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Meeting Title	**Leicester, Leicestershire and Rutland (LLR) Integrated Care Board meeting** (meeting held in public)	Date	**Thursday, 8 February 2023**
Meeting no.	**13**	Time	**Meeting in public: 9:00am – 10:55am** **Confidential meeting 11:00am – 11:30am**
Chair	**David Sissling** **Chair, ICB**	Venue / Location	MSTeams

REF	AGENDA ITEM	ACTION	PRESENTER	PAPER	TIMING
ICB/24/01	Welcome and Introductions	To receive	David Sissling (Chair)	**Verbal**	9:00am
ICB/24/02	Apologies for Absence: • Pauline Tagg, Non-Executive Member	To receive	David Sissling (Chair)	**Verbal**	9:00am
ICB/24/03	Notification of Any Other Business	To receive	David Sissling (Chair)	**Verbal**	9:00am
ICB/24/04	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/24/05	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/24/06	Minutes of the meeting held on 14 December 2023	To approve	David Sissling (Chair)	**A**	9:15am
ICB/24/07	Matters arising and actions for the meeting held on 14 December 2023	To receive	David Sissling (Chair)	**B**	
ICB/24/08	Update from the Chair	To receive	David Sissling (Chair)	**Verbal**	9:20am
ICB/24/09	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/24/10	Research update and Annual Report	To receive	Dr Nil Sanganee / Prof Mick Steiner / Carly McDonald	**C presentation**	9:35am
STRATEGY AND SYSTEM PLANNING					
ICB/24/11	Operational Planning 2024/25 update	To receive	Ket Chudasama (ICB Deputy Chief Strategy Officer)	**D**	9:50am
OPERATIONAL					
ICB/24/12	Gender Pay Gap report	To approve	Alice McGee (ICB Chief People Officer)	**E**	10:00am

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REF	AGENDA ITEM	ACTION	PRESENTER	PAPER	TIMING
ICB/24/13	Delegation of Specified Specialised Acute Services briefing paper	To receive	Ket Chudasama (ICB Deputy Chief Strategy Officer)	**F**	10:10am
ICB/24/14	LLR Delivery Partnership – Delivery of the LLR one- and five-year plans	To receive	Rachna Vyas (ICB Chief Operating Officer)	**G**	10:20am
ICB/24/15	LLR ICB Finance Report	To receive	Robert Toole (ICB Chief Finance Officer)	**H**	10:30am
ASSURANCE					
ICB/24/16	Assurance report from the Finance Committee	To receive	Jeff Worrall (ICB Finance Committee Chair)	**I**	10:40am
ICB/24/17	Assurance report from the System Executive Committee	To receive	Caroline Trevithick (ICB CEO)	**J**	
ICB/24/18	Assurance report from the Quality and Safety Committee	To receive	Kay Darby (ICB Chief Nursing Officer)	**K**	
ICB/24/19	Assurance report from the Audit Committee	To receive	Darren Hickman (ICB Non-Executive Member)	**L**	
ICB/24/20	Assurance report from the Health Equity Committee	To receive	Prof Azhar Farooqi (ICB Non-Executive Member)	**M**	
ANY OTHER BUSINESS					
ICB/24/21	Items of any other business and review of meeting	To receive	David Sissling	**Verbal**	10:55am

The next regular meeting of the LLR Integrated Care Board meeting will take place on **Thursday 11 April 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.*

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Minutes of the NHS LLR Integrated Care Board ("the ICB" or "the Board") Held in Public, Thursday 14 December 2023 9:00am – 11:05am, via MS Teams

Members present:

Mr David Sissling	NHS LLR ICB Independent Chair and Chair of the meeting
Dr Caroline Trevithick	Chief Executive, NHS LLR ICB
Ms Kay Darby	Chief Nursing Officer, NHS LLR ICB
Dr Nil Sanganee	Chief Medical Officer, NHS LLR ICB
Mr Robert Toole	Chief Finance Officer, NHS LLR ICB
Ms Sarah Prema	Chief Strategy Officer, NHS LLR ICB
Ms Alice McGee	Chief People Officer, NHS LLR ICB
Ms Rachna Vyas	Chief Operating Officer, NHS LLR ICB
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
Prof Azhar Farooqi	Non-Executive Member – Inequalities, Public Engagement, Third Sector and Carers, NHS LLR ICB
Sir Mayur Lakhani	Clinical Executive Lead, NHS LLR ICB
Mr Simon Pizzey	Associate Director of Strategy, University Hospitals of Leicester NHS Trust *(Deputising for Mr Richard Mitchell)*
Ms Angela Hillery	Partner Member - community/mental health sector representative (Chief Executive, Leicestershire Partnership NHS Trust)
Mr Mike Sandys	Partner Member – local authority sectoral representative (Director of Public Health, Leicestershire County Council)
Mr Mark Andrews	Partner Member – local authority sectoral representative (Chief Executive, Rutland County Council)
Dr Nainesh Chotai	Primary Care Sector representative

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:

Ms Rachel Dewar	Assistant Director of Urgent and Emergency Care, NHS LLR ICB
Ms Mel Thwaites	Head of Women's Maternity and Neonates Transformation, NHS LLR ICB *(for item ICB/23/141)*
Ms Sue Venables	Head of Engagement and Insights, NHS LLR ICB *(for item ICB/23/141)*
Ms Mina Bhavsar	Maternity Transformation Programme Manager, NHS LLR ICB *(for item ICB/23/141)*
Ms Anita Guest	Deputy Co-Chair of the Maternity and Neonatal Voices Partnership for LLR *(for item ICB/23/141)*
Ms Charlotte Gormley	Corporate Governance Officer, NHS LLR ICB (minute taker)

Seven members of the public attended to observe the meeting.

ITEM		LEAD RESPONSIBLE
ICB/23/132	**Welcome and Introductions** Mr David Sissling welcomed colleagues and members of the public to the meeting. He specifically welcomed Dr Trevithick (Chief Executive, LLR ICB),	

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ITEM		LEAD RESPONSIBLE
	Mr Toole (Chief Finance Officer, LLR ICB), and Ms Darby (Chief Nursing Officer) in their respective new roles. The meeting was held in public and was confirmed as quorate.	
ICB/23/133	**Apologies for absence from Members and Participants:** • Martin Samuels, Partner Member - local authority sectoral representative (Strategic Director, Partner Social Care and Education, Leicester City Council) • 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	
ICB/23/134	**Notification of Any Other Business** No additional items of business had been notified.	
ICB/23/135	**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/23/136	**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: Questions received from Sally Ruane *1. Please could you explain the governance arrangements surrounding the Maternity and Neonatal Voices Partnership? Is it a sub-committee of the ICB or does it have some other relationship to the ICB?* *2. Who appoints its co-chairs and board members?* Dr Trevithick advised that the Maternity and Neonatal Voices Partnership (MNVP) was an independent team of women and their families, commissioners (people who plan health services), healthcare professionals (midwives and doctors), and community organisations working together to improve local maternity and neonatal services. The Partnership provided a means for women to share their experiences of care and what mattered most to them. *Leicester Mammas* had been commissioned by the ICB, through the Local Maternity and Neonatal System (LMNS), to independently coordinate and run the MNVP for the local NHS. The MNVP had independently appointed its Chair and membership. The membership was open to women, birthing people, commissioners, providers, health professionals and community organisations. The MNVP reported to the LMNS Group. LMNS reported into the System Delivery Partnership Group (a sub-group of the System Executive Committee (Board Committee)), and the System Quality Group (a sub-group of the Quality and Safety Committee (Board Committee)).	
ICB/23/137	**Minutes of the meeting held on 12 October 2023 (Paper A)** The minutes of the ICB Board meeting held on 12 October 2023 were confirmed as an accurate record.	

ITEM		LEAD RESPONSIBLE
	It was RESOLVED to: • **APPROVE** the minutes of the ICB Board meeting held on 12 October 2023.	
ICB/23/138	**Matters Arising and actions for the meeting held on 12 October 2023 (Paper B)** Regarding action ICB/23/107, *to consider whether the impact of industrial action needs to be captured on the Board Assurance Framework (BAF)*, it was agreed that the associated risks would be explicitly specified within Emergency Preparedness, Resilience and Response (EPRR) risk. Regarding action ICB/23/119, Primary care access-*the Board requested a plan of actions with measurable indicators and outcomes*, it was agreed that the Board would receive an update in April 2024. Results from the patient experience survey would also be provided to contribute to the discussion. 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/23/139	**Update from ICB Chair** Mr Sissling advised that he had attended an event to celebrate the success of the reverse mentoring programme implemented by LLR ICB, UHL, LPT, local authorities, and primary care. He commented that this was an impressive programme aimed at developing informed insight for staff and was an excellent example of system working. Additionally, Mr Sissling had attended a recent meeting of the Leicester City Health and Wellbeing Board. Topics discussed had included winter planning, vaccinations and immunisations programmes, social care plans and a range of preventative initiatives aimed at children and young people and those experiencing fuel poverty. Mr Sissling observed that addressing inequity had been a key theme throughout a meeting which had served to further emphasise the benefits of effective integrated working. Finally, Mr Sissling described the opportunities associated with the Workwell Programme. This was a national initiative sponsored by the Department of Health and Social Care and the Department of Work and Pensions. He advised that LLR ICB was preparing a bid to act as a vanguard system for the programme, which aimed to reduce the significant barriers faced by those who had been out of work for health and care reasons, and to find accessible routes to enable a return to the workforce. It was noted that the Integrated Care Partnership would play a key role in supporting the bid. Mr Sissling confirmed that the Board would receive further updates once available. **It was RESOLVED to:** • **RECEIVE** the update.	
ICB/23/140	**Update from ICB, Acute Sector and Mental Health and Community Sector** Mr. Sissling invited Executive leaders to comment on the ongoing pressures being experienced in the urgent and emergency care pathways.	

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ITEM		LEAD RESPONSIBLE
	Dr Trevithick acknowledged that the system faced a number of challenges, including increasing Urgent and Emergency Care (UEC) demand. As a result, the escalation level had been raised to ensure that the system would deliver on all actions as set out in the winter plan. These included additional capacity, initiatives to control demand and strengthened discharge arrangements. Very detailed preparatory work had been undertaken for the forthcoming industrial action. The financial implications of the action taken to respond to the increasing urgent care pressures and industrial action would be carefully monitored. Dr Trevithick also reflected positively on the reverse mentoring programme as an active participant In his update regarding the acute sector, Mr Pizzey highlighted the Trust's commitment to addressing inequality, noting that UHL had hosted the British Indian Nurses Association (BINA) Conference on 1 December 2023. The commitment to becoming a better and more inclusive employer was also reflected in the recently updated Trust strategy. Furthermore, Mr Pizzey advised that UHL's success in reducing waiting times had been acknowledged nationally. He also commented on the urgent care pressure advising that demand was had increased by over 10% when compared to last year. Finally, Mr Pizzey noted that UHL was working closely in collaboration with Kettering and Northampton General Hospitals to introduce common, integrated improvement programmes. Ms Hillery highlighted the high occupancy rate in LPT's mental health beds. She noted that it was important to support timely discharge in order to maintain zero out of area placements for LLR patients. She also referenced the regional discussions to support improvements in Children and Adolescent Mental Health Services (CAMHS). More locally, Ms Hillery highlighted improved access to Children and Young People's services in Leicester City through targeted work that offered a range of appropriate services to local populations. Finally, Ms Hillery shared the positive response rate across LPT to a recent staff survey. Mr Sissling thanked members for their updates. **It was RESOLVED to:** • **RECEIVE** the updates.	
ICB/23/141	**Maternity and Neo-Natal Voices Partnership (MNVP) (Paper C)** Ms Thwaites introduced the presentation by highlighting the importance of listening to the views and experiences of those we care for. Recent reports and investigations into maternity services had evidenced the need to understand the issues that were important to women in order to make positive change.	

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ITEM		LEAD RESPONSIBLE
	Ms Guest continued and commented that a key aim of the Partnership was to listen to voices from all communities regarding how maternity services should be run. Work had therefore taken place to build a relationship of trust with communities and staff working within services. Steps had been taken to raise awareness of the MNVP through social networking and the development of a new website. There were currently 63 active members in the Partnership with support provided by a number of non-member organisations. A wide range of activities are being undertaken including work focussing on quality improvements at UHL. A recent survey had provided over 380 responses with good representation across Leicester City and Leicestershire. Key themes identified from the feedback included problems relating to providing informed consent, variable care received from community midwives, lack of breastfeeding support, and partners not being allowed overnight stays. On a positive note, respondents had reported compassionate care provided by midwives. In response, the Quality Improvement Team had developed solutions including improved information leaflets and a facilitation of partners remaining until midnight. Work continued towards enabling overnight stays. Next steps included a focus on fathers' experience, mental health considerations, anti-natal care, and bereavement. The MNVP would continue to be guided by the voices of parents and families. During discussion, concern was expressed regarding conflicting information being provided to patients on the benefits of natural birth versus interventions. Members were assured that patient information leaflets were being reviewed to ensure mothers were able to make informed decisions regarding their care. In response to queries raised, Ms Guest confirmed that a patient survey would be included on the new website as a continuous source of feedback in real-time. Specific issues were raised about service availability in Rutland and Melton. These included concerns about the future of St Mary's birth centre. Contact had been made with Healthwatch Rutland to raise awareness of the relevant issues. In terms of governance arrangements, Ms Thwaites confirmed that the Maternity Services Liaison Committee was no longer active, as the MNVP provided a more appropriate forum for involvement by patients and professionals. Members welcomed the presentation, acknowledging the value of the MNVP and its contributions to the maternity improvement programme. It was agreed that a progress update would be provided at a future meeting of the Board. **It was RESOLVED to:** • **RECEIVE** the presentation.	
ICB/23/142	**Operational Planning 2024/25 update (Paper D)** Ms Prema introduced the report, providing an update on 2024/25 Operational and Financial Planning processes. She covered key risks, emerging mitigations, and next steps. She also provided a brief update regarding the LLR	

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ITEM		LEAD RESPONSIBLE
	ICB 5 Year Plan (5YP) annual refresh and emphasised the need for alignment of the two planning processes to reduce duplication and provide a consistent narrative. Ms Prema confirmed that national guidance regarding Operational Planning for 2024/25 was expected to be released in the week commencing 18 December 2023. Work had however commenced, with agreement being reached in terms of key planning principles, the approach to investment and disinvestment, a prioritisation processes, and a process for the development of business cases. Work had also commenced on the financial plan with a view to developing a draft plan by mid-February 2024, and a plan for final approval by the end of March 2024. Members were assured that there would be numerous opportunities for Board involvement over the coming months. During discussion, Ms Prema confirmed that the requirement to produce a balanced plan would be confirmed in the planning guidance. Regarding business cases, she provided assurance that learning had been taken from the previous planning round. As a result, criteria had been put into place which greatly reduced the number of business cases which would be considered through the prioritisation process. Additionally, Dr Sanganee described the criteria which would be applied as part of the prioritisation process. Decisions would be taken with due attention to safety whilst also considering long-term objectives and the prevention agenda. The process would be bolstered by an understanding of internal decisions being made by partner organisations. Members supported the approach to planning as outlined within the report and acknowledged the need to focus on both financial requirements and service needs. Members also emphasised the requirement for executives to focus on productivity and workforce considerations. It was clear that an acceptable plan would require effective system working. It was agreed that a further update regarding operational planning would be provided to the Board in January 2024. **It was RESOLVED to:** • **NOTE** the 2024/25 Operational and Financial Plan update and 5YP annual refresh.	
ICB/23/143	**LLR ICB Workforce Race Equality Standard (WRES) and LLR ICB Workforce Disability Standard (WDES) (2022-2023) (Paper E)** Ms McGee introduced the item, providing an update on progress made against the Workforce Race Equality Standard (WRES) and Workforce Disability Equality Standard (WDES), together with a new combined WRES/WDES action plan. It was requested that the Board support the publication of the reports although there was no statutory requirement to do so. Ms McGee clarified that the data referred to the 300 employees of LLR ICB only. As partner organisations would follow a similar process, themes and actions would be cross-referenced. It was noted that the organisation was representative of the population in accordance with 2021 census data. This representation was not however consistent across all bands or the membership of the Board. Additionally,	

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ITEM		LEAD RESPONSIBLE
	Black, Asian and Minority Ethnic (BAME) staff were statistically less likely to be appointed following the short-listing stage of recruitment, and were more likely to report experiences of bullying, harassment, and lack of access to non-mandatory training opportunities. As a result, a responsive action plan had been developed. Concerns were expressed regarding the high percentage of staff reporting experiences of bullying and harassment by colleagues. Members were assured by the actions to address this and emphasised that the behaviours were unacceptable. In context, it was noted that 'colleagues' could refer to those working in a different organisation. There was a therefore a need for collective improvement as a system. During discussion, it was noted that the LLR ICB was appropriately mindful of the 9 protected characteristics as identified by the Equality Act 2010. It was agreed that a specific action would be developed regarding a review of representation on interview panels. Members welcomed the reports as timely and as a prompt for responsive action in respect of identified areas of concern. It was agreed to approve the reports and the action plan with an expectation of demonstrable progress in key areas. **It was RESOLVED to:** • **RECEIVE and APPROVE** for publication the WRES & WDES reports together with the combined action plan.	
ICB/23/144	**LLR Delivery Partnership – Delivery of the LLR one- and five-year plans (Paper F)** Ms Vyas introduced the item, providing an update on progress against the LLR Operational Plan and the LLR five-year plan made at Month 7 of 2023/24. She highlighted some areas of impressive progress, but also drew attention to performance challenges relating to aspects of cancer, urgent and emergency care and children's services. Ms Vyas provided updates on work in priority areas including the Children and Young People's (CYP) Partnership (which was focussing on immunisations and oral health), the collective delivery of the winter plan and programmes to address obesity in deprived areas. Additionally, health checks for individuals with Learning Disabilities (LD) were now being completed earlier, with a focus on medication reviews to reduce identified risk. Ms Vyas emphasised the importance the joint work regarding workforce. This was focussing on significant in-year variations in substantive staffing levels, bank and agency. The ICB was working particularly closely with LPT to support models of care which prevented the need for inpatient admissions. In particular, talking therapies were performing in line with agreed trajectory in targeted communities. Finally, Ms Vyas commented on the sustained improvements in elective waiting times which was being led by UHL.	

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ITEM		LEAD RESPONSIBLE
	Members acknowledged that particularly significant UEC pressures would remain throughout the system for 8-12 weeks, exacerbated by the impact of further industrial action. The contribution of the LLR ICB Clinical Executive in assessing clinical risk across the system was agreed to be vital. Members received assurance that detailed plans were in place in preparation for industrial action. During discussion, it was noted that rates of flu, COVID, and respiratory illness had increased nationally. Effective communication with patients was proving to of great benefit- encouraging ,for example, the acceptance of virtual wards. **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 committee.	
ICB/23/145	**LLR ICB Finance Report (Paper G)** Mr Toole introduced the report. He advised that the LLR system was reporting a year-to-date deficit at month 7 of £70.9m which represented a £48.3m adverse variance to plan. UHL were reporting a £44.5m deficit and the ICB a £25.6m deficit. LPT were reporting a small year-to-date deficit of £0.8m. Work was taking place in conjunction with NHS England to determine a realistic outturn forecast for the year. It was noted that national support had been announced since completion of the report, including a reduction in Elective Recovery Fund (ERF) targets to mitigate the impact of industrial action. Members were advised that Chief Finance Officers (CFOs) were meeting on a weekly basis to discuss key issues and agree relevant submissions. CEOs were also meeting regularly to steer necessary action. There was a particular focus on workforce considerations with Chief People Officers leading necessary work. **It was RESOLVED to:** • **RECEIVE and NOTE** the financial position as at month 7 and the forecast performance. • **RECEIVE** for assurance.	
ICB/23/146	**Assurance report from the Finance Committee (Paper H)** Ms Simone Jordan (Deputy Chair) introduced the report. She advised that the Committee had identified significant risk in all key areas. This was reflected in the risk rating. Relevant matters had been remitted to Executives for further action. **It was RESOLVED to:** • **RECEIVE** the report for assurance.	
ICB/23/147	**Assurance report from the System Executive Committee (Paper I)** The report was taken as read. Dr Trevithick highlighted that item which had received a rating of red related to the delivery and performance aspects which had been covered in the System Delivery report. **It was RESOLVED to:** • **RECEIVE** the report for assurance.	

