB/23/149	Assurance report from the Audit Committee	To receive	Darren Hickman (ICB Non-Executive Member)	**K**	
ICB/23/150	Assurance report from the Health Equity Committee	To receive	Prof Azhar Farooqi (ICB Non-Executive Member)	**L**	
ICB/23/151	UHL and LPT performance assurance briefing / report	To receive	For information	**M1 M2**	
ICB/23/152	Summary of the East Midlands Joint Committee held in October 2023	To receive	David Sissling (ICB Chair)	**N**	
GOVERNANCE					
ICB/23/153	ICB Board Assurance Framework 2023/24 review	To approve	Robert Toole (ICB Chief Finance Officer)	**O**	10:55am
ANY OTHER BUSINESS					
ICB/23/154	Items of any other business and review of meeting	To receive	David Sissling	**Verbal**	11:05am

The next regular meeting of the LLR Integrated Care Board meeting will take place on **Thursday 8 February 2024**, 9:00am to 11:30am, meeting to be held in public via MSTeams.

Where applicable *- motion for private session - the Chairman to move, that members of the public be excluded from the remainder of the meeting, owing to the confidential nature of the business to be transacted, which is related to the commercial affairs of the ICB.*

A

Minutes of the NHS LLR Integrated Care Board ("the ICB" or "the Board")
Held in Public, Thursday 12 October 2023
9:00am – 10:45am, via MSTeams

Members present:

Mr David Sissling	NHS LLR ICB Independent Chair and Chair of the meeting
Mr Andy Williams	Chief Executive, NHS LLR ICB
Dr Caroline Trevithick	Chief Nursing Officer, NHS LLR ICB
Dr Nil Sanganee	Chief Medical Officer, NHS LLR ICB
Mr Spencer Gay	Deputy Director of Finance (System), NHS LLR ICB *(Deputising for Ms Caroline Gregory)*
Ms Sarah Prema	Chief Strategy Officer, NHS LLR ICB
Ms Alice McGee	Chief People Officer, NHS LLR ICB
Ms Yasmin Sidyot	Deputy Chief Operating Officer – Integration and Transformation, NHS LLR ICB *(Deputising for Ms Rachna Vyas)*
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 Simon Bartin	Deputy Chief Executive, University Hospitals of Leicester NHS Trust *(Deputising for Mr Richard Mitchell)*
Ms Jean Knight	Deputy Chief Executive, Leicestershire Partnership NHS Trust *(Deputising for Ms Angela Hillery)*
Mr Mark Andrews	Partner Member – local authority sectoral representative (Chief Executive, Rutland County Council)

Participants:

Dr Janet Underwood	Chair, Healthwatch Rutland
Ms Harsha Kotecha	Chair, Healthwatch Leicester and Leicestershire
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 David Williams	Group Director of Strategy and Partnerships Leicestershire Partnership NHS Trust and Northamptonshire Healthcare NHS Foundation Trust
Mr Justin Hammond	Associate Director of Mental Health and Learning Disability, NHS LLR ICB *(for item ICB/23/117)*
Ms Julie Gibson	Learning Disability Services Manager, NHS LLR ICB *(for item ICB/23/117)*
Ms Joanna Clinton	Head of Strategy and Planning, NHS LLR ICB *(for item ICB/23/118)*
Ms Carrie Harris	Planning Manager, NHS LLR ICB *(for item ICB/23/118)*
Mr Mayur Patel	Head of Integration & Transformation, NHS LLR ICB *(for item ICB/23/118)*
Ms Julie Hogg	Chief Nurse, University Hospitals of Leicester NHS Trust *(for item ICB/23/121)*
Mrs Daljit Bains	Head of Corporate Governance, NHS LLR ICB
Ms Charlotte Gormley	Corporate Governance Officer, NHS LLR ICB (minute taker)

Eight members of the public attended to observe the meeting.

ITEM		LEAD RESPONSIBLE
ICB/23/108	**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/23/109	**Apologies for absence from Members and Participants:** • Ms Rachna Vyas, Chief Operating Officer, LLR ICB • Ms Caroline Gregory, Interim Chief Finance Officer, LLR ICB • Sir Mayur Lakhani, Clinical Executive Lead, NHS LLR ICB • Prof Azhar Farooqi, Non-Executive Member – Inequalities, Public Engagement, Third Sector and Carers, NHS LLR ICB • Mike Sandys, Partner Member – local authority sectoral representative (Director of Public Health, Leicestershire County Council) • Martin Samuels, Partner Member - local authority sectoral representative (Strategic Director, Partner Social Care and Education, Leicester City Council) • Ms Angela Hillery, Partner Member - community/mental health sector representative (Chief Executive, Leicestershire Partnership NHS Trust) • Mr Richard Mitchell, Partner Member - acute sector representative (Chief Executive, University Hospitals of Leicester NHS Trust) • Mr Richard Henderson, Chief Executive, East Midlands Ambulance Service • Dr Nainesh Chotai, Primary Care Sector representative	
ICB/23/110	**Notification of Any Other Business** No additional items of business had been notified.	
ICB/23/111	**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/23/112	**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 Giuliana Foster</u> *1. Can the Integrated Care Board tell me what procedures have been put in place to address the recommendations made by the East Midlands Clinical Senate and to obtain a positive outcome at the forthcoming Public Consultation regarding Fielding Palmer Hospital?* Mr Andy Williams advised that the ICB's response to the Senate recommendations were detailed in the Pre-Consultation Business Case (PCBC) in table 6.19 entitled 'Clinical Senate recommendations' The ICB responses are included in the same document at pages 199-122. The PCBC could be found at the following link: https://leicesterleicestershireandrutland.icb.nhs.uk/about/board-meetings/ *2. With reference to the statement/assessment from the Clinical Senate what assurances can the Integrated Care Board give me that the change in delivery of service from Feilding Palmer Cottage Hospital will be sustainable? And for what period of time does the ICB envisage its use for this purpose?* In response to the first question, Mr Williams confirmed the ICB's commitment to ensuring that the changes in services at the hospital would be sustainable. The intention was to bring care closer to home, thereby reducing travel times for the local population. He advised that, The ICB had considered the Clinical Senate's feedback, and remained confident that activity, as described within	

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	the PCBC would be carried out from Feilding Palmer Hospital, focussing initially on the top five specialities for repatriation. Furthermore, Mr Williams confirmed that changes made to the use of Feilding Palmer Hospital would be long-term. The current estimated date for occupation post-redevelopment was January 2026. Any proposed changes following this would be subject to further consultation and engagement. <u>Questions from Sally Ruane</u> *1. With regard to the UHL reconfiguration scheme, does the ICB share the misgivings of the National Audit Office and Public Accounts Committee regarding Hospital 2.0 and the Minimum Viable Product?* *2. Will any public consultation on a revised UHL reconfiguration plan will be led by UHL or by the ICB?* *3. Will the presence of more RAAC hospitals in the New Hospital Programme delay the UHL reconfiguration scheme even more as RAAC hospitals are prioritised?* *4. When will the ICB be communicating with the public, who are currently in the dark, as to developments in the UHL reconfiguration scheme?* Mr Williams advised that as the questions received were not directly pertinent to the agenda, a written response would be provided in line with the ICB's process for responding to general enquiries. <u>Questions from Jennifer Fenelon</u> *1. Will the ICB please tell us what the revised provision at UHL (i.e., with a 66% reduction) would look like as a consequence of modelling using the new formula and taking account of Mr Mitchell's announcement that UHL intended to return to three acute hospitals in Leicester?* *2. Would he also describe the range of services likely to transfer to the community as required by the new formula to compensate for the acute reductions as well as how and where that will be achieved.* Mr Williams advised again that as the questions received were not directly pertinent to the agenda, a written response would be provided in line with the ICB's process for responding to general enquiries. Mr Williams did however note that the questions made an assumption about bed activity and suggested that there may have been inaccurate extrapolations of future activity, this would be clarified in the written response. It was confirmed that responses to questions regarding the UHL reconfiguration would be shared via the Board minutes.	
ICB/23/113	**Minutes of the meeting held on 10 August 2023 and minutes of the Annual General Meeting held on 14 September 2023 (Papers A1 and A2)** The minutes of the ICB Board meeting held on 10 August 2023 were confirmed as an accurate record. The minutes of the Annual General Meeting held on 14 September 2023 were confirmed as an accurate record, with a request that the list of attendees be amended to include Dr Janet Underwood. **It was RESOLVED to:**	

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	• **APPROVE** the minutes of the ICB Board meeting held on 10 August 2023 and Annual General Meeting held on 14 September 2023.	
ICB/23/114	**Matters Arising and actions for the meeting held on 10 August 2023 (Paper B)** Progress made against actions was noted and the request to close specific actions was supported. **It was RESOLVED to:** • **RECEIVE** the update and progress made in relation to the actions.	
ICB/23/115	**Update from ICB Chair** Mr Sissling advised that the recruitment process for the Chief Executive role was underway and interviews were scheduled to take place on 25 October 2023. The interview panel consists of ICB board members and wider stakeholders. Mr Sissling confirmed that the Board would receive further updates in due course. Mr Sissling advised that he had his opened the Workforce Think Tank event held in October 2023, which was attended by colleagues from across Health, Local Government, regional bodies, the third sector and education providers. The event had provided an excellent opportunity to consider the future workforce models and related development opportunities. In addition, Mr Sissling had attended an event held by Patient Care Locally (PCL), focussing on the role of primary care and the delivery of services in partnership with other organisations. Mr Sissling expressed thanks to all involved in organising and delivering the two events. **It was RESOLVED to:** • **RECEIVE** the update.	
ICB/23/116	**Update from ICB, Acute Sector and Mental Health and Community Sector** Mr Williams confirmed the appointment of Mr Robert Toole, ICB Interim Chief Finance Officer, who brings a wealth of experience to the role and would be commencing in post during October 2023. In providing an update on performance, Mr Williams highlighted to the board the positive improvements in performance relating to elective recovery, primary care access, and urgent and emergency care. Mr Williams also referenced challenges relating to finance which is a current area of focus for the Executive Teams in UHL, LPT and the ICB. Mr Simon Barton advised that UHL's updated Trust Strategy and values are being presented to the UHL Trust Board for approval. The strategy and values have been developed following a process of engagement with partners and will support the wider system in the delivery of the LLR Five Year Plan. Mr Barton reflected on the positive achievement and progress made across the system and within UHL regarding waiting list recovery, noting the positive move from Tier 1 to Tier 2 oversight arrangements with NHSE. It was noted that,	

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	during Summer 2023, nationally performance had increased by 12% whilst UHL had decreased by 5%. Mr Barton drew attention to the recent CQC report regarding UHL maternity services and emphasised UHL's commitment to improve maternity care, noting that progress and improvement had already been made. He confirmed that an open letter had been sent to members of the public to provide reassurance. It was noted that this matter would be considered in detail later on the Board agenda. Mr Barton advised that UHL had successfully delivered safe services during periods of industrial action. There had however been an adverse impact on elective services during this period. Ms Jean Knight described a series of events led by LPT and the voluntary sector which were in recognition of World mental health Day. Many focussed on engaging with members of the public about their wellbeing. Furthermore, LPT had re-introduced the 'Move it Boom' initiative across primary schools, a physical activity competition for primary school children across LLR. Ms Knight was pleased to confirm that LPT had received a number of national awards. Finally, Ms Knight described a series of events which had been held to encourage staff to speak out and be heard. Mr Sissling thanked members for their updates. **It was RESOLVED to:** • **RECEIVE** the updates.	
ICB/23/117	**Learning Disability (LD) health checks (Paper C)** Mr David Williams introduced the presentation, highlighting that individuals with a learning disability living within LLR had a shorter life expectancy by 20 years compared to those without. As such, the system was taking action to tackle inequalities through prevention work and in particular through regular health checks. He noted that LLR was performing well with health checks and urged the Board to champion the ongoing work. Mr Justin Hammond emphasised the importance of annual health checks for individuals with learning disabilities, noting evidence from the Learning from Death Review (LeDeR) that receipt of health checks increased life expectancy. He noted that individuals with learning disabilities were more likely to experience avoidable conditions, including chronic health conditions, and to require emergency care. In response, an initiative had been launched by LPT with a focus on reaching individuals who had not accessed a health check in two or more years. This included patients with complex needs who required supported access. The health checks were undertaken by trained LD Nurses and care co-ordinators. It was noted that 223 referrals from across LLR were received to the programme during the first year.	

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	Overall, the pilot evidenced that access to health checks extended lives. As such, the programme was proactively reaching out to individuals to support access and to provide an equitable service across LLR. There was also a potential for learning to be applied to other services such as dementia care and to the provision of vaccinations, with a focus on the most vulnerable populations across LLR. Ms Julie Gibson confirmed that data regarding learning disability and autism was being explored at place and neighbourhood level. This data would be mapped out against areas of deprivation enabling very targeted interventions and action. Concern was expressed regarding the uptake of health checks in Rutland. Members were assured that health checks were generally carried out in the third and fourth quarters of the year, and this was reflected in the current data for 2023/24. Members were assured that health checks in Rutland would be carried out by the end of the financial year. Ms Gibson clarified the process for referring patients onward for treatment following the health check. It was noted that a template had been developed for General Practitioners (GPs) to refer patients to other services on the same day as their health check. Patients would receive a printed copy of their health action plan and be advised to expect additional invitations such as breast and bowel cancer screening services. In response to a query about demonstrating the wider impact of undertaking health checks, it was noted that increased health checks reduced admissions to Urgent and Emergency Care services. A dynamic pathway was in place to support patients in their own homes and in the community to prevent hospital admissions. It was anticipated that the decrease in admissions would be reflected in future data from LeDeR. Due to the success of the pilot, it was intended for the programme to be embedded in business as usual, with funding to be sourced across the system. The programme had enabled a novel approach to delivering improved and equitable care. Members welcomed the presentation and looked forward to receiving an update on progress in a year's time. **It was RESOLVED to:** • **RECEIVE** the presentation.	
ICB/23/118	**Feilding Palmer Pre-Consultation Business Case (PCBC) (Paper D)** Ms Prema introduced the report, setting out the ICB's plans to make changes to Feilding Palmer Hospital in Lutterworth to maximise access to health services for the local community. Ms Prema advised that the current site was not fit for purpose for inpatient activity. She drew attention to issues with infection prevention and control, privacy, and dignity that had resulted in bed closures during the COVID-19 pandemic. To date it had not been possible for these beds to be reopened. As such, a new model of care had been developed with a stronger community focus. The plans also took account of population growth associated with	

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	housing development in the area. The proposal would reduce the need for travel into Leicester's hospitals. Overall, it was considered as the best value for money from a range of options. The PCBC outlined the intention to deliver relevant care locally, with a focus on outpatient and day case appointments, diagnostics, and community clinics. This would necessitate the permanent closure of the current inpatient beds. Alternative inpatient options would continue to exist through alternative routes such as the Home First Pathway and care homes. The recommendations were supported by GPs, the East Midlands Clinical Senate, NHS England, UHL, LPT and the Health Overview Scrutiny Committee as reported within the PCBC. Ms Prema confirmed that in undertaking an options appraisal, deliverability and value for money aspects were considered. She confirmed that £5.8m capital would need to identify from system capital budgets in line with the strategic system capital plan. Revenue cost implications of the PCBC were detailed within the Finance Plan contained within the PCBC. Approval of the PCBC by the ICB Board would trigger the commencement of a formal 12-week consultation period. This would provide an opportunity for the ICB to consult with the local population and secure the views of local people. Following the end of the formal consultation period an independent report will be compiled for consideration by the Board. If the business case is approved, delivery of services would commence from 2026. Mr Gay drew the Board's attention to the source of funding for this business case. He highlighted the limited capital funding available and the associated requirement for rigorous prioritisation processes. He noted that relevant work was underway and an overview would be made available to the Board for consideration prior to finalisation of the Lutterworth Post-Consultation Business Case. Mr Barton advised that whilst UHL supported the proposal as set out in the PCBC, further discussions would need to take place with the UHL Trust Board. The Board received assurance that the PCBC focused on the repatriation of services from Leicester hospitals but also acknowledged anticipated population growth. Members confirmed approval subject to the following: 1. The Board would receive a recommendation for the prioritisation of capital expenditure. 2. Issues of affordability would be clarified when the Post-Consultation Business Case is received. 3. An update from UHL regarding the implications of repatriating services. 4. An overview of the strategic principles which would guide the future development of community hospitals going forward. **It was RESOLVED to:** • **APPROVE** the PCBC for Feilding Palmer Community Hospital, Lutterworth subject to the actions agreed above. • **APPROVE** the proposal to commence public consultation in line with the Consultation Document and the Communications and Engagement Plan	

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	available at the following link: https://leicesterleicestershireandrutland.icb.nhs.uk/about/board-meetings/	
ICB/23/119	**Primary Care Access Recovery Plan - LLR System-level Access Improvement Plan (Paper E)** Dr Nil Sanganee introduced the report, providing an overview of NHS England's Primary Care Recovery Plan (PCARP) and LLR ICB's "System-level Access Improvement Plan" (SLAIP). The LLR plan focused on providing clinically urgent patient access within 24 hours and empowering patients through digital initiatives. Dr Sanganee extended thanks to partners for the development of a smoother interface between services. It was noted that the 26 Primary Care Networks (PCNs) throughout LLR had produced capacity and access improvement plans. National metrics did not include a target for face-to-face appointments however this had been included as a local target in response to patient feedback. It was acknowledged that despite a significant increase in the number of appointments provided, patients continued to report difficulty accessing Practices via phone. In response, it was noted that a digital offer was being developed, including cloud-based telephony, as well as access to prescriptions and appointments via the NHS app. A Transferring Care Safely (TCS) document had been produced and shared with providers. This enabled issues regarding movement of patents between sectors and organisations to be resolved. The role of care navigators and social prescribers in supporting patients to access services was also emphasised. Furthermore, it was noted that work undertaken by LLR to address health inequalities and variation in access had received national recognition. It was acknowledged that, although cloud-based telephony and online consultation would improve access, Practices would remain significant strain. Sustainable solutions would depend on enhanced recruitment and retention and further initiatives to contain the demand on primary care Members approved the proposed approach but sought clarity about the timeframes for improvement. **The Board requested a plan of action with measurable indicators and outcomes to be presented at a future meeting.** **It was RESOLVED 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.	**Dr Nil Sanganee**
ICB/23/120	**LLR Delivery Partnership – Delivery of the LLR one- and five-year plans (Paper F)** Ms Yasmin Sidyot drew attention to the actions enabling the achievement of pledges outlined within the 5 Year Plan. She drew particular attention to improvements in elective care, Learning Disability, Mental Health and Autism services.	

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	Members welcomed the report, which continued to evolve and provide an integrated picture of delivery across the system. **It was RESOLVED 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.	
ICB/23/121	**National Thematic Review - Maternity CQC Inspection (including S29a Warning Notice) Update (Papers G(a) and G(b))** Dr Caroline Trevithick introduced the report, noting that the Care Quality Commission (CQC) had rated maternity services at UHL as 'Requires Improvement' overall. Services at the Leicester General and Leicester Royal Infirmary had been rated 'Inadequate' for safe, and 'Requires Improvement' for well-led. St Mary's remained rated as 'Good' overall. Governance arrangements for oversight of the UHL Maternity response to the CQC had been agreed with NHS England. An initial Rapid Review meeting would take place in November 2023 to monitor implementation of the plan with representation from clinical leaders across the system and ICB non-executives. Ms Julie Hogg emphasised that UHL fully accepted the CQC findings and were committed to providing safe services across LLR. Numerous improvements had already been secured with successful recruitment of additional staff being particularly significant. Members were assured that an appropriate improvement programme was in place which would be overseen by the UHL Maternity Assurance Committee. Members requested an update on progress at the February 2024 meeting of the Board. **It was RESOLVED to:** • **RECEIVE** the governance for oversight of the UHL Maternity CQC response. • **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. • **APPROVE** the 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.	
ICB/23/122	**LLR ICB Finance Report (Paper H)** Mr Spencer Gay reminded the Board of key contextual matters and the risks identified at the outset of the financial year. He advised that the LLR system was reporting a year-to-date deficit at month 5 of £51.6m which represented a £31.8m adverse variance to plan. UHL were reporting a £36m deficit and the ICB a £14.8m deficit. LPT were reporting a small year-to-date deficit of £0.8m. The adverse variance was due predominately to unanticipated inflationary pressures, industrial action, prescribing growth, and increased demand. There was a clear risk that the system may not deliver its full year plan however risks were being actively managed to minimise variation. Key areas of focus were outlined as [i] significant acceleration and delivery of efficiency plans to achieve	

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	savings of £125m; [ii] ensuring value for money and increased productivity in prescribing, workforce, and Continuing Healthcare; [iii] strengthening the internal financial controls. It was noted that the system was performing well in terms of capital expenditure, the Better Payment Policy, the Mental Health Investment Standard (MHIS), and operating within the reduced running cost allocation. **It was RESOLVED to:** • **RECEIVE and NOTE** the financial position as at month 5 and the forecast performance. • **RECEIVE** for assurance.	
ICB/23/123	**Assurance report from the Finance Committee and terms of reference (Paper I)** Ms Simone Jordan noted that the report provided assurance regarding matters discussed on 30 August 2023 and 27 September 2023. All rated items had received a rating of red and had been remitted to Executives for necessary responsive action. Members approved the minor amendments to the Committee terms of reference. **It was RESOLVED to:** • **RECEIVE** the report for assurance. • **APPROVE** the amendments to the Committee terms of reference (Appendix 1).	
ICB/23/124	**Assurance report from the System Executive Committee (Paper J)** The report was taken as read. Mr Williams highlighted the approval of proposed S256 agreements to retain the Harmless CIC community self-harm intervention service across LLR. The service had been due to expire on 31 August 2023 with no alternative arrangements in place. **It was RESOLVED to:** • **RECEIVE** the report for assurance.	
ICB/23/125	**Assurance report from the Quality and Safety Committee (Paper K)** Ms Pauline Tagg advised that neurodevelopmental assessment and treatment waiting times, services for Special Educational Needs and Disability (SEND), and certain delegated healthcare tasks managed by Local Authorities had received an assurance rating of red. It was however anticipated that the rating would improve once the Committee was in receipt of plans to address the concerns. **It was RESOLVED to:** • **RECEIVE** the report for assurance.	
ICB/23/126	**Assurance report from the Audit Committee (Paper L)** The paper was taken as read and received for assurance. **It was RESOLVED to:** • **RECEIVE** the report for assurance.	
ICB/23/127	**Assurance report from the Health Equity Committee (Paper M)** The paper was taken as read and received for assurance. Mr Sissling noted that health inequalities and health inequity had formed the basis of discussions at the recent Board development session. The Health Equity Committee's findings and assurance ratings were in line with this discussion. **It was RESOLVED to:**	

ITEM		LEAD RESPONSIBLE
	• **RECEIVE** the report for assurance.	
ICB/23/128	**Summary of the East Midlands Joint Committee held in August 2023 (Paper N)** The paper was taken as read and noted. **It was RESOLVED to:** • **RECEIVE** the report for assurance.	
ICB/23/129	**Partnership and governance self-assessment and review (Paper O)** Mr Sissling introduced the report, which outlined the requirement for the ICB to undertake a self-assessment of its decision-making arrangements after its first year. This self-assessment included a review of how partners could inform the ICB's decision-making. Members were invited to submit any further comments to Ms Prema prior to sign-off and submission to NHS England. **It was RESOLVED to:** • **RECEIVE** the report for assurance.	
ICB/23/130	**Specialised Services Pre-delegation Assessment Framework (PDAF) (Paper P)** The paper was taken as read and received for information. **It was RESOLVED 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.	
ICB/23/131	**Items of any other business and review of the meeting** Mr Sissling advised that it was Mr Williams' last meeting as LLR ICB Chief Executive. On behalf of the Board, Mr Sissling expressed gratitude for all Mr Williams had accomplished and wished him every success for the future. The meeting closed at 10:55am.	
Date and Time of next meeting: The next meeting of the NHS LLR Integrated Care Board would take place on **Thursday 14 December 2023,** 9:00am to 11:30am via MSTeams.		

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

Action Log

Key		
Completed	On-Track	No progress made

Minute No.	Meeting Date	Item	Responsible Officer	Action Required	To be completed by	Progress as at December 2023	Status
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**
ICB/23/119	12 October 2023	Primary Care Access Recovery Plan - LLR System-level Access Improvement Plan	Dr Nil Sanganee	The Board requested a plan of actions with measurable indicators and outcomes.	January 204 / February 2024	Work in progress.	**Amber**

C

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Maternity Voices
Working in partnership to improve maternity & neonatal services

Leicester, Leicestershire & Rutland Maternity & Neonatal Voices Partnership (MNVP)

14th December 2023

LLR MNVP – Listening to parents' experiences of Maternity Care

- A Maternity & Neonatal Voices Partnership is a team of women/families, commissioners, healthcare professionals & community organisations working together to review and contribute to the development of local maternity care.
- MNVPs are England wide, enabling every woman on the maternity pathway to have the chance to have her voice heard about the service she is receiving.
- The feedback we receive is relayed back to the Integrated Care Board, the Integrated Care System, University Hospitals of Leicester and other healthcare professionals so we can ensure the services are equitable and the needs of every woman are met whatever their culture, faith or ethnicity.

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Our Aims

- To listen to the voices of women, parents and families using maternity services
- To work in partnership with healthcare professionals to improve the quality of our local maternity services and implement person-centred care
- To focus on closing inequality gaps
- To relay the feedback we receive to the relevant boards so improvements can be made

How was the MNVP set up:

- Co-Chairs Fatimah Panchbhaya & Nafeesah Tutla were appointed in April this year
- MNVP relaunched 31/05/23
- Support provided by Leads Sally Etheridge and Anisa Rashid, Mammas Directors
- Vice Chair Anita Gondal was appointed in July to cover maternity leave for Nafeesah and Fatimah

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What have we done so far;

- Set up communications and engagement plans to promote benefits of MNVP.
- Social media strategy developed - 315 Followers across social media channels.
- Survey to gather feedback from service users – 381 responses
- Survey analysis – Themes identified where improvement needed
- 6 Information sessions held attracting 21 women, birthing partners and stakeholders.
- 11 Listening sessions held attracting 69 women sharing insights, specifically from underrepresented groups.
- 63 active service user/service user representative members and 12 UHL professionals
- 2 MNVP Members meetings have taken place – 20th Sept and 8th Nov; 32 members attended the last meeting, including 21 service user members
- 225 people with interest registered on MNVP database
- Community engagement activities undertaken
- Co-production work with UHL across a range of areas including Quality Improvement, Induction of Labour, Neonatal and the maternity website.
- Hospital Insight visits

Survey

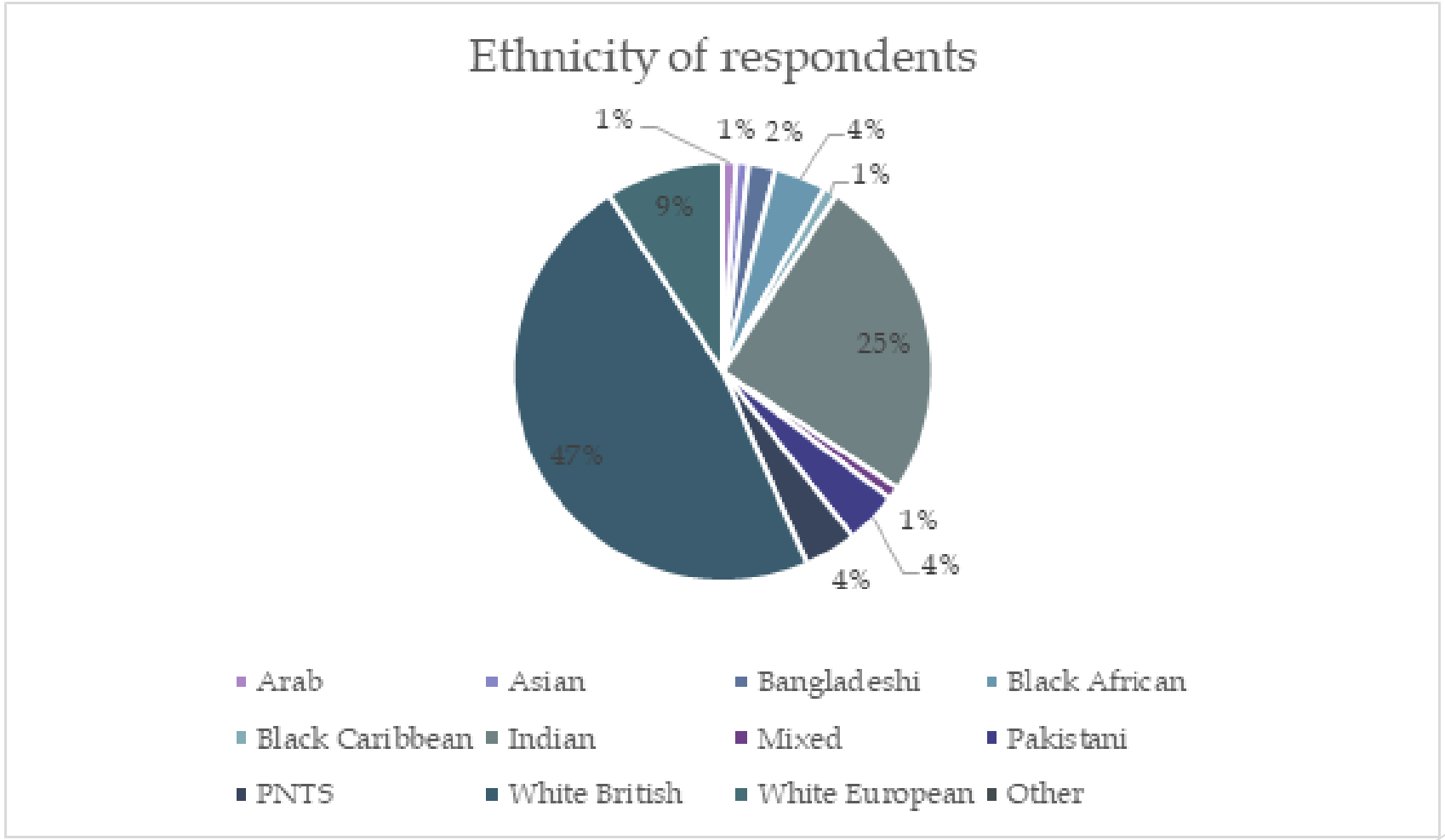
A survey was created using Microsoft Forms, questions were asked on four sections:

- **Pregnancy**
- **Labour and Birth**
- **Postnatal Care (After Birth)**
- **Digital Services**

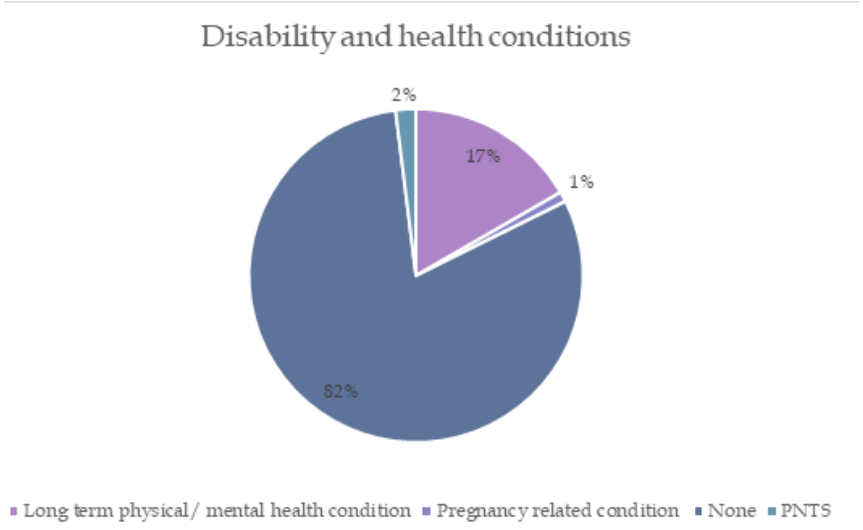
Aims of survey –

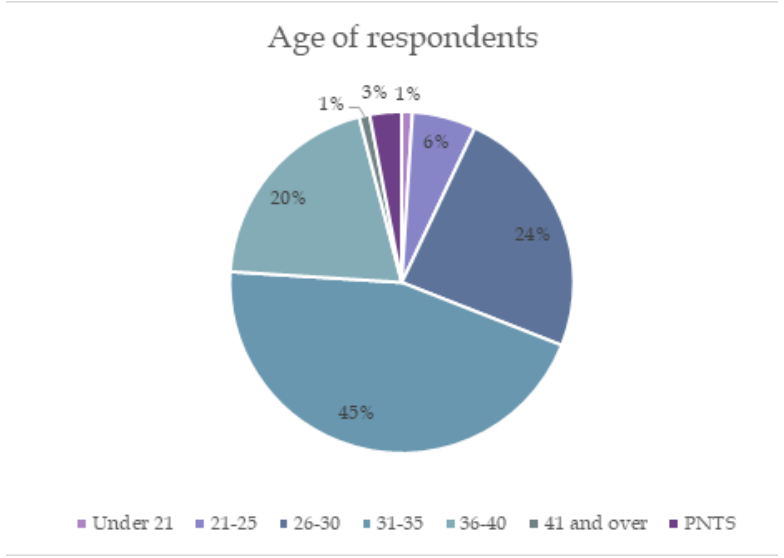
- Insight into parents' experiences of Local Maternity Services.
- Capture experiences that reflected the demographics of the area.
- Reach priority groups and groups that are less likely to be heard.
- Ensure good representation geographically.
- Enable service users to have a platform to share their experience of maternity care.
- To inform the direction of the MNVP.

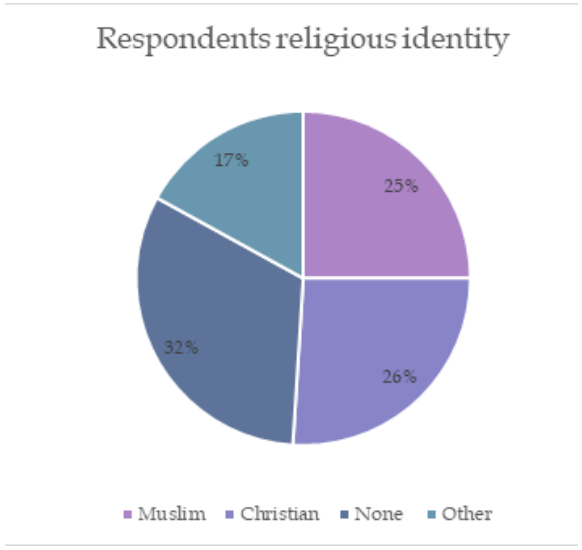
Survey outcomes – 381 respondents



Survey results







The Survey Results

Key themes that emerged:

1. Lack of informed consent - feeling pushed into procedures such as Inductions/ C-Sections etc. without sufficient explanation or options given and discussed with the patient
2. Poor care from Midwives – patient left alone, not listened to, being ignored
3. Lack of breastfeeding support
4. Lack of postnatal care on the ward
5. Overstretched service leading to poor care
6. Partner not allowed to stay overnight resulting in no overnight support
7. Home birth team provides excellent care
8. Compassionate care from midwives despite pressures

Actions taken following the survey

- Presented key themes to Quality Improvement team, leading to a number of actions:
  - The establishment of the IoL working group, to feedback Service user voices into the Induction Pathway.
  - Contributed to a growing weight of evidence on the detriment of partners being unable to stay overnight. Work is now underway to change this policy, with signs partners will be able to stay from early 2024.
  - In addition, work is underway to establish links with the perinatal mental health team with a view to support members and service users struggling with birth trauma, and to look at access to this support more widely.
- More broadly, we continue to make links with key organisations/VCSEs to ensure seldom heard groups are represented – Homestart Horizons Dad's group, AdaptPremBabies etc.

Next Steps

- Develop a range of surveys to understand experiences, specifically looking at key areas including father experiences and mental health
- Enhancing current database of interested parties to 500 by 31 March 2023.
- Creation of working groups - Antenatal, Bereavement, Pelvic health and Breastfeeding working groups.
- Continuation of community engagement to build membership and promote the MNVP.
- Planning and execution of 15 Steps in January 2024.

Our key message

The MNVP has had the opportunity to hear the stories of many women over the past few months, including from those who are least likely to be heard.

It has made us all the more aware that the MNVP needs to be the voice of mothers and parents, and our work must be guided by them, no matter how difficult it can feel.

Their priorities must be our priorities.

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Thank you!

Please follow us on social media

@llr_mnvp

Leicester, Leicestershire & Rutland MNVP

D

Name of meeting:	**Leicester, Leicestershire and Rutland Integrated Care Board**		
Date:	**Thursday, 14 December 2023**	**Paper:**	**D**
Report title:	**LLR ICB 2024/25 Operational and Financial Plan Submission**		
Presented by:	Sarah Prema, Chief Strategy Officer, LLR ICB		
Report author:	Ket Chudasama, Deputy Chief Strategy and Planning Officer, LLR ICB		
Executive Sponsor:	Sarah Prema, Chief Strategy Officer, LLR ICB		

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

Recommendations:

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

NOTE the 2024/25 Operational and Financial Plan update and 5YP annual refresh

Purpose and summary of the report:

1) The purpose of this paper is to provide an update to the LLR ICB Board on the 2024/25 Operational and Financial Plan. The paper outlines progress made to date, key risks, emerging mitigations and next steps.

2) The paper also provides a brief update on the LLR ICB 5 Year Plan (5YP) annual refresh and how we have aligned the two planning processes to reduce duplication and provide a consistent narrative.

Appendices:	Appendix one: System Planning Parameters
Report history (date and committee / group the content has been discussed / reviewed prior to presenting to this meeting):	Input and steer have been sought at the following meetings to support development of the plan: • System Executive 25 August 2023, 22 September 2023, 24 November 2023

The report is helping to deliver the following strategic objective(s) – *please tick all that apply*:		
1. Health outcomes	Increase the health outcomes of the Leicester, Leicestershire and Rutland population.	☒
2. Health inequalities	Reduce health inequalities across the Leicester, Leicestershire and Rutland population.	☒
3. Reduce variation	Reduce the variation in health outcomes across the Leicester, Leicestershire and Rutland population.	☒

4. Sustainable finance plan	Deliver a sustainable system financial plan, ensuring funding is distributed to where services are delivered.	☒
5. NHS Constitution	Deliver NHS Constitutional requirements.	☒
6. Value for money	Develop and deliver services with providers that are evidenced based and offer value for money.	☒
7. Integration	Deliver integrated health and social care.	☒

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

Implications:	
a) Does the report provide assurance against a corporate risk(s) e.g. risk aligned to the Board Assurance Framework, risk register etc? *If so, state which risk and also detail if any new risks are identified.*	The Operational Plan is developed to contain actions that reduce the key BAF risks eg performance, finance, quality and workforce etc
b) Does the report highlight any resource and financial implications? If so, provide which page / paragraph this can be found within the report.	The final Operational and Financial Plan submission will include financial implications and these will be highlighted during the planning process.
c) Does the report highlight quality and patient safety implications? If so, provide which page / paragraph this is outlined in within the report.	Operational Plan includes actions to improve quality and safety
d) Does the report demonstrate patient and public involvement? If so, provide which page / paragraph this is outlined in within the report.	Not in the context of this paper.
e) Has due regard been given to the Public Sector Equality Duty? If so, how and what the outcome was, provide which page / paragraph this is outlined in within the report.	An overarching equality impact and risk assessment will be undertaken as the plan is further developed.

