NHS England Midlands

**Sent via email**

**Pauline Tagg, ICB Chair**

Leicester, Leicestershire, and
Rutland Integrated Care Board

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Dear Pauline

**Annual assessment of Leicester, Leicestershire, and Rutland Integrated Care Board's performance in 2023-24**

I am writing to you pursuant to Section 14Z59 of the NHS Act 2006 (Hereafter referred to as "The Act"), as amended by the Health and Care Act 2022. Under the Act NHS England is required to conduct a performance assessment of each Integrated Care Board (ICB) with respect to each financial year. In making our assessment we have considered evidence from your annual report and accounts; available data; feedback from stakeholders and the discussions that our we have had with you and your colleagues throughout the year.

This letter sets out our assessment of your organisation's performance against those specific objectives set for it by NHS England and the Secretary of State for Health and Social Care, its statutory duties as defined in the Act and its wider role within your Integrated Care System across the 2023/24 financial year.

We have structured our assessment to consider your role in providing leadership and good governance within your Integrated Care System as well as how you have contributed to each of the four fundamental purposes of an ICS. For each section of our assessment, we have summarised those areas in which we believe your ICB is displaying good or outstanding practice and could act as a peer or an exemplar to others. We have also included any areas in which we feel further progress is required and any support or assistance being supplied by NHS England to facilitate improvement.

In making our assessment we have sought to take into account delivery against local strategic ambitions as detailed in your Joint Forward Plan (JFP) which you have reviewed and rebaselined. A key element of success of Integrated Care Systems will be the ability to balance national and local priorities together and we have aimed to highlight where we feel you have achieved this.

Thank you and your team for your work over this financial year in what remain challenging times for the health and care sector, and I look forward to continuing to work with you in the year ahead.

Yours sincerely

**Julie Grant**

**Director of System Co-ordination and Oversight, East Midlands**

Cc: Dale Bywater – Regional Director, NHS England – Midlands
Caroline Trevithick, ICB Chief Executive, Leicester, Leicestershire, and Rutland

**Section 1: System leadership and management**

Both as part of the annual assessment and as evidenced throughout the previous year, it is clear that the ICB works collaboratively with system partners both operationally and strategically. There is excellent engagement and governance in the decision making through the Health & Wellbeing Board to develop and review plans and strategies jointly. We can see that there is also good engagement with wider partners, across local authorities, Healthwatch and the Voluntary Community Social Enterprise (VCSE). The Triple aim is reflected in the ICB's Annual Report and throughout other aligned strategies and plans, this is also outlined as a thread throughout all major documentation. The Health Inequalities Framework is in place as approved by the Health Equity Committee and the system quality group is well established and clearly aligned to the NQB terms of reference.

LLR has a capable developing leadership team, with experienced system partners who have a wide range of skills and expertise. The Executive leads continue to build relationships and demonstrate consistent shared focus on local priorities. This is evidenced through progress being made in sustainable delivery of services and the national recognition of many areas of pathway work across the whole system.

There are mechanisms in place for Board development, to review major programmes of work such as strategy development, transformation programmes and current work programmes through the ICB Executive Board to ensure there are consistent collective approaches to decision making. A particular area of strength is the ICB's motivation to learn from others, where the ICB will visit or take advice from other systems in addition to providing support for others in areas where you have both excelled but also learnt lessons from challenge.

LLR co-develop a range of strategies including a comprehensive JFP, involving partnership organisations for input, demonstrating clear and efficient joint planning approaches from the outset. Operational planning and development are undertaken jointly across the system, but the result is a cohesive and joined up plan which recognises co-dependencies.

There is a clear focus on population health and inequalities demonstrated through the system's Health Inequalities Unit. Significant work on deprivation has been undertaken in the City, and the system is committed to reducing inequality, particularly for underserved groups. There is greater focus on reducing inequity in LLR's planning practices, strategy development and strategic change approaches.

Good governance is noted across the provider organisations with delegated workstreams and collaborative partnerships reporting to the ICB Board.