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ITEM		LEAD RESPONSIBLE
ICB/23/148	**Assurance report from the Quality and Safety Committee (Paper J)** Ms Tagg advised that items that had received a rating of red related to new and emerging risks for which details of mitigations had not yet been received. Further updates were anticipated at the next scheduled meeting of the Committee. It was highlighted that a deep dive session held in December 2023 would consider Board Assurance Framework (BAF) risk 5 in detail. **It was RESOLVED to:** • **RECEIVE** the report for assurance.	
ICB/23/149	**Assurance report from the Audit Committee (Paper K)** The paper was taken as read and received for assurance. **It was RESOLVED to:** • **RECEIVE** the report for assurance.	
ICB/23/150	**Assurance report from the Health Equity Committee (Paper L)** Professor Farooqi noted that health equity remained a high priority across the system. He advised that the Committee had received details of a range of pilots, programmes and schemes which offered assurance that progress was being made. The Health Inequality Support Unit (HISU) had provided critical data and support. Members expressed support for appropriate action to increase the supply of suitable measles vaccinations to City practices following receipt of a letter from the Leicester City Health and Wellbeing Board. **It was RESOLVED to:** • **RECEIVE** the report for assurance.	
ICB/23/151	**UHL and LPT performance assurance briefing / report (Papers M1 and M2)** The paper was taken as read and received for assurance. Mr Sissling noted that the UHL report provided a summary of key issues and challenges. The LPT report provided a detailed narrative and assurance regarding a wide range of performance indicators. **It was RESOLVED to:** • **RECEIVE** the reports for assurance.	
ICB/23/152	**Summary of the East Midlands Joint Committee held in October 2023 (Paper N)** The paper was taken as read and noted. Mr Sissling highlighted the significance of the national decision to delegate commissioning responsibility for specialised services to the East Midlands ICBs from April 2024. He also advised that Derbyshire Health United had been confirmed as the future provider of Midlands NHS 111 services. **It was RESOLVED to:** • **RECEIVE** the report for assurance.	
ICB/23/153	**ICB Board Assurance Framework 2023/24 review (Paper O)** Mr Toole introduced the item, noting that the impact of industrial action had not been identified as a specific risk within the BAF however the mitigations and	

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ITEM		LEAD RESPONSIBLE
	impact was reflected within BAF 6 - Emergency Planning, Resilience and Response (EPRR). Members approved the movement in the residual risk score for EPRR from 16 to 8, noting the good work and external assurance received from NHS England. **Furthermore, it was agreed that Executive Team would consider the inclusion of the prevention agenda within the BAF, particularly in terms of investment and sustainability.** **It was RESOLVED 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).	**Executive Management Team**
ICB/23/154	**Items of any other business and review of the meeting** There were no items of further business. The meeting closed at 11:06am.	
Date and Time of next meeting: The next meeting of the NHS LLR Integrated Care Board would take place on **Thursday 8 February 2024,** 9:00am to 11:30am via MS Teams.		

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

Key

Completed	On-Track	No progress made

Action Log

Minute No.	Meeting Date	Item	Responsible Officer	Action Required	To be completed by	Progress as at February 2024	Status
ICB/23/107	10 August 2023	Items of any other business and review of the meeting	Robert Toole (ICB Chief Finance Officer)	To consider whether the impact of industrial action needs to be captured on the Board Assurance Framework (BAF).	October 2023	It was agreed by the Board on 14 December 2023 that the impact of industrial action would be captured within Emergency Preparedness, Resilience and Response (EPRR).	**Green**
ICB/23/119	12 October 2023	Primary Care Access Recovery Plan - LLR System-level Access Improvement Plan	Dr Nil Sanganee (ICB Chief Medical Officer)	The Board requested a plan of actions with measurable indicators and outcomes.	~~January 2024 / February 2024~~ April 2024	It was agreed by the Board on 14 December 2023 that an update would be provided in April 2024 along with the results of the patient experience survey.	**Amber**
ICB/23/153	14 December 2023	ICB Board Assurance Framework 2023/24 review	ICB Executive Team	Executive Team would consider the inclusion of the prevention agenda, particularly in terms of investment and sustainability, within the BAF.	End February 2024	The ICB Executive Team will consider the action as part of the next review of the BAF in February 2024.	**Amber**

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Name of meeting:	**Leicester, Leicestershire and Rutland Integrated Care Board** (public)		
Date:	8 February 2024	**Paper:**	**C**
Report title:	**Leicester, Leicestershire, and Rutland ICB Research and Development Report**		
Presented by:	Nilesh Sanganee, Chief Medical Officer, NHS LLR ICB Carly McDonald, Research Manager, NHS LLR ICB		
Report author:	Carly McDonald, Research Manager, NHS LLR ICB		
Executive Sponsor:	Nilesh Sanganee, Chief Medical Officer, NHS LLR ICB		

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

Recommendations:

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

- **RECEIVE for information.**

Purpose and summary of the report:

To provide assurance that LLR ICB are meeting statutory duties with regards to research.

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.*	No
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.	All subject areas in this report have implications.
d)	**Does the report demonstrate patient and public involvement?** If so, provide which page / paragraph this is outlined in within the report.	yes
e)	**Has due regard been given to the Public Sector Equality Duty?** If so, how and what the outcome was, provide which page / paragraph this is outlined in within the report.	yes

Leicester, Leicestershire, and Rutland ICB
Research & Development Report to the ICB Board
8 February 2024

Introduction

1. The Health and Care Act 2022 (Legislation.gov.uk, 2022) states that each integrated care board must, in the exercise of its functions, facilitate or otherwise promote:

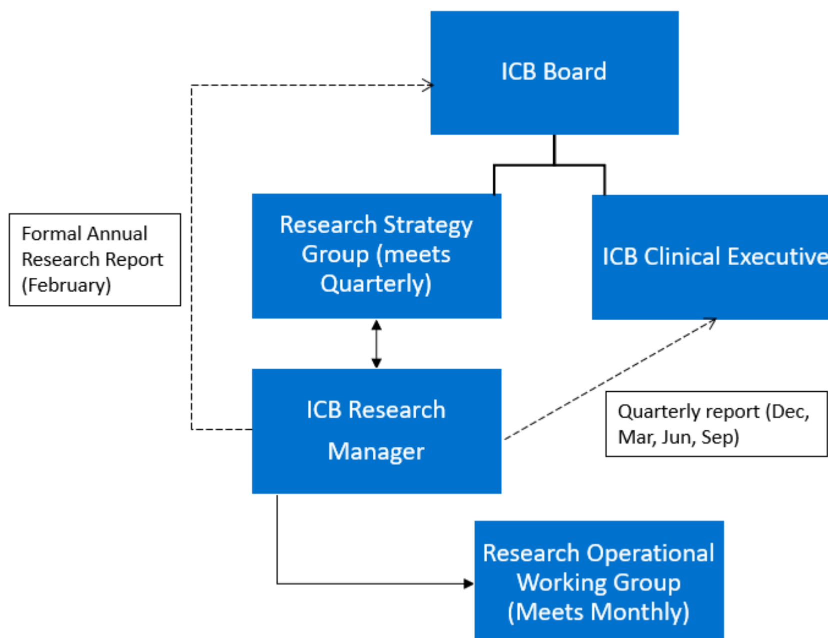
   (a) research on matters relevant to the health service, and
   (b) the use in the health service of evidence obtained from research.

2. This report provides an overview of Research Work happening across the system that the ICB is involved in and provides assurance that the ICB are supporting research as their statutory duty.

Background

3. Responsibility for ICB research management sits within the Quality and Safety team of the Clinical Quality & Performance Directorate. The Senior Responsible Officer for Research is the Chief Medical Officer who sits within the Medical Directorate. Previous Research reports have been provided to the System Quality Group (the last one was in May 2023). Going forward the governance arrangements for research in the ICB are outlined below including reporting to the Clinical Executive.

Figure1: LLR ICB Research Governance Structure



4. LLR ICB has a 1.0WTE Research Manager in post, and a 0.4wte administrator supports the Research Manager. The admin role is jointly line managed by the ICB Research Manager, and the UHL Research & Innovation Deputy Chief Operating Officer.

Update on ICB Research

5. The Research Manager has reviewed the NHSE guidance on maximising benefits of research and noted three legal duties for the ICB:
    - Duty to facilitate or otherwise promote research
    - Duty to facilitate or otherwise promote the use in the health service of evidence obtained from research
    - Duty for ICSs to include research in their joint forward plans and annual reports.

6. Gaps and opportunities have been identified and an implementation plan will be developed. The LLR ICS Embedding Research into practice document, developed in 2022 will be refreshed to give a more strategic focus and this document will become our LLR ICS Research Strategy. Work towards achieving this in currently underway, the aim is for the document to cover our obligation to support research and the use of research evidence in our decision making.

7. Discussions surrounding the governance and reporting structure of research in the ICB led to the decision to form a Research Operational Working Group (ROWG), chaired by the Research Manager. The purpose of the group is delivering the objectives of the ICB Research Strategy, particularly in primary care. The meetings commenced in September and are being held monthly. Outputs and developments are communicated to the Research Strategy Group.

8. The research passport service is a crucial R&D function to support GP practices to participate in research. It involves the processing of individual Research Passports (for higher education institution employees) and NHS to NHS Proformas (NHS employees) so that Letters of Access (LoAs) for Primary Care can be issued to support local GP practices. These letters provide assurance to practices that necessary checks have been carried out by the lead NHS organisation (e.g. DBS where relevant, employment contracts, CV , Good Clinical Practice (GCP) etc) and reviewed and agreed by R&D at the receiving sites before 'sign off'. The research passport is necessary to ensure safeguards about personnel conducting research with practices and their patients are in place. The ICB have a robust process in place for managing LOA requests which includes SOP, flowcharts, a guidance document, a checklist, and a template letter to ensure consistency. Between April 2023 and January 2024 there have been around 45 LOAs issued by the ICB.

9. The ICB have recently created a process for delivering Confirmation of Capacity (C&C) and Capability – this translates to notification that we wish to participate in a research project as an ICB (Staff research only). An SOP and working procedure documents/templates have been created and signed off by the Executive Management Team for use. Since May 2023 the ICB have issued to take part in 1 research project (qualitative survey).

10. The ICB does not have any dedicated research funding streams, therefore all research funding received is a result of funding applications/bids that have been developed, submitted and have been successful. In 2023/24 the ICB have been successful in securing £100,000 of research funding. We have also been successful in various other bids as a system (where the money isn't coming directly to the ICB, but the ICB was part of the application process and/or the work will directly benefit/complement the existing work of the ICB).

11. An overview of ICB led funding calls that have been successful are outlined below:

12. **ICB Led Funding Calls:**
    a. **Research Capacity Funding Award (£25,000)** – This funding was awarded to the ICB by the Department of Health and Social Care in recognition for the amount of patients that were recruited into research studies in Primary Care in 2021/22.

    b. **Research Engagement Funding (£50,000)** – This funding was from the Clinical Research Network. The call was open to ICBs and requested applications that demonstrate building stronger research engagement networks across the system.

    c. The Research Capacity Funding and Research Engagement Funding pots have been pooled together to create £75k of funding which has been spent on 3 different projects:
       - We have recruited 4x primary care research champions, all of which work at local practices, they will be helping increase primary care research participation.
       - A data analyst has been commissioned from Health Innovation East Midlands to support enabling effective networking across research, adoption, and innovation communities. A directory of research and research interests will be developed to link people and projects together when opportunities arise.
       - A LLR ICB health data science research conference is planned for 12 March 2024, with an aim of bringing together analysts, clinicians, and managers in the NHS together with academic colleagues who have expertise in data science and advanced analytic methods with the aim of fostering collaboration and enhanced use of healthcare data. The objective of the day is to create a network to share knowledge and support each other to improve healthcare for our population.

    d. **Underserved Communities Funding (£25,000**) – This funding is from the Clinical Research Network. The call was open to all health and social care services, in which research is undertaken. The funding is being used to develop insights into local underserved communities and what should be done to enable better access to services. This project will consist of a scoping exercise mapping existing engagement activity across LLR ICB. This information will help to inform the research manager and the Clinical Research Network (CRN) on communities that we are not yet engaging with and may form the basis of a further application to the CRN to provide some funding for targeted research engagement work with these communities.

<u>System Wide Research Updates</u>

13. Across LLR we have well established research and innovation management teams embedded in our hospitals, our ICB, partnership trusts and our universities. There are many examples of where these management teams come together to work collaboratively, for example in the Biomedical Research Centre, Loughborough University, University of Leicester and UHL work together to deliver the Biomedical Research Centre through robust and transparent governance arrangements which minimises bureaucracy and ensures the rapid deployment, effective resource use and timely delivery of the research objectives.

14. The formation of the Leicestershire Academic Health Partners a partnership between UHL, Leicester Partnership Trust and the University of Leicester, aims to harness the collective clinical and academic excellence to accelerate the transmission of cutting-edge research into health care innovations to improve the health and wellbeing of the people of LLR.

15. So far this year 19,695 patients have been recruited into research projects across all of LLR Health and social care services. NHS hospitals account for 42.5% of current recruitment. GP practices account for 56.3%, and other setting account for 1.2% of recruitment. There are currently 345 different studies open covering 29 different speciality areas.

16. Primary care research activity has increased this year, both in relation to the number of practices active in recruitment and the number of patients recruited. LLR is the seventh highest recruiting ICB in England, the second highest recruiting in the East Midlands and has the highest percentage of research active GP practices in the region.

Figure2: East Midlands Research Recruitment (Primary Care)

County	GP Practices with Recruitment	No. of Recruiting GP Practices	23/24 FY Recruitment to date
Derbyshire	74%	81 of 109	3,165
Leicestershire	93%	122 of 131	11,091
Lincolnshire	86%	69 of 80	8,193
Northamptonshire	76%	52 of 68	3,985
Nottinghamshire	82%	97 of 118	12,030

17. The ICS consists of many health and social care organisations that are research active. Below are some examples of fantastic work and developments that are occurring across the system:
    a. **Research Engagement Network Development Bid (REND funding, £100,000) –** The Collaborative Research Academy have been awarded £100,000 from October 2023 to March 2024 to work on increasing community engagement work with ethnic minorities. They will be working with VCSE organisations and the Centre for Ethnic Health Research to train community Research Ambassadors and create research materials suitable for those from Ethnic Minority backgrounds. The Academy was formed in 2023 and represents partnership working between UHL, the PRC and a group of GP practices located in the city.

    b. **Capital Funding Call (£4,736,115) –** The Clinical Research Network and University Hospitals of Leicester worked together with GP practices across LLR to apply for capital funding that can be used for equipment purchase and building refurbishment required for research purposes. £78,956 of this award is being used to fund the development of Research Rooms and the purchase of Research Equipment at 4 GP practices across LLR. The rest of the funding was awarded to UHL for equipment purchase and building refurbishments in their research areas.

    c. **Health Determinants Research Collaboration (HDRC) (£250,000 for a development year (2024) awarded and recommended for full funding in 2025-2030 at a value of £5,238,523.40 over the 5 years) –** Leicestershire County Council have been awarded a development year for the HDRC project starting in 2024 and have been recommended for funding for their full project from 2025 (dependant on the success of the development year). The HDRC program is an excellent opportunity to further embed and pull together the system work on population health management,

risk stratification and equity of access to identify and address the wider determinants of health. It will also provide the research infrastructure and training for colleagues across the wider system to evaluate interventions addressing the wider determinants of health.

d. **Expanding Excellence in England (E3) award (£14,071,927 over 5 years)** – Leicester Diabetes Centre have been successful in their application for this project. This research will be undertaken by Leicester Lifestyle and Health Research Group (LLHRG). LLHRG research harnesses the power of lifestyle behaviours to empower multi-ethnic populations with or at risk of long-term conditions or multiple long-term conditions to live longer and better lives. E3 funding will enable an uplift in capacity to deliver sustainable research excellence through an expanded staff with diversified expertise and new world-class research facilities.

e. **Leicestershire Academic Health Partners (LAHP)** – The LAHP are currently overseeing 8 projects (1 of which is completed, 7 are in progress). Funding of up to £30K had been advertised for projects that were aligned to the LAHP objectives and involved one of the two NHS partners. Some projects have been funded from financial contributions received from partners. 30 project applications were received and seven were selected which covered inequalities and a good mix of medical conditions.

f. **ENROLL_HD Study** – Leicestershire Partnership Trust is one of very few centres in the UK for the worldwide “ENROLL-HD” long-term registry study – recent monitoring by CHDI indicated LPT over twenty years have the highest participant retention for a centre in Europe and exceptional data integrity. ENROLL is now moving to become a clinical trials platform to seek effective treatments for a currently incurable condition. The sector also includes a trial of psychological self-help (GUIDE-HD).

g. **The Health Inequalities Support Unit (HISU)** – Established on 1st April 2023, with members from ICB, Public Health, Academic Links from LLR Research Collaborative, UHL Library Services, UHL, LPT, and LHIS. The HISU will develop an evidence base for the ICB on health inequalities.

h. **LOROS Hospice -** LOROS was one of 8 places involved in research led by the University of Southampton which found that there is great potential for patients who die in a hospice to donate corneas to save the sight of others. LINK [The potential for eye donation from hospice and palliative care clinical settings in England: a retrospective case note review of deceased patients' records | Cell and Tissue Banking (springer.com)]

i. **Patient Recruitment Centre (PRC): Leicester Research** Campaign - The PRC has been supporting the ‘Your Path in Research’ campaign from the National Institute for Health and care Research (NIHR). The campaign aims to encourage staff to consider making research part of their career. Better research leads to better services for patients and the public.

Public and Patient Involvement, Engagement and Participant (PPI/EP)

18. LLR hosts considerable NIHR infrastructure which has developed excellent PPI and EP aligned particularly to the Biomedical Research Centre, Clinical Research Facility and the Applied Research Collaboration. The infrastructure is positioned within local communities, hospitals, Universities, and also an extensive network of commercial and third sector partners. There is a close relationship with the Centre for Ethnic Health Research to mutually enhance PPI/EP strengths. For example, within the current BRC the PPI/EP approach was highly praised by NIHR with more than 600 contributors and a well-earned reputation in expertise in sharing novel approaches and sharing good practice.

19. PPI/EP work is assessed for equality, diversity and inclusivity and continues to work to address short falls in ethnic diversity.

20. Every year the NIHR Clinical Research Network (CRN) asks thousands of research participants to share their experiences of taking part in research. All responses are displayed on the 'Participant in Research Experience Survey (PRES)' dashboard. The survey is anonymous and is a useful tool for organisations to measure patients' experience and learn where they can make improvements. 380 responses have been received so far this year across LLR, out of these:
    - 97% of patients felt they had been adequality informed of what to expect during their research project participation.
    - 79% of patients feel they have been kept updated about the study they are on.
    - 75% of patients know how they will receive the results of the research study they participated in (at least to some extent).
    - 97% of patients knew how to contact the research team if they had any questions outside of a study visit.
    - 99% of patients felt they had been treated with kindness and respect during their research study participation.
    - 94% of patients would consider taking part in research again.

Areas of Potential Risk/Challenges

21. In September 2024 the current Local Clinical Research Networks (LCRN) contract will end. The existing 15x LCRNs that currently exist in England will become 12x Regional Research Delivery Networks (RRDNs). Leicester will remain the host for the RRDN, and the footprint of our network will not be affected like it has in other regions, but it will mean changes to the way we work, and the way things are funded. It will be important to keep up to date with the development of RRDNs as information is made available. The change comes as they wish to move towards more standardised ways of working as things differ immensely from CRN-CRN at present.

Conclusion

22. Research has a newly formed governance structure that will take some time to become established, but we are optimistic that this will be an effective way of managing it going forward.