2024/25 LLR Operational and Financial Plan

Thursday 14 December 2023

Introduction

1. The purpose of this paper is to provide an update to the LLR ICB Board on the 2024/25 Operational and Financial Plan. The paper outlines progress made to date, key risks, emerging mitigations and next steps. The paper also provides a brief update on the LLR ICB 5 Year Plan (5YP) annual refresh and how we have aligned the two planning processes.

2. The final submission of the 2023/24 Operational and Financial Plan included achievement of the majority of the NHS 31 national objectives and a planned system deficit of £10million following discussions with the NHS England national executive team.

3. The national planning guidance is usually published pre-Christmas and we expect it to contain similar priorities outlined in the 2023/24 guidance and build upon any themes from the recent plan revision exercise.

Progress made to date on the 2024/25 Operational Plan

4. We have developed the 2024/25 planning approach through discussions with the System Executive and progressed by the weekly System Planning Operational Group (SPOG) and Chief Finance Officers (CFOs) meeting. The key areas of development have been:

    a. Agreed 10 system planning parameters to help guide organisations to develop their plans covering workforce, productivity, equity and finance (appendix one)
    b. Agreed an LLR investment/disinvestment approach based upon four key criteria
        i. Statutory and legal requirements (risk-appetite based)
        ii. Prioritised 'unfunded' business cases from 2023/24 planning round (risk-appetite based)
        iii. Cash releasing efficiency schemes (signed off by all partners' finance / contract teams)
        iv. Supporting priorities and pledges stated in the Medium Term Financial Plan (MTFP) or 5YP such as prevention and children's services.
    c. Established a multi-disciplinary System Prioritisation Group and a framework which allows for independent scoring and ranking of system wide business cases. This group has reviewed the clinical risk and scored the prioritised unfunded business cases from the 2023/24 planning round and reported into the Clinical Executive and System Executive, recommending prioritising 2024/25 funding into the neurodevelopmental pathway.
    d. Refined the business case process based upon feedback from last year to enable a more focussed list based upon the agreed criteria for system wide investment/disinvestment and efficiency ideas to proceed to business case stage. To date, this process has not identified sufficient system wide efficiency savings to be generated in 2024/25.

e. Agreed that organisations (UHL / LPT / ICB) remain responsible for all aspects of their plan such as workforce, performance, activity, finance and efficiencies but would work with Partnerships / Collaboratives where it makes sense to do so.
f. The Finance Committee met on 29 November 2023 and discussed the production of the 2024/25 financial plan and refresh of the 5 Year Financial Strategy as part of the 5YP refresh. It is likely that we need to deliver at least 5% recurrent efficiency in each organisation in 2024/25 and beyond to reach a sustainable financial position over the next 3 years.

Key risks and mitigations

5. We discussed the key planning risks and proposed mitigations at the System Executive on 24 November 2023. The committee were assured they reflected the key risks but have scheduled a development session on 15 December 2023 to discuss them further together with the overall strategic intent of the plan.

Risk	Risk Description	Proposed Mitigations
1	Insufficient efficiency savings identified to date	• Task and Finish group to be established to work up 3/4 big ticket schemes (Acute and Community length of stay, mental health, patient initiated follow-up (PIFU) /outpatients (OP) /theatres, prevention etc) • 15 December 2023 System Executive Development Session to discuss overall system wide transformation approach
2	Focus of teams upon 2023/24 operational plan revisions rather than 2024/25 planning	• Minimise/ring fence staff/teams to work on either 2023/24 plan revisions or 2024/25 planning (where possible)
3	Lack of investment for medium term financial plan (MTFP) or Five Year Plan (5YP) priority areas (prevention, children's services etc)	• Consistent messaging to reinforce growth investment focus on longer term priorities rather than just 2024/25 cost pressures. • Identify schemes with the greatest 'value' ie broader set of benefits
4	Lack of affordability of 2024/25 financial plan due to cost growth, cost pressures, limited efficiency savings etc	• Clear assessment of the size of the gap following receipt of organisational financial and cost improvement plans (CIP) on 15 December 2023
5	Affordability of workforce in 2024/25 due to workforce cost growth in 2023/24	• Review future years' phasing of workforce following 2023/24 cost growth • Consider whether all proposed schemes for 2024/25 workforce cost growth continue

Next steps

6. The key high level system planning milestones are presented in the following table and will be aligned with individual organisational governance timelines and processes.

Timeline	Action
Early Dec 2023	• Agree prioritised list of efficiency ideas to progress to business case and communicate to organisations and partnerships / collaboratives
14 Dec 2023	• Operational Planning update to ICB Board
15 Dec 2023	• System Executive Development Session to focus upon strategic intent of the plan and approach to transformation • Receive draft organisational financial and efficiency plans
22 Dec 2023	• Receive second draft narrative operational plan chapters
Jan - Mid Feb 2024	• Update on implications from 2024/25 published national planning guidance • Further iteration of Activity & Performance/finance and workforce • System Prioritisation Group review of prioritised system wide efficiency / investment / disinvestment ideas • System Executive and ICB Board discussions on activity levels, performance trajectories, workforce levels, CIP / efficiency and financial plans, investment and disinvestment
By Mid Feb 2024	• First submission of Operational and Financial Plan to NHS England (narrative and accompanying templates)
Mid Feb – Mid Mar 2024	• Final changes made to activity plans, performance trajectories, workforce plans, CIP / efficiency and financial plans, investment and disinvestment plans
By end Mar 2024	• Final Submission of Operational and Financial Plan to NHS England (narrative and accompanying templates)

5 Year Plan Refresh

7. The 5YP is a joint plan with our system partners – University Hospitals of Leicester NHS Trust and Leicestershire Partnership NHS Trust. The purpose of the plan is to focus on key areas of delivery over the next five years that will improve outcomes and experiences for patients and ensure that the system is sustainable.

8. The 5YP has been produced in line with NHS England guidance published in December 2022 and was approved by the ICB Board in July 2023.

9. Statements of support have been received from all three LLR Health and Wellbeing Boards and the plan takes into account the three Local Authority Joint Health and Wellbeing Strategies. An overview of the 5YP was presented to Leicester, Leicestershire and Rutland Joint Health Scrutiny Committee on 18 September 2023.

10. We are required to undertake an annual refresh of the plan and are awaiting publication of guidance and deadlines from NHS England. The content of this refresh will be based upon the detail that is being produced with leads for the 2024/25 Operational Planning process and the MTFP, this will reduce duplication and provide a consistent narrative. We expect to update the finance and workforce sections of the plan and provide more detail on interventions in chapter 3, the delivery plan and the associated annex. We will present this to System Executive and the ICB Board by end June 2024 or earlier once submission timelines are clearer.

Recommendations:

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

NOTE	the 2024/25 Operational and Financial Plan update and 5YP annual refresh

Appendix One: System planning parameters

Zero workforce cost growth at Org level, unless specified by national guidance (excludes agreed ↑ capacity eg elective hub)

Delivery within LLR Agency Cap

- ↑ % compliance with Off framework usage
- ↑ % compliance price cap breaches

Prioritise investment in:

1. Statutory / legal reqt's (risk appetite based)
2. Prioritised unfunded BC from 23/24 (risk appetite based)
3. Efficiency schemes (cash releasing only)
4. MTFP/5YP investment priorities (prevention, Childrens)

↑ % allocation of non acute services and ↓ % allocation in acute services

Align with MTFP principles and assumptions eg each organisation to deliver in year efficiency target of 3-6% (tbc from MTFP)

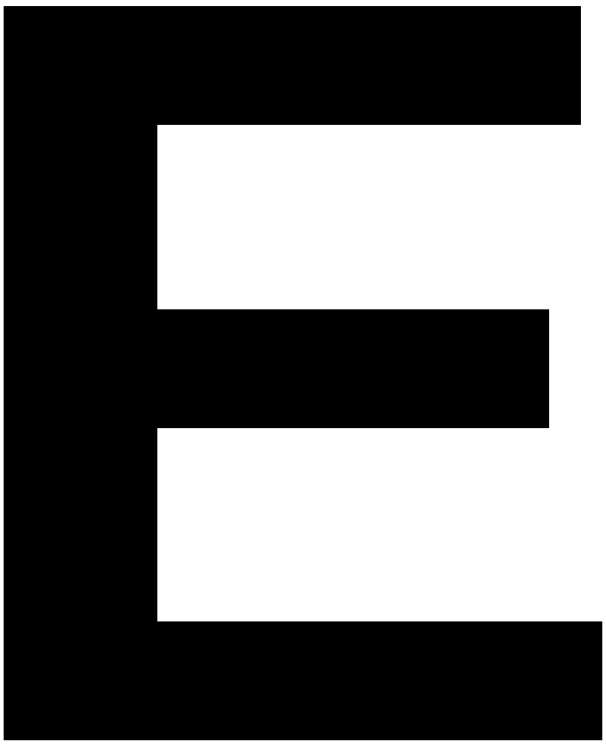
Maintain the Mental Health Investment Standard

Deliver upper quartile performance in terms of productivity and elimination of waste

Keep required agreed system UEC capacity open

Maximise health equity in delivery of all services

Meet all 2024/25 Operational Planning guidance requirements



Name of meeting:	**Leicester, Leicestershire and Rutland Integrated Care Board (LLR ICB)**		
Date:	14 December 2023	**Paper:**	**E**
Report title:	**Draft LLR ICB Workforce Race Equality Standard (WRES) & Draft LLR ICB Workforce Disability Standard (WDES) (2022-2023).**		
Presented by:	Alice McGee, Chief People Officer		
Report author:	Shaun Cropper, Equality, Diversity & Inclusion Business Partner		
Executive Sponsor:	Alice McGee, Chief People Officer		

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

Recommendations:

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

- **RECEIVE and APPROVE for publication the WRES & WDES reports together with the combined action plan.**

Purpose and summary of the report:

1. The report provides an update to the Executive Management Team on progress made against the Workforce Race Equality Standard (WRES) and Workforce Disability Equality Standard together with a new combined WRES/WDES action plan.

2. The report relates to ICB staff only which was 339 at the time of reporting.

3. The main purpose of the WRES is to help local and national NHS organisations to review their data against the 9 standard indicators and to produce an action plan to close the gaps in workplace experience between White, and Black and Minority Ethnic (BME) staff. The WRES also places an obligation on NHS organisations to improve BME representation at Board level.

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

5. At present, Integrated Care Boards (ICBs) are not required to undertake the WRES or WDES assessments. Recent correspondence from the NHS WDES team (April 2023) noted ‘At the moment, there is no mandate for ICBs to submit WDES and WRES data. Any information we receive will therefore be voluntary, but we will support, as we can, any organisation that wants to use the WDES and WRES methodology. What we are not planning to do at the moment is collect data from ICBs, nor publish an overall report on it’.

6. If the WRES had applied, the latest technical guidance also states that ‘formally, ICBs are not required by the NHS standard contract to fully apply the WRES to themselves as some ICB workforces may be too small for the WRES indicators to either work properly or to comply with the Data Protection Act.’ However, the guidance goes on to say ‘ICBs should commit to the principles

of the WRES and apply as much of it as possible to their own workforce. In this way, ICBs can demonstrate good leadership, identify concerns within their workforces, and set an example for their providers'. If the WDES had been mandated, for 2023 the ICB would only have been required to provide data for metric 10 'Board Representation'. The report will ensure that the ICB can make informed decisions whilst protecting the anonymity of staff.

7. As part of our commitment to workforce equality and inclusion it is important to commit to these standards as part of our continuous EDI improvement journey. The ICB plays an active role in the development of Equality and Inclusion across the LLR system and needs to be an active in progressing and collaborating with partners on the standard. This is particularly important following the launch of the Workforce EDI NHSE Improvement Plan in June (noted in paragraph 8).

8. In June 2023, NHSE launched their new **Workforce Equality, Diversity and Inclusion (EDI) Improvement Plan** which sets out six measurable actions for NHS organisations to address inequalities across the nine protected characteristics in the Equality Act 2010. Addressing all forms of discrimination and inequalities, will enable our workforce to use their full range of skills and experience to deliver the best possible care to our patients and service users. The action plan attached incorporates all the relevant actions contained in the Improvement Plan for both BME and disabled employees. It aims to address any issues identified in the reports.

9. The use of WRES and WDES evidence is also a requirement of new Equality Delivery System 2022 under the '**Workforce health and well-being'** Domain to ensure that there is symmetry across the NHS mandated standards.

10. As the ICB is a newly constituted organisation this year's analysis will act as baseline data. It covers the period 1st July 2022 - March 31st 2023. The WRES was also paused for CCGs in 2021-22 so any comparison would not be possible.

11. Note on terminology: The term "BME" is used throughout this report to mirror the wording of the WRES. However, this term is becoming less used in favour of more inclusive language which does not combine all minority ethnic groups together.

Appendices:	• **Appendix A**: Workforce Race Equality Standard (WRES) indicators • **Appendix B**: LLR ICB Workforce Disability Equality Standard (WDES) • **Appendix C**: Combined WRES / WDES Action Plan
Report history (date and committee / group the content has been discussed / reviewed prior to presenting to this meeting):	• ICB Operational Delivery Group

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

1. Health outcomes	Increase the health outcomes of the Leicester, Leicestershire and Rutland population.	☐
2. Health inequalities	Reduce health inequalities across the Leicester, Leicestershire and Rutland population.	☒
3. Reduce variation	Reduce the variation in health outcomes across the Leicester, Leicestershire and Rutland population.	☐
4. Sustainable finance plan	Deliver a sustainable system financial plan, ensuring funding is distributed to where services are delivered.	☐

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

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

Implications:	
a) Does the report provide assurance against a corporate risk(s) e.g. risk aligned to the Board Assurance Framework, risk register etc? *If so, state which risk and also detail if any new risks are identified.*	N/A
b) Does the report highlight any resource and financial implications? If so, provide which page / paragraph this can be found within the report.	No
c) Does the report highlight quality and patient safety implications? If so, provide which page / paragraph this is outlined in within the report.	No
d) Does the report demonstrate patient and public involvement? If so, provide which page / paragraph this is outlined in within the report.	No
e) Has due regard been given to the Public Sector Equality Duty? If so, how and what the outcome was, provide which page / paragraph this is outlined in within the report.	The aim of the report is to comply with the Equality Act 2010 (Public Sector Equality Duty and mandated Workforce Race Equality and Disability Standards.

LLR ICB - NHS WORKFORCE RACE EQUALITY STANDARD 2022/2023 and NHS WORKFORCE DISABILITY AND EQUALITY STANDARD

Introduction

1. The NHS Workforce Race Equality Standard (WRES) was introduced to the NHS in April 2015 and included in the NHS standard contract the same year. WRES baseline data has been provided and published by the NHS since 1 July 2015.

2. The main purpose of the WRES is to help NHS organisations to review their data against the nine WRES indicators **(as in Appendix A)** and produce an action plan to close the gaps in workplace experience between White, and Black, and Minority Ethnic (BME) staff. The WRES also places an obligation on NHS organisations to improve BME representation at Board level.

3. The requirements of the WRES are highlighted in the 'We are the NHS: People Plan 2020/21 – action for us all' which focusses on the need to have robust action plans in place to address equality and inclusion in the workplace. The ICB must also publish progress against the goals contained in NHSE 'A Model Employer' to ensure that at every level the workforce is representative of the overall BME workforce.

4. At present, Integrated Care Boards (ICBs) are not required to undertake the WRES assessment. Recent correspondence from the NHS WDES team (April 2023) noted 'At the moment, there is no mandate for ICBs to submit WDES and WRES data. Any information we receive will therefore be voluntary, but we will support, as we can, any organisation that wants to use the WDES and WRES methodology. What we are not planning to do at the moment is collect data from ICBs, nor publish an overall report on it'. Further detail in relation to the WDES is provided at **Appendix B** to this report. The combined action plan for the WRES and WDES is detailed at **Appendix C**.

5. If the WRES had been mandated, the latest technical guidance also states that 'formally, ICBs are not required by the NHS standard contract to fully apply the WRES to themselves as some ICB workforces may be too small for the WRES indicators to either work properly or to comply with the Data Protection Act.' However, the guidance goes on to say 'ICBs should commit to the principles of the WRES and apply as much of it as possible to their own workforce. In this way, ICBs can demonstrate good leadership, identify concerns within their workforces, and set an example for their providers'. The report will ensure that the ICB can make informed decisions whilst protecting the anonymity of staff.

6. As part of our commitment to workforce equality and inclusion it is important to commit to this standard as part of our continuous EDI improvement journey. The ICB plays an active role in the development of Equality and Inclusion across the LLR system and needs to be an active in progressing and collaborating with partners on the standard. This is particularly important following the launch of the Workforce EDI NHSE Improvement Plan in June (noted below).

7. In June 2023, NHSE launched their new **Workforce Equality, Diversity and Inclusion (EDI) Improvement Plan** which sets out six measurable actions for NHS organisations to address inequalities across the nine protected characteristics in the Equality Act 2010. Addressing all forms of discrimination and inequalities, will enable our workforce to use their full range of skills and experience to deliver the best possible care to our patients and service users. The action plan attached incorporates all the relevant actions contained in the Improvement Plan which aims to address any issues contained in this report.

8. As the ICB is a newly constituted organisation this year's analysis will act as baseline data. It covers the period 1st July 2022 - March 31st 2023. The WRES was also paused for CCGs in 2021-22 so any comparison would not be possible in any case.

9. Note on terminology: The term "BME" is used throughout this report to mirror the wording of the WRES. However, this term is becoming less used in favour of more inclusive language which does not combine all minority ethnic groups together.

The WRES Reporting Tool

10. The Workforce Race Equality Standard applies to all types of providers of nonprimary healthcare services operating under the full-length version of the NHS Standard Contract, and so is applicable to NHS providers, independent sector providers, and voluntary sector providers.

11. ICBs have two roles in relation to the WRES - as a commissioner of NHS services and as employers. In both roles, our work is shaped by key statutory requirements and policy drivers including those arising from:

    - The NHS Constitution
    - The Equality Act (2010) and the Public Sector Equality Duty
    - The NHS standard contract and associated documents
    - The ICB Improvement and Assessment Framework.
    - Workforce Equality, Diversity and Inclusion (EDI) Improvement Plan
    - Equality Delivery System 2022

12. In addition to the NHS standard contract, the ICB Improvement and Assessment Framework requires ICBs to give assurance to NHS England that our providers are implementing and using the WRES. Therefore, implementing the WRES and working on its results together with the subsequent action plans is a part of contract monitoring arrangements between the ICB and our system provider organisations.

13. The use of WRES evidence is also a requirement of new Equality Delivery System 2022 under the '**Workforce health and well-being'** Domain to ensure that there is symmetry across the NHS mandated standards.

The WRES Indicators

14. With over one million employees, the NHS is mandated to show progress against several indicators on workforce equality, including a specific indicator to address the low numbers of BME Board members across the organisations.

15. The nine WRES indicators (**Appendix A)** that NHS organisations report against on an annual basis are based on existing data sources which include Electronic Staff Records (ESR) and NHS Staff Survey results. Caution must be taken when looking at the data due to the small number of staff employed by the ICB. When publishing the data, we will ensure that no one can be identified.

Analysis of WRES (based on LLR ICB combined data for the reporting period 1st July 2022 – 31st March 2023)

WRES 2022/23 – Key Findings

16. The table below provides an overview of the ICBs workforce which includes employed and non-employed individuals on the payroll on 31 March 2023.

	2023
LLR ICBs' area BME population*	23.3%
Number of staff employed within the organisation	339
Proportion of BME staff	31.6 %
Proportion of staff self-reporting their ethnicity	89.3%

* ICB area BME population data taken from 2021 Census

Analysis:

- The data demonstrates that the BME workforce at the ICB is more than representative of the BME population across LLR population by 8.3%.
- The number of staff self-reporting their ethnicity is 89.3%

LLR ICBs WRES Data Summary

17. **WRES Indicator 1: percentage of staff both clinical and non – clinical combined in each of the AfC Bands 1-9 and VSM (including Executive Board members) compared with the percentage of staff in the overall workforce.**

Percentage of LLR ICB staff in each AfC Band			
	White	BME	Unknown
	2023	2023	2023
Under Band 1	50%	50%	0%
Band 1	0%	0%	0%
Band 2	0%	0%	100%
Band 3	100%	0%	0%
Band 4	27.8%	66.7%	5.5%
Band 5	56.7%	36.7%	6.6%
Band 6	56.9%	39.2%	3.9%
Band 7	53.4%	44.4%	2.2%
Band 8A	64.3%	27.1%	8.56%
Band 8B	69.4%	25%	5.6%
Band 8C	67.9%	28.6%	3.5%
Band 8D	100%	0%	0%
Band 9	70%	20%	10%
VSM*	47.7%	9.5%	42.8%
Other	28.6%	21.4%	50%
Total	**57.8%**	**31.6%**	**10.6%**

VSM includes senior employees that are not on Agenda for Change pay bands and includes other Governing Body members who are not banded.

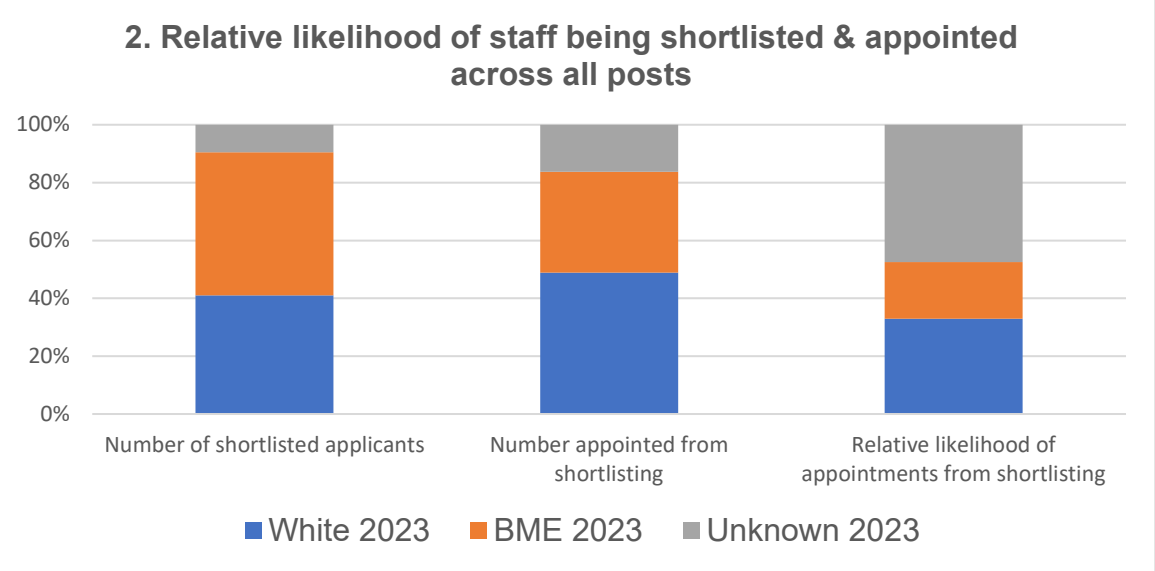
Analysis of Indicator 1.

- BME Representation of total staff in Bands Under 1-6 is 40.4 %
- BME Representation of total staff in Bands 7 – 8C is 31.3%
- BME Representation of total staff in Bands 8D, 9 and VSM is 10.8%
- BME Representation of total staff in “Other Bands” is 21.4%

The figures indicate that BME staff are represented less at the higher bands compared to the lower and middle bands.

18. **WRES Indicator 2: Relative likelihood of staff being appointed from shortlisting across all posts.**

	White 2023	BME 2023	Unknown 2023
Number of shortlisted applicants	69	83	16
Number appointed from shortlisting	21	15	7
Relative likelihood of appointments from shortlisting	30.43%	18.07%	43.75%



Analysis of indicator 2:

- The relative likelihood of appointment indicates that white applicants have a **1.68** better chance of securing a position than BME candidates.

19. **WRES Indicator 3: Relative likelihood of staff entering the formal disciplinary process.**

	White 2023	BME 2023	Unknown 2023
Number of staff entering the formal disciplinary process	N/A	N/A	N/A
Relative likelihood of staff entering the formal disciplinary process	N/A	N/A	N/A

Analysis of Indicator 3

- We cannot meaningfully report against this metric given the very small number of formal disciplinary cases we have in the ICB.

20. **WRES Indicator 4: Relative likelihood of staff accessing non-mandatory training and CPD.**

	White	BME	Unknown
	2023	2023	2023
Number of staff accessing non-mandatory training and CPD	Not collected	Not collected	Not collected
Likelihood of staff accessing non-mandatory training and CPD	N/A	N/A	N/A

21. **WRES Indicators 5-8 - LLR ICB National NHS Staff Survey results 2022**

LLR ICB National NHS Staff Survey results 2022: WRES indicators 5-8			
Staff survey question	**White staff**	**BME staff**	**BME Median***
Percentage of staff experiencing harassment, bullying or abuse from patients, relatives, or the public in the last 12 months	2.7%	0.0%	8.3%
Percentage of staff experiencing harassment, bullying or abuse from staff in the last 12 months	12.8%	21.7%	Median benchmark* 20.0%
Percentage believing that the organisation provides equal opportunities for career progression or promotion	64.9%	57.8%	38.3%
In the last 12 months have you personally experienced discrimination at work from any of the following: Manager/team leader or other colleagues	1.4%	13.3%	13.3%

*Average calculated as the median for benchmark group

Analysis of indicators 5-8

The staff survey results indicate that:

- BME staff are more likely to experience harassment, bullying or abuse from colleagues (21.7%) compared to white staff (12.8%). This is a difference of 8.9%

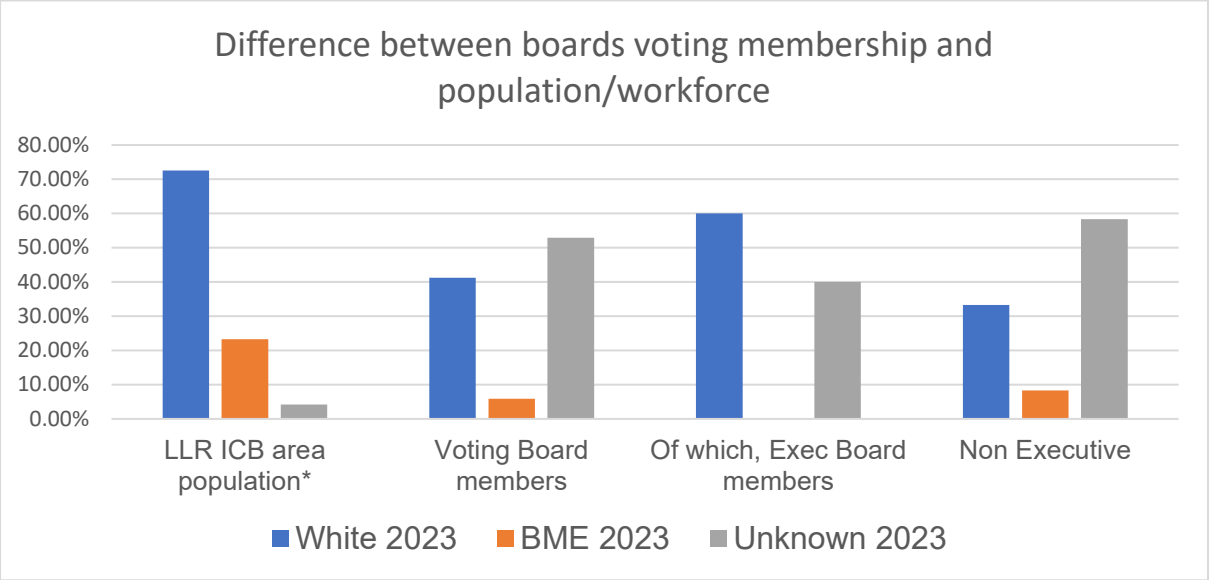
- 64.9% of white staff believe that the organisation provides equal opportunities for career progression or promotion compared to 57.8% of BME staff. This is, however, more than the median figure for ethnically diverse employees.

- 13.3 % of BME staff have personally experienced discrimination at work from a manager/team leader or other colleagues compared to 1.4% of white staff. This is a difference of nearly 12%.

22. **WRES Indicator 9: Percentage difference between the organisation's Board voting membership and its overall workforce**

	White	BME	Unknown
	2023	2023	2023
LLR ICB area population*	72.5%	23.3%	4.2%
Overall total workforce	196	107	36
Percentage of members who sit on the Board who are either White/BME or status unknown	41.2%	5.9%	52.9%
Of which, Voting members	41.2%	5.9%	52.9%
Of which, Exec Board members	60%	0	40%
Non-Executive	33.3%	8.3%	58.3%

* ICB area BME population data taken from 2021 Census



Analysis of indicator 9.

The total number of BME members on the ICB Board is 5.9% (and voting) which is less than representative of the workforce and local demographic profile. There were 52.9% of board members who did not register their ethnicity.

Contract monitoring arrangements and the WRES

23. The ICB with support from the Quality Team continues to ensure that the WRES is being monitored through the full NHS contract. The ICB receives regular reports and is assured that the WRES is being reported and monitored through its governance arrangements.

Accessibility Check

All charts are described in Alt text.

Where merged cells exist, the curser moves on logically to next cell.

All tables have narrative underneath explaining the overall findings.

Draft WRES report Date: V2 14/11/23

Appendix A

The Workforce Race Equality Standard indicators

	Workforce indicators For each of these four workforce Indicators, compare the data for white and BME staff
1.	Percentage of staff in each of the AfC Bands 1-9 or Medical and Dental subgroups and VSM (including executive Board members) compared with the percentage of staff in the overall workforce disaggregated by: • Non-Clinical staff • Clinical staff - of which - Non-Medical staff - Medical and Dental staff Note: Definitions for these categories are based on Electronic Staff Record occupation codes with the exception of Medical and Dental staff, which are based upon grade codes.
2.	Relative likelihood of staff being appointed from shortlisting across all posts. Note: This refers to both external and internal posts Data should be taken at year end.
3.	Relative likelihood of staff entering the formal disciplinary process, as measured by entry into a formal disciplinary investigation. Note: Data should be taken at year end.
4.	Relative likelihood of staff accessing non-mandatory training and CPD
	National NHS Staff Survey indicators (or equivalent) For each of the four staff survey indicators, compare the outcomes of the responses for white and BME staff
5.	Percentage of staff experiencing harassment, bullying or abuse from patients, relatives or the public in last 12 months
6.	Percentage of staff experiencing harassment, bullying or abuse from staff in last 12 months
7.	Percentage of staff believing that the trust provides equal opportunities for career progression or promotion

8.	In the last 12 months have you personally experienced discrimination at work from any of the following? b) Manager/team leader or other colleagues
	Board representation indicator For this indicator, compare the difference for white and BME staff
9.	Percentage difference between the organisations' Board membership and its overall workforce disaggregated: • By voting membership of the Board • By executive membership of the Board

Appendix B

Appendix B

LLR ICB – NHS WORKFORCE DISABILITY EQUALITY STANDARD (WDES) 2022/2323

Introduction

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

2. At present, Integrated Care Boards (ICBs) are not required to undertake the WDES assessment. Recent correspondence from the NHS WDES team (April 2023) noted 'At the moment, there is no mandate for ICBs to submit WDES and WRES data. Any information we receive will therefore be voluntary, but we will support, as we can, any organisation that wants to use the WDES and WRES methodology. What we are not planning to do at the moment is collect data from ICBs, nor publish an overall report on it.

3. If the WDES had been mandated, then in 2023 we would only have been required to provide data for metric 10 'Board Representation'.

4. As part of our commitment to workforce equality and inclusion it is important to commit to this standard as part of our continuous EDI improvement journey. The ICB also plays an active role in the development of Equality and Inclusion across the LLR system and needs to be progressing and collaborating with partners on the standard. This is particularly important following the launch of the Workforce EDI NHSE Improvement Plan in June (noted below).

5. In June 2023, NHSE launched their new **Workforce Equality, Diversity and Inclusion (EDI) Improvement Plan** which sets out six measurable actions for NHS organisations to address inequalities across the nine protected characteristics in the Equality Act 2010. Addressing all forms of discrimination and inequalities, will enable our workforce to use their full range of skills and experience to deliver the best possible care to our patients and service users. The action plan attached incorporates the relevant actions contained in the Improvement Plan which aims to address any issues contained in this report.

6. As the ICB is a newly constituted organisation this year's analysis will act as baseline data. It covers the period 1st July 2022 - March 31st 2023. Caution must be taken when looking at the data due to the small number of staff employed by the ICB. The report will ensure that the ICB can make informed decisions whilst protecting the anonymity of staff.

National context

7. Each year, the NHS WDES data analysis has highlighted that Disabled job applicants are less likely to be appointed through shortlisting, whilst Disabled NHS staff are:

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

The importance of WDES

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

9. The WDES is referenced in the **NHS People Plan**. Published in 2021, the Plan sets out actions to support transformation across the whole NHS. It focuses on how we must all continue to look after each other and foster a culture of inclusion and belonging, as well as take action to grow our workforce, train our people, and work together differently to deliver patient care. The Plan makes clear that the NHS must welcome all, building understanding, encouraging and celebrating diversity in all its forms.

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

11. The use of WDES evidence is also a requirement of new Equality Delivery System 2022 '**Workforce health and well-being'** Domain to ensure that there is symmetry across the NHS mandated standards.

12. Disabled people have had historic challenges in accessing employment. Recent official data highlights that, as of December 2021, 8.4 million people of working age were identified as Disabled. This represents 20% of the working age population and is an increase of 327,000 from 2019. Across the UK, 52.3% of Disabled people were in employment, compared to 81.1% of non-disabled people. In relation to unemployment, the rate for Disabled people was 8.4% in October-December 2021, up from 6.9% a year previously. This compared to an unemployment rate of 4.6% for non-disabled people.

The WDES Metrics (Summary)

13. There are ten (10) WDES metrics.

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

14. Three WDES metrics (2, 5 and 10) are the equivalent of indicators set out in the Workforce Race Equality Standard (WRES), whilst WDES metric 1 is similar to the WRES indicator on workforce representation. WDES metric 4is closely related to the two WRES metrics (5 and 6) on bullying and harassment.

15. WDES metric 9a draws from the NHS staff engagement score, which is an amalgamation of several questions in the NHS Staff Survey.

16. WDES metric 9b asks for evidence of action to facilitate the voices of Disabled staff to be heard. Depending on the response, evidence of actions or plans to address the gap should be added to the organisation's Annual report.

17. It should be noted that within the WDES metrics the term 'Disabled compared to nondisabled', analyses the differences in experience between those staff who have responded 'Yes' and 'No' to monitoring questions about whether they have a disability. The label "Unknown" is used to refer to the other options recorded on ESR, namely "Prefer not to answer", "Not declared" and "Unspecified "A.

Analysis of WDES (based on LLR ICB combined data for the reporting period 1st July 2022 – 31st March 2023)

WDES 2022/23 - Key findings

18. The table below provides an overview of the ICBs workforce which includes employed and non-employed individuals on the payroll on 31 March 2023.

	2023
LLR ICBs' area disabled population*	16.2%
Number of staff employed within the organisation	339
Proportion of disabled staff	4.4%
Proportion of staff self-reporting their disability	90.5%

* ICB area BME population data taken from 2021 Census

Analysis:

- The data demonstrates that the number of people with a declared disability that work at the ICB is unrepresentative of the local community by **11.8%.**
- A small proportion of staff **(9.5%)** have not declared their disability status.

19. **Metric 1 Percentage of disabled LLR ICB staff in each AfC Band**

Percentage of disabled LLR ICB staff in each AfC Band			
	Disabled	**Non-Disabled**	**Unknown**
	2023	**2023**	**2023**
Under Band 1	0%	50%	50%
Band 1	0%	0%	0%
Band 2	0%	100%	0%
Band 3	25%	75%	0%
Band 4	0%	94.4%	5.6%
Band 5	6.7%	86.6%	6.7%
Band 6	7.8%	88.2%	4%
Band 7	0%	95.5%	4.5%
Band 8A	5.7%	88.6%	5.7%
Band 8B	5.5%	94.5%	0%
Band 8C	3.6%	85.7%	10.7%
Band 8D	0%	83.3%	16.7%
Band 9	10%	90%	0%
VSM*	0%	66.7%	33.3%
Other	0%	35.7%	64.3%
Total	**4.4%**	**86.1%**	**9.5%**

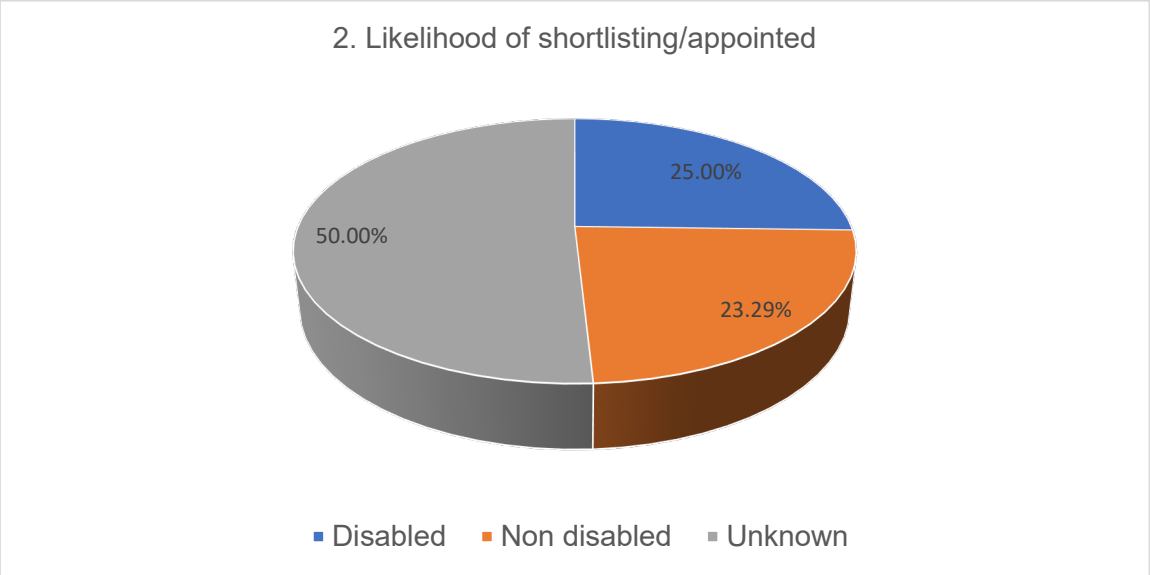
Analysis of Metric 1

- Disability Representation of total staff in Bands Under 1-6 is 6.3%
- Disability Representation of total staff in Bands 7 – 8C is 4.1%
- Disability Representation of total staff in Bands 8D, 9 And VSM is 2.7%
- Disability Representation of total staff in “Other Bands” is 0.0%

The figures indicate that there are low numbers of disabled people/those who declare a disability across all bands. There are three times as many disabled people at bands <1-6 compared to the upper banding.