LLR has good stakeholder engagement with comprehensive management and escalation of risks. Every partnership/collaborative has clinical leadership, ensuring clinically focused decisions and the ICB has a Professional Leadership Forum which encourages a diverse range of multiprofessional clinical leaders as well as supporting a pipeline of leaders. The Public and Patient Involvement Assurance Group reviews the impact that insights have on decision making. There is evidence of community engagement in data quality and assessment and scrutiny. Strong public engagement work is evidenced through the variety of strategic service change programmes.

There is a Developing Diverse Leaders (DDL) programme, with a second cohort launched – this is Inclusive leadership in the workplace: a partnership programme for aspiring leaders from diverse ethnic backgrounds across LLR

Overall, there is strong governance in place, particularly around the clinical areas of focus, with robust planning in place, although further work to ensure effective collaboration is in place in all areas would be helpful. Although provider oversight is in place in the clinical and operational

areas, further assurance would support the strategic areas such as finance and strategic planning.

**Section 2: Improving population health and healthcare**

During 2023/24 the system continued to improve healthcare, with significant progress in Elective and Cancer recovery. UEC also saw good improvement but remains significantly challenged. There is a robust UEC action plan and a number of initiatives in place to divert services to community settings to improve patient experiences

The ICB has worked well as a collaborative with strong oversight and assurance of delivery against the priorities in the Planning guidance. There has been good ICB oversight, engagement & ownership.

Following entry into tiering last year, there has been good work on developing a robust oversight model within the system to continue the improvement in performance with UHL (University Hospitals of Leicester) and exiting tiering for cancer and elective. UHL were recognised nationally as 1 of the top 10 trusts making largest improvements.

Regarding elective care there was a 16% reduction in the overall waiting list size and a 97% reduction in those waiting over 78 weeks with only a small number of patients remaining at the end of March. There were also significant reductions in patients waiting over 52 weeks. In diagnostics, those waiting over 13 weeks reduced by 80% and those over 6 weeks by 71%.

Cancer delivery saw significant progress, with major improvements in the 62-day backlog reduction and FDS (faster diagnosis standard) achievement in January 2024 delivering over 75% within 28 days of referral since September 23. There was a 60% reduction in patients waiting over 62 days for treatment and achieving the fair share position.

In UEC, the overall 4-hour 76% target & 30min cat 2 target were not met. This should remain an area of continued focus for 2024/25 performance. Demand & capacity modelling is in place, admission avoidance, and good inclusive practice with improved ambulance engagement and services maintained during industrial action. UEC tiering continues, but similar plans are in place in terms of oversight and planning. Ambulance handover delays were the biggest challenge last year, which has seen significant improvement more recently in 2024/25.

The system works well together with primary care and community services to deliver effective services and access to all and the primary care access recovery plan (PCARP) has been worked on together.

Whilst the system has not delivered against all of last year's operational planning metrics, there has been overall improvement throughout, with the exception of finance. There has also been challenges in maternity relating to safety, although the actions taken and approach to this has been strong, with evidence of delivery against requirements made by CQC and MSSP. There is a Professional Leadership Forum and a Developing Diverse Leaders Programme to encourage greater diversity. The 'Saving Babies Lives' care bundle is not compliant requiring oversight over the coming year.

Performance has been strong throughout the year for Mental Health overall, with further focus needed on dementia diagnosis which is underway.

There is clear evidence of improving patient outcomes and experience across a range of local services, such as health inequalities, patient safety and medicines optimisation.

LLR ICB uses a “Manage Need, Not Just Demand” model to address its approach to population health management, and this is referenced throughout the JFP. It is unclear how the approach will be embedded at Place level, what this will look like in practice and the anticipated impact it will have for the system and beyond. This is undoubtably understood within the system, but not clear from plans and evidence reviewed.

LLR promotes choice and involvement for patients, their representatives and the public. These are detailed in the JFP and through the Patient and Public Involvement Assurance Group, which reports to the Quality and Safety Committee.

