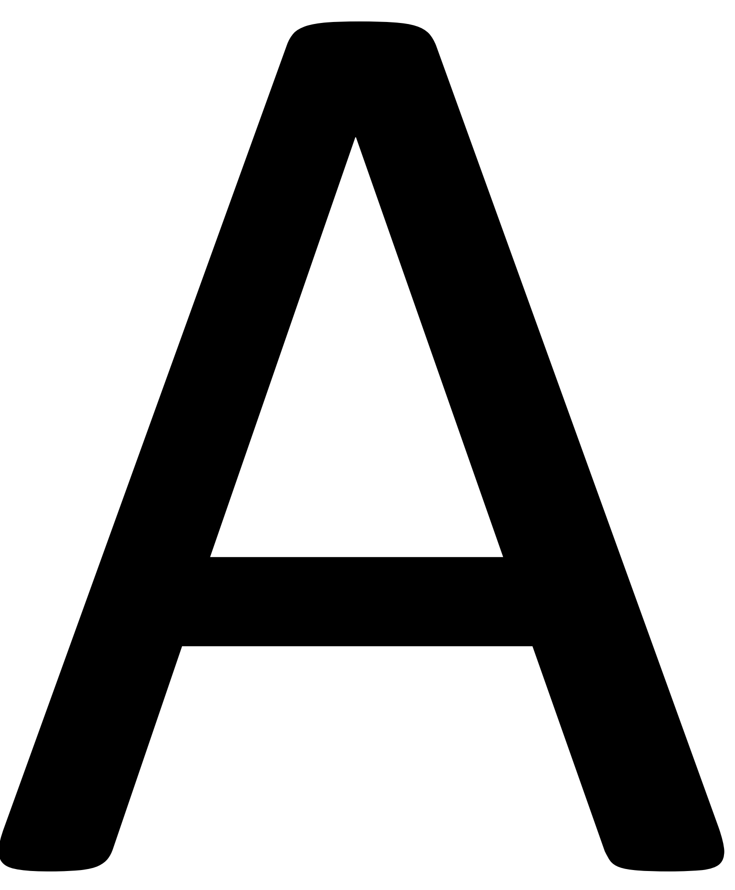

Minutes of the NHS LLR Integrated Care Board (“the ICB” or “the Board”) Held in Public, Thursday 12 June 2025 9:00am – 11.30am, via MS Teams

Members present:

Ms Paula Clark	NHS LLR ICB Chair
Ms Caroline Trevithick	Chief Executive Officer, NHS LLR ICB
Ms Hellen Makamure	Deputy Chief Nursing Officer, NHS LLR ICB *(Deputising for Ms Kay Darby)*
Mr Robert Toole	Chief Finance Officer, NHS LLR ICB
Mr Pete Burnett	Chief Strategy Officer, NHS LLR ICB
Ms Alice McGee	Chief People Officer, NHS LLR ICB
Dr Nil Sanganee	Chief Medical Officer, NHS LLR ICB
Ms Rachna Vyas	Chief Operating Officer, NHS LLR ICB
Ms Pauline Tagg	Non-Executive Member – Quality, Safety and Transformation, NHS LLR ICB
Mr Darren Hickman	Non-Executive Member – Audit and Conflicts of Interest, NHS LLR ICB
Mr Anil Majithia	Non-Executive Member – Health Inequality and Communities, NHS LLR ICB
Mr Simon Barton	Partner Member - acute sector representative (Deputy Chief Executive, 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 and Rutland County Council) (via telephone dial-in)
Mr Mark Andrews	Partner Member – local authority sectoral representative (Chief Executive, Rutland County Council) (via telephone dial-in)

Participants:

Dr Janet Underwood	Chair, Healthwatch Rutland (via telephone dial-in)
Ms Harsha Kotecha	Chair, Healthwatch Leicester and Leicestershire (via telephone dial-in)

In attendance:

Cllr Diane Ellison	Chair of Rutland Health and Wellbeing Board
Dr Sulaxni Nainani	Deputy Chief Medical Officer, NHS LLR ICB
Ms Louise Young	Deputy Chief Officer – People and Transformation, NHS LLR ICB
Ms Jenny Goodwin	Deputy Chief Officer – Communications and Engagement, NHS LLR ICB
Ms Anna Olek	External Communications Officer, NHS LLR ICB
Ms Sally Le-Good	Senior Cancer Service Manager, NHS LLR ICB *(for item ICB/25/49)*
Ms Shelley Winterton	Primary Care Liaison Nurse, LPT *(for item ICB/25/49)*
Ms Paula Watts	Primary Care Liaison Nurse, LPT *(for item ICB/25/49)*
Ms Emma Burns	Strategic Lead, Health Protection, NHS LLR IICB *(for item ICB/25/49)*
Prof Mohammed Al-Uzri	Mental Health Clinical Lead, NHS LLR ICB *(for item ICB/25/54)*
Dr Jo McKenna	Assistant Director of Contracts and Procurement, NHS LLR ICB *(for item ICB/25/66)*
Ms Lorna Simpson	Head of Strategic Estates, NHS LLR ICB *(for item ICB/25/67)*
Mrs Daljit Bains	Head of Corporate Governance, NHS LLR ICB
Ms Charlotte Gormley	Corporate Governance Officer, NHS LLR ICB (minute taker)

Eight members of the public attended to observe the meeting.

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ITEM		LEAD RESPONSIBLE
ICB/25/45	**Welcome and Introductions and apologies for absence from Members and Participants:** Ms Paula Clark welcomed colleagues and members of the public to the meeting. In particular, she welcomed Mr Pete Burnett in his role as Chief Strategy Officer, NHS LLR ICB. Apologies were noted from: • Ms Kay Darby, Chief Nursing Officer, NHS LLR ICB • Ms Simone Jordan, Non-Executive Member - Remuneration and People, NHS LLR ICB • Mr Richard Mitchell, Partner Member - acute sector representative (Chief Executive, University Hospitals of Leicester NHS Trust) • Mr Laurence Jones, Partner Member – local authority sectoral representative (Strategic Director, Social Care & Education, Leicester City Council) • Dr James Ogle, Partner Member – primary medical services representative The meeting was confirmed as quorate.	
ICB/25/46	**Declarations of Interest on Agenda Items** The register of interests was published on the ICB website and reviewed on a regular basis. No specific declarations were made.	
ICB/25/47	**Minutes of the meeting held on 10 April 2025 (Paper A)** The minutes of the ICB Board meeting held in public on 10 April 2025 were confirmed as an accurate record. **It was RESOLVED to:** • **APPROVE** the minutes of the ICB Board meeting held on 10 April 2025.	
ICB/25/48	**Matters Arising and actions for the meeting held on 10 April 2025 (Paper B)** It was noted that there were no outstanding actions. **It was RESOLVED to:** • **RECEIVE** the update and progress made in relation to the actions.	
ICB/25/49	**Improving uptake of cancer screening for patients with Learning Disabilities (Paper C)** Ms Le-Good informed that there were known health inequalities and poorer outcomes for patients with learning disabilities and autism (LDA) throughout LLR. She advised that Learning from Lives and Deaths (LeDeR) had identified a low uptake of cancer screening amongst this patient group. In response, the ICB was working in collaboration with LPT and the LDA collaborative to improve access to cancer diagnosis and treatment. She outlined the targets for improving screening uptake and achieving early identification of cancer by addressing hard to reach communities and encouraging early intervention. Ms Winterton provided examples of interventions which improved access to routine screening and reduced barriers to care. She described a data sharing process that identified patients who required reasonable adjustments, and a bowel cancer screening hub that was being piloted. Additional resources to increase the population's awareness of cancer included a myth busting video and engagement events that promoted self-checking for signs and symptoms. Ms Winterton advised that results from these interventions had been	

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	encouraging. She reported an increase in the return of completed fit kits and shared examples of positive feedback from members of the public. Regarding next steps, Ms Burns advised that local LDA events would be held to support communities. The team would also be visiting local care homes to discuss LeDeR data and increase awareness around making every contact count. Additionally, the programme was using health equality audit tools and gap analysis to ensure that support workers had the same opportunities to access screening. The team would continue to collaborate with LD partners to highlight good practice and to act on the feedback received from focus groups. Responding to queries raised, Ms Winterton confirmed that fear of dying was identified as a barrier to care by patients and their families. To address this, the teams provided reassurance around what would happen following a positive screening result. She noted that uptake amongst LDA patients might never be equal to that of the general population due to capacity issues and the impact of other medical conditions such as serious mental illness. However, it was important for the programme to reach as many individuals as possible, and to provide a positive experience to those who accessed screening to maximise the chance that they would return for an appointment in the future. Responding to the Board's offer of support, Ms Le-Good noted that funding from the East Midlands Cancer Alliance (EMCA) had decreased significantly across the patch. She therefore requested that the programme be considered to receive reallocation of underspend from other areas. Furthermore, she noted that reasonable adjustments such as longer appointment times were not always available to facilitate cancer screening. This could therefore be taken to Primary Care Network (PCN) meetings as a discussion point. Ms Clark thanked colleagues for the uplifting presentation. **It was RESOLVED to:** • **RECEIVE** for information.	
ICB/25/50	**Chair's update (Verbal)** Ms Clark acknowledged the fast pace of change across the NHS and highlighted the importance of keeping up to date with new information. She noted the recent publication of the Spending Review 2025 which the Board would review in detail at a future meeting. **It was RESOLVED to:** • **RECEIVE** the update.	
ICB/25/51	**Report from Chief Executive (Paper D)** Ms Trevithick informed that the high-level planning assumptions for the model ICB blueprint had been submitted to NHS England. A full report would be made following conclusion of the regional and national ratification processes. Ms Trevithick drew the Board's attention to the following key points within the report: [i] The NHS Leadership Event held in April 2025 had focused on shaping the new system architecture of the NHS. [ii] Annual reports on complaints and disclosure of information had provided a helpful indication of the ICB's engagement with the public. [iii] The ICB had given agreement for care home residents prescribed oral nutrition supplements to receive homemade nutrition	

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	shakes as supported by LLR dieticians. [iv] A planning application had been submitted to Hinckley Borough Council to demolish the existing Cottage Hospital and replace it with a modern build that would significantly increase elective activity. [v] There had been an increase in the volume of latent tuberculosis (TB) testing in response to Leicester reporting the highest rate of TB cases in England. Finally, Ms Trevithick reported that the LLR system finance team were the first to win the HMFA East Midlands Working Together award. She also extended congratulations to Ms Hillery, who had placed second in the Health Service Journal (HSJ) list of top 50 Chief Executives. Ms Tagg queried the increase in complaints, noting the increased availability of GP appointments and improvement in patient satisfaction scores. Ms Trevithick responded that the increase was partially related to the way the ICB received and managed complaints, noting the delegation of pharmacy, optometry and dental services (PODs) from NHSE to ICBs. She also noted that, despite the increased number of appointments and digital support, the level of dissatisfaction around access remained high. Dr Sulaxni elaborated that primary care looked different due to the increased use of multi-disciplinary teams. She assured that work was ongoing to assist the population's understanding of primary care services. **It was RESOLVED to:** • **RECEIVE** and **NOTE** the report.	
ICB/25/52	**LLR ICB 5-Year Plan Refresh (Paper E)** Mr Burnett outlined the guidance released by NHSE for ICBs to develop and review their 5-Year Plans. He reminded members of the light touch review approved by the Board in February 2024 due to the delay in publication of the Operational Planning Guidance, to which a refresh of the 5-Year Plan would need to be aligned. Further to this, in November 2024, the Board considered the impact of the three 'shift' areas and agreed to await publication of the 10-Year Plan before undertaking a full refresh of the 5-Year Plan. Taking account of the uncertain and rapidly changing environment, the System Executive had considered a set of options relating to the refresh of the 5-Year Plan. The recommendation to the Board was to approve option c) *Allow for key developments (NHS 10 Year Health Plan and Model ICB and ICB footprints) to be agreed and revisit at that time.* The Board agreed with the approach and approved the recommended option. **It was RESOLVED to:** • **APPROVE** the proposal for LLR ICB 5-Year Plan refresh and allow for key developments (NHS 10 Year Health Plan and Model ICB and ICB footprints) to be agreed and revisit at that time.	
ICB/25/53	**Briefing note: Neighbourhood Health programme month 1 (Paper F)** Ms Vyas introduced the briefing as a summary of the key development areas for neighbourhood health and an update against the commitments of the 2025/26 neighbourhood health programme. She thanked partner organisations for their contributions to the programme, noting the positive attendance at the clinically led visioning workshop held earlier in the month.	

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	Ms Vyas drew the Board's attention to section 8 of the report, which detailed the specific deliverables within the 2025/26 plan. She noted the positive performance against plan for ambulance conveyances and advised that future reports would include a wider set of metrics to broaden the focus from acute flow. In readiness for winter, work would continue to upscale specific services in pilot form based on local flow and outcomes. Additionally, discussions had taken place with neighbourhood health providers regarding the model ICB, and Local Authorities had supported the co-production of an outcomes framework tailored to each place. There was some discussion regarding the increased number of care plans for high complexity patients and how to ensure all care plans would be meaningful. Ms Vyas advised that the target was to complete care plans for 80% of patients in the identified patient need groups by 31 March 2026. The plans would be reviewed with family and carers, subject to audit, and informed by healthcare economics. The objective was to keep patients safe and ensure they were taken to the correct setting if they required acute care. Responding to queries raised, Ms Vyas confirmed that there had been no reports of staff burnout from workforce involved in the programme. Feedback from GP and nursing staff evidenced enthusiasm for changing the culture around complex cases and the need for support from system partners in achieving this. Furthermore, Ms Vyas emphasised the importance of evidencing the value of the interventions in place. She noted that links could be strengthened with universities to evaluate and upskill staff. The Board welcomed the progressiveness of the programme and offered support in overcoming barriers to success. It was agreed that the role of neighbourhood health would be considered in every part of the system and across all areas of planning guidance. **It was RESOLVED to:** • **RECEIVE** for assurance	
ICB/25/54	**Review of Intensive and Assertive Community Mental Health Treatment – Progress Update (Paper G)** Professor Al-Uzri advised that NHSE had provided guidance for ICBs to review the community mental health services in place for patients with serious mental illness. He reported that a self-assessment completed in 2024 had identified areas of good local practice, particularly the dedicated community based Assertive Outreach Team, whose role was to proactively work with people where engagement was a challenge. There were however areas of practice to be developed further. Professor Al-Uzri provided an update from the LLR steering group, noting that the group met monthly to implement the dynamic action plan developed through relevant forums. He drew the Boards attention to actions 8 and 17, which had improved in status from 'amber' to 'green'. It was noted that no actions were currently rated as 'red' and a further report would be presented by the end of the year. Responding to queries raised, Professor Al-Uzri advised that risks had been detailed within the plan. He highlighted the challenge of ensuring that digital	

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	systems were up to standard and used to their full potential. Whilst the summary care record (SCR) met some requirements such as flagging patients with a need for intensive support, more work was needed to increase accessibility in primary care, making every contact count for a group that was difficult to engage. Further challenges included the lack of resource in-year to recruit professionals with the required skill-mix. This was a national position and would continue to be examined. There was some discussion regarding the role of family and carers and how this would be reflected in the action plan. Professor Al-Azri gave assurance that work was taking place to enhance engagement with service users and their families. He acknowledged the contributions of stakeholders involved in the process. In particular, he advised that there would be a clear message to front line colleagues about gaining insight from individuals who knew the patient best without jeopardising confidentiality. The Board acknowledged the tragic circumstances which had led to the review, however, were assured that LLR was performing well in comparison to other health systems. The Board noted the progress made and assurances provided to colleagues and the public. **It was RESOLVED to:** • **NOTE** progress on the implementation of the LLR action plan. • **NOTE** next steps for local systems and national team	
ICB/25/55	**LLR Mental Health Collaborative Memorandum of Understanding (Paper H)** Ms Vyas introduced the item, noting that the LLR Mental Health (shadow) Collaborative had been operating since April 2023. A Memorandum of Understanding (MoU) had been drafted using the LDA Collaborative MoU as a template. This would support ongoing development and formalise the collaborative. The LLR MH (shadow) Collaborative members had agreed that LPT would operate as the Lead Provider on their behalf and the MoU had been updated to reflect this change. Ms Vyas highlighted the long history of partnerships and collaboratives in thematic areas across the system. She noted the recent approval of the LDA Collaborative MOU and the growing maturity of collaboratives across LLR. The Board was invited to review and approve the LLR Mental Health Collaborative MOU. **It was RESOLVED to:** • Review and **APPROVE** the LLR Mental Health Collaborative Memorandum of Understanding	
ICB/25/56	**Month 1 Finance Report (Paper I)** Mr Toole introduced the report, which included the year-end system outturn position for 2024/25. He highlighted the additional funding allocation at month 11 which brought the actual system deficit to £(117.2)m against a deficit supported plan of £(80)m. The year-end outturn variance was broken down as LPT and the ICB at break-even and UHL with a deficit variance at £(37.2)m.	

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	The system reported a £3.0m underspend on agency and breakeven on operating capital. Furthermore, Mr Toole reported that £80m of non-recurrent deficit support funding was included within the 2025/26 plan. He noted the need to reduce costs through productivity improvement, workforce controls, and management. At month 1, the system reported a year-to-date deficit of £(2.2)m, which was an adverse variance from plan of £(1.6)m. The variance was mainly driven by lower than anticipated levels of income at UHL and additional costs against the prescribing budget within the ICB. Ms Clark commented that the system would remain in a challenging position following the Spending Review and highlighted the need to drive efficiencies. **It was RESOLVED to:** • **RECEIVE** and **NOTE** Month 12 2024/25 & Month 1 2025/26 system financial position. • **RECEIVE** for assurance.	
ICB/25/57	**Assurance Report from the Finance Committee and revised terms of reference (Paper J)** Mr Majithia introduced the report which was taken as read. He highlighted the proposed reconfiguration of the finance committee following a governance review. The proposed changes to the terms of reference had been supported by NHS partner members and would enable the committee to maintain focus on the ICB financial position whilst reducing the level of duplication in assurance mechanisms. The Board would continue to receive assurances regarding the system financial position via existing provider processes and the regular finance report. The Board was invited to review and approve the proposed changes to the LLR ICB Finance Committee terms of reference. **It was RESOLVED to:** • **RECEIVE** the report for assurance. • **APPROVE** the updated Committee Terms of Reference as at Appendix 1.	
ICB/25/58	**Assurance Report from the System Executive Committee (Paper K)** Ms Trevithick introduced the report which was taken as read. She drew the Board's attention to the financial position at month 1, approval of the outline business case for the city-based urgent treatment centre, and the accountability arrangements for partnerships and collaboratives reporting into the System Executive following dissolution of the System Delivery Group. Additionally, she noted approval of the all-age mental health plan and the system's ongoing commitment to support LOROS. Ms Tagg requested a progress update regarding the neurodevelopmental waiting list. In response, Ms Vyas advised that it would be a topic of discussion at an upcoming System Executive development session. Further action would be taken forward via the relevant governance routes. **It was RESOLVED to:** • **RECEIVE** the report for assurance.	

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<tr><th colspan="2">ITEM</th><th>LEAD RESPONSIBLE</th></tr>
<tr><td>ICB/25/59</td><td>Assurance Report from the Audit Committee and terms of reference (Paper L)
Mr Hickman introduced the report which was taken as read. He noted that all areas of assurance were rated ‘green’ with the exception of the Board Assurance Framework (BAF), which remained under review. Finally, he highlighted the proposed update to the terms of reference regarding the Cyber Assessment Framework Data Security and Protection Toolkit (CAF DSPT).

The Board was invited to review and approve the proposed changes to the LLR ICB Audit Committee terms of reference.

It was RESOLVED to:
• RECEIVE the report for assurance.
• APPROVE the Committee terms of reference as at Appendix 1.</td><td></td></tr>
<tr><td>ICB/25/60</td><td>Assurance Report from the Health Equity Committee (to note the meeting in April 2025 was stood down, next meeting scheduled for 17 June 2025).</td><td></td></tr>
<tr><td>ICB/25/61</td><td>Assurance Report from the Quality and Safety Committee (Paper M)
Ms Tagg introduced the report which was taken as read. She highlighted the revised equality and quality impact assessment process, noting that a threshold for escalation was yet to be determined. An update would be provided to the Board following the committee’s next meeting.

It was RESOLVED to:
• RECEIVE the report for assurance.</td><td></td></tr>
<tr><td>ICB/25/62</td><td>Briefing Summary of the East Midlands Joint Committee Meeting (15 April 2025) (Paper N)
Ms Trevithick introduced the report from the East Midlands Joint Committee. She noted that building work on the National Rehabilitation Centre was nearing completion. A briefing note would be provided to all ICB Boards regarding the wider commissioning strategy to drive value from 2026/27 and beyond.

It was RESOLVED to:
• RECEIVE the report for assurance.</td><td></td></tr>
<tr><td>ICB/25/63</td><td>Assurance Report from the LLR Health and Wellbeing Partnership (Paper O)
Ms Clark introduced the report, which provided a summary of the key areas of discussion at the development session held in April 2025. She highlighted the need for the Health and Wellbeing Partnership to remain active during times of change and the importance of involving all partner organisations.

It was RESOLVED to:
• RECEIVE the report for assurance.</td><td></td></tr>
<tr><td>ICB/25/64</td><td>LLR ICB Board Assurance Framework 2025/26 and Risk Management Strategy and Policy (Paper P)
Mr Toole provided a progress update against actions agreed at the risk management development session. He outlined the recommendations supported by the Executive Management Team and Board-level task and finish group, and provided assurance that the BAF would continue to be reviewed at agreed intervals.</td><td></td></tr>
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ITEM		LEAD RESPONSIBLE
	There was some discussion regarding the proposed changes to risk categories and the risk appetite framework. It was agreed for a session to be held at the next non-executive directors' meeting to increase understanding and to ensure that risk ratings were applied consistently across sub-groups. The Board acknowledged the notable effort of the executive team to progress with transition work whilst continuing to deliver against ICB objectives. **It was RESOLVED to:** • **RECEIVE** for assurance the report and Appendix 1. • **APPROVE** the amendments to the risk description for BAF risk 4 (finance) as detailed in Table 1. • **APPROVE** the strategic risk on transition (Table 1) for inclusion in the ICB's BAF. • **APPROVE** the amendments to the risk categories (Table 2) and the risk appetite framework (Table 3). • **APPROVE** necessary changes be made to the ICB's *Risk Management Strategy and Policy* to reflect the above amendments.	
ICB/25/65	**Amendment to the LLR ICB Constitution (Paper Q)** Ms Trevithick invited the Board to approve the proposed amendment to the LLR ICB Constitution and Corporate Governance Handbook. The recommendation was to delete clause 3.5.4 (b) which stated that a Chief Executive "*will not be eligible if they hold any other employment or executive role*". Following Board approval, the ICB's Constitution would be submitted to NHSE for further approval. **It was RESOLVED to:** • **APPROVE** the required changes to the Constitution (and the Governance Handbook) ahead of approval being sought from NHS England.	
ICB/25/66	**LLR ICB Procurement and Provider Selection Policy (Paper R)** Ms McKenna invited the Board to approve and adopt the LLR ICB Procurement and Provider Selection Policy. She noted that the proposed version of the policy was for local application of the procurement rules and had been based on the version adopted by ICBs across the East Midlands. As per the policy, a Provider Selection Advisory Group (PSAG) would meet monthly to advise decision-making committees and support consistent application of the regime. It was noted that the formal procedure for considering provider representations had been tested on local cases. An annual report to the Audit Committee would provide assurance of compliance with policy and regulatory requirements. **It was RESOLVED to:** • **APPROVE** and **ADOPT** the LLR ICB Procurement and Provider Selection Policy • **NOTE** for assurance that an impact assessment and operational procedures underpin effective implementation and governance for the policy.	
ICB/25/67	**LLR NHS Infrastructure Strategy for Adoption (Paper S)** Ms Simpson invited the Board to approve the LLR NHS Infrastructure Strategy 2025-35, which had been developed by a working group that included	

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ITEM		LEAD RESPONSIBLE
	members from primary, community, and acute sectors. She drew the Board's attention to Chapter 4 of the strategy, which outlined the infrastructure objectives and proposed infrastructure capital development pipeline. It was noted that a prioritisation matrix had been used to compare and rank capital investment schemes. The strategy included an ambitious programme to transform the physical and digital infrastructure and would be reviewed following publication of the 10-Year Plan. Ms Clark sought assurance that the strategy was flexible enough to be adapted to align with the 10-Year Plan. In response Ms Simpson advised that, depending on the content of the 10-Year Plan, the Infrastructure Strategy would require a full re-write or a less extensive refresh in certain areas. She noted that a further iteration of the strategy would be presented to the Board for approval and the Board would receive updates as appropriate. Additionally, Ms Simpson advised that the strategy had taken the three 'shifts' into account and would be adjusted accordingly as the neighbourhood programme was developed. The Board noted that a greater level of detail would be included within the infrastructure plan whilst the strategy provided an appropriate framework. Mr Burnett noted that the production of an Infrastructure Strategy had been a requirement from NHSE, however the strategy was not underpinned by a significant amount of capital. Furthermore, the Spending Review 2025 had announced a flat capital budget over the next 3 years, and this would be a limiting factor. **It was RESOLVED to:** • **APPROVE** the NHS Infrastructure Strategy 2025 – 2035	
ICB/25/68	**Consider written questions received in advance from the Public in relation to items on the agenda** **<u>Questions from J Burbridge:</u>** *1. Does the ICB (or East Midlands / Midlands / national body) have a maximum budget each year for spend on cataract operations provided by the independent sector for NHS funded patients in Leicester, Leicestershire or Rutland?* **Response:** For 2025/26, LLR ICB has established indicative activity plans linked to budgets for cataract operations with each contracted independent sector provider. The NHS England financial and contracting rules for 2025/26 enable LLR ICB to exercise greater control over the budget for cataract operations, whilst ensuring that activity carried out under contracts is clinically appropriate and supports nationally set performance targets. Any variance to the indicative activity plan levels must be for agreed clinical or patient care reasons and should be understood and accepted by the ICB and the provider. *2. Are independent sector providers which provide cataract operations for NHS-funded patients in Leicester, Leicestershire and Rutland, permitted to offer financial incentives to high street opticians to refer patients to particular independent sector companies?*	

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	Response: Referrals for cataract operations are channelled via a central referral management service to ensure all patients are properly offered a choice of provider at the point of referral. The referral management service is independent of the high street opticians who may have referred the patients. All contracted providers are subject to the NHS Standard Contract General Conditions, which classify any payment of commission as a Prohibited Act, unless disclosed in writing to the Contracting Authority. **<u>Questions from G Jennings:</u>** *In the CEO's monthly report, a reference is made to the large increase in complaints received by the ICB, many relating to primary care and specifically to access. Please could you tell me:* *1. How many physician associates (PAs) are practicing in LLR?* **Response:** 60.4 whole time equivalents (WTE) across primary care, University Hospitals of Leicester NHS Trust and Leicestershire Partnership NHS Trust. *2. How many of these are practising in primary care?* **Response:** 36 WTE as of January 2025 (based on Additional Roles Reimbursement Scheme (ARRS) claims data). *3. How many new PAs were employed in primary care during 2024-25?* **Response:** During this period, the amount has remained static due to the ARRS budget remaining static from the previous year. *4. How many new GPs have started practicing in LLR as partners or salaried staff during 2024-25?* **Response:** In primary medical care this data is not available as we do not have starter and leaver data for primary care. However, in ARRS we can identify how many new claims have come in and in 2024/25 31.3 WTE newly qualified GPs in March 2025. *5. Did the provision of NHS funded dental care increase or decrease in 2024-25 compared with the year before?* **Response:** The provision of NHS funded dental care increased in 2024/25 compared to 2023/24. Our spend in 2024/25 was £63,637,000 compared to £54,197,000 in 2023/24. Ms Clark thanked members of the public for their attendance and thanked those who submitted questions in advance of the meeting.	
ICB/25/69	**Any other Business** Ms Clark thanked all for their participation.	

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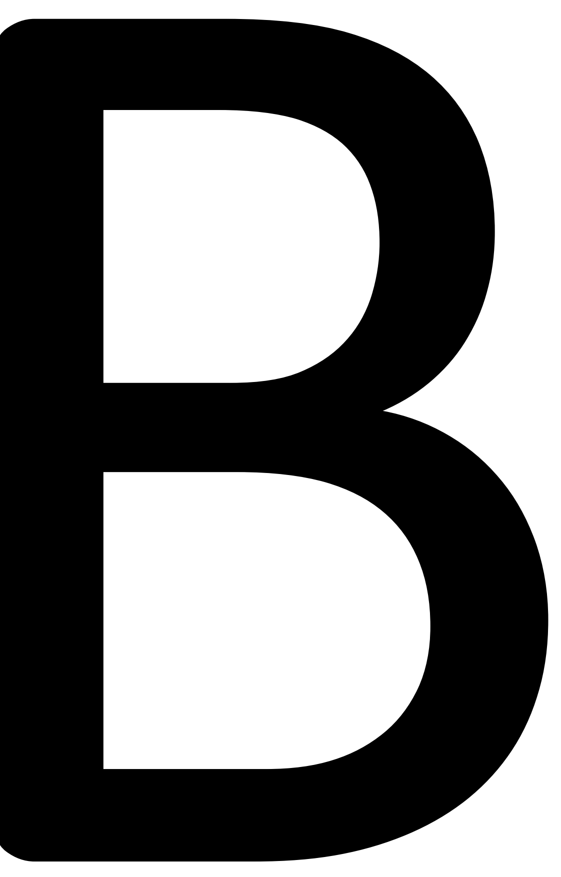
ITEM		LEAD RESPONSIBLE
	Ms McGee thanked Ms Trevithick for her leadership and support. On behalf of the Board, she wished her all the very best for the future. The meeting closed at 11.04am.	
Date and Time of next meeting: The next meeting of the NHS LLR Integrated Care Board would take place on **Thursday 14 August 2025,** 9:00am via MS Teams.		



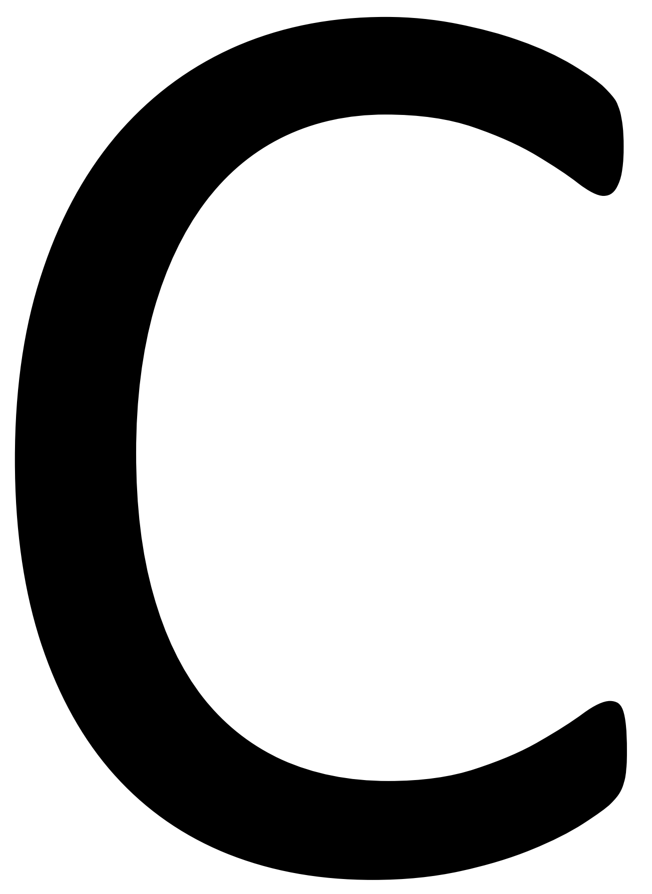
NHS Leicester, Leicestershire and Rutland (LLR) Integrated Care Board

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 August 2025	Status
				No outstanding actions.			



Name of meeting:	Leicester, Leicestershire and Rutland Integrated Care Board (public)		
Date:	14 August 2025	Paper:	C
Report title:	Patient Story		
Presented by:	Kate Dennison, Operational and Transformation Lead – Community Therapies, Leicestershire Partnership Trust		
Report author:	Kate Dennison, Operational and Transformation Lead – Community Therapies, Leicestershire Partnership Trust		
Executive Sponsor:	Rachna Vyas, Chief Operating Officer, LLR ICB		

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

Recommendations:

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

- **RECEIVE and NOTE**

Purpose and summary of the report:

To provide a patient story representing partnership patient centred care for patients enabling treatment at home and avoidance of hospital admission.

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

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.*	
b) Does the report highlight any resource and financial implications? If so, provide which page / paragraph this can be found within the report.	
c) Does the report highlight quality and patient safety implications? If so, provide which page / paragraph this is outlined in within the report.	
d) Does the report demonstrate patient and public involvement? If so, provide which page / paragraph this is outlined in within the report.	
e) Has due regard been given to the Public Sector Equality Duty? If so, how and what the outcome was, provide which page / paragraph this is outlined in within the report.	

Joan's Story- ICB board

Attendance at ED

Joan attended ED with exacerbation of COPD and recent falls. Family reported struggling at home, no POC.