20. **Metric 2 Relative likelihood of non-disabled staff compared to Disabled staff being appointed from shortlisting across all posts.**

	Disabled	Non-disabled	Unknown
Number of shortlisted applicants	8	146	14
Number appointed from shortlisting	2	34	7
Likelihood of shortlisting/appointed	25.00%	23.29%	50.00%



Analysis of Metric 2

- Relative likelihood of non-disabled staff being appointed from shortlisting compared to Disabled staff **93.15%.**

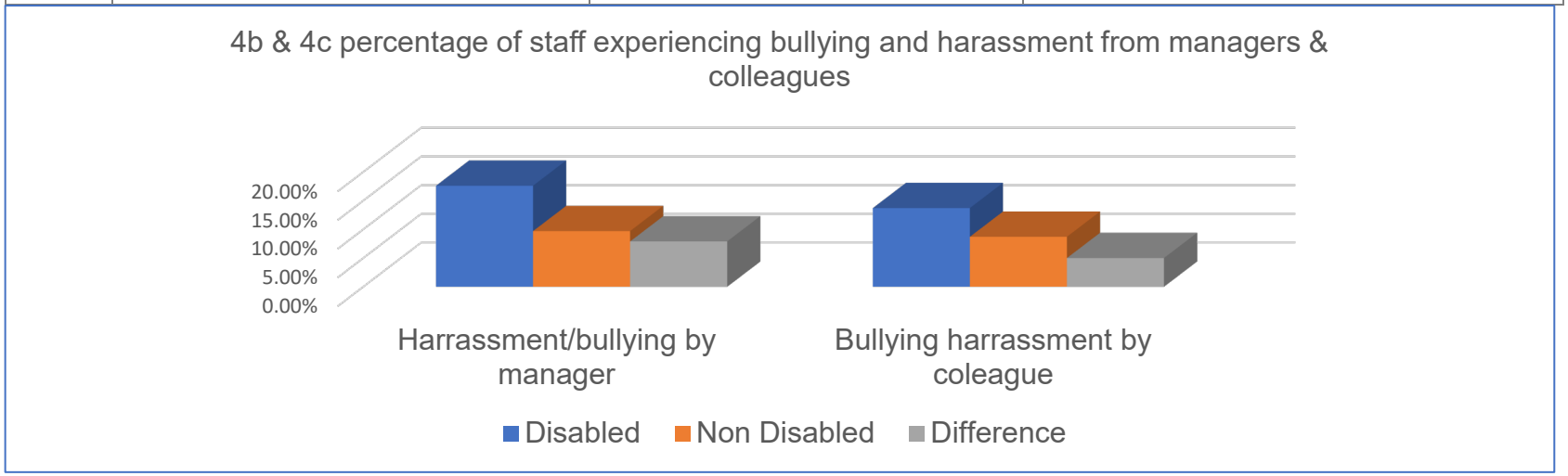
21. **Metric 3 - Relative likelihood of Disabled staff compared to non-disabled staff entering the formal capability process, as measured by entry into the formal capability procedure.**

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

22. **WDES Metrics 4-8 - LLR ICB National NHS Staff Survey results (for 2022 – 2023 reporting period) comparing the responses of Disabled staff members and non-disabled staff.**

	LLR ICB National NHS Staff Survey results 2022: WDES indicators/Metrics 4-9a		
Metric No	**Staff survey question**	**Disabled people (%)**	**Non-Disabled people (%)**
		2022	**2022**
4a.	Percentage of staff experiencing harassment, bullying or abuse from patients/service users, their relatives, or the public in the last 12 months	2.0	1.6
		Median benchmark 10.7	**Median benchmark** 7.3
Metric No	**Staff survey question**	**Disabled people (%)**	**Non-Disabled people (%)**
		2022	**2022**
4.b	Percentage of staff experiencing harassment, bullying or abuse from managers in last 12 months	17.6	9.7
		Median benchmark* 15.2	**Median benchmark*** 7.6

4c.	Percentage of staff experiencing harassment, bullying or abuse from other colleagues in the last 12 months	13.7	8.7
		Median benchmark 15.5	**Median benchmark** 8.7



Analysis of 4b & 4C - bullying and harassment from managers and colleagues

- Disabled staff experiencing harassment, bullying or abuse from managers is **17.6%** and from colleagues it is **13.7%.**
- Non-disabled staff experiencing bulling and harassment from managers is **9.7%** and from colleagues **8.7%.**
- The survey results indicate that disabled staff are more likely to experience harassment from managers compared to non- disabled people by **(7.9%)**
- The survey also indicates that disabled people are more likely to experience harassment from other colleagues compared to non-disabled staff by **(5%).**

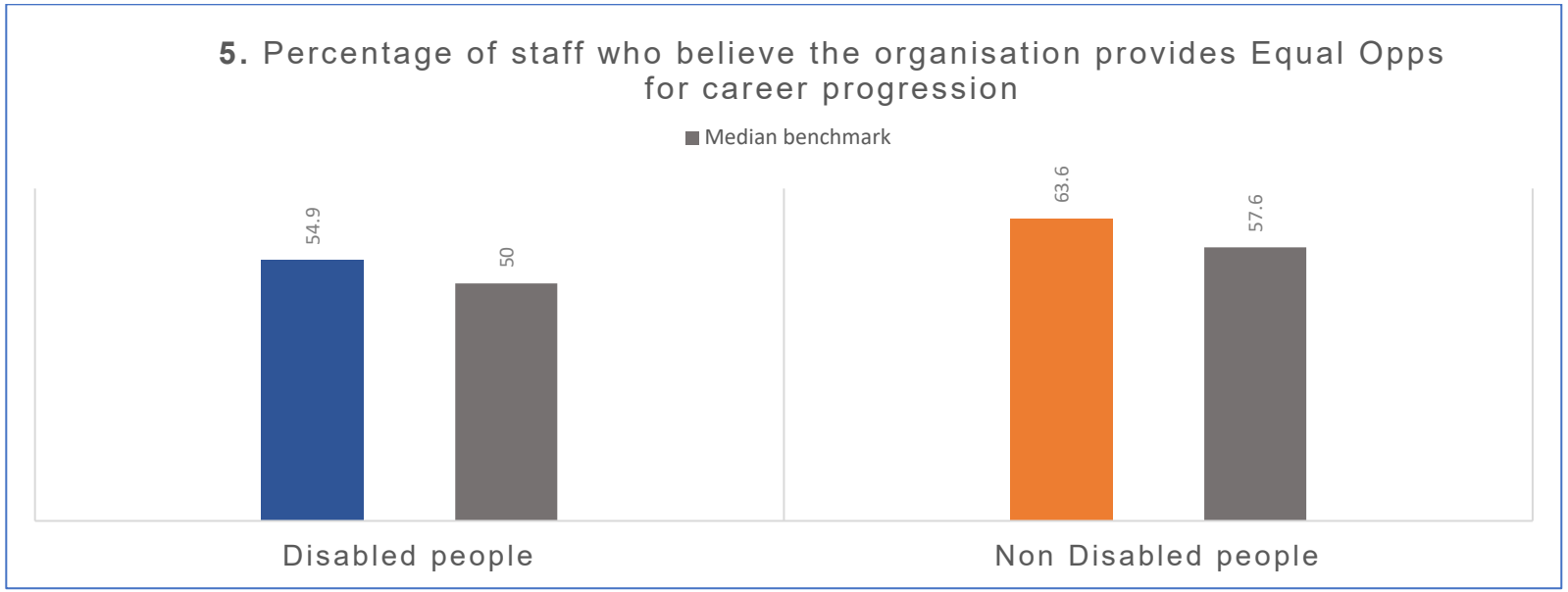
Metric No	Staff survey question	Disabled people (%)	Non-Disabled people (%)
		2022	**2022**
4.d	Percentage of staff saying that the last time they experienced harassment, bullying or abuse at work, they or a colleague reported it.	46.2	52.0
		Median benchmark 40.9	**Median benchmark** 42.2

Analysis of Metric 4d:

- **46.2%** of disabled staff said that the last time they experienced harassment, bullying or abuse at work, they or a colleague formally reported it compared to **52%** of non-disabled people.
- Conversely, the responses indicate that **54%** (approx. 7 disabled people) did not report harassment/bullying after experiencing it and that **48%** (approx.12 non-disabled people) did not report their experience.

The number of staff responding to this question in the survey was low.

Metric No	Staff survey question	Disabled people (%)	Non Disabled people (%)
		2022	**2022**
5.	Percentage of staff who believe that their organisation provides equal opportunities for career progression or promotion.	54.9	63.6
		Median benchmark 50.0	**Median benchmark** 57.6



Analysis of Metric 5:

- The percentage of disabled respondents believing that the organisation provides equal opportunities for career progression or promotion is **54.9%.** This is above the median of **50.0%**
- Non-disabled staff believing that their organisation provides equal opportunities for career progression or promotion is **63.6%** which is also above the median of **57.6%.**

The figures indicate that non- disabled people believe that the ICB provides equal opportunities for career progression by **8.7%.** more than disabled staff.

Metric No	Staff survey question	Disabled people (%)	Non Disabled people (%)
		2022	**2022**
6.	Percentage of staff who have felt pressure from their manager to come to work, despite not feeling well enough to perform their duties.	3.2	14.4
		Median benchmark 15.6	**Median benchmark** 11.0

Analysis of metric 6:

The responses indicate that non-disabled staff felt more pressure from their manager to come to work at **14.4%** compared to **3.2%** of disabled staff.

The figure for disabled staff is below the median of **15.6%,** while the figure for non-disabled staff is above the median of **11.0%.**

Metric No	Staff survey question	Disabled people (%)	Non Disabled people (%)
		2022	**2022**
7.	Percentage of staff satisfied with the extent to which their organisation values their work	51.0	52.9
		Median benchmark 45.6	**Median benchmark** 52.8

Analysis of metric 7:

The percentage of staff satisfied with the extent to which their organisation values their work is **51%** for disabled staff and **52.9%** for non-disabled staff and is on a par.

Metric No	Staff survey question	Disabled people (%)	Non Disabled people (%)
		2022	**2022**
8.	Percentage of disabled staff with a saying their employer has made adequate adjustment(s) to enable them to carry out their work.	80.0	-
		Median benchmark 80.4	**Median benchmark** -

Analysis of metric 8:

80.0% of disabled staff indicated that reasonable adjustments have been made. Although this suggests that **20.0%** of disabled staff had not received their adjustment at the time of reporting.

Metric No	Staff survey question	Disabled people (%)	Non Disabled people (%)
		2022	**2022**
9.a	*Staff engagement score (0-10)	6.5	7.0
		Median benchmark 6.6	**Median benchmark** 7.0
Number of respondents		**51/238**	**187/238**
*The staff engagement score is a composite score calculated using the responses to nine individual questions.			

Metric 9.b Have you taken action to facilitate the voices of Disabled staff in your organisation to be heard? (Yes) for example, The ICB has developed a new staff network called the People Forum, as well as the development of 'your voice' reporting tool – see Action plan.

23. **Metric 10** Board representation metric
    For this metric, compare the difference for Disabled and non-disabled staff.

    Percentage difference between the organisation's Board voting membership and its organisation's overall workforce, disaggregated:
    - By voting membership of the Board.
    - By Executive and non-executive membership of the Board.

    Analysis of Metric 10

    There are currently no Executive Board members or Voting Members who have a disability. Of the total voting members 47% have not declared their disability status. 40% of executive and 50 % of non-executive members have not declared their disability status.

Accessibility Check

All charts are described in Alt text.

Where merged cells exist, the curser moves on logically to next cell.

All tables have narrative underneath explaining the overall findings.

Final Draft WDES Report Date: V2 14/11/2023

APPENDIX 1

Workforce Metrics For the following three metrics, compare the data for both Disabled and non-disabled staff.	
Metric 1	Percentage of staff in AfC (Agenda for Change) paybands or medical and dental subgroups and very senior managers (including Executive Board members) compared with the percentage of staff in the overall workforce. This calculation should be undertaken separately for non-clinical and for clinical staff for clusters 1 to 4. Cluster 1: AfC Bands - Under 1, 1, 2, 3 and 4 Cluster 2: AfC Bands - 5, 6 and 7 Cluster 3: AfC Bands - 8a and 8b Cluster 4: AfC Bands - 8c, 8d, 9 and VSM (see note below) Cluster 5: Medical and Dental staff, consultants Cluster 6: Medical and Dental staff, non-consultant career grade
	Cluster 7: Medical and Dental staff, trainee grades Notes: 1. Definitions for these categories are based on Electronic Staff Record occupation codes with the exception of medical and dental staff, which are based upon grade codes. 2. Bank staff should be excluded from these figures (to be consistent with the WRES data collection). 3. VSMs are defined as including: • Chief executives. • Executive directors, with the exception of those who are eligible to be on the consultant contract by virtue of their qualification and the requirements of the post. • Other senior managers with board level responsibility who report directly to the chief executive. Non-executive directors should not be included.
Metric 2	Relative likelihood of non-disabled staff compared to Disabled staff being appointed from shortlisting across all posts. Note: This metric refers to both external and internal posts.

Metric 3	Relative likelihood of Disabled staff compared to non-disabled staff entering the formal capability process, as measured by entry into the formal capability procedure. Notes: 1. This metric is based on data from a two-year rolling average of the current year and the previous year. 2. This metric looks at capability on the grounds of performance only, rather than ill health.
National NHS Staff Survey metrics For each of the following four metrics, compare the responses for both Disabled and non-disabled staff.	
Metric 4 Staff Survey Q14a-d	Percentage of Disabled staff compared to non-disabled staff experiencing harassment, bullying or abuse from: a) Patients/service users, their relatives or other members of the public b) Managers c) Other colleagues d) Percentage of Disabled staff compared to non-disabled staff saying that the last time they experienced harassment, bullying or abuse at work, they or a colleague reported it.
Metric 5 Staff Survey Q15	Percentage of Disabled staff compared to non-disabled staff believing that the Organisation provides equal opportunities for career progression or promotion.
Metric 6 Staff Survey Q11e	Percentage of Disabled staff compared to non-disabled staff saying that they have felt pressure from their manager to come to work, despite not feeling well enough to perform their duties.
Metric 7 Staff Survey Q4b	Percentage of Disabled staff compared to non-disabled staff saying that they are satisfied with the extent to which their organisation values their work.
The following NHS Staff Survey metric only includes the responses of Disabled staff	
Metric 8 Staff Survey Q30b	Percentage of Disabled staff saying that their employer has made reasonable adjustment(s) to enable them to carry out their work. Note: Prior to 2022, the term “adequate adjustments” was used.
NHS Staff Survey and the engagement of Disabled staff For part a) of the following metric, compare the staff engagement scores for Disabled, non-disabled staff.	

Metric 9 Staff Engagement theme, made up of Q2a, Q2b, Q2c, Q3c, Q3d, Q3f, Q23a, Q23c and Q23d	a) The staff engagement score for Disabled staff, compared to non-disabled staff. Note: i) This part of the metric is now solely a comparison between the engagement score for Disabled staff and non-disabled staff. b) Have you taken action to facilitate the voices of Disabled staff in your organisation to be heard (Yes or No)? Note: For your response to b) If yes, please provide at least one practical example of current action being taken in the relevant section of your Annual report. If no, please include what action is planned to address this gap in your Annual report.
Board representation metric For this metric, compare the difference for Disabled and non-disabled staff.	
Metric 10	Percentage difference between the organisation's Board voting membership and its organisation's overall workforce, disaggregated: • By voting and non-voting membership of the board. • By Executive and non-exec membership of the board.

Appendix C

Appendix C

Combined Workforce Race and Workforce Disability Equality Standards Action Plan

The action plan is based on the requirements of NHS Equality, Diversity and Inclusion (EDI) Improvement plan as well as any other specific actions identified as part of the WDES and WRES analysis.

Key

HI = high impact actions contained in the NHS EDI Improvement plan
SR = specific recommendation contained in the Improvement Plan in relation to the protected characteristics of race and disability

Action	Responsibility	Timescale	Outcome
Board Representation and responsibilities **High impact action (HI) 1:** Chief executives, chairs and board members must have specific and measurable EDI objectives to which they will be individually and collectively accountable.			
Action	**Responsibility**	**Timescale**	**Outcome**
1. Every board and executive team member must have EDI objectives that are specific, measurable, achievable, relevant, and timebound (SMART) and be assessed against these as part of their annual appraisal process. **HI 1**	Chief People Officer	By March 2024	1.1 New appraisal framework with EDI objectives set for all employees is in operation. 1.2 Measured by Board Assurance framework.

2. Board members should demonstrate how organisational data and lived experience have been used to improve culture. **HI 1**	Chief People Officer	March 2025	2.1 Measured by Board Assurance framework.
3. ICB Board to review relevant data including the new EDI dashboard to establish areas of concern and prioritise actions. **HI 1**	Chief People Officer	March 2024	3.1 Areas of concern identified and acted upon. Progress will be tracked and monitored via the Board Assurance Framework
Staff progression & Recruitment High impact action (HI) 2 Embed fair and inclusive recruitment processes and talent management strategies that target under-representation and lack of diversity.			
4. Create and implement a talent Management plan to improve the diversity of executive and senior leadership. (Links to the ESR declaration campaign below). **HI 2.**	Chief People Officer	June 2024 Evidence on progress by 2025	4.1 Improvement in representation of senior leadership (Band 8C upwards). Links to WRES/WDES/National Survey

5. Launch a campaign to encourage more people to complete the equality monitoring on ESR and declare their disability and race. (**HI 2** and **SR**) – links to increased representation.	Equality, Diversity & Inclusion Business Partner	Advertised once per quarter. December 2023 - 2024.	5.1 Demonstrate year-on-year improvement in disability and race declaration rates so that ESR data is accurate about people with a disability, as measured by the WDES. 5.2 Year on year Improvement in race and disability representation with the workforce leading to parity
6. Promote the visibility of leaders with a disability through effective campaigns alongside providing leadership and career development opportunities tailored to disabled staff. **(SR)**	Chief People Officer	Ongoing	6.1 Increase the number of campaigns by leaders with a disability. 6.2 Progress measured by tracking the number of disabled staff in leadership roles.

7. Encourage staff to sign up to development opportunities: Access to career progression, training and development opportunities which must be accessible: **(HI2)** • Reverse Mentoring • Cultural Competency enablers • Active Bystander programme • Developing Diverse Leadership programme • Developing Me Developing You • Regional Leadership, Talent and EDI Academy Programmes • Quality Improvement Development Sessions • Health Inequalities Champions Development	Senior Organisational Development & Workforce Manager LLR Academy and Regional Academy	On-going	Success measured through Staff Survey.
8. Implement recommendations from the inclusive recruitment and promotion practices programme and ensure each stage of the recruitment pathway is accessible, does not discriminate and encourages disabled people to apply for roles in the ICB. **(SR)**	Head of Human Resources & Organisational Development /Senior Organisational Development and Workforce Manager	31st March 2024	8.1 Sign up to Disability Confident Scheme ensuring we become attractive to disabled applicants. Increase the number of disabled applicants by Q3 2024. 8.2 Review of recruitment policy which will also look at diverse interview panels.
9. The ICB will ensure that reasonable adjustments are effectively and efficiently implemented **(SR)**	Head of Human Resources & Organisational Development	September 2024	9.1 Year-on-year improvement in NHS Staff Survey metrics relating to reasonable adjustments at work

10. Improve the relative likelihood of BME and disabled staff being appointed from shortlisting across all posts **HI 2**	Head of Human Resources & Organisational Development	Annually from September 2023	10.1 Monitored through WRES/WDES
Develop and Implement an Improvement Plan to eliminate Pay Gaps High impact action (HI) 3: Develop and implement an improvement plan to eliminate pay gaps.			
11. Analyse data to understand pay gaps by protected characteristic and put in place an improvement plan. **HI3**	Equality, Diversity & Inclusion Business Partner/ Head of Human Resources & Organisational Development	Plan in place by 2024 for the Race as per NHS EDI improvement plan. Plan in place by 2025 for Disability as per NHS EDI improvement plan.	11.1 Year-on-year reductions in the gender, race and disability pay gaps. 11.2 Improvement plans in place.
12. Implement an effective flexible working policy including advertising flexible working options and a tool for staff to be able to request it. **HI3**	Head of Human Resources & Organisational Development	March 2024 Complete	12.1 Policy in place 12.2 Tool to request flexi leave is in place and advertised.

Bullying, harassment & discrimination High impact action 6 (HI6):

Create an environment that eliminates the conditions in which bullying, discrimination, harassment and physical violence at work occur

13. Mechanisms in place to ensure staff who raise concerns and are protected by their organisation: • Implementation of 'Your voice' – feel safe to speak up **(links to HI2)** • Roll out of Active Bystander • Psychological support/safe environment • LLR ICB People Forum in place • Speaking up against Bullying, Harassment and Discrimination – Listening into Action Events	LLR Academy/Senior Organisational Development and Workforce Manager	On-going	Year-on-year reduction in incidents of bullying, harassment and discrimination from line managers or teams (as per staff survey). **HI 6**
14. Create an environment where staff feel able to speak up and raise concerns	Chief People Officer	March 2024	14.1 Measured through the NHS staff survey/WRES/WDES/EDS
15. Anti-racism training for Human Resources/Organisational Development Teams and Nursing Midwives and AHPs	Head of Human Resources & Organisational Development	September 2024	15.1 Measured through WRES/WDES/Staff Survey

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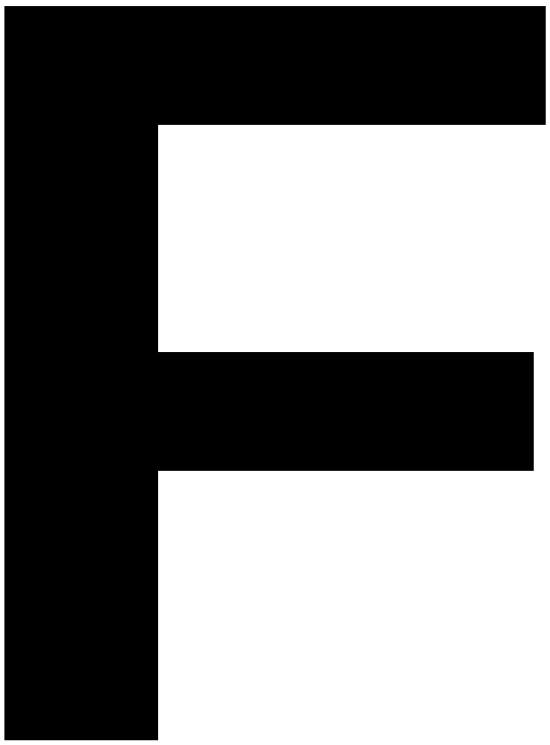

Name of meeting:	**Leicester, Leicestershire and Rutland ICB**		
Date:	**14 December 2023**	**Paper:**	**F**
Report title:	**LLR Delivery Partnership – Delivery of the LLR one- and five-year plans**		
Presented by:	Rachna Vyas, Chief Operating Officer, NHS LLR ICB		
Report author:	Rachna Vyas, Chief Operating Officer, NHS LLR ICB		
Executive Sponsor:	Caroline Trevithick, 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 Board 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 committee.

Purpose and summary of the report:

1. This is the fifth Integrated Delivery Report from the LLR Delivery Partnership on behalf of all System Partners, covering progress against the LLR Operational Plan and the LLR five-year plan made at Month 7 of 2023/24.

2. Assessments against each facet of the plan are recommended as follows:

a. **Performance**
In terms of performance, UEC and Cancer standards remain off track and are of primary concern. Whilst monthly trajectories are off plan for a small number of metrics, most are within tolerance levels against the planned positions at M7 and confidence remains high within Partnerships to recover the position by year-end. The full performance report is attached as Appendix A.

b. **Finance**
The key risk to delivery overall remains a financial risk; at M7, the financial position has deteriorated, with a significant portion of this position assessed as being due to external factors. The teams remain focused on delivering the agreed Cost improvement plans at organisational and system level, with a focus on preparation for 2425 planning. For 2425, benchmarking data is being used to understand which 3-5 key areas the system will relentlessly focus on, in order to deliver all facets of value.

c. **Quality & transformation**
In terms of quality, there are no new risks identified this month; focus remains on the CYP and maternity portfolios. Risks are beginning to materialise in areas of joint funding with local government due to the financial position across the health and care system. In order to ensure an equitable approach, a system set of impact assessments are being drawn up for agreement.

d. **Equity**
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; despite significant system pressure, system teams have remained focussed on delivery of both one- and five-year plans

Appendices:	N/A
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 2 – Health Inequalities BAF 3 – Demand and Capacity BAF 4 – Finance BAF 5 – Quality and Safety BAF 6 – Emergency Preparedness, Resilience and Response
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. Delivery / non-delivery of cost-improvement programmes highlighted throughout paper
c) Does the report highlight quality and patient safety implications? If so, provide which page / paragraph this is outlined in within the report.	Yes, throughout paper
d) Does the report demonstrate patient and public involvement? If so, provide which page / paragraph this is outlined in within the report.	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
November 2023

Background

1. This is the fifth, integrated delivery report from the LLR Delivery Partnership, covering progress against the LLR Operational Plan and the LLR five-year plan made at Month 7 of 2023/24. The 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**
   In terms of performance, UEC and Cancer standards remain off track and are of primary concern. Whilst monthly trajectories are off plan for a small number of metrics, most are within tolerance levels against the planned positions at M7 and confidence remains high within Partnerships to recover the position by year-end. The full performance report is attached as Appendix A.

b. **Finance**
   The key risk to delivery overall remains a financial risk; at M7, the financial position has deteriorated, with a significant portion of this position assessed as being due to external factors. The teams remain focused on delivering the agreed Cost improvement plans at organisational and system level, with a focus on preparation for 2425 planning. For 2425, benchmarking data is being used to understand which 3-5 key areas the system will relentlessly focus on, in order to deliver all facets of value.

c. **Quality & transformation**
   In terms of quality, there are no new risks identified this month; focus remains on the CYP and maternity portfolios. Risks are beginning to materialise in areas of joint funding with local government due to the financial position across the health and care system. In order to ensure an equitable approach, a system set of impact assessments are being drawn up for agreement.

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   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; despite significant pressure, system teams have remained focussed on delivery of both one- and five-year plans.

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 Board 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.

Children & Young Persons (delivered through various partnerships)

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. Limited mitigations are now in place, with partnerships requested to take an all-age approach to their workstreams. This is under assessment and whilst improved, capacity issues remain.

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 children and young people's visibility by embedding children and young people's objectives within the other Collaboratives and Partnerships.	October 23	Nov 23	Complete	High. Continual monitoring- to ensure CYP remain visible.
Address focused health inequalities as identified in the children and young people's core20plus5.	March 24	March 24	On track	High. Workstreams established and specific health inequality subjects chosen.
Implement and drive change through the CYP Transformation programme against NHSE set metrics and objectives (as per Long-term plan).	Jan 24	Jan 24	On track	High. Transformation team now established although there isn't full resource within workforce, workstreams are progressing.
Overall Assessment	**System exec to be aware that there is no standalone CYP team across the ICB / ICS as it stands, there is ongoing work to identify working portfolios- transformation, SEND/personalisation, mental health and key stakeholders who can support with progression.**			

Finance

Team	Scheme Name	Rag Rating	Plan	Actual / Forecast	Var	Confidence in delivery/mitigation
CYP	Community Paediatric Continence	Will not meet CIP	£209,000	£24,289	£184,711	Low
CYP	Paediatric Outpatient parenteral antibiotic therapy	Will not meet CIP	£203,000	£22,954	£180,046	Medium. Workforce remains a risk, however only 1 post outstanding. Aim of mobilisation January.
Overall Assessment		**CFO's to advise on scheme position vs plan**				

Quality & Equity

Issue	Escalation
Health Inequalities: LLR is not meeting WHO 95% standard for immunisations rate. There is a backlog of dental extractions for children and young people with 'was not brought' rates highest in the lowest IMD.	ALERT- These have been identified and proposal in creation with colleagues across the system to improve these metrics over winter 23/24.
There is no provision for quality continence intervention and care within Leicester City for those young people aged 11 years and above	ALERT- City council hold the contract for teen health but due to regulatory boards cannot provide nursing services that would address this need.
Paediatric Winter plan - Deep dive into children's emergency department shows expected increase with respiratory conditions through the winter but also significant increase in children presenting with febrile illness and difficulty in breathing last winter compared to previous years. Working with clinical leads to establish causality for this and identify next steps, potential for comms campaign.	ASSURE- winter plans to increase primary care capacity, providing acute respiratory infection appointments within PCNS continue to make pace, this is an all-age approach with proportionate appointments for children and young people.
Overall Assessment	**No escalation to the Quality Committee. The children and young people's quality and performance group is now re-established with revised targeted dashboard and appropriate membership to ensure visibility of all quality and risk.**

Transformation

Achievements (aligned to Step 4 of the NHS Impact framework)	Outcome for our patients / colleagues
Obesity: Funding secured to extend the tier2+ community excessive weight management clinic until the end of March 24. This clinic has proven to reverse long term co-morbidities in young people and is providing intervention to those young people with special educational needs and disabilities.	Ensuring our patients achieve their potential by preventing long term conditions that will cause lifelong effects within adulthood, aligned with **pledge two, pledge seven and pledge eleven** of the five year plan.
Continence: Digital platform launched to provide accessibility within service of annual reviews for those young people who are the longest waiters.	Young people with continence needs are now receiving regular reviews to ensure their needs are met whilst reducing wait times, which will provide patients and families with the ability to escalate any concerns in clinical condition early and prevent need for acute support within primary and secondary care, representing work within **pledge two, pledge four, pledge six and pledge eleven.**

Learning Disabilities & Autism

Good progress has been made on reduction of inpatients to within target, and to date no surge has been noted in CYP admissions which happened on previous years at start of new school year. Progress against **pledge nine** in the Five year plan, to increase the numbers of people on LD registers with health checks and health action plans, continues to be on track for year end delivery.

Performance against Operational Plan

Standard	Plan	Actual	RAG	Confidence in recovery / Year-end delivery
LD Annual Health Checks – 75% of all people with LD aged of 14+ people will receive a health check with a Health Action Plan.	78%	1717 (33.44%)	On track	Historically, the majority of AHCs were completed in Q3-4. Efforts to complete more in Q1-2 are beginning to take effect, and achievement is ahead of last year at this time.
Reduce reliance on inpatient care for adults	30	*27*	Met	High
Reduce reliance on inpatient care for under 18's	3	*3*	Met	High
Overall Assessment	**No escalations to System Executive**			

Finance

Team	Scheme Name	Rag Rating	Plan	Actual / Forecast	Var	Confidence in delivery/mitigation
The programme is on track to spend allocation with no CIP attributed to this SDF						
Overall Assessment		**No escalation to Finance Committee**				

Quality & Equity

Issue	Escalation
There is inadequate community support for young people with autism.	ALERT – issue flagged previously, services under design but held due through business case processes
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. This is in support of **Pledge eleven**, Improve access to, experience of, and outcomes of care for children and young people; with a special focus on driving up health equity.
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
Over 1700 people have received a review of their medications in response to the STOMP/STAMP agenda, compared with less than 100 in recent years.	A significant number of young people are no longer taking unnecessary medications and reported measures show that this means their quality of life improves as a result. Prescribing costs have also reduced on psychotropic medications. This supports delivery of **pledge one** around health equity and **pledge eleven**, improving the experience of care for our young people.
Successful discharges in September have reduced the number of inpatients to within target. Inpatients managed within LLR now at only 13, the remainder are managed and funded by Insight provider collaborative – total 27 people.	Our patients have consistently told us that they wish to be cared for in an environment of their choosing – this process enables us to deliver this. More care delivered in the least restrictive environment supports more patients living in community, a commitment noted in **pledge seven** of the 5YP**.**

Maternity & Women's (Delivered through our LMNS & Women's Partnerships)

Maternity

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 sill birth, neonatal mortality, maternal mortality, and serious intrapartum brain injury.	TBC	MBRACCE extended mortality is more than 5% greater than expected.		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.	TBC	TBC		Workforce plan in place Vacancies rate currently 12.7 %
Increase access so at least 10% of LLR women can access specialist Perinatal Mental Health Services by 31st March 2024	1260 March 24	662 Sept 23	On track	High On track to meet 1260 (cumulative) March 2024 end
Overall Assessment	**No escalations to System Executive, escalations managed through quality and safety processes**			

Finance

Team	Scheme Name	Rag Rating	Plan	Actual / Forecast	Var	Confidence in delivery/mitigation
The programme is on track to spend allocation with no CIP attributed to this SDF						
Overall Assessment		**No escalation to Finance Committee**				

Quality & Equity

Issue	Escalation
Actions in relation to safety issues identified as inadequate in recent CQC report for LGH	ASSURE - We continue to work with the Trust, LMNS and NHSE to strengthen internal and external governance and escalation routes. The LMNS is supporting the Trust's plan in response to the findings of the CQC report and we will be working closely with them, with oversight

and LRI maternity services.	from NHS England, setting up a structured process, to make the improvements required. We have strengthened our senior clinical leadership by appointing a new DOM and additional HOM. In line with the National Quality Board Guidance: National Guidance on Quality Risk Response and Escalation in Integrated Care Systems, our proposal is 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. **Agreement to provide assurance to the QSG against each of the four themes of the SDP plan over the forthcoming months starting with Theme 1.**
Meet The 10 safety actions, (CNST)	ALERT - Progress continues to be made against the 10 safety actions. However, NHSE have alerted all LMNS's to assess the implications of the ongoing junior Dr's strike on achieving the MDT training requirements that may impact on the applicable CNST safety standard to which it relates for this year. LMNS will monitor.
Deliver Neonatal Critical Care Review recommendations (NCCR)	ALERT - Recruitment in place to attract AHP's and some posts have been filled. However, attracting the right workforce remains a challenge. Remains on the LMNS risk log.
Make significant improvements in perinatal mortality MBRACE report.	ASSURE - MBRACCE extended mortality is more than 5% greater than expected; this is consistent with other trusts providing neonatal surgery and congenital heart surgery. All perinatal deaths are reviewed using the nationally prescribed perinatal mortality review tool. We have undertaken external peer review of our approach (with Leeds Teaching Hospitals) and our use of the tool is consistent and robust. We work hard to understand as fully as possible the reasons behind all deaths. We are undertaking work with public health colleagues and others to build a deeper understanding of our population. A focused session taking place 7th November 23 looking at improving outcomes for LLR perinatal mortality. Public Health will lead this session.
Workforce in relation to maternity and neonatal capacity	Sept 23- we have 54 WTE Midwife vacancies, with 24 midwifes due to start in November 2023. Maternity workforce oversight group bi-weekly meetings commenced March 2023. A draft workforce plan is in development, which they plan to share shortly. It covers Maternity, Neonatal and medical focusing on Recruitment, Retention, Skill mix, Pastoral support, Empowering voices, Personal / Leaderships development.
Overall Assessment	**All escalations being managed through System Quality Group and aligned processes**

Transformation

Achievements (aligned to Step 4 of the NHS Impact framework)	Outcome for our patients / colleagues
LLR Maternity and Neonatal Voice Partnership (MNVP) now in place LLR Neonatal Voice Partnership (linked to the LLR MNVP) in development. LMNS collaboration with public health to help address equity.	Ongoing dialogue/engagement to improve services via co production leading to: • Higher service user satisfaction experience and access. • Improved outcomes for birthing persons and babies • Reduced perinatal mortal rates. • Improved outcomes in relation to best start in life

Women's Partnership

Our women's partnership will support the delivery of **pledge twelve** of the five-year plan as well as meet the strategic priorities set by NHSE and DHSC national teams. 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 and the wider system.

The operational plan sets out performance metrics for the programme and it is important to note that progress will be measured by the National Women's Health Hubs submission template and a local delivery plan.

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	January 24	On track	Women's Operational Delivery Group in place with Women's System Partnership being developed for January 2024.
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	*Ongoing process to ensure equity*	Ongoing	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	Some delay	High – Awaiting EM policy review outcome and has recently been delayed
Work with system leaders to agree local models for implementation of women's	March 24	March 24	On track	High – on track for delivery

health hub across LLR, to provide social, emotional and health support including sexual health, menopause, and social prescribing.				
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. Initial finance model completed in September 2023 with plans in place to expand upon these once hub process completed.

Quality & Equity

From a general 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.

Issue	Escalation
No issues sighted	
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
Women's Health Hub models in place to begin 1st January 2024 with service specifications in development (due to be finalised end of November) and sign-off from Strategic Commissioning Group.	Improved access for women in pilot areas with focus on reducing inequalities across LLR. Pilot sits in City, County and Rutland / Melton Women's Hub including a core offer of menopause, screening, and sexual health – Evaluation programme currently in development.
Continuation of Engagement – The Women's Programme Team and linking in with the LLR Winter Wellbeing Festival to promote opportunities for women in the workplace as well as an opportunity to gain views on their experience. Women's Engagement Strategy discussion in progress with ICB's Comms and Engagement plan.	Women feel valued in the workplace, supported to progress/develop and their specific needs to be understood. ICB system to be the employer of choice for women and be a role model for other employers.
Women's Health Summit took place in October which brought together colleagues from across the	Workforce and wider system are aware of the Women's Programme after its launch

system with presentations on the initiative in situ across LLR as well as defining plans for the programme moving forward.	and its aims to improve care for girls and women across LLR.
Shortage in donor sperm for fertility treatment approved by Clinical Exec in that a 12-month pathway pilot will be in place for patients at UHL.	Allowing couples to access fertility treatment and donor sperm (addressing the reduction in donor sperm across the country).

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

Standard	Annual Spend Plan	Forecast Outturn Year End	RAG	Confidence in recovery / Year-end delivery
System Cost Improvement Programme				
LPT prescribing efficiencies.	£267K	*On track*		High (within provider CIP plans)
UHL prescribing efficiencies	£1,062K	*On track*		High (within provider CIP plans)
ICB commissioned high-cost drugs efficiencies	£376K	*On track*		High
Additional savings opportunities	TBC	--		Medium
Overall Assessment	**No escalations to System Executive**			

At M07 the LLR Prescribing Budget is at significant risk (**10.6%)** of being overspent at the end of the financial year as the drivers of growth are mainly outside of our control due to nationally set NCSO and Cat M cost pressures and growth associated with the health prevention program.

A Medicines Optimisation report has been developed for the lipid pathway and will be shared with the relevant Delivery Partnership group for feedback. The purpose is to provide a discussion paper for Collaboratives in order to:

- Understand the affordability of fully implementing the pathway.
- Understand the evidence base.
- Understand implementation plans.
- Prioritise cohorts of patients
- Inform prescribing budget allocation.
- Identify opportunities for reducing costs as part of the pathway.
- Identify and mitigate risks.

Work continues across the system to understand, quantify, and forecast the position across the system in readiness for 24/25.