23. LLR ICS has a wealth of research infrastructure and experience, some of the showcased projects across the ICS demonstrate excellent collaborative working.

24. Notably across the region LLR ICB has the highest percentage of research activity in GP Practices and second-highest recruitment figure across primary care in the region.

The LLR ICB board is asked to:

- **RECEIVE** this report as assurance that the LLR ICB is meeting their statutory duties for research.

Reference

Legislation.gov.uk. (2022). Health and Care Act 2022. [online] Available at: https://www.legislation.gov.uk/ukpga/2022/31/part/1/crossheading/integrated-care-boards-functions/enacted [Accessed 23 Feb. 2023].

Leicester, Leicestershire and Rutland

Research Update

ICB Board Meeting (Public)

8th Feb 2024

By Carly McDonald, Research Manager LLR ICB
Nilesh Sanganee, Chief Medical Officer LLR ICB
Michael Steiner, Deputy Chief Medical Officer, LLR ICB

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

A proud partner in the:

Leicester, Leicestershire and Rutland Health and Wellbeing Partnership

What is Research and How Can it Benefit Us?

- Research is about finding out new knowledge that could lead to changes in treatments, policies or care.
- Research often happens in a hospital or GP setting but it also occurs in other places, for example in the community or people's homes.
- It may involve taking a medication, using a device or being cared for in a certain way, or it may ask people to provide information about the care they usually have.

Under the Health and Care Act 2022 research is now a statutory duty for ICBS, we have:

- A duty to facilitate or otherwise promote research
- A duty to facilitate or otherwise promote the use in the health service of evidence obtained from research
- A duty for ICSs to include research in their joint forward plans and annual reports.

- It gives patients the chance to help scientists better understand their disease or condition and help to advance treatments and ways to prevent it in the future.
- Patients may feel more engaged in their health and may learn more about their condition.
- Healthcare organisations that are research active deliver improved quality of care including lower mortality rates
- Research can lead to additional investment that enhances our workforce and productivity
- Being research active increases the organisation's ability to attract outstanding staff, as well as enhancing staff retention. It also offers additional training, development & progression opportunities for staff.

Our Research Strengths

We have lots of NIHR funded Research Infrastructure bringing in local investment including the Biomedical Research Centre (BRC), Applied Research Collaboration (ARC), Clinical Research Facility (CRF) and the Patient Recruitment Centre (PRC). Leicestershire county council have recently been awarded funding for a Health Determinants Research Collaboration (HDRC) (£250,000 for a development year (2024) awarded, and recommended for full funding in 2025-2030 at a value of £5,238,523.40 over the 5 years)

We have strong and established relationships between researchers and clinicians. Such relationships improve our ability to recruit patients at scale and pace. University Hospitals of Leicester were top recruiters for the COVID-19 Recovery Trial, which discovered Dexamethasone can reduce deaths of hospitalised COVID-19 patients by one third.

Our system partners work collaboratively, strengthening our applications for funding and infrastructure. The Collaborative Research Academy have been awarded £100,000 to work on increasing community engagement work with ethnic minorities. They will be working with VCSE organisations and the Centre for Ethnic Health Research to train community Research Ambassadors and create research materials suitable for those from Ethnic Minority backgrounds. The Academy was formed in 2023 and represents a partnership between UHL and a group of GP practices located in city.

This Year in Numbers So Far (Apr 23-Jan 24)

19,695 patients recruited in LLR
345 different studies
29 different specialities
NHS hospitals 42.5% of recruitment
GP Practices 56.3% of recruitment
Other Settings 1.2% of recruitment

What Our Patients Say About Taking Part in Research

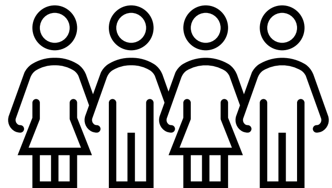
- **97%** of patients felt they had been adequality informed of what to expect during their research project participation.
- **79%** of patients feel they have been kept updated about the study they are on.
- **75%** of patients know how they will receive the results of the research study they participated in (at least to some extent).
- **97%** of patients knew how to contact the research team if they had any questions outside of a study visit.
- **99%** of patients felt they had been treated with kindness and respect during their research study participation.
- **94%** of patients would consider taking part in research again.

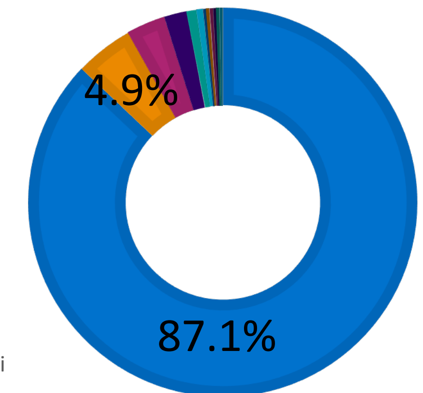
> I feel I am helping to improve future care and giving back for the enormous improvement in my health and life having XXXX surgery gave me.

> I was treated with respect and welcomed in all departments.

> Everything was explained thoroughly, and I was treated really well.

> The staff were very appreciative of my taking part.





Reference - https://sites.google.com/nihr.ac.uk/crneastmidspres/results

Fun Facts about LLR

8th Highest recruiting ICB (Primary Care recruitment) in England (Out of 42)

2nd Highest recruiting ICB in East Midlands

Highest % of research active GP practices in the region

2nd Highest number of open studies (359) as an ICS in the region

9.36 recruits per 1K population, 4th highest out of all 42 ICBs

We have research studies currently recruiting covering 29 different speciality areas

Summary

- Health and care focused applied research is a strength in LLR
- The ICB is supporting local research through the research strategy board
- All our healthcare ,Local Authority and University partners are represented at this board
- Our ambition is to make research participation “business as usual” across the ICB and its partners

If you have any questions or comments, or require further information about any of the information in this presentation please contact:

Carly McDonald,
Research Manager, LLR ICB
07770930070
carly.mcdonald2@nhs.net

D

NHS

Name of meeting:	Leicester, Leicestershire and Rutland Integrated Care Board		
Date:	Thursday 8 February 2024	Paper:	D
Report title:	LLR ICB 2024/25 Operational and Financial Plan and LLR 5 Year Plan Refresh		
Presented by:	Ket Chudasama, Deputy Chief Strategy and Planning 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:

APPROVE the arrangements set out for the revision of the LLR ICB 5-Year Plan

APPROVE the inaugural LLR ICB 5YP is being maintained for 2024/25

NOTE the 2024/25 Operational and Financial Plan update

Purpose and summary of the report:

1) The purpose of this paper is to set out the approach to revise the LLR ICB 5 Year Plan, based upon the latest guidance and how our local approach aligns to the production of the 2024/25 Operational Plan.

2) In line with the guidance, ICBs and their partner trusts should review their JFP before the start of each financial year, by updating or confirming that it is being maintained for the next financial year. They may also revise the JFP in-year if they consider this necessary.

3) We are seeking agreement of the LLR ICB Board to carry over the existing 5YP with a planned refresh to take place during Q1 post operational plan submission, noting that certain sections (for example Finance) will be revised post operational plan submission.

4) The paper also provides an update on the 2024/25 Operational and Financial Plan. The paper outlines progress made to date, key risks, emerging mitigations and next steps.

Appendices:	Appendix one: LLR 5-Year Plan Web link to LLR 5-Year Plan - https://leicesterleicestershireandrutland.icb.nhs.uk/wp-content/uploads/2023/07/LLR-ICB-5YP-FINAL-v5.0_FINAL_Signed.pdf
Report history (date and committee / group the content has been	Input and steer have been sought at the following meetings to support development of the plan:

discussed / reviewed prior to presenting to this meeting):	• System Executive 25 August 2023, 22 September 2023, 24 November 2023, 12 January 2024, 26 January 2024. • ICB Board Development Session 11 January 2024

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 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.

LLR ICB 5-Year Plan Refresh and
2024/25 LLR Operational and Financial Plan
Thursday 8 February 2024

Introduction

1. The purpose of this paper is to set out the approach to revise the LLR ICB 5 Year Plan, based upon the latest guidance and how our local approach aligns to the production of the 2024/25 Operational Plan.

2. The paper also provides 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.

Background and context

3. Board members will recall that NHS England published 'Guidance on developing the joint forward plan' in December 2022. This set out the requirements for the inaugural 5-Year Plan (5YP) for Integrated Care Boards. The inaugural LLR ICB 5YP (Appendix 1) was jointly produced with Leicestershire Partnership NHS Trust and University Hospitals Leicester NHS Trust. It was formally approved by the LLR ICB Board on 13 July 2023 and subsequently published on the ICBs public facing website.

4. NHS England are not required to formally approve our plan but have a role in supporting systems in its development. Guidance states: "To support ICBs and their partner trusts to develop Joint Forward Plans (JFP). NHSE will review and comment on the draft JFP. This will not be a formal assurance process but an opportunity to support ICBs and their partner trusts to develop their plans. Separately we will continue to conduct formal assurance of the information submitted in operational planning returns."

5. Feedback was received from NHS England stating that "Overall, the JFP submitted was excellent. There is very strong evidence in each section of listening to patients, families and carers and using their voice to plan, develop and improve services including access to services. Integration of health and social care services is a 'golden thread' that runs throughout the JFP".

Revision of 5 Year Plans Guidance

6. In line with the guidance, ICBs and their partner trusts should review their JFP before the start of each financial year, by updating or confirming that it is being maintained for the next financial year. They may also revise the JFP in-year if they consider this necessary.

7. The annual review is an opportunity to update plans based on updated assumptions or priorities, including those set out in the 2024/25 priorities and operational planning guidance. At the time of writing this report, the 2024/25 Operational Planning Guidance had not been published by NHS England,

Revision of 5 Year Plan – Local Approach

8. Locally there is a clear consensus that the annual operational planning round will dovetail and inform the refresh of our 5YP. This ensures a consistent and aligned narrative, establishes a clear linkage between the annual operational plan and 5YP and reduces duplication of effort and asks on partners across the system.

9. During January 2024 NHS England sought clarification from systems regarding their outline intentions and timelines for revision of their JFPs. We have received feedback on our approach from NHS England. Given that the publication of operational planning guidance has been further delayed, it has been agreed that our proposal is pragmatic. NHS England

have asked for sight of the minutes indicating support from LLR ICB Board members. Our current working assumption, based on steer to date and in the absence of operational planning guidance 2024/25 being formally published is outlined in table 1 below:

Timeline	Action
Jan – Feb 2024	Ongoing works to refresh 5YP and to author LLR 24/25 Operational and Financial Plan
8th Feb 2024	Seeking LLR ICB Board approval to carry existing 5YP into 24/25
March 2024	Full submission of Operational and Financial Plan to NHS England
May 2022	Final submission of Operational and Financial Plan to NHS England
May – June 2024	Seeking LLR ICB Board approval of revised 5YP

Table 1 - Indicative timeline for 5YP refresh

10. Table 2 below articulates the sections of the 5YP that have been identified as requiring a refresh:

Section to be updated/ revised	Rationale
Chapter 3.1 – Preventing Illness	To reflect the publication of the NHS England National Vaccine Strategy
Chapter 6 – Our Finances	To reflect Medium-Term Financial Strategy To reflect the NHS England *Guidance on developing joint capital resource use plans 2024/25*
Chapter 7 – Our People	To reflect local interpretation and implementation of NHSE Long Term Workforce Plan
Specialised Commissioning	To reflect delegated NHS England commissioning functions from April 2024
Annex 1 – Delivery Plan	To add greater detail to year 2 reflecting operational plan 24/25 submission.

Table 2 - 5YP Refresh sections

11. We are seeking agreement of the LLR ICB Board to carry over the existing 5YP with a planned refresh to take place during Q1 post operational plan submission, noting that certain sections (for example Finance) will be revised post operational plan submission.

12. The above proposal regarding our approach and sections identified for refresh have been discussed and endorsed by:

- LLR ICB Executive Management Team (Monday 22nd Jan 2024)
- LLR ICB System Executive Committee (Friday 26th Jan 2024)

Progress made to date on the 2024/25 Operational Plan

13. The national operational planning guidance has not yet been published, however the communication received to date, states the expectations and priorities are as per 2023/24 planning guidance and published recovery plans for urgent and emergency care (UEC),

primary care and elective and cancer care. In addition, whilst there is an expectation for systems to submit a balanced financial plan; this will be extremely difficult based upon the underlying financial position of the system which has deteriorated due to the significant financial challenges faced in 2023/24.

14. 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
    b. Agreed an LLR investment/disinvestment approach
    c. Established a multi-disciplinary System Prioritisation Group and a framework which allows for independent scoring and ranking of system wide business cases.
    d. 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.
    e. Early draft organisation financial plans have been shared across the system and work continues to test, revise and refine assumptions and develop options to improve the overall affordability of the plan.

15. The ICB Board Development Session took place on 11 January 2024 and discussed;
    a. Reflections on the 2023/24 planning process;
    b. 2024/25 planning progress made to date;
    c. 2024/25 financial and transformation planning approach;
    d. 2024/25 suggested planning aims.

16. The ICB Board supported a focus upon a smaller number of transformation areas to improve financial efficiency plans and convening a workforce summit to reach a shared understanding on organisational workforce plans in 2023/24 and 2024/25.

Key risks and mitigations

17. The key planning risks remain similar to those presented to the ICB Board in December and the mitigations have been updated.

Risk	Risk Description	Mitigations
1	Insufficient efficiency savings identified to date	• Key system transformation areas agreed and outputs to be presented to System Executive on 9 Feb 2024 (for UEC, planned care, managing long term conditions, mental health, learning disabilities and autism and SEND)
2	Focus of teams upon 2023/24 operational plan revisions and delivery rather than 2024/25 planning	• Minimise/ring fence staff/teams to work on either 2023/24 plan revisions / delivery or 2024/25 planning (where possible) • Identify areas of support for teams eg strategy and planning colleagues helping to draft narrative chapters with teams
3	Lack of investment for MTFP or 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 • Publish progress against the 13 pledges of the 5YP (specifically pledge one and two)

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 CIP plans in December and January and emerging options to reduce the gap
5	Affordability of workforce in 2024/25 due to workforce cost growth in 2023/24	• Workforce summit to take place on 2 Feb 2024 to develop a shared understanding of the 23/24 and 24/25 workforce plans. Outputs of the summit to feed into System Executive on 9 Feb 2024

Next steps

18. The key high level system planning milestones are presented in the following table and will be aligned with individual organisational governance timelines and processes. They are potentially subject to considerable amendment depending on when clear guidance and allocation information is finalised and released to ICBs from NHSE.

Timeline	Action
31 Jan 2024	• Submission of draft operational plan narratives
9 Feb 2024	• System Executive Development Session to focus upon • Overall progress of the operational and financial plan • Outputs of the workforce summit • Options and outputs of the prioritised system transformation schemes
13 Feb 2024	• Final SPG meeting to review and score business cases
16 Feb 2024	• Feedback on narrative chapters
By end Feb 2024	• Submission of plan to NHSE (numerical)
14 Mar 2024	• Approval of full draft Operational and Financial Plan by ICB Board (tbc)
By end Mar 2024	• Submission of full plan to NHSE (tbc)
11 Apr 2024	• Approval of final Operational and Financial Plan by ICB Board
26 Apr 2024	• System Executive (to finalise any outstanding matters as agreed by ICB Board)
2 May 2024	• Submission of final Operational and Financial Plan to NHSE (narrative and accompanying templates)

Recommendations:

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

APPROVE the arrangements set out for the revision of the LLR ICB 5-Year Plan

APPROVE the inaugural LLR ICB 5YP is being maintained for 2024/25

NOTE the 2024/25 Operational and Financial Plan update

E

NHS

Name of meeting:	Leicester, Leicestershire and Rutland Integrated Care Board		
Date:	8 February 2024	Paper:	E
Report title:	Draft Gender Pay Gap Report 2023		
Presented by:	Alice McGee, Chief People Officer LLR ICB		
Report author:	Shaun Cropper, Equality, Diversity & Inclusion Business Partner		
Executive Sponsor:	Alice McGee, Chief People Officer LLR ICB		

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

Recommendations:

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

- **Approve** the Gender Pay Gap Report 2023 for publication on the ICB Website.

Purpose and summary of the report:

1. Since 31 March 2017, all public sector organisations in England employing 250 or more staff have been required to publish annually their gender pay gap information.

2. Previously, Leicester City CCG, East Leicestershire & Rutland CCG and West Leicestershire CCG were not required to report this information as each organisation had less than 250 employees.

3. Since the establishment of the LLR Integrated Care Board in July 2022 there is now a requirement to report on the gender pay gap as we are above the 250-employee threshold. The Government's Equalities Office has advised that the first date for public reporting is April 2024. This year the ICB needs to collect baseline data as of 31st March 2023 and publish by 30th March 2024.

4. Gender pay reporting is different to equal pay. Equal pay deals with the pay differences between men and women who carry out the same jobs, similar jobs, or work of equal value. It is unlawful to pay people unequally because they are a man or a woman.

5. Pay gap reporting looks at the difference in the average pay between two groups.

6. The enclosed report provides information on the following as of 31st March 2023:

- Percentage of men and women employed at the ICB.
- Average gender pay gap as a mean average.
- Average gender pay gap as a median average.
- Their proportion of males and females in each quartile pay band.

Appendices:	None
Report history (date and committee / group the content has been discussed / reviewed prior to presenting to this meeting):	• Operational Delivery Group - Actions were recommended and added to the report 01/08/2023. • Renumeration Committee and Non-Executives received with thanks. Additional actions were recommended and added to the report 09/01/2024

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

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

Implications:	
a) Does the report provide assurance against a corporate risk(s) e.g. risk aligned to the Board Assurance Framework, risk register etc? *If so, state which risk and also detail if any new risks are identified.*	N/A
b) Does the report highlight any resource and financial implications? If so, provide which page / paragraph this can be found within the report.	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 and subsequent Gender Pay Gap provisions.

LLR ICB

Gender Pay Gap Report Baseline data (snapshot) 31st March 2023

To be published by 31st March 2024

Since 31 March 2017, all public sector organisations in England employing 250 or more staff have been required to publish annually their gender pay gap information.

Previously, Leicester City CCG, East Leicestershire & Rutland CCG and West Leicestershire CCG were not required to report this information as each organisation had less than 250 employees.

Since the establishment of the LLR Integrated Care Board in July 2022 there is now a requirement to report on the gender pay gap as we are above the 250-employee threshold. The Government's Equalities Office has advised that the first date for public reporting is April 2024. This year the ICB needs to collect baseline data as of 31st March 2023 in readiness to publish in 2024.

Gender pay reporting is different to equal pay. Equal pay deals with the pay differences between men and women who carry out the same jobs, similar jobs or work of equal value. It is unlawful to pay people unequally because they are a man or a woman.