Step up into Community Services

Referral made from team in ED to ICRS for review of care needs

Initial Community Ax

Home Assessment completed by ICRS identified:

- Reduced mobility and falls risk
- Numerous packets of medication, patient unsure what to take when
- Risk of skin breakdown, sleeping in a chair
- Reduced appetite, not eating or drinking sufficiently

MDT

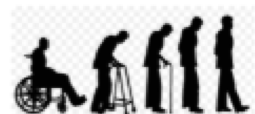
- Urgent referral made to Community Nursing (Trusted Ax)
- Urgent referral to Community Therapy (Trusted Ax)
- Lifeline referral made
- Handyman referral made to support removal of furniture
- POC put in place

Urgent Community Response

- Joint visit completed by Nurse and Therapy, full hollistic Ax completed, care plans agreed with Joan
- Essential equipment e.g. mobility, transfer and pressure relief equipment provided
- Medicines management review completed, discussion with GP re de-prescribing
- Advice provided to Joan and her family re: nutrition, referral to dieticians made
- ICRS liaise with local dispensing pharmacy for blister packs to allow Joan to meds manage independently
- Falls risk ax and associated actions completed

Reablement

- Reablement team seamlessly take over from ICRS
- Joint reablement response from Community Therapy and Reablement
- Bi-weekly MDT to discuss progress and care planning



Outcome

- Joan was able to remain at home returning to her previous level of function and mobility
- Her POC was removed as no longer required
- Onward referrals were made to the Falls prevention service

Impact

- Positive patient outcomes
- Positive patient experience
- Admission avoidance
- Reduction in ASC input

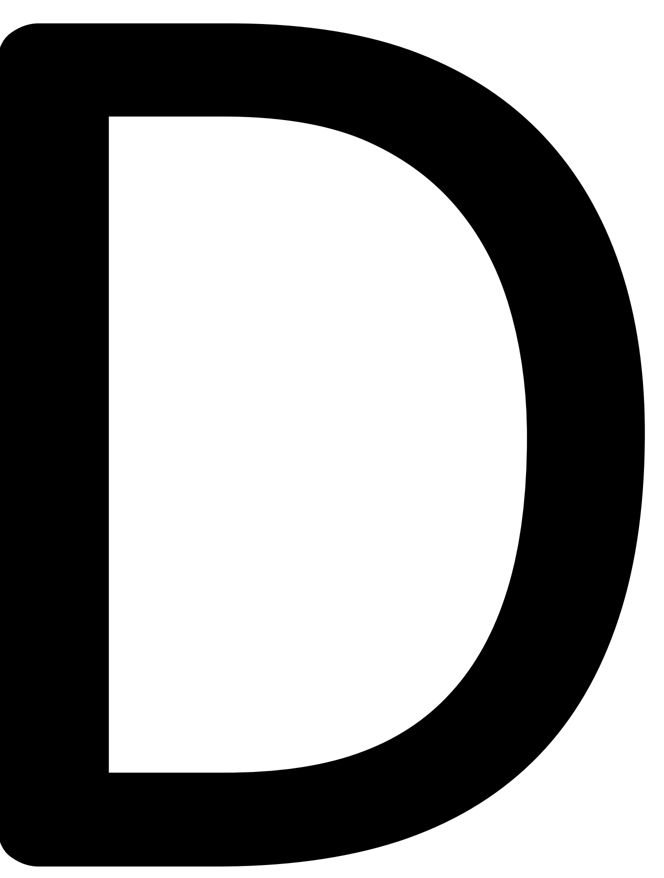
"The service was absolutely brilliant, the team helped me with washing, dressing and walking. I was looked after incredibly well and the carers worked with the Physio team to help me get moving again. The I am very grateful for their support and don't know what I would have done without them"

Integrated Home First Response

- Trusted assessments
- Shared information – reducing duplication
- Joint reablement approach allowing continuous progression

Opportunities for improvement

- Enhance referral pathways into UCR/Virtual Wards from EMAS/DHU
- Strengthen integration at neighbourhood level to support more cohesion with Virtual Ward services.
- Development of Single Point of Access/Clinical triage hub to support pathways



Name of meeting:	**Leicester, Leicestershire and Rutland Integrated Care Board**		
Date:	**14 August 2025**	**Paper:**	**D**
Report title:	**LLR ICB Chief Executive Officer's Monthly Report**		
Presented by:	Toby Sanders, Chief Executive, Leicester, Leicestershire and Rutland ICB and Northamptonshire ICB		
Report author:	Jenny Goodwin, Deputy Chief Officer Communications and Engagement LLR ICB		
Executive Sponsor:	Toby Sanders, Chief Executive		

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

Recommendations:

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

- **RECEIVE and NOTE** the report.

Purpose and summary of the report:

The LLR ICB Chief Executive Officer's monthly report focuses on emerging national and local issues and national policy developments since the last meeting. The details below are drawn from a variety of sources, including local meetings and information published by NHS England, the NHS Confederation. The report includes significant developments that are not otherwise covered on the Board Agenda from across the breadth of Chief Officer portfolios to keep members aware of key areas of work happening within LLR ICS (ICB, System, Place, Neighbourhood and Sector).

Appendices:	Appendix 1 – Annual assessment of LLR ICB's performance in 2024/25
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.*		BAF 1 – Partnership BAF 2 – Health Inequalities BAF 3 – Demand and Capacity BAF 4 – Finance BAF 5 – Quality and Safety
b) Does the report highlight any resource and financial implications? If so, provide which page / paragraph this can be found within the report.		None
c) Does the report highlight quality and patient safety implications? If so, provide which page / paragraph this is outlined in within the report.		None
d) Does the report demonstrate patient and public involvement? If so, provide which page / paragraph this is outlined in within the report.		Yes – Annual General meeting
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.		Reflects Health inequalities work

LLR ICB Chief Executive Officer's Monthly Report

Introduction

1. NHS England and Department of Health and Social Care (DHSC) have confirmed that our new 'cluster' – covering Leicester, Leicestershire and Rutland and Northamptonshire – has been formally approved.

2. This is part of a national move to reduce the number of Integrated Care Boards (ICBs) from the current 42 into 26 clusters, with some remaining standalone organisations.

3. Clustering' means that, although both ICBs will continue to exist, we will work as one – with a single Board, leadership team and staffing structure.

4. Through an arrangement supported by NHS England, and while NHS England works to establish future leadership arrangements, Toby Sanders will take on the role of interim Chief Executive for NHS Leicester, Leicestershire and Rutland (LLR) ICB alongside his permanent role as Chief Executive of Northamptonshire ICB.

5. Paula Clark, will serve as Chair across both organisations from 1 July 2025.

6. This is a critical transition period for ICBs as we focus on delivering our in-year priorities, progress our work – aligned to the three big shifts on the 10-year plan, particularly neighbourhood services – and at the same time responding to the reform agenda. The coming months will be challenging for staff as we work to reduce the size of ICBs and develop our roles as strategic commissioners.

Constitutional changes

7. In July 2025, NHS England wrote to all ICBs with required amendments to be made to ICB Constitutions to allow joint Chief Executive appointments to ICB Clusters. In line with this, clause 3.5 within the LLR ICB Constitution has been amended to read as follows (blue text indicates the mandated change):

3.5 Chief Executive

3.5.1 The chief executive will be appointed by the chair of the ICB in accordance with any guidance issued by NHS England.[31]

3.5.2 The appointment will be subject to approval of NHS England in accordance with any procedure published by NHS England.[32]

3.5.3 The chief executive must fulfil the following additional eligibility criteria:

a) be an employee of the ICB or a person seconded to the ICB who is employed in the civil service of the State or by a body referred to in paragraph 19(4)(b) of Schedule 1B to the 2006 Act

*b) *OPTIONAL/INSERT* specify any further local criteria [33]*

3.5.4 Individuals will not be eligible if:

a) any of the disqualification criteria set out in 3.2 apply

b) subject to clause 3.5.3(a), they hold any other employment or executive role other than chief executive of another Integrated Care Board.

c) *OPTIONAL/INSERT* specify any further local exclusions]

8. Unlike an ICB initiated amendment, NHS England approval is not required in this instance as it is an NHS England directed change. The amended LLR ICB Constitution is available on the LLR ICB website at the following: https://leicesterleicestershireandrutland.icb.nhs.uk/corporate-governance-documents/ .

Annual Report and Accounts 2024/25

9. I am pleased to confirm that the LLR ICB Annual Report and Accounts 2024/25 is now available:https://leicesterleicestershireandrutland.icb.nhs.uk/annual-reports-and-accounts/ .

10. It showcases some of our achievements in delivering our strategic objectives, and it details how we have spent our financial resources.

11. We will reflect on the past year at the end of this Board meeting, during the Annual General Meeting, where we will also highlight some key priorities for 2025/26.

Annual Assessment of LLR ICB's performance in 2024/25

12. On 31 July 2025, NHS England wrote to the ICB setting out its assessment of our organisation's performance during 2024/25.

13. Our performance is measured against the specific objectives set by NHS England and the Secretary of State for Health and Social Care, and the statutory duties defined in the Health and Care Act 2022. In addition, an assessment of the ICB's wider role within the Integrated Care System was also considered by NHS England.

14. NHS England have provided a summary of their assessment under the following headings, covering areas of good practice and areas that require further improvement within each section:

    a. Section 1: System leadership and management
    b. Section 2: Improving population health and healthcare
    c. Section 3: Tackling unequal outcomes, access and experience
    d. Section 4: Enhancing productivity and value for money
    e. Section 5: Helping the NHS support broader social and economic development

15. The letter in full is appended to this report (see Appendix 1).

National Updates

10-Year Health Plan launch

16. The Government's "Fit for the Future: 10-year plan for England" was published on 3 July 2025, setting out a transformative vision to address the critical challenges faced by the NHS and to ensure its sustainability.

- The Ten-Year Health Plan sets out a bold, ambitious and necessary new course for the NHS centred on three core shifts – from hospital to community, from analogue to digital, and from treatment to prevention – we will personalise care, give more power to patients, and ensure that the best of the NHS is available to all.
- The Plan seizes the opportunities provided by new technology, medicines, and innovation to deliver better care for all patients - no matter where they live or how much they earn - and better value for taxpayers.
- We are fundamentally reinventing our approach to healthcare, so that we can guarantee the NHS will be there for all who need it for generations to come.

17. The 10 year plan can be found here: 10 Year Health Plan

18. As an ICB we are supporting colleagues and partners to understand what the 10-Year health plan means for us and how we will work collaboratively together across the system to effect real change for those we serve.

Safety report from Penny Dash

19. Dr Penny Dash's independent review of patient safety across the health and care landscape has been published. The review maps the broad range of organisations that impact on quality and focuses on six key national organisations that have an impact on safety.

Further information:

Review of patient safety across the health and care landscape - GOV.UK

NHS Oversight Framework 2025/26

20. The NHS Oversight Framework 2025/26 has been published and can be found at: NHS England » NHS Oversight Framework 2025/26. It outlines NHS England's updated approach to assessing and supporting ICBs, NHS Trusts and Foundation Trusts. It introduces a segmentation model for providers based on delivery against key metrics across six domains, including access, safety, workforce and finance. ICBs will not be segmented this year due to ongoing structural changes; however, we will still undergo statutory annual assessments. The framework requires all systems to achieve a balanced financial position, and links performance to regulatory intervention where necessary. It also supports the delivery of the 10-Year Health Plan by aligning oversight with national priorities.

Urgent and Emergency Care Plan 2025/26

21. The government has set out a package of investment and reforms aimed at improving patient experience for those accessing urgent and emergency care. The plan aims to deliver:
    - Around 40 new same day emergency care and urgent treatment centres to avoid unnecessary admissions to hospital.
    - Up to 15 mental health crisis assessment centres to offer timely access to specialist support and avoid patients waiting in A&E for care.
    - Almost 500 new ambulances across the country by March 2026.

- Increased paramedic-led care in the community, which means patients will receive more effective treatment at the scene of an accident or in their own homes.
- Increasing numbers of patients seen at home by urgent community response teams.
- Better use of virtual wards.

22. The plan's emphasis will be on shifting more patient care into more appropriate settings as part of the move from hospital to community under the government's Plan for Change.

23. Further information can be found here: NHS England » Urgent and emergency care plan 2025/26

Dental consultation

24. DHSC have announced a dental contract consultation.

25. The proposed NHS dental contract quality and payment reforms will help improve access to, and the quality of, NHS dentistry. DHSC now wants to hear from dental professionals, commissioners, patients and organisations with experience in the dental sector. The consultation is open until Tuesday 19 August.

26. Further information: More NHS dentistry for those who need it most - GOV.UK

LLR ICB Headlines

Neighbourhood Health Programme

27. We held the third meeting of the LLR Neighbourhood programme Board in July, with all partners across health and care. The Board looked at three specific areas of work – a vision for LLR, workstreams needed to progress the vision, and the programme deliverables for 25/26. The Board recognised the scale of the work required, and the need to employ a model of distributed leadership across health and care in order to deliver real change. Since the session, we now have neighbourhoods agreed in all three places across LLR. Further detail is available in the broader board paper as part of this pack.

Hinckley Hub

28. The Hinckley Hub will be opening to patients in August with an official opening in September 2025. The hub is a joint venture between LPT and Hinckley and Bosworth Borough Council. Previously adult and children's therapy was carried out in a portacabin. The council have made space available at the Hinckley Hub and LPT will now be able to offer care from 10 treatment rooms, alongside office space and a gym.

Engagement: VCSE Alliance Conference 9 July 2025

29. More than 40 VCSE organisations attended our VCSE Alliance half-day conference. The session set out the latest updates on the NHS changes and what they mean locally, including an overview of the 10-year plan.

30. Attendees were also invited to explore the Roving Healthcare Unit, sharing their experiences of vaccinations in the community and suggesting opportunities for future locations. We encourage continued collaboration and partnership working over the coming months and are committed to updating the sector on future changes.

Transferring Care Safely – HSJ Patient Safety Awards Finalist

27. The LLR *Transferring Care Safely* group, a long-standing collaborative that has been driving safer care transitions, has been shortlisted as a finalist for the HSJ Patient Safety Awards. The group's work has helped to transform care pathways, enhance access, improve patient outcomes, and elevate the overall experience across the system.

National Oliver McGowan Trainer Award

28. I would like to congratulate Charlotte Dickens, Programme Manager and facilitating trainer at the ICB who won The Oliver McGowan Mandatory Training Award at the National Learning Disabilities and Autism Awards 2025. The awards celebrate excellence in the support for people with learning disabilities. Charlotte's role was recognised for achieving large scale delivery of Oliver's training, having trained over 30,000 staff, which is the largest rollouts nationally. The breakthrough in delivery to primary care achieved the highest Tier 2 uptake in England's primary care.

NHS Northamptonshire and Leicestershire and Rutland Quarterly System Review (Quarter 1 – 16 July 2025)

29. A first joint Quarterly System Review Meeting (NHSE Northamptonshire/Leicester, Leicestershire and Rutland ICBs) was held in July, focused on Q1 delivery of operational plans and implementation of the model ICB requirements. There are some encouraging signs of savings control, however, acute and LLR ICB in particular continue to seek to address the historic financial position and continuing significant risks to the delivery of the 25/26 financial plan. The cost reduction savings recovery profile will need to step up over the coming months. We are awaiting formal feedback from NHSE.

Extracts from Leicestershire Partnership NHS Trust's (LPT) Board report:

CQC Inspection

30. The CQC visited LPT in May this year and inspected community mental health services for working age adults, the crisis teams and health-based place of safety. Reports will be received in due course.

CQC/NHSP Trust Level Assessment External Reference Group

31. Angela Hillery, LLR ICB has recently been invited to join a national advisory group for clinical and professional leaders to be involved in ongoing co-production of CQCs well-led methodology. This opportunity is welcomed to provide input, challenge and feedback to proposed improvements and changes to the well-led framework and methodology.

Psychiatric Ward reopens after £1.6 M Upgrade

32. Belvoir Ward is a psychiatric intensive care unit, providing care for patients with some of the greatest mental health needs in Leicester, Leicestershire and Rutland. The ward had been temporarily closed for refurbishment and has been completely re-decorated, with all new flooring, new windows and upgraded doors and security improvements, and all rooms ensuite. A significant proportion of the money for the work was provided in a grant from NHS England.

Extracts from University Hospitals of Leicester NHS Trust's (UHL) Board report

UHL Team Receives HSJ Award for Multilingual digital check-in-kiosks

33. University Hospital of Leicester NHS Trust (UHL) has received a HSJ Award for their work to improve access to healthcare through digital innovation.

34. UHL won the Digital Equality, Diversity and Inclusion Award for the introduction of multilingual self-check-in kiosks at the East Midlands Planned Care Centre at the Leicester General Hospital**.**

University Hospital of Leicester NHS Trust named as a Centre of Excellence by the European Academy of Allergy and Clinical Immunology (EAACI)

35. This Prestigious international designation – which recognises the work of allergy, immunology, asthma and severe asthma services, in collaboration with partners at the University of Leicester's Department of Respiratory Sciences – has been earned by just 12 centres worldwide. UHL's Centre of Excellence status was announced at the EAACI Congress 2025, held in Glasgow.

Preston Lodge – New Rehabilitation Facility opens

36. UHL have opened their new rehabilitation centre for patients who no longer need acute care but would benefit from recovery or rehabilitation before being discharged. Preston Lodge is the first phase of new rehabilitation facilities with phase 2 expected to be completed by the end of the year. The facility in North Evington will support our patients with recovery from a hospital stay by providing specialist care such as physiotherapy, occupational therapy speech and language support and rehabilitation. Not only does it support the government's shift from acute to community care, but it will also allow our patients to receive care in the right place, provided by a multi-disciplinary team. This new model will free up vital beds in our acute hospitals, which will improve the flow through our acute sites.

Recommendations:

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

RECEIVE and **NOTE** the LLR ICB Chief Executive Officer's Monthly Report.

Appendix 1

Sent via email

Paula Clark – ICB Chair
Leicester, Leicestershire, and
Rutland Integrated Care Board

Julie Grant
Director of System Co-ordination and Oversight, East Midlands
23 St Stephenson Street
Birmingham
B2 4JB

W: www.england.nhs.uk

31 July 2025

Dear Paula

Annual assessment of Leicester, Leicestershire, and Rutland Integrated Care Board's performance in 2024/25.

We are 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 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 2024/25 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. In each section of our assessment, we have summarised areas in which we believe your Integrated Care Board (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 and performance improvement is required, detailing any support or assistance being supplied by NHS England to facilitate improvement.

In making our assessment we have also sought to take into account how you have delivered against your local strategic ambitions as detailed in your Joint Forward Plan. A key element of the success of Integrated Care Systems is the ability to balance national and local priorities together and we have aimed to highlight where we feel you have achieved this and where further specific work is required.

Thank you and your team for all of your work over this financial year, and we look forward to continuing to work with you in the year ahead.

Yours Sincerely,

Julie Grant

Julie Grant
Director of System Co-ordination and Oversight – East Midlands

Cc: Dale Bywater, Regional Director, NHS England Midlands Region
Toby Sanders, Chief Executive Officer, Leicester, Leicestershire & Rutland ICB

Section 1: System leadership and management

After a period of leadership instability across the Leicester, Leicestershire, and Rutland (LLR) ICB and NHS provider organisations, the executive leadership stabilised and in December 2024, you were welcomed as Chair of the LLR ICB.

Evidence gathered as part of the annual assessment process and for the pilot ICB capability assessment, clearly demonstrates the skills, experience and capabilities of the executive team to lead the ICB well. There is a continued focus on Board development to strengthen the ICB's effectiveness in leading the NHS across the LLR system.

The ICB has maintained its strong approach to strategy and planning and continues its commitment to collaboratively develop plans with the Integrated Care Partnership (ICP), providers, and wider system partners. The Joint Forward Plan, Health and Wellbeing Partnership Strategy, and the 2024/25 financial and operational plans, illustrate how the ICB has worked together with system partners to co-produce credible and strategically aligned plans with goals aligned to system priorities.

Stakeholder engagement remains strong regarding Strategy and plan development with partners, including the Local Authorities, Healthwatch, and the Voluntary Community and Social Enterprise (VCSE) sector. The established Collaboratives/Partnerships, such as the VCSE Alliance, ensure diverse perspectives continue to shape decisions and support the delivery of plans. The Public and Patient Involvement Assurance Group brings together patient and public insights which inform local decisions. The commitment to engage with people and communities, patients and families, voluntary and community sector and professional is evident by the wide range of engagement and public consultation activities the ICB has undertaken. The End-of-Life Strategy Engagement Report, published on the LLR ICB website is an example of this work.

As highlighted in last year's Annual Assurance letter, we are pleased that the ICB continues to have robust governance, risk management, and escalation processes, with clear accountability and delivery frameworks reporting to the ICB Board. This is evidenced by the governance structures, supporting policies and procedures that are in place. While the ICB Board is ultimately accountable, it gains assurance that is fulfilling its function and duties through the committees and sub-committees in place.

The financial challenges are recognised across both the ICB and provider organisations, requiring strong leadership, robust governance and management to demonstrate accountability and improvement across the ICS.

It is evident that clinical leadership plays a key role in shaping strategic plans and informing key decisions, remaining consistent across the ICB Board, committees and in the established Collaboratives/Partnerships. The Clinical Executive Group focuses on a number of areas including, but not limited to, improving quality, safety, performance, managing system risk and reducing health inequalities.

Mechanisms are in place to ensure the ICB takes account of the 'Triple Aim' as part of its decision-making process. This is facilitated through the work of the various ICB committees, including the Health Equity Committee, Quality and Safety Committee, and Finance Committee, as well as the local Health and Wellbeing Boards. In October 2024, The 'Triple Aim' is also reflected across

strategic and operational plans. The ‘Decision-Making Business Case’ for service changes at the Fielding Palmer Hospital demonstrate how the ‘Triple Aim’ forms part of the Board’s decision-making, and the Board paper included data on population health management, quality and equity impact assessments, finance, and public and patient feedback.

Evidence supports the use of an inclusive decision-making framework, which ensures equality and inequality is considered as part the local decision- making process. There is an ongoing commitment by the ICB to ensure Health Inequality leads and financial leaders are cross-trained in each other's specialisms to ensure comprehensive decision-making is embedded.

NHS England delegated direct commissioning functions for pharmaceutical, general ophthalmic services and dentistry (POD) to ICBs in April 2023. The ICB is a member of a formal Joint Commissioning Committee with 4 ICBs in the East Midlands to jointly exercise its delegated commissioning functions, which included specialised commissioning services from April 2024. In August 2024, NHS England completed a primary care assurance framework which assessed the ICB as ‘substantial’, meaning that the ICB was discharging the delegated function safely, effectively and in line with legal requirements but one or two processes were not running effectively, exposing possible risk and issues in discharging the function. The ICB has continued to work towards ‘full’ assurance throughout the year.

Feedback from Health and Wellbeing Boards (HWBs), has been positive overall in relation to the effectiveness of the working relationships with the ICB. However, whilst recognising the significant work undertaken by the ICB, and the positive approach with which the ICB has worked with NHS and wider system partners to implement the Joint Local Health and Wellbeing strategy, it was cited that it would be helpful to consider better utilisation of the existing local community groups, VCSE, and research which the Local Authority already has in place. In addition, the ICB should consider a broader approach to the health inequalities agenda using the experience and specialisms outside of the NHS, available through other partners.

The ICB has arrangements in place to assure the Board of performance, quality and delivery. Performance and progress against plans are reported by the System Executive Committee to the LLR Delivery Partnership. The ICB Board is updated on progress in relation to strategic and operational plans.

There is evidence of good governance and oversight in relation to Quality and Safety. This is led by the Quality and Safety Committee, supported by subgroups including the Quality and Safety group and the Patient and Public Involvement Group. Evidence gathered as part of a regional patient safety stock take demonstrates a very robust patient safety and quality oversight of primary care providers (QA tool). This has enabled the ICB to escalate concerns and undertake rapid quality reviews.

ICB Board papers provide further evidence of ICB oversight and scrutiny of quality and safety. In October 2024 Board papers describe the Quality and Safety Committee being asked by the Board to provide assurance regarding the measures put in place for winter to ensure the safe care of patients.

The ICB continues to work well with system partners to develop its leadership and staff teams. We note the excellent work undertaken as part of LLR Inclusive Culture and Leadership approach including programmes such as, ‘Developing Diverse leaders’ cohort 2 launched in July 2024 and

the Active Bystander programme, which is being rolled out across the NHS England (Midlands). This training aims to empower individuals to challenge poor behaviour.

Section 2: Improving population health and healthcare

LLR faced several challenges in 2024/25, which resulted in delivery of plans not meeting national priorities and standards. However, it is important to acknowledge the efforts of system partners, as progress was observed across a number of areas.

After entering NHS England' s performance tiering regime last year for elective care, the ICB worked well with University Hospitals of Leicester NHS Trust (UHL) to ensure robust oversight and support was in place to implement elective care improvement plans. Progress led to UHL exiting tiering arrangements for elective delivery. There was a reduction in the overall waiting list size and 52 week waits reduced to 2,242, but both were off plan at year-end. Despite strong performance in delivering care below 65 weeks at the start of the year, it was disappointing that latterly the performance deteriorated, and the plan was not met, with 140 patients waiting over 65 weeks at the end of March 2025. It will be important to ensure close oversight of delivery in 2025/26.

In relation to Cancer, we were pleased to see the strong and sustained achievement of the Faster Diagnosis Standard, with 82.1% achieved in March 2025, the second highest performance in the region. There has been an increased focus on reducing the 62-day backlog, resulting in a reduction of 25%, and the 104-day backlog to 53%, from March 2024 to March 2025. However, 62-day and 31-day performance has been significantly challenged, UHL was escalated from Tier 2 to Tier 1 in Quarter 4 2024/25 due to 62 day performance and delivery was 62.1% in March 2025. This is an area where continued focus is necessary to ensure Cancer 62-day and 31-day performance is recovered in line with the system plan for 2025/26.

In diagnostics, UHL entered Tier 1 in Quarter 4 2024/25, and the plan for March 2025 was not met. However, we are encouraged by the improvements being seen; those waiting over 13 weeks reduced by 57% between March 2024 and March 2025 a reduction of 2,085. At end of March 2025, those waiting over 6 weeks was 16.9%. Specific focus will be required to deliver improvements in line with the plan for 2025/26.

Regarding UEC, performance fell short of the 4-hour A&E (all types) 78% target. However it is acknowledged that significant progress has been made and performance was 75.3% in March 2025. Ongoing Tier 3 support has been provided by the regional UEC team and it is noted that 'Release to Respond' has been implemented well. However, Ambulance Category 2 performance and the volatility of ambulance handovers remains challenged and should remain a focus for delivery in 2025/26. Your UEC Collaborative should work at pace, to deliver UEC improvements with a focus on reducing unwarranted variation for ambulance conveyances, by maximising alternative services to the Emergency Department (ED), including, but not limited to, Single Point of Access, Urgent Community Response and Urgent Treatment Centres. An ongoing focus to improve Mental health waits in ED and discharge processes is also required.

During 2024/2025 the system continued to perform well across several Mental Health performance standards. Notably, the standard for people with Serious Mental Illness (SMI)

receiving a physical health check was 66.7% in March 2025, above the national standard of 60%. A continued focus on Dementia Diagnosis is needed for 2025/26.

The year-end outturn position for your Community Pathways did not meet the requirement of the Operating Plan to reduce Waiting List sizes and improve the number of over 52-week waits. However, you have maintained your zero over 52 week waits on your Adult Community Pathways.

There was ongoing work to make progress in Primary Care and deliver the Primary Care Recovery Plan (PCARP) over the last year, with significant gains made through PCARP and the Capacity & Access Improvement Programme (CAIP). Through 2024/25, the regional assessment of Primary Care has been positive, being amongst the top performers in metrics such as the number of appointments delivered and pharmacy first consultations etc.

We note the collaborative efforts to develop the integrated Neighbourhood Teams. The LLR Chronic Kidney Disease Integrated Care Delivery Project is an excellent example of how the system is working in collaboration to provide equitable care for adults with Chronic Kidney Disease. The project also demonstrates the systems progress towards achieving the 'left shift' from hospital to the community.

The ICB established 3 women's health hubs in 2024/25 and will continue to develop and implement plans to improve the healthcare of girls and women and reduce inequalities. The ICB has plans in place to sustain its women's health programme in 2025/26.

Section 3: Tackling unequal outcomes, access and experience

The ICB 5 Year Plan, ICP strategies, and health and well-being plans set out a clear vision and aligned priorities including preventing ill health. The Collaborative/Partnerships in place such as VCSE Collaborative has a core focus on health prevention.

There is clear evidence that health equity and Health Inequalities remain a key priority for the ICB. Strategies and plans are designed to support prevention, promote equity and improve population health outcomes. Plans are driven by an embedded approach to Population Health Management, supported by the Health Inequalities Unit, which ensures the system understands and plans for the needs of the local population. ICB Board papers in February 2025 demonstrate Board oversight of Health Inequalities, with assurance reports from the ICB Health Equity Committee presented to the ICB Board and the Board being asked to approve the publication of Health Inequalities report in LLR.

The ICB Finance Team has been instrumental in developing a new strategic long-term model of primary care (GP practice) funding, distribution and investment. This will 'level up' funding based on population need rather than historical allocation. The LLR Primary Care Funding Model has gained significant national and regional interest from NHS England, the Department of Health and Social Care and other ICBs.

The ICB is recognised both nationally and regionally for its approach to Population Health Management approach and supporting interventions, with some excellent examples spanning across several programme areas. We were pleased to be shown recently the newly implemented cancer screening dashboard which has been developed to understand the gaps in uptake to allow

focused work in specific areas to improve access and understand population take up of screening services.

Regarding prevention the tobacco dependency treatment, a steering group oversees all of the tobacco work within the NHS and Local Authority, with in-reach provision and Local Authorities providing services within trusts. All tobacco workstreams are well established within the system. The tobacco dependency treatment service at UHL receives the highest number of referrals compared to all other acute trusts across the country.

Acute hospitals in Leicester rank first nationally with the highest number of referrals to community services. However, referrals into the digital weight management programme are lower than in previous years and the percentage of eligible referrals has seen a decrease from previous years.

The alcohol care team service is now permanent, delivered as a commissioned service by the Local Authority. The service has seen improvements and is now offering Fibroscans alongside management and support.

The ICB published its response to NHS England's Statement on Information on Health Inequalities (duty under section 13SA of the National Health Service Act 2006) in January 2025 and the ICB should ensure that this is updated in line with its Annual Report in 2025.

Section 4: Enhancing productivity and value for money

The system remained challenged in relation to its use of resources and financial position in 2024/25. It was disappointing that the system outturn was a deficit of £34.7m against a breakeven plan, however the ICB achieved break even in line with plan. The total system efficiency delivery was £137.7m against a plan of £161.7m The ICB delivery was £59.8m against a plan of £61.6m but recurrent efficiencies were £6m over plan. In addition, bank spend was £80.8m against plan of £62.8m.

The ICB has met the planning guidance requirements in relation to agency by achieving spend against the baseline planned pay of 2.6%. Universal support included off framework removal and price cap spend reduction for nursing and other staff groups; targeted support included removal of off framework, specialised nursing price cap negotiations.

In relation to productivity, the system is 10.1% below 2019/20 productivity levels but 3.8% up on 2023/24. Despite this, evidence suggests that the ICB and system have not been realising the Productivity and Efficiency opportunities available to them i.e. in comparison to Month 10 2023/24 the ICB's overall Implied Productivity (new methodology) has increased from -9.4% to +2.5% at Month 10 2024/25. Implied workforce Productivity Growth (new methodology) has increased from -14.5% to 8.5%. The national Productivity Packs, published during the 2025/26 planning round, provided further evidence that several productivity and efficiency opportunities were not being realised.

The ICB Finance team continues to work well with NHS England, with clarity of the issues, but it has remained a challenge to ensure the providers have well-developed medium term financial plans, which is similar to the concerns in the previous year. UHL has remained in the national Recovery Support Programme (RSP) and has Undertakings in relation to finance in place. NHS

England continues to work with the ICB and UHL regarding oversight of delivery of their financial recovery plan and delivery of the RSP transition criteria.

The ICB leadership actively oversees and supports digital maturity initiatives across the system, ensuring robust governance for the rollout of key digital infrastructure, patient-facing technologies, and the comprehensive adoption and utilisation of national platforms. The ICB has been onboarded to the Federated Data Platform (FDP). UHL is live with the Inpatients product via the FDP, demonstrating concrete adoption and utilisation of a key FDP capability. This signifies effective progress in establishing a modern, integrated data infrastructure. For 2025/26, priorities include the continued utilisation and further embedding of FDP capabilities to enhance system-wide digital maturity.

In 2024/25, the ICB demonstrated strong delivery against its digital maturity plans. All eligible GP Practices successfully transitioned to high-quality Cloud-based Telephony. Online Consultation (OC) tools are available to all General Practices, with contractual arrangements secured for 2025/26, and work continues to ensure availability during core hours. The NHS App is promoted at ICB and local level, with uptake and usage increasing at a fast pace.

As demonstrated above, the system has made significant progress in 2024/25 moving from analogue to digital. Moving into 2026, UHL is implementing a new Patient Administration System In diagnostics, the system is part of the East Midlands-wide pathology network and is making plans to onboard to the national LIMS platform. On Cybersecurity, the system has demonstrated an exemplary approach to investment through collaboration with Northamptonshire
Research in LLR remains strong, with an executive lead and clear governance structure for research in place. The Research Strategy group meets bi-monthly and has representation from all key research partners. An example of the work done was the Research passport service provided by the ICB on behalf of Primary Care delivering 65 Letters of Access for researchers in 2024/25, along with a process in place for issuing confirmation of Capacity and Capability for Research within the ICB. Since April 2024, the ICB has delivered strategic support, expert advice, and tailored guidance for over 58 projects across LLR, centring on funding applications, training opportunities, and project proposals, to secure outcomes that bring value to the ICB and meaningful benefits to the local population.

The ICB does not have dedicated research funding streams, all research funding received is a result of funding applications/bids that have been successful. In 2024/25 £274,125 in external funding was secured.

LLR has the highest total recruitment to NIHR Portfolio studies within NHS trusts in the region (29,371), outperforming other areas. LLR also excels in GP practice recruitment with 5,416 participants. The system achieved 65% of GP practices recruiting, significantly more than others, demonstrating strong engagement with primary care settings.

The LLR Research Engagement Network (REN) were successful in securing £110,000 to continue its work from 2024/25 and has actively engaged under-served ethnic minority groups to raise awareness and increase participation in research. This has been achieved by several methods including: the training and support of multilingual community ambassadors in partnership with the voluntary sector and working with research teams to deliver a series of roadshows and events encouraging sign up for the National Research registry.

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

The ICB has implemented shared priorities across the system with an evident golden thread in the ICP Improving Health and Wellbeing Integrated Care Strategy, setting out a collective vision, principles and priorities, and aligned to the strategic priorities outlined in the ICB 5 Year Plan. The ICB is an active member of the three Health and Wellbeing Boards and worked in partnership to develop and implement the BCF plan.