Quality & Equity

Issue	Escalation
1.Risk to AMR work (primary care) due to capacity. Clarification of reporting mechanisms for AMR (prescribing/ diagnostics and infection prevention) within the system. Capacity issues within Pharmacy/ medicine Op 2.Narrow NHSE focus working to targets. Resistance strains emerging at UHL. 3.National shortage of ADHD medicines will affect approximately 3000 patients in LLR including children. No feasible mitigations or alternatives available and pressure on LPT to provide advice. 4.Increase in referrals to private providers under Right to Choose legislation, especially for ADHD diagnosis and treatment. Risk if drugs supplied that would be under a shared care agreement as gap in usual patient pathway and pressure to prescribe. Potentially applies to other pathways. Potentially poor patient experience.	ALERT - Paper to go to SQG recommending future reporting mechanisms for AMR. Escalation to NHSE. Escalation to NHSE. Info to be shared with mental health and CYP Delivery Groups. Escalation to NHSE.
Progress against operational plan at risk due to pharmacy work force pressures against all sectors.	ALERT – being managed through individual organisations.
LLR prescribing of green inhalers is significantly behind the NHSE expectation (7.5% vs 25%)	ALERT – being managed through delivery group.
Overall Assessment	**All escalations being managed through System Quality Group**

Transformation

A paper has been circulated for comment to inform an LLR response to the National Medicine Optimisation opportunities 2023/24

Achievements (aligned to Step 4 of the NHS Impact framework)	Outcome for our patients / colleagues
Highest referral rate for CPCS in midlands region.	Our patients have told us through engagement that they want to be seen in the right place, at the right time – often this is a time which suits their lifestyle. **Pledge 4** of the 5YP refers to supporting people to access GP appointments and these pathway support both what patients have asked for and the pledge made.
NHSE support for community pharmacy independent prescribing pilot to support respiratory and CPCS in 4 community pharmacies.	
Community pharmacy service for EoL and Specialised medicines was at risk of not continuing. System-wide work undertaken to review efficacy of pathway which has resulted in commissioning of service.	This pathway is essential to those nearing the end of their lives – this will mean that our patients are more likely to receive the medication they need efficiently and effectively, without needing either an ambulance call-out or a conveyance to hospital.

	Integrating the service with our pathways means we are closer to delivering **pledge seven** of the 5YP, joining up our services to deliver care closer to home.

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 Neighbourhood Cafes (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	13,651 *June 23*	13,335 *June 23*	Within 5% tolerance	High Plans in place, key risks understood
Increase the number of adults and older adults accessing IAPT	6426 June 23	4985 June 23	Out of 5% tolerance	High Updated Recovery Action Plan being developed. Key risks understood.
5% increase in the know of adults and older adults supported by community mental health services	6,456 Target by Q1	12725 *May-23*	Met	High Plans in place, key risks understood
Eliminate out of area placements	0 Monthly Target	0	Met	High Plans in place, key risks understood
Recover the dementia diagnosis rate to 66.7%	66.7% Target by Q4	64.9% Aug -23	Within 5% tolerance	High Monthly improvement. Key risks understood
Improve access to perinatal mental health services	324 *(rolling 12 months)*	400 *(rolling 12 months)*	On track	High Plans in place, key risks understood
Overall Assessment	**No performance escalations to System Executive** **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 it is 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

The MH Partnership has raised no unmitigated risks.

From the programme perspective, 3 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 c.2 years. 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 both regionally and nationally with NHSE. LLR waiting times (c2yrs) are lower than many in the region, the highest is 10 years.	ALERT - EIA and QIA and clinical prioritisation undertaken. Monthly escalation to NHSE. Regional NHSE lead identified, and group established.
Future of ARRS: PCN concerns raised that ARRS funding will not continue in 24/25, leaving a gap in service provision within PCN's. No guidance issued from NHSE and further concerns that roles will be different.	ALERT – Escalation to primary care team for support. Request raised with NHSE for release of guidance.
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
Rutland MH Neighbourhood Group: The strategy "Rutland Neighbourhood Mental Health Strategy 2023 – 2027" and action plan was approved at the Rutland Health and Wellbeing Board on 10th October 2023. The aim of the strategy is to take preventative approaches by	Part of our work to deliver **pledge one** of five-year plan to tackle inequity and **pledge ten** to reduce inequity in access to mental health services in our neighbourhoods has been to work closer with our communities in each neighbourhood.

addressing the wider factors that influence mental wellbeing.	This will ensure that people with MH needs have responsive, high-quality services and support available in Rutland and the local area.
LLR Mental Health Collaborative Addressing Health Inequalities: A coauthored paper was approved by the LLR MH Collaborative on the approach being taken to address MH inequalities. The work involves a broad range of stakeholders operating at neighbourhood, place, and system level including people with lived experience.	Our insights data tells us that there is still much stigma around mental health across our communities. **Pledge two and Pledge ten** of the 5YP focus us on prevention and inequity and taking this consistent approach supports these pledges. By adopting consistent methods at Place, neighbourhood, and locality, to address MH inequalities, in line with the LLR System Inequalities framework, we will reduce premature mortality of people with Serious Mental Illness. Two out of three deaths of people with SMI are from physical illness, so this approach will aid the uptake of screening and lifestyle interventions.
The Joy platform: The rollout of the social prescribing platform called Joy has not begun across PCN's, starting in Charnwood. Blaby will follow this, then Lutterworth, Melton, Hinckley, Bosworth, and City East before the end of December. The system will put all the local support offers at the fingertips of GP staff and social prescribers, as well as being widely available to the public.	This system will better enable GP staff know what local services are available for people to access, delivering **pledge seven** of the 5YP, bringing care closer to people. Knowing there is a MH Neighbourhood café in their local area, or a VCSE organisation has a drop-in session, means people can get support quickly and easily, rather than experiencing the timely delay of a referral.
City Fuel Poverty & Health Programme: The main priority identified for the city MH place is around cost-of-living as we go into winter. Taking a focus on Fuel Poverty with Leicester Energy Action who are providing an advice service, outreach, training, and education, joined up with mental health support, commissioned by the public health team. **www.nea.org.uk/leicester-referrals/**	Part of our work to deliver **pledge one** of five-year plan to tackle inequity, **pledge 3** to support the frailest in our communities, and **pledge ten** to reduce inequity in access to mental health services in our neighbourhoods, has been to work closer with our communities in each neighbourhood and tackle some of the root causes of mental illness. **Case study:** Alex had nearly £1,000 of fuel debt and was referred to LEA by one of the community organisations. They could not afford to make a repayment offer that the supplier would accept. Alex is a single parent with a young child living in social housing. The LEA team worked with Alex around all their energy issues, including an application for fuel debt relief. This resulted in Alex being awarded enough to clear her arrears with a small surplus to put credit on their meter.

Planned Care Partnership (*covering Elective Care, Cancer & Diagnostics)*

Our planned care Partnership delivers **pledge eight** of the five-year plan to reduce waiting times for consultant led treatment. The cancer programme also supports **pledge two**, preventing illness through cancer screening and diagnostics.

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.	2,337 Sep 23	2,016 Sep 23	Met	Confidence in recovery to zero 65+ weeks remains high – main risks to activity are any future industrial action and impact of increased winter pressures. Monitored by NHSE Tiering. Variance to plan -5.4% A lower than plan position for Follow ups without a procedure is positive and aligns to the national ask to reduce Follow ups by 25%.
Deliver the system specific activity target (agreed through the operational planning process). Total elective and day case spells (Ops Plan E.M.10) Tolerance 5%	12,527 Sep 23	11,844 Sep 23	Not met	
Deliver the system specific activity target (agreed through the operational planning process) Follow up outpatient attendances without procedure (Ops Plan E.M.38)	49,766 Sep 23	44,050 Sep 23	Met	
Continue to reduce the number of 62 days waits for cancer. Sep	394 Sep 23	436 Sep 23	Within 5% tolerance	Confidence in recovery to fair shares and FDS delivery remains high – risks are OPA & surgical capacity to reduce the backlog and increase % performance. Monitored via NHSE Tiering.
Meet the faster diagnosis standard of 75%	75% Aug 23	72.5% Aug 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 2024).	67% Sep 23	73% Sep 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.	31,023 Sep 23	34,312 Sep 23	Met	Confidence in delivery is high.
Overall Assessment	**System performance against the operational plan remains relatively good despite the impact of Industrial action (IA). This is evidenced by improvement locally against the 65+ and 52+ trajectories and compared to peers. No escalations to System Executive**			

Finance

Team	Scheme Name	Rag Rating	Plan (£000)	Actual / Forecast (£000)	Var (£000)	Confidence in delivery/mitigation
PC	ERF income		11,951	21,300	9,349	Confidence in place.

PC	Cataract contract	CIP removed	392	0	0	Opportunity assessed and agreed as not viable for 23/24. Agreed by ODG/EMT as closed
PC	**Total**		**12,343**	**21,300**	**9,349**	
Overall Assessment		**Further opportunities continue to be assessed using GIRFT and Model hospital benchmarks. Improving productivity and outpatient provision across the system to increase activity is the biggest opportunity in H2 of 23/24. Ideas for 24/25 will include a review of contracts in place with providers to ensure good VFM – support from contracting and finance will be required.**				

Quality & Equity

The measures of quality in the Planned Care Partnership are yet to be established. 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
Performance - Industrial action has impacted on performance against plan and the 78+ week route to zero. The latter has now shifted to December 23, with 94 expected at the end of October and 28 at the end of November. Cancer capacity has been significantly affected (as is mirrored nationally), however this continues to be prioritised in terms of available capacity and re-booking of patients. Good progress continues to be made on reducing the 62-day backlog with a 59% reduction over the last 12 months and expected position to be under 400 by the end of October. There is a high degree of confidence in delivery of the fair shares target by March 2024. FDS has also improved and is expected to deliver in September at 75%. Next steps are to increase the proportion of 1st appointments offered within 7 days from 25% to 40% and increase urology op capacity. A benchmarking exercise will also be undertaken re Skin and FDS actions & trajectories by tumour sites are due by Mid-November. Reporting of cancer performance regionally and nationally now focusses on the combined position across 3 metrics: 62 day / 31 day and FDS. There is a real drive to move to delivery of the 85% 62-day standard which is reported via the Tier 2 programme.	The numbers of patients waiting for elective care for long periods of time is reducing, meaning that patients are being seen faster despite the impact of industrial action, delivering **pledge eight** of the 5YP.
LLR Community Capacity Plan – The capacity workstream will focus on opportunities within existing Community Hospital estate, utilising capacity or creating additional capacity through operational changes (e.g., 6-day working, extended session days, type of procedures undertaken, etc). Demand plans will be at PLACE level, working with leads to identify both met and un-met demand for City, County and Rutland. Initial data gathering has been completed, with visits to community hospitals to discuss opportunities with operational leads and a review of current activity and utilisation. The capacity plan will be complete by December in order to support and inform annual planning for 2024/25. Demand plans will be progressed alongside this, with alignment of demand and capacity plans by	The outputs of the work are centred around: 1. Understanding needs and plans at a PLACE base. 2. Utilising the community capacity as much as possible. 3. Opportunities for the future – aligned to public consultation. 4. Delivering best value for money from our assets.

March 2024. A methodology for the assessment of Value for Money will be developed to aid future decision making. Key points raised by partnerships members included: • Importance of early consideration of the impact on workforce. • Consolidation of services (e.g., focusing particular specialties in particular Community locations) helps mitigate workforce pressures, however strategies to deliver care closer to home need to be considered. • It will be important to discuss demand plans with Primary Care Networks (PCNs) to gain a good understanding of local population needs and existing referral pathways. • Patient pathways will need reviewing to support changes. The capacity intervention workstream has been established to lead this work. This group, chaired by the Director of System Planned Care, will include representatives from BI, Finance, Operational/ Clinical /Strategy and PLACE-based leads. In addition to and aligned to this work, the UHL Trust Leadership Team have discussed the need to take a strategic view on its future plans for elective services in the community hospitals. The aims and objectives of this work will focus on the wider principles UHL are working towards and will include the views of colleagues who work in those services currently across a range of professions. The timescale for this will be high level principles by the end of December and a draft strategy by the end of March 24.	5. A strategy for UHL in the community hospitals.

Urgent and emergency care – (*delivered by our UEC 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 pledges have yielded sustained improvement, evidenced in the performance metrics below.

Performance against Operational Plan - September 2023

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 2024 (Type 1 activity only)	68.50%	56%	Target not met	Low Variability remains high and risk of de-stabilisation through Winter
Improve Category 2 ambulance response times to an average of 30 mins across 2023/2024	30:00m	36m 17s	Target not met	Medium Variability remains high and risk of de-stabilisation through Winter
Reduce General and Acute bed occupancy to 92% or below	91.1%	89.7%	Target met	Medium Variability remains high and risk of de-stabilisation through Winter
Overall Assessment	**System executive to note the variability of performance and interlink with financial position**			

Finance - CIP

Team	Scheme Name	Rag Rating	Plan	Actual / Forecast	Var	Confidence in delivery/mitigation
Acute	Contract / pathway changes	CIP at risk	11,990	11,023	(967)	Low Variance is against patient transport contract. Further work to do on plan to recover
Overall Assessment	The gap against the CIP attributed to UEC remains under assessment and will be driven by the Interim UEC Director via escalation to Chief Finance Officers for support					

Quality & Equity

Two unmitigated issues have 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	ALERT – Escalated to System Quality Group to support review of actions and trajectory, with clinical support provided as needed. - A UHL Action Plan has been developed and shared with the Acute Care Collaborative. - A trajectory plan has been submitted and signed off as a part of the Winter Plan. The trajectory ambition is to achieve 4% by March 2024 in line with the KPMG Midlands Region Review and agreed targets. - September 2023 position was 11.14% against a plan of 5.8%.
Increase in incomplete discharges for complex patients. August 61% September 55% October 59%	ALERT – October discharge data shows an increase in incomplete discharges. Various discharge improvement workstreams in place at UHL. Themes identified include increase in delays in; - Patient choice (3%-6%) - Patients awaiting medical reviews - TTO delays - Equipment delays due to late ordering or lack of next of kin availability for delivery - Families unwilling to support discharges for Covid positive patients A deep dive into the above themes identified, whilst patients were involved with discharge planning, they are often unhappy with placement location and placement selection. UHL are currently reviewing the discharge booklet and communication that is shared with patients. UHL are currently undertaking a deep dive into patients awaiting medical reviews. Await next steps and timeline.
Change in discharge process causing delays for County Adults	ADVISE – Increase in delays for patient awaiting County ASC support. Additional panels now in place, there are currently no patients awaiting panel review. Delays are due to: Mental Capacity Assessments (MCAs) – this task was previously completed by UHL. However, as the final discharge decision maker is no longer UHL and is ASC, the task falls to ASC to complete. As per MCA core principles, this is not a one-off assessment, and the patient required to have multiple visits to determine capacity. As UHL completed MCAs previously, it was often ward staff or discharge sisters that were already in the area. Whilst ASC completing the task is correct and this is good practice, unfortunately it is also creating delays. As we now have the IDT involved in early decision making there is delay with arranging face to face meetings due to the MDTs availability. There has been a recent change in care home behaviour. City and County both report reluctance from care homes to take patients with complexity.
Overall Assessment	**System Quality Group to support both concerns raised**

Three projects have been identified to support improvements in equity outcomes:

1. High frequency homeless patients, including mental health presentations, in the LRI Emergency Department.

The regional accelerator meetings have finished, and a project group is being established to

- Agree a process for the identification of different patient cohorts.
- Undertake a baseline review of activity.
- Meet twice monthly to progress a programme of work.

2. Outreach for high frequency high complexity COPD patients.
3. Wider support for CAMHS patients in ED.

These will report progress through this report in Q3 and Q4.

Transformation

Achievements (aligned to Step 4 NHS Impact programme)	Outcome for our patients / colleagues
County HART (reablement services) taking an additional 20 patients a week into the service. This is an increase from original demand modelling.	This model provides the service user to receive reablement care in their own allowing them to maintain independence for as long as possible. Access to RRR reduces long term deconditioning resulting in a reduction in long term care demands. This supports delivery of **Pledge three** of 5YP, to identify the frailest in our communities and wrap care and support around them.
LPT report and increase in patients returning to their own home after a community hospital stay. Increase in patients returning to their own home from LPT. Increase from 65% to 69%.	Positive outcomes for patients that are receiving Intermediate Care support. Long term positive effects include reduction in deconditioning and improving hospital flow.
Same day discharge improvements for Community Hospitals. August 77% September 74 % October 79%	Safe a timely discharge enables positive outcomes for patients, reduces deconditioning and improves patient flow. Integrating the service pathways also delivers **pledge seven** of the 5YP, the provision of joined up, holistic care across our system.
100% of ward receiving onsite support from City ASC via ICRS and reablement.	This is key to delivering **pledge seven** of the 5YP – our patient / carer feedback is that they would like to be more involved in discharge planning – this supports patients and families being involved earlier in discharge planning and face to face MDT reviews allow for a more robust review of patient's needs. This 'one team' ethos also supports **Pledge thirteen** of the 5YP – to shape our people and services around the needs of people by building a one team culture to maximise the people potential of the LLR population. Excellent staff feedback: • Onsite MDT working has significantly improved relationships.

	• Face 2 face IDT working had reduced patient hand offs between partners. • Working this was helps us understand system wide risks, both financial and quality. • This method allows up to deliver person centred care and support. • We have seen better working relationships by reducing organisational boundaries. Patient/family feedback: • I feel involved in my care. • Having a full conversation means I do not need to repeat myself as I have done previously.
EMAS 999 call taking process – transition from AMPDS to NHS Pathways across 8th and 15th November 2023	A bulk re-upload of LLR GP practice profiles back onto the LLR Directory of Services ("DoS") to support an improved patient signposting process. Confirmation from EMAS to General Practice of the introduction of Post Event Messaging ("PEM") for the sharing of clinical information from a 999 call to the registered GP practice.
ED Streaming to community -based services at Oadby UTC, Westcotes Extended Access Hub, Merlyn Vaz UTC and Merlyn Vaz Out of Hours Clinic	Our patient feedback has shown that patients are willing to go to another site if hey know they have a booked appointment or can be seen quicker. ED streaming began as a result of winter pressures but is now becoming part of our normal pathways to support overcrowding and patient experience in the ED. Thus far this year, 1,933 patients have been streamed to Oadby, 3,519 to Westcotes EA Hub and 2,424 to Merlyn Vaz UTC/OoH supporting **pledge six** of the 5YP, to reduce waiting times in the ED.

Community Care – (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%	93% *October*	Met	High
Meet 80% occupancy for virtual ward by September 2023	80%	*87% October*	Met	High
Overall Assessment	**No escalations to System Executive**			

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	BCF, discharge funding, community SDF		600	800	200	High Slippage will support system baseline
Overall Assessment		**No escalation to Finance Committee Finance Committee to note that slippage from virtual and physical plans will be supporting the system deficit; however, with no specific funding for winter available, this may be required in Q4 to sustain quality, safety, performance, and flow. Above CIP identified within ICB finances; this is outside the reported LPT position.**				

Quality & Equity

An issue has been raised through the Community Care Partnership which may impact on quality and outcomes:

Issue	Escalation
Leicester City Council's occupational therapist waiting list has reached 1300 cases. This is owing to the volume of assessments needed.	ALERT- Therapies workstream (LPT and LA) to support review of actions and trajectory, with clinical support provided as needed. - LPT and LA action plan is being developed and will be shared at the next Community Care Partnership. The workstream are discussing how they own waiting pressures as a system to help reduce backlog.
Overall Assessment	**System Quality Group to support concern raised once action plan completed**

Transformation

Achievements (aligned to Step 4 of the NHS Impact framework)	Outcome for our patients / colleagues
Increase in Virtual Ward occupancy to from 30% in April 23 to 87% in Sept 23 with an increase in patients admitted onto VW (step up/down). Supporting earlier discharge and avoiding acute admission.	This quality improvement programme supports our patients to be treated in the place they call home, without unnecessary ambulance and hospital conveyance. It empowers our population to manage their own condition but with an evidence-based support pathway and a safety net for crisis – all of which have been requested by our staff and our patients repeatedly through our insights work. This programme supports the delivery of multiple pledges in the 5YP – **pledge three** to support our frailest, **pledge seven** around holistic care and **pledges five and six** focussed on ambulance response times and the four-hour standard. Further work around equity of service provision, taking into account digital access and literacy will be reported in the next report. A patient engagement event demonstrated positive patient experience and our clinical teams are reporting increased confidence with the services.
Strengthened our end-of-life provision, resulting in a 25% increase in hospital discharges for this cohort	This supports the ICB pledges around 'right patient, right time, right place' and will support appropriate flow across the system in readiness for winter 2023/24
As part of our joint carers strategy a pilot has commenced to discover and support	These carers have been able to access the right support at the right time, supporting them to live fulfilled lives' while still being able to care for their

carers. 7000 carers have been identified with support being offered.	loved ones. This has been a clear ask from our carer's group; action now is to grow this pilot further to include equity assessments given the growing needs of our communities.
Strengthened our work in Charnwood through integrated neighbourhood teams to look at social determinants and impact for asthma and chronic kidney disease. Recognised by regional MD of primary care and public health and are planning to visit.	Improves access and reduces health inequalities, as per **pledges one and two** of the 5YP. The programmes are providing earlier interventions, self-management opportunities, and community-based treatment and recovery pathways for these patients.

Long Term Conditions

Our Long Term Conditions Partnership will support the delivery of **pledges one, two and three** of the five-year plan which includes 1) Improving the health of our most deprived communities and narrow the gap between those who have the best and the worst health; 2) spending more money on preventing people becoming ill in the first place; 3) identifying the frailest in our communities and wrap care and support around them. Through the earlier identification of people at risk of developing a LTC and the optimisation of people with one or more long term conditions, we will help to reduce health inequities.

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	67.43%*		Further work needed to validate local data. 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	61.67% = 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**			

*New data sources have been used this month which has led to a change in reporting. Previously local data sources have been used. This month, data is taken from the national website 'CVD Prevent' for Q1 23/24.

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 because 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.

From a programme perspective three key finances issues have been highlighted, that are impacting on delivery of projects. Two have already been flagged.

Issue	Action to date	Escalation
System Development Funding is provided on an annual basis and needs to be spent in year which makes longer term planning difficult	Support requested from LLR Delivery Partnership in September and October 2023. Issue raised with new CFO	ALERT - mechanism to allow SDF projects to run across financial years to allow full year effect
Return on investment analysis for our Cardiovascular Prevention programmes shows better health outcomes for people, as well as financial savings for the system. However, the increased prescribing spend outweighs any potential savings	LTC Steering Group working closer with Business Intelligence and Medicines Optimisation Team to unpack findings. Delivery Partnership made aware September 2023. Issue raised with new CFO	ADVISE – to note risk for future discussion
Stability of LTC Project Team with a team member starting a secondment January 2024 and three other roles on secondments.	Secondments secured until March 2024. Exercise to review roles across the wider I&T teams following vacancy holds.	ALERT – to note risk for future discussion.

Quality & Equity

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

Issue	Action to date	Escalation
The provider of our **type 2 diabetes structured education and behaviour change programme**, Oviva, are overperforming on capacity commissioned.	Teams have discussed referral activity with the provider and are working with the Contracts Team to better understand causation for oversubscription and options. 30% of City population has English as second language but only 3% uptake of Oviva service.	ALERT – Contracts Team to confirm if cost pressure has been identified.
Not achieved full practice sign up to the **Diabetes Enhanced Service** by 31 August 2023	Practices supported by ICB and Diabetes Mentors. 89 practices (70%) are now accredited to deliver Diabetes Enhanced Service following a year of upskilling and training. 38 practices have not been accredited.	ALERT - Options appraisal prepared for ODG 14th November 2023 to mitigate any resulting inequity in service provision across LLR
Delays in recruitment for the **Familial Hypercholesterolaemia** service, as well as reduced staffing model as 1 ICB has	Regional Team leading, overall model being hosted by Nottingham University Hospital. Advert going through vacancy approval panel, still awaiting advertisement.	ALERT - Potential reduction in service offer Risk to long term patient outcome will need to be understood, with mitigations in place

withdrawn, increasing costs to LLR		
National shortage of pharmacological element for **Tier 3 Weight Management Service**	Not available until start of the next financial year. Some pharmacotherapy elements are available through clinical trials and potential for a limited supply to become available which will be prioritised. Meanwhile, other elements of the programme are being bolstered.	ADVISE – To note risk to service provision
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
89 practices are now accredited to offer a **Diabetes Enhanced Service**	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. Supports **pledges one and two**
The **Integrated Chronic Disease programme** (pilot) has • LUCID clinics set up for 11 PCNs. • 65% of practices have received education sessions	Part of our work on equity. Through 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. Supports **pledges one, two and three**
A grant application for an **Atrial Fibrillation** detection project has been approved by NHSE, subject to remaining funding being available.	Part of our work on equity, this programme will help reduce inequalities in detection, diagnosis, and management of AF through opportunistic screening, public awareness campaigns and educational sessions. Supports **pledges one and two**
Our partnership with Interface Clinical Services, to manage the **COPD** backlog of reviews during the Covid pandemic, has been shortlisted for the national Pharmaceutical Market Excellence Awards (PMEA) awards.	Part of our work on equity, the project prioritised patients with COPD at high risk of exacerbations and poor health outcomes. Through pharmacist-led remote reviews, the COPD backlog was reduced by 41% in 7 weeks. Supports **pledges one and two**

Primary Care – delivered via our 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	80.9% Sept 23	Not achieved	High Although plan not achieved, an increase of 11% compared to same month las year (68K more appts)
Continue on trajectory to deliver more appts in general practice by March 2024	671,739	686,851 Sept 23	Within 5% tolerance	
Continue on trajectory to recruit additional roles (ARRS) by end of March 2024	497	590 Aug 23	Achieved	Two months behind due to claims process
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 additional funding		1,041	1,041	0	High
Primary Care	Primary Care SDF		133	133	0	High
Overall Assessment						

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
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 ASSURE – Following further meetings between ICB, LA and Practices, as no EOI were received in response to the

	procurement, the current model will remain, and primary care providers will continue to deliver the service for 2024/25. Future planning will become part of Place plans and neighbourhood developments. No escalation
General Practice Funding Model	ALERT – There is risk that re-costing of phlebotomy and wound care community-based services will exceed the current financial envelope. T&F groups have been established to work through costings ASAP in preparation for proposal to SCG in January for approval. Any cost pressures will be highlighted and with recommendations and associated risks. No escalation
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
A Community Health and Wellbeing workshop was held for Leicester City 'place' in October. The reps included PCNs, Voluntary Sector, LPT, Public Health and Local Authority and feedback to date has been positive. The purpose of the session is to support collaborative working and strengthening relationships to support integration.	The event was an opportunity to develop relationships across health and care and share experiences of where integrated working is improving outcomes and experience as well as building new networks for staff groups outside their own organisation. This will support delivery of the ambitions within Fuller and locally **Pledge 3 –** wrap around care for the frailest in our communities and **Pledge 7**– proving more joined up, holistic and person-centred care from the 5YP.
PCNs are progressing delivery of Capacity Access Improvement Plans (CAIP). Many are focussing on the improving digital access which includes website focus groups to improve functionality and ensure it is user friendly, education for using NHS App and the use of social media. The outcomes will be monitored via dashboard and shared with PCNs. The monthly drop-in session will provide opportunity to share learnings and review the improvements. In September, there was **3,899** logins on NHS App – a **13% increase** from the previous month.	A key ambition locally and nationally is to empower our people to confidently take control of their health care. Digital services such as the NHS App is key to this as it enables patients to securely access clinicians, personalised health information and book appts to better manage their conditions. LLR PCNs are embracing this fully by working with their patients to ensure accessibility and usability locally which supports overall access and experience. This supports delivery of **Pledge 4 –** access to routine GP appts.
Working in collaboration with the ICB contracts team, the Contracts Assurance Self-Assessment has been sent out to **18** practices for completion. To support the 'fragility' agenda under the resilience and sustainability (R&S) workstream, additional questions have been added to provide practices opportunity to raise issues around estates, finance, and workforce. This intelligence will allow primary	As we head into winter, it is important that we support our practices to be resilient and remain sustainable, now, and in the future. We have processes in place to proactively identify and support practices to ensure they can continue to deliver safe and optimal quality of care for our population. This supports delivery of **Pledge 4 –**

care workstreams to **proactively** engage with practices and provide support to mitigate risk/impact to core service delivery. Feedback to date has been positive from practices on the self-assessment and responses are due back mid-November.	access to routine GP appts and **Pledge 13 –** our people.
All 26 PCNs have submitted Health Inequality Plans which are linked to their CAIP. The key focus areas include MH, Long Term Conditions, Cancer Screening, Women's Health and improving lifestyle and preventing chronic conditions. During the next month, the plans will be reviewed further with the PCNs, and reporting arrangements will be in place to monitor outcomes based on the interventions proposed.	As an ICB we are committed to reducing health inequalities across our programmes of work and in particular, general practice. We can use data and local intel to target specific patient cohorts who are at greatest risk of poor health outcomes and deliver services to meet their needs and prevent onset/deterioration of ill-health. This work will be a key driver to delivering **pledge 1**, **9, 10, and 11** in the 5YP which all focus on improving inequity in our population.
As of Sept 2023, 64,462 Enhanced Access hours have been delivered in LLR since October 2022 by 26 PCNs. This is in addition to the appointments delivered at practice level. 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.
96% of practices delivering against the benchmark of 75/1000 clinical contacts against a plan of 75% (Aug 23)	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
37% of same day appointments delivered against an England average of 42% (Aug 23)	
76% of face-to-face appointments delivered against a plan of 70% (Sept 23)	

Name of meeting:	**Leicester, Leicestershire, and Rutland Integrated Care Board – meeting in public**		
Date:	14 December 2023	**Paper:**	**G**
Report title:	**Finance Report month 7 2023/24**		
Presented by:	R D Toole Chief Finance Officer		
Report author:	Spencer Gay, Deputy Director of Finance (System).		
Executive Sponsor:	R D Toole Chief Finance Officer		

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

Recommendations:

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

- **RECEIVE and NOTE** the financial position as at month 7 and the forecast performance.
- **RECEIVE for assurance.**

Purpose and summary of the report:

The overall year-to-date (YTD) LL&R Health system position is a deficit of £(70.9)m which is £(48.3)m adverse variance to the YTD £(22.5)m plan.

UHL have reported a YTD deficit of £(44.5)m [(£22.7)m adverse variance to plan], LPT have reported a YTD deficit of £(0.7)m (in line with plan), whilst the ICB have reported a £(25.6)m YTD deficit (£25.6m adverse variance to its break-even £0m plan).

The system has a £(10)M Deficit plan for 23/24; UHL £10.0m deficit; both LPT and LL&R ICB to be £0m / break-even.

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 experienced both to date e.g. Industrial Action and on-going related to inflation, demand and prescribing costs, the ICS will be unable to achieve the £(10)m planned deficit.

We are undertaking work collectively and in conjunction with NHSE colleagues to provide an assessment of a realistic out-turn forecast for the year given the financial pressures being faced by the NHS both locally and nationally.

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 with 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 7 2023/24

14th December 2023

Month 7 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)	(22,540)	(70,876)		(10,002)	(10,002)	
System Revenue expenditure not to exceed income	3,083,489	3,154,365		5,262,928	5,272,929	
System Capital expenditure not to exceed allocations	52,707	29,398		113,881	111,689	
System Operates within Cash Reserves	85,266	73,962		115,305	114,506	
ICB Running Costs Allocation not to be exceeded *(included within system position)*	11,891	9,874		20,385	17,403	
ICB Primary Care Co-Commissioning Allocation not to be exceeded *(included within system position)*	116,078	119,327		199,055	202,364	
ICB Newly Delegated Allocation not to be exceeded *(included within system position)*	56,280	55,593		95,842	95,842	
System CIP delivery	67,574	51,641		142,569	133,094	
System Better Payment Practice code % NHS invoices paid within target (£)	95%	95%		95%	95%	
System Better Payment Practice code % NHS invoices paid within target (number)	95%	91%		95%	91%	
System Agency spend within ceiling				45,392	55,521	
ICB MHIS spend requirement to meet target				189,313	189,450	

Revenue

2. **The system is reporting a year-to-date deficit of £(70.9)m which is £(48.3)m worse than plan**, (UHL £(22.7)m adverse variance and ICB £(25.6)m variance against plan). The position reflects pressures relating to industrial actions, unfunded inflation, prescribing growth, and efficiency delivery lower than plan.

3. All system partners are taking action to mitigate risks, strengthen financial controls and deliver increasing levels of financial efficiency as the year progresses. Given the financial pressures being experienced related to inflation, industrial action, demand and prescribing costs, the ICS will be unable to achieve the £(10)m planned deficit.

4. The system has planned **efficiencies** of £142.6m, Month 7 work confirmed we were forecasting £133m delivery (£51.6m 36% of plan achieved year to date). Work undertaken

more recently to highlight and confirm mitigation plans in place means we are expecting full delivery by the end of the year – this position is expected to be reflected in our Month 8 report.

Capital

5. Operating capital spend is currently below plan by £12.5m with a year-to-date actual spend of £17.2m, however, the system is anticipating full spend by year-end.

6. The plan against national schemes has been adjusted to reflect £8.5m of UEC schemes which will now not be received by the system but include within the forecast a further £7.7m anticipated capital against Diagnostic capability, Endoscopy capacity and the New Hospital programme. The end-of-year forecast variance for national schemes is a £2.2m underspend.

Other Indicators of note

7. **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 specialities.

8. **Better Payments Policy** expectation across all public sector organisations is to pay creditors in a timely manner (within 30 days):-

   ICB is achieving the cumulative standard of 95% of invoices (both in value and volume).
   UHL is cumulatively at 82% in relation to the numbers of NHS invoices (non-NHS at 96%)
   LPT is cumulatively at 91% in relation to the numbers of NHS invoices (non-NHS at 97%).

9. 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 cash usage across all partners. There is no system for transferring cash between partners without the raising of invoices. LPT is currently holding above-plan cash balances and is expected to be in line with planned cash reserves by the end of the year, while UHL is slightly below plan on both accounts. The ICB is as required maintaining a minimal end-of-month cash balance.

10. 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 has taken action to ensure underspend against Running Costs.

Conclusion

11. As a system at month 7, we have reported an in-year deficit of £(70.9)m against revenue budgets. The ICS will not achieve a £(10)m Deficit Plan at year end without significant additional funding.

12. Operational capital spending is forecasting a breakeven position with National programme capital spend expected to underspend by £2.2m.

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

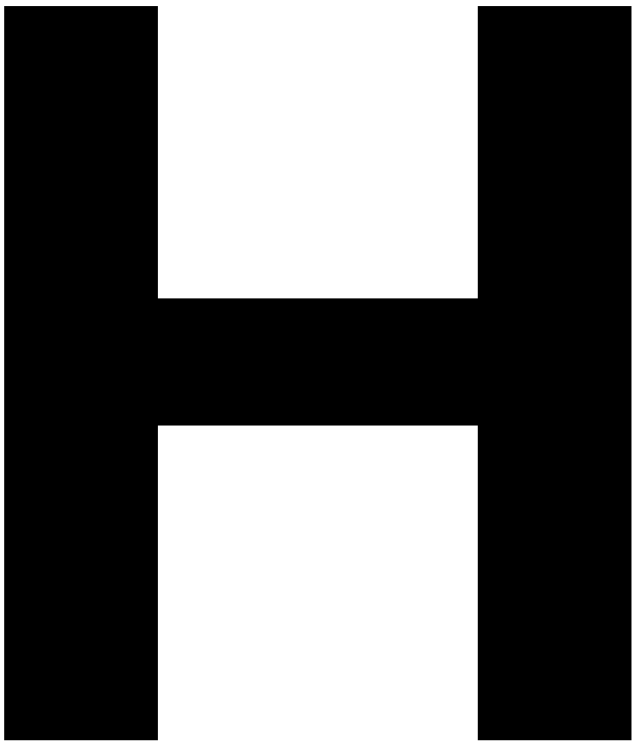
14. The cash position remains largely positive across the system, there is some concern that cash could become a problem if financial recovery and mitigation plans do not deliver as expected in the second half of the year – this will be monitored closely.

15. All system partners are taking action to mitigate risks, further strengthen financial controls as well as deliver increasing levels of financial efficiency as the year progresses.

16. We are undertaking work collectively and in conjunction with NHSE colleagues to provide an assessment of an achievable forecast for the year given the financial pressures being faced by the NHS both locally and nationally.

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

- **RECEIVE and NOTE** the financial position as at month 7 and the forecast performance.
- **RECEIVE for assurance.**



Name of meeting:	**Leicester, Leicestershire and Rutland Integrated Care Board – meeting in public**		
Date:	**14 December 2023**	**Paper:**	**H**
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 Jeffrey Worrall, Non-Executive Director from University Hospitals of Leicester NHS Trust		
Sponsor:	R D Toole, Chief Financial 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 LLR Integrated Care Board is asked to:

- **RECEIVE** the report for assurance.

Purpose and summary of the report:

1. This report provides a summary of the key areas of discussion and outcomes following the meeting of the **ICB Finance Committee** held on the **29 November 2023**.

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

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

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

Conflicts of interest screening		**Summary of conflicts** *(detail to be discussed with the Corporate Governance Team)*
☒	No conflict identified.	No conflicts of interests were identified in relation to this report.
☐	Conflict noted, conflicted party can participate in discussion and decision	

☐	Conflict noted, conflicted party can participate in discussion but not in decision	
☐	Conflict noted, conflicted party can remain in meeting but not participate in discussion or decision.	
☐	Conflict noted, conflicted party to be excluded from the meeting.	
Implications:		
a) Does the report provide assurance against a strategic risk(s) e.g. risk aligned to the Board Assurance Framework, risk register etc? *If so, state which risk and also detail if any new risks are identified.*		Aligned to BAF financial sustainability risk.
b) Does the report highlight any resource and financial implications? If so, provide which page / paragraph this can be found within the report.		Revenue and Capital risks highlighted for 2023/2024.
c) Does the report highlight quality and patient safety implications? If so, provide which page / paragraph this is outlined in within the report.		None specifically in relation to this report.
d) Does the report demonstrate patient and public involvement? If so, provide which page / paragraph this is outlined in within the report.		None specifically in relation to this report.
e) Has due regard been given to the Public Sector Equality Duty? If so, how and what the outcome was, provide which page / paragraph this is outlined in within the report.		Not specifically in relation to this report, however, the principles are contained with the Constitution and governance arrangements.

Assurance Report from the ICB Finance Committee

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

Key area discussed at the Committee meeting	Level of assurance (RAG)	Rationale for level of assurance	Risk(s) / issue(s) to escalate where required
1. ICS System Financial Report for Month 7 2023/24 – Revenue, capital, efficiency schemes and POD	**RED**	The Finance Committee received the M07 ICS System Finance position including an update on revenue, capital, efficiency schemes and the POD delegation. The Finance Committee were not assured because of the emerging risks and overall YTD deficit of £(70.9)m which was an adverse variance of £(48.3)m against the plan. The system partner risks of not achieving breakeven for the year are listed below: • UHL - £ (44.5) m • LPT - £0m • ICB - £ (15.6) m	There is a significant risk of the LLR system not achieving the year end plan out-turn.
2. ICB Finance Report Month 7 2023/24	**RED**	The Finance Committee received the M07 ICB financial position which was a deficit of £25.6m. Detail was provided around the financial position and risks highlighted within the efficiency plan with further detail provided in the 5-Year Financial Strategy update.	There is a significant risk of the ICB not achieving the year end plan out-turn.
3. 3 Year Capital Plan – Update on Process	**RED**	The Finance Committee received an update on the development of the 3 Year Capital Plan being developed via the Strategic Capital Planning Group. Pertinent points to note were: - • A system level top slice will be allocated to fund strategic system capital schemes; • A consistent prioritisation and risk process is being developed that will be used by organisations within the ICS; and • A draft list of schemes will be produced and presented to finance committee in January and then taken to System Executive.	There is a risk that the capital allocation for LLR over the next two years would not be sufficient enough to deliver all schemes.
4. 5 Year Financial Strategy	**RED**	The Finance committee were presented the 5 Year Financial Strategy report which provided an update against the refreshed medium term recovery plan and the implications of financial pressures for 2023/2024 and 2024/2025.	
5. LLR System Delivery Partnership Month 7 Report	**AMBER**	The Finance Committee received the LLR System Delivery Partnership report for M07. Performance had been holding well against key metrics and activity was performing well in terms of contracted activity and work done in triangulating this back in terms of productivity.	