The guidelines require the ICB to publish the following calculations:

1. Average gender pay gap as a mean average
2. Average gender pay gap as a median average
3. Their mean bonus gender pay gap (The ICB does not pay staff bonuses)
4. Their median bonus gender pay gap (The ICB does not pay staff bonuses)
5. Their proportion of males receiving a bonus payment (The ICBs does not pay staff bonuses)
6. Their proportion of females receiving a bonus payment (The ICB does not pay staff bonuses)
7. Their proportion of males and females in each quartile pay band

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Table of Definitions

Pay gap	Difference in the average pay between two groups
Mean gap	Difference between the mean hourly rate for female and male employees
Median gap	Difference between the median hourly rate of pay for female and male employees
Mean bonus gap	Difference between the mean bonus paid to female and male employees
Median bonus gap	Difference between the median bonus pay paid to female and male employees
Bonus proportions	Proportions of female employees who were paid a bonus and the proportion of male employees who were paid a bonus
Quartile pay bands	Proportions of female and male employees in the lower; lower middle; upper middle; and upper quartile4 pay bands
Equal pay	Being paid equally for the same/similar work

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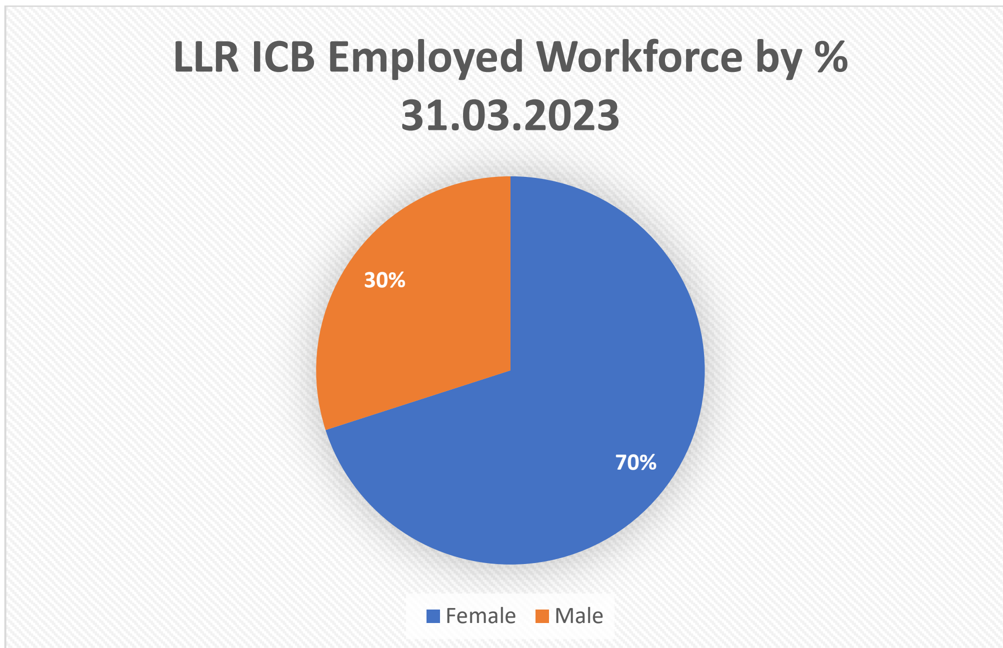
The calculations make use of two types of averages as noted above. A mean average and a median average. Using these two different types of average is helpful to give a more balanced overview of an employer's overall gender pay gap.

The gender pay gap shows the difference between the average (mean or median) earnings of men and women in an organisation. It is expressed as a percentage of earnings.

Mean averages are useful because they give a good overall indication of the gender pay gap, but very large or small pay rates can 'dominate' and/or distort the results. For example, a median average might show a better indication of the 'middle of the road' pay gap where a mean average might be distorted by very highly paid specific employees and board members. However, it could also fail to pick up, as effectively, where the pay gap issues are most pronounced, for example in the lowest paid or highest paid employees.

Summary of findings



Average Hourly Rates

Gender	Gender (Mean Average)
Male	32.8813
Female	26.4363
Difference	6.4450
Pay Gap %	**19.6008**

Analysis

When we consider the population of LLR the 2021 census data shows that 49.5% of our population are male and 50.5% of our population are female. Across the LLR NHS workforce we employ 69.5% who are female and 30.5% who are male. This is representative of the wider national NHS workforce where the workforce is predominately female across all professions.

The mean/average Gender Pay Gap (GPG) table above shows the mean hourly rates for LLR ICB. The mean hourly rate is the average hourly wage across the entire workforce and is a measure of the difference between women's mean hourly wage and men's mean hourly wage. **The Mean Pay Gap is 19.6 % in favour of men.**

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The mean pay gap is significant statistically however the difference of average hourly pay is small i.e. £6.45 per hour, once the analysis of what is driving the difference in pay which is predominantly due to the medical pay rates.

It is important to note that, the data is from 31st March 2023 as a base line and throughout 2024 we have seen changes that is likely to see a closing of the pay gap due some significant changes; 25 clinical leads TUPE transferring into the ICB on 1st July 2023 which has more women in posts and the change of the Executive Team which has more women in the executive leadership roles. This will be evaluated in 2024 when we use our 2024 data to understand trends and impacts of actions.

Comparative data:

This is the first year that LLR ICB is required to collect their baseline data and makes comparison difficult with other ICBs. Therefore, for this baseline year, we have used two local provider Trusts as comparators the data point for our providers is June 2023

- Leicestershire Partnership Trust (LPT) mean pay gap is 12.9% in favour of men. This is below the ICBs figure.
- University Hospital Leicester (UHL) mean pay gap is 28% in favour of men. This is above the ICBs figure.

Median Hourly Rates

Gender	Gender (Median Average)
Male	26.2518
Female	24.8164
Difference	1.4354
Pay Gap %	**5.4679**

Analysis

The median Gender Pay Gap table above shows the median hourly rates for LLR ICB. Median average is useful to indicate what the 'typical' situation is i.e., in the middle of an organisation and are not distorted by very large or small pay rates. **The Median Pay Gap is 5.5%**

Comparative data as of 21/06/23

- LPT median pay gap is 4.2% in favour of men. This is below the ICB figure.
- UHL median pay gap is 13% in favour of men. This is above the ICB figure.

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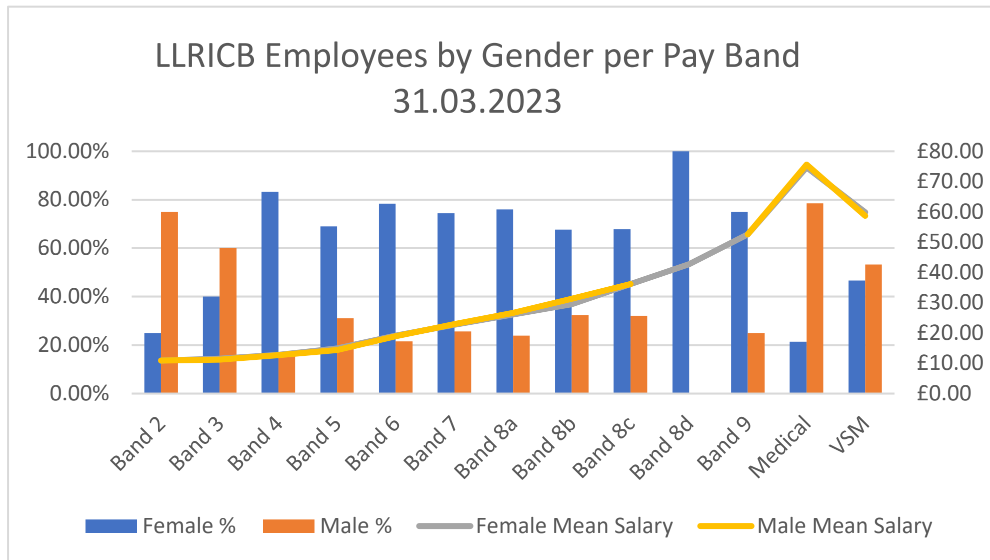
Proportion of Males and Females by Pay Bands



Note for analysis – left axis is the % of the workforce, the right axis is the equivalent mean hourly rate

Analysis of male/female workforce representation by pay band

When looking at the female and male mean salary by banding, the pay gap is negligible. However, when considering all the statistical information and the reason for there are some information that should be explored.

- More men than women are found at band 2 (75% compared to 25%) & band 3 (60% compared to 40%). In the ICB these band 2 posts represent the ICB Apprentices and are all currently held by males. Apprentice posts by nature are development posts and therefore these lowest banded posts are the most likely to change by gender due to annual changes to apprentices.
- More women are found in bands 4 to 9.
- Band 8d is only occupied by women. There are also a higher proportion of women to men at band 9 (75% compared to 25%).
- More men are found in the medical band (79% compared to 21 %) and VSM band (53 compared to 47%). The significant male dominance in the medical banding explains the majority of the pay disparity when looking at mean hourly rates due to the increased hourly rate for medical staff.

Analysis of pay bands by quartile

Number of employees | Q1 = Low, Q4 = High

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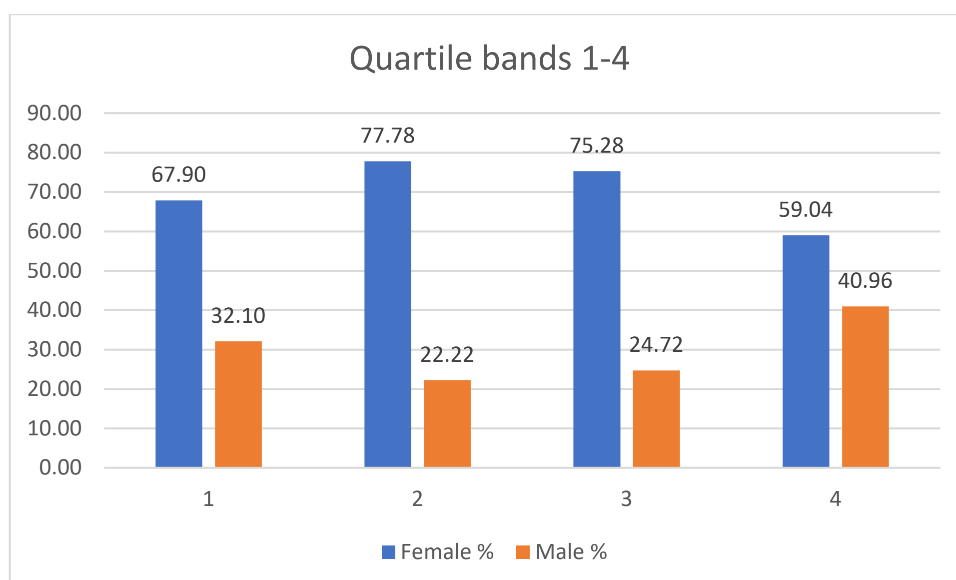

Q1 Lower Quartile Pay Band

- The figures demonstrate that 68% are women and 32% are men in this quartile. Female staff are under representative in this quartile compared to the combined workforce of female workers which is 70% however this is a small proportion when we look at the small numbers behind the statistics.

Q2 Lower Middle Quartile Pay Band

- The figures demonstrate that 78% are women and 22% are men in this quartile. Female staff are over representative in this quartile compared to the combined workforce of females which is 70%.

Q3 Higher Middle Quartile Pay Band

- The figures demonstrate that 75% are women and 25% men in this quartile. Female staff are over representative in this quartile compared to the combined workforce of females which is 70%.

Q4 Upper Quartile Pay Band

- The figures also demonstrate that 59% are women and 41% are men in this quartile. Female staff are under representative in this quartile compared to the combined workforce of females which is 70%.

Conclusion

Females make up two thirds (70%) of the workforce. This generally reflects the latest available statistics from NHS Digital, which details that 76.7% of the total NHS workforce are women.

The gender pay gap is showing there is a 19.6% average difference between males and females pay at LLR ICB.

Reducing the gender pay gap usually implies either increasing the proportion of men in lower grades or increasing the proportion of women occupying the more senior roles.

Effective policies for closing the gender pay gap not only seek to address the factors and barriers common to all women (such as numbers in low grade jobs with low pay), they, also target the inequalities faced by women belonging to specific groups, based on characteristics such as ethnicity, age and profession.

Actions from the Operational Delivery Group :

1. to refer to at PDRs to ensure managers are considering career progression
2. to take the report to team meetings for discussion.
3. to obtain a comparison against other ICBs once published

Actions from Renumeration Committee and Non-Executive Directors:

4. Explore the data further to understand the impact if the medical Workforce is removed, therefore understanding the focus of the discussions to close the gap.

5. The largest pay gender gap is in lower bands (apprentice, band 2 and band 3) due to men not being represented sufficiently in these posts. An action to consider future attraction campaigns to roles that may not be considered traditionally male roles. Focus to be placed on the detail of the data understanding the impact of apprentices, entry levels for future development into more senior positions.

6. Consider the drivers of career breaks due to caring responsibilities and maternity leave, whether the drivers for career progression are linked to these responsibilities that are traditionally orientated towards women and whether a fast-track career approach could be implemented to close the gap.

7. ICB to continue with national and local programmes to support women in leadership positions (LLR Women in Clinical Leadership network and national BAME women mentorship programme for Primary Care).

8. That these actions together with the data and reports for 2023 & 2024 will then be discussed and developed at the LLR ICB People Forum during 2024.

Recommendation:

That the ICB Board approves the Gender Pay Gap Report for publishing on the ICB Website.

09/01/24 Final Draft

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F

NHS

Name of meeting:	**Leicester, Leicestershire and Rutland Integrated Care Board** (public)		
Date:	8 February 2024	Paper:	F
Report title:	**Delegation of Specialised Acute Services briefing paper**		
Presented by:	Ket Chudasama, Deputy Chief Strategy and Planning Officer, NHS LLR ICB		
Report author:	Jo Grizzell, Senior Planning Manager, NHS LLR ICB		
Executive Sponsor:	Sarah Prema, Chief Strategy Officer, NHS LLR ICB		

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

Recommendations:

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

- **RECEIVE and NOTE** the Delegation of Specified Specialised Acute and Services Briefing and associated appendices and provide feedback as required.

Purpose and summary of the report:

With effect from 1st April 2024, the LLR ICB will take on delegated responsibility for 59 specialised acute and pharmacy services. The attached briefing (appendix 1) has been produced by NHS England for the East and West Midlands ICBs. Also attached (appendix 2) is a list of the 59 services to be delegated.

It should also be noted that regular meetings are in place with UHL where delegation arrangements are discussed. Colleagues from the LLR ICB contracting team also attend these meetings.

The draft template Delegation Agreement, Multi-ICB Collaboration Agreement and the hosting agreement (embedded within appendix 1) are being presented to the LLR ICB Board on 8th February 2024 with a view to taking them to the Board on 14th March for formal approval.

In addition, appendix 3 sets out the collaboration arrangements including the distributed leadership currently in place that Board members are asked to note.

Appendices:	• Appendix 1 - Delegation of Specified Specialised Acute Services briefing • Appendix 2 – List of delegated services • Appendix 3 – East Midlands Collaboration arrangements (including distributed leadership model)
Report history (date and committee / group the content has been discussed / reviewed prior to presenting to this meeting):	• LLR ICB Executive Management Team – 22nd January 2024 • LLR ICB Operational Delivery Group – 23rd January 2024 • LLR ICB System Executive Committee – 26th January 2024

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

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

Implications:	
a) Does the report provide assurance against a corporate risk(s) e.g. risk aligned to the Board Assurance Framework, risk register etc? *If so, state which risk and also detail if any new risks are identified.*	NHS England have an overarching risk register in place that is monitored by the Midlands Acute Specialised Commissioning Group (MASCG). Any risks that directly impact the LLR ICB will be captured within a risk register that will be monitored by the LLR PODs, Specialised Acute and Pharmacy Steering Group.
b) Does the report highlight any resource and financial implications? If so, provide which page / paragraph this can be found within the report.	Not in the context of this report.
c) Does the report highlight quality and patient safety implications? If so, provide which page / paragraph this is outlined in within the report.	Not in the context of this report.
d) Does the report demonstrate patient and public involvement? If so, provide which page / paragraph this is outlined in within the report.	Not in the context of this report.
e) Has due regard been given to the Public Sector Equality Duty? If so, how and what the outcome was, provide which page / paragraph this is outlined in within the report.	Not in the context of this report.

Delegation of Specified Specialised Acute Services Briefing

8 February 2024

Introduction

1. With effect from 1st April 2024, the LLR ICB will take on delegated responsibility for 59 specialised acute services. The attached briefing (appendix 1) has been produced by NHS England for the East and West Midlands ICBs. Also attached (appendix 2) is a list of the 59 services to be delegated.

2. It should also be noted that regular meetings are in place with the UHL strategy and partnerships team where delegation arrangements are discussed. Colleagues from the LLR ICB contracting team also attend these meetings.

3. There are three key documents as set out below. Templates of these are embedded within appendix 1 and are being shared with members to ensure they are sighted on the direction of travel. They are currently being further developed with a view to taking them to the Board on 14th March 2024 for formal approval:

    - Delegation Agreement – replaces the existing Joint Working Agreement between the ICBs and NHS England. It is a mandatory requirement and sets out the delegated functions to the ICBs under Section 65Z5 of the NHS Act while retaining the Reserved Functions.

    - Multi-ICB Collaboration Agreement - is a statutory requirement as part of the delegation of specialised services under section 8 of the delegation agreement. The Collaboration Agreement will be for 2024/25 only to reflect the 2024/25 transitional position for contracting, workforce and amber services. It covers all 11 Midlands ICBs. NHSE are included in the agreement to cover the continued hosting of the workforce and the further specialised services that will be delegated in April 2025. NHSE have a ‘seat at the table’ in terms of governance at the East and West Boards. The agreement is for 2024/25 only, to enable further development and inclusion of any other collaborative arrangements ICBs wish to put in place for 2025 onwards.

    - Commissioning Team Agreement (hosting) – is for the provision of administrative and management services by NHS England Commissioning Hubs in respect of the Delegated Specialised Services for financial year 2024/25 in accordance with Clause 9.6 of the Delegation Agreement for Specialised Services.

4. In addition, appendix 3 sets out the collaboration arrangements including the proposed distributed leadership that Committee members are asked to note. These are the arrangements that are currently in place across the Midlands region.

Learning from the delegation of Pharmacy, Optometry and Dental Services (PODs) delegation

5. The NHSE Midlands specialised commissioning team were keen to learn from ICB experiences following the delegation of PODs services. Leicester, Leicestershire and Rutland ICB and Birmingham and Solihull ICB were instrumental in those discussions. As a result, it

was agreed that an Operating Model Group (OMG) would be established providing a robust joined up working approach. This is Chaired by Karen Helliwell, Specialised Services Advisor, NHS Birmingham and Solihull ICB.

6. In addition to the OMG, a number of workstreams have been established that feed directly into it, the majority of which have representation from the ICB. The OMG is attended by the Senior Planning Manager, Strategy and Planning Directorate, LLR ICB. The workstreams are as follows:

    - Governance
    - Finance (FCAG)
    - BI/IT/IG
    - Workforce
    - Planning
    - Contracting
    - Regional quality group
    - Clinical and quality

Pre-Delegation Assessment Framework and Regional Summary

7. To support the delegation of specialised services, a Pre-Delegation Assessment Framework (PDAF) was produced collaboratively with NHS England and the ICBs. This involved the formation of working groups across the six domains contained within the PDAF:

    1. Health and Care Geography
    2. Transformation
    3. Governance
    4. Finance
    5. Workforce
    6. Data, Reporting and Analytical Infrastructure.

8. The domain responses were collated and reviewed by the Operating Model Group, consisting of senior leaders from the 11 Midlands ICBs and NHS England. It was also reviewed by the East Midlands Joint Commissioning Committee.

9. The deadline for submission to the NHS England national moderation panel of the PDAF was 25th September 2023. It was then reviewed in October by the NHS England Executive Group in November 2023 before final approval by the NHS England Board on 7th December 2023.

10. LLR took the decision to allow the Executive Management Team to approve the PDAF which occurred on 18th September 2023.

11. To support the PDAF, a regional summary was produced that provided a RAG status against each of the domains as to the readiness to take on delegation. This was broken down into three categories.

12. Initially, the East Midlands were RAG rated as Category 1, however following moderation this was amended to Category 2 within the workforce domain.

- Category 1 - The (multi) ICB is ready for full delegated commissioning responsibility from April 2024.
- Category 2 - The (multi) ICB is ready for delegated commissioning responsibility from April 24 subject to developmental conditions being attached.
- Category 3 - Where the (multi) ICB is not yet ready for full delegated commissioning responsibility from April 24 and needs an additional year of development and support through more intensive conditions being attached to the arrangement.

Internal governance arrangements

13. We have in place a PODs, Specialised Acute and Pharmacy Steering Group that meets on a monthly basis. This is the internal forum where in-depth discussions will take place in relation to specialised acute and pharmacy services. It provides a monthly highlight report to the LLR ICB Strategic Commissioning Group where any concerns or risks are flagged.

Financial Risk and Pooling Framework

14. Risks to delegation focus primarily on the finance elements and in particular the Financial Risk and Pooling Framework. This is currently being worked through; however, a Midlands FCAG meeting took place on 16th January 2024 where this was discussed in detail.