The ICB has established a VCSE Alliance and the LLR Disabilities Collaborative to drive transformational change across the system, which is the first of its kind nationally. UHL supports and hosts Project Search, the aim of which is to improve employment opportunities for people with recognised learning disabilities. Recognising that for economic and social development to occur, the healthcare offer to the local population has to be delivered equitably and to those who need it most.

The Health and Wellbeing Integrated Care Strategy sets out how the ICB will work with partners to act as an anchor organisation. The document outlines actions partners will undertake to achieve this. The actions and plans are also reflected in the ICB 5 Year Plan describing the bringing together of partners from across health and social care to work with local communities to make a positive difference and create opportunities.

These strategies are underpinned by the 'one workforce' approach to bring estates, resources and facilities together as part of a shared anchor agenda. This is also underpinned by the 3-year Green Plan which outlines the collaborative vision and actions to support the delivery of sustainable healthcare while ensuring the ICB impacts positively on the local environment and delivers against national requirements.

The LLR Health and Care People Plan is overseen by the People and Culture Board, and reports to the board through the LLR system Executives. There have been some key successes with some recognised nationally and regionally as best in country including: the Women In leadership conference, Active Bystander Training, Inclusive ICS of the Year, Developing Diverse Leadership Programme, Sexual Safety Charter implementation and the Work Well vanguard. To measure the impact of the People and Culture programmes, a culture dashboard has been developed.

The ICB has robust arrangements in place to ensure its duty to improve equality, diversity and inclusion is delivered and is assured through the Health Equity Committee. The ICB produced a Public Sector Duty Equality, Diversity and Inclusion Annual report 2024/25 which set out the progress made in relation the equality actions and objectives and how the ICB is meeting its Public Sector Equality Duty and other statutory and NHS mandated requirements in relation Equality, Diversity and Inclusion (EDI).

Although not mandated for ICBs, the ICB analyses WRES and WDES (workforce race and disability equality standards) and uses this information to report into the Equality, Diversity & Inclusion (EDI) improvement plan and Equality Delivery system. Further evidence demonstrating good practice examples include: 'Your Voice', an online tool for LLR staff for reporting bullying, harassment, victimisation and discrimination.

In relation to net zero, the ICB continues to show good progress on the Greener agenda, updating the Green Plan in line with their statutory duties. However, it is noted that the retirement of the

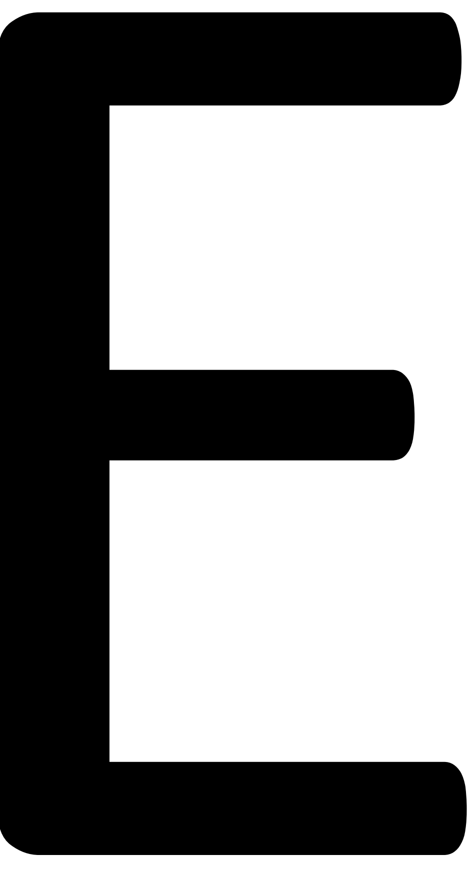
current SRO and uncertainty over the future operating model may cause some delays. There is good engagement from providers, but this could improve with more embedding across the system. Focus areas are progressing well, but it is noted that the Fleet Data Collection return is not submitted, so this position is unclear. An area of positive work is the 7.9% reduction in inhaler emissions and there is compliance against the implementation of the net zero and social value requirements for new procurements.

Conclusion

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. 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 we look forward to working with you to support improvement and performance throughout your system.

We ask that 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.



Name of meeting:	Leicester, Leicestershire and Rutland Integrated Care Board – Public Board meeting		
Date:	14 August 2025	Paper:	E
Report title:	Update on transformation of ICBs and Joint Transition Committee assurance report		
Presented by:	Rachna Vyas, Chief Operating Officer and Deputy Chief Executive		
Report author:	Alice McGee, Chief People Officer and Transition Director		
Sponsor:	Toby Sanders, Chief Executive Officer		

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

Recommendations:

The LLR Integrated Care Board is asked to:

- **Receive and Note** the approach to the transition

Purpose and summary of the report:

The Joint Transition Committee has commenced meeting to consider the safe transition in 2025/26 for the ICB cost reduction programme and move to Model ICB. The Board will receive a regular assurance report on the committee and will have decisions escalated as appropriate. This is the first report in the public board and summarises the approach to transition since March 2025 national announcements.

Appendices:	
Report history (date and committee / group the content has been discussed / reviewed prior to presenting to this meeting):	29th May 2025 – extraordinary Private Board, Transition Committee Terms of Reference 12th June 2025 – Private Board, Transition update

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	Conflicts identified for Board members as will be directly affected by change

☐	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.*	BAF 01 – Partnership BAF 02 – Health Inequalities BAF 03 – Demand and Capacity BAF 04 – Finance BAF 05 – Quality & Safety New BAF to be created to reflect the risk of transition
b) Does the report highlight any resource and financial implications? If so, provide which page / paragraph this can be found within the report.	Yes, redundancy cost risks are within the change programme and confirmation of national funding is not confirmed.
c) Does the report highlight quality and patient safety implications? If so, provide which page / paragraph this is outlined in within the report.	Yes, requirements to maintain statutory functions during transition and until legislation changes will be a feature of the transition plan.
d) Does the report demonstrate patient and public involvement? If so, provide which page / paragraph this is outlined in within the report.	No, this transition does not require public engagement but stakeholder plan does include engagement of the community.
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.	A full Equality Impact Assessment will be completed as part of the transition. An initial EIA on the management of change process has commenced and has been reviewed by Transition Committee and Social Partnership Forum (unions).

Update on Transformation of ICBs and Joint Transition Committee Assurance Report – June 2025

Context

1. In March 2025 a national decision was made to significantly reduce the size, remit and expenditure for ICBs, alongside radical changes to NHS England and regional teams.

2. Nationally, for ICBs, the expectation is that all ICBs implement a change programme to reduce costs by up to 50% and transform into strategic commissioners. In May 2025, the Model ICB guidance was published and Boards were required to submit plans on how each Cluster and organisation would meet the financial and future model. These plans were approved at extra ordinary Boards before submission on 30th May 2025.

3. As part of the proposal to comply with the national directive, LLR and Northamptonshire ICBs proposed a clustering arrangement as it was felt that neither organisation was viable on their own given the significant cost reductions. This was supported by the respective Boards and approval was received by NHS England to progress with a Cluster arrangement.

4. The principles of the Cluster, which is not necessarily a route to a merger include:

    a. A single Executive team.
    b. A single staffing and functional structure.
    c. Shared governance, including committees in common and joint committees as appropriate.
    d. Continuing with the statutory duties as two organisations but discharging through a single team.

5. The target saving for LLR and Northamptonshire is 31% collectively based on the achievement of £19.00 per head of population. The principle of the change is that the achievement of the respective financial target reductions will only be achieved together and Table 1 shows the scale of the reductions required by organisation and by Cluster.

Table 1

	LLR	Northamptonshire	LNR total
Total weighted population	1,124,240	816,244	1,940,240
Current total running costs	£31.7m	£21.5m	£53.2m
Required savings	33%	29%	31.4%
Actual £ saving required	£10.6m	£6.1m	£16.7m
Headcount as at 31st March 2025	335	205	540
WTE as at 31st March 2025	286 WTE	184 WTE	469 WTE

6. It is expected that these changes and the reductions will be in place by the end of Quarter three of the financial year, although nationally there has been some concerns about the pace of that change and the affordability of any redundancy implications. It is expected the pace of change will continue into Quarter 4.

7. Both ICBs built in assumptions about in year staffing costs being part of the operational cost improvement programme to meet financial balance, therefore, any slippage on the timeline will have an impact on financial balance, irrespective of the cost of redundancies.

Transition Committee

8. The Transition Committee was set up in shadow form in May 2025. The draft Terms of Reference were considered at an extraordinary Board on 29th May 2025 and feedback was received from members of the Board and finalised in June 2025.

9. The primary purpose of the Joint Committee is to oversee and scrutinise arrangements for the transition of the ICBs into their future operating model, in line with national guidance. This is particularly focussed on the internal transaction of leading a management of change and readiness for any changes in the delivery of functions, particularly statutory functions.

10. The committee is not a decision-making committee, any decisions will be reverted to the respective ICB Board, Committees or Officers, or to NHS England, in line with each ICB's Governance Framework.

11. The Transition Committee has created a risk and issues log to consider during the transition. This is a dynamic risk log that will consider emerging risks and the mitigations in place. It was agreed at the first meeting that it is appropriate that an overarching risk about the transition should be put on the Board Assurance Framework (BAF) for consideration at Board. This will be updated and presented to the respective Boards.

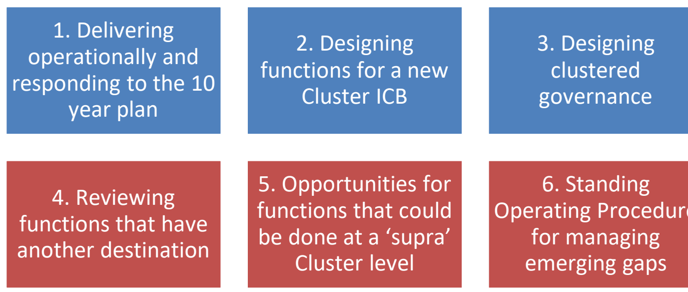
12. In summary the risk and issues log consider the likelihood and impact of issues across the following areas:

    a. Oversight of the transition across the complexity of all the functions.
    b. Readiness assurance of any transferred functions, including resources, legal basis and receiver readiness.
    c. Impact of clustering on place and neighbourhood development including relationships with partners and development of improved outcomes for the population.
    d. Financial risks associated with transformation (cost of management of change and ability to deliver in year plans).
    e. Workforce turnover, morale injury and risk of employee relations cases up to and including employment tribunals as a result of the management of change process.
    f. Pace of change, linked to the need for national guidance and an ambitious timeline for implementation.

Programme oversight

13. The programme of transition has been set out to consider 6 core programmes of work, which have a range of stakeholders involved in the development. Diagram 1 shows the key programmes of work that are reported via Transition Committee.

Diagram 1



14. Progress has been made in a significant number of programmes and table 2 below shows the key highlights of progress for the Board to be aware of.

Table 2

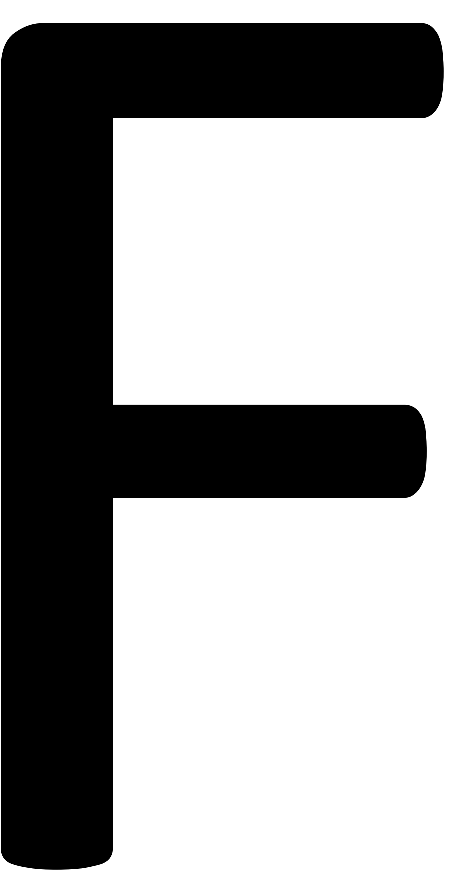
Programme 2 – Designing functions for a new Cluster ICB	Consultation for a new Clustered Executive team commenced on 24th July 2025. The Outcome of consultation and implementation of the structure will take place in August and September 2025. Following this, further steps will be taken regarding design for the rest of the organisation. The appointment of a new Cluster CEO and Chair is being led by NHS England and outcomes of these processes are subject to approval by ministers and NHS England, the outcome of which will be confirmed in the coming weeks.
Programme 3 – Designing clustered governance	In June 2025 a development session took place between NEDs and Executives from both organisations to agree the principles of design of a new governance approach considering the need to meet the 'model ICB' requirements and a reduced workforce. Design workshops will take place in Quarter 2 to consider readiness for Cluster arrangements of the governance of both organisations by October 2025. It is anticipated that by October 2025, as a minimum, Boards will meet in common for both public and private meetings.
Programme 4 – reviewing functions that have another destination	There are 17 functions that ICBs currently undertake that are going to be undertaken by another public body in the future, these functions are listed within the Model ICB and are broadly described as:

	- Going to a NHS Provider - Going to NHSE/DHSC regional offices - To be explored further Many of the functions are described within primary legislation, therefore the ICBs are working with partners to consider the implications and timelines for any functional changes.
Programme 5 – Functions that could be done at a 'supra' cluster level	As part of the review of functions it was identified that some of the corporate and statutory functions could be done on a footprint that is larger than the Cluster. The primary aims would be to increase the efficiency, attract expertise, improve quality. Currently 12 functions are being explored as potentially being done at a larger footprint than the Cluster – either East Midlands or Midlands. The programme is exploring the opportunities and considering the announcement in July that CSU's (Commissioning Support Units) will cease as part of the national transformation agenda.

Recommendations

The LLR Integrated Care Board is asked to:

- **Receive and Note** the approach to the transition.



Name of meeting:	Leicester, Leicestershire and Rutland Integrated Care Board (public)		
Date:	14 August 2025	Paper:	F
Report title:	Leicester, Leicestershire, and Rutland ICB Research & Development Report		
Presented by:	Dr Nilesh Sanganee, Chief Medical Officer, NHS LLR ICB Carly McDonald, Research Manager, NHS LLR ICB Professor Michael Steiner, Deputy Chief Medical Officer, NHS LLR ICB		
Report author:	Carly McDonald, Research Manager, NHS LLR ICB		
Executive Sponsor:	Dr 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:	• *Appendix 1 – Partner Updates* • *Appendix 2 - Research in Strategic Commissioning*
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
14th August 2025

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

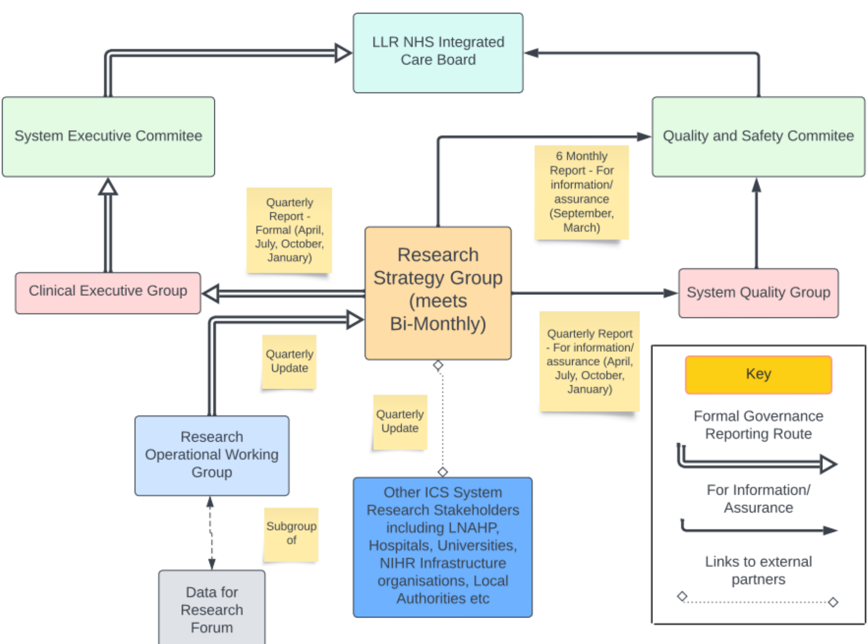
3. Responsibility for ICB research management sits within the Quality and Safety team of the Clinical Quality & Performance Directorate. The Senior Responsible Officer for Research is the Chief Medical Officer (CMO), who sits within the Medical Directorate.

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

5. The CMO and Deputy Chief Medical Officer (DCMO) actively support research across the system, including endorsing and facilitating research project funding bids. They also provide strategic and operational support to the Research Manager, helping to ensure alignment with organisational priorities and the wider research agenda.

6. Governance arrangements for research in the ICB are outlined below.

Figure 1: LLR ICB Research Governance Structure



Summary of ICB Achievements

7. The LLR ICS Research Strategy was approved by the ICB Board in August 2024. This strategy has been collaboratively developed by the ICB and all ICS Research system partners. The document consists of 3 sections:
    1. The ICS Research Strategy
    2. Mapping our Research infrastructure section
    3. Governance section

8. The LLR Research Strategy Group (RSG), chaired by the ICB Chief Medical Officer, and delivered by members of the medical directorate (MCS) and research management (CM) underwent a significant refresh this year, prompted by a change in leadership. As part of this process, the group updated its terms of reference, established a comprehensive work programme, and expanded its membership to ensure as many system partners as possible are engaged and informed about the group's work. In December 2024, the RSG hosted its first-ever face-to-face meeting, which was a resounding success, bringing together over 20 delegates representing system partners from across Leicester, Leicestershire, and Rutland.

9. The research passport service supports GP practices in participating in research by processing Research Passports (for HEI employees) and NHS-to-NHS Proformas to issue Letters of Access (LoAs). The ICB has a robust process, including SOPs and templates, to manage LoA requests. From April 2054 to August 2025, 25 LoAs were issued, with 12 active requests in progress.

10. Since April 2025, the ICB research team (CM, MCS) has delivered strategic support, expert advice, and tailored guidance for over 30 projects across Leicester, Leicestershire, and Rutland. This assistance has centred on funding applications, training opportunities, and project proposals, with the goal of securing outcomes that bring significant value to the ICB and meaningful benefits to the local population.

11. 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 FY 24/25, the ICB was successful in securing £102,664 of research funding. We have also actively supported other research grant submissions from partner organisations where the ICB is a key partner in the research and will benefit from the research being undertaken in our region. This has contributed to a total value of around £500,000 in income to the LLR health and life science economy.

    An overview of ICB led funding calls that have were successful are outlined below:

Research Engagement Funding 24/25 (£42,664):

- Project 1: Extend contracts of 2 Research Champions to 01 Oct 2025 to continue their work in patient recruitment and practice activity.
- Project 2: Allocate additional hours for a part-time staff member to lead research implementation for LTC/Mental Health collaboratives and develop the ICS Research Strategy implementation plan.

- Project 3: Organise two events to advance the research strategy: a development session in Dec 2024 and a workshop with key stakeholders to refine the implementation plan.

Research Capability Funding (£50,000):

- Continue secondments of 2 Research Champions.
- Offer remaining funds to Primary Care and other out-of-hospital settings via a competitive bidding process. Supported 2 applications.

Underserved Communities Funding (£20,000):

- Support the ongoing Research Engagement Network Development (REND) project, adding a mental health arm in collaboration with Mind, Headway, and Sharma Women's Centre.

12. So far, in FY25/26 we have secured £138,701 which will be used on the following projects:

Research Engagement Funding 25/26 (£33,701):

- Project 1: Extend contracts of 1 Pharmacist Research Champion to 01 Oct 2026 to expand the reach of pharmacy research engagement and activity.
- Project 2: Continue the additional hours for a part-time staff member to lead research implementation for LTC/Mental Health collaboratives and develop the ICS Research Strategy implementation plan.

Research Capability Funding (£55,000):

- Continue secondment of 1 Research Champion, with a focus on raising awareness across GP trainees and NMAPPs.
- Remaining funds use to be determined.

Innovate UK Weight loss Accelerator (£50,000):

- This project proposes an innovative, community-based model to improve access to obesity care in Leicester, Leicestershire, and Rutland. By leveraging community pharmacies and co-designing with underserved populations, it aims to address barriers to engagement and lay the foundation for a scalable, inclusive, and patient-centred obesity pathway. Potential to access additional £2-3M funding for innovative obesity therapies from later in 2025 from Innovate UK.
  The project will focus on three areas:
  1. Identifying tools and strategies (e.g. digital communication, population segmentation) to locate and understand target populations.
  2. Co-designing access pathways for groups facing barriers to engagement.
  3. Understanding the additional resource required to reach and support these groups to inform future business planning.

<u>Summary of ICS Achievements</u>

13. The ICS consists of many health and care organisations that are research active. Below are some examples of fantastic work and developments that are occurring across the system:

- **Applied Research Collaboration (ARC) Refunding Bid:** Leicester are a key partner in this bid. If successful, LLR ICB (Prof Steiner on behalf of medical directorate) will lead a council of ICSs across the EM ARC footprint that will provide a consistent engagement vehicle for the ARC.
- **University Hospitals of Leicester NHS Trust (UHL)**: secured funding as part of a £100m national investment to give more people the opportunity to take part in health research. Based at the Leicester General Hospital, the National Institute for Health and Care Research (NIHR) Commercial Research Delivery Centre (CRDC) will act as a regional hub for pioneering clinical trials.
- **University of Leicester**: LLR ICB has a strong relationship with the University of Leicester based on areas of mutual interest and a shared vision for improving health and well being for people in LLR.
    - CMO award of honorary chair highlights the productivity and value of this relationship
    - Shared development of college of leadership over coming years
    - Collaboration of newly formed UoL Centres for epidemiology and public health and population health management with ICB.
    - Appointment of DCMO to chair of proposed ARC regional ICS council (subject to ARC refunding bid) and as director of LNAHP
- **East Midlands Ambulance Service (EMAS)**: had a successful year for research in 2024. In the year 23/24 they finished second for recruitment into CRN East Midlands Trauma & Emergency portfolio studies, in large due to their recruitment into the PARAMEDIC-3 study.
- **De Montfort University (DMU):** preparing to launch NIHR INSIGHT (East Midlands) scholarships, 2025 entry.
- **The Leicester & Northamptonshire Academic Health Partners (LNAHP)**: continuing collaboration with their partners to develop the LNAHP Health Innovation Hub (HIH), a collaborative initiative that aims to streamline and support healthcare innovation. Prof Steiner (DCMO) has been appointed as LNAHP director.
- **The Health Determinants Research Collaboration (HDRC):** continue to make progress with their development year. In November they held their first staff research skills conference, and in June 2025 they held a Health Inequalities conference, supported by the ICB (NS, MS, CM).
- **Leicester Partnership Trust (LPT):** successfully recruited 12 new care homes, bringing their total to 44 homes on the ENRICH register. ENRICH is a dynamic national database that connects care homes, staff, resident, and their families with researchers, fostering exciting opportunities for collaboration.

Further Updates are avalible in *Appendix 1 – Partner Updates.*

Research Implementation

14. It is vital to understand the capacity of our partnerships and collaboratives to apply research knowledge in their decision-making processes. To assess this, we conducted a survey asking all partnerships and collaboratives to self-rate their competencies across 13 key areas, including skills to access research evidence, data analysis capabilities, and awareness of knowledge and library services. The survey results revealed varying levels of competency in utilising research evidence, highlighting both strengths and areas requiring targeted support to enhance evidence-based decision-making across the system.

15. Following the launch of our ICS Research Strategy an implementation plan to ensure we are working towards our ambitions over the next 5 years is currently under development.

16. Evidence from rigorously tested research trials is essential for driving improvements in clinical practice and service delivery. By applying research findings, we can enhance patient outcomes, improve efficiency, and address local health needs. Below are examples of 2 studies conducted in Leicester that have directly informed service changes and the adoption of innovative practices across our system.

- Falls Steady Steps: The FaME (Falls Management Exercise) programme, piloted and evaluated by the University of Nottingham in Leicestershire and Rutland, was funded by Public Health and the Better Care Fund. The programme is now rolled out across LLR and funded by the ICB
- Egg Donation Study: This interdisciplinary study, led by De Montfort University in collaboration with institutions in Belgium and Spain, was funded by the ESRC. Its egg donation films are now featured by the UK's Human Fertilisation and Embryology Authority and will soon be adopted by the Donor Conception Network, providing crucial information for donors and recipients.

LLR Research Recruitment

17. Recruitment into research studies is a key indicator of how well an area is engaging with research activity and contributing to evidence-based healthcare improvements. It reflects the level of participation across NHS Trusts, GP practices, and other community settings, as well as the engagement of healthcare professionals and the local population in research. Below, we compare recruitment figures from FY24/25 across counties in the region, highlighting areas where Leicestershire is performing well and identifying opportunities for further improvement.

Figure 2: East Midlands Research Recruitment FY24/25 (to February 2025)

County	Total Recruitment	In NHS Trusts	In GP Practices	In Other Settings	% of GP Practices Recruiting
Derbyshire	6,918	6,010	806	102	11%
Leicestershire	25,943	21,565	4,161	217	60%
Lincolnshire	6,392	4,981	1,386	25	36%
Northamptonshire	8,603	7,867	723	13	28%
Nottinghamshire	17,333	13,910	3,159	264	33%

Areas Where Leicestershire Is Performing Very Well: Leicestershire has the highest total recruitment (25,943), significantly outperforming other areas. Leicestershire also excels in GP practice recruitment with 4,161 participants, more than double any other area. Nottinghamshire (3,159) is the closest. Leicestershire achieves a remarkable 60% of GP practices recruiting, which is nearly double the next highest percentage (36% in Lincolnshire). This demonstrates strong engagement with primary care settings.

Areas for Improvement: While Leicestershire has 217 participants recruited in other settings, it lags behind Nottinghamshire (264). This could indicate an opportunity to expand recruitment efforts beyond NHS Trusts and GP practices, targeting settings like community care, schools, or other public venues.

18. Our four Primary Care Research Champions have made significant progress. To enhance their impact, we've added a commercial research focus, encouraging practices to undertake more complex studies. They hosted a commercial research webinar for primary care colleagues to support engagement with commercial research opportunities. We've also engaged community pharmacies in research, with 36 pharmacies in Leicester, Leicestershire, and Rutland participating in the FluCare study, delivering flu vaccination clinics in care homes for staff. A review of their activity is available in *Appendix 1 – Partner Updates.*

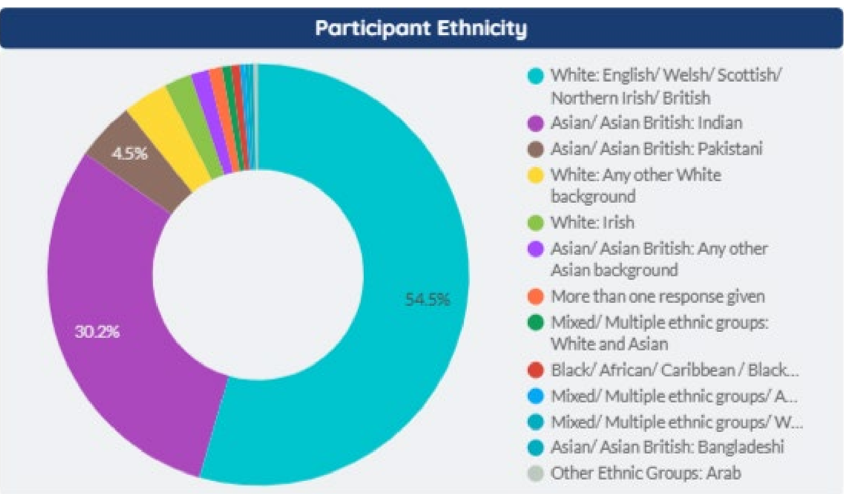
Public and Patient Engagement and Satisfaction

19. 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. 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. 300 responses have been received so far this year across LLR, out of these:

- 95.6% of patients felt they had been adequality informed of what to expect during their research project participation.
- 85% of patients feel they have been kept updated about the study they are on.
- 84.7% of patients know how they will receive the results of the research study they participated in (at least to some extent).
- 94% of patients knew how to contact the research team if they had any questions outside of a study visit.
- 97% of patients felt they had been treated with kindness and respect during their research study participation.
- 93% of patients would consider taking part in research again.

Figure 3: Pres Survey Participant Ethnicity



21. In September 2024, the ICB's Engagement and Insights Team held two research webinars for the LLR VCSE Alliance (230+ organisations) based on feedback. The first covered data collection and analysis, and the second focused on using insights to improve services and support funding proposals. Attendees were also guided on using the ICB's online patient experience library. The Centre for Public Innovation delivered the webinars, which participants found practical and useful, along with the accompanying toolkit.

22. The Research Engagement Network (REN) is a program funded by NHS England and the Department of Health and Social Care to increase participation in health and care research by underrepresented groups. The LLR REN program has actively engaged under-served ethnic minority groups to raise awareness and increase participation in research. This has been achieved by several methods including:
    - The training and support of multilingual community ambassadors in partnership with the voluntary sector
    - Working with research teams to deliver a series of roadshows and events encouraging sign up for the National Research registry.

      Additionally, the REN ambassadors are producing a video with University of Leicester to explain research, its importance, and how to participate and launching a community art project for young people, including those with learning difficulties themed “Well in the Future -the role of research in improving family health’’.

23. Public and Community Involvement, Engagement and Participation (PCIEP) has been a key focus of HDRC this year. They have now recruited 7 members to their Public Advisory Group (PAG), who have received three training sessions on Research, EDI and Wider Determinants of Health and have been involved in developing the PCIEP strategy. They are also involved in developing plans for our Citizens’ Assembly and Youth Engagement which will inform the HDRC research priorities

Potential Risk/Challenges

24. A key risk to delivering our research objectives is the limited management capacity within the ICB research team. This constraint impacts our ability to fully support the growing volume of research activity across the system and to attend to all projects, funding

opportunities, and collaborative initiatives. While we prioritise high-impact work, the current capacity limits our ability to proactively expand research support and fully embed research across all areas of the ICB's remit. Addressing this risk will be essential to sustaining and building upon our research achievements.

25. The release of the new model Integrated Care Board (ICB) suggests that research will become a regional function, with strategic partnerships remaining under the remit of the ICB. However, there is currently no clarity on how this will be implemented in practice, particularly in relation to the statutory duties that ICBs are expected to uphold. This uncertainty presents a risk to the continuity and visibility of the research work already embedded locally across Leicester, Leicestershire, and Rutland.

26. The capabilities and resources that exist among academic partners of the LLR ICS are likely to be crucial to delivering the new model ICB vision. These include support for epidemiology and population health management, health economics, data science and advanced analytics (Machine learning and AI) and rapid deployment and scaling of innovation. The loss of ongoing ICB support to access these functions and continue the achievements outlined above is a significant risk as the ICB transforms. There is to date no clear NHS body suitable to receive research functions at a regional level. Moreover, ensuring that the local voice remains central in shaping regional research priorities will be critical to preserving the integrity and momentum of our existing research initiatives. The success of the LLR ICS research strategy group puts us in prime position to deliver research functions at a regional supra-cluster level and we have received strong support from local academic partners for us to do this (incl EM ARC, LNAHP). See *Appendix 2 - Research in Strategic Commissioning* for further information on the potential impacts of these changes.

<u>Conclusion</u>

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

28. LLR is leading the region in total recruitment, NHS Trust recruitment, and GP practice engagement. The focus on GP practice recruitment, with 60% participation, is a standout success. However, expanding efforts in "Other Settings" and ensuring a more balanced distribution of recruitment across sectors could strengthen overall performance.

29. LLR ICS is a leader in system research support both regionally and nationally and is in a strong position to deliver this function at a regional supracluster level

The LLR ICB board is asked to:

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

<u>Reference</u>

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].

Appendix 1

LLR ICB Research Champions: a review July 2024

Author: Dr Ian Brockhurst. MBChB BSc FRCGP MRCP. Partner, Pinfold Medical Practice, Loughborough, LLR ICB Research Champion

Acknowledgements:

- Dr Imran Farooqi (GP Partner East Leicester Medical Centre, and Research Champion)
- Vishal Mashru (Head of PCN Medicines and Research Cross Counties PCN, and Research Champion)
- Melissa Coleman (Operations Manager at Hugglescote Surgery, and Research Champion),
- Professor Michael Steiner (Deputy Chief Medical Officer LLR ICB, professor of Respiratory Medicine)
- Carly McDonald (Research Manager, LLR ICB)

Introduction

One of the core principles of the Leicester, Leicestershire and Rutland Integrated Care System (LLR ICS) is to improve outcomes in health and healthcare whilst tackling inequality in outcomes, experience and access (Link to the LLR ICS 5 year plan: From the office of: (icb.nhs.uk)). Since the Covid-19 pandemic, NHS England and other organisations have committed to increase public participation in research (https://www.gov.uk/government/publications/the-future-of-uk-clinical-research-delivery/saving-and-improving-lives-the-future-of-uk-clinical-research-delivery) . Supporting research is a statutory obligation for ICBs as set out in the health social care act. Coupled with this, the NIHR-INCLUDE project showed that some groups of patients were underrepresented in research (https://www.nihr.ac.uk/documents/improving-inclusion-of-under-served-groups-in-clinical-research-guidance-from-include-project/25435). Therefore, future studies should look to increase diversity in the participant base (https://www.england.nhs.uk/aac/wp-content/uploads/sites/50/2023/02/B1905-increasing-diversity-in-research-participation-v2.pdf.pdf).

Background

Building on the strong links with existing local and regional research stakeholders, the ICS has developed a strategy that seeks to embed research at the heart of patient care in the region. Aiming to give all patients the opportunity to take part in clinical research, the work is underpinned by the principle of increasing research capacity so that participating in research becomes "business as usual" for all partner organisations, whilst reducing health inequalities.

In 2023, the LLR ICS secured £50,000 of Research Engagement Funding from the Clinical Research Network East Midlands to employ four research champions. The successful candidates comprised of two GP partners, a PCN head of pharmacy and a practice

operations manager. The champions were allocated a number of Primary Care Networks (PCNs: collaborative groups of GP practices) to oversee that linked with their geographical area.