6. ICS Estates Infrastructure Policy	**AMBER**	The Finance Committee were informed that the ICB have been tasked by NHSE to update and provide a revised ICS Estates Strategy. Work is underway to engage with all stakeholders, a further update will be brought to the Finance Committee at the end of Q4.	
7. Prescribing – Oversight and Assurance	**RED**	It was reported that the LLR Prescribing Budget is at risk of being overspent at the end of year by 10.6%. The Finance Committee were assured that the forecast additional costs / overspend was due to financial allocations attributed to improvements for long term conditions, mental health, and women's health. Further efficiencies are being considered and sought to minimise the variance from original budget.	
8. ICB Risks and Issues Log Month 7	**N/A**	The Finance Committee received the ICB Risks and Issues Log for M07. There were no risks closed for M07, however, minor amendments were shared for information.	

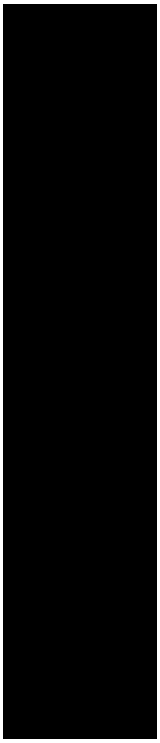
Key for level of assurance:

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 – meeting in public**		
Date:	14 December 2023	**Paper:**	I
Report title:	**Assurance Report from the System Executive**		
Presented by:	Dr Caroline Trevithick, Chief Executive LLR ICB and Chair of the System Executive		
Report author:	Charlotte Gormley, Corporate Governance Officer		
Sponsor:	Dr Caroline Trevithick, 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 27 October 2023, 17 November 2023, and 24 November 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 20.

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 27 October 2023, 17 November 2023, and 24 November 2023. The report also covers items for escalation and consideration by the Board ensuring that it is alerted to emerging risks or issues.

Strategy and Planning

2. The **Children and Young People (C&YP) Local Mental Health Transformation refresh 2023/24** was approved for publication on the LLR ICB website. The plan was previously known as Future in Mind and summarised the CYP Transformation Programme, in addition to the system's ambitions over the coming year. The Communications and Engagement Team would assist in promoting the plan via social media.

3. The System Executive received the **LLR ICS Green Plan – Report on Progress** and approved proposed changes to the Green Plan actions. Particularly, it was noted that the Take AIR pilot had not received national funding to continue. As such, alternative schemes for the safe recycling of inhalers would be explored, which would potentially require some financial investment.

4. Following a review of **Reinforced Autoclaved Aerated Concrete (RAAC) in LLR Health Estate,** results provided assurance that essential health care provision would not be disrupted by the presence of RAAC.

5. **Hearing and Balance Engagement (part of the UHL Reconfiguration / Our Future Hospital Programme)** - the Hearing and Balance service was not within the scope of the Reconfiguration Programme at the time of the public consultation held in 2020. An engagement exercise regarding relocation of the service was therefore completed. Survey results highlighted that patients were largely unaware of a number of community outreach facilities. The facilities would be further publicised to address this. The proposal would be taken to the Health Overview Scrutiny Committee (HOSC) for information in December 2023.

6. The System Executive approved the **LLR ICS Cyber Strategy and joint Cyber Information Security Officer (CISO) proposal.** The CISO post would be split 60/40 between LLR ICB and Northamptonshire ICB and would be hosted by Leicestershire Partnership NHS Trust. An associated financial risk would also be split 60/40 and included within the planning assumptions for both LLR ICB and Northamptonshire ICB.

Operational performance assurance

7. An **Update on the ICB 2023/24 Financial Position at month 6 (September 2023)** identified that the system year to date (YTD) deficit at month 6 was £62m, which was an adverse variance from plan of £40.4m. All organisations were taking steps to minimise variation through strengthened financial controls and efficiencies.

8. **Update on the ICB 2023/24 Financial Position at month 7 (October 2023)** identified that the system year to date (YTD) deficit at month 7 was £70.9m, which was an adverse variance from plan of £48.3m. This position would inform the refresh of the 2023/24 Plan.

9. **Presentation on required confirmation of Operational Plans - performance metrics and measures (including associated risks and opportunities) and actions to get back to the Operational Plan's financial outcome of a £(10)m deficit** - a letter had been received from

NHS England on 8 November 2023, requesting that each ICB set out its plans to achieve the financial position detailed in their 2023/24 Operational Plan whilst maintaining and achieving critical capacity and performance measures. An extraordinary meeting of the System Executive was held on 17 November 2023 to begin developing LLR ICB's response.

10. **2024/25 Operational Planning Update and LLR ICB 5-Year Plan Refresh Process** - planning parameters, the approach to investment and disinvestment, and the role of collaboratives had been agreed. Key risks and mitigations were identified. A development session would be held in December 2023 to determine the strategic intent of the 2024/25 Operational plan.

11. National guidance was not yet available to inform the 5YP annual refresh. Updates were expected in the areas of finance, workforce, and any key changes to programme areas.

12. The **LLR Delivery Partnership – October briefing** reported on the progress made against the Operational Plan at month 6 (September 2023). Highlights included positive performance in talking therapies and perinatal health, whilst Urgent and Emergency Care metrics remained a concern moving towards winter. All other metrics were in line with plan. Waiting times in the neurodevelopmental pathway were raised as a key area of focus.

13. The **LLR Delivery Partnership – November briefing** reported on the progress made against the Operational Plan at month 7 (October 2023). Focus remained on the delivery of agreed Cost Improvement Plans (CIP) and preparation for 2024/25 financial planning. It was noted that additional assurance meetings had been implemented with the East Midlands Ambulance Service (EMAS) to support the performance trajectory and work had been completed on the impact of SDF reductions.

14. An **Update from System Capital Group** identified that the 2024/25 capital envelope would be less than the depreciation incurred by organisations. It was proposed that a top slice of 15% be taken from the capital allocation and prioritised to fund strategic system capital schemes. A draft list of strategic system capital schemes would be completed by January 2024. The remaining funds would be allocated to organisations based on depreciation, enabling organisations to prioritise their own risk. It was agreed that a consistent prioritisation and risk process would be used by all organisations to allocate capital funding.

15. The System Executive received the **Urgent and Emergency Care (UEC) Collaborative – update and proposed principles,** outlining opportunities agreed through the UEC Partnership. It was noted that a Memorandum of Understanding (MOU) would be taken through each Executive Team prior to the System Executive Committee meeting in December 2023.

16. The **Outcome Letter from Quarter Two Review Meeting** noted continued positive improvement in a number of areas. Overall financial position, nursing workforce, and the quality of care in UHL Maternity services remained the key areas of challenge. Segmentation scores were confirmed as level three for the ICB, level four for UHL, and level two for LPT. The next Quarterly System Review Meeting would take place on 26 January 2024.

17. The **Emergency Planning, Resilience and Response (EPRR) Update** provided assurance regarding LLR ICS's levels of compliance with EPRR statutory requirements. All organisations accepted the results of the core standards process and plans were in place to address areas of non-compliance.

Other decisions including business cases, procurements and contracts:

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

    a. Following the **Local Resilience Forum (LRF) Funding Review,** the System Executive approved the proposal to increase the LRF contribution from University Hospitals of Leicester NHS Trust (UHL), Leicestershire Partnership NHS Trust (LPT) and LLR ICB to a total of £42k. The split between the three organisations remained to be agreed.

    b. **NHS England Letter – Transition from Tier 1 to Tier 2 for Cancer and Elective –** it was noted that the positive step for UHL reflected a significant reduction in long waits, confidence in the leadership team, and delivery of improvements over the last 17 months. It was agreed that current processes would remain in place as work remained to be done in terms of reducing waiting lists, with an aim to leave tiered arrangements by early 2024.

    c. The System Executive approved the **VCSE Getting Help in Neighbourhoods (GHiN) Mental Health Grant Scheme – Re-issue of Round 2 Grant Awards** as committed within the 2023/24 Mental Health Financial Plan.

    d. The System Executive approved the **Digital Enhancements to the LLR System Coordination Centre.** NHS England had approved non-recurrent funding to support LLR with the purchase of the full SHREWD Resilience software package. The procurement of SHREWD products would follow the G-Cloud 13 national process with a financial risk of recurrent spend in the future.

    e. The System Executive supported the recommendations regarding **Access to primary care and urgent care services in Leicester Leicestershire and Rutland post 1 April 2024** for onward approval by the Board.

    f. The **East Midlands Assisted Fertility Policy Review Update** highlighted that the initial report provided by Arden and Greater East Midlands Commissioning Support Unit (AGEM CSU) did not meet a number of the agreed specifications. Further work was required, and the review timeline would be extended by three months.

19. Regular assurance reports were received from the Strategic Commissioning Group and Clinical Executive Group.

Summary of assurance from the Committee

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

Key area	Level of assurance	Rationale for level of assurance	Risk(s) to escalate where required
1. Strategy and planning	**Amber**	• The Children and Young People (C&YP) Local Mental Health Transformation refresh 2023/24 was approved for publication on the LLR ICB website. • Proposed changes to the LLR ICS Green Plan actions were approved. As the Take AIR pilot for safe recycling of inhalers did not receive national funding to extend, alternative schemes would be explored that may require financial investment.	N/A

		• Appointment of a joint Cyber Information Security Officer (CISO) presented a potential financial risk for 2024/25. The risk would be split 60/40 and included within the planning assumptions for both LLR ICB and Northamptonshire ICB.	
2. Operational performance assurance	**Red**	• The financial position of the LLR ICB was highlighted as a challenge. • Urgent and Emergency Care metrics heading into winter and neurodevelopment pathway waiting times were highlighted as areas of concern. • A consistent prioritisation process would be used by all organisations to allocate capital funding. • Plans were in place to address all areas of non-compliance for Emergency Preparedness, Resilience and Response. • The December development session of the System Executive would determine the strategic intent of the 2024/25 Operational Plan.	N/A
3. Other decisions including business cases, procurements and contracts	**Amber**	• The LRF contribution from UHL, LPT and LLR ICB would increase to £42k. The split between the three organisations remained to be agreed. • Positive news was received that UHL would Transition from Tier 1 to Tier 2 for Cancer and Elective Care. • The procurement of SHREWD products as required under the new System Co-ordination Centre (SCC) specification may present a financial risk due to the need for recurrent funding. • Recommendations for access to primary care and urgent care services in LLR post 1 April 2024 were supported for onward approval by the Board. • The timeline of the East Midlands Assisted Fertility Policy Review had been extended by three months. This delay presented opportunity for challenge against aspects of the current policy.	N/A
4. 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.

J

Name of meeting:	**Leicester, Leicestershire and Rutland Integrated Care Board meeting**		
Date:	**14 December 2023**	**Paper:**	**J**
Report title:	**Assurance Report from the ICB Quality and Safety Committee**		
Presented by:	Pauline Tagg, Non-Executive Member - Quality, Safety and Transformation		
Report author:	Tamara Hazell, Corporate Governance Officer		
Sponsor:	Dr Nil Sanganee, Chief Medical Officer		

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

Recommendations:

The LLR Integrated Care Board is asked to:

- **RECEIVE** the Assurance Report from the ICB Quality and Safety Committee

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 **2 November 2023**. The report also covers items for escalation and consideration by the Board ensuring that the Board is alerted to emerging risks and issues.

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

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

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

Conflicts of interest screening		Summary of conflicts *(detail to be discussed with the Corporate Governance Team)*
☒	No conflict identified.	No conflicts of interest 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.*	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**	**Good Practice** The Committee were advised of good practice following a primary care visit to The Limes Medical Centre who had demonstrated themselves as a high performing practice.	NA
	GREEN	**Assure** The Committee were assured that risks were being escalated to the System Quality Group and mitigations were being tested and monitored appropriately.	N/A
	AMBER	**Advise** Digital risks relating to GP letters on SystemOne were added to the SQG risk log. Since October 2023 however, the risk had been closed as the SQG were assured around patient safety risks being fully mitigated.	N/A
	RED	**Alert** 1. The ICB had been given approval to oversee the UHL Maternity CQC response of 'Required Improvement' that was received in February 2023. 2. Low performing elements from the GP Patent Survey would see various actions taken through the primary care infrastructure. 3. A Bronze cell would be set up to develop an action plan around paediatric audiology. 4. Issue identified by PCL of pathology results being sent to unmonitored electronic inboxes.[1]	[1]Mitigating actions implemented to ensure a move to electronic systems and awareness raised for areas requiring a digital resolution.
Maternity Services Quality Assurance Report – Engagement	**GREEN**	The Committee received a focus and assurance report against one of the four themes outlined in the NHSE Maternity and Neonatal Services Delivery Plan. Theme 1 focused on – Listening to and working with women and families with compassion. The Committee were assured of the positive work on the maternity strategy.	N/A
LLR Delivery Partnership Report	**RED**	**Escalation** • There were some emerging risks around the number of military and temporary families coming into LLR. These were being quantified through safeguarding and operational discussions. • Emerging risks linked to discharge pathways and processes being reviewed across health.	N/A
Update from Public and Patient Involvement Assurance Group	**AMBER**	The Committee received an update from the PPIAG from the September 2023 meeting. Two programme areas were reviewed looking at emerging key themes for – Children, Young People and Families Voice on Health Care across LLR and the National GP Patient Survey 2023. The Committee agreed to two deep dives looking at the CYP accessing dentistry and the national challenges of the PODs and a deep dive around CAMHS and the emerging risks to neuro-developmental assessments.	N/A
ICB Board Assurance	**AMBER**	The Committee received the BAF 2023/24 update with specific focus on BAF risk 5 relating to quality and safety.	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
Framework 2023/2024 update and LLR System Quality Risk Log		The residual risk score for BAF risk 5 had remained at 16. A future deep dive session would look at this BAF in more detail to understand how the BAF had been described and whether mitigations in place were robust enough to reduce the residual score.	

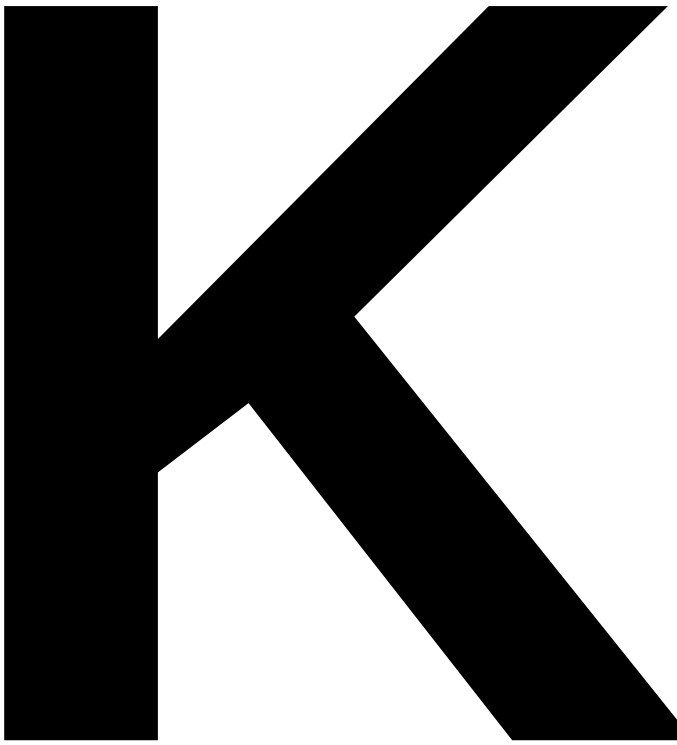
Key for level of assurance:

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:	**14 December 2023**	**Paper:**	**K**
Report title:	**Assurance Report from the ICB Audit Committee**		
Presented by:	Darren Hickman, Non-Executive Member and Chair of Audit Committee		
Report author:	Tamara Hazell, 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 **17 October 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. Committee Effectiveness Reviews	**GREEN**	The Audit Committee received the effectiveness reviews conducted by all Board sub-committees, including the Strategic Commissioning Group, and were assured that all actions had been implemented.	**None.**
2. External Audit Update	**GREEN**	The Audit Committee noted the outcome of the Value for Money work as well as the final External Auditor's Report for period ending 21 March 2023. The committee were advised that the work for 2022/23 was concluded and a certificate of completion of the audit and intentions for 2023/24 would be issued.	**None.**
3. Internal Audit Progress Report	**GREEN**	The Audit Committee received the Internal Audit Progress report for 2022/23 and 2023/24 Internal Audit Plans, which provided significant assurance against the 2022/23 plan. The Head of Internal Audit Opinion 2023/24 Stage One work was completed with no formal findings. The committee approved a change in focus to Continuing Healthcare for Children, focusing on the ICBs' preparedness for Liberty Protection Safeguards implementation.	**None.**
4. Environmental Sustainability Governance	**GREEN**	As part of the 2022/23 Internal Audit Plan, Environmental Sustainability Governance received an opinion of significant assurance.	**None.**
5. Counter Fraud and Security Progress Report	**GREEN**	The Audit Committee were assured of the sufficient controls and management mechanisms were in place to mitigate fraud, bribery and corruption risks.	**None**
6. Audit Follow-Up Progress Report	**GREEN**	The Audit Committee were assured of the actions implemented following both internal and external audit reviews.	**None**
7. ICB Board Assurance Framework 2023/24 Update	**GREEN**	The Audit Committee received the current ICB BAF 2023/24 with an update on the ongoing review of risk management arrangements.	**None**
8. Business Continuity Plans Assurance Report and Post Testing Outcome	**GREEN**	The Audit Committee received the outcome of the testing exercise that was carried out in June 2023 and assurance against the Business Continuity Plans.	**None**.
9. Losses and Special Payments	**GREEN**	There were no losses and special payments received during the period up to September 2023.	**None.**
10. Waiver of Standing Orders	**GREEN**	Three Waiver of Standing Orders were received for period July to October 2023.	**None.**
11. Pharmacy, Optometry and Dental primary (POD) care Delegation Assurance Process	**GREEN**	The Audit Committee were assured of the governance arrangements in place for the delegation of PODS and primary care complaints procedures for LLR and the East Midlands region.	**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.

Name of meeting:	**Leicester, Leicestershire and Rutland Integrated Care Board meeting**		
Date:	14 December 2023	**Paper:**	**L**
Report title:	**Assurance Report from the ICB Health Equity Committee**		
Presented by:	Professor Azhar Farooqi, Non-Executive Member - Health Inequalities, Public Engagement, Third Sector and Carers, LLR ICB		
Report author:	Imran Asif, Corporate Governance Officer, LLR ICB		
Sponsor:	Sarah Prema, Chief Strategy 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 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 **17 October 2023**. The report also covers any 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. Health Inequality Support Unit – Progress Report	**GREEN**	The committee received an update on progress made by the Health Inequality Support Unit (HISU) against the Core 20 Plus 5 metrics for adults and children and young people.	**None.**
2. Health Inequality Support Unit – Cancer Update	**AMBER**	A report was shared which detailed the LLR ICB's performance against cancer outcomes and inequalities. The committee noted that the cancer data provided was informative and requested a coherent strategy to be developed by the cancer design group.	**None.**
3. Workforce Assurance	**GREEN**	The committee received a summary position of the ICS workforce profile, which included programmes of work that related to health equity and inequality.	**None.**
4. Overview from Leicestershire Partnership NHS Trust	**GREEN**	The committee received an update against the LPT programme of work designed to address health inequalities which included the development of the Health Inequality Framework and its Social Value Charter.	**None.**
5. LLR Delivery Partnership Report	**AMBER**	The committee received the LLR Delivery Partnership Report for September. The report included a section on quality and equity for each partnership.	**None.**
6. ICB Board Assurance Framework Update Report	**N/A**	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.

M1

Meeting title:	LLR Integrated Care Board					
Date of the meeting:	14 December 2023					
Title:	Performance Assurance report - UHL					
Report presented by:	Richard Mitchell, UHL CEO					
Report written by:	Becky Cassidy, UHL Director of Corporate and Legal Affairs					
Action – this paper is for:	Decision/Approval		Assurance	X	Update	
Where this report has been discussed previously	UHL Trust Board 9 November 2023					

Purpose of the Report

At the request of the ICB, this report provides the key assurances in relation to performance at UHL.

Recommendation

The ICB should receive the report noting the assurances provided.

Main report detail

Summary of UHL Performance: SEPTEMBER 2023

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

Urgent & Emergency Care **Updates on** **Flow in** **Flow through** **Flow out** 	In September 2023 we saw an increase in overall ED attendances (Types 1 to 3) with 2,083 more attendances than the previous month. Type 1 attendances were significantly increased from August; seeing an average of 80 more attendances per day and Type 3 attendances saw an average of 26 more attendances per day. 4-hour performance for September 2023 was 70.6% (ranked 70th out of 124), a noticeable deterioration from 74.3% the previous month (ranked 53rd out of 124). While Type 1 & 2 (combined) performance is still below the new national target of 76% we can see that the LLR performance continues to be very close to achieving it. Ambulance handovers remain strong with sustained improvement. 12 hour waits in ED remains challenged. An action plan is in place, and this is being monitored through UEC Steering Group. The key actions around this are the additional capacity and discharge improvements which will result in improved flow. We continue to look at internal improvements and have set up a task and finish group to review waiting times for diagnostics and develop an action plan

	to address this. We are also developing our same day emergency care pathways to ensure patients can access the right care in the right place. Improvement in discharge pathways is progressing, LLR continues to be ranked the best performing in the region in terms of discharge metrics; 11/11 being the best. The higher rankings are against the % of adult beds occupied by patients who do not meet criteria to reside (CTR), and 7-, 14- and 21-day Length of Stay (LOS). A key focus remains the utilisation of the additional capacity in the system and community beds.
Elective Care **Referrals and Outpatient performance** **Elective activity** **Pathway Improvements** 	Continue to be at zero 104 week waits, forecasting to be at 98 78 week waits at the end of October (due to the impact of Industrial Action), seeing a steep downward trend on the 65 week and 52 week waits. A significant administrative validation exercise has taken place this month. Across the week and a half, the RTT team reviewed 9,841 pathways, identified due to common pathway recording errors, and closed 7269 of them, a removal rate of 73.8%. The overall waiting list size for UHL and Alliance sites combined fell by 6639, with a combined waiting list size last achieved in January and February 2022. UHL continue to be part of the GIRFT Further Faster pilot group and have been successful in receiving £80k revenue to support specific projects to improve performance. Initial impact of this funding has been beneficial in completing first appointments and reducing the long term follow up backlog. Challenges remain in improving PIFU numbers, although we are starting to see improvements following the action plan put in place to address performance (Focus on PIFU month). We have also developed specialty level targets based on GIRFT best practice.
Cancer **Referrals** **2 week wait** **Faster Diagnosis Standard** **62-day referral to treatment** 	Sustained improvement in the >62 day overall, noting some impact from industrial action on recovery. 62 day backlog is still on track to deliver the Trust's fair share commitment of no more than 309 patients waiting by 31/03/24. 2ww appointments delivered within 7 days has seen a further improvement, which will support FDS and 62 day backlog. 28 days Faster Diagnosis Standard metric improved in August and is forecast to deliver in September. From October the 10 constitutional standards for cancer will reduce to three; 28 Day Faster Diagnosis Standard (FDS), 62 Day Combined (to include Upgrades and Screening) and 31 Day Combined. Work on recovery plans continues, to reduce the 62 day backlog and improve FDS. There will be particular focus to improve time to first seen to support delivery of FDS and 62 day.

Quality 	Plans to launch a UHL PALS service in October 2023 are on track and the separation of the complaints and Patient Safety functions and recruitment into a dedicated new Complaints Lead post will support the overall responsiveness in managing the complaints process We continue our Harm Free Care Quality Improvement Programmes to reduce hospital acquired infections and hospital acquired pressure Ulcers. Our Exemplar Programme is continuing to undertake Quality Assurance Visits across the Trust, currently focusing on Maternity, Paediatrics & Emergency Care.
Finance 	The Trust is reporting a year-to-date deficit at Month 6 of £41.8m which is £20.9m adverse to plan. The main drivers for this are Industrial Action, Inflation above plan and undelivered CIP. The Trust has reported a year-to-date cash releasing CIP delivery of £14.7m against a £17.3m CIP target. The Trust committed gross capital expenditure of £25.5m in the year to 30th September, which nets down to £22.8m, after deducting charitable donations and the net book value of assets disposed. The cash position at the end of September was £33.8m, representing a reduction of £17.4m in the month.
Workforce 	There have been a number of changes to our vacancy position with a decrease in adult nursing vacancies from 7.1 to 5.3%. Another positive outcome this month is related to non-maternity healthcare assistant vacancy levels which have decreased to 13.1% evidencing the work which is taking place to strengthen our recruitment pipeline and reduce agency activity in this area. Retention remains a priority and we continue to see the positive impact of our programmes of work as the Trust's turnover rate for September 2023 has reduced further to 7.1% and is sitting within the Trusts target of 10%. The percentage of staff who have received an annual appraisal has increased slightly by 0.8% and remains an improved position from April 2023. This is below the agreed KPI levels but is being worked through with CMGs. Staff compliant with mandatory training has decreased slightly but this is not considered to be significant and is a known consequence of recent operational pressures. An amber rating remains in place and KPIs continue to be monitored through Trust Performance Review meetings.
Transformation & Productivity **Key Overview** **e.g Urgent and Emergency Care, Elective, digital, Estates etc**	Elective Care The below interventions are to support increased capacity in both outpatients and theatres to see more New OPD, decrease follow ups by 25%, deliver 3.5% PIFU, increase day case utilisation, reduce OTDC to 5%: • First only waiting list initiatives, to ensure the 65 week cohort have had their first appointment • Established digital validation with year to date 20,000 patients being safely removed from the waiting list • DNA Florey's providing a quantitative view of reasons for DNA with a plan to tackle 23% of DNAs due to not knowing about appointments and improve our overall DNA rate

	• Consolidation of Text reminders to one provider and improving our overall performance in outpatients and inpatients • Pre-Operative digital Questionnaires being introduced to improve OTDC • Further work and improvement required with the offer of PIFU

M2

X

Leicestershire Partnership NHS Trust

Trust Board – 28.11.23

Board Performance Report October 2023 (Month 7)

Purpose of the report

To provide the Trust Board with the Trust's performance against KPI's for October 2023 Month 7.

Analysis of the issue

The report is presented to Executive Management Team each month, prior to it being released to level 1 committees.

Proposal

The following should be noted by the Trust Board with their review of the report and looking ahead to the next reporting period:

- The Clinical Supervision exception page has been removed after performance indicated an improvement in SPC assurance analysis in last month's BPR and shown that the metric will either achieve or miss the target due to random variation
- An anomaly in the recording of part two of CQUIN 15a (i.e. paired PROM) has been identified and the 3% reported in Qtr. 1 has been updated. The ability to separate out the paired proms from the paired overall is not feasible at this moment in time but remains a priority for finding a solution to aid reporting.
- The Agency Costs exception page is retained in the report at the request of EMB to allow for exceptional monitoring outside of the standard SPC rules for generating an exception page.

Decision required

The Trust Board is asked to

- Approve the performance report

Governance table

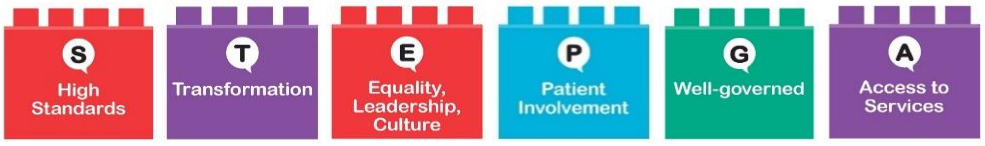
For Board and Board Committees:	Trust Board	
Paper sponsored by:	Sharon Murphy, Director of Finance and Performance	
Paper authored by:	Prakash Patel, Head of Information	
Date submitted:	20.11.23	
State which Board Committee or other forum within the Trust's governance structure, if any, have previously considered the report/this issue and the date of the relevant meeting(s):	N/A	
If considered elsewhere, state the level of assurance gained by the Board Committee or other forum i.e. assured/ partially assured / not assured:	None	
State whether this is a 'one off' report or, if not, when an update report will be provided for the purposes of corporate Agenda planning	Standard month end report	
STEP up to GREAT strategic alignment*:	High **S**tandards	
	Transformation	
	Environments	
	Patient Involvement	
	Well **G**overned	x
	Reaching Out	
	Equality, Leadership, Culture	
	Access to Services	
	Trustwide Quality Improvement	
Organisational Risk Register considerations:	List risk number and title of risk	69 - If we do not appropriately manage performance, it will impact on the Trust's ability to effectively deliver services, which could lead to poor quality care and poor patient experience
Is the decision required consistent with LPT's risk appetite:	Yes	
False and misleading information (FOMI) considerations:	None	
Positive confirmation that the content does not risk the safety of patients or the public	Yes	
Equality considerations:	None identified	

Leicestershire Partnership NHS
NHS Trust

Trust Board
28 November 2023

Board Performance Report
October 2023 (Month 7)

The metrics in this report relate to the following bricks in the Step Up to Great Strategy



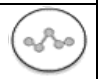
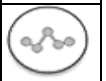
NHS
Leicestershire Partnership

EXCEPTION REPORTS SUMMARY

EXCEPTION REPORTS - Consistently Failing Target

Indicator	Monthly Target	Data As At	Current Reporting Period	Previous Reporting Period	SPC Assurance	SPC Trend
Adult CMHT Access (Six weeks routine) - Complete pathway	>=95%	Sep-23	50.9%	53.5%		
Adult CMHT Access (Six weeks routine) - Incomplete pathway	>=95%	Sep-23	45.1%	49.2%		
Memory Clinic (18 week Local RTT) - Complete pathway	>=92%	Sep-23	33.0%	36.5%		
Memory Clinic (18 week Local RTT) - Incomplete pathway	>=92%	Sep-23	68.8%	66.7%		
ADHD (18 week local RTT) - Complete pathway	>=95%	Sep-23	14.3%	9.1%		
ADHD (18 week local RTT) - Incomplete pathway	>=92%	Sep-23	0.1%	0.7%		
CINSS (20 Working Days) - Complete Pathway	>=95%	Sep-23	38.8%	45.2%		
Continence - Complete Pathway	>=95%	Sep-23	14.3%	16.3%		
Children and Young People's Access (13 weeks) - Incomplete pathway	>=92%	Sep-23	52.0%	45.6%		
Community Paediatrics (18 weeks) - Complete pathway	>=92%	Sep-23	40.5%	41.0%		
Adult Autistic Spectrum Disorder (without a Learning Disability) Assessment Clinic (Aspergers) (18 weeks) - Complete pathway	>=95%	Sep-23	90.0%	53.8%		

Indicator	Monthly Target	Data As At	Current Reporting Period	Previous Reporting Period	SPC Assurance	SPC Trend
6-week wait for diagnostic procedures - Incomplete pathway	>=99%	Sep-23	35.8%	36.6%		
Dynamic Psychotherapy - No of waiters	0	Oct-23	10	11		
CAMHS - No of waiters	0	Oct-23	397	355		
All LD - No of waiters	0	Oct-23	10	8		
Community Paediatrics - assessment waits over 52 weeks - No of waiters	0	Sep-23	1834	1729		
Safe staffing - No. of wards not meeting >80% fill rate for RNs - Day	0	Oct-23	3	2		
Vacancy Rate	<=10%	Oct-23	19.4%	20.6%		

EXCEPTION REPORTS - Consistently Achieving Target						
Indicator	**Monthly Target**	**Data As At**	**Current Reporting Period**	**Previous Reporting Period**	**SPC Assurance**	**SPC Trend**
Average Length of stay - Community Hospitals	**<=25**	**Oct-23**	**21.8**	**20.5**		
Gatekeeping	**>=95%**	**Oct-23**	**100.0%**	**97.9%**		
Normalised Workforce Turnover (Rolling previous 12 months)	**<=10%**	**Oct-23**	**8.3%**	**8.1%**		
Core Mandatory Training Compliance for substantive staff	**>=85%**	**Oct-23**	**96.0%**	**95.8%**		
Staff with a Completed Annual Appraisal	**>=80%**	**Oct-23**	**86.8%**	**86.3%**		
% of staff from a BME background	**>=22.5%**	**Oct-23**	**27.1%**	**26.8%**		

EXCEPTION REPORTS MATRIX SUMMARY

		Assurance		
		Achieving Target 	**Inconsistently Achieving Target** 	**Not Achieving Target** 
Variation/Trend	**Special Cause - Improvement** 	Normalised Workforce Turnover (Rolling previous 12 months) Core Mandatory Training Compliance for substantive staff Complete Appraisal % of staff from a BME background		*Waiting Times* : AASD / LD
	Common Cause 	Average Length of stay - Community Hospitals Gatekeeping		*Waiting Times:* Adult CMHT (Complete/Incomplete) / Memory Clinic (Complete/Incomplete) /ADHD (Complete) / CINSS / Community Paediatrics (Complete) / DPS 52 Wks Safe Staffing
	Special Cause - Concern 			*Waiting Times:* ADHD (Incomplete) / Continence / CAMHS Access / Diagnostics / CAMHS 52 weeks / Community Paediatrics 52 wks assessment Vacany Rate

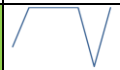
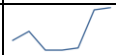
SUMMARY

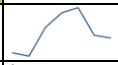
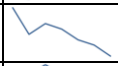
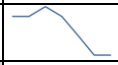
WORKFORCE						
Indicator	Monthly Target	Data As At	Current Reporting Period	Previous Reporting Period	SPC Assurance	SPC Trend
Normalised Workforce Turnover (Rolling previous 12 months)	<=10%	Oct-23	8.3%	8.1%	P	L
Vacancy Rate	<=10%	Oct-23	19.4%	20.6%	F	H
Sickness Absence (in arrears)	<=4.5%	Sep-23	5.1%	5.2%	?	
Agency Costs	<=£2,432,000	Oct-23	£2,522,962	£2,604,396	?	