15. A half-day workshop to go through the detail with ICB CFOs is being arranged for early February 2024.

Decision-making arrangements

16. A CEO and NHSE timeout session was held on 23rd January 2024 to discuss next steps relating to the decision-making arrangements for 2024/25. These have been discussed within the governance workstream and also FCAG. Three options were developed as a framework to guide the multi-ICB collaboration agreement and the development of the governance arrangements. These conversations link to the Financial Risk and Pooling Framework. The options were as follows:

    - Option 1 – Joint Sub-Group
    - Option 2 – Sub-Groups in Common
    - Option 3 – Delegation to individuals in consultation with Midlands Acute Specialised Commissioning Group (MASCG)*

    *It should be noted that throughout 2023/24 the ICBs have been members of the Midlands Acute Specialised Commissioning Group (MASCG) and as such have been informing the development and creation of these arrangements.

17. A further CEOs timeout session is taking place on 7th February 2024 where there will be further discussions in relation to the decision-making options with a clear steer that option 1 be explored further.

Additional Risks

18 In addition to the finance risks outlined above, further areas of concern have been identified that relate to resources/staff (capacity and capability), quality and the development of a quality framework, service opportunities and a further piece of work to look at wider risks.

19 A due diligence exercise is being undertaken being led by NHS Birmingham and Solihull ICB and NHSE looking at these areas to be completed by the end of January 2024. The areas of focus were agreed by the CEOs at their timeout session on 23rd January 2024. Quality, finance and workforce considerations will be discussed at the next CEO timeout session on 7th February 2024 and then at the East Midlands Board meeting on 20th February 2024. The outputs of the exercise will then be shared with the LLR ICB Board at its meeting on 14th March 2024.

20 Also, it has been agreed that a session for ICB Non-Executive Directors will be arranged for early February 2024.

Next steps

21. It is anticipated that the agreements outlined within section 3 are presented to the Board meeting on 14th March 2024 for consideration. For the purposes of this meeting, NHSE have been asked to produce a standard paper for use by all 11 Midlands ICBs that explains the primary purpose of the delegation of specialised services and the impact on individual accountabilities, in particular quality and finance, as well as the technical aspects of delegation.

22. Finally, to note, all 11 Midlands ICBs have Board meetings during March where they will be asked to consider the delegation arrangements and in particular the agreements set out in section 3 above.

Recommendations

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

- **RECEIVE and NOTE** the Delegation of Specified Specialised Acute and Services Briefing and associated appendices and provide feedback as required.

Appendix 1

NHS

Briefing Paper

Date: December 2023

Paper Title: Delegation of Specified Specialised Acute Services

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Executive summary: This paper provides a summary of the process for the delegation of the 59 Acute Specialised Commissioning Service lines that are due for delegation to ICBs in April 2024

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1 Introduction and purpose of the paper

1.1 The 2022 legislation enabled NHS England to delegate some of its statutory commissioning functions to another NHS body.

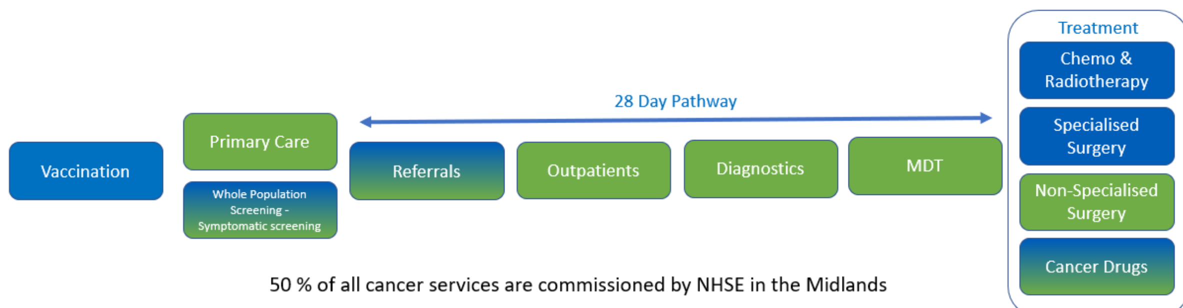
1.2 Delegation means that NHS England will delegate its statutory functions with finances and liability to follow the function that is delegated. ICBs will have decision making authority, details of which will be laid out in the terms of the delegation agreement.

1.3 On the 6th December 2023 the NHS England Board approved plans to delegate 59 specialised acute services to the Midlands region, the North West region and the East Region. The remaining regions will continue with Joint Working until delegation in April 2025.

2. What is delegation trying to achieve

2.1 The overarching aim is to bring the population resource closer to the populations served, breaking down organisational barriers across pathways of care. This is expected to reduce health inequalities, whilst improving the quality of health and care for patients, by ensuring that ICBs can strategically plan and commission services for their whole population.

2.2 The key objective of delegation is to join up fragmented pathways to improve outcomes for patients. The current cancer pathway illustrates fragmentation and opportunities for joint planning.



3. What services are being delegated from 2024?

3.1 There are 3 categories of specialised services illustrated below.

3.2 In April 2024 the 59 specialised acute services in category 1 are being delegated to ICBs.

3.3 There is currently a rapid review of the category 2 services which will either remain with NHS England or be delegated to ICBs in April 2025. These include Mental Health Learning Disability and Autism and specialised Pharmacy services (as well as some additional Acute Services).

3.4 The delegation of specialised services will build upon experience and lessons learnt from the delegation of Pharmacy, Optometry and Dentistry. Each of the 11 ICBs has senior representatives on the oversight group for the transition – the Operating Model Group (OMG), who lead the design and development of the approach to delegation. Several working groups focussing on Quality, Finance, and Governance, all with ICB involvement feed into OMG (oversight group).

3.5 Retention of the skills, knowledge and experience of existing teams and ensuring continuity of support and organisational memory of those operational teams remains a key priority.

3.7 There is a national policy intention to work towards the delegation of vaccination services in April 2025.

3.8 Screening services may be considered for future delegation and are currently undergoing national review to determine if and when this could take place.

3.9 Health and Justice services will not be delegated.

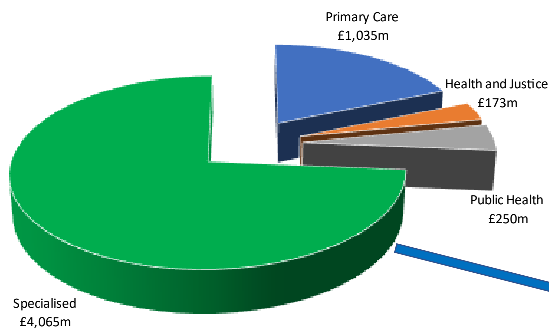
3.10 NHS England's updated policy position is that there needs to be a clean break between NHS England retained functions and ICB delegated functions. Therefore, previous assumptions of a shared NHS England/ICB workforce requires further work. As such NHS England will continue to host the workforce for the 59 specialised services that will be delegated on the 1st April 2024 for a further year. 2024/25 will be a transitional year for the workforce which will be supported by a hosting agreement between NHS England and the ICBs.

4. Finance

4.1 The budget for these services will be transferred to ICBs upon delegation. ICB directors of finance and NHS England, through the finance working group are developing mechanisms for financial governance. The diagram below is an illustration of the financial operating context based on 2023/24

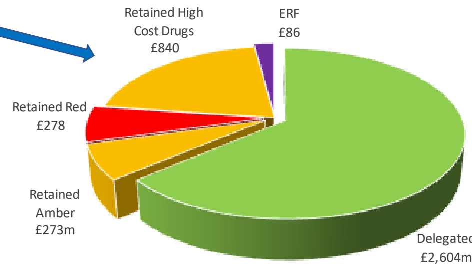
NHS England

Operating Context



Integrated Care Board West Midlands	Population
NHS Birmingham and Solihull ICB	1,575,773
NHS Black Country ICB	1,295,518
NHS Coventry and Warwickshire ICB	1,062,935
NHS Herefordshire and Worcestershire ICB	821,214
NHS Shropshire, Telford and Wrekin ICB	524,267
NHS Staffordshire and Stoke-on-Trent ICB	1,175,828
East Midlands	
NHS Derby and Derbyshire ICB	1,115,047
NHS Leicester, Leicestershire and Rutland ICB	1,196,729
NHS Lincolnshire ICB	810,765
NHS Northamptonshire ICB	819,533
NHS Nottingham and Nottinghamshire ICB	1,249,094
Total	**11,646,703**

Service Area	Status
Primary Care	Delegated April 2023
Health and Justice	No plan to delegate
Public Health	Future delegation 2025 onwards
Specialised	Partially delegated April 2024



3 |

4.2 Specialised Commissioned Services have the potential for significant variation in spend levels due to the high cost of procedures. These procedures could vary greatly between areas. As with the delegation of Pharmacy, Optometry and Dental (POD) services, consideration is being given to establishing a financial risk framework (a set of rules and behaviours which govern the way we manage the risk that may arise within the specialised delegated budgets between delegated ICBs of the Midlands Region). The focus of the risk share being a pooling of resources enabling risks to be understood and managed.

5. The Delegation Process

5.1 Delegation agreements will be between individual ICBs and NHS England, who will be required (through clause 8 in the delegation agreement) to form joint working arrangements with other ICBs within a Multi-ICB footprint. This will be supported by formal ICB Collaboration Agreements which will be between the East ICBs and the West ICBs.

5.2 The Multi-ICB commissioning footprints for the Midlands are:

- East Midlands (Notts and Nottinghamshire ICB, Derby and Derbyshire ICB, Lincolnshire ICB, Leicester, Leicestershire and Rutland ICB, and Northamptonshire ICB)
- West Midlands (Birmingham & Solihull ICB, the Black Country ICB, Shropshire, Telford and Wrekin ICB, Staffordshire & Stoke-on-Trent ICB, Herefordshire and Worcestershire ICB, Coventry and Warwickshire ICB).

5.3 The Delegation Agreement and Multi-ICB Collaboration Agreement will need to be approved by ICB boards before the end of March 2024. These agreements are currently being co-produced by ICBs and NHS England working groups.

5.4 The Multi-ICB Collaboration Agreement (with appropriate updated ToRs) will replace the current Joint working agreement that supports the East and West Boards. This agreement (1 East and 1 West) will be between the ICBs and will outline how ICBs work together, how decisions will be made including the following components:

- Governance arrangements

- Financial arrangements
- Joint committees
- Information governance and sharing
- Commissioning hub arrangements

5.5 The Multi-ICB Collaboration Agreement will be developed through the various joint ICB and NHS England working groups (finance, quality, governance) which all include nominated ICB representatives. This will be overseen by the Operating Model Group chaired by Karen Helliwell and Ali Kemp.

5.6 The Delegation Agreement and Multi-ICB Collaboration Agreement require final approval by ICB CEO's by mid-March 2024, to allow for 1st April delegation. Final drafts of these documents will be available by 31st January 2024.

5.7 Templates for the three key governance documents have been shared with your teams and are included below for reference and information.

1%20Delegation%20
Agreement.docx

1.Delegation Agreement

2%20-%20ICB%20Co
llaboration%20Agreer

2.Collaboration Agreement

3%20DRAFT%20Host
ing%20Agreement%2

3.Hosting Agreement 24/25

Appendix 2

SCHEDULE 3: JOINT SPECIALISED SERVICES

The following are the Specialised Services that NHS England has determined as being suitable and ready for greater ICB involvement:

PSS Manual Line	PSS Manual Line Description	Service Line Code	Service Line Description
2	Adult congenital heart disease services	13X	Adult congenital heart disease services (non-surgical)
		13Y	Adult congenital heart disease services (surgical)
3	Adult specialist pain management services	31Z	Adult specialist pain management services
4	Adult specialist respiratory services	29M	Interstitial lung disease
		29S	Severe asthma
5	Adult specialist rheumatology services	26Z	Adult specialist rheumatology services
7	Adult Specialist Cardiac Services	13A	Complex device therapy
		13B	Cardiac electrophysiology & ablation
		13C	Inherited cardiac conditions
		13E	Cardiac surgery (inpatient)
		13F	PPCI for ST- elevation myocardial infarction
		13H	Cardiac magnetic resonance imaging
		13T	Transcatheter Aortic Valve Replacement (TAVI)
		13Z	Cardiac surgery (outpatient)
9	Adult specialist endocrinology services	27E	Adrenal Cancer
		27Z	Adult specialist endocrinology services
11	Adult specialist neurosciences services	08E	Neurosurgery - Low Volume Procedures (National)
		08F	Neurosurgery - Low Volume Procedures (Regional)
		08G	Neurosurgery - Low Volume Procedures (Neuroscience Centres)
		08O	Neurology
		08P	Neurophysiology
		08R	Neuroradiology
		08S	Neurosurgery
		08T	Mechanical Thrombectomy
12	Adult specialist ophthalmology services	37C	Artificial Eye Service
		37Z	Adult specialist ophthalmology services
13	Adult specialist orthopaedic services	34A	Orthopaedic surgery
		34R	Orthopaedic revision
15	Adult specialist renal services	11B	Renal dialysis
		11C	Access for renal dialysis
16	Adult specialist services for people living with HIV	14A	Adult specialised services for people living with HIV
17	Adult specialist vascular services	30Z	Adult specialist vascular services
18	Adult thoracic surgery services	29B	Complex thoracic surgery
		29Z	Adult thoracic surgery services: outpatients
30	Bone conduction hearing implant services (adults and children)	32B	Bone anchored hearing aids service
		32D	Middle ear implantable hearing aids service
35	Cleft lip and palate services (adults and children)	15Z	Cleft lip and palate services
36	Cochlear implantation services (adults and children)	32A	Cochlear implantation services
40	Complex spinal surgery services (adults and children)	06Z	Complex spinal surgery services
54	Fetal medicine services (adults and adolescents)	04C	Fetal medicine services
58	Specialist adult gynaecological surgery and urinary surgery services for females	04A	Severe Endometriosis

PSS Manual Line	PSS Manual Line Description	Service Line Code	Service Line Description
		04D	Complex urinary incontinence and genital prolapse
58A	Specialist adult urological surgery services for men	41P	Penile implants
		41S	Surgical sperm removal
		41U	Urethral reconstruction
59	Specialist allergy services (adults and children)	17Z	Specialist allergy services
61	Specialist dermatology services (adults and children)	24Z	Specialist dermatology services
62	Specialist metabolic disorder services (adults and children)	36Z	Specialist metabolic disorder services
63	Specialist pain management services for children	23Y	Specialist pain management services for children
64	Specialist palliative care services for children and young adults	E23	Specialist palliative care services for children and young adults
65	Specialist services for adults with infectious diseases	18A	Specialist services for adults with infectious diseases
		18E	Specialist Bone and Joint Infection
72	Major trauma services (adults and children)	34T	Major trauma services
78	Neuropsychiatry services (adults and children)	08Y	Neuropsychiatry services
83	Paediatric cardiac services	23B	Paediatric cardiac services
94	Radiotherapy services (adults and children)	01R	Radiotherapy services (Adults)
		51R	Radiotherapy services (Children)
		01S	Stereotactic Radiosurgery / radiotherapy
105	Specialist cancer services (adults)	01C	Chemotherapy
		01J	Anal cancer
		01K	Malignant mesothelioma
		01M	Head and neck cancer
		01N	Kidney, bladder and prostate cancer
		01Q	Rare brain and CNS cancer
		01U	Oesophageal and gastric cancer
		01V	Biliary tract cancer
		01W	Liver cancer
		01Y	Cancer Outpatients
		01Z	Testicular cancer
		04F	Gynaecological cancer
		19V	Pancreatic cancer
		24Y	Skin cancer
106	Specialist cancer services for children and young adults	01T	Teenage and young adult cancer
		23A	Children's cancer
106A	Specialist colorectal surgery services (adults)	33A	Complex surgery for faecal incontinence
		33B	Complex inflammatory bowel disease
		33C	Transanal endoscopic microsurgery
		33D	Distal sacrectomy for advanced and recurrent rectal cancer
107	Specialist dentistry services for children	23P	Specialist dentistry services for children
108	Specialist ear, nose and throat services for children	23D	Specialist ear, nose and throat services for children
109	Specialist endocrinology services for children	23E	Specialist endocrinology and diabetes services for children
110	Specialist gastroenterology, hepatology and nutritional support services for children	23F	Specialist gastroenterology, hepatology and nutritional support services for children
112	Specialist gynaecology services for children	23X(b)	Specialist paediatric surgery services - Gynaecology
113	Specialist haematology services for children	23H	Specialist haematology services for children
115B	Specialist maternity care for adults diagnosed with abnormally invasive placenta	04G	Specialist maternity care for women diagnosed with abnormally invasive placenta
118	Neonatal critical care services	NIC	Specialist neonatal care services

PSS Manual Line	PSS Manual Line Description	Service Line Code	Service Line Description
119	Specialist neuroscience services for children	23M	Specialist neuroscience services for children
		07Y	Paediatric neurorehabilitation
		08J	Selective dorsal rhizotomy
120	Specialist ophthalmology services for children	23N	Specialist ophthalmology services for children
121	Specialist orthopaedic services for children	23Q	Specialist orthopaedic services for children
122	Paediatric critical care services	PIC	Specialist paediatric intensive care services
125	Specialist plastic surgery services for children	23R	Specialist plastic surgery services for children
126	Specialist rehabilitation services for patients with highly complex needs (adults and children)	07Z	Specialist rehabilitation services for patients with highly complex needs
127	Specialist renal services for children	23S	Specialist renal services for children
128	Specialist respiratory services for children	23T	Specialist respiratory services for children
129	Specialist rheumatology services for children	23W	Specialist rheumatology services for children
130	Specialist services for children with infectious diseases	18C	Specialist services for children with infectious diseases
131	Specialist services for complex liver, biliary and pancreatic diseases in adults	19L	Specialist services for complex liver diseases in adults
		19P	Specialist services for complex pancreatic diseases in adults
		19Z	Specialist services for complex liver, biliary and pancreatic diseases in adults
132	Specialist services for haemophilia and other related bleeding disorders (adults and children)	03X	Specialist services for haemophilia and other related bleeding disorders (Adults)
		03Y	Specialist services for haemophilia and other related bleeding disorders (Children)
134	Specialist services to support patients with complex physical disabilities (excluding wheelchair services) (adults and children)	05P	Prosthetics
135	Specialist paediatric surgery services	23X(a)	Specialist paediatric surgery services - General Surgery
136	Specialist paediatric urology services	23Z	Specialist paediatric urology services
139A	Specialist morbid obesity services for children	35Z	Specialist morbid obesity services for children
139AA	Termination services for patients with medical complexity and or significant co-morbidities requiring treatment in a specialist hospital	04P	Complex termination of pregnancy
ACC	Adult Critical Care	ACC	Adult critical care

Appendix 3

ICB Board Briefing

East Midlands ICB Collaborative Arrangements

Purpose and Principles

The East Midland ICBs (Derby and Derbyshire, Leicester Leicestershire and Rutland, Lincolnshire, Northamptonshire and Nottingham and Nottinghamshire) have agreed to collaborate in areas that are most effectively undertaken at scale.

A key operating principle for the collaboration is that working at scale should add value to common goals, whilst retaining local ICB population health sensitivity where appropriate. Distributed leadership across all five members is also a key component.

Scope

The collaborative arrangements cover:

- NHSE delegated commissioning responsibilities to ICBs (pharmacy, optometry, dentistry [PODs])
- Oversight of future NHSE commissioning delegations (including specialised commissioning, vaccinations)
- Other East Midlands wide commissioning (non-specialised, initially assisted reproduction)
- 111 and ambulance commissioning
- Commissioning Committee governance
- Commissioning Support Units
- Strategic partnerships with East Midlands bodies (including Local Government Association, Association of Directors of Adult Social Services, Cancer Alliance, clinical networks)

Leadership and Governance

A tiered committee structure has been established as the mechanism for joint decision making (Appendix 1). Tier 1 is an oversight and strategy setting function, with CEO and Chair membership. Tier 2 undertakes operational commissioning functions and makes most of the commissioning decisions. Although decisions are made jointly, each ICB representative applies local knowledge to the development and approval of decisions. Tier 3 provides subject matter expertise for quality, finance and contracting in support of tier 2 decision making. Tier 3 groups have considerable technical and subject matter expertise.