The role of the Research Champions (RCs) was to utilise research delivery knowledge and experience to support other practices and PCNs to participate in research, particularly those in areas of deprivation and high patient need. Also, to use their expertise and experience to talk to colleagues at a range of GP practices and from across the system, to better understand the barriers and facilitators to practice involvement in research and then work to develop innovative solutions with PCNs and the NIHR CRN East Midlands.

As a first step, the RCs aimed to increase practice participation in the local NIHR Research Site Initiative (RSI) Scheme, Research Surveillance Centre (RSC) virology and serology programme, signing up to the Clinical Practice Research Datalink (CPRD) and the Data For Research platform, a local data sharing agreement between Primary and Secondary Care to facilitate health research. In the process of doing this, the RCs were able to understand the barriers that practices and systems faced in engagement and participation in research.

The RCs employed a variety of approaches. This included presentations and attendance at regional meetings to gain access to large numbers of practices and key personnel. This was then followed up with meetings with PCNs and then individual practices. The RCs developed some basic resources for practices, including documents on getting started in research, flyers on the RSC programme and CPRD, glossary of terms and useful contacts lists.

Local Approaches	**Regional Meetings**
○ Meeting with other local research champions ○ Introductions with PCN clinical directors and presentations at PCN meetings ○ Individual practice follow-up ○ Development of useful basic resources for practices ○ Promotion of the RSI scheme ○ Promotion of the RSC virology/serology scheme ○ Promotion of CPRD and data-for-research ○ Attendance at the ICB research operational working group and research strategy group.	○ LLR multidisciplinary conference ○ Careers event with GP ST-3 trainees ○ Training hub online seminar ○ County and City PLT ○ Local Federation Board Meetings and practice managers meeting ○ County practice managers academy meeting

Table 1: Summary of approaches used by the LLR Research Champions

Results

The RCs started in their role in September 2023. Overall, there was an increase in research activity in Primary Care in LLR between the financial year 2022/23 and 2023/24.

Primary Care recruitment increased from 6,168 to 12,526 patients between 22/23 and 23/24 (**Fig. 1**).

The number of GP practices involved in research at any level increased from 81% to 94% over the same timeframe.

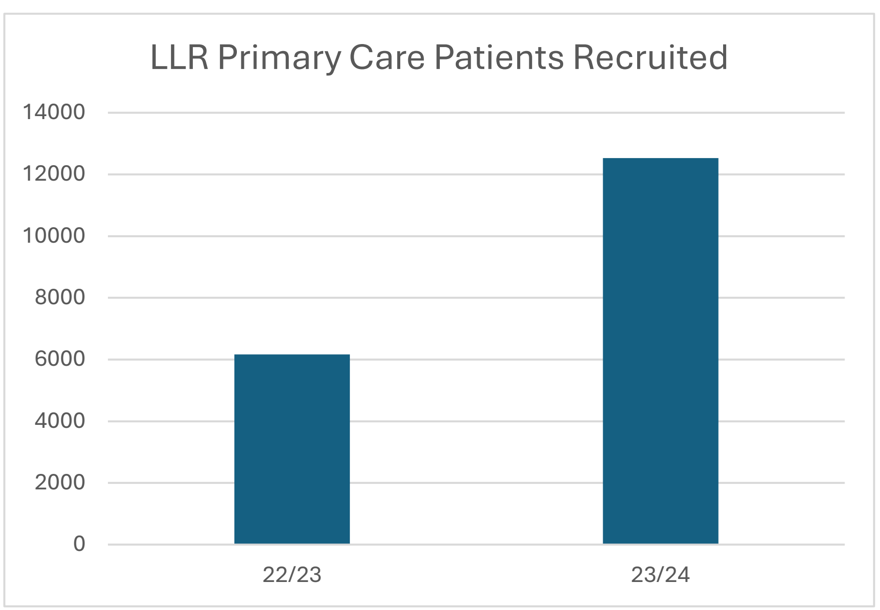


Figure 1. LLR primary care patient recruitment between 2022/23 and 2023/24

More practices signed up to the Clinical Practice Research Database (CPRD), increasing from 22 practice to 43 over 12 months (**Fig. 2**).

Figure 2: LLR practices signed up to CPRD

There are now 36 practices signed up to the Leicestershire Data for Research Platform. In 2024, LLR has 25 practices signed up to the Research Surveillance Centre.

The LLR Research Site Initiative (RSI) Scheme is a mechanism by which practices are funded by the Clinical Research Network East Midlands (CRN-EM) to undertake portfolio studies. There are four levels which attract increasing funding, depending on the number and complexity of studies undertaken.

There was a record number of LLR practices applying for the 2024/25 RSI scheme. This was an increase from 57 practices for the previous year, to 80 for the current year (**Fig. 3**). Furthermore, there were more practices applying for higher levels of the scheme (**Fig. 4**). This demonstrates not just an increasing number of practices getting involved in research but also an increasing capacity within practices able to undertake a larger volume of work.

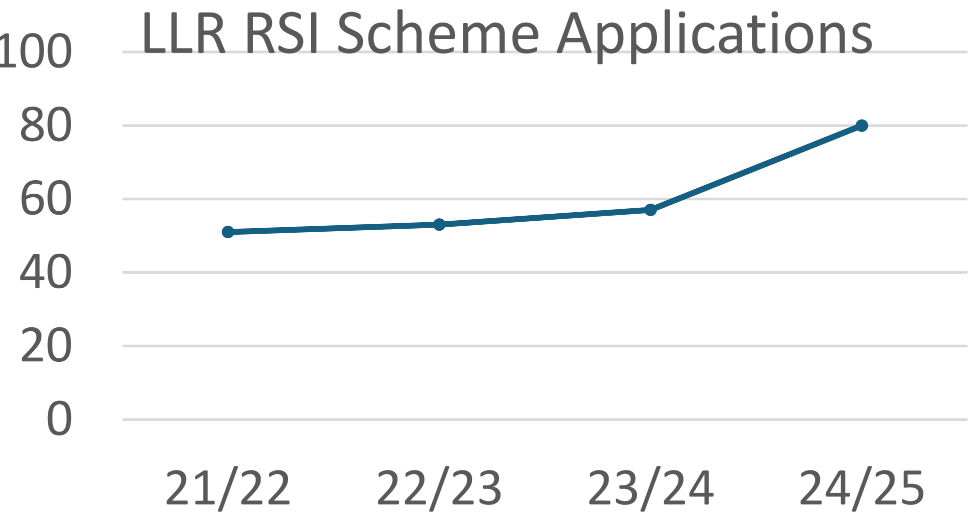


Figure 3: Number of applications for the LLR RSI scheme

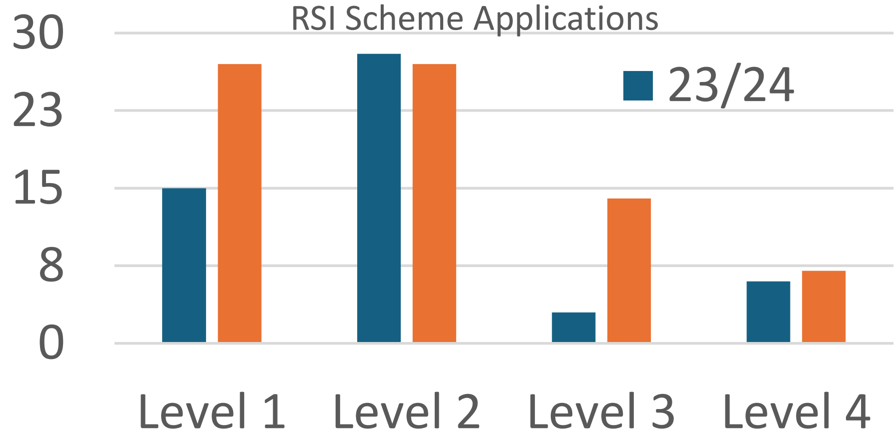


Figure 4: Number of applications for the different levels of the RSI scheme

Fig 5 and 6 is data taken from the NIHR Participant in Research Experience Survey (PRES) 2024. This demonstrates the increased ethnic diversity of research participants in Leicestershire. This includes Primary and Secondary Care.

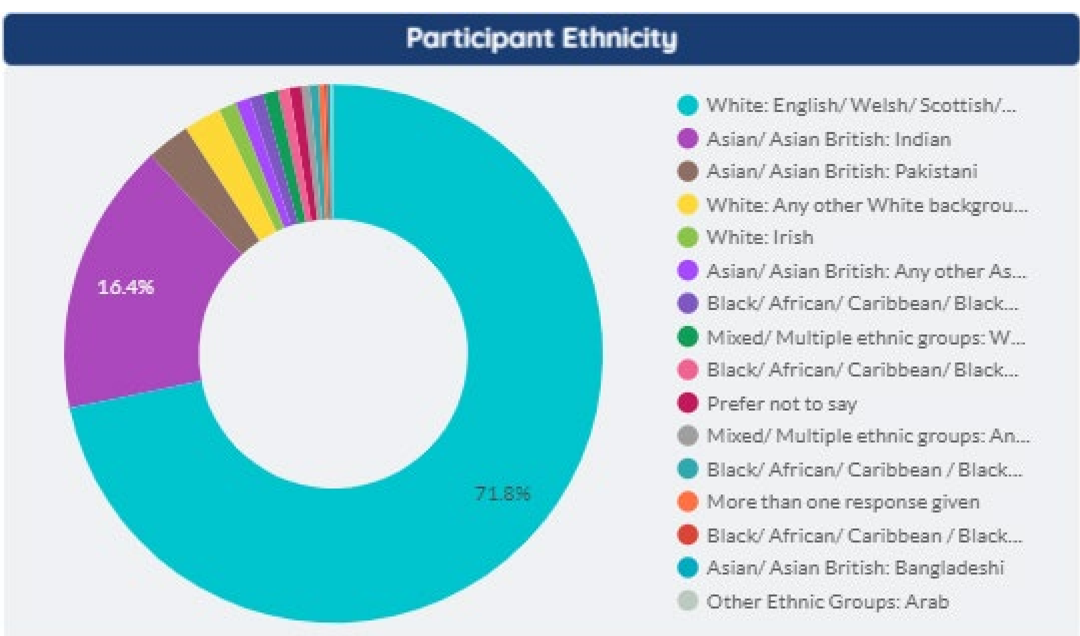


Figure 5: Research Participants in East Midlands by Ethnicity 2024

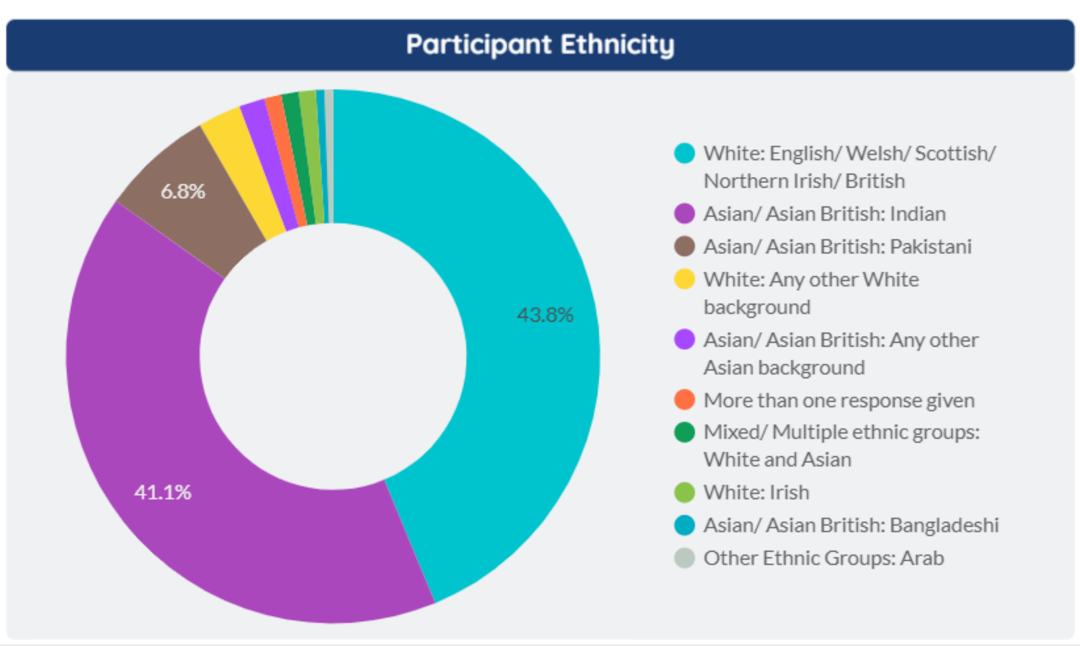


Figure 6: Research Participants in Leicestershire Primary and Secondary Care by Ethnicity 2024

There is also evidence of increased emphasis being placed on research at PCN level, with resources being spent on developing projects. For example, two PCNs have hired a “research co-ordinator" to support research activity in their member practices. Another PCN, following introductory meetings with one of the RCs, created a strategy group: practices working together and sharing information as they start their research journeys. Whilst it is not possible to quantify this impact at the present time, it demonstrates a research culture being embedded in some areas to support work in the future, catalysed by the RCs.

Understanding the barriers

In the course of their work, the RCs identified several barriers that practices and local organisations faced in implementing research into their workload. Firstly, at a practice level, key personnel (e.g. a practice manager and/or GP) needs to have an interest and see the value in research. Research is seen as an extra thing to do. Practices are already struggling to meet the demands and service provision of their core contract requirements and may simply not have the capacity to be able to contemplate optional extras. This was particularly apparent if there were key managerial staff vacancies. Funding is a key driver: practice finances are constrained, and they are looking to diversify income streams. Therefore, the RSI is looked upon favourably by practices: if they have the staff capacity to be able to deliver the work.

Instability at PCN level also had a ripple-down effect on practices. For example, if practices were leaving a PCN, or merging to form a new one, they would be less inclined to undertake research until these changes were complete. Some PCNs were more engaged than others in research, and often that was directly related to the culture from the clinical director and managerial team and the existing research experience within the member practices. There were examples of practices working together to utilise PCN resources to deliver some of the studies, including PCN-level research working groups and employed research co-ordinators.

Practices need a stable base to conduct research. Key ingredients of this include a research culture at practice and PCN level, a stable managerial and clinical team and adequate funding.

There is also a lack of awareness of the opportunities of research in Primary Care in certain cohorts of the workforce. When presenting at a careers event for over 100 ST-3 GP trainees, it was apparent that very few of the future GPs were even aware that research was conducted in Primary Care. This was also the case when presenting at meetings for allied health professionals that work in GP practices: e.g. First Contact Physiotherapists, Pharmacists and Mental Health Practitioners. Longer term investment in first-5 GPs and allied health professionals could embed research into their training and help to develop a more sustainable research culture in Primary Care.

Conclusion

Whilst we cannot definitively attribute the uplift in research engagement to the work of the champions, our experience of speaking to colleagues on the ground in practices and PCNs is that the persuasive influence of co-workers who already work in primary care was highly effective in driving up engagement. Each of the RCs have success stories of several practices they have directly supported to start on their research journey. It is hoped that this starts to embed research into the normal working culture, to make participation available to all patients and their GP practices in Leicestershire.

Next Steps

The appointment of the 4 RCs has had a positive impact on the engagement of GP practices in Leicestershire and has started to understand some of the barriers to further growth. The LLR ICB and NIHR CRN EM have agreed to continue funding the RCs to further engage Primary Care, promote commercial research and to understand the feasibility of involving community pharmacies in research.

The RCs are currently working on a website hosted by the LLR ICS that will have readily available, practical information for practices on how to conduct research studies. Work is ongoing to encourage practices to get involved, work collaboratively, and draw in other practices to create a critical mass of research activity in Primary Care in Leicestershire.

The work so far is hopefully just the beginning. As we continue to encourage and enable practices to get involved in research, we hope to see the capacity and resilience for this work increase in Leicestershire Primary Care. Further understanding and addressing the barriers to this aspiration is key to inform future strategy and commissioning decisions.

BRC Updates

The NIHR is now entering the third year of its current funding cycle, and research across its six themes is continuing at pace, with public involvement and research inclusion embedded in everyone's work.

Some examples of globally valuable research being conducted at the NIHR Leicester Biomedical Research Centre (BRC) include:

Respiratory Research - Severe Asthma Research and Tezepelumab. Our groundbreaking research identified thymic stromal lymphopoietin (TSLP) as a key factor in asthma inflammation, leading to the development of tezepelumab, a monoclonal antibody that targets TSLP. This innovative treatment offers transformative potential for patients with severe asthma and has already been approved by NICE. Leicester BRC's involvement in the CASCADE and Phase 3 studies has been pivotal in forming the licensing package for this revolutionary therapy.

Revolutionary new treatment set to transform lives of severe asthma sufferers - NIHR Leicester Biomedical Research Centre

Cardiovascular Disease Research - The NIHR Leicester BRC's cardiovascular team is advancing global care through innovative diagnostics and precision therapies. Key achievements include major grants for studies on novel imaging, Spontaneous Coronary Artery Dissection SCAD, cardiac surgery, and vascular disease. Notable trials like EVOCC and HTA-BCIS-4 explore critical cardiovascular issues. Highlights include progress in using polygenic risk scores to predict major cardiovascular events and identifying markers for Sudden Cardiac Death.

Example: University Chancellor volunteers for BRC cardiovascular study - NIHR Leicester Biomedical Research Centre

Lifestyle research

Sector leaders are conducting translational research at the interface with the NHS investigating how lifestyle behaviours (from sleep to high intensity exercise) can be harnessed in the prevention and management of long-term conditions.

Their research has pioneered the use of physical activity and targeted exercise training in high-risk patient populations (including in those with diabetic foot complications and kidney transplants), as well as in public health and occupational setting

Example; A 10 minute walk a day could add a year to your life – study finds - NIHR Leicester Biomedical Research Centre

The BRC leads the way in diabetes and obesity research, with notable advancements in managing and reversing Type 2 diabetes in risk populations, including younger adults. Our research is underpinned by an aim to reduce ethnic health inequalities, supported by cutting edge studies including NIHR and MRC grants aimed at culturally tailored diabetes management programmes for South Asian and Black communities.

Example: Study suggests over half of women with gestational diabetes in the UK are going undiagnosed - NIHR Leicester Biomedical Research Centre

Environmental Health and Noise Pollution The Environment theme has led groundbreaking research on noise pollution and its health impacts, with a focus on its role in public health and well-being. Our research contributed to a crucial report presented to the House of Lords, and we are currently exploring environmental exposures and their effects on public health, backed by a £5.5M grant from the National Institute for Health and Care Research (NIHR). Our work has been widely cited, influencing policy and raising awareness about environmental health.

Example: Leicester research making a big noise wins national award - NIHR Leicester Biomedical Research Centre

Night-time noise linked to restless nights for airport neighbours - NIHR Leicester Biomedical Research Centre

Our Cancer research is making significant contributions to global cancer care. Key achievements include the development of the Leicester Experimental Cancer Medicine Centre, which secured £1.83M in funding from Cancer Research UK and NIHR. We are also pioneering studies on mesothelioma, with Prof. Dean Fennell receiving the Pioneer Award from the Mesothelioma Applied Research Foundation. Leicester BRC is actively involved in multiple collaborative efforts to tackle cancer disparities, including addressing uterine cancer mortality rates in Black ethnic minority women.

Leicester Cancer researchers are leading on the COLO-PREVENT study: Scientists investigate if red grape chemical can keep bowel cancer at bay - NIHR Leicester Biomedical Research Centre

Ethnic Health and Long-Term Conditions The EXCEED study, which investigates the genetic, environmental, and lifestyle factors affecting long-term health conditions in over 11,000 participants, is central to our research on ethnic health disparities. This large-scale study provides crucial insights

that will help shape personalised treatment strategies and improve health outcomes for diverse populations globally.

Global Health and Multimorbidity

The BRC is actively involved in addressing global health challenges, particularly in low- and middle-income countries. One notable example is Prof Kamlesh Khunti's work on tackling multimorbidity, which is the occurrence of multiple chronic diseases in the same individual. This research is pivotal for designing healthcare systems that can address the complex needs of populations with high rates of chronic illness.

The PERFORM study led by Prof Sally Singh aims to improve rehabilitation for people with multiple long-term conditions. The program has demonstrated the importance of personalised rehabilitation programs that address the specific needs of people with chronic conditions, ensuring better outcomes for a wide range of patients. Some combinations of long-term health conditions linked to worse quality of life - NIHR Leicester Biomedical Research Centre

LAHP Updates – January 2025

The Leicestershire Academic Health Partners (LAHP) remain focused on priority areas like improving healthcare delivery and research through the LAHP Training Hub, which is expanding with regular content sharing.

In November 2024, the LAHP Board held a strategic planning meeting, which was well-attended with key board members from each partner. During the meeting, we reviewed our progress over the past five years, including significant achievements such as increased external grant income, LAHP-supported grant applications, external investment in LAHP projects, growing LAHP social media presence, and enhanced website. The board also compared our progress with other similar Academic Health Partnerships, which underscored our excellent communication and collaboration. We are excited about the upcoming year and will outline the strategic aims of the LAHP in the coming weeks.

LAHP Health Innovation Hub

We're continuing our collaboration with our partners to develop the LAHP Health Innovation Hub (HIH), a collaborative initiative that aims to streamline and support healthcare innovation across Leicester, Leicestershire, and Rutland. As part of this new initiative, we launched the first "Innovation Clinic" on 3rd December, 2024, in partnership with the Institute for Precision Health (IPH), Medilink Midlands, and Charnwood Campus Science and Innovation and Technology Park. These clinics offer a triage process for innovators to present their ideas for assessment and will evaluate the level of support required for each innovation. This ensures that tailored assistance is provided for both early-stage and more developed projects.

Dr Lynne Howells, Operations Manager for the Institute for Precision Health is leading the programme of clinics and said "*They will be a valuable resource for innovators in Leicestershire who*

may need support to get their ideas of the ground. The clinics are designed to help innovators get advice on next steps and to connect them with the people they need to help them grow their ideas into a reality through our wealth of knowledge".

We'll share more details about the Health Innovation Hub in the coming months as we aim to make it a key component of the LLR healthcare innovation ecosystem. This will help reduce confusion and fragmentation that many innovators currently encounter. We're thrilled about this development and eagerly anticipate sharing updates as the hub continues to evolve.

LAHP Funded Projects:

As mentioned in previous updates, the LAHP funded seven projects in April 2023, most of these projects are now being finalised with the final project report being presented to the LAHP Board in the next month. Once we have these final project reports we will share and communicate these with our partners and website. These projects include the following areas:

- Developing Minimum Dataset for Health Inequalities Research
- MDT Case Management approach to reduce Asthma Exacerbation in Adults using Data and Tackling Health Inequalities
- Evaluating Communication around unwell child and impact of inequality
- Tackling Head and Neck Cancer Inequalities in Diverse Communities of Leicester, through awareness and prevention education programme
- Cardio-Respiratory Rehabilitation in Multi-Morbid Patients
- Improving Prediction of the need for Kidney Replacement Therapy in Chronic Kidney Disease
- Communication Interventions to raise Dementia Awareness for African and Caribbean & South Asian Communities in LLR and surrounding areas

UHL Updates

1. We have recently celebrated the achievements of Marie Hubbard, one of our Lead Neonatal Research staff members at UHL. Marie was awarded the Cavell Star for over 20 years of service at UHL, during which she has contributed towards the transformation of the Research Nurse role, and led a huge number of national research projects. Marie was the very first very first dedicated Neonatal Research Nurse at UHL, and has developed initiatives including an empowerment project supporting parents of premature babies, a bereavement photography course for staff ensuring that bereaved families had precious memories captured, and the set-up of Leicester's first parent iPads, enabling unwell parents of premature and sick babies to see and speak to their babies via video call.

2. Our Maternity research team is set to launch a brand-new study at the end of this month. The £1 million study is funded by Genomics England, and is the largest project to focus on the genetic health of newborn babies. Using an umbilical cord blood sample taken at the

point of birth, the study screens babies for more than 200 rare diseases and conditions. The results of the screening will contribute towards learning more about how genes might impact health later in life, and will also allow parents to potentially access diagnoses and treatments for their children far in advance of any visible symptoms showing.

3. Our research project teams are moving forward with a new file management system, known as Florence Healthcare. The aim of Florence is to improve upon patient safety and data protection, with all files and documents kept in one secure, digital space. We have rolled out Florence within our study support teams this month, and the launch has been very successful. We look forward to expanding it across Departments in the future.

4. The Institute for Excellence in Healthcare (IEH) continues to grow - we delivered our second Research Forum on the 22/1/25 which was very well attended and brought a mix of HCPs together to discuss clinical and academic careers in research. The next forums will be on the 19th of February and the 19th of March 2025. Contact Antonella Ghezzi, Assistant Chief Nurse R&I for further info and to book a place (antonella.ghezzi@uhl-tr.nhs.uk).

Appendix 2

The role of Research in Strategic Commissioning

1. Policy Background

The 10 Year Health Plan will focus on three major shifts to NHS care:

- **Treatment to Prevention:** A stronger emphasis on preventative health and wellbeing, addressing the broader determinants of ill health before they require costly medical intervention and initiatives, working closely with local authorities, to keep people healthy.
- **Hospital to Community:** Moving care closer to home by building more joined-up, person-centred care in local neighbourhoods, reducing reliance on acute care.
- **Analogue to Digital:** Harnessing technology and data to transform care delivery and decision-making. From digital health services for patients, to advanced analytics (population health management, predictive modelling) for planners, the focus is on innovation to deliver smarter, more efficient, and more personalised care.

In addition, the focus of the Ten Year Plan is around the development of Neighbourhood Health. The NHS England requirements for 2025/26 set out "the need to move to a neighbourhood health service that will deliver more care at home or closer to home, improve people's access, experience and outcomes, and ensure the sustainability of health and social care delivery." Delivery of this will require integration from all parts of the health and care system.

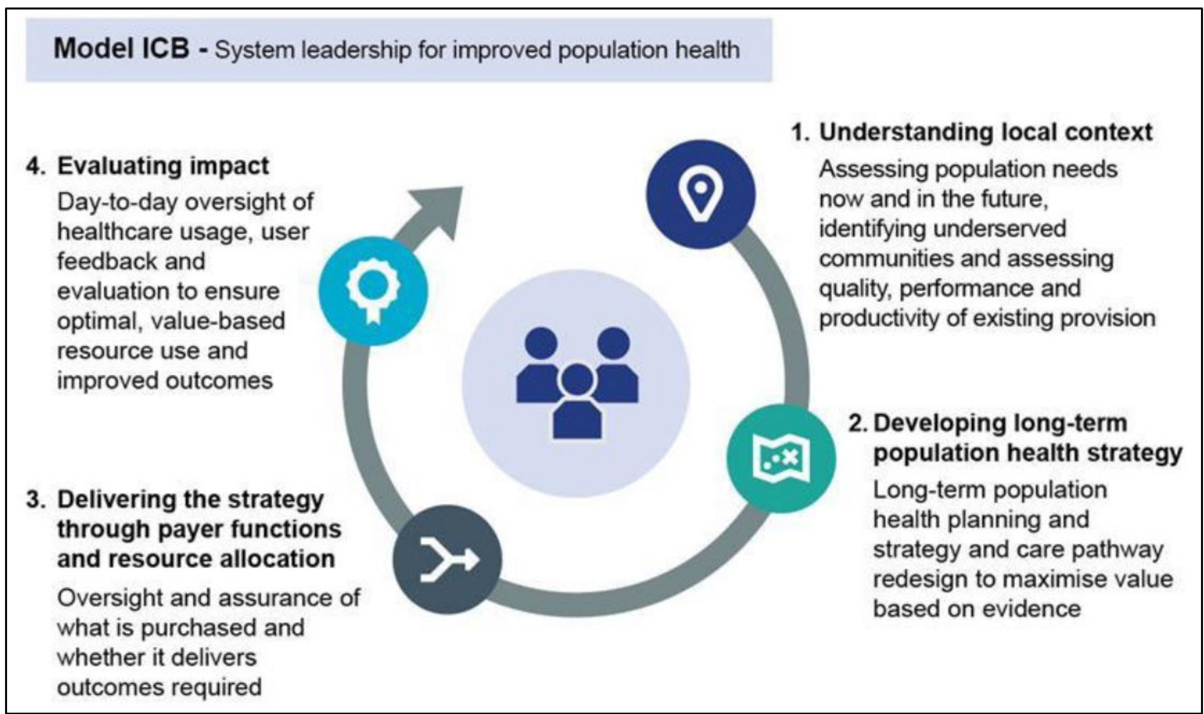
The neighbourhood health model requires us to:

- **apply a consistent, system-wide population health management approach** which draws on sophisticated analysis of quantitative population data and qualitative insights to understand needs and risks for different population cohorts
- **use this information to design and deliver the most appropriate care for each population cohort** and to inform best-value commissioning decisions that empower frontline staff to provide more person-centred care, enabling people to live independently for longer
- **continue to embed, standardise and scale the 6 initial core components of a neighbourhood health service** (detailed in appendix 1) and ensure capacity and structures across providers are aligned to best meet demand

The **Model ICB Blueprint** sets out the role for ICBs as Strategic Commissioners to improve population health, reduce inequalities and ensure access to consistently efficient and high quality care.

The Model ICB Blueprint suggests research and innovation functions could be delegated regionally although detail about how this would be supported is yet to be provided. ICBs will still be required to define its research strategy and priorities aligned to population health and inequalities in its footprint and indeed many of the capabilities that will be needed do not currently exist in ICBs but can be accessed through collaboration with academic partners and aligned NIHR infrastructure.

An illustration of ICB's core functions is set out as below:



2. The role of Research in Strategic Commissioning for Model ICBs

For ICBs to succeed in their role as Strategic Commissioners and deliver Neighbourhood Health, it will be essential for them to continue to develop the knowledge, skills and expertise around research and how best to use it, and working in greater partnership with the research community.

In a climate of continued and increasing pressure on finance, resources and an ageing population, we will be required to do more, for a greater number of people, and mobilise resources differently and more efficiently to meet these challenges. Therefore, what we do must be based on rigorous evidence and research.

We can support LLR and Northamptonshire ICBs as Strategic Commissioners to commission Research-Driven services in the following ways:

Understanding the local context:

- Providing evidence to help us to understand the local population and needs of different communities. LLR has a diverse population, and we know that different communities and ethnic groups require different approaches in terms of prevention, treatment, and engagement with their health and care. There are accessible assets locally that with the right collaborative environment, could be deployed to benefit the NHS, for example ARC EM, the Centre for Ethnic Health Research (UoL/UHL) and the NIHR Health Determinants Research Collaboration (Leicester county council).
- As Neighbourhoods develop, we will need to understand our local population at more granular levels, and research can assist us with this. In LLR, it will be essential that we embed research into the work on Population Need Groups, as they are used to prioritise patient groups and allocate resources accordingly. An understanding of relevant health economic evidence and the deployment of tailored, personalised interventions will be of increasing importance. Local assets within ARC EM and the Leicester Biomedical Research Centre will be able to provide substantial insight into these needs.
- Identifying emerging and future trends in population needs to inform strategic plans on a longer term basis
- Understanding current evidence and gaps in our knowledge

<u>Neighbourhood Level Research Integration</u>

The ten year plans sets out the following expectations of ICBs to discharge the following research related activities at Neighbourhood level:

- Use genomic and risk stratification data to define care groups and commission accordingly.
- Support genomics champions and local testing uptake through neighbourhood teams.
- Facilitate research inclusion in underserved communities via neighbourhood health services.

In LLR, we are at the forefront of understanding population health needs through programmes such as the EXCEED cohort, the Precision Health Unit at the University of Leicester, and research across the Leicester BRC. Our ongoing work to improve research inclusion in underserved communities further strengthens our ability to deliver equitable, evidence-based care.

<u>Developing our long-term population health strategy</u>

- Using evidence to inform long-term planning and strategic priorities
- Working with the research community to address gaps in our understanding or where additional studies and research could help us to develop better understanding of our communities

- Support the use of clinical audits, outcome reviews, and programmes like Getting It Right First Time (GIRFT).

Delivering the strategy through payer functions and resource allocation

- ICBs as strategic commissioners should ensure that commissioned services are based in evidence and research, participate in evidence and research in their delivery, and are robustly monitored and evaluated. These measures should be built into the writing and management of contracts as a matter of course. Added value can be achieved through strategic research collaborations that enable co-designed service models, shared evaluation frameworks, and the rapid adoption of innovations.
- Using research evidence to support choices about which services to commission, how to structure them, and how to evaluate their impact

Evaluating Impact

- Ensuring that robust, evidence-based outcomes and evaluation is written into all contracts and service specifications
- Using evaluation data to inform future commissioning decisions and improve service delivery
- Enable to case-mix adjusted insights inform local service improvement and research

3. **Building skills and expertise in Research for Strategic Commissioning in LLR and beyond**

Success in embedding an evidence based and research led approach to Strategic Commissioning will be dependent on developing a culture of research and specific skills and expertise within the workforce.

- Board level
  - Strengthening Board level oversight and leadership of research priorities for the ICB and scrutiny in relation to evidence-based decision making
  - Ensuring the board actively partners with other bodies across LNR especially LNAHP and EM ARC ICS council

- Commissioning and contracting functions
  - Key skills: critical appraisal, evaluating impact, defining research questions

- Creating a culture where commissioners are open to learning from research and evaluation findings.
- Developing contracting mechanisms, such as outcomes-based contracts, that encourage the use of research, engagement with the research community and robust evaluation of services

- Regional leadership
    - As ICBs seek to cluster functions across larger footprints, it follows that some of the work to develop skills, capacity and expertise around research could be done at a cluster or regional level
    - By working over larger footprints we can ensure a better use of resources and avoid duplication

- Partnership with the Research community
    - Collaborate with academic institutions, industry, and voluntary sectors to trial and adopt innovations. In LLR we have existing bodies such as the Leicestershire and Northamptonshire Academic Health Partners, who can encourage and develop partnership working
    - Participate in Regional Health Innovation Zones, where they can test new models of care and commissioning, including outcomes-based contracts.
    - Support clinical trial recruitment and real-world evaluations of new technologies and treatments.