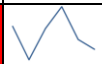
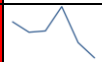
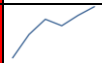
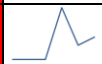
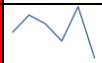
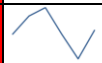
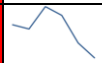
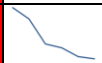
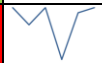
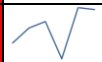
QUALITY & SAFETY						
Indicator	Monthly Target	Data As At	Current Reporting Period	Previous Reporting Period	SPC Assurance	SPC Trend
Serious incidents		Oct-23	0	0		L
Safe staffing - No. of wards not meeting >80% fill rate for RNs - Day	0	Oct-23	3	2	F	
Safe staffing - No. of wards not meeting >80% fill rate for RNs - Night	0	Oct-23	1	1		

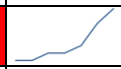
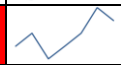
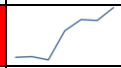
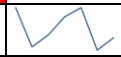
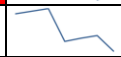
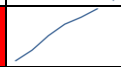
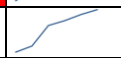
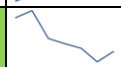
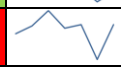
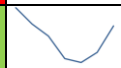
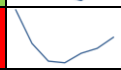
FINANCE (Metrics TBC)

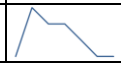
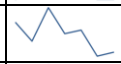
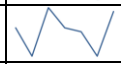
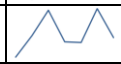
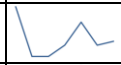
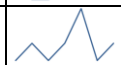
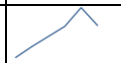
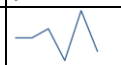
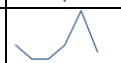
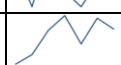
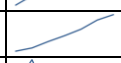
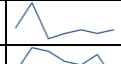
Board Performance Report
Summary Dashboard

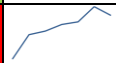
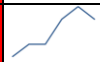
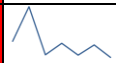
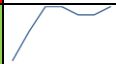
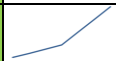
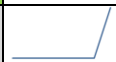
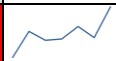
Section	Source	Reporting Frequency	Indicator	Monthly Target	Data As At	Current Reporting Period	Previous Reporting Period	Sparkline YTD	SPC Assurance	SPC Trend	Exception Report
Quality Account	TRUST	Monthly	The percentage of admissions to acute wards for which the Crisis Resolution Home Treatment Team (CRHT) acted as a gatekeeper during the reporting period	>=95%	Oct-23	100.0%	97.9%				
	TRUST	Yearly	The Trusts "Patient experience of community mental health services" indicator score with regard to a patient's experience of contact with a health or social care worker during the reporting period		22/23	6.6	6.4				
	TRUST	Monthly	The percentage of inpatients discharged with a subsequent inpatient admission within 30 days - 0-15 years		Oct-23	0.0%	0.0%				
	TRUST	Monthly	The percentage of inpatients discharged with a subsequent inpatient admission within 30 days - 16+ years		Oct-23	5.4%	7.2%				
	TRUST	Monthly	The number of patient safety incidents reported within the Trust during the reporting period		Oct-23	1377	1384				
	TRUST	Monthly	The rate of patient safety incidents reported within the Trust during the reporting period		Oct-23	66.6%	66.3%				
	TRUST	Monthly	The number of such patient safety incidents that resulted in severe harm or death		Oct-23	14	10				
	TRUST	Monthly	The percentage of such patient safety incidents that resulted in severe harm or death		Oct-23	1.0%	0.7%				
	MHSDS	Monthly (a quarter in arrears)	72 hour Follow Up after discharge (Aligned with national published data)	>=80%	Jul-23	79.0%	82.0%				
CQUINS		Quarterly	CQUIN01: Staff flu vaccinations	Min- 75% Max- 80%							
		Quarterly	CQUIN12: Assessment and documentation of pressure ulcer risk	Min- 70% Max- 85%	Q2	74.3%	71.7%				
		Quarterly	CQUIN13: Assessment diagnosis and treatment of lower leg wounds	Min- 25% Max- 50%	Q2	60.2%	60.6%				
		Quarterly	CQUIN14: Malnutrition screening for community hospital inpatients	Min- 70% Max- 90%	Q2	75.0%	76.6%				
		Quarterly	CQUIN15a: Routine outcome monitoring in community mental health services - Paired Overall	Min- 20% Max- 50%	Q2	10.8%	13.6%				
		Quarterly	CQUIN15a: Routine outcome monitoring in community mental health services - Paired Prom	Min- 2% Max- 10%	Q2	Not Known	Not Known				
		Quarterly	CQUIN15b: Routine outcome monitoring in CYP and community perinatal mental health services	Min=20% Max=50%	Q2	20.2%	27.0%				
		Quarterly	CQUIN16: Reducing the need for restrictive practice in CYPMH inpatient settings	Min=70% Max= 90%	Q2	100.0%	100.0%				
		Quarterly	CQUIN17: Reducing the need for restrictive practice in adult/older adult acute mental health inpatient settings	Min=75% Max= 90%	Q2	94.1%	94.9%				

Section	Source	Reporting Frequency	Indicator	Monthly Target	Data As At	Current Reporting Period	Previous Reporting Period	Sparkline YTD	SPC Assurance	SPC Trend	Exception Report
NHS Oversight	TRUST	Monthly	2-hour urgent response activity	>=70%	Oct-23	82.8%	83.7%				
	TRUST	Monthly	Daily discharges as % of patients who no longer meet the criteria to reside in hospital		Oct-23	23.0%	23.6%				
	CCG	Monthly	Reliance on specialist inpatient care for adults with a learning disability and/or autism		Oct-23	24	26				
	CCG	Monthly	Reliance on specialist inpatient care for children with a learning disability and/or autism		Oct-23	3	3				
		Monthly	Overall CQC rating (provision of high quality care)		2021/22	2					
		Monthly	CQC Well Led Rating		2021/22	2					
		Monthly	NHS SOF Segmentation Score		2022/23	2	2				
	NHSE	Monthly (In Arrears)	Potential under-reporting of patient safety incidents - Number of months in which patient safety incidents or events were reported to the NRLS		Aug-23	Not Published	Not Published				
	MHRA	Monthly	National Patient Safety Alerts not completed by deadline		Oct-23	0	0				
	TRUST	Monthly	MRSA Infection Rate		Oct-23	0	0				
	TRUST	Monthly	Clostridium difficile infection rate		Oct-23	0	1				
	UHL	Monthly (In Arrears)	E.coli bloodstream infections		Sep-23	0	0				
			VTE Risk Assessment								
	GOV	Monthly	Percentage of people aged 65 and over who received a flu vaccination		Feb-23	80.8%	80.4%				
			Proportions of patient activities with an ethnicity code								

Section	Source	Reporting Frequency	Indicator	Monthly Target	Data As At	Current Reporting Period	Previous Reporting Period	Sparkline YTD	SPC Assurance	SPC Trend	Exception Report
Access Waiting Times - DMH	TRUST	Monthly (In Arrears)	Adult CMHT Access (Six weeks routine) - Complete pathway	>=95%	Sep-23	50.9%	53.5%				
	TRUST	Monthly (In Arrears)	Adult CMHT Access (Six weeks routine) - Incomplete pathway	>=95%	Sep-23	45.1%	49.2%				
	TRUST	Monthly (In Arrears)	Memory Clinic (18 week Local RTT) - Complete pathway	>=95%	Sep-23	33.0%	36.5%				
	TRUST	Monthly (In Arrears)	Memory Clinic (18 week Local RTT) - Incomplete pathway	>=92%	Sep-23	68.8%	66.7%				
	TRUST	Monthly (In Arrears)	ADHD (18 week local RTT) - Complete pathway	>=95%	Sep-23	14.3%	9.1%				
	TRUST	Monthly (In Arrears)	ADHD (18 week local RTT) - Incomplete pathway	>=92%	Sep-23	0.1%	0.7%				
	TRUST	Monthly (In Arrears)	Early Intervention in Psychosis with a Care Co-ordinator within 14 days of referral	>=60%	Sep-23	70.0%	46.2%				
Access Waiting Times - CHS	TRUST	Monthly (In Arrears)	CINSS (20 Working Days) - Complete Pathway	>=95%	Sep-23	38.8%	45.2%				
	TRUST	Monthly (In Arrears)	Continence - Complete Pathway	>=95%	Sep-23	14.3%	16.3%				
Access Waiting Times - FYPCLD	TRUST	Monthly (In Arrears)	CAMHS Eating Disorder (one week) - Complete pathway	>=95%	Sep-23	100.0%	100.0%				
	TRUST	Monthly (In Arrears)	CAMHS Eating Disorder (four weeks) - Complete pathway	>=95%	Sep-23	100.0%	90.0%				
	TRUST	Monthly (In Arrears)	Children and Young People's Access (13 weeks) - Incomplete pathway	>=92%	Sep-23	52.0%	45.6%				
	TRUST	Monthly (In Arrears)	Community Paediatrics (18 weeks) - Complete pathway	>=92%	Sep-23	40.5%	41.0%				
	TRUST	Monthly (In Arrears)	Adult Autistic Spectrum Disorder (without a Learning Disability) Assessment Clinic (Aspergers) (18 weeks) - Complete pathway	>=95%	Sep-23	90.0%	53.8%				
	TRUST	Monthly (In Arrears)	Adult Autistic Spectrum Disorder (without a Learning Disability) Assessment Clinic (Aspergers) - No of Referrals - (18 weeks) - Complete pathway		Sep-23	60	64				
	TRUST	Monthly (In Arrears)	6-week wait for diagnostic procedures - Incomplete pathway	>=99%	Sep-23	35.8%	36.6%				

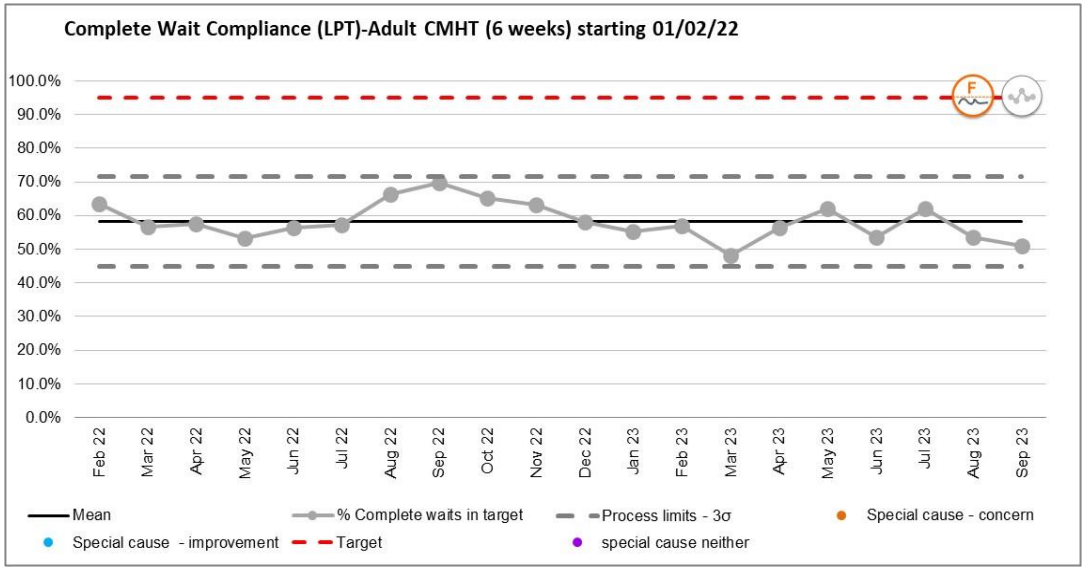
Section	Source	Reporting Frequency	Indicator	Monthly Target	Data As At	Current Reporting Period	Previous Reporting Period	Sparkline YTD	SPC Assurance	SPC Trend	Exception Report
52 Week Waits	TRUST	Monthly	Cognitive Behavioural Therapy - No of waiters	0	Oct-23	7	5				
	TRUST	Monthly	Cognitive Behavioural Therapy - Longest waiter (weeks)		Oct-23	59	55				
	TRUST	Monthly	Dynamic Psychotherapy - No of waiters	0	Oct-23	10	11				
	TRUST	Monthly	Dynamic Psychotherapy - Longest waiter (weeks)		Oct-23	77	73				
	TRUST	Monthly (In Arrears)	Therapy Service for People with Personality Disorder - assessment waits over 52 weeks - No of waiters	0	Sep-23	0	0				
	TRUST	Monthly (In Arrears)	Therapy Service for People with Personality Disorder - assessment waits over 52 weeks - Longest waiter (weeks)		Sep-23	0	0				
	TRUST	Monthly	CAMHS - No of waiters	0	Oct-23	397	355				
	TRUST	Monthly	CAMHS - Longest waiter (weeks)		Oct-23	103	99				
	TRUST	Monthly	All LD - No of waiters	0	Oct-23	10	8				
	TRUST	Monthly	All LD - Longest waiter (weeks)		Oct-23	73	97				
	TRUST	Monthly (In Arrears)	Community Paediatrics - assessment waits over 52 weeks - No of waiters		Sep-23	1834	1729				
	TRUST	Monthly (In Arrears)	Community Paediatrics - assessment waits over 52 weeks - Longest waiter (weeks)		Sep-23	136	132				
Patient Flow	TRUST	Monthly	Occupancy Rate - Mental Health Beds (excluding leave)	<=85%	Oct-23	84.5%	81.1%				
	TRUST	Monthly	Occupancy Rate - Community Beds (excluding leave)	>=93%	Oct-23	90.8%	83.9%				
	TRUST	Monthly	Average Length of stay - Community Hospitals	<=25	Oct-23	21.8	20.5				
	TRUST	Monthly	Delayed Transfers of Care	<=3.5%	Oct-23	4.5%	3.8%				
	TRUST	Monthly	Gatekeeping	>=95%	Oct-23	100.0%	97.9%				
	TRUST	Monthly	Admissions to adult facilities of patients under 18 years old	0	Oct-23	0	0				

Section	Source	Reporting Frequency	Indicator	Monthly Target	Data As At	Current Reporting Period	Previous Reporting Period	Sparkline YTD	SPC Assurance	SPC Trend	Exception Report
Quality & Safety	TRUST	Monthly	Covid Positive Following Swab During Admission - 15 and over		Oct-23	5	8				
	TRUST	Monthly	Covid Positive Following Swab During Admission - Hospital Acquired Rate		Oct-23	1.6%	3.1%				
	TRUST	Monthly	Serious incidents		Oct-23	0	0				
	TRUST	Monthly	Complaints		Oct-23	16	15				
	TRUST	Monthly	Concerns		Oct-23	57	46				
	TRUST	Monthly	Compliments		Oct-23	159	193				
	TRUST	Monthly	Safe staffing - No. of wards not meeting >80% fill rate for RNs - Day	0	Oct-23	3	2				
	TRUST	Monthly	Safe staffing - No. of wards not meeting >80% fill rate for RNs - Night	0	Oct-23	1	1				
	TRUST	Monthly	Care Hours per patient day		Oct-23	11.7	12.1				
	TRUST	Monthly	No. of episodes of seclusions >2hrs		Oct-23	13	12				
	TRUST	Monthly	No. of episodes of prone (Supported) restraint		Oct-23	1	0				
	TRUST	Monthly	No. of episodes of prone (Unsupported) restraint		Oct-23	0	0				
	TRUST	Monthly	Total number of Restrictive Practices		Oct-23	152	110				
	TRUST	Monthly (In Arrears)	No. of Category 2 pressure ulcers developed or deteriorated in LPT care		Sep-23	110	126				
	TRUST	Monthly (In Arrears)	No. of Category 3 pressure ulcers developed or deteriorated in LPT care		Sep-23	15	24				
	TRUST	Monthly (In Arrears)	No. of Category 4 pressure ulcers developed or deteriorated in LPT care		Sep-23	5	11				
	TRUST	Monthly (In Arrears)	No. of repeat falls		Sep-23	48	40				
	TRUST	Monthly	No. of Medication Errors		Oct-23	76	84				
	TRUST	Monthly	LD Annual Health Checks completed - YTD		Oct-23	33.9%	29.0%				
	TRUST	Monthly	LeDeR Reviews completed within timeframe - Allocated		Oct-23	8	6				
	TRUST	Monthly	LeDeR Reviews completed within timeframe - Awaiting Allocation		Oct-23	2	9				
	TRUST	Monthly	LeDeR Reviews completed within timeframe - On Hold		Oct-23	2	6				

Section	Source	Reporting Frequency	Indicator	Monthly Target	Data As At	Current Reporting Period	Previous Reporting Period	Sparkline YTD	SPC Assurance	SPC Trend	Exception Report
HR Workforce	TRUST	Monthly	Normalised Workforce Turnover (Rolling previous 12 months)	<=10%	Oct-23	8.3%	8.1%				
	TRUST	Monthly	Vacancy Rate	<=10%	Oct-23	19.4%	20.6%				
	TRUST	Monthly (In Arrears)	Sickness Absence	<=4.5%	Sep-23	5.1%	5.2%				
	TRUST	Monthly (In Arrears)	Sickness Absence Costs		Sep-23	£871,192	£877,602				
	TRUST	Monthly (In Arrears)	Sickness Absence - YTD	<=4.5%	Sep-23	5.0%	4.9%				
	TRUST	Monthly	Agency Costs	<=£2,432,000	Oct-23	£2,522,962	£2,604,396				
	TRUST	Monthly	Core Mandatory Training Compliance for substantive staff	>=85%	Oct-23	96.0%	95.8%				
	TRUST	Monthly	Staff with a Completed Annual Appraisal	>=80%	Oct-23	86.8%	86.3%				
	TRUST	Monthly	% of staff from a BME background	>=22.5%	Oct-23	27.1%	26.8%				
	TRUST	Monthly	Staff flu vaccination rate (frontline healthcare workers)	>=80%	Oct-23	36.6%	n/a				
	TRUST	Monthly	% of staff who have undertaken clinical supervision within the last 3 months	>=85%	Oct-23	85.5%	83.0%				

EXCEPTION REPORT - Adult CMHT Access (Six weeks routine) - Complete pathway *(Month in arrears)*

	Target	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23
DMH	>=95%	66.4%	69.7%	65.1%	63.2%	58.1%	55.3%	56.9%	48.1%	56.3%	62.1%	53.5%	50.9%



Analytical Commentary

The metric is showing a common cause variation with no significant change. The metric will consistently fail to meet the target as demonstrated by the target line falling above the process limits.

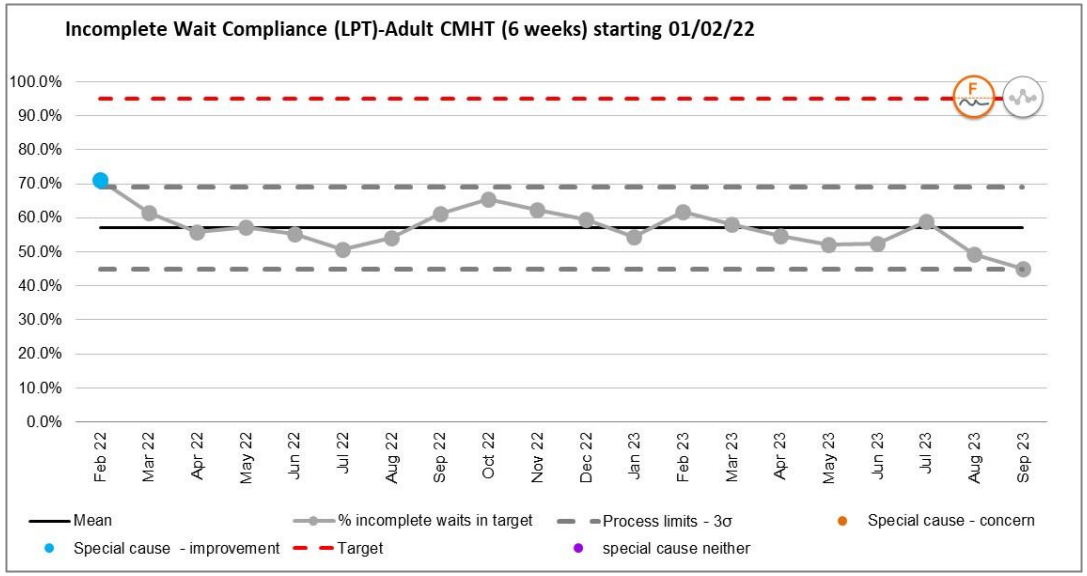
Mean	Lower Process Limit	Upper Process Limit
58.3%	45.0%	72.0%

Operational Commentary (e.g. referring to risk, finance, workforce)

- Industrial action continues to impact capacity to assess and treat patients within waiting times thresholds.
- A caseload review project is continuing. The project team have been out to visit teams sharing methodology and scoping out plans to further progress caseload reviews. Updates are being shared through FPP and the INO Meetings.
- There are challenges around staffing levels across all teams, both nursing and medical. Teams are linking with the recruitment team to develop more attractive adverts, in the new neighbourhood model.
- The transformation implementation programme continues to progress with focus on the pilot for the front door being established.

EXCEPTION REPORT - Adult CMHT Access (Six weeks routine) - Incomplete pathway *(Month in arrears)*

	Target	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23
DMH	>=95%	65.5%	62.4%	59.6%	54.4%	61.7%	58.1%	54.7%	52.0%	52.3%	58.8%	49.2%	45.1%



Analytical Commentary

The metric is showing a common cause variation with no significant change. The metric will consistently fail to meet the target as demonstrated by the target line falling above the process limits.

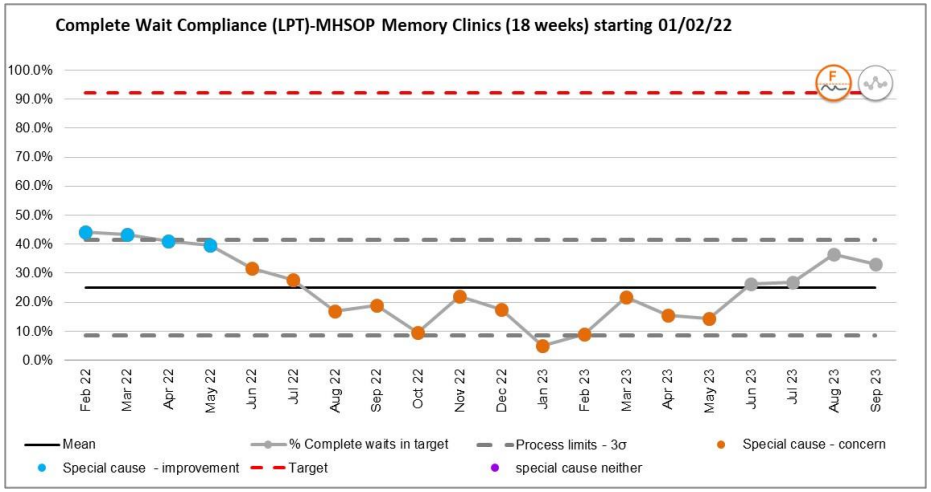
Mean	Lower Process Limit	Upper Process Limit
57.0%	45.0%	69.0%

Operational Commentary (e.g. referring to risk, finance, workforce)

- Industrial action continues to impact capacity to assess and treat patients within waiting times thresholds.
- A caseload review project is continuing. The project team have been out to visit teams sharing methodology and scoping out plans to further progress caseload reviews. Updates are being shared through FPP and the INO Meetings.
- There are challenges around staffing levels across all teams, both nursing and medical. Teams are linking with the recruitment team to develop more attractive adverts, in the new neighbourhood model.
- The transformation implementation programme continues to progress with focus on the pilot for the front door being established.

EXCEPTION REPORT - MHSOP - Memory Clinics (18 weeks local RTT) - Complete pathway *(Month in arrears)*

	Target	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23
DMH	>=92%	9.6%	22.1%	17.6%	5.0%	9.0%	21.9%	15.6%	14.4%	26.3%	27.0%	36.5%	33.0%



Analytical Commentary

The metric is showing a common cause variation with no significant change. The metric will consistently fail to meet the target as demonstrated by the target line falling above the process limits.

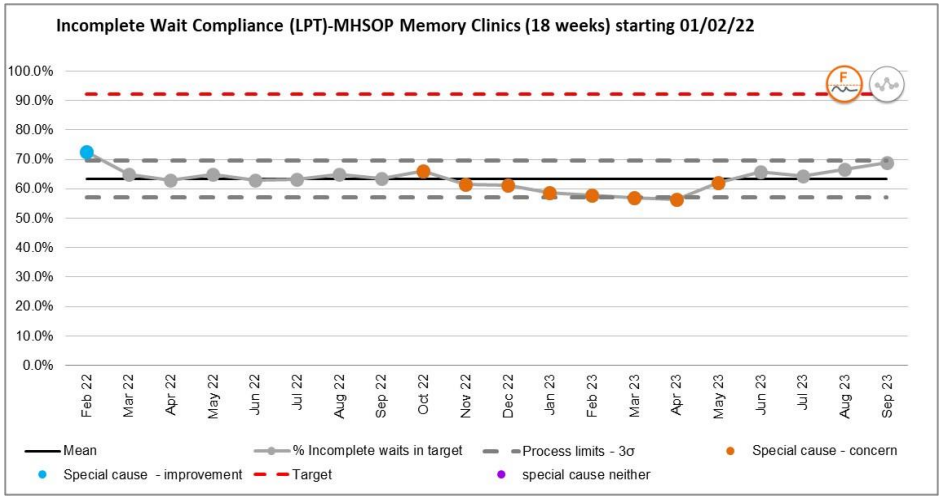
Mean	Lower Process Limit	Upper Process Limit
25.1%	7.0%	42.0%

Operational Commentary (e.g. referring to risk, finance, workforce)

- Senior leadership are working on service remodel of whole team caseload utilising weekend clinic capacity to deliver diagnosis and medication review follow ups, therefore, improving efficiency and reducing the length of time patients wait for a diagnosis following assessment.
- Recruiting to 1.0WTE vacancies and reviewing investment plans to recruit further.
- Expanding community clinics established in Lutterworth, Coalville and Rutland.
- Continuing breach process to review people whilst waiting for any escalations.
- Role description completed for 2 x volunteering roles. One role will be to contact patients and next of kin who have appointments booked to reduce DNAs. Currently out to advert.
- System approach to Demential Diagnosis Rate (DDR), reconciliation work taking place in primary care and ICB looking at DDR reconciliation in care homes, LPT utilising weekend capacity to deliver diagnosis.

EXCEPTION REPORT - MHSOP - Memory Clinics (18 weeks local RTT) - Incomplete pathway *(Month in arrears)*

	Target	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23
DMH	>=92%	65.9%	61.4%	61.1%	58.6%	57.8%	56.9%	56.5%	62.1%	65.8%	64.2%	66.7%	68.8%



Analytical Commentary

The metric is showing common cause variation with no significant change. The metric will consistently fail to meet the target as demonstrated by the target line falling above the process limits.

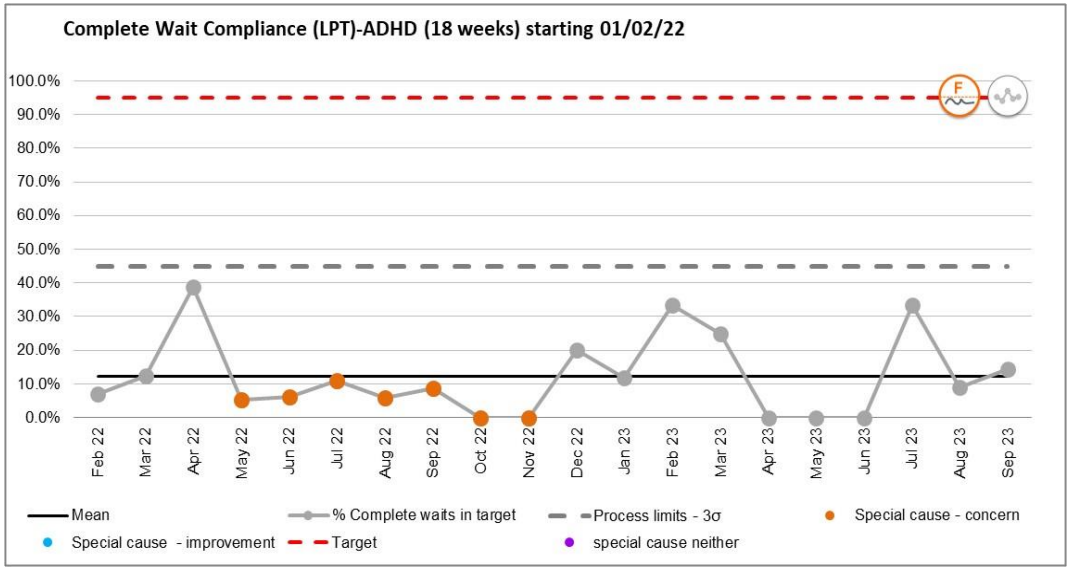
Mean	Lower Process Limit	Upper Process Limit
63.3%	57.0%	69.0%

Operational Commentary (e.g. referring to risk, finance, workforce)

- Senior leadership are working on service remodel of whole team caseload utilising weekend clinic capacity to deliver diagnosis and medication review follow ups, therefore, improving efficiency and reducing the length of time patients wait for a diagnosis following assessment.
- Recruiting to 1.0WTE vacancies and reviewing investment plans to recruit further.
- Expanding community clinics established in Lutterworth, Coalville and Rutland.
- Continuing breach process to review people whilst waiting for any escalations.
- Role description completed for 2 x volunteering roles. One role will be to contact patients and next of kin who have appointments booked to reduce DNAs. Currently out to advert.
- System approach to Demential Diagnosis Rate (DDR), reconciliation work taking place in primary care and ICB looking at DDR reconciliation in care homes, LPT utilising weekend capacity to deliver diagnosis.

EXCEPTION REPORT - ADHD (18 weeks local RTT) - Complete pathway *(Month in arrears)*

	Target	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23
DMH	>=92%	0.0%	0.0%	20.0%	11.8%	33.3%	25.0%	0.0%	0.0%	0.0%	33.3%	9.1%	14.3%



Analytical Commentary

The metric is showing common cause variation with no significant change. The metric will consistently fail to meet the target as demonstrated by the target line falling above the process limits.

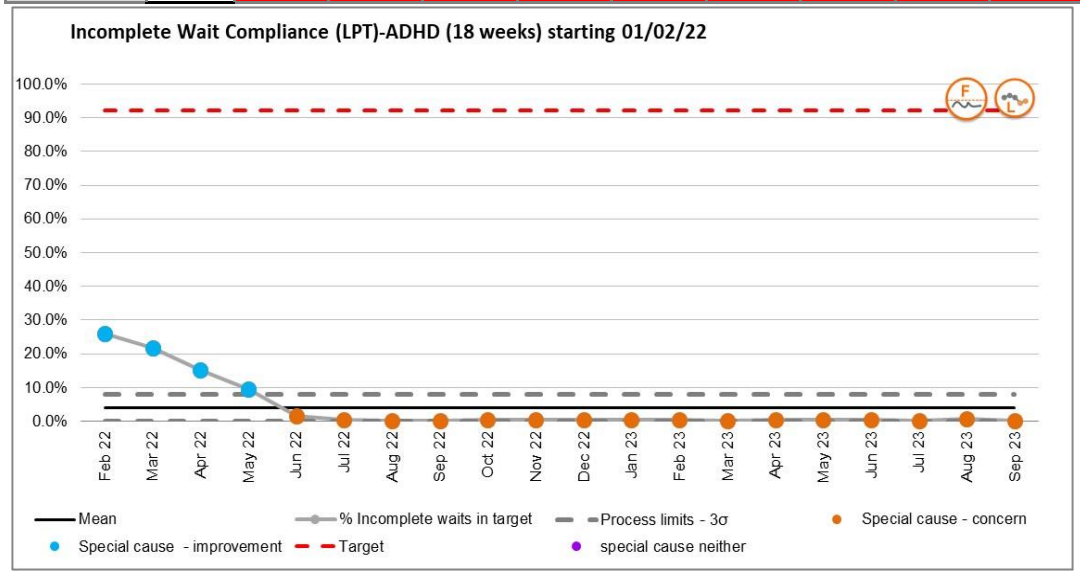
Mean	Lower Process Limit	Upper Process Limit
12.1%	-21.0%	45.0%

Operational Commentary (e.g. referring to risk, finance, workforce)

- Referral rates for the service remain high and continue to increase.
- A refreshed demand & capacity exercise reveals a substantial increase in workforce is required to manage the current demand and reduce the waiting lists.
- Major issues with national supplies of ADHD medication continue. Unlikely to be resolved until January 2024. Added to local risk register. A LPT task and finish group has been established to review the medication supply issues and associated comms.
- Recruitment to vacant NMP and Specialist Pharmacist roles continues.
- Review of secondary care model and reduction in treatment waits for those with co-morbidities. Half day timeout session scheduled to agree pathway.

EXCEPTION REPORT - ADHD (18 weeks local RTT) - Incomplete pathway *(Month in arrears)*

	Target	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23
DMH	>=92%	0.4%	0.6%	0.6%	0.5%	0.5%	0.3%	0.4%	0.6%	0.5%	0.3%	0.7%	0.1%



Analytical Commentary

The metric is showing a special cause variation of a concerning nature due to lower values. The metric will consistently fail to meet the target as demonstrated by the target line falling above the process limits.

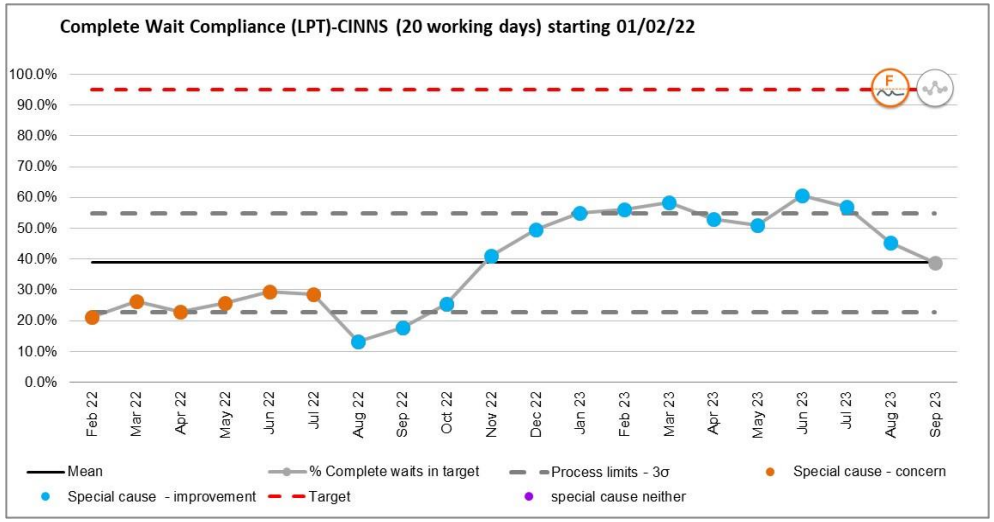
Mean	Lower Process Limit	Upper Process Limit
4.0%	0.0%	8.0%

Operational Commentary (e.g. referring to risk, finance, workforce)

- Referral rates for the service remain high and continue to increase.
- A refreshed demand & capacity exercise reveals a substantial increase in workforce is required to manage the current demand and reduce the waiting lists.
- Major issues with national supplies of ADHD medication continue. Unlikely to be resolved until January 2024. Added to local risk register. A LPT task and finish group has been established to review the medication supply issues and associated comms.
- Recruitment to vacant NMP and Specialist Pharmacist roles continues.
- Review of secondary care model and reduction in treatment waits for those with co-morbidities. Half day timeout session scheduled to agree pathway.

EXCEPTION REPORT - CINNS (20 working days) - Complete pathway *(Month in arrears)*

	Target	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23
CHS	>=95%	25.6%	41.1%	49.7%	55.0%	56.0%	58.3%	53.0%	51.1%	60.7%	56.9%	45.2%	38.8%



Analytical Commentary

The metric is showing common cause variation with no significant change. The metric will consistently fail to meet the target as demonstrated by the target line falling above the process limits.

Mean	Lower Process Limit	Upper Process Limit
38.8%	23.0%	55.0%

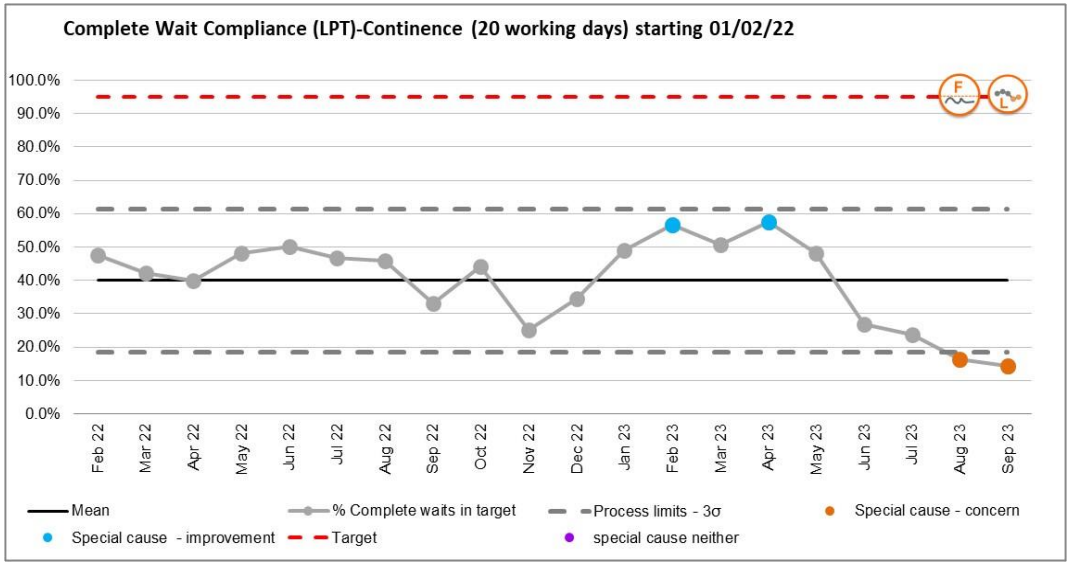
Operational Commentary (e.g. referring to risk, finance, workforce)

Newly proposed contractual waiting times target of 6 weeks has been approved by the ICB, the new waiting times have been built and are ready to be reported on once the CV has been progressed by the LPT and ICB Contracting Teams.

The following key improvement actions are in progress:
- Updated triage process for clarity in decision making around pts with pressure ulcers.
- Additional training for staff member to prevent further errors of this kind.
- Review and revise expectations around documentation.
- Delegation of clinical tasks from qualified staff to TI and between TI's.
- Review skill mix and roles and responsibilities of B7 team. Consider operational/admin roles to release clinical lead time to care.
- Work with BAT to team to fully explore demand and capacity. Understanding capacity fully will allow realistic expectations on staff time and improve staff wellbeing.
- Roll out job planning across service
- Recruitment – B6 rotational Physio – recruited to, awaiting start date. B6 Static – interview 7/11/23. B6 OT static – Interview 31/10/23. TI4 – Interview 6/11/23. B3 – recruited to awaiting start date.
- Explore digital offer for appropriate referrals to further facilitate health education and self-management
- Continue to monitor impact of change using the EQIA

EXCEPTION REPORT - Continence (20 working days) - Complete pathway *(Month in arrears)*

	Target	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23
CHS	>=95%	44.3%	25.2%	34.6%	48.9%	56.7%	50.8%	57.6%	48.1%	27.0%	23.7%	16.3%	14.3%



Analytical Commentary

The metric is showing a special cause variation of a concerning nature due to lower values. The metric will consistently fail to meet the target as demonstrated by the target line falling above the process limits.

Mean	Lower Process Limit	Upper Process Limit
40.1%	19.0%	61.0%

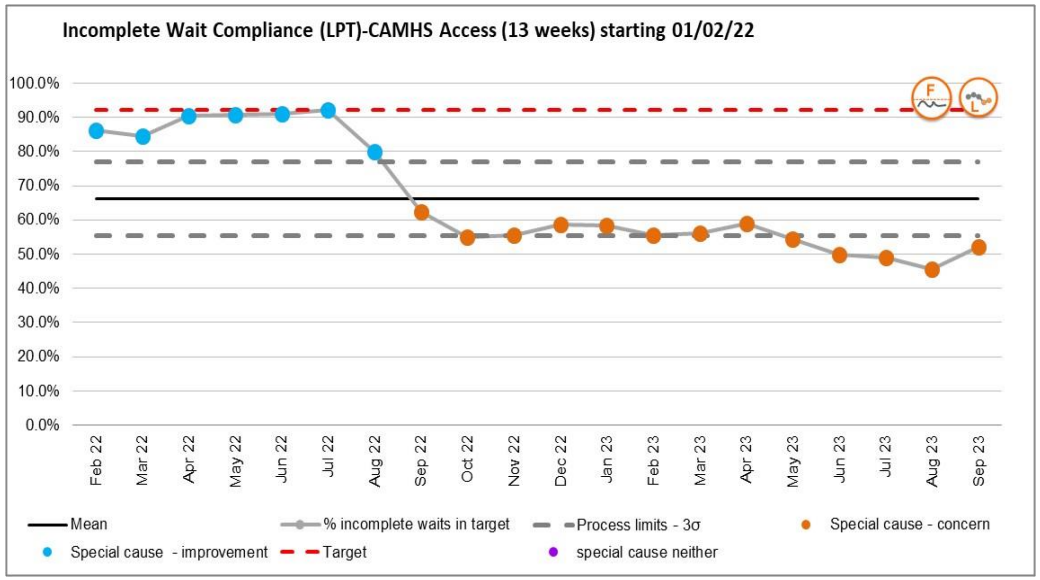
Operational Commentary (e.g. referring to risk, finance, workforce)

Newly proposed contractual waiting times target of 18 weeks has been approved by the ICB, the new waiting times have been built and are ready to be reported on once the CV has been progressed by the LPT and ICB Contracting Teams.

The following key improvement actions are in progress:
- Ongoing review of activity against service targets. Review number of assessments and follow ups completed by each staff member. Line management providing support to clinicians in order to hit targets. Reviewing number of follow up attempts completed prior to discharge.
- Implementing changes for low-risk patients and encouraging patients to self-help model before prescribing products. Patients being reviewed against harm matrix to identify routine and high priority patients, those identified as high priority receive urgent appointment, those identified as routine are sent routine self-help letter.

EXCEPTION REPORT - CAMHS Access (13 weeks) - Incomplete pathway *(Month in arrears)*

	Target	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23
FYPC	>=92%	54.9%	55.5%	58.6%	58.3%	55.4%	56.1%	59.0%	54.3%	49.8%	49.1%	45.6%	52.0%



Analytical Commentary

The metric is showing a special cause variation of a concerning nature due to lower values. The metric will consistently fail to meet the target as demonstrated by the target line falling above the process limits.

Mean	Lower Process Limit	Upper Process Limit
66.3%	55.0%	77.0%

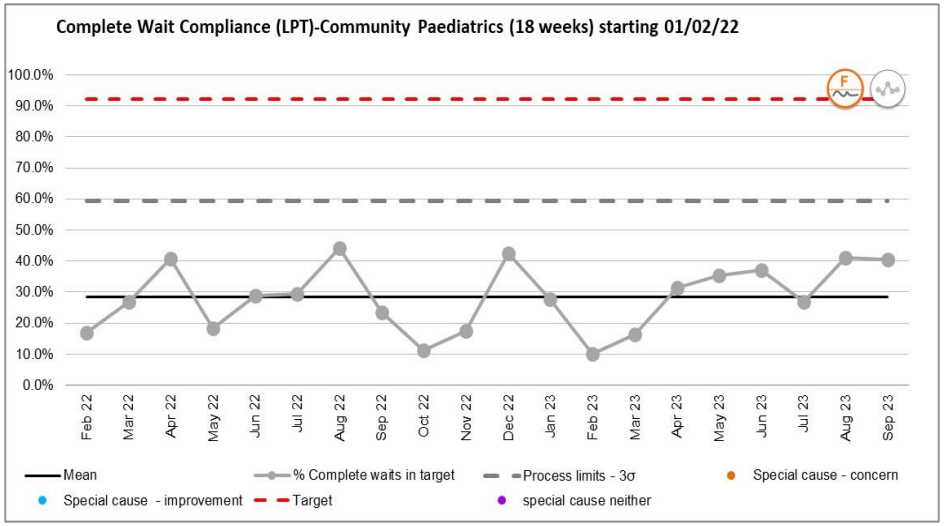
Operational Commentary (e.g. referring to risk, finance, workforce)

The service has expanded capacity to meet increased demand see through 2022/23.