ICB Boards have delegated POD commissioning decisions to the tiered committee structures, so this function is exercised jointly. ICB Boards can also choose to delegate additional specific decisions to the joint structures. A recent example of this is the outcome of the 111 procurement.

Hosting Arrangements

Nottingham and Nottinghamshire ICB is the East Midlands host for the POD team and will host the East Midlands Cancer Alliance from April 2024. A hosting agreement is in place and the host responsibilities are:

- Staff transferred to the host (employing) ICB under TUPE arrangements, with shared liability across the five East Midlands ICBs.
- Staff within the hosting arrangements operate on behalf of all five ICBs and commissioning decisions / operations are exercised jointly through the joint governance arrangements.
- The host ICB determines the continuous professional development and provides line management support to the hosted team.

Distributed leadership arrangements

Each ICB contributes to the work of the East Midlands Collaborative through a number of routes:

- Each CEO has specific lead sponsor responsibilities, meaning that they lead collaborative work in their area and can represent the views of all five ICBs. The CEOs meet monthly, alternately in person and via Teams.
- An executive group has been established, with a nominated executive director for each ICB. This group enables discussion and agreement of preferred approaches and helps to gain alignment. The frequency of meetings depends on the work schedule at that time. Lead executives also attend joint working groups with NHSE, particularly concerning delegations and areas of joint working with NHSE.
- Each ICB contributes some of their leadership capacity to support the collaborative. This may be to support the work of their CEO lead sponsor or it may be to provide expertise into the committee tiers.

The collaborative has considered appointing designated programme support capacity, but this has been put on hold considering the current financial and running cost allowance constraints. This will be reconsidered in future months, now that the new CEO is in place for Leicester, Leicestershire and Rutland ICB.

Lead areas are distributed as follows:

ICB	Lead Area
Derby and Derbyshire	NHS111, Ambulance Services
Leicester, Leicestershire and Rutland	Specialised Commissioning (linking with Birmingham & Solihull ICB as combined East and West hosting organisation).
Lincolnshire	Broader collaboration with Local Authority, Cancer Alliance and Cardiovascular Disease and Respiratory (CVD-R) Clinical Network and Commissioning Policies
Northamptonshire	Collaborative governance and Commissioning Support Unit arrangements.

Nottingham and Nottinghamshire	Primary Pharmacy, Optometry & Primary and Secondary Dental Services (PODs) and vaccinations.

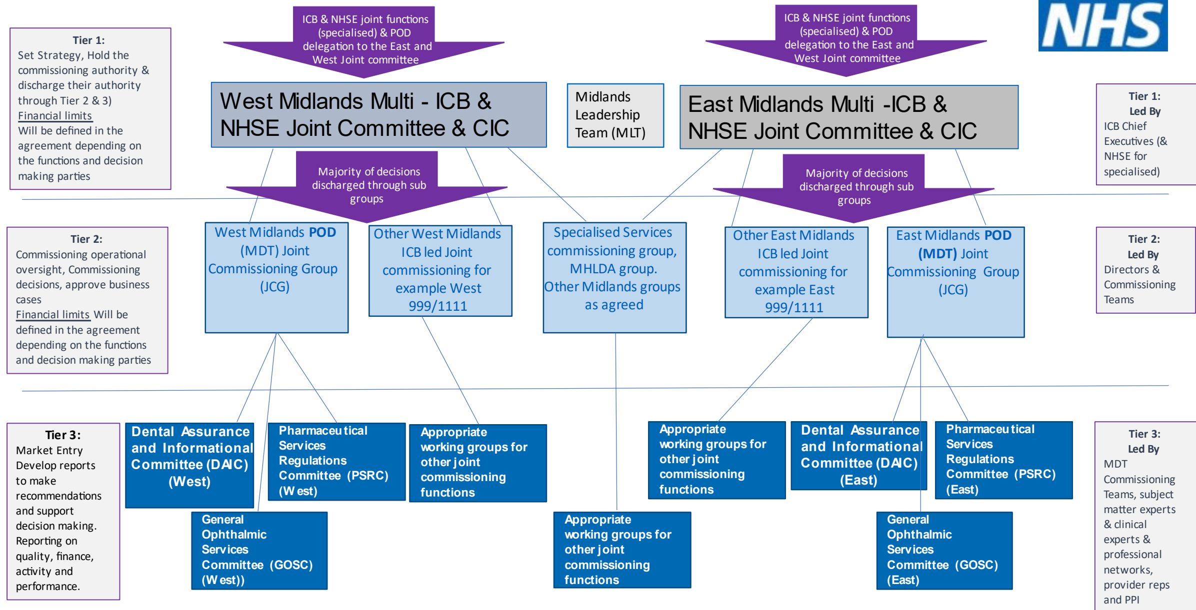
Additional collaborative working

There are some collaborative arrangements across the whole of the Midlands Region. The Midlands Leadership Team meets fortnightly and is chaired by the Regional Director. Members include regional executives and ICB CEOs.

The Midlands Decision Making Network is a membership learning and development collaborative for analyst development and joint analytical programmes.

ICBs are also collaborating at a sub-East Midlands level where this makes sense. For example, Leicester Leicestershire and Rutland ICB formally collaborate with Northampton where this makes sense in terms of shared provider leadership. Nottingham and Nottinghamshire ICB and Derby and Derbyshire ICBs are beginning to collaborate on skills pipelines and workforce planning and meet jointly to consider further opportunities linked to the forthcoming devolution deal.

Appendix 1



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NHS

Name of meeting:	Leicester, Leicestershire and Rutland Integrated Care Board (public)		
Date:	8 February 2024	Paper:	G
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 Integrated Care Board is asked to:

- **Receive and note** the full contents of the report
- **Note** the increasing risks within the UEC pathway and the risk this poses to the H2 plan

Purpose and summary of the report:

- Presented here is the December integrated delivery report from the LLR Delivery Partnership, covering progress against the LLR Operational Plan and the LLR five-year plan made at Month 9 of 2023/24.

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

Performance

- In terms of performance, continued improvement noted in the eliminating 78 week waits, meeting the agreed plan and trajectory by March 2024. Although Cancer standards have seen some improvement, they remain a primary concern. All UEC, primary care and long-term conditions metrics have been impacted with winter pressures and industrial action and are significantly off track for the month. UEC has moved to CEX-led system escalation as a result. The full performance report was presented to the System Executive in January 2024 for assurance.

Finance

- The key risk to delivery overall remains a financial risk; The ICB have a revised H2 Plan with the aim to maintain the financial position as per this revision at M9. The teams remain focused on delivering the agreed Cost improvement plans at organisational and system level, with a focus on preparation for 2024/25 planning. Significant risk is being held in the UEC pathway, with minimal mitigation as it stands.

Quality & transformation

- In terms of quality, there are no new risks identified this month; focus remains on managing the increased risk within the UEC pathway and the residual risk within 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.

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.

- Progress continues to be made across the month despite significant pressure in terms of Industrial Action, Storm Henk etc. System teams have remained focussed on delivery of both one- and five-year plans.

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

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

Conflicts of interest screening		**Summary of conflicts** *(detail to be discussed with the Corporate Governance Team)*
☒	No conflict identified.	
☐	Conflict noted, conflicted party can participate in discussion and decision	
☐	Conflict noted, conflicted party can participate in discussion but not in decision	
☐	Conflict noted, conflicted party can remain in meeting but not participate in discussion or decision.	
☐	Conflict noted, conflicted party to be excluded from the meeting.	
Implications:		
a)	**Does the report provide assurance against a corporate risk(s) e.g. risk aligned to the Board Assurance Framework, risk register etc?** *If so, state which risk and also detail if any new risks are identified.*	BAF 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

NHS

LLR Delivery Partnership – Delivery of the LLR one - and five - year plans
December 2024

Background

1. Presented here is the December integrated delivery report from the LLR Delivery Partnership, covering progress against the LLR Operational Plan and the LLR five-year plan made at Month 10 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, continued improvement noted in the eliminating 78 week waits, meeting the agreed plan and trajectory by March 2024. Although Cancer standards have seen some improvement, sustainability of standards remain a primary concern. All UEC, primary care and long term conditions metrics have been impacted with winter pressures and industrial action and are significantly off track for the month. UEC has moved to CEX-led system escalation as a result. The full performance report was presented to the System Executive in January 2024 for assurance.
      Finance
      The key risk to delivery overall remains a financial risk; The ICB have a revised H2 Plan with the aim to maintain the financial position as per this revision at M9. The teams remain focused on delivering the agreed Cost improvement plans at organisational and system level, with a focus on preparation for 24/25 planning.

   b. **Quality & transformation**
      In terms of quality, there are no new risks identified this month; focus remains on managing the increased risk within the UEC pathway and the residual risk within 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.

   c. **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.

4. Progress continues to be made across the month; despite significant pressure in terms of Industrial Action, Storm Henk etc. 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.
- Note the risk of variation in performance, particularly with UEC, as the impact of winter and industrial action are noted

System Quality Committee is asked to:
- Receive & note the full contents of the report, including the progress of the transformative schemes showcased.
- Note the increased risk within UEC and the CEX-led escalation process in place
- Note that the System Quality Group has cross-checked quality risks highlighted in this report with either risk registers or for discussion through quality governance.

System Finance committee is asked to:
- Receive & note the full contents of the report.

System Health Equity committee is asked to:
- Receive & note the full contents of the report.
- Support identification of areas of focus for Partnerships in preparation for planning 24/25.

The ICB is asked to:
- NOTE the full contents of the report, the progress outlined against both the one- and five-year plans and the escalations made to each sub-committee.

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	Month	Plan	Actual	Status	Confidence in recovery / Year-end delivery
Improve access to mental health support for children and young people aged 0-25 accessing NHS funded services (compared to 2019) (Rolling 12 months data)	Oct-23 Q3 Plan	14228	14475	Met	High Plans in place, key risks understood
Increase the number of adults and older adults accessing talking therapies (IAPT) (Rolling 3 months data)	Oct-23 Q3 Plan	8101	5445	Not met	High Updated Recovery Action Plan being developed. Key risks understood.
Increase in the number of adults and older adults supported by community MH services with Severe Mental Illness (SMI) Number of people who receive two or more contacts from NHS or NHS commissioned community MH service (Rolling 3 months data)	Oct-23	6456	12860	Met	High Plans in place, key risks understood
Work towards eliminating out of area placements (Quarterly rolling Bed days)	Sep-23	0	0	Met	High Plans in place, key risks understood
Recover the dementia diagnosis rate to 66.7% 23/24	Nov-23 Q3 Plan	65.8%	65.5%	Within 5% tolerance	High Monthly improvement. Key risks understood
Improve access to perinatal mental health services (Number of women accessing specialist perinatal MH services (Cumulative position)	Oct-23 Q3 Plan	65.8%	65.5%	Within 5% tolerance	Unknown 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 known 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 co-authored 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	Month	Plan	Actual	Status	Confidence in recovery / Year-end delivery
Eliminate waits of over 65 weeks for elective care by Mar 24 (except where patients choose to wait longer or in specific specialties)	Nov-23	1,223	1,223	Met	Will not deliver zero by end of March 24. Confidence in recovery to zero non-admitted patients 65+ weeks is high. There will be Admitted 65+ waits due to the impact of industrial action and winter pressures. Monitored by NHSE Tiering. A lower than plan position for Follow ups without a procedure is positive.
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%	Nov-23	13,097	13,428	Met	
Follow up outpatient attendances without procedure (Ops Plan E.M.38) Tolerance 5%	Nov-23	52,580	49,581	Met	
Continue to reduce the number of patients waiting over 62 days (UHL Only)	Nov-23	368	372	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 cancer faster diagnosis standard by March 2024 so that 75% of patients who have been urgently referred by their GP for suspected cancer are diagnosed or have cancer ruled out within 28 days.	Nov-23	76%	76.7%	Met	
Patients that receive a diagnostic test over 6 weeks waiting - as per the Operational Plan 23/34	Nov-23	28%	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 diagnostic waiting time ambition	Oct-23	32,391	35,395	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	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.

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.	
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 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.	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. 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

Standard	Month	Plan	Actual	Status	Confidence in recovery / Year-end delivery
Improve A&E waiting times so that no less than 76% of patients are seen within 4 hours by March 2024 with further improvement in 2024/25	Nov-23	75%	73%	Within tolerance	Medium Variability remains high and risk of de-stabilisation through Winter
Improve category 2 ambulance response times to an average of 30 minutes across 2023/24, with further improvement towards pre-pandemic levels in 2024/25. EMAS performance for LLR ICB.	Nov-23	00:30:00	00:46:14	Not Met	Low Variability remains high and risk of de-stabilisation through Winter
Reduce adult general and acute (G&A) bed occupancy - Reported at ICB level. National Target =<92%	Nov-23	94%	95.7%	Not met	Low 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. Remains part of the ICB savings plans.
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

Issue	Escalation
The NHS England Midlands 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 shared with the Acute Care Collaborative. - A trajectory plan has been 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. - The Winter challenges / UEC pathway issues have been escalated to extraordinary Clinical Executive meetings and added to the System Quality Committee Risk Log.
Significant increase in delays to local authority funded care (particularly for County residents). Increase from circa 20 patients awaiting care to 40 per day significantly impacting flow	ALERT – Chief nurses supporting conversation with local authority on mitigations to delays. These include: 1. Additional staffing on wards to decrease process delays 2. Additional panels in place (twice daily where reqd) 3. Spot purchasing to increase These actions thus far have not resulted in a reduction in delays and therefore chief exec to Chief exec support has been sought
Reduction in incomplete discharges for UHL complex patients due to internal factors. August 61% September 55% October 59% November 53% December 46%	December discharge data shows a decrease in incomplete discharges. Positive improvements from UHL discharge workstreams, aligned to 3a of the recovery plan. Themes identified through workstreams that require further work include: - Patient choice - Patients awaiting medical reviews - TTO process delays
Increase in incomplete discharges for UHL due to external factors	December discharge data shows an increase in incomplete discharges caused by external factors. -Transport process delays

August 30% September 37% October 30% November 37% December 42%	-Allocated beds no longer being available -Provider changed discharge date
Overall Assessment	**System Quality Group to support concerns raised – in particular the delays to discharge pathways**

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.

Transformation

Achievements (aligned to Step 4 NHS Impact programme)	Outcome for our patients / colleagues
Same day discharges remain stable for Community Hospitals. September 74 % October 79% November 73% December 72%	Safe a timely discharge enables positive outcomes for patients, reduces deconditioning and improves patient flow. Integrating the service pathways also delivers 3a of the Recovery Programme Plan and **pledge seven** of the 5YP, the provision of joined up, holistic care across our system.
Increase in incomplete discharges at Community Hospitals due to an internal factor. September 44% October 49% November 37% December 58%	The themes of avoidable delays are: -delays in ordering equipment -family availability to receive equipment -patient/NOK choice -Mental Capacity Assessment
Reduction in number of incomplete discharges in UHL and Community Hospitals due to patients becoming Not Medically Optimised for Discharge. In UHL: September 13% October 14% November 11% December 10% In LPT: September 6%	Discharge improvement workstreams focussing on reducing incomplete discharges which includes a senior review of Not Medically Optimised for Discharge patients that have been identified for discharge.

October 7% November 7% December 5%	
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	UHL LRI ED patient feedback has shown that patients are willing to go to another site if they have a booked appointment and can be seen more quickly. ED streaming began because of winter pressures in 2022/23 but is now provided via business-as-usual contracting to support overcrowding and patient experience. Community UEC capacity is 770 / week, or 3,234 / month. April – November 2023 streaming from ED, supporting **pledge six** of the 5YP, to reduce waiting times in the ED: - 2,319 ED streamed to Oadby UTC - 1,767 ED streamed to M/Vaz (OoH & UTC – from 08/2023) - 1,980 ED streamed to Westcotes Extd Access Hub (from 04/2023) Further additionality outside of contracts has been provided during Winter 2023/24 to support various industrial action and January 2024 surge: - 43 appts / day Monday-Sunday @ Oadby UTC 10/01/2024 to 31/03/2024 - 24 appts / day on Monday 15/01/2024 and Tuesday 16/01/2024, targeted at respiratory presentations, @ Merlyn Vaz Out of Hours Service as a PDSA.
Maximising capacity within the GP Out of Hours Service @ Merlyn Vaz	Ongoing messaging via the daily 09:30 System Flow Call is improving the pathways from the EMAS Cat 3/4 stack and the Clinical Navigation Hub. Utilisation has improved by month: - 59.0% April 2023 - 53.9% July 2023 - 42.7% October 2023 - 61.1% November 2023 - 85.7% December 2023 - 92.9% January 2024 (1st to 14th)
LLR System Coordination Centre digital developments	The VitalHub SHREWD Resilience software mobilisation has commenced and is scheduled to go live mid-March 2024.

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%	94% *December*	Met	High
Meet 80% occupancy for virtual ward by September 2023	80%	*80% December*	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	1,152	552	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 developed and will be shared at the next Community Care Partnership including improvement trajectories. The workstream have several key actions that are being progressed to help reduce the backlog.
Overall Assessment	**System Quality Group to support action plan once presented at the next Community Care Partnership**

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 80% in December 23 and increased VW bed plan by 40 beds. Supporting 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.
Strengthened our end-of-life provision, resulting in a 50% reduction in LoS and a 25% increase in supporting community referrals, thus reducing avoidable admissions.	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
Improving variation in care homes and increasing access into our community falls response services there has been a 15% (Q2 & Q3) reduction in falls conveyances	Improves access as **per pledge one**, **pledge three** to support our frailest, **pledge seven** around holistic care and supports 'right patient, right time, right place'.
Micare (Rutland's ASC service supporting step down and step up) latest CQC inspection has been awarded an overall rating of 'outstanding' The inspector highlighted that People's experience of using this service and what we found was that People were at the heart of the service and received exceptionally responsive, person-centred care which enabled them to live a life of their choosing. Now supporting 175 P1 referrals, compared to 78.	Improves access, support to our frailest and holistic care, as per **pledges one, three and seven** of the 5YP. Providing earlier interventions, self-management opportunities, and community-based treatment and recovery pathways for these patients.
Charnwood Ward Community Hospital taking all nursing home D2A patients. Significant reduction in delayed LOS in UHL for this cohort	All nursing home D2A patients have the opportunity to access Recovery, Reablement and Rehabilitation as per **pledge three** of the 5-year plan to identify the frailest in our communities

of patients since the ward opened 30th October 2023. Delayed LOS % of D2A P2 NH patients September 8% October 6% November 0% December 1%	and wrap care and support around them. And 3a of the UEC Recovery Programme Plan.
Increase in patients accessing Intermediate Care beds in Community Hospitals. September 14% October 32% November 37% December 33%	Positive outcomes for patients that are receiving Intermediate Care support. Long term positive effects include reduction in deconditioning and improving hospital flow. As per the Intermediate Care Strategy, supporting more patients to receive RRR increases opportunity for patients to remain independent for longer in their own home environment. This scheme is aligned to **pledge three** to identify the frailest in our communities and wrap care and support around them, and **pledge seven** to provide more joined up, holistic and patient-centred care, delivered closest to home.