Conclusion

It is clear from published policies and the Ten Year Health Plan, that in the new world ICBs are to be active enablers of research-informed transformation. Key to this will be effectively embedding research into commissioning, workforce planning, service delivery and evaluation. We will need to work with our partners to develop research agendas and ensure that findings are translated into practice. Maintaining a research function held within the ICB will be a critical step in ensuring that the capabilities of local research partners can be harnessed and coordinated for the benefit of the NHS with the aim of improving health for the people of LNR.

Name of meeting:	Leicester, Leicestershire and Rutland Integrated Care Board (public)		
Date:	14 August 2025	Paper:	G
Report title:	**Leicester, Leicestershire and Rutland Operational Planning Update 2025/26**		
Presented by:	Peter Burnett, Chief Strategy & Planning Officer		
Report author:	Ket Chudasama, Deputy Chief Strategy & Planning Officer		
Executive Sponsor:	Peter Burnett, Chief Strategy & Planning 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 update on the Leicester, Leicestershire and Rutland Operational Plan for 2025/26

Purpose and summary of the report:

The purpose of this report is to provide the Board with an update on the Leicester, Leicestershire and Rutland Integrated Care Board 2025/26 Operational Plan.

The report outlines the key headlines for finance, workforce, performance (by exception and with mitigating actions) and an update on progress against the three shifts which form the basis of the recently published 10 Year Health Plan.

The key risk remains delivery of the financial plan.

Appendices:	• Appendix 1 – Performance Priorities Summary
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 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 Operational and Financial Plan focuses on the 25/26 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.	Operational Plan includes actions to maintain 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.	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

Leicester, Leicestershire and Rutland Integrated Care Board

2025/26 Operational Plan Update

14 August 2025

Introduction

1. The purpose of this report is to provide the Board with an update on the Leicester, Leicestershire and Rutland Integrated Care Board 2025/26 Operational Plan.

2. The plan has been developed to deliver the four national priorities and key deliverables within the planning guidance whilst also considering the three 'shifts' which formed the basis of Fit for the Future: 10 Year Health Plan for England, published on 3 July 2025.

3. The Board considered and approved the Operational and Financial Plan at its extraordinary confidential meeting on 26 March 2025. It was acknowledged the Operational Plan is not risk-free and will require significant action and constant work through the year to deliver required outcomes and seek to mitigate risks and issues as they materialise.

Key delivery headlines of the 2025/26 Operational Plan

Finance

4. Delivery of the Operational Plan in quarter one is encouraging, particularly on workforce and the majority of performance standards. The key risk remains delivery of the Financial Plan.

5. The system submitted a final 2025/26 financial plan to NHS England on 30th April 2025. The LLR plan is a breakeven position across the system. £80.00m of non-recurrent deficit support funding is included within the 2025/26 plan.

6. At month 03, the system is reporting a year-to-date (YTD) deficit before support funding of £(38.10)m, an adverse variance from plan of £(5.56)m. The drivers of the YTD variance are under recovery of income at UHL, prescribing growth in excess of reduced budget and reducing costs and delivering sufficient efficiency schemes within the ICB and on-going Independent Sector activity above plan.

7. The system is reporting a year end deficit forecast outturn (FOT) before support funding of £(80.0)m, which is in line with plan. Significant work continues to reduce the level of risk and enable delivery of the financial plans.

Workforce

8. The system has a plan to reduce 1820 WTE by year end. By month 03, the system has reduced workforce by 723 WTE, which is 40% of the reduction target and ahead of plan (25%) by month 03.

9. System control is on plan for workforce spend at -£0.3m variance year to date (-£1.1m UHL and £0.7m LPT).

Performance

10. A summary of the key national performance priorities is included in appendix 1.

11. The key metrics behind plan (by exception) and their corresponding actions to improve performance are presented below.

Metric	Plan	Actual	Key Actions
Reduce the proportion of people waiting over 52 weeks for treatment to less than 0.9% of the total waiting list by March 2026	1.4%	2.4%	• The UHL long waiter position (adults and children) is monitored daily by the Deputy COO for elective care (UHL). • Additional escalated meetings focussing on 65+ and 52+ position commenced in August in the specialties with the longest waits. This includes paediatric specialties. • Utilising super-clinics to increase outpatient capacity. • Reviewing MSK pathway to streamline referrals into spines / rheumatology and pain. • Continued roll-out and focus on Patient Initiated Follow Ups to increase capacity for new patients. • Validating patients on the waiting list who have been waiting over 12 weeks. • Theatre productivity and outpatient transformation workstreams to improve productivity and increase capacity. • Hinckley Community Diagnostic Centre opened in June supporting faster time to reach a treatment decision. This will accommodate some paediatric activity in Quarter 3. • Working closely with University Hospitals of Northampton and the Northants ICB to review benefits to working together to improve waits.
Improve Category 2 ambulance response times to an average of 30 minutes across 2025/26	00:30:00	00:36:57	• Release to Respond 45 mins handover SOP embedded at LRI. • Deep dive into recent LRI performance 07/08/2025 for learning. • Release to Respond 45 mins handover SOPs in development across Summer 2025 for Glenfield Hospital and Leicester General Hospital.
Number of people on community waiting lists for CYP services	5647	5723	• The service is continuing to work with the NWL PCN to manage ADHD medication reviews within primary care to free up capacity • A parent/carer and young person digital questionnaire has been devised to obtain the information required for a competent review in place of annual reviews. • Pathway reviews are being carried out to release capacity and efficiencies

Metric	Plan	Actual	Key Actions
who are waiting over 52 weeks			• Implementing digital contacts to replace bi-annual reviews for ADHD medication - plan to start in March 2026 to free up capacity • ADHD Nurse pilot has been completed with nursing team to lead on assessment of ADHD with results showing significant time reduction in assessment pathway. Competency framework currently under review with full pathway to be rolled out in coming months.
Reduce average length of stay in adult acute mental health beds	56.1	62	**10 High Impact Actions - Project Group Mobilised to ensure Actions Implemented and to Strengthen Oversight** • Identify the purpose of the admission, set an expected date of discharge (EDD) for when this purpose will be achieved, and communicate this with the person, family/carers and any teams involved in the person's care post-discharge, e.g. community mental health team (CMHT) or crisis resolution home treatment team (CRHTT). • Complete care formulation and care planning at the earliest opportunity with the person, and within a maximum of 72 hours of admission. • Identify any potential barriers to discharge early on in admission and take action to address these. Where appropriate action cannot be taken, escalate this to the ICB Discharge Lead. • Conduct daily reviews, such as the 'Red to Green' approach, to ensure each day is adding therapeutic benefit for the person and is in line with the purpose of admission. • Hold Multi Agency Discharge Events (MADE) with key partners on a regular basis, to review complex cases. • Ensure partnership working and early engagement with the person, family/carers and teams involved in the person's post-discharge support; agree a joint action plan with key responsibilities, for example for social care, housing, primary care, CMHT, CRHTT, etc. • Apply 7-day working to enable people who are clinically ready for discharge to be discharged over weekends and bank holidays, and allow people who require admission timely access to local beds. Identify common reasons and solutions to people being delayed in hospital, e.g. housing support/accommodation. Start by reviewing: • Those who are clinically ready for discharge but occupying beds. • Adults and older adults with a long length of stay (over 60/90 days for adult/older adult admissions). • Communicate notice of discharge at least 48 hours prior to the person being discharged, to the person, their family/carers and any ongoing support services. • Follow up to be carried out with the person by the CMHT or CRHTT at the earliest opportunity and within a

Metric	Plan	Actual	Key Actions
			maximum of 72 hours of discharge, to ensure the right discharge support is in place.

10 Year Health Plan: Progress on 'Three Shifts'

12. The 10 Year Health Plan, aims to transform the NHS by making three key shifts: from hospital to community, from analogue to digital, and from sickness to prevention. The plan outlines how the NHS will evolve to meet future healthcare needs and deliver better care for all. Examples of progress being made include:
    a. Hospital to community
        i. System wide neighbourhood workshop held in May to focus on short and medium term vision, agreed in June
        ii. Short term focus upon community UCC pathways to support attendance avoidance, frailty pathway, increase of care plans, proactive care via Integrated Neighbourhood Teams, upscale of community admission avoidance schemes and UCR type activity
        iii. M1 and M2 acute figures show delivery against plan in terms of activity for both hospital and ambulance services,
        iv. No increase in MOFD or readmission rate as balancing figure
        v. Increasing uptake in community mental health support for lower acuity patients
    b. Analogue to Digital
        i. LLR Care Record – information sharing for direct care to enable quicker, more informed, safer, right-first-time decisions for better patient and family experiences
            - 13 health and care IT systems interacting with the Care Record
            - 8,600+ logins per month across all sectors, excl EMAS
            - 5,700+ patient records accessed each month
        ii. UHL has successfully delivered the first-of-type deployment of Nervecentre PAS nationally, replacing legacy systems including a 35-year-old PAS and providing a modern patient administration foundation.
        iii. Maternity Inpatient, Community Midwifery, and Neonatal services to be consolidated onto a single supplied system. BadgerNet is an end-to-end system supporting all aspects of electronic recording for women and children's health
        iv. NHS App as the digital front door and using Artificial Intelligence to triage patients in primary care
    c. Sickness to Prevention
        i. Strong and continued public health engagement embedded into ICB and wider governance arrangements and working groups eg System Health Equity Committee (HEC) etc
        ii. LLR tobacco dependency/smoking cessation programme is delivered across all three places by Public Health
        iii. Early cancer diagnosis by increasing screening uptake rates for bowel, breast and cervical cancer
        iv. Joined up and strategic approach to improving vaccination uptake via the LLR Immunisation Board for Covid-19, flu, RSV etc.

Recommendations:

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

- **RECEIVE and NOTE** the update on the Leicester, Leicestershire and Rutland Operational Plan for 2025/26

Appendix 1

LLR ICB Board

NHS Priorities Performance Report 25/26

Appendix 1

14 August 2025

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

Performance Priorities Summary

Area	NHS PRIORITIES 2025/26	Month	Plan	Actual	RAG
Reduce the time people wait for elective care	Improve the percentage of patients waiting no longer than 18 weeks for treatment by March 2026 (Every trust expected to deliver a minimum 5% point improvement) (Trajectories set as part of Ops Plan 25/26)	Jun-25	57.8%	57.6%	
	Improve the percentage of patients waiting no longer than 18 weeks for a first appointment by March 2026. (Trajectories set as part of Ops Plan 25/26)	Jun-25	63.0%	TBC	
	Reduce the proportion of people waiting over 52 weeks for treatment to less than 0.9% of the total waiting list by March 2026	Jun-25	1.4%	2.4%	
	Improve performance against the headline 62-day cancer standard to 70.3% by March 2026	May-25	60%	61.3%	
	Improve performance against the 28 day Faster Diagnosis Standard to 80% by March 2026 (ICS)	May-25	77%	77.5%	
Improve A&E waiting times and ambulance response times	Improve A&E waiting times of patients seen within 4 hours in Mar 26 (All Types System Wide, Trajectories set as part of Ops Plan 25/26)	Jun-25	74.8%	75.9%	
	A higher proportion of patients admitted, discharged and transferred from ED over 12 hours	Jun-25	11%	9%	
	Improve Category 2 ambulance response times to an average of 30 minutes across 2025/26	Jun-25	00:30:00	00:36:57	
Community Services	Number of people on waiting lists for CYP services who are waiting over 52 weeks	May-25	5647	5723	
	Number of people on waiting lists for adult services who are waiting over 52 weeks	May-25	0	0	

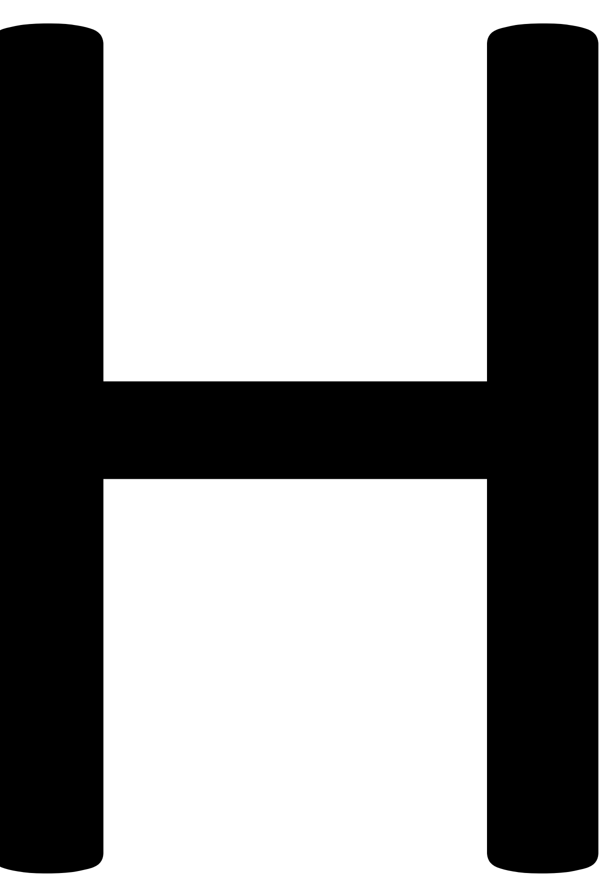
	Under achieved target
	5% Threshold
	Achieved target
*	Supressed numbers <5

Performance Priorities Summary

Area	NHS PRIORITIES 2025/26	Month	Plan	Actual	RAG
Improve access to general practice and urgent dental care	Improve patient experience of access to general practice as measured by the ONS Health Insights Survey *Q.14a- Perception of overall experience of GP practice, for those who tried to contact their GP practice in the last 28 days*	May-25	England 73.3%	69.3%	
Improve mental health and learning disability care	Reduce average length of stay in adult acute mental health beds	May-25	56.1	62	
	Increase the number of CYP accessing services (Trajectories set as part of Ops Plan 25/26)	May-25	17,745	18,475	
	NHS talking therapies- Completing a Course of Treatment (having had at least two treatment sessions)	May-25	793	860	
	Reduce reliance on mental health inpatient care for people with a learning disability and people with autism	July 25 Q2 Plan	10	13	
	Reduce reliance on mental health inpatient care for adults with autism	July 25 Q2 Plan	14	16	
	Reduce reliance on mental health inpatient care for children with a LDA	July 25 Q2 Plan	3	*	
Live within the budget allocated, reducing waste and improving productivity	2025/26- System Delivery of planned deficit (gross of deficit support funding)	M3	(32.54)	(38.10)	
	Close the activity/WTE gap against pre-Covid levels (adjusted for case mix)	TBC			

Performance Priorities Summary

Area	NHS PRIORITIES 2025/26	Month	Plan	Actual	RAG
Maintain our collective focus on the overall quality and safety of our services	Continue to implement the Three-year delivery plan for maternity and neonatal services:- Increase registered midwives fill rates	May-25	TBC	416	
	Improve safety in maternity and neonatal services, delivering the key actions of the of the 'Three year delivery plan'				
	National safety ambition to reduce stillbirth	Feb-25	Reduction 2023 4	4	
	Neonatal mortality (per 1,000 births)	2023	Reduce 2021 2.4	2.8	
	Maternal mortality	2023/24	Reduce 21/22 *	0	
Address inequalities and shift towards prevention	CVDP002HYP: Percentage of patients aged 18 to 79 years with GP recorded hypertension, in whom the last blood pressure reading within the preceding 12 months is equal to 140/90 mmHg or less	Q4 24/25	67.1%		N/A
	CVDP003HYP: Percentage of patients aged 80 years or over with GP recorded hypertension, in whom the last blood pressure reading within the preceding 12 months is 150/90 mmHg or less	Q4 24/25	82.2%		N/A
	CVDP007HYP - Percentage of patients aged 18 and over, with GP recorded hypertension, in whom the last blood pressure reading (measured in the preceding 12 months) is below the age appropriate treatment threshold	Q4 24/25	80.0%	70.1%	
	CVDP003CHOL - Increase the percentage of patients aged between 25 and 84 years with a CVD risk score greater than 20 percent on lipid lowering therapies to 60%	Q4 24/25	60.0%	66.1%	



Name of meeting:	Leicester, Leicestershire and Rutland Integrated Care Board		
Date:	14 August 2025	Paper:	H
Report title:	LLR Winter Plan 2025/26		
Presented by:	Rachna Vyas, Deputy Chief Exec / Chief Operating Officer, NHS LLR ICB		
Report author:	Sarah Smith, Head of Urgent & Emergency Care, NHS LLR ICB		
Executive Sponsor:	Rachna Vyas, Deputy Chief Exec / Chief Operating Officer, NHS LLR ICB Nil 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 LLR ICB (public) board is asked to:

NOTE that the LLR UEC Collaborative governance structure and the LLR Clinical Executive have assessed and assured the full plan, and all appendices, with further work identified to de-risk the plan.

APPROVE the LLR Winter Plan Executive Summary for 2025/26, noting the Board Assurance Statement in Appendix A.

APPROVE for delegated authority to be granted to the ICB Chair and ICB Chief Executive to sign an updated version of the Board Assurance Statement following the NHS England review on 17 September 2025.

Purpose and summary of the report:

As part of the annual winter assurance planning process, each ICB is asked by NHS England to submit a Winter Plan is to ensure the health and care system is fully prepared to manage the increased pressures that typically arise during the winter months (October to March).

The full narrative plan has seven appendices, some of which are also standalone iterative documents to manage risk and performance across the financial year:

- Appendix 1: LLR Neighbourhoods and UEC Working Groups Governance Structure.
- Appendix 2: LLR Surge & Escalation Plan April – September 2025.
- Appendix 3: LLR System Escalation Action Card.
- Appendix 4: Winter Plan Actions for LLR Primary Care.
- Appendix 5: LLR's Immunisation Priorities 2025/26.
- Appendix 6: Examples of local communications materials to support Winter messaging across LLR.
- Appendix 7: LLR UEC Winter Metrics Return Workbook.
- Appendix 8: LLR Board Assurance Statement (Draft) for final submission by 30/09/2025.

For winter 2025/26, a Board Assurance Statement is required by the end of September 2025 – a draft of this is attached, based on the current winter plan. NHS England have confirmed that each ICB's Winter Plan submission will be stress tested at a regional event on 17th September 2025. Feedback from this will support further strengthening of the plan, the full plan will be refreshed with this learning and the Board Assurance Statement will then be updated.

We ask the Board for delegated authority to be granted to the ICB Chair and the ICB Chief Executive for signing an updated version of the Board Assurance Statement following the NHSE review on 17th September 2025.

Each Health Overview and Scrutiny Commission will also be presented with a precis of the plan in September 2025.

Appendices:	Appendix A - LLR Board Assurance Statement (Draft).
Report history (date and committee / group the content has been discussed / reviewed prior to presenting to this meeting):	30/07/2025 - LLR UEC Operational Group. 31/07/2025 – LLR Clinical Executive Group. 01/08/2025 – LLR UEC Collaborative Transformation Group.

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

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

Implications:	
a) Does the report provide assurance against a corporate risk(s) e.g. risk aligned to the Board Assurance Framework, risk register etc? *If so, state which risk and also detail if any new risks are identified.*	BAF 1 – Partnership. BAF 2 – Health Inequalities. BAF 3 – Demand and Capacity. BAF 4 – Finance. BAF 5 – Quality and Safety.
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 implications have been identified.
c) Does the report highlight quality and patient safety implications? If so, provide which page / paragraph this is outlined in within the report.	The outputs of the LLR Winter Plan will support quality and safety of service outcomes across multiple pathways.
d) Does the report demonstrate patient and public involvement? If so, provide which page / paragraph this is outlined in within the report.	We have a programme of proactive patient and public engagement in UEC services across the year.
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.	As care pathways develop, all due regard processes will be followed across health and care.

Planning for a resilient winter 2025/26 across the LLR health and care system

Executive Summary

FINAL v2.0
04 August 2025

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

A proud partner in the:

Leicester, Leicestershire and Rutland
Health and Wellbeing Partnership

Executive Summary

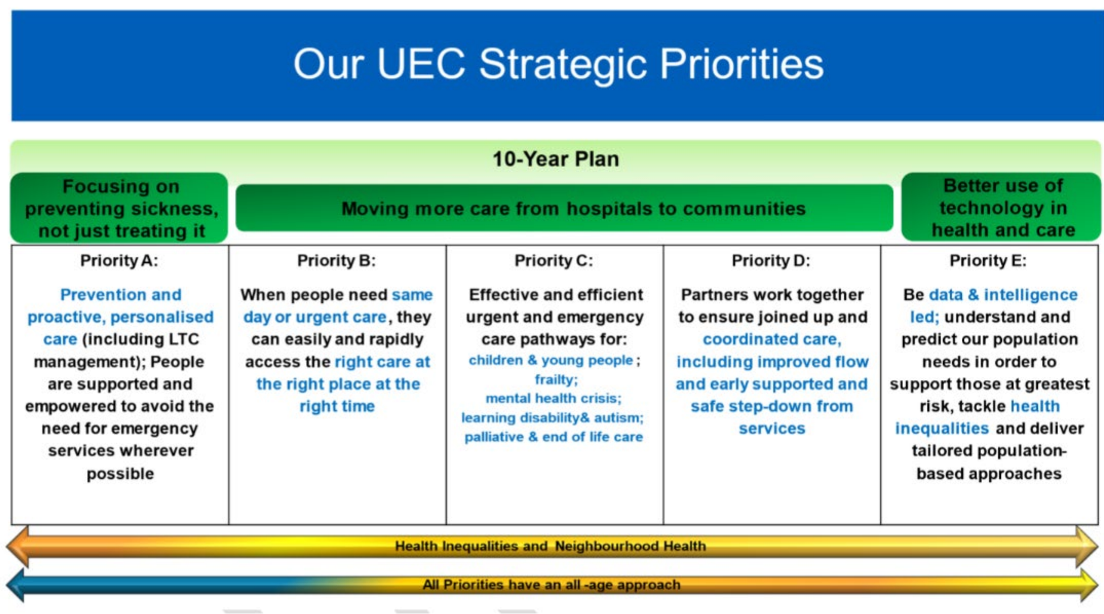
Introduction

1. The Leicester, Leicestershire and Rutland ("LLR") Integrated Care System anticipates significant pressures on urgent and emergency care ("UEC") services during the 2025/26 winter period. Our collective winter plan outlines our collective response to this expected period of surge. The full plan consists of a significant number of detailed documents, and therefore this paper provides a precis of the work undertaken through our UEC collaborative to prepare for this period across health and care.
2. The full plan and appendices have been assured via our joint governance at system level:
    - 30/07/2025 – the LLR UEC Operational Group (via Sarah Smith, LLR ICB)
    - 31/07/2025 – the LLR Clinical Executive Group (via Damian Roland, UEC Clinical Lead)
    - 01/08/2025 – the LLR UEC Collaborative Transformation Group (via UEC SRO's)

    As a part of the assurance process the system has acknowledged that there is further work to complete during August and ahead of the stress testing process to review and confirm the impact of schemes, which in turn will support further bed modelling.

Our collective UEC strategy

3. To address these pressures, now and into the future, we have recently agreed our LLR UEC strategy for 2025-2030 which has six priorities.



4. Within this strategy we have identified four critical implementation priorities for 2025-2027 moving forwards:

- Identification of people in the most at-risk groups for proactive care planning.
- Establish a consolidated Urgent Treatment Centre (UTC) model that delivers equitable access closer to home for all residents.
- Deliver an integrated frailty pathway.
- Deliver Discharge Improvement Programmes (including complex discharges).

5. Our strategy aims to address underlying system challenges which are driven by seasonal illness spikes, long-term workforce challenges, physical and mental health care need driven by high levels of deprivation and inequality, and system-wide capacity constraints. Due to being a solitary Emergency Department for a large geographic area raw numbers of ambulance arrivals, walk-ins and referrals are high. These underlying challenges present themselves in various UEC pressures:

- Challenged Category 2, ambulance handover and 4-hour performance.
- Persistently high admission demand resulting in challenged 12-hour performance.
- Persistent bed capacity pressures risking delayed discharges and impacting bed availability.
- Risk of critical incidents due to system overload (e.g. UHL incident in October 2024 and EMAS incident in January 2025).

Focus areas for the winter plan

6. Our LLR Winter Plan outlines a coordinated response to mitigate these risks and maintain safe, effective care across our footprint

- **Flow In:** Strengthening NHS 111, community pharmacy access, and direct booking into Urgent Treatment Centres.
- **Flow Through:** Expanding bed capacity via a reduction in length of stay, strengthening criteria to admit, and creation of additional community hospital capacity (Preston Lodge).
- **Flow Out:** Enhancing discharge planning and strengthening criteria-led discharge across seven days.
- **Mental Health Support:** Promoting awareness of local services and expanding crisis response capacity.
- **Vaccination Campaigns:** Targeted outreach for flu, COVID-19, and childhood immunisations.
- **Internal and External Communications:** Strengthened and targeted messaging for health and care colleagues and patients.

The full plan includes key learning from Winter 2024/25 and highlights improvement opportunities during Winter 2025/26, as well as detailed modelling of impact.

The narrative has been developed across each Neighbourhood working group and UEC working group. These groups have described their approach to supporting winter surge, over and above that already detailed in the operational plans for 2025/26 and acknowledging that no additional funding is expected to be forthcoming to support winter.

The appendices, each of which has been assessed by the UEC Collaborative governance structure and the LLR Clinical Executive, include:

1. Neighbourhoods and UEC Working Groups **Governance Structure in place**
2. **LLR Surge & Escalation Plan April** – September 2025 (noting that this will be updated in September for the period October 2025 – March 2026 as per the usual annual process).
3. **LLR System Escalation Action Card**, detailing the escalation processes from the LLR System Coordination Centre to the LLR ICB and providers on call structures.
4. Summary of the **Winter Plan actions for Primary Care** in LLR.
5. LLR's approach to the **immunisation priorities** in 2025/26.
6. Examples of local **communications materials** to support Winter messaging across LLR.
7. LLR **UEC Winter Metrics workbook** to meet the national requirements for data reporting.

Governance, leadership and risk management

7. The LLR Urgent and Emergency Care Collaborative, led by University Hospitals of Leicester ("UHL"), oversees delivery with weekly system-wide reviews and escalation protocols.
8. Clinical leadership ensures safety and responsiveness to emerging risks. The three Senior Responsible Officers from LLR ICB, UHL and Leicestershire Partnership Trust ("LPT") have collective responsibility for the development and delivery of the LLR UEC Strategy. Working groups covering UEC themes sit beneath a transformation and collaborative group to deliver operational and strategic actions.
9. NHS England Midlands have indicated that there will be a collective event on 17/09/2025 (to be confirmed) to stress test each Midlands ICB's Winter Plan. Following this, LLR will undertake a collaborative risk assessment process to yield key risks for articulating and monitoring in a summarised format. These risks will be monitored and managed per existing UEC governance and the LLR System Quality Group. ICBs anticipate being asked to submit a further iteration of their full Winter Plan 2025/26 to NHS England Midlands by 30/09/2025 together with the LLR ICB Board Assurance Statement.

Acknowledged risks

10. While comprehensive, our winter plan highlights area where there still needs to be mitigations, especially during surge and super-surge:

- Ensuring provider processes are as efficient as can be through the patient pathway
- Keeping attendance avoidance capacity open in form of additional UTC capacity.
- Ensuring admission avoidance schemes for frailty and PTCDA (care home access to specialist geriatrician advise) are viable in the short, medium and long term.
- The impact of neighbourhood schemes is quantified and matched against the current bed gaps.

- Sign off for schemes which consider what services could be paused or scaled down to free capacity during winter.

  These will continue to be progressed through August 2025.

Performance monitoring

11. Performance monitoring will include the nine key metrics outlined across the Department of Health & Social Care (“DHSC”) and NHS England UEC Plan 2025/26, and the NHS England Winter 2025/26 Expectations for Planning, Preparedness, and Assurance (18 June 2025).

a) Ambulance Category 2 Mean: <30 mins standard.
b) Ambulance pre-handover: LLR Operational Plan (and max. 45 mins handover).
c) ED 4hr Type 1 (All Age): LLR Operational Plan.
d) ED 4hr Type 1 (0-17y): improvement via a stretch target of 90%.
e) ED 4hr Type 1 & Type 3 (All Age): minimum 78% standard.
f) ED 12hrs: <10% standard.
g) Reduce the number of patients in ED >24hrs awaiting a mental health admission.
h) Reduce the number of patients staying 21 days over their discharge ready date.
i) Improve flu vaccination rates for frontline staff by at least 5%.

12. Trajectories against each of these were submitted as part of planning for 2025/26, considering data and intelligence available at the time. Based on these trajectories, the LLR system is expecting to achieve its full year performance for each.
13. Delivery against these will also support the elective delivery plan for LLR, covering both elective care and urgent cancer care.

Conclusion

14. LLR’s winter planning has been data-driven, collaborative, and focused on maintaining patient safety and system resilience.
15. The current plan has been assessed and assured through the UEC Collaborative structure, and the LLR Clinical Executive, with further work to strengthen the plan in August.
16. In recognition that our initial Winter Plan submission will be stress-tested, supported by NHS England colleagues, we expect to produce a further iteration of this plan.
17. There remains an inherent risk with the delivery of winter, particularly noting that the financial position of each organisation within LLR health and care will prevent additional capacity being added at short notice.
18. The teams across health and care continue to work collectively to de-risk the plan as much as possible.

Recommendation

19. We ask the LLR ICB Board for delegated authority to be granted to the ICB Chair and the ICB Chief Executive for signing an updated version of the Board Assurance Statement following the NHSE review on 17th September 2025.

Appendix 1

Integrated Care Board:	Leicester Leicestershire and Rutland

Section A: Board Assurance Statement

Assurance statement	Confirmed (Yes / No)	Additional comments or qualifications (optional)
Governance		
The Board has assured the ICB Winter Plan for 2025/26.		Mtg 14/08/2025
A robust quality and equality impact assessment (QEIA) informed development of the ICB's plan and this has been reviewed by the Board.		Currently in development
The ICB's plan was developed with appropriate levels of engagement across all system partners, including primary care, 111 providers, community, acute and specialist trusts, mental health, ambulance services, local authorities and social care provider colleagues.	Yes	
The Board has tested the plan during a regionally-led winter exercise, reviewed the outcome, and incorporated lessons learned.		Mtg 17/09/2025 (TBC)
The Board has identified an Executive accountable for the winter period, and ensured mechanisms are in place to keep the Board informed on the response to pressures.		Pending outcome of discussions
Plan content and delivery		
The Board is assured that the ICB's plan addresses the key actions outlined in Section B.		Mtg 14/08/2025
The Board has considered key risks to quality and is assured that appropriate mitigations are in place for base, moderate, and extreme escalations of winter pressures.		Mtg 14/08/2025
The Board is assured there will be an appropriately skilled and resourced system control centre in place over the winter period to enable the sharing of intelligence and risk balance to ensure this is appropriately managed across all partners.		Mtg 14/08/2025

ICB CEO/AO name	Date	ICB Chair name	Date

Section B: 25/26 Winter Plan checklist

Checklist	Confirmed (Yes / No)	Additional comments or qualifications (optional)
Prevention		
1. Vaccination programmes across all of the priority areas are designed to reduce complacency, build confidence, and maximise convenience. Priority programmes include childhood vaccinations, RSV vaccination for pregnant women and older adults (with all of those in the 75-79 cohort to be offered a vaccination by 31 August 2025) and the annual winter flu and covid vaccination campaigns.	Yes	
2. In addition to the above, patients under the age of 65 with co-morbidities that leave them susceptible to hospital admission as a result of winter viruses should receive targeted care to encourage them to have their vaccinations, along with a pre-winter health check, and access to antivirals to ensure continuing care in the community.	Yes	
3. Patients at high risk of admission have plans in place to support their urgent care needs at home or in the community, whenever possible.	Yes	
Capacity		
4. The profile of likely winter-related patient demand across the system is modelled and understood, and individual organisations have plans that connect together to ensure patients' needs are met, including at times of peak pressure.	Yes	Detailed metrics submission to support this (Appendix 7).
5. Seven-day discharge profiles have been shared with local authorities and social care providers, and standards agreed for P1 and P3 discharges.	Yes	Coordinated via the System Discharge Working Group.
6. Action has been taken in response to the Elective Care Demand Management letter,	Yes	

issued in May 2025, and ongoing monitoring is in place.		
Leadership		
7. On-call arrangements are in place, including medical and nurse leaders, and have been tested.	Yes	Coordinated via the LLR ICB EPRR Team.
8. Plans are in place to monitor and report real-time pressures utilising the OPEL framework.	Yes	Coordinated via the LLR System Coordination Centre.

DRAFT

Name of meeting:	Leicester, Leicestershire and Rutland Integrated Care Board		
Date:	14 August 2025	Paper:	I
Report title:	Draft LLR ICB Equality Delivery System (EDS) 2024-25 Report		
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 ICB Board are asked to:

a) To **approve** the draft EDS report prior to publishing on the ICB Website

Purpose and summary of the report:

1. The purpose of this report is to demonstrate how LLR ICB has implemented the Equality Delivery System (EDS) 2022 together with the results, for the reporting period 2024-2025.

2. The EDS cycle spans April to February annually and this is the second year that the ICB has assessed against the Equality Delivery System (EDS) 2022.

Background

3. The EDS is the foundation of equality improvement within the NHS. It is an accountable improvement tool for NHS organisations in England - in active conversations with patients, public, staff, staff networks and trade unions - to review and develop their services, workforces, and leadership. It is driven by evidence and insight. This is the third version of EDS and was commissioned by NHS England and NHS Improvement supported by the NHS Equality and Diversity Council (EDC). It is a simplified and easier-to-use version of EDS2.

4. The EDS comprises eleven outcomes (found in attached report on page 2) spread across three Domains, which are:

- Domain 1 - Commissioned or provided services.
- Domain 2 - Workforce health and well-being
- Domain 3 - Inclusive leadership.

5. The outcomes are evaluated, scored, and rated using available evidence and insight. All the scores from the three domains are required to produce a final rating. Domain 1 is determined by using the middle score out of the three services from Domain 1, in line

with the EDS Technical Guidance [EDS Technical Guidance](). It is these ratings that provide assurance or point to the need for improvement.