The actions being taken are:
1. Using MHIS investment the service have recruited 6 additional staff to Access which has increased the weekly capacity to over 60 assessment slots per week. The impact of this is the number of CYP waiting for an initial assessment continues to fall, with the number down below 500 from a high of over 110 at the beginning of the year. The conversion of failed pathways will continue to yield low performance until December when appointments will routinely be offered pre the 13 week target.
3. The increase in demand is reflected in the increase in CYP being referred for Neurodevelopment diagnosis and intervention. A revised business case is being developed for next financial year bidding process. The ND team are utilising what resources they have to start to develop a specific ND service.

EXCEPTION REPORT - Community Paediatrics (18 weeks) - Complete pathway *(Month in arrears)*

	Target	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23
FYPCLD	>=92%	11.2%	17.6%	42.5%	27.7%	10.1%	16.5%	31.4%	35.4%	37.2%	27.0%	41.0%	40.5%



Analytical Commentary

The metric is showing a common cause variation with no significant change. The metric will consistently fail to meet the target as demonstrated by the target line falling above the process limits.

Mean	Lower Process Limit	Upper Process Limit
28.4%	-0.03%	59.0%

Operational Commentary (e.g. referring to risk, finance, workforce)

It is likely that there will be no significant change to the current perfomance figures due to the service seeing the urgent referrals within 18 weeks offsetting the long waits for the routine referrals.

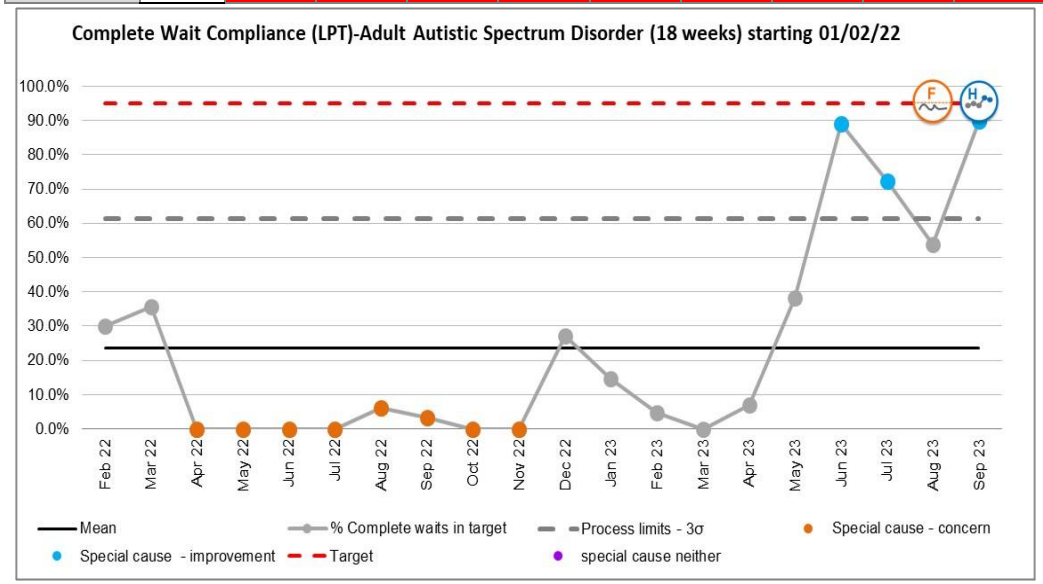
The service continues to receive more referrals than they have capacity to see. The non-recurrent investment into the service will slow the rate of increase in the waiting list but the trajectory will continue to rise. The service now have over 2 year waits for first appointment for routine referrals. The CYP who are waiting longer than 18 weeks have been sent a letter explaining the long waits, signposting for support whilst waiting and also outlining steps to be taken if the referral becomes more urgent.

The majority of the long waits are for neurodevelopmental assessment for Autism and ADHD.

1. Through non-recurrent internal investment, recruitment of additional staff to support the ASD and ADHD pathway to increase patient flow to allow increased uptake of new cases. This has slowed the rate of waiting list increase but not reversed it
2. Support the establishment of a new Neurodevelopmental service across CAMHS and Community Paediatrics including a new SystmOne Unit which will improve data collection and new MDT pathways.
3. A review of the current pathways and associated requests for second opinions, disputes over assessment outcomes, referrals following private diagnosis
4. Development of a part digitisation of the physical health monitoring requiried for CYP prescribed medication for ADHD
5. An increased digitial offer to support families whilst waiting and post assessment.

EXCEPTION REPORT - Adult Autistic Spectrum Disorder (18 weeks) - Complete pathway *(Month in arrears)*

	Target	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23
FYPCLD	>=95%	0.0%	0.0%	27.3%	14.8%	4.8%	0.0%	7.1%	38.1%	88.9%	72.2%	53.8%	90.0%



Analytical Commentary

The metric is showing a common cause variation with no significant change. The metric will consistently fail to meet the target as demonstrated by the target line falling above the process limits.

Mean	Lower Process Limit	Upper Process Limit
23.6%	-0.14%	61.0%

Operational Commentary (e.g. referring to risk, finance, workforce)

Significant impact of increased referrals - 866 2021/22, an increase of 57% from 2019/20.

Capacity and demand model have been updated to take account of both increased referrals and additional staff.

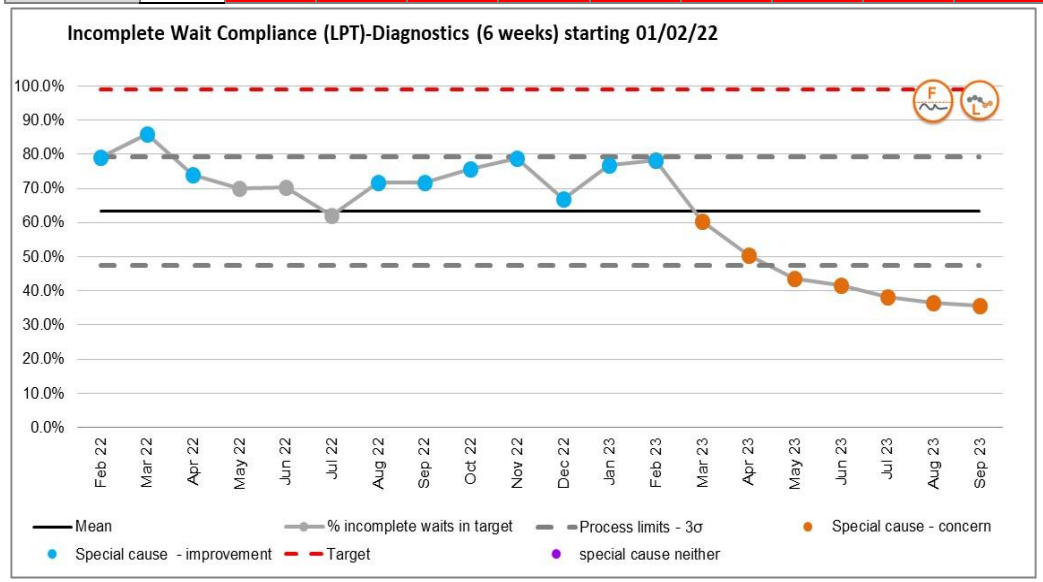
The service has utilised funding to recruit additional capacity to support undertaking assessments.

Consultant psychologist interviews planned.

The service has seen an increase in the performance, however this position will stabilise through the next few months and focus will subsequently shift towards the follow-up and wait to diagnosis.

EXCEPTION REPORT - 6-week wait for diagnostic procedures - Incomplete pathway *(Month in arrears)*

	Target	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23
FYPC	>=99%	75.6%	78.7%	66.8%	76.9%	78.2%	60.4%	50.3%	43.5%	41.7%	38.1%	36.6%	35.8%



Analytical Commentary

The metric is showing a special cause variation of a concerning nature due to lower values. The metric will consistently fail to meet the target as demonstrated by the target line falling above the process limits.

Mean	Lower Process Limit	Upper Process Limit
63.4%	47.0%	79.0%

Operational Commentary (e.g. referring to risk, finance, workforce)

in light of the recent recommendations received for improvements to sound treating/soundproofing in all 6 Audiology clinic rooms, there is likely to be further reduction in clinic capacity in the next 3-6 months if the capital bid is approved and estate modification progresses. The increase in referrals is being sustained post COVID in comparison to 2019/20. 16% increase in referrals for 2022/23 in comparison to 2019/20. 2023/24 referrals are on track to match 2022/23.

Mitigation to reduce backlog and achieve sustainable position.

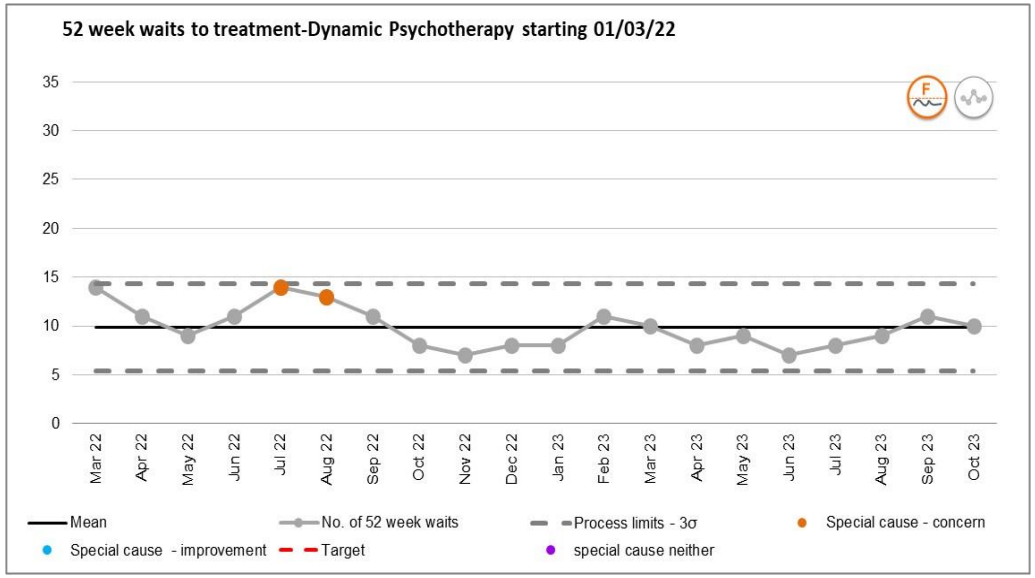
Non-recurrent investment to increase capacity by 2 WTE, Current local staffing difficulty is impacting recovery and additional staff are being financially risk managed.

Pace of recovery has been impacted due to 1 WTE Band 6 withdrawing from recruitment and retirement of staff.

The service has live recruitment, and delays will require adjustment the trajectory.

EXCEPTION REPORT - Dynamic Psychotherapy - No of waiters over 52 weeks

	Target	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23
DMH	0	7	8	8	11	10	8	9	7	8	9	11	10



Analytical Commentary

The metric is showing a common cause variation with no significant change. The metric will consistently fail to meet the target as demonstrated by the target line falling below the process limits.

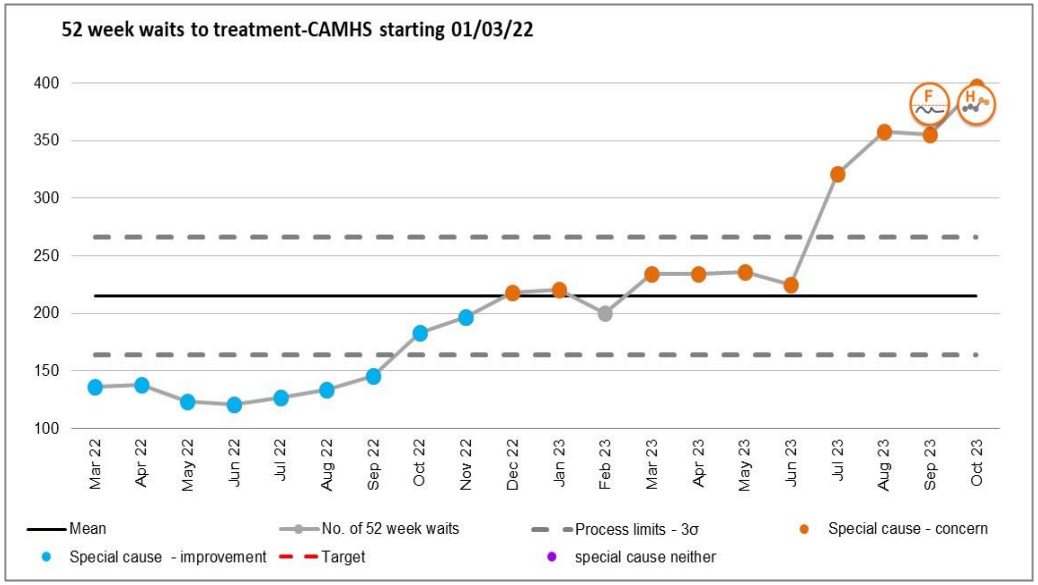
Mean	Lower Process Limit	Upper Process Limit
9.9	5.37	14.33

Operational Commentary (e.g. referring to risk, finance, workforce)

- Recruitment to vacancies is underway, but there are vacancies and recruitment lead times that will impact on capacity.
- Plan to focus on assessment capacity over the coming months with a plan that treatment waits will begin to significantly reduce in the new year.
- Job planning is now in place and regular reviews are taking place to ensure that clinician capacity is used effectively.

EXCEPTION REPORT - CAMHS - No of waiters over 52 weeks

	Target	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23
FYPCLD	0	197	218	221	200	234	234	236	225	321	358	355	397



Analytical Commentary

The metric is showing special cause variation of a concerning nature due to higher values. The metric will consistently fail to meet the target as demonstrated by the target line falling below the process limits.

Mean	Lower Process Limit	Upper Process Limit
215.3	164.15	266.35

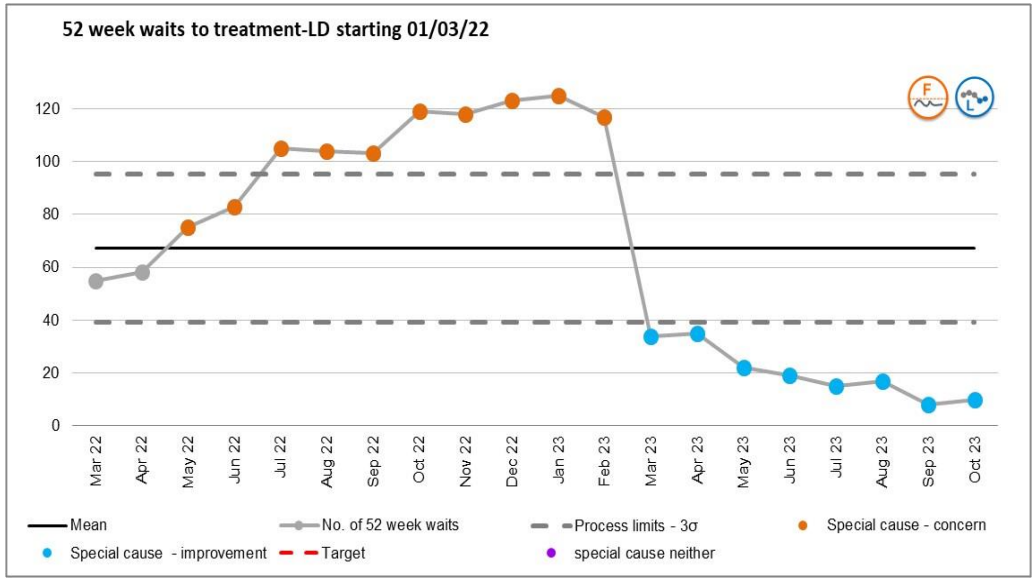
Operational Commentary (e.g. referring to risk, finance, workforce)

This increase in the number of CYP waiting over 52 weeks is linked to the number of children waiting for a neurodevelopmental Assessment. The System Neurodevelopmental Project and current business plan for investment in 2023/24 and the following 2 years of increased funding was designed to reduce these waits, this has not been successful this financial year and a new bid is being prepared for 2024/25 financial year.

The general CAMHS waits will be addressed through the latest round of MHIS funding and this will have some impact to the waits, however, with no further neurodevelopmental investment it is predicted that this will continue to rise. The neurodevelopmental project team are considering mitigation solutions for this year.

EXCEPTION REPORT - LD - No of waiters over 52 weeks

	Target	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23
FYPCLD	0	118	123	125	117	34	35	22	19	15	17	8	10



Analytical Commentary

The metric is showing special cause variation of an improving nature due to lower values. The metric will consistently fail to meet the target as demonstrated by the target line falling below the process limits.

Mean	Lower Process Limit	Upper Process Limit
67.3	39.11	95.39

Operational Commentary (e.g. referring to risk, finance, workforce)

The service implemented a referral assessment service "Access" in January 2022.

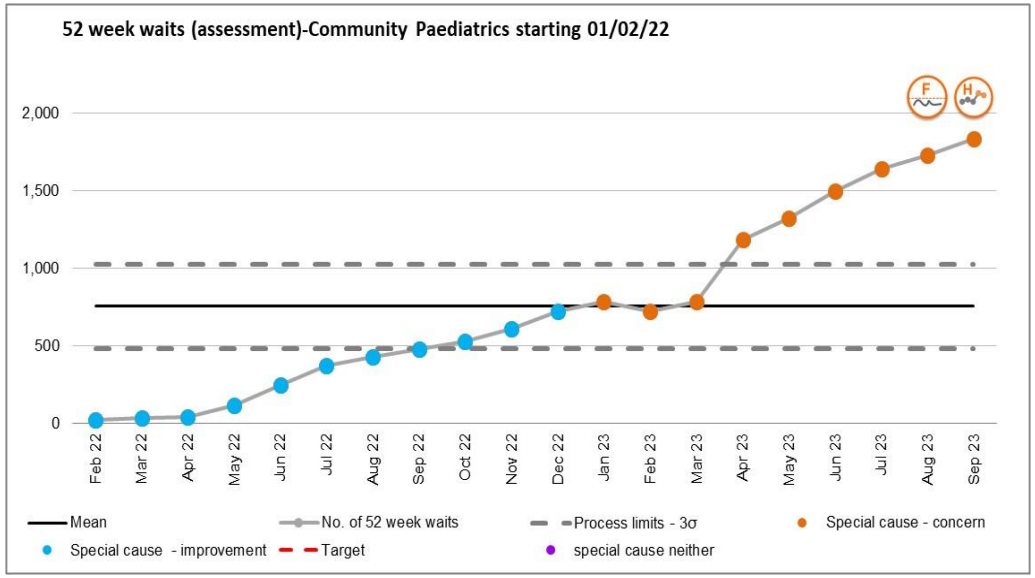
The service had seen a steady increase in performance from November 2022, through to April 2023.

Capacity due to waiting times for treatment and workforce sickness has impacted KPI delivery & will continue to impact the KPI in the months ahead as the backlog is cleared.

Vacancies and complexity of patients has impacted on waiting times for treatment.

EXCEPTION REPORT - Community Paediatrics (assessment) - No of waiters over 52 weeks *(Month in arrears)*

	Target	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23
FYPCLD	0	531	611	720	785	720	785	1186	1319	1498	1640	1729	1834



Analytical Commentary

The metric is showing special cause variation of a concerning nature due to higher values. The metric will consistently fail to meet the target as demonstrated by the target line falling below the process limits.

Mean	Lower Process Limit	Upper Process Limit
755.4	484.08	1026.72

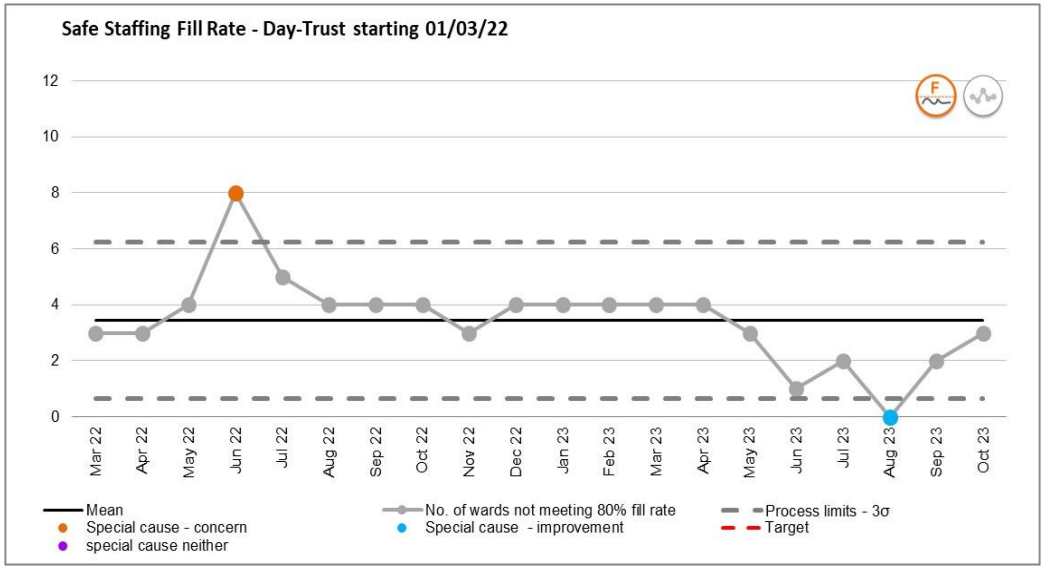
Operational Commentary (e.g. referring to risk, finance, workforce)

The service are utilising the non-recurrent investment to recruit additional ADHD nurses, SALT's and educational psychology support to release capacity from the paediatricians to enable them to see more new referrals. The investment will slow down the rate of increase but is not sufficient to reverse the trend of an increase to the numbers waiting over 52 weeks.

To note some CYP are now waiting over 2 years.

EXCEPTION REPORT - Safe staffing - No. of wards not meeting >80% fill rate for RNs - Day

	Target	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23
TRUST	0	4	3	4	4	4	4	3	1	2	0	2	3
DMH		4	2	3	2	2	2	2	1	0	0	0	2
LD		0	0	1	1	1	1	0	0	1	0	2	1
CHS		0	0	0	0	0	0	0	0	0	0	0	0
FYPC		0	1	0	1	1	1	1	0	1	0	0	0



Analytical Commentary

The metric is showing a common cause variation with no significant change. The metric will consistently fail to meet the target as demonstrated by the target line falling below the process limits.

Mean	Lower Process Limit	Upper Process Limit
3.5	65.00	6.3

Operational Commentary (e.g. referring to risk, finance, workforce)

No. of wards not meeting >80% fill rate for RNs – Day was 3 wards

LD

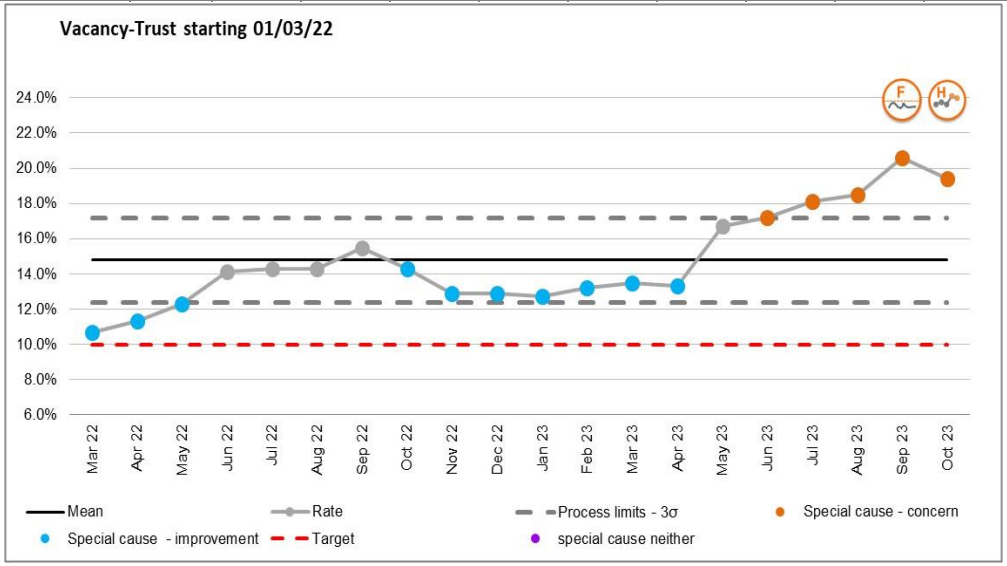
The Grange (Short Breaks service) had a fill rate of 73% of RN's in the day. This was due to the Grange being closed for refurbishment during the month and staff groups being amalgamated with Gilivers.

DMH

Kirby had fill rate of 78.8% of Rns on days and Aston had fill rate of 77.4%

EXCEPTION REPORT - Vacancy Rate

	Target	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23
TRUST	<=10%	12.9%	12.7%	13.4%	13.2%	13.5%	13.3%	16.7%	17.2%	18.1%	18.5%	20.6%	19.4%
DMH		15.4%	14.5%	15.6%	15.1%	15.5%	15.7%	20.0%	19.8%	21.5%	22.2%	22.1%	20.8%
CHS		15.6%	16.1%	14.5%	14.1%	14.3%	14.4%	16.5%	16.5%	16.4%	15.8%	23.4%	23.0%
FYPCLD		11.0%	10.2%	12.0%	12.4%	12.1%	13.6%	18.3%	18.6%	18.9%	20.8%	18.7%	17.8%



Analytical Commentary

The metric is showing a special cause variation of a concerning nature due to higher values. The metric will consistently fail to meet the target as demonstrated by the target line falling below the process limits.

Mean	Lower Process Limit	Upper Process Limit
14.8%	12.0%	17.0%

Operational Commentary (e.g. referring to risk, finance, workforce)

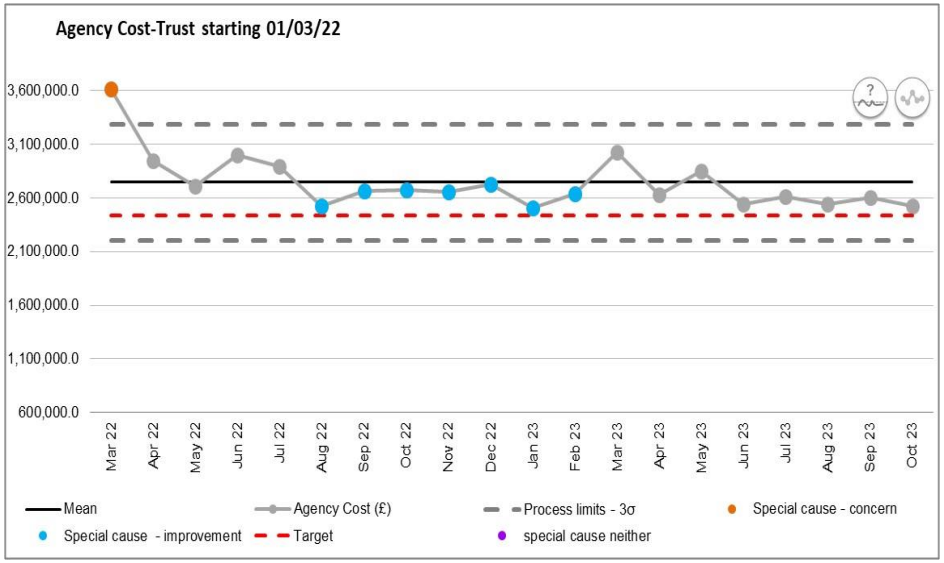
The vacancy rate is impacted by joiners and leavers, and by changes to the budgeted establishment. Year to date there has been a planned increase to the budgeted establishment of **563.7fte** (212.7fte in the last two months - the majority of which relates to additional posts in community hospitals to staff additional bed capacity), creating more vacant posts to recruit to. This increased establishment is predominantly due to inpatient safer staffing reviews and investment in mental health and virtual wards, all of which is accounted for in our 2023/24 operational plan. Vacancy levels vary significantly according to the staff group and service line, but are concentrated in the Registered Nursing and Healthcare Assistant workforce.

As part of the Trust-wide Workforce, Recruitment and Agency Programme there are two workstreams contributing to a reduction in the vacancy rate:
- Recruitment & Retention Workstream - KPIs: Increase HCAs on Bank, reduce vacancies, sustainable pipeline
- Growth & Development Workstream - KPIs: Improve retention, embed new roles and skill mixing

The People and Culture Commitee are responsible for providing assurance to the Trust Board on the mitigation of risks relating to the Trust vacancy rate and risks are contained in ORR risk 94.

EXCEPTION REPORT - Agency Costs

	Target	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23
TRUST	<=£2,432,000	£2,653,661	£2,723,956	£2,507,308	£2,640,025	£3,023,461	£2,628,635	£2,853,592	£2,540,910	£2,615,416	£2,539,262	£2,604,396	£2,522,962
DMH		£1,280,009	£1,235,580	£1,056,684	£1,114,900	£1,038,686	£1,123,693	£1,185,111	£1,008,044	£926,354	£924,065	£870,418	£1,034,661
CHS		£684,110	£798,737	£798,241	£809,239	£1,041,707	£915,267	£945,115	£845,562	£1,006,433	£1,048,524	£1,048,827	£1,024,130
FYPCLD		£536,528	£587,339	£591,990	£593,238	£820,253	£524,887	£520,578	£581,556	£482,534	£406,714	£442,666	£302,453



Analytical Commentary

The metric is showing a common cause variation with no significant change. There is no assurance that the metric will consistently achieve the target and is in common cause variation.

Mean	Lower Process Limit	Upper Process Limit
2744358.5	2201404	3287312.9

Operational Commentary (e.g. referring to risk, finance, workforce)

According to LPT's operational finance plan, planned agency spend for 2023/24 is £29,184,000. The planned spend for each month shows a month-on-month decrease in planned spend as actions to reduce the volume and cost of agency use come to place. However for this purposes of the report, the target shown is the total planned spend divided equally across the 12 months.

As part of the Trust-wide Workforce, Recruitment and Agency Programme there are three workstreams contributing to agency spend reduction:
- Recruitment & Retention Workstream - KPIs: Increase HCAs on Bank, Reduce vacancies, sustainable pipeline
- Agency Reduction Workstream - KPIs: Stop off-framework use, reduce agency spend
- Growth & Development Workstream - KPIs: Improve retention, embed new roles and skill mixing

The People and Culture Commitee are responsible for providing assurance to the Trust Board on the mitigation of risks relating to the Trust agency spend and risks are contained in ORR risk 94.

SPC Business Rules

Assurance: Failing

Assurance	Variation	Understanding the Icons	Business Rule
		Special Cause of a concerning nature due to (H)igher or (L)ower values. Assurance indicates consistently (F)ailing the target.	Metric is expected to consistently Fail the Target and is showing a Special Cause for Concern. An exception page is required on the Board Performance Report to support actions and delivery of a performance improvement.
		Common Cause - no significant change. Assurance indicates consistently (F)ailing the target.	Metric is expected to consistently Fail the Target and is showing Common Cause variation. An exception page is required on the Board Performance Report to support actions and delivery of a performance improvement.
		Special Cause of an improving nature due to (H)igher or (L)ower values. Assurance indicates consistently (F)ailing the target.	Metric is expected to consistently Fail the Target and is showing a special cause variation for improvement. An exception page is required on the Board Performance Report to support actions and delivery of a performance improvement.

Assurance: Hit and Miss

Assurance	Variation	Understanding the Icons	Business Rule
		Special Cause of a concerning nature due to (H)igher or (L)ower values. Assurance indicates the metric may achieve or fail the target due to random variation.	There is no assurance that the metric will consistently achieve the target and is showing a Special Cause for Concern. Metric to be monitored at Directorate Performance Reviews.
		Common Cause - no significant change. Assurance indicates the metric may achieve or fail the target due to random variation.	There is no assurance that the metric will consistently achieve the target and is in Common Cause Variation. Metric to be monitored at Directorate Performance Reviews.
		Special Cause of an improving nature due to (H)igher or (L)ower values. Assurance indicates the metric may achieve or fail the target due to random variation.	There is no assurance that the metric will consistently achieve the target and is showing a Special Cause for Improvement. Metric to be monitored at Directorate Performance Reviews.

Assurance: Achieving

Assurance	Variation	Understanding the Icons	Business Rule
		Special Cause of a concerning nature due to (H)igher or (L)ower values. Assurance indicates consistently (P)assing the target.	Metric is expected to consistently Achieve the Target and is showing a Special Cause for Concern. Metric to be monitored at Directorate Performance Reviews.
		Common Cause - no significant change. Assurance indicates consistently (P)assing the target.	Metric is expected to consistently Achieve the Target and is showing Common Cause variation. Metric to be monitored at Directorate Performance Reviews.
		Special Cause of an improving nature due to (H)igher or (L)ower values. Assurance indicates consistently (P)assing the target.	Metric is expected to consistently Achieve the Target and is showing a special cause variation for improvement. Metric to be monitored at Directorate Performance Reviews.

Appendix - Mental Health Core Data Pack

Indicator	Monthly Target	Data As At	Current Reporting Period	Previous Reporting Period	Sparkline
(B1) Discharges followed up within 72hrs - LLR		Jul-23	78.0%	81.0%	
(B1) Discharges followed up within 72hrs - LPT	>=80%	Jul-23	79.0%	82.0%	
(D1) Community Mental Health Access (2+ contacts) - LLR	4115	Jul-23	12795	12725	
(D1) Community Mental Health Access (2+ contacts) - LPT		Jul-23	12735	12670	
(E1) CYP access (1+ contact) - LLR	12517	Jul-23	14010	13335	
(E1) CYP access (1+ contact) - LPT		Jul-23	6815	6720	
(E4) CYP eating disorders waiting time - Routine - LLR		Q4	71.1%	56.5%	
(E4) CYP eating disorders waiting time - Routine - LPT	>=95%	Q4	75.8%	57.3%	
(E5) CYP eating disorders waiting time - Urgent - LLR		Q4	82.4%	87.2%	
(E5) CYP eating disorders waiting time - Urgent - LPT	>=95%	Q4	82.1%	88.1%	
(G3) EIP waiting times - MHSDS - LLR		Jul-23	73.0%	73.0%	
(G3) EIP waiting times - MHSDS - LPT	>=60%	Jul-23	73.0%	73.0%	
(I1) Individual Placement Support - LLR	320	Jul-23	415	360	
(I1) Individual Placement Support - LPT		Jul-23	410	355	
(K2) OOA bed days - inappropriate only - rolling quarter - LLR		Jul-23	0	5	
(K2) OOA bed days - inappropriate only - rolling quarter - LPT		Jul-23	0	5	
(L1) Perinatal access - rolling 12 months - LLR	1259	Jul-23	1020	1010	
(L1) Perinatal access - rolling 12 months - LPT		Jul-23	1015	1005	
(L2) Perinatal access - year to date - LLR	420	Jul-23	470	400	
(L2) Perinatal access - year to date - LPT		Jul-23	470	400	
(N1) Data Quality - Consistency - LLR		Jul-23	100.0%	83.0%	
(N1) Data Quality - Consistency - LPT		Jul-23	100.0%	100.0%	
(N2) Data Quality - Coverage - LLR		Jul-23	100.0%	100.0%	
(N2) Data Quality - Coverage - LPT	>=98%	Jul-23	100.0%	100.0%	
(N3) Data Quality - Outcomes - LLR		Jul-23	21.0%	22.0%	
(N3) Data Quality - Outcomes - LPT	>=50%	Jul-23	21.0%	23.0%	
(N4) Data Quality - DQMI score - LLR		Apr-23	62.5	62.1	
(N4) Data Quality - DQMI score - LPT	95.0	Apr-23	95.0	95.1	
(N5) Data Quality - SNOMED CT - LLR		Jul-23	97.0%	95.0%	
(N5) Data Quality - SNOMED CT - LPT	>=100%	Jul-23	100.0%	100.0%	

N

Briefing Summary of the Meetings of the East Midlands Joint Committee Meetings Held on Tuesday 17 October 2023

1. Purpose

1.1. This **ADVISORY** report is presented to provide a summary of the East Midlands Joint Committee meetings held on Tuesday 17 October 2023.

2. NHS East Midlands Joint Committee for Specialised Services

2.1 2023/24 Month 5 Finance & Contracting Update

The Committee were provided with an update on the finance and contracting position for East Midlands Specialised Services through which they received assurance with no concerns for escalation and the forecast to plan, noting central confirmation of Elective Recovery Funding (ERF) remains awaited. 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). Consideration was given to the potential for related cost pressures to be evident within ICB budget rather than budgets for specialised services and how this could be managed upon delegation.

2.2 Specialised Delegation – Policy Update and Midlands Next Steps

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 and the approach being taken toward timeframes for delegation across the country, noting the East Midlands remains April 2024 in line with policy. The committee noted the timeframes for delegation (April 2024) and workforce transfer (2025) and agreed to revisit this at future meetings.

2.3 National Delegated Commissioning Group Update

As part of preparing the agenda of preparing the Committee for delegation the paper provided a detailed understanding of the national approach, feeding to local arrangements, on Neonatal Services, Disease Modifying Therapies for Alzheimer's Disease and High Consequence Infections Disease Centres. .

2.4 Midlands Specialised Commissioning Group Assurance Report

The Committee were provided with a highlight summary of key matters from the September MASCG meeting. There were no matters for escalation and the Committee noted the level of detail and assurance provided. The Committee considered how the paper drew attention to the practical decisions being made by the Group and asked that future papers set out such decisions clearly to both support the preparation for delegation, and how decisions made were taken with consideration of Health inequalities and with non-Executive challenge. It was suggested a retrospective review of decisions was undertaken to test the approach and support learning.

2.5 Quality Governance and Reporting to Joint Committees – Quality Exception Report: East Midlands

The Committee noted the Quality Exception Report as presented to the regions Quality Groups in September and October. The paper drew the Committee's attention to matters relating to the Rampton Hospital and Kettering Neonatal Services.

2.6 Deep Dive – Vascular Surgery

In support of preparation for delegation the Committee has established a series of Deep Dives. This meeting noted a paper focused on Vascular Surgery Services.

3. NHS East Midlands Integrated Care Boards Joint Committee

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. Key highlights discussed included Optometric over performance at Month 5 and the go live of the Electronic Referral System, the work ongoing to support delivery of dental activity, and the overall financial underspent position. The Committee drew attention to the need to link local and regional planning, the need to find innovative solutions, and specific examples of challenges to access dental services. It was confirmed for Tier 2 to lead the development of a Strategic Framework and preparation for 2024/25 operational delivery, and for dental to be a deep dive area at the next meeting.

3.2 Midlands NHS 111 Procurement and Contract Award

The Committee received a further update on the procurement and mobilisation of Midlands NHS 111 services. Derbyshire Health United are confirmed as the successful provider and assurance was provide that the services would mobilise to the expected timeframes. It was agreed for CEOs to link back within the respective ICBs, particularly on finance and contract approval.