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 – Wider offer in place to mitigate any resulting inequity in service provision across LLR
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	Month	Plan	Actual	Status	Confidence in recovery / Year-end delivery
Percentage of patients where time from booking to appointment was two weeks or less	Nov-23	Lower 85% Upper 90%	80%	Not met	High The Nov delivery is below trajectory. Working to plan to achieve by March 2024.
Continue on trajectory to deliver more GP appointments in general practice by the end of March 2024	Nov-23	744,970	667,939	Not met	
Continue to recruit 26,000 (Nationally) Additional Roles Reimbursement Scheme (ARRS) roles by the end of March 2024	TBC				
Recover dental activity, improving units of dental activity (UDAs) towards pre-pandemic levels	Nov-23	1,867,483	1,716,163	Not met	Regional plan in place to manage UDAs
Overall Assessment	**No escalations to System Executive**				

Finance

Team	Scheme Name	Rag Rating	Plan	Actual / Forecast	Var	Confidence in delivery/mitigation
Primary Care	Primary Care		1,041	1,041	0	High – this will now been factored into the M10 position
Primary Care			133	133	0	High – this has been delivered
Overall Assessment	**Recommended removed from CIP and closed**					

Quality & Equity

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

Issue	Escalation
Currently No Issues that require escalation for Alert/Assure	
Overall Assessment	

Transformation

Achievements (aligned to Step 4 NHS Impact programme)	Outcome for our patients / colleagues
Cloud Based Telephony (CBT): Across LLR 100% of eligible analogue practices have migrated or have signed or issued contracts with digital telephony providers. This will now provide sufficient time for practices to go live in this financial year, that is before 31 March 2024. The recovery plan set this out as over the next 2 years but in reality, this was condensed nationally into less than 8 months and had left little time for any flexibility , but we were the first in the region to have a practice migrate, we were the first to achieve full contract sign up and this week, we have successfully achieved the first hurdle of provider selection for phase 2. The work continues and we have another big milestone in 2 weeks' time of contract sign up.	This supports delivery of **Pledge 4 –** access to routine GP appts, supporting ease of access for our people of LLR and demand management for our general practices. This is a tremendous achievement and will bring considerable benefits to patients with new call management and navigation functionality. We will continue to support practices through the migration phase.
A Community Health and Wellbeing health fest was held for Leicester City residents at Aylestone Leisure Centre. This was fair was organised in parentship by Social Prescriber and Care Navigators inviting many partners across the City, which included Age UK, Carer Centre, Mental Health friendly pace, HealthWatch etc. The event was attended by over 100 people with great feedback. Health checks and flu vaccinations were also available for eligible patients access.	The event was received by local residents as a great opportunity for to be empowered in understanding the availability of services they can access locally, as well as receive advice and guidance from specialist services. This supports the **Pledge 13** – Our People
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.	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.
93% of practices delivering against the benchmark of 75/1000 clinical contacts against a plan of 75% (Nov 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
40% of same day appointments delivered against an England average of 42% (Nov 23) (an increase by 3% from previous reporting period)	
73% of face-to-face appointments delivered against a plan of 70% (Sept 23)	

Personalisation– delivered through various Directorates (Updated Jan 2024)

Performance against Operational Plan

There are no Personalisation metrics within the 31 standards of the NHS Operational Plan. These are pledges and standards included within LLR's 5-year plan:

1. **Develop a Personalisation Strategy**

Currently in the process of revising the governance structure to introduce a new Health and Social Care Executive to focus on personalisation at Director level across the system. In addition, to develop an LLR Integration Partnership to focus on a systemwide Personalisation Strategy. The Partnership will also be responsible for development and oversight of policies that enable effective joint commissioning, and all funding streams that require joint working, i.e. CHC, s117 aftercare, shared care, FNC, etc. The first formal meeting will take place in January 2024.

2. **Increase Social Prescribing Link Worker capacity and referrals**

Whilst there has been no project funding allocated by NHSE for personalisation programmes in 2023/24, funding is available via the Multi-professional Education and Training Investment Plan 2024-2029. The ICB Workforce Team have collaborated with LLR Training Hub to ensure training and development is factored into Primary Care and available to third party organisations through funding programmes and engagement via Community of Practice (CoP), peer support, alignment of the competency framework of SPLW existing and new into role. Initial stages have taken place to introduce a Buddy Framework into Primary Care and Anchor Organisations, to further support the current workforce.

3. **Develop a Liberty Protection Safeguards service and deliver training across the system – LPS has been paused at a national level pending next general election**

Work is being progressed on the current Court of Protection backlog, which health are responsible for. This will ensure ICB is in the best possible position once direction of travel for LPS is known, following the next general election. In the meantime, current Deprivation of Liberty processes within ICB and Local Authority continue.

4. **Embed a working culture that embraces personalisation as the default approach to supporting people**

Part of the new Personalisation Strategy will focus on how to improve awareness of personalisation across the system.

5. **Implement processes to create All Age Continuing Care Model**

Currently working to change the terminology within the contract specification to ensure that it reflect an all age continuing care model and we will make sure that policy reviews reflect this change.

6. **Maternity: increasing personalisation and choice**

UHL have committed to reviewing support planning processes and develop plans for Maternity PCSP in 2023/24. Patients who book an outpatient appointment online are supported to exercise their choice and identify a service to meet their needs (utilising e-RS). A further update on UHL PCSPs will be provided within February's report.

The team are delivering against the parameters below set out by NHSE, who have advised they are no longer actively monitoring this data. There are, however, much greater issues affecting Personalisation as the delivery model for packages of care is currently unsustainable financially.

Standard	Plan	Actual	RAG	Comments
Number of people with a personal healthcare budget (Q1 & Q2 23/24)*	2,916	884		The PHB numbers have reduced as the criteria for counting Personal Wheelchair Budgets (PWB) has changed in 2023. Previously we had been allowed to count wheelchairs which were supplied by direct issue, following a comprehensive referral, as long as the recipient was aware that they had the option of choosing a PWB if they required a wheelchair that was more individualised. On reflection by NHSE and wheelchair services, it was felt this was no longer a true experience of Personalisation and therefore the wheelchairs which are issued in this way cannot be counted, resulting in a reduced number of PHB in total. Whilst actuals are not in line with trajectory, in LLR we are at default for the right to have a PHB for those in receipt of Continuing Healthcare, Continuing Care for Children, PWB and the S117 offer is available for those who wish to access it with support from MLCSU.
Personalised Care & Support Plans (cumulative April 2019 – Oct 2023)*	16,867	42,433		There are no expected risks to being over target for PCSPs. In comparison to other ICBs in the Midlands, we are on a par for Dementia and Primary Care and slightly behind on Maternity. All other Midlands ICBs are also exceeding their targets and this may suggest that the targets have been set too low.
Shared Decision Making (cumulative April 2019 – Oct 2023)*	N/A – no target set by NHSE	50,506		
Social Prescribing Link Worker referrals (cumulative April 2019 – Oct 2023)*	15,431	46,498		There are no expected risks to being over target for SPLWs. Again, all other Midlands ICBs are also exceeding their targets, suggesting that the targets have been set too low
Social Prescribing Link Worker numbers (and those employed through ARRS) (FTE) (as at M7)	79.5	53**		**A figure for M8 was reported in the M9 Delivery Partnership report however this report has now been updated to align with the National Workforce Reporting System (NWRS) claims submitted by PCNs. PCNs can determine their own workforce to meet their needs and therefore this is difficult to influence. There has been 1% growth in SPLWs employed since April 2023.

				The ICB Workforce Team have collaborated with LLR Training Hub to ensure training and development is factored into Primary Care and available to third party organisations through funding programmes and engagement via Community of Practice (CoP), peer support, alignment of the competency framework for existing SPLWs and those new into role. Initial stages have taken place to introduce a Buddy Framework into Primary Care and Anchor Organisations, to further support the current workforce.
Overall Assessment	**No Escalation to System Executive**			

*Data source – NHSE futures platform. Last updated Oct 23

Finance

There are no formal transformation programmes aligned to Personalisation.

Quality & Equity

Issue	Escalation
Application of eligibility frameworks	ALERT - This will be overseen by LLR Integrated Partnership Group. Separate workstreams have been developed to address CHC, S117 and CC concerns. CYP CC Policy review meetings are commencing w/c 15/01/2024. S117 review meetings are being led by County LA; these commenced in June 2023 and are ongoing.
Training for Health Delegated Tasks - There is recent evidence of social care providers being rated inadequate by CQC due to a lack of training for delegated tasks. Local Authorities have raised the financial and quality concerns to the ICB and are considering only commissioning placements/home care packages with providers who can evidence training. This would have a negative impact on hospital discharge and flow across our UEC system, as well as disruption, instability, and escalating rates (as we saw during the pandemic) within the care market. There is also a risk to patient safety if health tasks are undertaken by inappropriately trained staff.	This is now being overseen by Integrated Personalised Care Board, who are overseeing the planning and delivery of a procurement exercise to identify a training provider who can meet need. A business case to secure additional funding to support the new training model is currently under consideration by the system. The improved model of training supports several pledges within the LLR 5-year plan: • Pledge two – Preventing Illness • Pledge three– Keeping People Well • Pledge seven – Health & Wellbeing Hubs (holistic & person-centred care) • Pledge thirteen - Our People
Overall Assessment	**No escalation to the Quality Committee.**

Transformation

.Achievements (aligned to Step 4 of the NHS Impact framework)	Outcome for our patients / colleagues
LDA – all inpatients in MH hospitals have PCSP completed to identify needs in community. Completed in conjunction with in-patient MDT, social care, ICB, any relevant community providers & individual and family/carers	Packages are personalised in line with needs identified within PCSP Supports pledge seven - Health & Wellbeing Hubs (holistic & person-centred care)

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.

tandard	Plan	Actual	RAG	Confidence in recovery / Year-end delivery
Improve and strengthen children and young peoples visibility by embedding children and young peoples objectives within the other Collaboratives and Partnerships.	October 23	Nov 23	Met	High. Continual monitoring- to ensure CYP remain visible.
Address focused health inequalities as identified in the children and young peoples core20plus5.	March 24	March 24		High. Workstreams established and specific health inequality subjects chosen. Focus: Oral health
Implement and drive change through the CYP Transformation programme against NHSE set metrics and objectives (as per Long-term plan).	Jan 24	Jan 24	Met	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 are four working portfolios within CYP:** **Transformation- Helen Mather, Mental Health- Justin Hammond, SEND and Personalisation- Fay Bayliss**			

Finance

Team	Scheme Name	Rag Rating	Plan	Actual / Forecast	Var	Confidence in delivery/mitigation
CYP	Community Paediatric Continence		£209k	£24,289	£184,711	Service in place
CYP	Paediatric Outpatient parenteral antibiotic therapy		£203k	£22,954	£180,046	Service in place
CYP	CYP Transformation programme		121k	121k	-	High. Funds allocated and on track. Delivery of several workstreams as per below.
CYP	Epilepsy Nurse Pilot		131k	66k	65k	Service in place
CYP	Complications from Excessive Weight Clinics		450k	450K	-	High. Funds allocated. No slippage.
CYP	Weight Management Tier2+		63k	63k	-	High. Funds allocated. No slippage.
Overall Assessment	**Support from CFO's requested with regards to red rated efficiency programmes**					

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.	ASSURE- These have been identified and proposal in creation with colleagues across the system to improve these metrics over winter 23/24 with relevant colleagues. ALERT- work with the immunisations team to establish plans to mitigate increasing amounts of measles diagnosed within the West Midlands.
There is no provision for quality continence intervention and care within Leicester City	ALERT- City council hold the contract for teen health but due to regulatory boards cannot provide nursing services that would address this need. Scoping work complete to enable understanding of service required for commissioning. 12 CYP on waiting list who require this service over the last 12 months. The local authority have identified

for those young people aged 11 years and above	funds to provide this service, however LPT have declined proposal. Difficulty to commission a full service for such small proportion of CYP and therefore continued high level discussion required within LPT.
Paediatric Winter plan	ASSURE- Good utilisation of ARI appointments at PCN footprint. Rapid access clinic commencing at the start of February, provide capacity for primary care to refer CYP who require urgent assessment without being critically ill for CED. Ongoing work with UHL to create improved utilisation of consultant connect, in order to reduce referrals into CED. Scoping work with IT teams to establish virtual communications with families post diagnosis of viral wheeze/exacerbation of asthma to address need for 48 hour reviews.
CYP Community Services	ALERT- Difficulties within services to achieve key performance indicators, causing review of service delivery within CYP physiotherapy. Service specification in renewal process for CYP Salt, Physiotherapy and Occupational Therapy. ALERT- Unable to obtain data regarding CYP community nursing services. LPT are working with business team to establish performance/finance report and up to date service specification.
Overall Assessment	**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**
Diabetes: Health inequalities workstream has delivered continuous glucose monitoring to CYP who previously suffered poor diabetic control. This work has identified many alternative barriers to accessibility, and also identified that language often isn't a barrier but can cause healthcare bias and perception- causing the barrier.	Ensuring our patients achieve their potential by preventing co-morbidities that will cause life long effects within adulthood, aligned with **pledge 2, pledge 7 and pledge 11**.
Urgent and Emergency Care: Rapid access clinics to operationalise 5/2/24. Senior primary care clinicians are working within CED to provide triage and diversion at the CED front door. Thus far, Children's ED attendances remain within range, which is a better position than winter 22/23	Ensuring all CYP are seen in the right service, by the right clinician in order to improve outcomes and reduce CED waiting times, aligned with **pledge 6 and 11.**

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	Month	Plan	Actual	Status	Confidence in recovery / Year-end delivery
Ensure 75% of people aged over 14 on GP learning disability registers receive an annual health check and health action plan by March 2024 (Target 4284)	Oct -23 Q3 Plan	1,109	336	Met	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.
Number of adults with LD/Autism in inpatient care	Nov -23 Q3 Plan	26	26	Met	High
Number of children with LD/Autism in inpatient care	Nov -23 Q4 Plan	4	4	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, in 2425 business case processes
Long waiting times for autism assessments for both children and	ADVISE - QIA and EIA have been completed and submitted for review. This does have a significant impact on patient outcomes. The outputs of the

adults. The required level of investment needed to meet the demands is significant.	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 and LRI maternity services.	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 from NHS England, setting up a structured process, to make the improvements required. We have strengthened our senior clinical leadership by appointing additional staff.

	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 –as lack of pool to draw from. Ockenden funding 22/23 has helped – still waiting for 23/24 confirmation of funding for Neonates (which was supposed to go directly to Trust via ODN's notification) 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, and we know the number of cases at UHL in which care may have contributed to death is very low. We are undertaking work with public health colleagues and others to build a deeper understanding of our population.
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.

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 health hub across LLR, to provide social, emotional and health support including sexual health, menopause, and social prescribing.	March 24	March 24	On hold	Low – project on hold, EIA and QIA being undertaken
Overall Assessment	**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.

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
Continuation of Engagement – The Women's Programme Team and linking in with the LLR Winter Wellbeing Festival to promote opportunities for women in the	Women feel valued in the workplace, supported to progress/develop and their specific needs to be understood.

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.	ICB system to be the employer of choice for women and be a role model for other employers.
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
Achieve £7.3 million prescribing efficiency savings for 23-24.	£7.3 mil	£6.2 mil		Medium
Break even or underspend at March 24 on prescribing budget.	£184 mil	£199.6 mil		Low
System Cost Improvement Programme				
LPT prescribing efficiencies.	£267K			High (within provider CIP plans)
UHL prescribing efficiencies	£1,062,482 K			High (within provider CIP plans)
ICB commissioned high-cost drugs efficiencies	£376K			High
Additional savings opportunities	TBC			Medium
Overall Assessment	**No escalations to System Executive**			

Quality & Equity

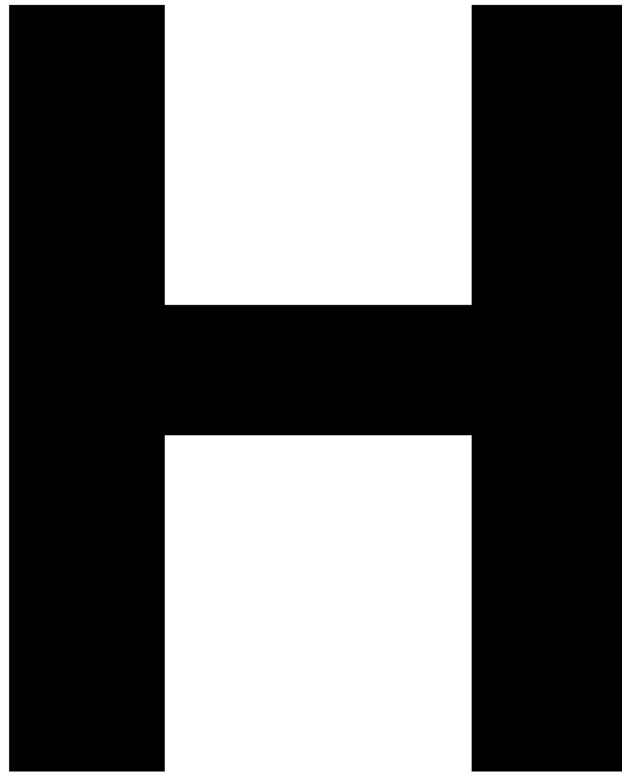
Issue	Escalation
1.Risk to AMR work (primary care) due to capacity. Clarification of reporting mechanisms for AMR (prescribing/ diagnostics and infection prevention) within the system. Capacity issues within Pharmacy/ medicine Op 2.Narrow NHSE focus working to targets. Resistance strains emerging at UHL. 3.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.
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.



NHS

Name of meeting:	Leicester, Leicestershire, and Rutland ICB Finance Committee		
Date:	8th February 2024	Paper:	H
Report title:	**Finance Report Month 9 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 9 and the forecast performance.
- **RECEIVE for assurance.**

Purpose and summary of the report:

The overall year-to-date (YTD) system position at month 9 is a deficit of £(66.6)m which is a £(43.3)m adverse variance from plan.

UHL have reported a YTD deficit of £(47.3)m which is a £(24.5)m adverse variance against plan, whilst LPT have reported a YTD deficit of £(0.5)m, which is almost break even against their YTD plan.
The ICB have reported a £(18.8)m YTD deficit against a break-even plan.

The system has forecast a year-end deficit of £(61.1)m, which is a £(51.1)m adverse variance from plan. This excludes any impact of the Industrial Action taken at the end of December and beginning of January by Junior Doctors and which is currently being assessed. This can be broken down to; UHL £(45.5)m deficit [£(35.5)m adverse variance against plan], LPT £(0.0)m deficit, and ICB £(15.6)m deficit. LPT and the ICB had both planned to breakeven in 23/24 so their deficit also represents the variance from plan.

The scale of the deficit YTD in comparison to the agreed forecast clearly represents a significant challenge. In addition, we are facing significant specific risks related to pay inflation, additional urgent care demand, and resultant potential impacts on efficiency delivery.

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 9 2023/24

8th February 2024

Month 9 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)	(23,269)	(66,594)		(10,002)	(61,072)	
System Revenue expenditure not to exceed income	4,034,171	4,100,765		5,357,894	5,418,965	
System Capital expenditure not to exceed allocations	73,451	59,909		124,130	119,615	
System Operates within Cash Reserves	97,470	55,430		115,305	31,183	
ICB Running Costs Allocation not to be exceeded *(included within system position)*	15,289	12,796		20,385	17,392	
ICB Primary Care Co-Commissioning Allocation not to be exceeded *(included within system position)*	149,269	155,116		199,055	202,751	
ICB Newly Delegated Allocation not to be exceeded *(included within system position)*	73,220	71,413		97,820	88,351	
System CIP delivery	93,542	80,527		142,572	144,036	
System Better Payment Practice code % NHS invoices paid within target (£)	95%	96%		95%	96%	
System Better Payment Practice code % NHS invoices paid within target (number)	95%	92%		95%	92%	
System Agency spend within ceiling				45,392	60,875	
ICB MHIS spend requirement to meet target				189,313	189,541	

Revenue

2. **The system is reporting a year-to-date deficit of £(66.6)m which is £(43.3)m worse than plan**, (UHL £(24.5)m adverse variance and ICB £(18.8)m variance against plan). The position reflects pressures relating to unfunded inflation, urgent & emergency care and other demand pressures, and prescribing growth.

3. Given the financial pressures faced across the NHS and following work in conjunction with NHSE colleagues the system has provided an assessment of a realistic though challenging forecast outturn (FOT) being a £(61.1)m forecast deficit position. This is a £(51.1)m variance from plan which is in line with the recognised level of financial risk and consistent with the agreement reached with NHSE. This excludes any impact of Industrial action by Junior Doctors which is being assessed relating to December/January.

4. Work undertaken recently to highlight and confirm efficiency plans/offsetting income in place means we are forecasting full delivery by the end of the year. This is reflected in the M9 position which forecasts delivery of £144m against a plan of £142.5m.