6. In line with the EDS Technical Guidance, **Domain 1** requires implementation at system level. It must be applied to three clinical services or pathways selected from the local system partner NHS organisations**. Domains 2 and 3**, on the other hand, must be completed at local organisational level and led by individual NHS organisations.

7. NHS EDI colleagues from LPT (Leicestershire Partnership Trust), UHL (University Hospitals of Leicester) and the ICB led on one service each for Domain 1 (see below). UHL, LPT and the LLR ICB were responsible for implementing Domains 2 and 3 within their respective organisations.

8. The three clinical services within the LLR system selected for the 2024-25 EDS cycle that Domain 1 was applied to are:

   - Chaplaincy – Led by UHL
   - Intermediate Care – Led by LLR ICB
   - Mental Health – Perinatal Strand - Led by LPT

9. **Grading process**: Domain 1 involved evidence being presented to a wide range of stakeholders from NHS system partner organisations, LLR Voluntary Community Social Enterprise (VCSE) Alliance, Patient Participation Groups, Citizens' Panel and the Public & Patient Involvement Assurance Group across LLR. The stakeholders invited were representative of the protected groups, socio-economic demographic groups/communities and other people living locally.

10. The ICB's Domain 2 involved the evidence being presented to members of the People Champions and Domain 3 was peer reviewed with NHS Northamptonshire ICB and NHS Lincolnshire ICB.

11. This overall report was delayed due to the system level Domain 1 taking longer than expected. This was also the case with last year's report.

12. All the evidence will be made available on the ICB website together with the report should anyone wish to access it. We will also be publishing a simplified version of the EDS Domain 1 report.

13. The Health Equity Committee (HEC) assured the report on 17/6/2025.They requested a paragraph on how the ICB monitors actions and implementation (see below).

a) EDI related reports go through a robust governance process. Papers are approved by the Chief People Officer prior to being submitted to ODG/RemCom, EMT and the ICB Board. Some EDI papers with health inequalities elements also go to HEC.

b) Most of the EDS actions relating to Domains 2 (Health & Wellbeing) and 3 (Inclusive Leadership) are monitored through the ICB EDI Improvement Plan (linked to the People Plan). Other relevant aspects are reported through the EDI Annual Report.

c) Relevant Race and Disability Standards data (WRES/WDES), staff survey results and the gender pay gap are also monitored through the EDI Improvement plan.

14. HEC noted that due to the current situation that we are unlikely to undertake EDS this year (25/26) and the need to take some time to pause, reflect and re-focus. 15. The overall grade for the LLR ICB is **Developing.**

Appendices:	Appendix 1 - Draft LLR ICB Report on EDS 2024-25
Report history (date and committee / group the content has been discussed / reviewed prior to presenting to this meeting):	Health Equity Committee 17/06/2025

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.*	Yes. BAF 2 - Health Inequalities: 'Failure to adequately address health inequalities due to a lack of investment and / or lack of partnership working, therefore unable to improve health equity and outcomes for the population of LLR.'
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. Outcome 1c of EDS Domain 1 focuses on patient safety
d) Does the report demonstrate patient and public involvement? If so, provide which page / paragraph this is outlined in within the report.	Yes. The EDS Domain 1 requires insight from and engagement with stakeholders, including patients/patient participation groups, VCSE sector.
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. The EDS is designed to aid NHS organisations' compliance with statutory requirements such as the Public Sector Equality Duty under the Equality Act 2010

Appendix 1

APPENDIX A

DRAFT

LLR ICB Equality Delivery System (EDS) 2022

Reporting Period 2024- 25

This is the second year that the ICB has assessed against the new Equality Delivery System (EDS) 2022.

Background

The EDS is the foundation of equality improvement within the NHS. It is an accountable improvement tool for NHS organisations in England - in active conversations with patients, public, staff, staff networks and trade unions - to review and develop their services, workforces, and leadership. It is driven by evidence and insight.

The third version of the EDS was commissioned by NHS England and NHS Improvement with, and on behalf of, the NHS, supported by the NHS Equality and Diversity Council (EDC). It is a simplified and easier-to-use version of EDS2.

To take account of the significant impact of COVID-19 on Black, Asian, and Minority Ethnic community groups, and those with underlying and long-term conditions such as diabetes, the EDS now supports the outcomes of the Workforce Race Equality Standard (WRES) and the Workforce Disability Equality Standard (WDES) by encouraging organisations to understand the connection between those outcomes and the health and wellbeing of staff members. The EDS provides a focus for organisations to assess the physical impact of discrimination, stress, and inequality, providing an opportunity for organisations to support a healthier and happier workforce, which will in turn increase the quality of care provided for patients and service users.

The EDS comprises eleven outcomes (see page 2 below) spread across three Domains, which are:

- Commissioned or provided services.
- Workforce health and well-being
- Inclusive leadership.

The outcomes are evaluated, scored, and rated using available evidence and insight. **All the scores from the three domains are required to produce a final rating**. It is these ratings that provide assurance or point to the need for improvement. The EDS is designed to encourage the collection and use of better evidence and insight across the range of people with protected characteristics described in the Equality Act 2010, and so to help NHS organisations meet the public sector equality duty (PSED) and to set their equality objectives.

The EDS is integral to core equality work and addressing health inequalities and applies to all the protected characteristic groups.

The outcomes we measure against for each of the three EDS domains are as follows:

Domain 1: Commissioned or provided services

1A: Patients (service users) have required levels of access to the service *(simpler version of EDS2 2.1)*

1B: Individual patients (service user's) health needs are met *(simpler version of EDS2 1.2)*

1C: When patients (service users) use the service, they are free from harm *(like EDS2 1.4)*

1D: Patients (service users) report positive experiences of the service *(same as EDS2 2.3)*

Domain 2: Workforce health and well-being

2A: When at work, staff are provided with support to manage obesity, diabetes, asthma, COPD, and mental health conditions (response to COVID-19)

2B: When at work, staff are free from abuse, harassment, bullying and physical violence from any source *(like EDS2 3.4)*

2C: Staff have access to independent support and advice when suffering from stress, abuse, bullying, harassment, and physical violence from any source (response to Covid-19)

2D: Staff recommend the organisation as a place to work and receive treatment *(like EDS2 3.6)*

Domain 3: Inclusive leadership

3A: Board members, system leaders (Band 9 and VSM) and those with line management responsibilities routinely demonstrate their understanding of, and commitment to, equality and health inequalities (like *EDS* 4.1)

3B: Board/Committee papers (including minutes) identify equality and health inequalities related impacts and risks and how they will be mitigated and managed (like *EDS2* 4.2)

3C: Board members, system, and senior leaders (Band 9 and VSM) ensure levers are in place to manage performance and monitor progress with staff and patients (response to Covid-19)

Draft

Background to how we have graded or assessed the domains.

In line with the EDS Technical Guidance, **Domain 1** requires implementation at system level. It must be applied to three clinical services or pathways selected from the local system partner NHS organisations**.**

Domains 2 and 3, on the other hand, must be completed at local organisational level and led by individual NHS organisations. However, the scores or grading results from each of the three domains must determine each individual organisation's overall EDS organisational rating in line with the EDS Technical Guidance.

Background to the Grading Events

EDS Domain 1: Commissioned or provided services (completed at a system level by the Head of EDI for Leicestershire Partnership Trust (LPT) and LLR System Projects, EDI Business Partner LLR Integrated Care Board (ICB) and Head of Equality, Diversity & Inclusion University Hospitals of Leicester (UHL).

The three clinical services within the LLR system selected for the 2024-25 EDS cycle that Domain 1 was applied to are:

- **Chaplaincy – Led by UHL**
- **Intermediate Care – Led by LLR ICB**
- **Mental Health – Perinatal Strand - Led by LPT**

LLR system's approach to the application of Domain 1 to these clinical services was driven by engagement, evidence and insight. Notably, the involvement of and engagement with clinical leads was imperative.

Following the selection of the three clinical services, a partnership working, and co-production approach was adopted to actively involve the clinical leads and service managers as well as assemble evidence against Domain 1 Outcomes over a few months.

Three grading events/workshops took place with system colleagues. These were:

- **Dates of Workshops**

- **Chaplaincy – Led by UHL 29th January**
- **Intermediate Care – Led by LLR ICB 27th February**
- **Mental Health – Perinatal Strand - Led by LPT 20th November**

At the three grading workshops, the clinical leads presented their services' evidence to wide-ranging stakeholders drawn from NHS system partner organisations, LLR Voluntary Community Social Enterprise (VCSE) Alliance, Patient Participation Groups, Citizens' Panel and the Public & Patient Involvement Assurance Group across LLR.

The stakeholders invited were representative of the protected groups, socio-economic demographic groups/communities and other people living locally.

They were asked to grade the evidence presented against the four Domain 1 outcomes and scoring criteria line with the EDS Ratings and Score Card Guidance

Information on scoring can also be found on **pages 16.**

The stakeholders were also asked for feedback on the evidence and suggestions on improvement areas and actions.

Draft

The clinical leads were notified of the grading results, including the feedback received. Importantly, they are required to incorporate these into their respective future service business plans and embed improvements across the pathways.

EDS Domain 2: Workforce Health and Wellbeing (completed at an organisational level)

A grading event took place with LLR ICBs People Champions on 11th October 2024

Background to the Grading Event.

Evidence relating to this domain was collected from relevant colleagues within the ICB starting in May 2024.

The technical guidance recommends the involvement of staff networks in grading. The following steps were taken prior to the grading session on 11th October:

- A drop-in session/workshop was organised to help the People Champions with any questions/issues as well as considering the evidence and scoring rationale. This was held with on 6th September 2024.
- Subsequently, evidence for all four outcomes together with scoring rationale was circulated on 6th September.
- An email reminding the Forum members of the grading exercise was sent out on the 4th October together with a recirculation of the evidence.
- The grading event was held on 11th October 2024 with the People Champions. A summary slide deck was presented to assist people with remembering the evidence on the day.

A copy of the slides used to present a summary of the evidence for domain 2A - 2D is found at Appendix 2

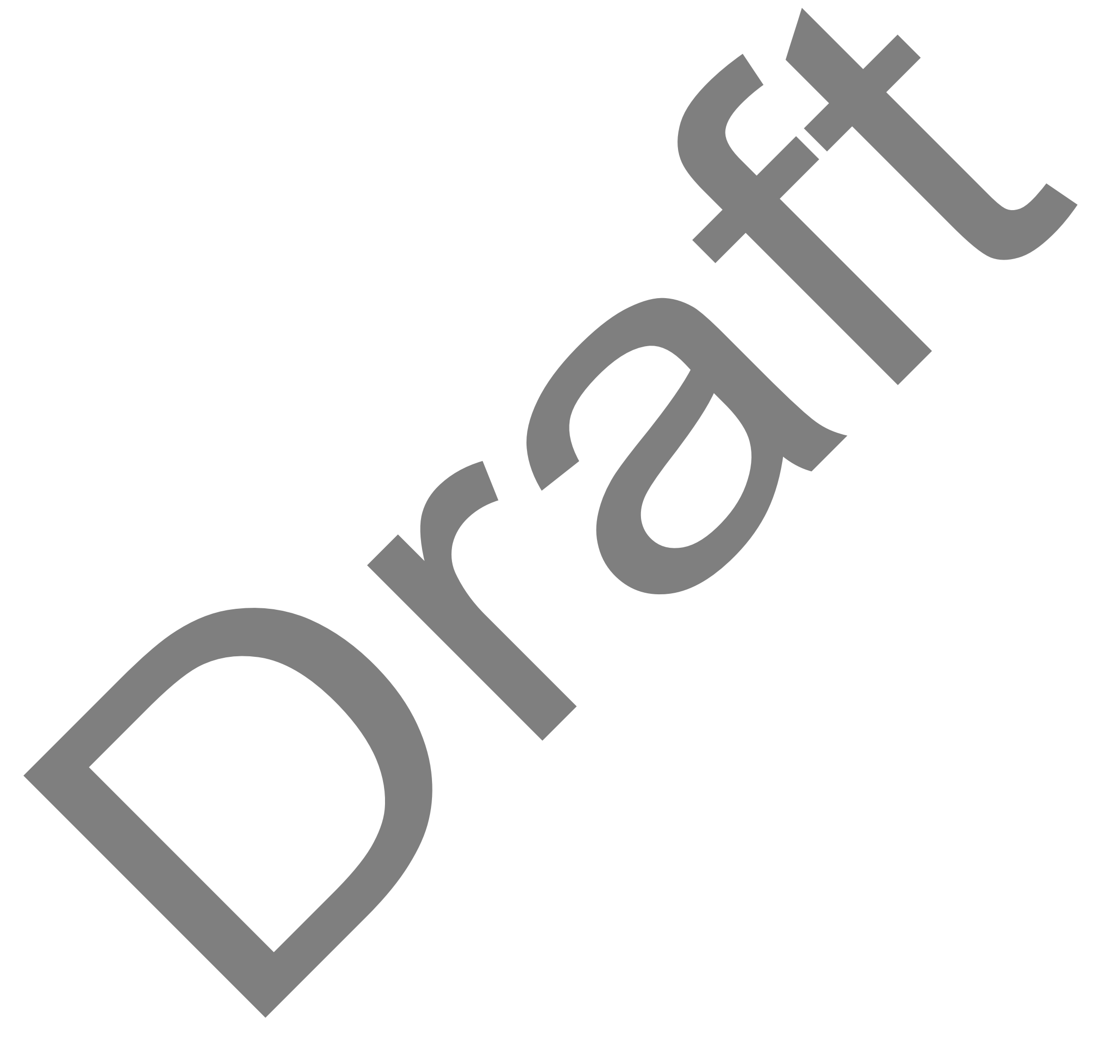
Scoring Guidance can be found here.

Draft

EDS Domain 3: Inclusive Leadership (completed at an organisational level)

The EDS technical guidance suggests that this Domain should reviewed by a peer group. This year we entered a partnership with NHS Northamptonshire ICB and NHS Lincolnshire ICB. The review took place on the 8th January 2025. Each ICB presented their evidence which was then scored by fellow peers as well as an independent peer from the Royal College of Nursing East Midlands.

Scoring Guidance can be found here.


Draft

NHS Equality Delivery System Reporting Template

Name of Organisation		**Leicester, Leicestershire & Rutland ICB**	**Organisation Board Sponsor/Lead**		
			Alice McGee **Chief People Officer**		
Name of Integrated Care System		**Leicester, Leicestershire & Rutland ICS**			

EDS Lead	**Shaun Cropper**		**At what level has this been completed?**	
				***List organisations**
EDS engagement date(s)	11/10/2024 08/01/25		**Individual organisation**	Domain 2 People champions Domain 3 Peer Review with NHS Northamptonshire ICB and Lincolnshire ICB.
Chaplaincy – Led by UHL 29th January Intermediate Care – Led by LLR ICB 25th & 27th January Mental Health Perinatal Strand – Led by LPT 20th November			**Partnership* (two or more organisations)**	Domain 1 – see Appendix 1 for list of organisations

			Integrated Care System-wide*	

Date completed	April 2025	**Month and year published**	June 2025
Date authorised		**Revision date**	End February 2026

Scoring

Domain 1: Commissioned or provided services score

Feedback - see system report Appendix 1

Domain 1: Commissioned or provided services Overall Rating		**Developing**

Domain 2: Workforce health and well-being score

The scores are based on the frequency of responses to each question. The facilitator used Menti-meter (an interactive presentation software facility) to collect the results. Participants were then circulated with a feedback form asking them for their rationale behind their scores.

Feedback

Outcome 2A: When at work, staff are provided with support to manage obesity, diabetes, asthma, COPD and mental health conditions.

What was the reason behind you score?

- Whilst we have the foundations in the ICB we need to embed a lot of our work. The health and wellbeing audit is likely to also suggest further recommendations.
- Whilst progress has been made on a lot of areas, some of the condition areas are not as established as others.

Outcome 2B: When at work, staff are free from abuse, harassment, bullying and physical violence from any source.

What was the reason for your score?

- We have developed a lot of resources this year, but I am not assured these are embedded into our culture yet.

- Further strides have been made in this area with active bystander programme already well received by staff and introduction of further resources and programmes.

Outcome 2C: Staff have access to independent support and advice when suffering from stress, abuse, bullying harassment and physical violence from any source.

What was the reason for your score?

- We have a lot of resources available to our colleagues.
- Programmes have been established to support, Freedom to Speak up guardians established. We're on a good trajectory.

Outcome 2D: Staff recommend the organisation as a place to work and receive treatment.

What was the reason for your score?

- We have repeating data that staff feel the workload is too much and we don't have enough resources. We haven't cracked this yet.
- We can only demonstrate developing in this area based on staff survey statistics and choosing to treat and work in this area. This is also reflective for the other components; however, these are perhaps not as strong.

General feedback: There was some feedback that the ICB does not support those who are neurodiverse and that there are no safe places or training for managers. It was also felt that there should be more training around the protected characteristics.

Domain	Outcome	Evidence	Rating	Owner (Dept/Lead)
Domain 2: Workforce health and well-being	2A: When at work, staff are provided with support to manage obesity, diabetes, asthma, COPD and mental health conditions	**Enclosed at Appendix 3 is the evidence presented as a summary and made accessible for screen readers. This will be available on the website. A full version with embedded documents is available by emailing: llricb-llr.enquiries@nhs.net** **The documents will also be available in other formats on request.**	**Developing**	Senior People Services Lead Development /Senior Organisational Development and Workforce Manager
	2B: When at work, staff are free from abuse, harassment, bullying and physical violence from any source	**Enclosed at Appendix 4 is the evidence presented as a summary and made accessible for screen readers. This will be available on the website. A full version with embedded documents is available by emailing: llricb-llr.enquiries@nhs.net** **The documents will also be available in other formats on request.**	**Developing**	Senior People Services Lead Development /Senior Organisational Development and Workforce Manager

	2C: Staff have access to independent support and advice when suffering from stress, abuse, bullying harassment and physical violence from any source	**Enclosed at Appendix 5 is the evidence presented as a summary and made accessible for screen readers. This will be available on the website. A full version with embedded documents is available by emailing: llricb-llr.enquiries@nhs.net** **The documents will also be available in other formats on request.**	**Achieving**	Senior People Services Lead Development /Senior Organisational Development and Workforce Manager
	2D: Staff recommend the organisation as a place to work and receive treatment	**Enclosed at Appendix 6 is the evidence presented as a summary and made accessible for screen readers. This will be available on the website. A full version with embedded documents is available by emailing: llricb-llr.enquiries@nhs.net** **The documents will also be available in other formats on request.**	**Developing**	Senior People Services Lead Development /Senior Organisational Development and Workforce Manager
Domain 2: Workforce health and well-being overall rating				**Developing**

Domain 3: Inclusive leadership

Feedback from Peer Review

Domain 3A: Board members, system leaders (Band 9 and VSM) and those with line management responsibilities routinely demonstrate their understanding of, and commitment to, equality and health inequalities

- Create a better system of capturing all senior leaders' involvement/visibility in EDI events and activities and build in robustness through ensuring more participation.
- Capture evidence from Leader's actions on their equality objectives from appraisals.

Domain 3B: Board/Committee papers (including minutes) identify equality and health inequalities related impacts and risks and how they will be mitigated and managed

Comments & rationale:

- Develop a mechanism for capturing robust evidence that EIAs are considered in the decision-making process such as through improving the front sheet.

- Peer group thought we were at the upper level of developing going towards achieving.

Domain 3C: Board members and system leaders (Band 9 and VSM) ensure levers are in place to manage performance and monitor progress with staff and patients

Comments & rationale:

- Improve our exit interviews to understand by protected characteristics and any themes

Overall

The Peer group said we had not achieved but were achieving and one member of the group commented that the work LLR ICB is doing is commendable.

Domain	Outcome	Evidence	Rating	Owner (Dept/Lead)
Domain 3: Inclusive leadership	3A: Board members, system leaders (Band 9 and VSM) and those with line management responsibilities routinely demonstrate their understanding of, and commitment to, equality and health inequalities	**Appendix 7 - The evidence is provided as a summary which is compatible with screen readers. This will be available on the website. A full version with embedded documents is available by emailing: llricb-llr.enquiries@nhs.net** **The documents will also be available in other formats on request.**	**Achieving**	Alice Mc Gee, Chief People Officer

	3B: Board/Committee papers (including minutes) identify equality and health inequalities related impacts and risks and how they will be mitigated and managed	**Appendix 8 - The evidence is provided as a summary which is compatible with screen readers. This will be available on the website. A full version with embedded documents is available by emailing: llricb-llr.enquiries@nhs.net** **The documents will also be available in other formats on request.**	**Developing**	Alice Mc Gee, Chief People Officer
	3C: Board members and system leaders (Band 9 and VSM) ensure levers are in place to manage performance and monitor progress with staff and patients	**Appendix 9 - The evidence is provided as a summary which is compatible with screen readers. This will be available on the website. A full version with embedded documents is available by emailing: llricb-llr.enquiries@nhs.net** **The documents will also be available in other formats on request.**	**Achieving**	Alice Mc Gee, Chief People Officer
Domain 3: Inclusive leadership overall rating				**Achieving**

Third-party involvement in Domain 3 rating and review	
Trade Union Rep(s):	Non

Overall Score

What is the process for scoring?

Firstly, each outcome is scored individually. Following this, the overall score is produced by adding the scores of all outcomes together. Domain 1 is **determined by using the middle score out of the three services from Domain 1, in line with the EDS Technical Guidance.** This will provide the EDS Organisation Rating.

Ratings are in accordance with scores below:

Undeveloped activity – organisations score out of 0 for each outcome	Those who score **under 8,** adding all outcome scores in all domains, are rated **Undeveloped**
Developing activity – organisations score out of 1 for each outcome	Those who score **between 8 and 21,** adding all outcome scores in all domains, are rated **Developing**
Achieving activity – organisations score out of 2 for each outcome	Those who score **between 22 and 32,** adding all outcome scores in all domains, are rated **Achieving**
Excelling activity – organisations score out of 3 for each outcome	Those who score **33,** adding all outcome scores in all domains, are rated **Excelling**

Overall Score: 2025

Domain	Outcome	Rating	Score value	Rating status
D1 Commissioned & provided services middle scoring service	1A		1	
	1B		2	
	1C		2	
	1D		2	
D2 workforce health and wellbeing	2A	Developing	1	
	2B	Developing	1	
	2C	Achieving	2	
	2D	Developing	1	
D3 Inclusive leadership	3A	Achieving	2	
	3B	Developing	1	
	3C	Achieving	2	
TOTAL			**17**	**Developing**

Overall Score 2024

Domain	Outcome	Rating	Score value	Rating status
D1 Commissioned & provided services middle scoring service	1A	Developing	1	
	1B	Developing	1	
	1C	Achieving	2	
	1D	Developing	1	
D2 workforce health and wellbeing	2A	Developing	1	
	2B	Developing	1	
	2C	Developing	1	
	2D	Developing	1	
D3 Inclusive leadership	3A	Achieving	2	
	3B	Excelling	3	
	3C	Achieving	2	
TOTAL			**16**	**Developing**

LLR ICB overall rating 2025	**Developing**

EDS Action Plan LLR ICB	
EDS Lead	**Year(s) active**
Shaun Cropper EDI Business Partner	2025-2026
EDS Sponsor	**Authorisation date**
Alice McGee, Chief People Officer	

Domain	Outcome	Objective	Action	Completion date
Domain 2: Workforce health and well-being	2A: When at work, staff are provided with support to manage obesity, diabetes, asthma, COPD and mental health conditions	Increase awareness of all the support mechanisms available to help with staff's health and wellbeing and work on the actions in the recent health and Wellbeing Audit.	To continue to provide events, services, and promotional activities at a variety of times. **There is also a specific and measurable equality objective around increasing people's declaration rates of their protected characteristics to understand and plan for our workforce better. This is one of our equality objectives found in the EDI Annual Report and linked to the new Internal People Plan.**	Ongoing

	2B: When at work, staff are free from abuse, harassment, bullying and physical violence from any source	Year-on-year reduction in incidents of bullying, harassment and discrimination from line managers or teams (as per staff survey).	Actions already contained in the WRES/WDES data/Staff Survey and EDS evidence which feeds into the NHS EDI Improvement plan.	March 2026
	2C: Staff have access to independent support and advice when suffering from stress, abuse, bullying harassment and physical violence from any source	Continue to use the tools that are already in place e.g. Your Voice reporting Tool, Active Bystander Programme, Speak up Champions/Guardians, Talking Therapies.	Actions already contained in the WRES/WDES data/Staff Survey and EDS evidence which feeds into the NHS EDI Improvement plan.	March 2026
	2D: Staff recommend the organisation as a place to work and receive treatment	Year on year improvement through staff survey and pulse	Measured through staff survey and Pulse	March 2025

Domain	Outcome	Objective	Action	Completion date
Domain 3: Inclusive leadership	3A: Board members, system leaders (Band 9 and VSM) and those with line management responsibilities routinely demonstrate their understanding of, and commitment to, equality and health inequalities	To seek continuous improvement by building on what we are already achieving to excel at this outcome.	1. Create a better system of capturing all senior leaders' involvement/visibility in EDI events and activities and build in robustness through ensuring more participation. 2. Capture evidence from Leader's actions on their	To review as part of next EDS assessment

			equality objectives from appraisals.	
	3B: Board/Committee papers (including minutes) identify equality and health inequalities related impacts and risks and how they will be mitigated and managed	To maintain the good work already taking place on the completion of impact assessments. There is a need to better embed equalities in the decision making at the LLR ICB.	1. To maintain the good work already taking place on the completion of impact assessments. 2. Develop a mechanism for capturing robust evidence that EIAs are considered in the decision-making process such as through improving the front sheet.	To review as part of next EDS assessment
	3C: Board members and system leaders (Band 9 and VSM) ensure levers are in place to manage performance and monitor progress with staff and patients	To continue to collect the relevant data as per mandatory and statutory duties.	1. Compare the next collection of data for WRES/WDES/Gender Pay Gap /EDI Improvement plan/senior representation to understand what the data is saying. • **There is also a specific and measurable equality objective on Board makeup to: Ensure 100% of members have completed their details relating to the protected characteristics.** (This is one of our objectives	To review as part of next EDS assessment

			in the EDI Annual Report linked to WRES/WDES/EDI Improvement Plan & EDS). 2. Improve our exit interviews to understand by protected characteristics and any themes	

Final Draft 020525

Alt/Accessibility Text Checked 020525

Name of meeting:	Leicester, Leicestershire, and Rutland Integrated Care (Public) Board		
Date:	14th August 2025	Paper:	J
Report title:	**Finance Report M03 2025/26**		
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 3 and the forecast performance.
- **RECEIVE for assurance.**

Purpose and summary of the report:

The system is reporting a year-to-date (YTD) deficit before support funding of £(38.10)m, a £(5.56)m adverse variance to plan. This is broken down as follows:

Organisation	YTD Planned Surplus/(Deficit) £'m	YTD Actual Surplus /(Deficit) £'m	YTD Variance £'m
UHL	(27.23)	(29.99)	(2.76)
LPT	(1.44)	(1.44)	0
ICB	(3.86)	(6.66)	(2.80)
Total	**(32.54)**	**(38.10)**	**(5.56)**

UHL have reported a YTD deficit of £(29.99)m, adverse variance £(2.76)m against plan, LPT have a YTD deficit of £(1.44)m in line with plan, and the ICB have reported a £(6.66)m YTD deficit, adverse variance £(2.80)m against plan.

The system continues to forecast a year end deficit of £(80.00)m before support funding, in line with plan. The planned deficit is; UHL £(64.85)m, LPT £0.31m & ICB £(15.46)m.

Appendices:	
Report history (date and committee / group	• ICB(S) Finance Committee

the content has been discussed / reviewed prior to presenting to this meeting):	

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

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

Implications:	
a) Does the report provide assurance against a corporate risk(s) e.g. risk aligned to the Board Assurance Framework, risk register etc? *If so, state which risk and also detail if any new risks are identified.*	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 3 (June) 2025/26

Background

1. The system submitted a final 2025/26 financial plan to NHS England on 30th April 2025. The LLR plan is a breakeven position across the system, split organisationally as;
- UHL: breakeven
- LPT: £0.31m surplus
- ICB: £(0.31)m deficit

2. £80.00m of non-recurrent deficit support funding is included within the 2025/26 plan and has been distributed across the organisations in the same proportions as 2024/25;
   i. UHL £64.8m
   ii. LPT £0m
   iii. ICB £15.2m

Headlines

Table 1 – M3 System Financial Position

Position Pre / Post support funding		Plan YTD £m	Actual YTD £m	Variance YTD £m	Plan FOT £m	Actual FOT £m	Variance FOT £m
UHL	Position before support	(27.23)	(29.99)	(2.76)	(64.85)	(64.85)	-
	Deficit Support	21.22	21.22	-	64.85	64.85	-
	Net Position after support	**(6.02)**	**(8.78)**	**(2.76)**	**-**	**-**	**-**
LPT	Position before support	(1.44)	(1.44)	-	0.31	0.31	(0.00)
	Deficit Support	-	-	-	-	-	-
	Net Position after support	**(1.44)**	**(1.44)**	**-**	**0.31**	**0.31**	**(0.00)**
ICB	Position before support	(3.86)	(6.66)	(2.80)	(15.46)	(15.46)	0.00
	Deficit Support	3.79	3.79	-	15.15	15.15	-
	Net Position after support	**(0.08)**	**(2.88)**	**(2.80)**	**(0.31)**	**(0.31)**	0.00
Total ICS	Position before support	(32.54)	(38.10)	(5.56)	(80.00)	(80.00)	(0.00)
	Deficit Support	25.01	25.01	-	80.00	80.00	-
	Net Position after support	**(7.54)**	**(13.09)**	**(5.56)**	**0.00**	**0.00**	**(0.00)**

Table 2 - Movement from Previous Month (before support funding)

Gross movement from prior month		Plan YTD £m	Actual YTD £m	Variance YTD £m	Plan FOT £m	Actual FOT £m	Variance FOT £m
Month 3	UHL	(27.23)	(29.99)	(2.76)	(64.85)	(64.85)	-
	LPT	(1.44)	(1.44)	-	0.31	0.31	(0.00)
	ICB	(3.86)	(6.66)	(2.80)	(15.46)	(15.46)	0.00
	ICS Total	**(32.54)**	**(38.10)**	**(5.56)**	**(80.00)**	**(80.00)**	**(0.00)**
Month 2	UHL	(18.75)	(22.53)	(3.78)	(64.85)	(64.85)	-
	LPT	(1.07)	(1.07)	-	0.31	0.31	(0.00)
	ICB	(2.58)	(3.42)	(0.84)	(15.46)	(15.46)	0.00
	ICS Total	**(22.40)**	**(27.01)**	**(4.62)**	**(80.00)**	**(80.00)**	**0.00**
Movement	UHL	(8.48)	(7.47)	1.02	-	-	-
	LPT	(0.37)	(0.37)	-	-	-	-
	ICB	(1.29)	(3.25)	(1.96)	(0.00)	(0.00)	(0.00)
	ICS Total	**(10.14)**	**(11.09)**	**(0.94)**	**(0.00)**	**(0.00)**	**(0.00)**

3. Table 1 above details the position before and after deficit support funding. At month 03, the system is reporting a year-to-date (YTD) deficit before support funding of £(38.10)m, an adverse variance from plan of £(5.56)m.

4. The YTD variance is driven by the following key areas:
    - Under recovery of income at UHL
    - Prescribing growth in excess of reduced budget
    - Challenge to reduce costs/identify and deliver sufficient efficiency schemes within the ICB and on-going Independent Sector activity above plan.

5. The system is reporting a year end deficit forecast outturn (FOT) before support funding of £(80.0)m, which is in line with plan.

6. Table 2 above details the gross movement from the previous month i.e. the movement before support funding. It can be seen from the table that the system YTD variance has deteriorated by £(0.94)m since last month but there has been no change to the reported FOT position.

7. At month 3, system cost reduction / efficiencies are below plan by £(1.71)m. LPT have reported achievement of plan, UHL £(0.14)m under achievement, and the ICB £(1.56)m under achievement.

8. System agency spend is forecasting a £0.61m underspend against plan which is below the system agency cap.

9. NHSE have also applied a system cap to bank spend for 2025/26. System bank spend is forecast to be £2.12m below planned levels, however this is still above the cap level by £(7.25)m. Planned spend exceeds the cap due to UHL medical staff realignment and reflects where expenditure is expected to be incurred.

10. The M03 YTD operating capital spend (before impact of IFRS16) is £6.53m which is £7.45m behind a plan of £14.00m. The System is forecasting a breakeven position on their operating capital (including IFRS16) of £65.45m.

11. The current assessment of residual risk reported at month 3 was £(62.63)m variance to plan. This comprises of UHL £(29.97)m, LPT £(5.36)m, and ICB £(27.30)m.

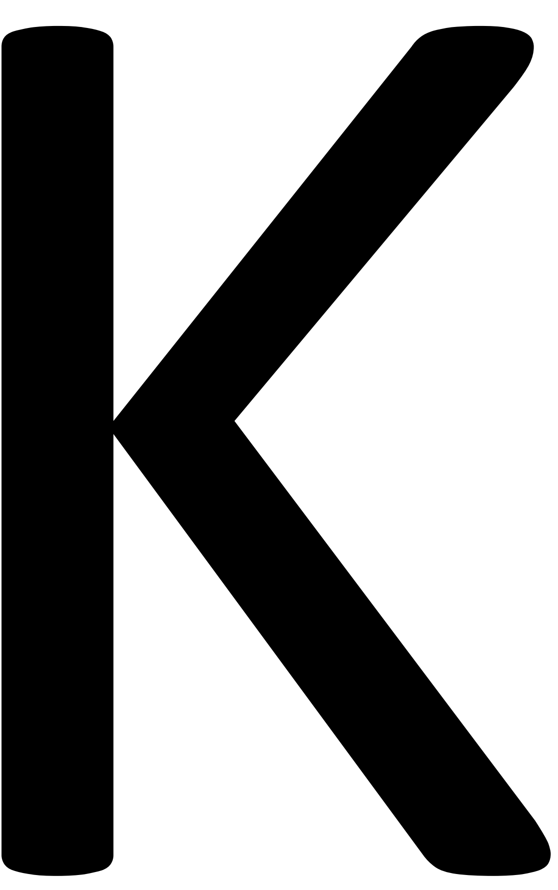
12. Significant work continues to reduce the level of risk and enable delivery of the financial plans.