3.3 Programme Director to Support East Midlands Collaboration

The Committee received a proposal for recruitment to a fix term post (ending March 2025) for Programme Director in support of East Midlands Collaboration and discussed at length the added value gained against a backdrop of ICB Running Cost challenge. The Committee approved the post.

o

Name of meeting:	**Leicester, Leicestershire and Rutland ICB Board – meeting in public**		
Date:	14 December 2023	**Paper:**	**O**
Report title:	**ICB Board Assurance Framework 2023/24 update**		
Presented by:	Robert Toole, Chief Finance Officer		
Report author:	Daljit Bains, Head of Corporate Governance		
Executive Sponsor:	Robert Toole, Chief Finance Officer		

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

Recommendations:

The LLR ICB Board is requested to:

- **RECEIVE and APPROVE** the updated ICB Board Assurance Framework (BAF) 2023-24 as at Appendix 1, this includes the reduction in residual risk score for BAF 6 – Emergency Preparedness, Resilience and Response (from a residual risk score of 16 to 8).

- **BE ASSURED** that the BAF continues to be aligned to the ICB's Strategic Objectives and that it is reviewed at agreed intervals by the Executive Management Team and the Board Committees (assurance reported through each Committee's assurance report to the Board).

Purpose and summary of the report:

This report aims to provide the Board with assurance that the risk management arrangements across the organisation continue to be fit for purpose and that the ICB's Board Assurance Framework (BAF) continues to be reviewed in line with agreed processes.

The Board is asked to note that the BAF captures a snapshot of the ICB's risk profile at a point in time and that the content of the BAF will continue to be reviewed by the Executive Management Team on at least a bi-monthly basis to ensure it remains up to date. Subsequently, the strategic risks within the BAF are assessed and scrutinised through the Board Committees.

The Board is requested to approve the updated BAF as at Appendix 1, noting in the main the changes relate to confirmation of additional controls in place, and update in respect of actions taken or additional actions identified.

Since the last report to the Board in July 2023, the residual risk score for BAF risk 6 – Emergency Preparedness, Resilience and Response has been reviewed and tested through both System Executive Committee and the Executive Management Team and reduced from a residual score of 16 to a residual risk score of 8.

The residual risk scores across the remaining strategic risks have remained consistent over the last couple of months.

Appendices:	• Appendix 1 – LLR ICB BAF 2023/24 •
Report history (date and committee / group the content has been	• 23 March 2023 – proposal presented for consideration and discussion at the Board development session. • 3 April 2023 – EMT further considered the proposal for ICB BAF 2023/24.

discussed / reviewed prior to presenting to this meeting):	• April 2023 – July 2023 – each of the Board Committees have received and commented on the BAF • July – November 2023 - all Board Committees received the BAF at agreed intervals following review by EMT. • October 2023 – EMT reviewed the BAF and agreed content. • December 2023 – EMT reviewed the BAF and agreed content.

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

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

Implications:	
a) Does the report provide assurance against a corporate risk(s) e.g. risk aligned to the Board Assurance Framework, risk register etc? *If so, state which risk and also detail if any new risks are identified.*	Not having the fundamental governance and risk management arrangements could result in non-compliance with legal and statutory requirements.
b) Does the report highlight any resource and financial implications? If so, provide which page / paragraph this can be found within the report.	None specifically in relation to this report.
c) Does the report highlight quality and patient safety implications? If so, provide which page / paragraph this is outlined in within the report.	None specifically in relation to this report.
d) Does the report demonstrate patient and public involvement? If so, provide which page / paragraph this is outlined in within the report.	None specifically in relation to this report.
e) Has due regard been given to the Public Sector Equality Duty? If so, how and what the outcome was, provide which page / paragraph this is outlined in within the report.	Not specifically in relation to this report, however the principles are contained with the Constitution and governance arrangements.

ICB Board Assurance Framework 2023/24

Purpose

1. This report aims to provide the Board with assurance that the risk management arrangements across the organisation continue to be fit for purpose and that the ICB's Board Assurance Framework (BAF) continues to be reviewed in line with agreed processes.

Governance arrangements and assurance

Risk Management Strategy and Policy

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

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

Executive and Committee responsibility

4. The Executive Management Team is responsible for the effective implementation of risk management arrangements and for ensuring adequate controls are in place to manage / mitigate risks. The Executive Management Team is also responsible for the regular review of the BAF in its entirety and evaluate strategic risks prior to escalation to the Board.

5. Each Board Committee is responsible for oversight of specific risks as assigned to it within the BAF and for providing appropriate assurance through the Committee assurance reports to the Board.

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

Consideration of system wide risk profile

7. Risks arising across the system will continue to be evaluated through the Committee structure to assess whether a risk solely relates to the ICB or whether there are implications for the ICB and other partner organisations. The Board agreed that it was key to identify the event that could potentially lead to a risk materialising and then identify which organisation would be responsible for managing and controlling this event. This would determine whether the risk is already being managed through existing risk management arrangements within partner organisations.

8. As alluded to in previous reports to the Board, the following principles continue to apply:

    a. The ICB BAF will capture strategic risks that the ICB can influence and / or control relating specifically to the ICB (i.e. specific to the ICB as a statutory body) and
    b. The ICB BAF will capture strategic risks that the ICB can influence and / or control where they collectively impact the ICB objectives and system objectives (categorise these as "system" risks). However, this element will continue to evolve as processes mature and develop.

9. **Risk profile across partner organisations –** periodically a comparison of the risk profile across the ICB, LPT and UHL is carried out to ascertain the risk profile across the health organisations across LLR. The recent review undertaken in October identified the continued similarities in the risk profiles, although recognising the cause and the impact of risks vary given the nature of each organisation. It is anticipated that this review will be extended to local authority partners in the new year and for the review to be undertaken in conjunction with respective leads across the three local authorities.

Board Assurance Framework (BAF) updates

10. The ICB's Board Assurance Framework (BAF) continues to be aligned to the ICB's Strategic Objectives and Five Year Plan. The risk descriptions were agreed by the Board in April and amendments approved in July 2023. The ICB BAF is a live document and has therefore been updated to reflect change in controls, gaps identified, and action taken. In reviewing the BAF lead officers were reminded to consider the following:

    i. What are the key drivers for each strategic risk?
    ii. Are the key drivers sufficient and mitigating the risk?
    iii. What further actions are required to achieve the residual risk score? Or if the actions continue to be appropriate, how long will it take to reduce the residual risk and for it to align with the risk appetite level?
    iv. Are you still confident that the actions being taken are the correct actions to mitigate the risks?

11. The updated BAF is as at **Appendix 1** with a high-level summary captured in **Table 1.**

12. Since the last report to the Board in July 2023, each of the Board Committees have also reviewed and scrutinised the risk(s) assigned to them and have also had the opportunity to assess interdependencies across strategic risks. Each Committee has sought assurance from the executive officers in respect of controls and assurances in place and actions taken and have also offered observations and suggestions to support further action. This is evidenced through the BAF (as at Appendix 1) and also through the Committee assurance reports presented to the Board.

13. The Board's attention is drawn to the following specific updates in relation to the BAF:

    a) **Risk Owners** - have been updated across the BAF to reflect recent executive appointments.

    b) **Risks with a high residual risk scores:** BAF 2 - Health inequalities (residual risk score of 20) and BAF 4 - finance (residual risk score of 20) remain the highest scoring residual risks, closely followed by BAF 5 - quality and safety (residual risk score of 16).

    c) **Change in residual risk scores**:
        - Since the last report to the Board in July 2023, the residual risk score for BAF risk 6 – Emergency Preparedness, Resilience and Response has been reviewed and tested through both System Executive Committee and the Executive Management Team and reduced from a residual score of 16 to a residual risk score of 8. This followed completion of specific actions and external assurance received from NHS England following a review of the ICB's core standards submission.

        - The residual risk scores across the remaining strategic risks have not changed and have remained consistent over the last couple of months.

d) **Updates against actions and mitigations** - detailed in Appendix 1.

e) Updates in relation to specific risks:

a. **BAF risk 2 – health inequalities** – the Health Equity Committee has undertaken a detailed review of the actions required to reduce the residual risk score. The actions for completion over a 6 – 8 month period aim to focus on creating recurrent processes which endeavour to give all patients an equitable opportunity to access the full range of NHS care through the life course and to obtain good outcomes. This in turn will aim to affect, firstly, the likelihood of the risk materialising and, secondly (over a longer time scale), the impact of the strategic risk. The evidence that would provide that assurance will emerge over time. The Board considered a detail review of the content of this risk at its development session in September 2023 and were assured by the actions being taken.

b. **BAF risk 4 – finance** – a detailed report on the current financial position is presented to the Board under a separate agenda item.

c. **BAF risk 5 - quality and safety** – the Quality and Safety Committee will be undertaking a deep dive into the BAF risk on 7 December 2023. Subsequently, a further review of the BAF risk will be undertaken.

d. **BAF risk 8 - workforce** – the risk owner is currently reviewing the risk in line with comments and observations made by the Remuneration Committee in November 2023. The Committee members asked if the risk, as described, remains relevant and whether the "pressures" as referenced within the risk description need to be specified. In addition, it is noted that the residual risk scores remains at 12 and the risk appetite has been assessed as 8, further actions may need to be considered to address the residual risk.

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

Strategic risk	Residual risk score (trend)	Exec Lead	Committee oversight
BAF 1 – Partnership The ICB is unable to develop and sustain a culture of collaboration / partnership working and thus unable to improve outcomes in population health and healthcare.	**12**	**CT**	System Executive Committee / EMT
BAF 2 – Health Inequalities Failure to adequately address health inequalities due to a lack of investment and / or lack of partnership working, therefore unable to improve health equity and outcomes for the population of LLR.	**20**	**SP**	Health Equity Committee
BAF 3 – Demand and Capacity Demand could exceed capacity in commissioned services due to a variety of factors. This could result in patients not accessing services in the right place, at the right time, at the right level of care.	**12**	**RV**	System Executive Committee
BAF 4 – Finance The financial viability of the local health economy (over the short, medium and long term) cannot be assured due to a lack of robust transformation processes and tested schemes, this could impact organisational reputation, incur possible financial penalties and result in closer regulatory scrutiny.	**20**	**RT**	Finance Committee
BAF 5 – Quality and Safety Failure to maintain and improve the quality of services and meet the core standards could result in poor patient experience and potential harm and poor quality outcomes for patients.	**16**	**KD / NS**	Quality and Safety Committee

Strategic risk	Residual risk score (trend)	Exec Lead	Committee oversight
BAF 6 – Emergency Preparedness, Resilience and Response Failure to have robust emergency preparedness, resilience and response (EPRR) processes in place due to lack of capacity and / or lack of partnership could result in inadequate response to major and / or business continuity incidents.	**8** ⬇	**RV**	System Executive Committee / EMT
BAF 7 – Cyber A significant rise in new and unknown cyber-attacks (locally or nationally) could make access to IT services unavailable for extended periods of time. This may result in risks to the confidentiality of corporate or patient confidential data, disruption to organisational business continuity and to operational services.	**12**	**RT**	Executive Management Team
BAF 8 – Workforce The ability to recruit and retain staff may be affected by the pressures and reduction in running costs impacting on enhancing productivity and delivering the ICB's strategic objectives.	**12**	**AMcG**	Remuneration Committee / People Board

Recommendations

The LLR ICB Board is asked to:

- **RECEIVE and APPROVE** the updated ICB Board Assurance Framework (BAF) 2023-24 as at Appendix 1, this includes the reduction in residual risk score for BAF 6 – Emergency Preparedness, Resilience and response (from a residual risk score of 16 to 8).

- **BE ASSURED** that the BAF continues to be aligned to the ICB's Strategic Objectives and that it is reviewed at agreed intervals by the Executive Management Team and the Board Committees (assurance reported through each Committee's assurance report to the Board).

Appendix 1

APPENDIX 1

Leicester, Leicestershire and Rutland Integrated Care Board

Board Assurance Framework 2023/24

(Version 9 as at December 2023)

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

CONTENTS **PAGE**

LLR ICB Strategic Objectives

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

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

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

Principal / strategic risk:

BAF 1 – Partnership

The ICB is unable to develop and sustain a culture of collaboration / partnership working and thus unable to improve outcomes in population health and healthcare.

Date risk identified	ICB Executive lead (risk owner)	ICB Committee oversight	Risk category (✓ applicable category(ies))		ICB only or system risk (✓ one)		Risk rating (impact x likelihood = risk score)						Risk treatment *(i.e. state whether to terminate, treat, transfer, or tolerate the risk)*	If to be treated confirm frequency of review (e.g. monthly, quarterly)
					ICB	System								
March 2023	**Caroline Trevithick**	EMT / System Executive Committee	Clinical		✓		**Gross/inherent risk score**	4	x	4	=	**16**	Treat	**Quarterly**
			Organisational	✓			**Risk appetite score**	4	x	2	=	**8**		
			Financial				**Net/residual/ current risk score**	4	x	3	=	**12**		
			Information				**Residual / current risk score trend since last report:**						 **October 2023** – risk assessed and no further changes required at present.	
							Next review date:						End January 2024	

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

Actions being taken to address gaps in controls and/or assurance					
Detail the actions to be taken *What actions are required to bridge the gaps in controls and/or assurance?*	**Action to be completed by (date)**	**Will the action reduce impact of risk score or likelihood or both?**			**Progress on action(s)** *Brief note on updates/progress where appropriate and confirm when action completed.*
		Impact	Likelihood	Impact and likelihood	
a) Look for formal tool to measure partners' assessment of collaboration to provide structured feedback to ICB on their perception of our performance. If a suitable one can be identified – request system partners to complete and evaluate response.	~~30 August 2023~~ End March 2024			✓	

Principal / strategic risk:

BAF 2 – Health Inequity

Failure to adequately address health inequalities due to a lack of investment and / or lack of partnership working, therefore unable to improve health equity and outcomes for the population of LLR.

Date risk identified	ICB Executive lead (risk owner)	ICB Committee oversight	Risk category (✓ applicable category(ies))		ICB only or system risk (✓ one)		Risk rating (impact x likelihood = risk score)						Risk treatment *(i.e. state whether to terminate, treat, transfer, or tolerate the risk)*	If to be treated confirm frequency of review (e.g. monthly, quarterly)
					ICB	System								
20 March 2023	**Sarah Prema**	**EMT / System Executive Committee**	Clinical	✓		✓	**Gross/inherent risk score**	5	x	5	=	**25**	Treat	Bi-monthly
			Organisational	✓			**Risk appetite score**	5	x	3	=	**15**		
			Financial	✓			**Net/residual/ current risk score**	5	x	4	=	**20**		
			Information				**Residual / current risk score trend since last report:**						**October 2023** – risk assessed and no further changes required at present.	
							Next risk review date:						End December 2023	

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

• Maternity Equity Plan submitted to NHSE September 2022 – Delivery Group meets monthly to oversee action on plan. • Each PCN has nominated a HI Lead as part of the national reducing Health Inequalities in Neighbourhoods DES.			

Actions being taken to address gaps in controls and/or assurance					
Detail the actions to be taken *What actions are required to bridge the gaps in controls and/or assurance?*	**Action to be completed by (date)**	**Will the action reduce impact of risk score or likelihood or both?**			**Progress on action(s)** *Brief note on updates/progress where appropriate and confirm when action completed.*
		Impact	Likelihood	Impact and likelihood	
Undertake a review of the quality of ethnicity coding in primary care and develop an improvement plan	September 2023			✓	Clinical coding deep dive completed and improvement plan being developed.
Establish re-current data processing to allow reports to be created for information and analysis enabling profiling of access, experience, and outcomes data by Ethnicity and postcode to support Health equity initiatives across all clinical specialties.	March 2024			✓	Working on establishing a re-current process. A draft report on elective waiting lists completed.
Develop the information governance and data processing framework to support population health management and Risk stratification.	March 2024			✓	New Section 251 application for risk stratification submitted by ICB on 7 August 2023. There may be additional requirements to enable processing of data for population health management to link NHS data with wider datasets, which is being explored with the information governance lead.
Promote a culture within the organisation that enables staff to feel empowered to address health inequity.	October 2023			✓	LLR Head of PHM and Health Equity has delivered a number of sessions across the organisation on the ICB's role in promoting health equity. For example, sessions delivered to two Integrated Neighbourhood Teams in August 2023, and to LPT Mental Health senior leadership. Application submitted for three-year MacMillan funding to resource a programme to reduce health Inequalities in Cancer in LLR.

Ensure health inequalities is integral to the Research Strategy and is more prominent in LLR research activities.	October 2023			✓	Action in progress, meeting to take place with LLR Research Group to discuss health inequalities in research in August and October 2023.
Engage the communities most affected by health inequalities to raise awareness and co-produce solutions to challenges in understanding, accessing, and benefitting from NHS services.	March 2024			✓	The ICB has supported partners in a range of engagement activities across various communities about how best to access screening and prevention offers. For example, 23 Somali bowel cancer champions recruited and trained at UHL in July via ICB funding and the annual Health Check programme for LD and SMI underway.

Principal / strategic risk:

BAF 3 – Demand and Capacity

Demand could exceed capacity in commissioned services due to a variety of factors. This could result in patients not accessing services in the right place, at the right time, at the right level of care.

Date risk identified	ICB Executive lead (risk owner)	ICB Committee oversight	Risk category (✓ applicable category(ies))		ICB only or system risk (✓ one)		Risk rating (impact x likelihood = risk score)					Risk treatment *(i.e. state whether to terminate, treat, transfer, or tolerate the risk)*	If to be treated confirm frequency of review (e.g. monthly, quarterly)
					ICB	System							
March 2023	Rachna Vyas (Chief Operating Officer)	System Executive (operational oversight: LLR Delivery Partnership)	Clinical	✓		✓	**Gross/inherent risk score**	4	x	5	=	**20**	Treat	Quarterly
			Organisational	✓			**Risk appetite score**	3	x	3	=	**9**		
			Financial	✓			**Net/residual/ current risk score**	4	x	3	=	**12**		
			Information				**Residual / current risk score trend since last report:**						⟷ Reviewed in October 2023.	
							Next risk review date:						End January 2024

Key controls in place and rationale for current / residual risk score	Internal and / or external assurances *Where can we gain evidence that our controls/systems on which we are placing our reliance are effective?*		Gaps in controls and/or assurance *Where are the gaps in our control/systems? Where are we failing to make them effective? Where is the ICB failing to gain evidence that the controls/systems are effective?*
	internal	**external**	
Operational performance monitoring and review of metrics through various groups and Committees. This will primarily be led through the LLR Delivery Partnership, reporting into the System Executive Committee and escalating to Clinical Executive Group, & the Quality and Safety Committee as needed.	Assurance reports and mitigations plans reported to the ICB Board and relevant Committee.	NHS England Quarterly System Review meetings.	A set of metrics, against all facets of the LLR 2023/24 operational plan, have been developed by each partnership. These cover the 31 metrics in the NHS mandate and are mapped to the 5 Year Plan pledges.
Revised Terms of Reference and governance in place for 2023/24, with a focus on performance, activity, finance, equity and quality by each programme lead. Terms of reference strengthened following review at some of the Committees of the ICB.	Assurance reports and mitigations plans reported to the ICB Board and relevant Committee.	NHS England Quarterly System Review meetings.	N/A

Actions being taken to address gaps in controls and/or assurance					
Detail the actions to be taken *What actions are required to bridge the gaps in controls and/or assurance?*	**Action to be completed by (date)**	**Will the action reduce impact of risk score or likelihood or both?**			**Progress on action(s)** *Brief note on updates/progress where appropriate and confirm when action completed.*
		Impact	Likelihood	Impact and likelihood	
Development of an operational plan delivery dashboard detailing performance against the 31 nationally mandated indictors in the 2023/24 operational plan.	Yasmin Sidyot (30 June 2023)			✓	Draft dashboard completed, trialled in April 2023. **ACTION COMPLETE**
Development of a single summary report for System Executive, detailing performance against all facets of delivery, with SMART escalations for action from either the clinical exec, system exec or quality group	Yasmin Sidyot (via the internal ODG by 30 June 2023)			✓	Draft report for April being trialled. **ACTION COMPLETE**
Strengthen accountability and understanding of where escalations should be made within system governance when any facet of 'value' is off track i.e. CIP or performance	Yasmin Sidyot / Ket Chudasama (via the internal ODG by end November 2023)			✓	New CEO and CFO delivery group established w/c 3rd Oct to assess further escalations Commissioning framework for each Partnership under development, draft expected at System Exec in November 2023.

Principal / strategic risk:

BAF 4 – Finance

The financial viability of the local health economy (over the short, medium and long term) cannot be assured due to a lack of robust transformation processes and tested schemes, this could impact organisational reputation, incur possible financial penalties and result in closer regulatory scrutiny.

Date risk identified	ICB Executive lead (risk owner)	ICB Committee oversight	Risk category (✓ applicable category(ies))		ICB only or system risk (✓ one)		Risk rating (impact x likelihood = risk score)						Risk treatment *(i.e. state whether to terminate, treat, transfer, or tolerate the risk)*	If to be treated confirm frequency of review (e.g. monthly, quarterly)
					ICB	System								
Carried forward from 2022/23	**Robert Toole**	Finance Committee	Clinical			✓	**Gross/inherent risk score**	5	x	4	=	**20**	Treat	**Bi-monthly**
			Organisational	✓			**Risk appetite score**	4	x	2	=	**8**		
			Financial	✓			**Net/residual/ current risk score**	4	x	5	=	**20**		
			Information				**Residual / current risk score trend since last report:**						⟺ Reviewed in December 2023	
							Next risk review date:						February 2024	

Key controls in place and rationale for current / residual risk score	Internal and / or external assurances *Where can we gain evidence that our controls/systems on which we are placing our reliance are effective?*		Gaps in controls and/or assurance *Where are the gaps in our control/systems? Where are we failing to make them effective? Where is the ICB failing to gain evidence that the controls/systems are effective?*
	internal	**external**	
System Financial Strategy refreshed following submission of the 2023/24 ICB Operational Plan and Financial Plan, and aligned to the LLR ICB medium term financial plan. Three-year Capital Plan reflecting the 2023/24 guidance approved by the ICB Board in April 2023. Proposes sustainable position at the end of the term.	Approval of the 5 Year Plan by the ICB Board.	Internal and External Auditor reports and findings are in progress (integrity of the General Ledger and Financial Systems Report 2022/23).	Significant transformation and efficiency schemes will be required over the next few years to bring about balance both in terms of organisational and system designed programmes.
Long term capital programme developed to address infrastructure and IT risks.	Systemwide approach to reviewing and determining capital needs.		Three year capital envelopes may not be sufficient to deliver all partners' capital asks.
System Finance Team monitor the system position and provide monthly reports to LLR ICB Finance Committee.	Financial performance reports are reviewed monthly by the Finance Committee and assurance reports reviewed by the Board.		The 23/24 financial plans include a number of risks and pressures across ICS which will need to managed in year, including unmitigated planning risks which crystallise in year
			The level of pressure currently (and for a sustained period) on the urgent care system could lead to a necessary increase in costs
			Recruitment and retention are key to system transformation and financial recovery. There is limited workforce available within the area and a number of competing employers. Lack of workforce may cause schemes to slip or costs to rise due to agency usage. Recruitment to additional posts may cause financial pressures.
Monthly finance report to Finance Committee refreshed to cover POD delegation and raise visibility over risks given magnitude.	Financial performance reports are reviewed monthly by the Finance Committee and assurance reports reviewed by the Board.		**N/A**
Internal and External Auditors conduct annual audits on financial systems to provide assurance that internal controls are effective.		Internal and external auditor reports and opinion. Unqualified opinion received from the external auditors and satisfactory value for money report.	Year end governance processes for 2022/23 underway (i.e. Annual Report and Accounts).

Actions being taken to address gaps in controls and/or assurance					
Detail the actions to be taken *What actions are required to bridge the gaps in controls and/or assurance?*	**Action to be completed by (date)**	**Will the action reduce impact of risk score or likelihood or both?**			**Progress on action(s)** *Brief note on updates/progress where appropriate and confirm when action completed.*
		Impact	Likelihood	Impact and likelihood	
Implementation of NHSE Financial Controls	~~**July 2023**~~ ~~**September 2023**~~ **December 2023**		✓		Comprehensive review to ensure to all of NHSE specified financial controls are in place and embedded in ways of working. Assurance sought across individual organisations in relation to implementation, assurance to be presented at the September 2023 Finance Committee. Agreed to undertake an audit of the key controls believed would have the most impact – terms of reference agreed in September 2023, report due in December 2023. Providers are strengthening controls to bring further improvement in bank / agency spend.
Cost Improvement Plans to be established with credible schemes to enable financial targets for 2023/24 to be achieved.	~~**July 2023**~~ **January 2024**		✓		In July 2023 - ICB Board approved a system wide plan focusing on four workstreams. Plan will be risk assessed each month to identify any gaps in delivery through Delivery Programme Board and overseen by Finance Committee. August 2023 - update reported to the Board in respect of deliverability. Further work undertaken to identify high risk schemes which are described as because of their contractual, performance, clinical, safety and political implications. Proposal shared with system Exec in August and Board in September to establish feasibility of taking these forward – opportunity not

					sufficient to mitigate financial risks across the system. Now working on "what good looks like" to feed into the medium term financial plan to deliver sustainable financial position over the longer term. October 2023 – update on in year and medium term reviewed at confidential Board meeting. Update on in year and medium term given to October Confidential board and finance committee in November. Finance Committee in January to focus on efficiency plans for future years.
Systemwide review of capital needs and risks vs three year capital allocation	~~**July 2023**~~ **November 2023**		✓		System Capital Group to identify issues. Report presented at the System Executive meeting. Further work ongoing to prioritise strategic and operational schemes within envelope available.
HFMA financial sustainability audit	**September 2023**			✓	Update on progress being achieved on implementing actions coming out of the HFMA financial sustainability review. **ACTION COMPLETE**
More comprehensive review of the financial impact of taking forward priorities in medium term plan to ensure they can deliver cost efficiencies and are affordable	**September 2023**			✓	Detailed review as we head into 24/25 planning round through Delivery Programme Board and partnerships /collaboratives. This will need to incorporate consequences of the national workforce plan. Finance Committee (January 2024) to focus on efficiency plans for future years.
Taking forward development of Lead Provider Framework approach for UEC to enable cost improvement plan of circa £17m to be achieved	**June 2023**			✓	Strategy leads across ICB, UHL and LPT developing MOU. Verbal update provided to System Exec (August 2023).
Ensure delivery of the financial plan for 2023/24 with an agreed deficit of £10m and an expectation from NHSE that we improve against that to deliver break even	**March 2024**			✓	Monthly finance reports, CIP scorecards and overview of risks to be received for scrutiny by Finance Committee, System Exec and ICB Board.

Principal / strategic risk:
BAF 5 – Quality and Safety
Failure to maintain and improve the quality of services and meet the core standards could result in poor patient experience and potential harm and poor quality outcomes for patients.

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

Key controls in place and rationale for current / residual risk score	Internal and / or external assurances *Where can we gain evidence that our controls/systems on which we are placing our reliance are effective?*		Gaps in controls and/or assurance *Where are the gaps in our control/systems? Where are we failing to make them effective? Where is the ICB failing to gain evidence that the controls/systems are effective?*
	internal	**external**	
Monthly performance monitoring reports reviewed by the Quality and Safety Committee and the System Executive Committee. LLR Deliver Partnership reports to include section on Quality	Committee assurance reports presented to the ICB Board.	External scrutiny via NHS England Quality System Review Meetings.	Quality concerns relating to Children and Young and Cancer performance. Quality concerns relating to LDA homes
UEC Partnership Board established and reviews pressures across urgent and emergency services.	Regular briefings and reports to the ICB Board.	External scrutiny via NHS England.	None at present from ICB perspective, note working in partnership with provider organisations.
Quality Impact and Equality Impact Assessment of projects and business cases not receiving investment funding in 23/24	System Review Panel and Clinical Executive informed about assessment findings and impact on quality and outcomes	NHS E quarterly assurance meetings	Seek assurance and undertake review of completed EQIAs of the business cases that have not received investment. (this means that the residual risk score remains the same).
Clinical Prioritisation process established for business cases.	System Executive Committee oversight and to be appraised of progress.		N/A

Actions being taken to address gaps in controls and/or assurance					
Detail the actions to be taken *What actions are required to bridge the gaps in controls and/or assurance?*	**Action to be completed by (date)**	**Will the action reduce impact of risk score or likelihood or both?**			**Progress on action(s)** *Brief note on updates/progress where appropriate and confirm when action completed.*
		Impact	Likelihood	Impact and likelihood	
SROs and leads to complete QIAs & EIAs – notified in letter from ICB	**Chris West & Dr S Nainani**		✓		Process in place. **ACTION COMPLETE**
Establish the System review Panel – to review and determine overarching level of risk associated with unfunded business cases. EQIA policy and procedure to be reviewed and updated.	**Dr Nainani** **Chris West**		✓		Review of unfunded business cases completed (note risk removed from the System Quality risk log). **ACTION COMPLETE** EQIA procedure approved at System Quality Group August 2023. **ACTION COMPLETE**
Quality summit for CYP – June 2023. CYP Partnership to progress agreed actions.	**Helen Mather**			✓	Actions being implemented through the Children and Young People, Urgent and Emergency Care and Elective Partnerships and Mental Health and Learning Disability &

Quality summit for Cancer – May 2034. Elective Partnership Board to progress agreed actions	**Dr Andy Ayhow**				Autism Collaborative. **ACTION TO BE CLOSED.** Actions reviewed by Quality and Safety Committee in July 2023. **ACTION COMPLETE**
Work with Public health through the health and wellbeing Boards to address inequalities in health outcomes linked to the wider determinants of health	**Caroline Trevithick**			✓	Work commencing to identify ways to monitor quality outcomes at 'place' included in the Quality Strategy Implementation Plan – quarterly updates scheduled for Quality and Safety Committee.
LDA Partnership developing clinical standards within LD residential care home contracts to ensure providers can be held accountable. Small multidisciplinary team of healthcare professionals for intensive support package, for homes	**David Williams**			✓	Actions in place

Principal / strategic risk:

BAF 6 – Emergency Preparedness, Resilience and Response

Failure to have robust emergency preparedness, resilience and response (EPRR) processes in place due to lack of capacity and / or lack of partnership could result in inadequate response to major and / or business continuity incidents.

Date risk identified	ICB Executive lead (risk owner)	ICB Committee oversight	Risk category (✓ applicable category(ies))		ICB only or system risk (✓ one)		Risk rating (impact x likelihood = risk score)					Risk treatment *(i.e. state whether to terminate, treat, transfer, or tolerate the risk)*	If to be treated confirm frequency of review (e.g. monthly, quarterly)
					ICB	System							
July 2022	**Rachna Vyas**	System Executive / EMT	Clinical			✓	**Gross/inherent risk score**	5	x	4	= **20**	~~Treat~~	**Quarterly**
			Organisational	✓			**Risk appetite score**	4	x	3	= **12**	Tolerate	
			Financial	✓			**Net/residual/ current risk score**	4	x	2	= **8**		
			Information				**Residual / current risk score trend since last report:**					⟷ **November 2023** - all actions completed from ICB perspective, no gaps identified therefore residual risk score remains the same.	
							Next risk review date:					End January 2024	

Key controls in place and rationale for current / residual risk score	Internal and / or external assurances *Where can we gain evidence that our controls/systems on which we are placing our reliance are effective?*		Gaps in controls and/or assurance *Where are the gaps in our control/systems? Where are we failing to make them effective? Where is the ICB failing to gain evidence that the controls/systems are effective?*
	internal	**external**	
LLR Incident Response Plan in place and Corporate Business Continuity Plan in place. Both have been updated and test exercise conducted on the Business Continuity Plan in June 2023.	• ICB checklist and evidence review. • Updates on EPRR core standards compliance presented to the ICB Board. • Internal Audit undertaken in 2022/23 providing "significant assurance". • ICB Major Incident Exercise to take place in December 2023. This will also test ICC arrangements and Comms EPRR Plan.	• Regular meetings with NHS England and LHRP. • NHS England reviews ICB's compliance with EPRR core standards.. ICB have achieved substantial compliance against the standards for 2023/24 with 89%. • 360 Assurance conducted an internal audit review providing significant assurance.	Plans to be reviewed to align responsibilities to Level 1 responder. **ACTION COMPLETE**
ICB Training Needs Assessment completed and DoC training plan in place.			N/A
ICS EPRR Work programme actions continue to be implemented and will be updated following the outcome of the Core Standards assessment.			N/A
Health Emergency Planning Operational Group (HEPOG) oversees actions from the LHRP meetings.			Testing of partner organisation plans underway and confirmation awaited.
Health EPRR Risk Management Group to assess local health risks and priorities and establish a system risk register for EPRR.			N/A
Testing of emergency planning takes place.			N/A
Strategic Control Centre and Incident Command Centre arrangements in place.			N/A
LRF Executive Board meetings in place quarterly.			N/A
Regular Director on Call lunch and learn sessions in place providing update on SCC functions, updates to ICB plans and policies and updates from ICS partners.			N/A

Actions being taken to address gaps in controls and/or assurance					
Detail the actions to be taken *What actions are required to bridge the gaps in controls and/or assurance?*	**Action to be completed by (date)**	**Will the action reduce impact of risk score or likelihood or both?**			**Progress on action(s)** *Brief note on updates/progress where appropriate and confirm when action completed.*
		Impact	Likelihood	Impact and likelihood	
1. Table-top exercise yet to be arranged to test the Business Continuity Plans across LLR ICB. (Corporate Governance Team in conjunction with the EPRR team). 2. Review the ICB's Corporate Business Continuity Policy and Plan following NHS England's review of the EPRR core standards (Corporate Governance Team in conjunction with the EPRR team).	End June 2023 End August 2023			✓	• Directorate level risk registers in place across all directorates / functions and table-top test exercise carried out on 8 June 2023.**ACTION COMPLETE** • Feedback from NHS England's review of the core standards to inform the review of the Corporate Business Continuity Plan prior to testing the plan. Following which the Corporate Business Continuity Policy and Plan will be reviewed. **ACTION COMPLETE**

Principal / strategic risk:

BAF 7 – Cyber

A significant rise in new and unknown cyber-attacks (locally or nationally) could make access to IT services unavailable for extended periods of time. This may result in risks to the confidentiality of corporate or patient confidential data, disruption to organisational business continuity and to operational services.

Date risk identified	ICB Executive lead (risk owner)	ICB Committee oversight	Risk category (✓ applicable category(ies))		ICB only or system risk (✓ one)		Risk rating (impact x likelihood = risk score)						Risk treatment *(i.e. state whether to terminate, treat, transfer, or tolerate the risk)*	If to be treated confirm frequency of review (e.g. monthly, quarterly)
					ICB	System								
Carried forward from 2022/23	**Robert Toole (as SIRO)**	Executive Management Team	Clinical		✓		**Gross/inherent risk score**	4	x	4	=	**16**	Treat	**Quarterly**
			Organisational	✓			**Risk appetite score**	2	x	4	=	**8**		
			Financial	✓			**Net/residual/ current risk score**	3	x	4	=	**12**		
			Information				**Residual / current risk score trend since last report:**						⟺ Last reviewed in October 2023.	
							Next risk review date:						End January 2024	

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

Actions being taken to address gaps in controls and/or assurance					
Detail the actions to be taken *What actions are required to bridge the gaps in controls and/or assurance?*	**Action to be completed by (date)**	**Will the action reduce impact of risk score or likelihood or both?**			**Progress on action(s)** *Brief note on updates/progress where appropriate and confirm when action completed.*
		Impact	Likelihood	Impact and likelihood	
Efficacy of local continuity plans for service provision in the event of a successful cyber-attack, preventing access to IT systems (including VPN) for an extended period (e.g., days).	End October 2023			✓	• Acquire assurance, through testing, that local service continuity plans are established and are operating as expected (i.e. service provision is not affected by outage).
Additional controls being considered to address risk (e.g. 3rd party monitoring of network estate OoO, etc).	End January 2024			✓	• Work in progress.

Principal / strategic risk:

BAF 8 – Workforce

The ability to recruit and retain staff may be affected by the pressures and reduction in running costs impacting on enhancing productivity and delivering the ICB's strategic objectives.

Date risk identified	ICB Executive lead (risk owner)	ICB Committee oversight	Risk category (✓ applicable category(ies))		ICB only or system risk (✓ one)		Risk rating (impact x likelihood = risk score)						Risk treatment *(i.e. state whether to terminate, treat, transfer, or tolerate the risk)*	If to be treated confirm frequency of review (e.g. monthly, quarterly)
					ICB	System								
March 2023	**Alice McGee**	Remuneration Committee / People Board	Clinical		✓		**Gross/inherent risk score**	4	x	4	=	**16**	Treat	**Bi-monthly**
			Organisational	✓			**Risk appetite score**	4	x	2	=	**8**		
			Financial				**Net/residual/ current risk score**	4	x	3	=	**12**		
			Information				**Residual / current risk score trend since last report:**						⟷ **October 2023** – risk reviewed content remains the same and no further actions identified.	
							Next risk review date:						End December 2023	

Key controls in place and rationale for current / residual risk score	Internal and / or external assurances *Where can we gain evidence that our controls/systems on which we are placing our reliance are effective?*		Gaps in controls and/or assurance *Where are the gaps in our control/systems? Where are we failing to make them effective? Where is the ICB failing to gain evidence that the controls/systems are effective?*
	internal	**external**	
Regular workforce dashboard reports presented to the Executive Management Team and the People Board meetings to understand trends of leavers and sickness rates.	Trends are being tracked and there has been no rise in workforce metrics. Current turnover rate is c.2% and sickness rates remain below 3%. Staff Survey results.		No gaps identified at present.
Remuneration Committee terms of reference updated to include assurance reports on ICB workforce and the people plan.	Workforce dashboard presented to the Committee.		No gaps identified at present.
Participation and analysis of monthly, quarterly and annual staff survey.	Outcomes of staff survey shared with EMT and Remuneration Committee.		No gaps identified at present.
Regular staff briefings and communication about impact of Running Cost Allowance reductions.	Workforce reports presented to the Remuneration Committee at agreed intervals.		No gaps identified at present.
Analysis of exit interview questionnaires to understand any trends.	Analysis shared with EMT and Remuneration Committee.		No gaps identified at present.
Annual appraisals to manage workload and priorities.	Dashboard assurance report to be produced for Remuneration Committee and EMT		No gaps identified at present.

Actions being taken to address gaps in controls and/or assurance					
Detail the actions to be taken *(including* *What actions are required to bridge the gaps in controls and/or assurance?*	**Action to be completed by (date)**	**Will the action reduce impact of risk score or likelihood or both?**			**Progress on action(s)** *Brief note on updates/progress where appropriate and confirm when action completed.*
		Impact	Likelihood	Impact and likelihood	
No actions identified.					

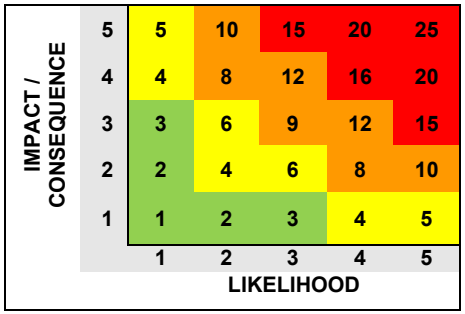
Appendix 1: Definitions and 5x5 Risk Matrix (as within the LLR ICB's Risk Management Strategy and Policy)

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

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

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

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



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

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

Key for Executive Directors:
CT = Caroline Trevithick, Chief Executive
AM = Alice McGee, Chief People Officer
RT = Robert Toole, Chief Finance Officer
KD = Kay Darby, Chief Nursing Officer
NS = Dr Nil Sanganee, Chief Medical Officer
RV = Rachna Vyas, Chief Operating Officer
SP = Sarah Prema, Chief Strategy and Planning Officer