The ICB is well versed on public and partner engagement in relation to the commissioning of new or service redesign models. The strategic service change work has a strong emphasis on engagement and there are effective communications approaches to connecting with these groups on day-to-day issues as well as the larger change programmes. LLR is focussed on unmet needs and able to engage in a way that is meaningful to the various communities.

The system ensures the population is engaged at every part of the development process and they are included in any changes, seeking their advice and ideas. This is incorporated from the early stages of any change programmes and is consistently applied throughout.

CYP is a delivery priority with a pledge to improve access, experience, and outcomes with a focus on improving health equalities. CYP Partnership Board is well-attended with strong clinical leadership. This is evident in the operational delivery of the service. Following the SEND inspection in Rutland, the system is required to strengthen its senior leadership and partnership working. Workforce capacity is also key risk to delivering the transformation programme. Local safeguarding arrangements are in place, these are structured, clear, and evidenced through the embedded ICB systems and processes.

**Section 3: Tackling unequal outcomes, access, and experience**

There is a clear focus on population health and inequalities demonstrated through LLR’s Health Inequalities Unit. Significant work on deprivation has been undertaken in the City to reduce inequalities, particularly for underserved communities. There is greater focus on reducing inequity in LLR’s planning practices, strategy development and strategic change approaches. This was established on the back of LLR’s approach to HI during Covid-19. Evidence can be seen within all documentation as a key theme and in practical terms. LLR are recognised leaders in health inequalities and often asked to present their work regionally and nationally.

The Health Inequalities Unit works on driving down inequality, by using research and business intelligence in the form of a HI framework, to identify areas of focus, for example this is highlighted in the deprivation work and the impact on the City. Population health management impacts on this with the City and County Councils contributing to the inequalities agenda.

LLR has effective approaches to reducing health inequalities, with targeted interventions in place for the City and continue to make good progress against the 5 key priority areas and Core20plus5. There is strong leadership and governance with excellent cross collaboration with local authorities and public health who feed into the Health Equity Committee. Steering Groups cover the clinical areas of Core20Plus5 & Core20Plus5 CYP and there is a Health inequalities Strategy– *Better Care for All* is in place,

There is a named SRO, and the Health Inequality Committee is chaired by a non-executive member and assurance reports from the Committee are presented to the ICB Board.

The Health Inequalities Champions programme has 36 learners embarking on their journey to become Health Inequalities Champions. Digital exclusion is led by the ICB to look at digital competency and exclusion, working with communities to provide training and support.

LLR has been able to incorporate health inequalities work into operational management through close working as a system in understanding underserved communities and associated performance improvement needs. By considering both together, they have been able to put in place innovative ideas and schemes to ensure communities access services equitably and aligned to that local population. This has many times over seen increased access of the public to services such as screening and vaccination programmes.

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**Section 4: Enhancing productivity and value for money**

This is the area which has been the most challenged. In the financial year 2023/24 the system's reported financial performance was £68.4m deficit against an initial plan of a £10m deficit. Non-recurrent funding of £10m was made available to support cashflow requirements. For financial performance management purposes, the applicable financial position was £78.4m deficit. Within the reported value the ICB financial position of a £15.6m deficit.

Total system efficiencies delivered were £137.3m, 6% of system allocation. Of this total, £45.9m (33.4%) was recurrent, increasing the recurrent efficiency requirement in future years.

Agency costs also increased, surpassing the plan by £8.4m and agency cap by £18.8m. The main operational risks were in the emergency care pathway and discharges as these areas drove most of the cost pressures, alongside the use of agency staff.

Whilst the ICB Finance Team are working well with NHS England and understand the issues, holding providers to account and ensuring they have well developed medium term financial plans has been problematic for the system. Ongoing grip and control are needed if financial recovery is to be achieved by the system.

UHL have remained in the national Recovery Support Programme (RSP) and have undertakings in relation to finance in place and NHSE continue to work with the ICB and UHL to agree the Transition criteria to exit the RSP programme and oversight of delivery of their financial recovery plan.