13. To support existing workstreams, the ICB have agreed to roll-out specific 'Tiger' teams to:

    a. progress delivery of existing efficiency schemes with limited resources
    b. identify and eliminate obstacles
    c. generate new ideas
    d. revisit previously rejected schemes/opportunities

14. Tiger teams approach wider roll-out 4th August 2025 and work on a 3-week turnaround period.

Recommendations:
The Leicester, Leicestershire and Rutland Integrated Care Board is asked to:
- **RECEIVE and NOTE** the financial position as at month 3.
- **RECEIVE for assurance.**



Name of meeting:	Leicester, Leicestershire and Rutland Integrated Care Board (Public)		
Date:	14 August 2025	Paper:	K
Report title:	Assurance Report from the Finance Committee		
Presented by:	Anil Majithia – LLR ICB Non-Executive Member and Chair of Finance Committee		
Report authors:	Tamara Hazell – LLR ICB Corporate Governance Officer Claire Middlebrook – LLR ICB Corporate Governance Officer Robert D Toole – LLR ICB Chief Finance Officer		
Executive Sponsor:	Robert D Toole – LLR ICB 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** the Assurance Report from the Finance Committee (June and July 2025)

Purpose and summary of the report:

This report provides a summary of the key areas of discussion and outcomes following the meeting of the LLR ICB Finance Committee held in June and July 2025. The report covers items for escalation and consideration by the ICB Board ensuring that it is alerted to emerging risks and issues.

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 Conflict 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 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 LLR ICB Finance Committee

A summary of the key areas of assurance and escalation are detailed in the table below.

Key area discussed at the Committee meeting	Level of risk	Detail – Alert / Advise / Assure (to include mitigations to reduce risk)	Action required (where necessary)
1.ICB Finance	**RED**	**Alert** - The Finance Committee received the ICB's financial position as at **Month 3** which was showing a year-to-date (YTD) deficit plan of £(0.08)million, with a variance of £(2.8)million. The current remaining risk to delivery is c.£27m, a reduction from original plan with mitigations continuing to be developed noting however that the M3 forecast position remains is to break even at year end. The Committee discussed broader system level challenges, including concerns over national focus on the risk of increased prescribing of the weight loss drug Tirzepatide, which is for some cases principally diabetes prescribed in LLR. This raised questions about the ICB's influence over national decisions and its accountability for outcomes outside of its direct control. A further example involved inefficiencies stemming from limited local access to ADHD assessments and associated treatment/drug plans, resulting in patients seeking an initial diagnosis assessment (with no treatment plan) outside of area. The Committee further discussed the challenges in acute care and mental health, noting that some contracts are yet to be confirmed. The ongoing pressures with CHC were highlighted, with additional support being put into this area to ensure costs are appropriate. The Committee recommends that the Board reflect on its accountability in such areas and consider how best to address risks arising from nationally driven or externally constrained decisions.	**Action required:** The Board is requested to reflect on its accountability responsibilities in relation to matters beyond its direct control. It is asked to consider how it communicates its limitations with national bodies regarding the extent of its influence. A cohesive and unified approach would be expected to strengthen this.
2.ICB Efficiencies	**RED**	**Alert** - The Finance Committee received the ICB efficiency delivery briefing detailing the development and implementation of efficiency measures in line with the ICBs planned priorities for 2025/26. The Committee noted that the submitted cost reduction / efficiency plan totalled £70.2 million, with the FOT at **Month 3** reported as £70.02 million. The in-year efficiency target for Month 3 was £10.2 million, of which £8.7million had been delivered. Across all schemes there is a £61.5m total financial risk, which is broken down to £20.5m low risk, £5.2m medium risk and £35.8m high risk.	**No action required** The Board is asked to note overall assurance rating of Red as there are gaps in assurance, although the Finance Committee were assured that appropriate plans were in place / being developed to address the gaps.
3.Financial Recovery plan	**AMBER**	**Advise** - The Committee received an update on the Financial Recovery Plan, noting the c.£40m risk and on-going actions being taken to mitigate. The plan is being overseen by Operational Delivery Group with executive oversight, with c.200 suggested ideas / long list schemes reviewed on a line-by-line basis for appropriateness and prioritisation.	**No additional actions required.**

4. Board Assurance Framework	**AMBER**	**Advise** – The Committee received the current Board Assurance Framework, noting that it is still under review and that the statement of financial risk needs re-wording.	**No action required**
5. System Finance	**RED**	The Finance Committee received the overall YTD system position as at **Month 3**. The following positions were noted: • UHL reported a YTD deficit of £(27.23)m which was a £(2.76)m variance against plan. • LPT reported a YTD deficit of £(1.44)m which was a breakeven position against plan.	**Updates on Recovery and Sustainability and Actions requested via System Executive to be reviewed.**

Definitions:

Alert	What are the key issues/risks that you need to alert the Board? These are issues/risks that require action/escalation in order to aid or support decision/actions to mitigate or manage. The report needs to be clear about what action we are asking the Board to take.
Assure	What are the key areas where you need to provide assurance on where progress is being made but may not yet have achieved the trajectories set or met the milestones anticipated. The report needs to be clear about the mitigations that are in place to address the gaps in assurance.
Advise	What are the key areas/items you want to advise the board/meeting on where key achievements have been made that have had an impact – benefits/outcomes.

Key for level of risk:

Green	**No risks identified:** there are no gaps identified.
Amber	**Risks identified:** there are some gaps in assurance, although assured that appropriate plans are in place / being developed to address the gaps.
Red	**Unmitigated risks:** there are significant gaps in assurance and not assured as to the adequacy of the plans.

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

- **RECEIVE** the Assurance Report from the Finance Committee

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<table>
<tr><td>Name of meeting:</td><td colspan="3">Leicester, Leicestershire and Rutland ICB Board – meeting in public</td></tr>
<tr><td>Date:</td><td>14 August 2025</td><td>Paper:</td><td>L</td></tr>
<tr><td>Report title:</td><td colspan="3">LLR ICB Board Assurance Framework 2025/26</td></tr>
<tr><td>Presented by:</td><td colspan="3">Robert Toole, Chief Finance Officer</td></tr>
<tr><td>Report author:</td><td colspan="3">Daljit Bains, Head of Corporate Governance</td></tr>
<tr><td>Executive Sponsor:</td><td colspan="3">Robert Toole, Chief Finance Officer</td></tr>
</table>

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

Recommendations:

The LLR ICB Board is requested to:

- **APPROVE** the amendment to the risk description for BAF risk 4 (finance) as outlined in Table 2 in the report.
- **APPROVE** the re-evaluation of the inherent risk score, risk appetite score and the residual risk score for BAF risk 2 (health inequalities) as outlined in Table 1 in the report.
- **APPROVE** the risk description, controls, assurances, actions and associated risk scores for the two new risks: BAF 10 (NHS Reforms and lack of financial resources) and BAF 11 (delivery of strategic objectives) as detailed in Appendix 1.
- **APPROVE** the updated Board Assurance Framework in its entirety (as at Appendix 1), noting that the content is reviewed on a regular basis.

Purpose and summary of the report:

This report aims to assure the LLR ICB Board that the ICB's risk management arrangements continue to be effective. This includes a regular review of the ICB's Board Assurance Framework (BAF) which is reviewed at agreed intervals by the Executive Team and the respective Board Committees.

The Board is requested to approve the updated BAF in its entirety, including the specific amendments drawn to the Board's attention. An updated version of the ICB's BAF is appended to this report **(Appendix 1)** with a high-level overview and amendments captured in paragraphs 8 – 9, Tables 1 - 3, and Figure 1 within the report.

The Joint Executive Team have considered and supported the content of the BAF (Appendix 1) for onward consideration and approval by the Board.

Appendices:	• Appendix 1 – LLR ICB BAF 2025/26
Report history (date and committee / group the content has been discussed / reviewed prior to presenting to this meeting):	• April 2025 – Board approved the opening BAF. • April 2025 – Audit Committee received an update. • April – May 2025 – reviewed at various Committees. • February and May 2025 – discussions with the working group consisting of LLR ICB Board members. • 27 May 2025 – Executive Management Team reviewed the BAF, the proposed BAF risk in relation to transition, and the proposed updated risk appetite framework and updated risk categories .

	• 28 May 2025 – Finance Committee reviewed the BAF. • 12 June 2025 – LLR ICB Board approved the change in risk appetite framework, risk categories, change to a couple of strategic risks and approved amendments to the Risk Management Strategy and Policy. • June 2025 – July 2025 – reviewed at various Board Committees. • 6 August 2025 – BAF reviewed and considered by the Joint Executive Team.

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

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

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

LLR ICB Board Assurance Framework 2025/26

Purpose

1. This report aims to assure the LLR ICB Board that the ICB's risk management arrangements continue to be effective. This includes a regular review of the ICB's Board Assurance Framework (BAF) which is reviewed at agreed intervals by the Executive Team and the respective Board Committees.

2. The Board is requested to approve the updated BAF in its entirety, including the specific amendments drawn to the Board's attention. An updated version of the ICB's BAF is appended to this report (Appendix 1) with a high-level overview and amendments captured in paragraphs 8 – 9, Tables 1 - 3, and Figure 1 within the report.

3. The Joint Executive Team have considered and supported the content of the BAF (Appendix 1) for onward consideration and approval by the Board.

Board Assurance Framework 2025/26 update

4. The BAF captures a snapshot of the ICB's strategic risk profile at a point in time and the content of the BAF continues to be reviewed by the executive team every couple of months, as agreed by the Board, to ensure it remains as up to date as possible.

5. The Board will recall that it approved the new risk appetite framework and revised risk categories at its meeting in June 2025. Subsequently, each of the BAF risks have been assessed against the new risk appetite framework and aligned to the new risk categories as detailed in Appendix 1.

6. An initial assessment of the impact of the NHS Reforms on existing strategic risks has also been considered, including the impact on the in-year finance position – this detail is captured within the BAF at Appendix 1. Furthermore, two new BAF risks specifically relating to the NHS Reforms have been escalated to the BAF by the Joint Transition Committee and the Joint Executive Team (see paragraph 8 c) of the report).

7. The updated BAF is as at **Appendix 1** with a high-level summary captured in **Table 3.** Amendments made to the controls, assurances, actions and risk scores across the BAF have been reviewed by the executive team.

8. The LLR ICB Board's attention is drawn to the following **specific updates:**

   a) **<u>Risks with a high residual (current) risk score</u> –** the following risks continue to be the high rated risks within the LLR ICB BAF:
      i. BAF 2 - Health inequalities (residual risk score of 16)
      ii. BAF 4 - finance (residual risk score of 20)
      iii. BAF 5 - quality and safety (residual risk score of 16)
      iv. BAF 7 – cyber (residual risk score of 20)
      v. BAF 10 – NHS reforms/transition and lack of financial resources (residual risk score of 16) – new risk.

   b) **<u>Change in risk scores</u>:**

      i. **Risk appetite scores** – all existing risks have been reviewed against the new risk appetite framework and no changes have been proposed thus confirming that the risk appetite scores are considered appropriate, with the exception of BAF risk 2 (health inequalities) as highlighted in Table 1 below.

ii. **Residual risk scores (current risk score)** – changes are proposed as detailed in Table 1.

Table 1: changes to risk scores

BAF risk	Proposed change to the relevant risk scores
BAF 2 (health inequalities)	• **Risk re-evaluated** – a re-evaluation of this risk has been undertaken to assess if the risk remains current. It has been determined that the risk remains current, however having assessed the controls and assurances in place now, it is suggested that the impact score of the risk (i.e. the impact if the risk was to materialise) be reduced to '4 – major' as opposed to '5 – catastrophic'. • This would mean that: ○ The **inherent / initial risk score would be 20** (as opposed to 25) ○ The **risk appetite score would be 12** (as opposed to 15) and ○ The **current / residual risk score would be 16** (as opposed to 20). • This is a positive re-evaluation of the risk and is also supported by the level of controls and assurances in place currently. The Joint Executive Team has considered and support the amendments highlighted above for further consideration at the next Health Equity Committee meeting.
<u>System level risk</u> **BAF S1 – ICS Workforce**	• **Residual risk score reduced** - the residual risk score has reduced from 20 to 15 as a result of the positive progress made with implementing the actions.

c) **<u>New risks and amendments to existing risk descriptions</u>**: overview detailed in Table 2.

Table 2: new risks and amendments to existing risk descriptions

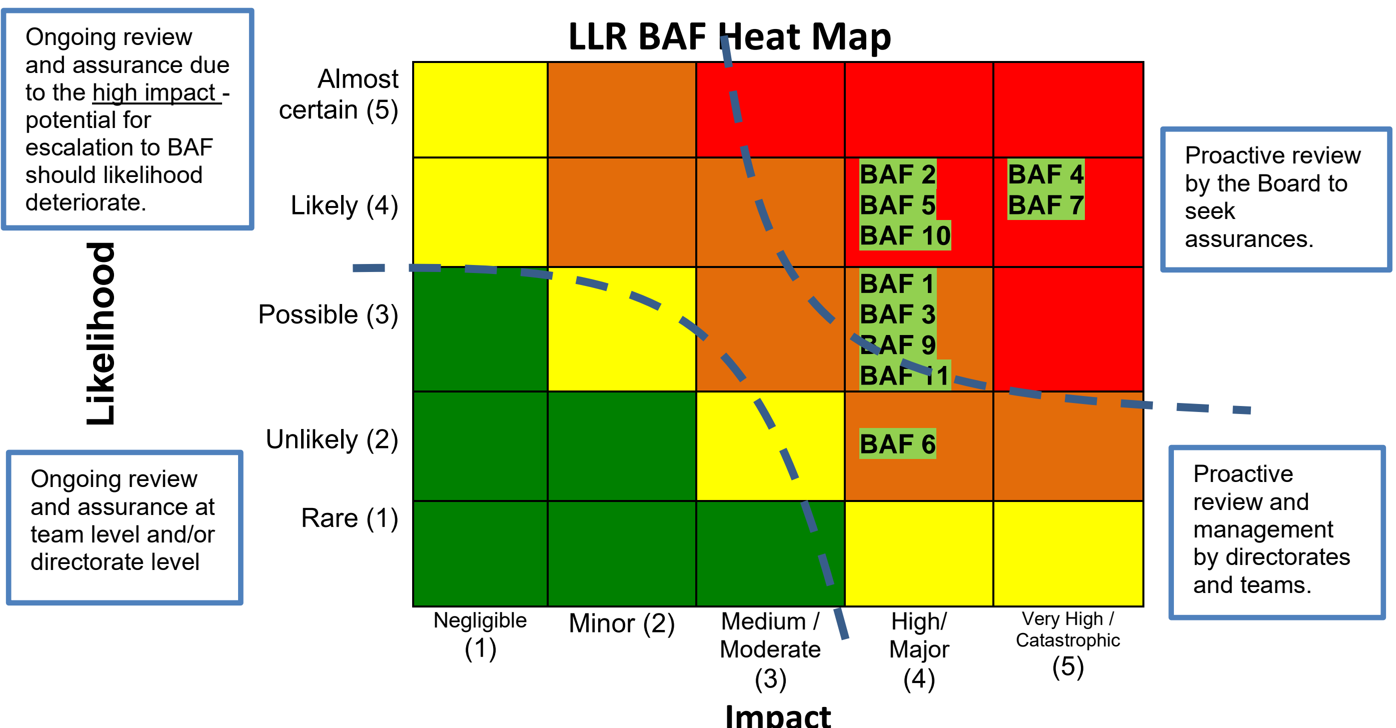
BAF risk	Amendments
BAF risk 4 (finance)	• **Existing risk - r**isk description has been reviewed further drawing out the specific cause (text struck through to be replaced with text in red): *"The ICB is unable to sustain the financial viability of the organisation in the short, medium and long term due to inability to re-align resources ~~efficiently to deliver improved outcomes for the population and therefore not being able to realise the benefits and achieve the efficiencies~~ within the available NHS contracting arrangements, guidance and allocations efficiently and thus deliver further improved outcome for the population."*
BAF risk 10 (NHS Reforms and lack of financial resources) and **BAF risk 11 (delivery of strategic objectives)**	• **New risks** – two new risks have been escalated to the BAF through the LLR ICB and Northamptonshire ICB Joint Transition Committee and the Joint Executive Team. • The format to capture and articulate risks across the respective ICBs differ slightly, however the controls, assurances, actions and the evaluation of the risk scores are aligned in the main, with some organisation specific arrangements captured where appropriate. • It is noted that a number of existing BAF risks have interdependencies with the new BAF risk 11, in particular the following BAF risks: 1 (partnership), 2 (health inequalities), 4 (finance), 5 (finance) and 6 (EPRR) and therefore the risks have been cross-referenced accordingly. • **BAF risk 10** - see page 27 of Appendix 1 for the details, and Table 3 within this report for the high-level overview. • **BAF risk 11** – see page 30 of Appendix 1 for the details, and Table 3 within this report for the high-level overview.

Table 3: High-level summary of the LLR ICB BAF 2025/26 (detail contained in Appendix 1)

Strategic risk	Residual risk score (trend) July 2025	Risk appetite	Exec Lead	Committee oversight
BAF 1 – Partnership The ICB is unable to develop and sustain a culture of collaboration / partnership working and thus unable to improve outcomes in population health and healthcare.	12 ⟺	8	**Chief Executive**	Joint Executive Team
BAF 2 – Health Inequalities Failure to adequately address health inequalities due to a lack of investment and / or lack of partnership working, therefore unable to improve health equity and outcomes for the population of LLR.	16 ⇓	12	**Chief Strategy Officer**	Health Equity Committee
BAF 3 – Demand and Capacity Demand could exceed capacity in commissioned services due to a variety of factors. This could result in patients not accessing services in the right place, at the right time, at the right level of care.	12 ⟺	12	**Chief Operating Officer**	System Executive Committee
BAF 4 – Finance The ICB is unable to sustain the financial viability of the organisation in the short, medium and long term due to inability to re-align resources ~~efficiently to deliver improved outcomes for the population and therefore not being able to realise the benefits and achieve the efficiencies~~ within the available NHS contracting arrangements, guidance and allocations efficiently and thus deliver further improved outcome for the population.	20 ⟺	10	**Chief Finance Officer**	Finance Committee
BAF 5 – Quality and Safety Failure to maintain and improve the quality of services and meet the core standards could result in poor patient experience and potential harm and poor quality outcomes for patients.	16 ⟺	12	**Chief Nursing / Chief Medical Officer**	Quality and Safety Committee
BAF 6 – Emergency Preparedness, Resilience and Response Failure to have robust emergency preparedness, resilience and response (EPRR) processes in place due to lack of capacity and / or lack of partnership could result in inadequate response to major and / or business continuity incidents.	8 ⟺	12	**Chief Operating Officer**	System Executive Committee / Joint Executive Team
BAF 7 – Cyber A significant rise in new and unknown cyber-attacks (locally or nationally) could make access to IT services unavailable for extended periods of time. This may result in risks to the confidentiality of corporate or patient confidential data, disruption to organisational business continuity and to operational services.	20 ⟺	10	**Chief People Officer**	Joint Executive Team
BAF 8 – Workforce Archived as approved by the Board on 11 April 2024.				
BAF 9 – ICB Workforce Increased turnover and lack of leadership succession planning if the ICB does not adequately utilise workforce strategies aligned to the People Promise will result in an inability to deliver the ICB objectives.	12 ⟺	8	**Chief People Officer**	Remuneration Committee
(NEW) BAF 10 – NHS Reforms and lack of financial resource The ICB is unable to enact and deliver the required NHS Reforms due to a lack of additional financial resources to support implementation.	16	12	**Chief People Officer**	Joint Transition Committee
(NEW) BAF 11 – Delivery of statutory duties The ICB is unable to deliver against its strategic objectives due to the pace of change, impact on workforce and distraction caused by the NHS reform requirements resulting in non-compliance with statutory duties.	12	8	**Chief People Officer**	Joint Executive Team
Risks associated with system priorities and objectives (i.e. the LLR Integrated Care Strategy):				
BAF S1 – ICS Workforce Failure to improve workforce retention, reduce agency use and grow our workforce around new integrated and community-based services will result in an inability to deliver care and our strategic aims.	15 ⇓	10	**Chief People Officer**	System Executive / People and Culture Board

9. An alternative method of presenting the strategic risk profile is on a risk matrix "heat map". The heat map **Figure 1** details the current/ residual risk scores.

Figure 1: ICB BAF 2025/26 Heat Map using 5 x 5 risk matrix and residual risk scores from Appendix 1 / Table 3 (July 2025)



Recommendations

The LLR ICB Board is requested to:

- **APPROVE** the amendment to the risk description for BAF risk 4 (finance) as outlined in Table 2 in the report.
- **APPROVE** the re-evaluation of the inherent risk score, risk appetite score and the residual risk score for BAF risk 2 (health inequalities) as outlined in Table 1 in the report.
- **APPROVE** the risk description, controls, assurances, actions and associated risk scores for the two new risks: BAF 10 (NHS Reforms and lack of financial resources) and BAF 11 (delivery of strategic objectives) as detailed in Appendix 1.
- **APPROVE** the updated Board Assurance Framework in its entirety (as at Appendix 1), noting that the content is reviewed on a regular basis.

Appendix 1

APPENDIX 1

Leicester, Leicestershire and Rutland Integrated Care Board

Board Assurance Framework 2025/26

(Version 6, as at end of July 2025)

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

CONTENTS | **PAGE**

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Summary of the Board Assurance Framework	4
Detailed version of the Board Assurance Framework	6
Definitions	35
Risk matrix and risk appetite framework	37

LLR ICB Strategic Objectives

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

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

Strategic risk	Current / residual risk score	Exec Lead	Committee oversight	Risk aligned to the LLR ICB Strategic Objective(s)					Page
				1.	2.	3.	4.	5.	
BAF 1 – Partnership The ICB is unable to develop and sustain a culture of collaboration / partnership working and thus unable to improve outcomes in population health and healthcare.	**12**	**TS**	Joint Executive Team	✓	✓	✓	✓	✓	6
BAF 2 – Health Inequalities Failure to adequately address health inequalities due to a lack of investment and / or lack of partnership working, therefore unable to improve health equity and outcomes for the population of LLR.	**16**	**PB**	Health Equity Committee	✓	✓		✓	✓	8
BAF 3 – Demand and Capacity Demand could exceed capacity in commissioned services due to a variety of factors. This could result in patients not accessing services in the right place, at the right time, at the right level of care.	**12**	**RV**	System Executive Committee		✓			✓	11
BAF 4 – Finance The ICB is unable to sustain the financial viability of the organisation in the short, medium and long term due to inability to re-align resources ~~efficiently to deliver improved outcomes for the population and therefore not being able to realise the benefits and achieve the efficiencies~~ within the available NHS contracting arrangements, guidance and allocations efficiently and thus deliver further improved outcome for the population.	**20**	**RT**	Finance Committee	✓		✓		✓	13
BAF 5 – Quality and Safety Failure to maintain and improve the quality of services and meet the core standards could result in poor patient experience and potential harm and poor quality outcomes for patients.	**16**	**KD / NS**	Quality and Safety Committee	✓	✓			✓	16
BAF 6 – Emergency Preparedness, Resilience and Response Failure to have robust emergency preparedness, resilience and response (EPRR) processes in place due to lack of capacity and / or lack of partnership could result in inadequate response to major and / or business continuity incidents.	**8**	**RV**	System Executive Committee / Joint Executive Team	✓	✓			✓	19
BAF 7 – Cyber A significant rise in new and unknown cyber-attacks (locally or nationally) could make access to IT services unavailable for extended periods of time. This may result in risks to the confidentiality of corporate or patient confidential data, disruption to organisational business continuity and to operational services.	**20**	**AMcG**	Joint Executive Team	✓		✓		✓	22
BAF 8 – Workforce (risk archived April 2024)	**12**	**AMcG**	Remuneration Committee / People Board						

Strategic risk	Current / residual risk score	Exec Lead	Committee oversight	Risk aligned to the LLR ICB Strategic Objective(s)					Page
				1.	2.	3.	4.	5.	
BAF 9 – Workforce Increased turnover and lack of leadership succession planning if the ICB does not adequately utilise workforce strategies aligned to the People Promise will result in an inability to deliver the ICB objectives.	12	AMcG	Remuneration Committee	✓	✓	✓	✓	✓	25
NEW - BAF 10 – NHS Reforms and lack of financial resources The ICB is unable to enact and deliver the required NHS Reforms due to a lack of additional financial resources to support implementation.	16	Alice McGee	Joint Transition Committee	✓	✓	✓	✓	✓	27
NEW - BAF 11 – Delivery of strategic objectives The ICB is unable to deliver against its strategic objectives due to the pace of change, impact on workforce, and distraction caused by the NHS reform requirements resulting in non-compliance with statutory duties.	12	Alice McGee	Joint Executive Team	✓	✓	✓	✓	✓	30
Risks associated with system priorities and objectives (i.e. the LLR Integrated Care Strategy)									
BAF S1 – ICS Workforce Failure to improve workforce retention, reduce agency use and grow our workforce around new integrated and community based services will result in an inability to deliver care and our strategic aims.	15	AMcG	System Executive Committee / People and Culture Board						33

Detailed version of the LLR ICB Board Assurance Framework

Principal / strategic risk:
BAF 1 – Partnership
The ICB is unable to develop and sustain a culture of collaboration / partnership working and thus unable to improve outcomes in population health and healthcare.

Date risk identified	ICB Executive lead (risk owner)	ICB Committee oversight	Risk category (✓ **one** main category that the risk would impact)		ICB only or system risk (✓ one) ICB	System	Risk rating (impact x likelihood = risk score)						Risk treatment (i.e. state whether to terminate, treat, transfer, or tolerate the risk)	If to be treated confirm frequency of review (e.g. monthly, quarterly)
March 2023	**Toby Sanders (Chief Executive)**	Joint Executive team	Quality		✓		**Gross/inherent risk score**	4	x	4	=	**16**	Treat	**Quarterly**
			Financial				**Risk appetite score**	4	x	2	=	**8**		
			Regulatory				**Net/residual/ current risk score**	4	x	3	=	**12**		
			Reputational				**Residual / current risk score trend since last report:**						**July 2025** – risk reviewed, no material changes.	
			People	✓										
							Next review date:						End September 2025	

Key controls in place and rationale for current / residual risk score	Internal and / or external assurances *Where can we gain evidence that our controls/systems on which we are placing our reliance are effective?*		Gaps in controls and/or assurance *Where are the gaps in our control/systems? Where are we failing to make them effective? Where is the ICB failing to gain evidence that the controls/systems are effective?*
	internal	**external**	
• ICB works with partners (i.e. LAs and NHS) to identify priority areas for joint working, development of joint strategies and plans (including plans for prevention and reducing health inequalities), reviews progress and resources, risks, issues and mitigations. • Committees in place include ICB Board, System Executive Committee, LLR Health and Wellbeing Partnership, Quality and Safety Committee, Health Equity Committee, Finance Committee. • Attendance at and joint working with other partnership forums including: Health and Wellbeing Boards across all three places, District councils' Health Leaders meetings, Integrated Systems of Care (ISOC) meeting (Leicester), Joint Integrated Commissioning Board (Leicester) Staying Healthy Partnership meetings (Leics.) Community Safety Partnership meetings, ICB-VCS Alliance regular meetings, regular meetings with Healthwatch across all three places, Collaborative meetings, Patient Participation Information and Assurance Group, LLR Research Strategy Board.	• Outcomes and progress following these meetings are reported through the ICB Board and respective ICB Committee. • Staff survey results • Complaints/disputes	• NHSE Quarterly System Review meetings • NHSE Regional Coordination Centre Daily calls • NHSE feedback on submissions such as Annual Operational plans, Joint Five Year Plan, Integrated Care Strategy, Better Care Fund Plans, Fuller Stocktake updates.	• No gaps identified, risk continues to be kept under review.
• See also controls and actions detailed under BAF risk 11 relating to the impact of NHS Reforms (BAF risk 11 re delivery of statutory functions).	• N/A	• N/A	N/A

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

Principal / strategic risk:

BAF 2 – Health Inequity

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

<table>
<tr><th rowspan="2">Date risk identified</th><th rowspan="2">ICB Executive lead (risk owner)</th><th rowspan="2">ICB Committee oversight</th><th rowspan="2" colspan="2">Risk category (✓ one main category that the risk would impact)</th><th colspan="2">ICB only or system risk (✓ one)</th><th rowspan="2" colspan="6">Risk rating (impact x likelihood = risk score)</th><th rowspan="2">Risk treatment (i.e. state whether to terminate, treat, transfer, or tolerate the risk)</th><th rowspan="2">If to be treated confirm frequency of review (e.g. monthly, quarterly)</th></tr>
<tr><th>ICB</th><th>System</th></tr>
<tr><td rowspan="5">~~20 March 2023~~

Re-evaluated July 2025</td><td rowspan="5">Peter Burnett

(Chief Strategy Officer)</td><td rowspan="5">Health Equity Committee</td><td>Quality</td><td></td><td rowspan="5"></td><td rowspan="5">✓</td><td>Gross/inherent risk score</td><td>4</td><td>x</td><td>5</td><td>=</td><td>20</td><td rowspan="3">Treat</td><td rowspan="3">Bi-monthly</td></tr>
<tr><td>Financial</td><td></td><td>Risk appetite score</td><td>4</td><td>x</td><td>3</td><td>=</td><td>12</td></tr>
<tr><td>Regulatory</td><td>✓</td><td>Net/residual/ current risk score</td><td>4</td><td>x</td><td>4</td><td>=</td><td>16</td></tr>
<tr><td>Reputational</td><td></td><td rowspan="2" colspan="6">Residual / current risk score trend since last report:</td><td rowspan="2" colspan="2">July 2025 ⬇</td></tr>
<tr><td>People</td><td></td></tr>
<tr><td colspan="7"></td><td colspan="6">Next risk review date:</td><td colspan="2">End September 2025</td></tr>
</table>

Key controls in place and rationale for current / residual risk score	Internal and / or external assurances *Where can we gain evidence that our controls/systems on which we are placing our reliance are effective?*		Gaps in controls and/or assurance *Where are the gaps in our control/systems? Where are we failing to make them effective? Where is the ICB failing to gain evidence that the controls/systems are effective?*
	internal	**external**	
• Senior Leaders in Health Equity (including an Executive and Non-Executive ICB lead) have been appointed. • ICB Health Equity Committee in place and provides assurance to the Board regarding the effectiveness of programmes of improvement to reduce health inequity including the effective use of allocated funding. • An agreed LLR Integrated Care Strategy across health and care, underpinned by Health and Wellbeing Plans at each place and neighbourhood level. • Compliance with the Public Sector Duty of Equality. • Business case and change management process in place strengthening the requirement to complete a quality and equality impact assessment for business cases that require financial investment. • A Health Inequalities Framework (Better Care for All) and delivery plan agreed across health and care partner organisations across LLR, in addition Healthwatch from Leicester and Leicestershire, and Rutland • Alignment of medicines management and health inequalities. • LLR Health Inequalities Support Unit (LLR HISU) has been established with dedicated analytical resource. Purpose is to support the Collaboratives/Partnerships in undertaking intelligence-led improvement projects to reduce health inequity.	• Assurance reports from Health Equity Committee to the ICB Board. • LLR Workforce and Public Sector Equality Duty reports to the ICB Board. • Health Inequalities Dashboard showing delivery against Core20Plus5 metrics (adults and children) presented to ICB Health Equity Committee. • Reviews undertaken e.g. LeDeR reviews identifies lessons learnt in relation to access, experience of care and outcomes of care from people with learning disabilities.	• Positive feedback from NHSE at Quarterly System Review Meetings (QSRMs). • LLR Maternity Services reports. • Joint Strategic Needs Assessments from Public Health - especially for PLUS groups • Nationally validated uptake data by ethnicity and postcode for vaccination and cancer screening programmes. • Completion of all audit recommendations following the Internal Audit review on equality, diversity and inclusion (January 2025)	• Consider the impact of the Digital Strategy e.g. digital poverty and health inequalities.