5. The scale of the deficit YTD in comparison to the agreed forecast clearly represents a significant challenge. In addition, we are facing significant specific risks related to pay inflation, additional urgent care demand, and resultant impacts on efficiency delivery.

Capital

6. Operating capital spend is currently below plan by £4.9m with a year-to-date actual spend of £41.1m, however, the system is anticipating full spend by year-end.

7. National capital schemes have been impacted by issues outside of the systems control ie planning permission causing an underspend to be flagged to region.

Other Indicators of note

8. **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.

9. **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 83% in relation to the numbers of NHS invoices (non-NHS at 96%)
   LPT is cumulatively at 92% in relation to the numbers of NHS invoices (non-NHS at 97%).

10. The **cash** position remains positive across the system. Now that the forecast deficit position has been agreed, the implications for cash balances are clearer, and we expect cash balances to reduce as the year continues, this will be monitored closely.

11. 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

12. As a system, at Month 9, we have reported an in-year deficit of £(66.6)m and a year-end deficit of £(61.1)m against revenue budgets. This year end position is in line with the forecast agreed with NHSE in November excluding additional Industrial action costs incurred in December and January.

13. Operational capital spending is forecasting a breakeven position with National programme capital spend forecasting to underspend by £4.5m.

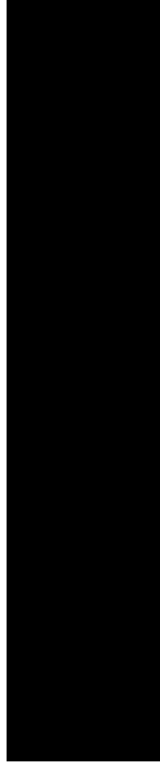
14. The ICB are declaring achievement of the Mental Health Investment Standard and Running Costs targets.

15. The scale of the deficit YTD in comparison to the agreed forecast clearly represents a significant challenge. In addition, we are facing significant specific risks related to Industrial Action; pay inflation; additional urgent care demand; and potential resultant impacts on efficiency delivery.

Recommendations:

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

- **RECEIVE and NOTE** the financial position as at month 9 and the forecast performance.
- **RECEIVE for assurance.**



NHS

Name of meeting:	Leicester, Leicestershire and Rutland Integrated Care Board Finance Committee meeting		
Date:	8 February 2024	Paper:	I
Report title:	Assurance Report from the ICB Finance Committee		
Presented by:	Jeffrey Worrall, Non-Executive Director from University Hospitals of Leicester NHS Trust		
Report author:	Imran Asif, Corporate Governance Officer, LLR ICB 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 **20 December 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 8 2023/24 – Revenue, capital, efficiency schemes and POD	**RED**	The Finance Committee received the M08 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 £(58.3)m which was an adverse variance of £(35.7)m against the plan. The system partner risks of not achieving breakeven for the year are listed below: • UHL - £ (40.7)m • LPT - £ (0.6)m • ICB - £ (17)m	There is a significant risk of the LLR system not achieving the year end plan out-turn.
2. ICB Finance Report Month 8 2023/24	**RED**	The Finance Committee received the M08 ICB financial position which was a deficit of £(17)m. The committee were informed that a supplementary financial return was submitted in November 2023 to NHSE.	There is a significant risk of the ICB not achieving the year end plan out-turn.
3. 2024/2025 Planning	**RED**	In light of the financial deficit the LLR system are anticipating a £(61)m deficit year-end target for 2023/2024 whilst noting further risks materialising for industrial action. The committee were provided assurance on planning expectations and assumptions that could assist in minimising the scale of the deficit for 2024/2025.	There is a significant risk that the year-end target total will continue to deteriorate due to emerging risks.
4. ICB Risks and Issues Log Month 8	**N/A**	The Finance Committee received the ICB Risks and Issues Log for M08. There were no risks closed for M08, however, minor amendments were shared for information.	None.
5. Board Assurance Framework 2023/2024 update	**N/A**	Focusing on BAF risk 4 (finance) the committee received an updated version and noted its content.	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.

J

NHS

Name of meeting:	Leicester, Leicestershire and Rutland Integrated Care Board		
Date:	8 February 2024	Paper:	J
Report title:	Assurance Report from the System Executive		
Presented by:	Caroline Trevithick, Chief Executive LLR ICB and Chair of the System Executive		
Report author:	Charlotte Gormley, Corporate Governance Officer		
Sponsor:	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 22 December 2023 and 26 January 2024. 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 18.

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 22 December 2023 and 26 January 2024. The report also covers items for escalation and consideration by the Board ensuring that it is alerted to emerging risks or issues.

Operational performance assurance

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

3. The next scheduled Quarterly System Review Meeting (QSRM) was scheduled to take place on 26 January 2024 with slides to be submitted to NHS England by 19 January 2024. The slide pack was developed for consideration at the System Executive development session with a focus on the financial reset and workforce position as a system.

4. A set of principles was proposed to develop a **Transformation Operating Model** and to agree on areas that would benefit from a system transformation approach. The proposed Model would be developed further at the next scheduled meeting of the Board and System Executive Committee development session.

5. **2024/25 Operational Planning Update and LLR ICB 5-Year Plan Refresh Proposal –** Work continued on the 2024/25 Operational Plan pending the release of national planning guidance. The draft plan would provide a comprehensive narrative behind the system's position and demonstrate improvements made during 2023/24. Elements of the plan including workforce, finance, and system transformation would be the focus of a development session to be held in February 2024.

6. To follow relevant guidance, the ICB and partner Trusts would be required to review the 5-Year Plan (5YP) before the start of each financial year and revise in-year if necessary. However, the LLR annual operational planning round would inform the 5YP refresh. It was therefore proposed to carry over the existing 5YP with a planned refresh to take place during Quarter 1 of 2024/25 following submission of the operational plan. The System Executive supported the proposal.

7. The **Delegation of Specified Specialised Acute Services briefing paper** outlined arrangements for LLR ICB to take on delegated responsibility for 59 specialised acute services from 1 April 2024. A session had been scheduled to take place on 5 February 2024 to give provider colleagues an opportunity to understand transition arrangements in further detail. The draft Delegation Agreement, Multi-ICB Collaboration Agreement and the hosting agreement would be presented to the LLR ICB Board on 8 February 2024 with a view to being taken to the Board on 14 March 2024 for formal approval.

8. An **Update on the ICB 2023/24 Financial Position at month 8 (November 2023)** identified that the system year to date (YTD) deficit at month 8 was £(58.3)m, which was an adverse variance from plan of £(35.7)m. All organisations were taking steps to minimise variation

through strengthened financial controls and efficiencies. Work was ongoing in conjunction with NHS England to provide an assessment of a realistic outturn forecast for the year.

9. An update was provided regarding the anticipated release of operational planning guidance for 2024/25 in early 2024. The two-year allocation agreed in 2023/24 is expected to be reconfirmed by the regional team and ICBs would be set a financial target to breakeven. No date had been confirmed as to when the planning guidance would be released.

10. The System Executive received assurance that the small number of schemes progressing to business cases would drive efficiencies or address identified risks within the system. It was agreed that business cases that aimed to drive efficiencies would be reviewed after one year and that funding would be discontinued if the expected efficiencies had not been delivered.

11. An **Update on the ICB 2023/24 Financial Position at month 9 (December 2023)** identified that the system year to date (YTD) deficit at month 9 was £(66.6)m, which was an adverse variance from plan of £(43.3)m. The system was forecasting a year-end deficit of £(61.1)m, which was a £(51.1)m adverse variance from plan. This excludes any impact of the Industrial Action taken at the end of December and beginning of January by Junior Doctors and which is currently being assessed.

12. The **LLR Delivery Partnership – January briefing** identified improvements in the areas of Mental Health, Learning Disabilities, and elective care, which remained on track to deliver year-end plans despite the impact of industrial action. Face-to-face appointments with GPs and the availability of out of hours appointments had risen to greater than pre-COVID levels. Work on women's hubs had however been paused during a review of the system's financial position. The meeting of the Delivery Partnership had been stood down in December 2023 due to industrial action and the holiday period.

13. An update regarding **Additional Urgent and Emergency Care (UEC) Financial Costs** outlined the financial impact of measures put in place to address the current clinical risk on the emergency pathway since October 2023.

Other decisions including business cases, procurements and contracts:

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

    a. The System Executive approved a number of **Proposals for expiring contracts under the Provider Selection Regime (PSR).** The PSR was the new set of rules governing healthcare service procurement with effect from 2 January 2024. The System Executive considered and approved the procurement decision options proposed for each contract due to expire on 31 March 2024.

    b. **Access to primary care and urgent care services in Leicester Leicestershire and Rutland post 1 April 2024 –** The System Executive approved the continuation of service provision for UEC services and for contracts to be awarded under the new PSR. This would continue provision across 16 sites until 31 March 2025.

Assurance Reports for Information Only (including reports from sub-groups)

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

16. The System Executive received the **Board Assurance Framework (BAF) report.** It was noted that completed actions regarding BAF 6 – Emergency Preparedness, Resilience and Response and BAF 5 – Quality and Safety would be included in the next iteration of the BAF.

17. The ICB Executive Management Team would consider the addition of Prevention to the BAF.

Summary of assurance from the Committee

18. 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. Operational performance assurance	**Red**	• Provider segmentation scores were agreed as follows: LPT: 2, UHL: 4. • Operational planning guidance would be released in early 2024. The two-year allocation agreed in 2023/24 would continue into 2024/25 and ICBs would be expected to breakeven.	N/A
2. Other decisions including business cases, procurements and contracts	**Green**	• The System Executive considered and approved the recommended procurement decision options proposed for each contract due to expire on 31 March 2024 under the new Provider Selection Regime.	N/A
3. Information only	**Green**	• Assurance reports from sub-groups are regularly received, and issues and risks identified along with mitigations. • The Board Assurance Framework (BAF) would be updated to reflect completed actions for BAF 6 and BAF 5.	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.

K

NHS

Name of meeting:	Leicester, Leicestershire and Rutland Integrated Care Board meeting		
Date:	8 February 2024	Paper:	K
Report title:	Assurance Report from the ICB Quality and Safety Committee		
Presented by:	Pauline Tagg, Non-Executive Member - Quality, Safety and Transformation, LLR ICB		
Report author:	Imran Asif, Corporate Governance Officer, LLR ICB		
Sponsor:	Kay Darby, Chief Nursing Officer, LLR ICB		

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

Recommendations:

The 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 (QSC) held on **4 January 2024**. 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
	AMBER	**Advise** **Digital risks** There has been an increase in Digital risks. QSC will hold a deep dive session to assess concerns and consider mitigations/actions to manage new risks that are identified. **Pressure Ulcers** Patients at home or in care homes settings are receiving support to reduce the risk and or harm of pressure ulcers.	N/A
	RED	**Alert** **Urgent and Emergency Care (UEC)** Through the UEC winter forum and data from +12 hour waits and ambulance delays the LLR system is reporting increased pressure and cases of harm further exacerbated by industrial action. Escalations have taken place and the pathway has been re-assessed to improve flow and manage demand. **Paediatric Audiology** An onsite review has taken place for paediatric audiology services. It was reported that concerns have been highlighted with short and long terms actions identified. A full report will be presented to the System Quality Group and then shared with the QSC.	Board to be alerted to the increased pressure in the UEC pathway.
System Quality Provider Updates	N/A	**UHL** UHL remain concerned by the system wide deteriorating financial position and the impact this will have on the LLR system including Local Authorities. **LPT** Nothing further to report. **EMAS** It was reported that four Patient Safety Incident Investigations (PSII) were recorded during November 2023 of which two related to delayed responses. EMAS have successfully implemented the NHS Pathways from November 2023, members of the QSC will visit the EOC to observe the pathways scheme. **GP Report** It was noted that two General Practices have been removed from the risk log. Significant wrap around support were provided to move the General Practices out of the intensive quality assurance and improvement assurance level.	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
Quality Assurance Scorecard	**AMBER**	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 2 focused on – *"Growing, retaining, and supporting our workforce".* The Committee were assured of the positive work being undertaken for maternity services; however, it was noted that the lack of continuing care for the neonatal department remains an area for improvement and would be escalated to the Board.	Board to be made aware of the risk that lack of continuing care in neonatal could lead to patient harm.
Patient Safety Report	**GREEN**	The Committee received a focus and assurance report for Patient Safety for Quarter 2 (July – September 2023). The report detailed the ICBs objectives in line with the NHS England Patient Safety Strategy 2019 and priorities defined for 2023/24 under the following headings: - • Safety culture; • Safety system; • Insight; • Involvement; and • Improvement. The Committee were informed that the LLR system is moving towards the Patient Safety Incident Review Framework (PSIRF) which was agreed in September 2023 at the System Quality Group (SQG). A new dashboard is being developed to enable a system wide analysis of patient safety data. The Committee were assured and noted the progress to date.	N/A
Counting Births – Investigation Report and Follow Up Actions	**GREEN**	The Committee were provided assurance that an independent investigation had been undertaken following concerns raised by the UHL Practice Learning Team that two student midwifes had in error counted the same eight births as part of their facilitated birth numbers. A singular root cause was not identified; however, it was noted that no patient safety concerns were evident. During the investigation it was highlighted that three midwife students had counted three instrumental births (one per student) as part of their facilitated birth numbers which was not compliant with the Nursing and Midwifery Council's (NMC) Standards. A separate investigation will be taking place and the report will be shared with the QSC.	N/A
Update from Public and Patient Involvement Assurance Group	**AMBER**	The Committee received an update from the PPIAG for the October and December 2023 meetings and the following points were highlighted: - **Primary care** Access to primary care services remains a concern; further work is required to improve digital engagement with patients.	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
		Update on Lutterworth consultation following mid-point public consultation review The PPIAG have conducted a mid-point assessment of the public consultation. Assurance was provided that in the first six weeks the engagement exercise was diverse in reaching out to the LLR population. **Update on LLR ICB's People and Communities Strategy June 2022- July 2024** The PPIAG reviewed the ICB's People and Communities Strategy, noting it had 17 priorities which it felt was a high number. The PPIAG recommended that the priorities are grouped into categories based on their interdependencies to enable greater focus by the LLR System.	
ICB Board Assurance Framework 2023/2024 update	**AMBER**	In December 2023 a deep dive session was held to review the BAF risk 5 (Quality and Safety). An updated version was shared with the Committee. It was noted that BAF risk 5 (Quality and Safety) required further strengthening to include the following: - • Broadening of the external assurance to include i.e., NMC, Care Quality Commission (CQC), Royal Colleges etc; and • Update key controls i.e., include PPIAG. The executive team will conduct further work and bring a revised version of the BAF Risk 5 (Quality and Safety) to the Committee.	N/A
LLR System Quality Risk Log	**AMBER**	The Committee received the System Quality Risk Log (SQRL). Discussions were focused on how risks were captured within the system. It was noted that risks identified by the system delivery partnership would need to be escalated to the SQG to be included in the SQRL. The committee will receive from the corporate governance team the risk escalation and de-escalation overview to support in developing robust governance arrangements for risks management.	N/A

Key for level of assurance:

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

Recommendations

The LLR Integrated Care Board is asked to:

- **RECEIVE** the report for assurance.

NHS

Name of meeting:	Leicester, Leicestershire and Rutland Integrated Care Board		
Date:	Thursday 8 February 2024	Paper:	L
Report title:	Assurance Report from the ICB Audit Committee		
Presented by:	Darren Hickman, Non-Executive Member and Chair of Audit Committee, NHS LLR ICB		
Report author:	Tamara Hazell, Corporate Governance Officer, NHS LLR ICB Daljit Bains, Head of Corporate Governance. NHS LLR ICB		
Sponsor:	Darren Hickman, Non-Executive Member and Chair of Audit Committee, 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 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 **19 December 2023.** The report also covers items for escalation and consideration by ICB Integrated Care Board ensuring that it is alerted to emerging risks and issues.

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

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

Conflicts of interest screening		Summary of conflicts *(detail to be discussed with the Corporate Governance Team)*
☒	No conflict identified.	No conflict identified in relation to this report.
☐	Conflict noted, conflicted party can participate in discussion and decision	
☐	Conflict noted, conflicted party can participate in discussion but not in decision	
☐	Conflict noted, conflicted party can remain in meeting but not participate in discussion or decision.	
☐	Conflict noted, conflicted party to be excluded from the meeting.	
Implications:		
a)	**Does the report provide assurance against a strategic risk(s) e.g. risk aligned to the Board Assurance Framework, risk register etc?** *If so, state which risk and also detail if any new risks are identified.*	The remit of the Audit Committee is to provide assurance in respect of the ICB's risk management arrangements including the BAF.
b)	**Does the report highlight any resource and financial implications?** If so, provide which page / paragraph this can be found within the report.	Not in relation to this report.
c)	**Does the report highlight quality and patient safety implications?** If so, provide which page / paragraph this is outlined in within the report.	Not in relation to this report.
d)	**Does the report demonstrate patient and public involvement?** If so, provide which page / paragraph this is outlined in within the report.	Not in relation to this report.
e)	**Has due regard been given to the Public Sector Equality Duty?** If so, how and what the outcome was, provide which page / paragraph this is outlined in within the report.	Not in relation to this report.

Assurance Report from the ICB Audit Committee

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

Key area discussed at the Committee meeting	Level of assurance (RAG)	Rationale for level of assurance	Risk(s) / issue(s) to escalate where required
1. External Audit Update	**GREEN**	The Audit Committee received notice that the planning work had commenced for the 2023/24 External Audit. Initial conversations with the ICB Finance team had commenced in terms of phasing of work and roles and responsibilities.	**None.**
2. Internal Audit	**AMBER**	The Audit Committee received the Internal Audit Progress Report for 2023/24. It was reported that the plan was marginally behind schedule and that additional focus was required from executive team to ensure completion. The Budget Setting, Monitoring and Reporting audit had been issued which provided significant assurance against the plan. The committee approved of a change to timing of the Patient Carer and Resident Engagement review to be completed in Q1 of 2024/25.	**None.**
3. Audit Follow-up Progress Report	**GREEN**	The Audit Committee were assured of the actions implemented following both internal and external audit reviews.	**None**
4. Review Board Assurance Framework	**GREEN**	The Audit Committee received the current ICB BAF 2023/24 with an update on the ongoing review of risk management arrangements.	**None**
5. Losses and Special Payments	**GREEN**	There were no losses or special payments during the period up to 30 November 2023.	**None**
6. Waiver of Standing Orders	**GREEN**	There were no waiver of standing orders received for the period between 2 October 2023 – 11 December 2023.	**None**.
7. Third Party Assurance Deep Dive	**GREEN**	The Audit Committee undertook a deep dive into Third Party Assurance in order to explore the management of risks associated with third party suppliers.	**None.**

Key for level of assurance:

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

Recommendations

The LLR Integrated Care Board is asked to:

- **RECEIVE** the report for assurance.

M

NHS

Name of meeting:	Leicester, Leicestershire and Rutland Integrated Care Board meeting		
Date:	8 February 2024	Paper:	M
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 **19 December 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. ICB Board Assurance Framework Update Report	**AMBER**	Focusing on BAF risk 2 (health inequalities) the committee agreed that it would be imperative to demonstrate progress against investment and partnership work to assist in the reduction of the risk score.	HEC to support Cancer and LLR Delivery Partnership to provide evidence on progress against investment and partnership work.
2. 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.**
3. 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 clearly detailed the challenges being faced in oral, bowel, breast, and cervical cancer.	Lack of access to NHS dentists is a growing concern in LLR population.
4. Digital Health Hub	**N/A**	The LLR system was not successful in being awarded the national UK research funding.	**None.**
5. LLR Delivery Partnership Report	**AMBER**	The committee received the LLR Delivery Partnership Report for November. Members were informed that work with partnerships continues, and health equity is an integral golden thread throughout the report.	**None.**
6. REN Project – Reducing health inequalities in research	**N/A**	The committee were informed that the LLR system will be working with the local voluntary sector to train up research ambassadors that will become part of a network.	**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.