The areas requiring improvement including the review of investment and efficiencies, clarity of UEC schemes and assessing the impact of these schemes against the investment. In addition, there needs to be continued close working with the NHSE finance team to ensure there is robust oversight of plans and delivery. These require greater scrutiny and strengthening, alongside agency spend and rostering for UHL.

Research is strong within LLR, with Professor Michael Steiner Deputy CMO being the lead for research technology and innovation in the system. There is also a dedicated research team and a research strategy group. A plan on a page document describes the current research, along with any gaps, barriers, and opportunities. In primary care 79% of its sites were 'research active' LLR has the highest proportion of inclusion of the East Midlands Cancer Research Network, with 119 out of 131 practices engaged with 9,855 patients.

There are opportunities to work with local communities to raise awareness of research for the future, including the prospect of amending the NHSE commissioning contract templates to include facilitation and support research activity.

People & workforce

The ICB has developed several system level programmes to support staff wellbeing and retention, the staff survey indicates a strong and improving position for staff engagement. Workforce turnover data shows a reduction of 1.7% (up to February) and staff sickness has reduced at 0.2% in the last 12 months.

Various inclusive training programmes support staff, such as, active bystander (which is being rolled out across the region), health inequality champions programmes and leadership programmes. There are substantial programmes of work with the Workforce development fund allocation to support new ways of working and a retention programme to reduce the high proportion of leavers within the first 12-months of employment, creating career pathways to attract, train and retain more staff.

There is also the one workforce approach underway, to help grow the staff with training and education subgroups, such as placements, quality and learner experience groups, professional development opportunities and an LLR OSCI training centre.

We do recognise that the system has had to put plans and mitigations in place throughout the year due to industrial action, which may have impacted on delivery.

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**Section 5: Helping the NHS support broader social and economic development**

The ICB works closely with local authorities and other partners to implement the Joint Health and Wellbeing Strategy. As a system there are strong effective partnerships to support collective service delivery, supporting the five priorities for LLR: carers, healthy weight, homes for independence, physical activity, Mental Health, and Dementia. Shared system priorities are an important part of the ICS approach to partner collaboration. There are a wide range of system strategies and plans such as JFP, annual operational and finance plans to ensure local needs are met.

There is clear evidence that these priorities are aligned with the ICP Strategy and NHS Five Year Forward Plan. The ICP strategic enablers for example include prevention and health inequalities, workforce/skills, personalisation, technology, and data.

We are aware that the Health and Wellbeing Partnership meets weekly, demonstrating a collective approach to campaigns and initiatives, to improving access to services, reducing system pressures, supporting the inequalities agenda and wider determinants of health.

Wider partners also work together across the NHS, local authority, primary care, independent care providers, third sector and education to support, develop and grow local health and social care through the ‘One Workforce’ approach. This includes utilising estates, resources, and other facilities where the ICB acts as an anchor institution. Provider contracts also support the broader agenda with performance and quality indicators, to help to ensure delivery against local/national priorities are delivered safely, measured and provider good standards of care. Performance reports are presented to the System Executive Committee to enable oversight of progress and address issues.

The system has had good representation at the Midlands Green Board and supports the delivery of work programs, the co-ordination of workstreams and collaborative projects. The JFP demonstrates commitment to the ICB’s vision to support the environment. There are programmes of work to deliver targets and actions in the “Net Zero,” Green Plan.

An example of the work undertaken is that LLR has successfully eliminated desflurane and made a 19% reduction in the emissions from inhalers.

## Conclusions

This has been challenging year in many respects and in making our assessment of your performance we have sought to fairly balance our evaluation of how successfully you have delivered against the complex operating landscape in which we are working. This is the first full year in which you have been operating as well as the first year of your Joint Forward Plan and we are keen to continue to see progress towards a maturing system of integrated care structured around placing health and care decisions as close as possible to those people impacted by them. We will continue to work alongside you in the year ahead and look forward to working with you to support improvement throughout your system.

Please can you share our assessment with your leadership team and consider publishing this alongside your annual report at a public meeting. NHS England will also publish a summary of the outcomes of all ICB performance assessments in line with our statutory obligations.