• An innovative model of primary medical care funding is in place which has improving health equity as a core purpose. • Each of the Collaboratives / Partnerships have a core purpose to improve health equity in their respective pathways in relation to access, experience of care and outcomes - metrics / dashboard / plans. • Core20 Connectors partnership programme (involving e.g. Local Authorities and VCSE) focus on cancer, respiratory and cardiovascular disease in the most deprived populations. • VCSE Alliance Hub in place to support involvement and engagement with VCSE organisations.			
• See also controls and actions detailed under BAF risk 11 relating to the impact of NHS Reforms (BAF risk 11 re delivery of statutory functions).	• N/A	• N/A	• N/A

Actions being taken to address gaps in controls and/or assurance					
Detail the actions to be taken *What actions are required to bridge the gaps in controls and/or assurance?*	**Action to be completed by (date)**	**Will the action reduce impact of risk score or likelihood or both?**			**Progress on action(s)** *Brief note on updates/progress where appropriate and confirm when action completed.*
		Impact	Likelihood	Impact and likelihood	
Consider the impact of the Digital Strategy e.g. digital poverty and health inequalities.	June 2025		✓		Reviewed in conjunction with the digital lead. **Action complete**

Principal / strategic risk:

BAF 3 – Demand and Capacity

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

<table>
<tr><th rowspan="2">Date risk identified</th><th rowspan="2">ICB Executive lead (risk owner)</th><th rowspan="2">ICB Committee oversight</th><th rowspan="2" colspan="2">Risk category (✓ one main category that the risk would impact)</th><th colspan="2">ICB only or system risk (✓ one)</th><th rowspan="2" colspan="6">Risk rating (impact x likelihood = risk score)</th><th rowspan="2">Risk treatment (i.e. state whether to terminate, treat, transfer, or tolerate the risk)</th><th rowspan="2">If to be treated confirm frequency of review (e.g. monthly, quarterly)</th></tr>
<tr><th>ICB</th><th>System</th></tr>
<tr><td rowspan="5">March 2023</td><td rowspan="5">Rachna Vyas (Chief Operating Officer)</td><td rowspan="5">System Executive</td><td>Quality</td><td>✓</td><td rowspan="5"></td><td rowspan="5">✓</td><td>Gross/inherent risk score</td><td>4</td><td>x</td><td>5</td><td>=</td><td>20</td><td rowspan="3">Treat</td><td rowspan="3">Quarterly</td></tr>
<tr><td>Financial</td><td></td><td>Risk appetite score</td><td>4</td><td>x</td><td>3</td><td>=</td><td>12</td></tr>
<tr><td>Regulatory</td><td></td><td>Net/residual/ current risk score</td><td>4</td><td>x</td><td>3</td><td>=</td><td>12</td></tr>
<tr><td>Reputational</td><td></td><td rowspan="2" colspan="6">Residual / current risk score trend since last report:</td><td rowspan="2" colspan="2">↔
July 2025 no further changes.</td></tr>
<tr><td>People</td><td></td></tr>
<tr><td colspan="7"></td><td colspan="6">Next risk review date:</td><td colspan="2">September 2025</td></tr>
</table>

Key controls in place and rationale for current / residual risk score	Internal and / or external assurances *Where can we gain evidence that our controls/systems on which we are placing our reliance are effective?*		Gaps in controls and/or assurance *Where are the gaps in our control/systems? Where are we failing to make them effective? Where is the ICB failing to gain evidence that the controls/systems are effective?*
	internal	**external**	
Operational performance monitoring and review of metrics through various groups and Committees. This will primarily be led through the reporting into the System Executive Committee and escalating to Clinical Executive Group, & the Quality and Safety Committee as needed.	Assurance reports and mitigations plans reported to the ICB Board and relevant Committee.	NHS England Quarterly System Review meetings.	A set of metrics, against all facets of the LLR 2023/24 operational plan, have been developed by each partnership. These cover the 31 metrics in the NHS mandate and are mapped to the 5 Year Plan pledges.
Revised Terms of Reference and governance in place, with a focus on performance, activity, finance, equity and quality by each programme lead. Terms of reference strengthened following review at some of the Committees of the ICB.	Assurance reports and mitigations plans reported to the ICB Board and relevant Committee.	NHS England Quarterly System Review meetings.	N/A
Delivery dashboard in place detailing performance against the 31 nationally mandated indictors, the Operational Plan and Five-Year Plan.		NHS England Quarterly System Review meetings.	N/A
A single summary report development for System Executive, detailing performance against all facets of delivery, with SMART escalations for action from either the Clinical Executive Group, System Executive Committee or the Quality and Safety Committee.	Reports presented to the System Executive Committee for review and scrutiny and onward to the ICB Board for assurance.	NHS England Quarterly System Review meetings.	N/A
Recovery and Sustainability Group established and escalations linked to CIP are raised through this forum. ICB CIP delivery escalations and plans report into the refreshed monthly finance confirm and challenge meetings with now attendance of the relevant CEO to the meeting	Reports presented to the System Executive Committee for review and scrutiny and onward to the ICB Board for assurance.	N/A	N/A
Urgent and Emergency Care Collaborative in place.	Reports presented to the System Executive Committee.	N/A	N/A

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

Principal / strategic risk:

<u>BAF 4 – Finance</u>

The ICB is unable to sustain the financial viability of the organisation in the short, medium and long term due to inability to re-align resources ~~efficiently to deliver improved outcomes for the population and therefore not being able to realise the benefits and achieve the efficiencies~~ within the available NHS contracting arrangements, guidance and allocations efficiently and thus deliver further improved outcome for the population.

Date risk identified	ICB Executive lead (risk owner)	ICB Committee oversight	Risk category (✓ **one** main category that the risk would impact)		ICB only or system risk (✓ one): ICB	System	Risk rating (impact x likelihood = risk score)						Risk treatment (*i.e. state whether to terminate, treat, transfer, or tolerate the risk*)	If to be treated confirm frequency of review (e.g. monthly, quarterly)
Carried forward from 2022/23	**Robert Toole (Chief Finance Officer)**	Finance Committee	Quality				**Gross/inherent risk score**	5	x	4	=	**20**	Treat	**Bi-monthly**
			Financial	✓		✓	**Risk appetite score**	5	x	2	=	**10**		
			Regulatory				**Net/residual/ current risk score**	5	x	4	=	**20**		
			Reputational				**Residual / current risk score trend since last report:**						⟷ July 2025	
			People											
							Next risk review date:						End September 2025	

Key controls in place and rationale for current / residual risk score	Internal and / or external assurances *Where can we gain evidence that our controls/systems on which we are placing our reliance are effective?*		Gaps in controls and/or assurance *Where are the gaps in our control/systems? Where are we failing to make them effective? Where is the ICB failing to gain evidence that the controls/systems are effective?*
	internal	**external**	
ICB Operational Plan and Financial Plan, the medium-term plan and the Five Year Plan are in place. The Operational Plan and Financial Plan are reviewed in their entirety on an annual basis.	Approval of the 5 Year Plan by the ICB Board. Financial performance reports are reviewed monthly by the Finance Committee and assurance reports reviewed by the Board.	Internal and External Auditor reports and findings are in progress (e.g. Accounts Receivable – significant assurance, Pay Expenditure – significant assurance 2024/25).	Significant grip and control of spend and investments demonstrating value for money alongside transformation and efficiency schemes will be required over the next few years to bring about balance both in terms of organisational and system designed programmes.
Long term capital programme developed to address infrastructure and IT risks. Contingency budget (£1.3m) and additional allocation amounting to (£0.8m) due to be received in month 4 to be allocated to providers as agreed by Strategic Capital Group to reduce risk levels associated with shortfalls in BAU capital for providers at the planning stage (c£2m).	System-wide approach to reviewing and determining capital needs. Strategic Capital Group in place to monitor system capital. Terms of reference and work plan in place.		Three year capital envelopes may not be sufficient to deliver all partners' capital asks and enable delivery of patient treatment and services effectively and efficiently (e.g impact of back-log maintenance).
System Finance Team monitor and review the system position attending NHS Provider Finance Committees and provides updates and monthly reports to LLR ICB Board and Finance Committee. The ICB also provides specific organisational report recognising it also currently holds the system risk related to £9m stretch target to £(80)m plan. The ICB has instigated the establishment of a Recovery and Sustainability Group with CEO leadership and engagement to further support system and organisational leadership to ensure partnership approach to delivering the plan and address issues arising.	Financial performance reports are reviewed monthly by the Finance Committee and assurance reports reviewed received by the Board. Monthly review of Finance variances by the Executive Team as month end position agreed. Spend Review Panel meetings.	NHS England Quarterly System Review Meetings.	The 2025-26 financial plans include a number of risks and pressures across ICS which will need to managed in year, including currently unmitigated planning risks and stretch challenges which crystallise in year The level of pressure currently (and for a sustained period) on the urgent care activity could lead to a necessary increase in costs. Recruitment and retention are key to system transformation and financial recovery. There is limited workforce available within the area and a number of competing employers. Lack of workforce may cause schemes to slip or costs to rise due to agency usage. Recruitment to additional posts may cause financial pressures.

Monthly finance report to Finance Committee includes Pharmacy, Ophthalmic, Dental and Specialised Commissioning delegation and raise visibility over risks given scale and magnitude of challenges in these areas. Monthly finance reports also cover ICB running and programme costs in detail. Monthly cost improvement programme (CIP) reports presented to the ICB's Finance Committee.	ICB Financial performance reports are reviewed monthly by the Finance Committee and assurance reports reviewed by the Board.	NHS England Quarterly System Review Meetings.	Lack of financial control locally as decisions are taken at a Midlands and/or East Midlands level or nationally. Risk of resource reductions impacting on ability to manage services and contract performance and activity leading to greater financial exposure.
Internal and External Auditors conduct annual audits on financial systems to provide assurance that internal controls are effective.		Internal and external auditor reports and opinion. Unqualified opinion (positive assurance) received from the external auditors and satisfactory value for money report 2024/25.	N/A
Implementation of NHS England Financial Controls.		NHS England Quarterly System Review Meetings.	N/A
Development and implementation of a financial recovery plan by the formation of dedicated resources aligned to specific portfolios ('tiger teams'). To identify areas of opportunity for increased / new efficiencies.	Weekly progress reports to the Operational Delivery Group.	NHS England Quarterly System Review Meetings.	Progress and outcomes from this approach to be evaluated end of August 2025.
See also controls and actions detailed under BAF risk 11 relating to the impact of NHS Reforms (BAF risk 11 re delivery of statutory functions).	N/A	N/A	N/A

Actions being taken to address gaps in controls and/or assurance					
Detail the actions to be taken *What actions are required to bridge the gaps in controls and/or assurance?*	**Action to be completed by (date)**	**Will the action reduce impact of risk score or likelihood or both?**			**Progress on action(s)** *Brief note on updates/progress where appropriate and confirm when action completed.*
		Impact	Likelihood	Impact and likelihood	
Evaluate impact of dedicated resources aligned to specific portfolios.	End August 2025		✓		Approach developed and proposed. Operational Steering Group approved approach on 28 July 2025. Review to be undertaken at end of August 2025.

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

Date risk identified	ICB Executive lead (risk owner)	ICB Committee oversight	Risk category (✓ one main category that the risk would impact)		ICB only or system risk (✓ one)		Risk rating (impact x likelihood = risk score)						Risk treatment (i.e. state whether to terminate, treat, transfer, or tolerate the risk)	If to be treated confirm frequency of review (e.g. monthly, quarterly)
					ICB	System								
March 2023	**Kay Darby** (Chief Nursing Officer) **/ Dr Nil Sanganee** (Chief Medical Officer)	Quality and Safety Committee	Quality	✓		✓	**Gross/inherent risk score**	4	x	5	=	**20**	Treat	Bi-monthly
			Financial				**Risk appetite score**	4	x	3	=	**12**		
			Regulatory				**Net/residual/ current risk score**	4	x	4	=	**16**		
			Reputational				**Residual / current risk score trend since last report:**						⟷ July 2025 – residual risk score remains the same as risk continues to be under review.	
			People											
							Next risk review date:						September 2025	

Key controls in place and rationale for current / residual risk score	Internal and / or external assurances *Where can we gain evidence that our controls/systems on which we are placing our reliance are effective?*		Gaps in controls and/or assurance *Where are the gaps in our control/systems? Where are we failing to make them effective? Where is the ICB failing to gain evidence that the controls/systems are effective?*
	Internal	**external**	
ICB Quality and Safety Committee meeting takes place bi-monthly: - receives assurance from the System Quality Group including risks and issues. - undertake deep dive / scrutiny into core areas bi-monthly. - Chief Nursing Officer and Chief Medical Officer are members of this Committee and provide the executive and clinical leadership.	Committee assurance reports presented to ICB Board.	NHSE Regional quality meeting and Quality Review System (QSRM) held quarterly. Internal Auditor reports and findings (e.g. Personal Health Budgets– significant assurance and Commissioned Support/Third Party working arrangements– significant assurance 2024/25).	N/A
LLR ICB Quality Strategy 2024- 2027 approved by the Quality and Safety Committee June 2024.			
LLR System Quality Group (SQG) meet monthly and review: - monthly updates from core providers: UHL, LPT, DHU, EMAS and independent contractors. - workplan / schedule of reporting and presentations from partnerships. - Safe staffing is monitored at SQG. - Dynamic risk approach adopted with partner organisations.	Group assurance reports presented to Quality Safety Committee.	NHSE membership and attendance at SQG. NHS E Regional QSRM held quarterly.	N/A
LLR Clinical Executive provide clinical oversight and leadership to strategy and operational matters and supports in understanding system quality risks and issues.	Reports to System Executive Committee.		N/A
Policy and procedures in place to assess risk and impact including: - equality and quality impact assessment process - planning process ensures equality / quality impact assessments and clinical prioritisation as fundamental steps to inform decision making. Training and support developed to support the use of the impact assessments and improving the flow of information.	Where appropriate reports to the relevant committees and Board demonstrate equality / quality impact assessments have been completed and also clinical prioritisation (where appropriate).		N/A
Partnerships / collaboratives use a self assessment tool to understand quality implications.	Updates presented at the System Quality Group.		

Locally established the Pharmacy, Ophthalmic and Dental and Specialised Commissioning Steering Group to support the transition and post-transition of the delegated functions. Region wide joint committees established to support implementation of the delegated functions including clinical and quality groups.	Assurance reports from the internal Steering Group presented to the Strategic Commissioning Group on progress and risks and onwards to System Executive Committee. Reports from the overarching regional joint committee presented to the Board.	NHS England Quarterly System Review Meetings (QSRM)	N/A
See also controls and actions detailed under BAF risk 11 relating to the impact of NHS Reforms (BAF risk 11 re delivery of statutory functions).	N/A	N/A	N/A

Actions being taken to address gaps in controls and/or assurance					
Detail the actions to be taken *What actions are required to bridge the gaps in controls and/or assurance?*	**Action to be completed by (date)**	**Will the action reduce impact of risk score or likelihood or both?**			**Progress on action(s)** *Brief note on updates/progress where appropriate and confirm when action completed.*
		Impact	Likelihood	Impact and likelihood	
Reviewed risk appetite and residual risk score in conjunction with the Quality and Safety Committee. No further actions proposed. Controls and risk appetite will continue to be reviewed in light of the NHS Reforms.					

Principal / strategic risk:

BAF 6 – Emergency Preparedness, Resilience and Response

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

Date risk identified	ICB Executive lead (risk owner)	ICB Committee oversight	Risk category (✓ ***one*** *main category that the risk would impact)*		ICB only or system risk (✓ one) ICB	System	Risk rating (impact x likelihood = risk score)						Risk treatment *(i.e. state whether to terminate, treat, transfer, or tolerate the risk)*	If to be treated confirm frequency of review (e.g. monthly, quarterly)
July 2022	**Rachna Vyas (Chief Operating Officer)**	Joint Executive Management Team	Quality			✓	**Gross/inherent risk score**	4	x	5	=	**20**	~~Treat~~ Tolerate	**Quarterly**
			Financial				**Risk appetite score**	4	x	3	=	**12**		
			Regulatory	✓			**Net/residual/ current risk score**	4	x	2	=	**8**		
			Reputational				**Residual / current risk score trend since last report:**						**July 2025** – no significant gaps identified at present.	
			People											
							Next risk review date:						End September 2025	

Key controls in place and rationale for current / residual risk score	Internal and / or external assurances *Where can we gain evidence that our controls/systems on which we are placing our reliance are effective?*		Gaps in controls and/or assurance *Where are the gaps in our control/systems? Where are we failing to make them effective? Where is the ICB failing to gain evidence that the controls/systems are effective?*
	internal	**external**	
LLR ICB Incident Response Plan in place and Corporate Business Continuity Policy and Business Continuity Plan in place and have been updated in 2025 and test exercise to be conducted on the Business Continuity Plan on 30 July 2025.	• ICB Incident Response Plan and Business Continuity Plan exercises conducted in June and July 2024 respectively. Further exercises will take place on 5 August and 30 July 2025 respectively. Learning and actions will be compiled following exercises.	• Regular meetings with NHS England and LHRP. • NHS England reviews ICB's compliance with EPRR core standards.. ICB has achieved assurance rating self-assessed of substantial compliance in 2024. ICB aiming for full compliance in 2025.	N/A
ICB Training Needs Assessment completed and Director On-Call (DoC) training plan in place. EPRR Training module added to on-call director personal development reviews. ICB training programme in place and updated on MYRUS. Local Resilience Forum (LRF) multi-agency immersive exercises in place with attendance by the ICB DoCs.			N/A
ICS EPRR Work programme actions continue to be implemented and will be updated following the outcome of the Core Standards assessment.	• Report following Mercury HESCG Exercise in March 2025. • Updates on EPRR core standards compliance presented to the ICB Board.	• The ICB ICC Plan was tested as part of Exercise Mercury HESCG post command exercise in June 2025. • Pan-ICS Strategic Cyber Exercise took place in June 2025. Pan-ICS Cyber Framework to follow.	The plan is updated annually to reflect the work programme for the next 3 years, however with the agreement of the LHRP the 2026 plan is limited to 1 year with a further update once the NHS reforms have been agreed and the role of EPRR in the ICB has been confirmed. This is reflected in the EPRR Risk Register.
Health Emergency Planning Operational Group (HEPOG) oversees actions from the LHRP meetings.			Testing of partner organisation plans underway and confirmation awaited.
Health EPRR Risk Management Group to assess local health risks and priorities and establish a system risk register for EPRR.			N/A
Table-top exercises take place to test the directorate Business Continuity Plans across LLR ICB. Testing of emergency planning takes place.			Directorate Business Continuity Plans continue to be updated and work has been identified to strengthen cyber security elements of the plans.
Strategic Control Centre and Incident Command Centre arrangements in place.			N/A
LRF Executive Board meetings in place quarterly.	LRF Live Exercise Mercury took place in March 2025, followed by LRF SCG and Recovery and Inquiry element will take place in September 2025.		N/A

Regular Director on Call lunch and learn sessions in place providing update on SCC functions, updates to ICB plans and policies and updates from ICS partners.			N/A
Planning for industrial action led by the ICB is in place. Debriefing in place to ensure learning from previous I.A is incorporated into future planning.	• Weekly Health Economy Tactical Coordinating Group meetings (HETCG). • Daily ICS GOLD (Strategic) Command meetings during Industrial Action. • Ability to stand up ICS Clinical Executive Group as required. • Enhanced SCC/UEC cover during I.A. • All plans have been updated in light of the July 2025 Resident Doctors Industrial Action.	• Regional Incident Management Meetings led by NHSE 3 x day during I.A. National Communications pack issued by NHSE National team.	Industrial Action can be affected by external factors including but not limited to, high demand for services, severe weather episodes and staffing shortages. Planning does cover these factors however due to the nature of these factors the risk remains. Work continues on managing the GP Collective Action with a robust meeting cadence and cell structure in place. ICB partake in all regional meetings. The ICB are also closely involved in Operation Drakeful (early prisoner release scheme) and have representation on strategic and tactical groups led by the police and Ministry of Justice.
A 2 tier on call structure implemented to provide resilience to current on call processes.	•	• NHS England core standards review.	N/A
See also controls and actions detailed under BAF risk 11 relating to the impact of NHS Reforms (BAF risk 11 re delivery of statutory functions).	• N/A	• N/A	N/A

Actions being taken to address gaps in controls and/or assurance					
Detail the actions to be taken *What actions are required to bridge the gaps in controls and/or assurance?*	**Action to be completed by (date)**	**Will the action reduce impact of risk score or likelihood or both?**			**Progress on action(s)** *Brief note on updates/progress where appropriate and confirm when action completed.*
		Impact	Likelihood	Impact and likelihood	
The EPRR team continue to manage all mandatory functions and incident management, however future planning has been impacted by the NHS reforms and the uncertainty around future arrangements for EPRR. Regular reviews of work programmes, meeting attendance, mandatory exercising takes place through EPRR meetings (HEPOG, LHRP).	Every 2 months at HEPOG meetings and quarterly at LHRP		✓		Review takes place every couple of months through the relevant meetings.

Principal / strategic risk:

BAF 7 – Cyber

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

Date risk identified	ICB Executive lead (risk owner)	ICB Committee oversight	Risk category (✓ *one* main *category that the risk would impact)*		ICB only or system risk (✓ one)	
					ICB	System
Carried forward from 2022/23	**Alice McGee (Chief People Officer)**	Executive Management Team	Quality			
			Financial		✓	
			Regulatory	✓		
			Reputational			
			People			

Risk rating (impact x likelihood = risk score)						Risk treatment *(i.e. state whether to terminate, treat, transfer, or tolerate the risk)*	If to be treated confirm frequency of review (e.g. monthly, quarterly)
Gross/inherent risk score	5	x	5	=	**25**	Treat	**Quarterly**
Risk appetite score	5	x	2	=	**10**		
Net/residual/ current risk score	5	x	4	=	**20**		
Residual / current risk score trend since last report:						↔ July 2025	
Next risk review date:						End September 2025	

Key controls in place and rationale for current / residual risk score	Internal and / or external assurances *Where can we gain evidence that our controls/systems on which we are placing our reliance are effective?*		Gaps in controls and/or assurance *Where are the gaps in our control/systems? Where are we failing to make them effective? Where is the ICB failing to gain evidence that the controls/systems are effective?*
	internal	**external**	
• Network boundary protection (firewalls) using multi-tiered approach. • Internal counter measures in place. • Routine and cyclical technical security testing of network boundaries. • Established and tested incident response procedures and desktop simulations conducted including lessons learned. • Business continuity and disaster recovery plans in place. • Cyber lunch and learn sessions for all staff completed in December 2024. • Simulated phishing exercises to test staff resilience to be conducted twice a year.	• Active directory audit conducted. • NCSC desktop simulations completed and more planned for December 2024 • Ransomware simulation being delivered in June 2025. • LHIS continues to conduct security testing of various estate-wide services. • CIS Benchmark Audit – to review secure configuration and process status and inform roadmap to achieve (this will align and support with CAF requirements).	• External evaluation of security posture (e.g. Bitsight) • Audit reviews of security and governance frameworks (e.g. ISO27001, DSPT) • LHIS has attained a Cyber scheme penetration testing accreditation (positive assurance). • Externally commissioned technical security testing. • NHSE CSOC Active Services pilot programme onboarding to be completed to provide partial MDR (managed detection and response)	• Standardisation of cyber security risk articulation and governance process. • Efficacy of local continuity plans for service provision in the event of a successful cyber-attack, preventing access to IT systems (including VPN) for an extended period (e.g., days). • EPRR BC/DR plans require development to assure we can withstand outages over 72 hours and CAF requirements to be achieved to be assured. • IT service supply chain dependency which could have collateral impact on services. • Lack of sustainable funding model mean cyber investment can be inefficient and risk prioritised investments are hindered/compromised.
• Compliance with the Cyber Assurance Framework Data Security and Protection Toolkit (CAF DSPT). • Cyber action section and cards added to ICB Incident Response Plan.	• Compliance with minimum DSPT CAF standards 2024/25. • 2025 ICB Incident Response Exercise will focus on Cyber Security. 2025 ICB BC Exercise will focus on Cyber Security. • Pan-ICS Strategic Cyber Exercise took place in June 2025 with actions to create a Cyber Security Framework for LLR and Northants ICB, UHL, UHN, LPT and NFHT.	• Internal Audit review on CAF DSPT provided positive confidence in the processes applied by the ICB to assess its self-assessment for 2024/25.	• Cyber Security Framework for LLR and Northants ICB, UHL, UHN, LPT and NFHT to be created.

Actions being taken to address gaps in controls and/or assurance					
Detail the actions to be taken *What actions are required to bridge the gaps in controls and/or assurance?*	**Action to be completed by (date)**	**Will the action reduce impact of risk score or likelihood or both?**			**Progress on action(s)** *Brief note on updates/progress where appropriate and confirm when action completed.*
		Impact	Likelihood	Impact and likelihood	
To standardise cyber security risk articulation and governance processes.	End September 2025		✓		NHSE are seeking to standardise, actions being progressed locally.
Compliance with DSPT CAF standards 2024/25.	End June 2025		✓		2024/25 CAF DSPT self-assessment submitted end June 2025 **(Action Complete).**
Onboarding to NHSE Active Services pilot (partial MDR)	~~April 2025~~ September 2025	✓	✓		• Bid to NHSE to be accepted onto pilot for all pan-ICS orgs made and accepted. • LHIS internal adoption process initiated and await approval to fulfil
Evaluate true supply chain risk and purchase and implementation of Vendor Privileged Access Management	~~June 2025~~ September 2025			✓	• Funding has been secured from NHSE to procure a Vendor Privileged Access Management tool, once in place this will reduce the supply chain risk. • Await capital acceptance at local level, and confirmation if matched funding required. • National supply chain assurance policies to be adopted once released.
Development of assured Business Continuity and EPRR Incident response to achieve CAF achieved status.	June 2025		✓		EPRR plan updated to address the gap. **(Action Complete)**

Principal / strategic risk:
BAF 9 – ICB Workforce
Increased turnover and lack of leadership succession planning if the ICB does not adequately utilise workforce strategies aligned to the People Promise will result in an inability to deliver the ICB objectives

Date risk identified	ICB Executive lead (risk owner)	ICB Committee oversight	Risk category (✓ **one** main category that the risk would impact)		ICB only or system risk (✓ one)		Risk rating (impact x likelihood = risk score)						Risk treatment (i.e. state whether to terminate, treat, transfer, or tolerate the risk)	If to be treated confirm frequency of review (e.g. monthly, quarterly)
					ICB	System								
December 2023	**Alice McGee (Chief People Officer)**	Remuneration Committee	Quality		✓		**Gross/inherent risk score**	4	x	4	=	**16**	Treat	**Bi-monthly**
			Financial				**Risk appetite score**	4	x	2	=	**8**		
			Regulatory				**Net/residual/ current risk score**	4	x	3	=	**12**		
			Reputational				**Residual / current risk score trend since last report:**						**July 2025 – no significant gaps identified.**	
			People	✓										
							Next risk review date:						End September 2025	

Key controls in place and rationale for current / residual risk score	Internal and / or external assurances *Where can we gain evidence that our controls/systems on which we are placing our reliance are effective?*		Gaps in controls and/or assurance *Where are the gaps in our control/systems? Where are we failing to make them effective? Where is the ICB failing to gain evidence that the controls/systems are effective?*
	internal	**external**	
Regular workforce dashboard reports, including staff survey results, presented to the Executive Management Team and the Remuneration Committee meetings to understand trends of leavers and sickness rates.	Trends are being tracked and there has been no rise in workforce metrics. Current turnover rate is c.2% and sickness rates remain below 3%. Staff Survey results to review quarterly.		No gaps identified at present.
Remuneration Committee reviews assurance reports on ICB workforce and the people plan.	Workforce dashboard presented to the Committee.	Internal Audit and report findings (e.g. Health and Wellbeing Audit 2024/25 – moderate assurance).	No gaps identified at present.
Participation and analysis of monthly, quarterly and annual staff survey.	Outcomes of staff survey shared with EMT and Remuneration Committee.		No gaps identified at present.
Regular staff briefings and communication about the ICB, its ambitions, priorities, and strategic direction.	Workforce reports presented to the Remuneration Committee at agreed intervals.		No gaps identified at present.
Analysis of exit interview questionnaires to understand any trends.	Analysis shared with EMT and Remuneration Committee.		Data is limited at present which is limiting ability to put controls in place. Recognition of links to NHS Reforms noted.
Annual appraisals to manage workload and priorities, identify talent and personal development plans to grow our leadership pipeline. PDPs will include identification of participation in regional and national Talent Pipeline programmes.	Dashboard assurance report to be produced for Remuneration Committee and EMT		No gaps identified at present.

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

Principal / strategic risk:
BAF 10 – NHS Reforms and lack of financial resources
The ICB is unable to enact and deliver the required NHS Reforms due to a lack of additional financial resources to support implementation.

<table>
<tr><th rowspan="2">Date risk identified</th><th rowspan="2">ICB Executive lead (risk owner)</th><th rowspan="2">ICB Committee oversight</th><th rowspan="2" colspan="2">Risk category
(✓ one main category that the risk would impact)</th><th colspan="2">ICB only or system risk
(✓ one)</th><th rowspan="2" colspan="6">Risk rating
(impact x likelihood = risk score)</th><th rowspan="2">Risk treatment
(i.e. state whether to terminate, treat, transfer, or tolerate the risk)</th><th rowspan="2">If to be treated confirm frequency of review
(e.g. monthly, quarterly)</th></tr>
<tr><th>ICB</th><th>System</th></tr>
<tr><td rowspan="5">June 2025</td><td rowspan="5">Alice McGee

(Chief People Officer)</td><td rowspan="5">Joint Transition Committee</td><td>Quality</td><td></td><td rowspan="5">✓</td><td rowspan="5"></td><td>Gross/inherent risk score</td><td>4</td><td>x</td><td>4</td><td>=</td><td>16</td><td rowspan="3">Treat</td><td rowspan="3">Bi-monthly</td></tr>
<tr><td>Financial</td><td>✓</td><td>Risk appetite score</td><td>4</td><td>x</td><td>3</td><td>=</td><td>12</td></tr>
<tr><td>Regulatory</td><td></td><td>Net/residual/ current risk score</td><td>4</td><td>x</td><td>4</td><td>=</td><td>16</td></tr>
<tr><td>Reputational</td><td></td><td rowspan="2" colspan="6">Residual / current risk score trend since last report:</td><td rowspan="2" colspan="2">New risk</td></tr>
<tr><td>People</td><td></td></tr>
<tr><td colspan="7"></td><td colspan="6">Next risk review date:</td><td colspan="2">September 2025</td></tr>
</table>

Key controls in place and rationale for current / residual risk score	Internal and / or external assurances *Where can we gain evidence that our controls/systems on which we are placing our reliance are effective?*		Gaps in controls and/or assurance *Where are the gaps in our control/systems? Where are we failing to make them effective? Where is the ICB failing to gain evidence that the controls/systems are effective?*
	internal	**external**	
Joint Transition Committee established between LLR ICB and Northamptonshire ICB. The Committee has oversight of the transition delivery work programme and associated programme level risks.	Assurance reports from the Joint Transition Committee presented to the ICB Board for assurance.	Assurance reported to the Regional governance structure (Regional Transition Group and Regional Transition Board).	N/A
Joint executive team oversight of transition plan. Transitional executive lead in place overseeing the implementation of the programme and oversight of associated risks.	Assurance reports from the Joint Transition Committee presented to the ICB Board for assurance.	N/A	N/A
Management of Change policy and processes for the executive team and staff.	Oversight of executive level process through Remuneration Committee, with staff level oversight through the executive team.		Implementation of the management of change process for executive members and staff.
Arrangements for voluntary redundancy programme.	Oversight through the Remuneration Committee.	Assurance reported to the Regional governance structure (Regional Transition Group and Regional Transition Board).	Local voluntary redundancy arrangements need to be determined once the national policy guidance has been published.
Assessment of Commissioning Support Unit services / functions and determination of future destination (where appropriate) including implications of any stranded costs.		Regional coordination group in place to consider consistent approach.	CSUs services / functions need to be assessed to identify future destination for the functions aligned to the Model ICB Blueprint. Should there be any ‘stranded costs’ these need to be quantified to ascertain the implication.
Financial efficiency plans in place to address the in-year financial pressures aligned to the Operational Plan and Five Year Plan.	Regular reports to the Finance Committee for oversight.	NHS England Quarterly System Review meetings	Position / plans continue to be reviewed through the Finance Committee.
High level plan in place to comply with the financial target / savings and transition of functions to partner organisations.	Assurance reports from the Joint Transition Committee presented to the ICB Board for assurance.	Assurance reported to the Regional governance structure (Regional Transition Group and Regional Transition Board).	Functional level ‘receiver’ organisations to be identified.

Actions being taken to address gaps in controls and/or assurance					
Detail the actions to be taken *(including What actions are required to bridge the gaps in controls and/or assurance?*	**Action to be completed by (date)**	**Will the action reduce impact of risk score or likelihood or both?**			**Progress on action(s)** *Brief note on updates/progress where appropriate and confirm when action completed.*
		Impact	Likelihood	Impact and likelihood	
Establish local arrangements and policy for voluntary redundancy (VR) and implementation programme.	National timeline awaited		✓		National approval required, including affordability. Intention to use VR as part of management of change.
Management of Change process to be implemented for executive members and staff.	End March 2026				• Change management process for the executive members commenced end July 2025.
Undertake an assessment of the CSU functions and future destination, and quantify any potential 'stranded costs'.	End August 2025		✓		• Joint executive team review underway. • National principles published. • August 2025 review with managing directors for AGEM and ML CSUs of timelines and people impact.
Functional level 'receiver' organisations to be identified to enable roadmap for functions to be developed and progress to be reviewed by the Transition Committee at regular intervals.	End September 2025		✓		• July 2025, NHS partners meeting taking place to review strategic intent, impact of responsibilities and accountabilities. Agreement of governance to approve transfer dates to be agreed.

Principal / strategic risk:

BAF 11 – Delivery of statutory duties

The ICB is unable to deliver against its strategic objectives due to the pace of change, impact on workforce, and distraction caused by the NHS reform requirements resulting in non-compliance with statutory duties.

<table>
<tr><th rowspan="2">Date risk identified</th><th rowspan="2">ICB Executive lead (risk owner)</th><th rowspan="2">ICB Committee oversight</th><th rowspan="2" colspan="2">Risk category
(✓ one main category that the risk would impact)</th><th colspan="2">ICB only or system risk
(✓ one)</th><th rowspan="2" colspan="6">Risk rating
(impact x likelihood = risk score)</th><th rowspan="2">Risk treatment
(i.e. state whether to terminate, treat, transfer, or tolerate the risk)</th><th rowspan="2">If to be treated confirm frequency of review
(e.g. monthly, quarterly)</th></tr>
<tr><th>ICB</th><th>System</th></tr>
<tr><td rowspan="5">June 2025</td><td rowspan="5">Alice McGee

(Chief People Officer)</td><td rowspan="5">Joint Executive Team</td><td>Quality</td><td></td><td rowspan="5">✓</td><td rowspan="5"></td><td>Gross/inherent risk score</td><td>4</td><td>x</td><td>4</td><td>=</td><td>16</td><td rowspan="3">Treat</td><td rowspan="3">Bi-monthly</td></tr>
<tr><td>Financial</td><td></td><td>Risk appetite score</td><td>4</td><td>x</td><td>2</td><td>=</td><td>8</td></tr>
<tr><td>Regulatory</td><td>✓</td><td>Net/residual/ current risk score</td><td>4</td><td>x</td><td>3</td><td>=</td><td>12</td></tr>
<tr><td>Reputational</td><td></td><td rowspan="2" colspan="6">Residual / current risk score trend since last report:</td><td rowspan="2" colspan="2">New risk</td></tr>
<tr><td>People</td><td></td></tr>
<tr><td colspan="7"></td><td colspan="6">Next risk review date:</td><td colspan="2">End September 2025</td></tr>
</table>

Key controls in place and rationale for current / residual risk score	Internal and / or external assurances *Where can we gain evidence that our controls/systems on which we are placing our reliance are effective?*		Gaps in controls and/or assurance *Where are the gaps in our control/systems? Where are we failing to make them effective? Where is the ICB failing to gain evidence that the controls/systems are effective?*
	internal	**external**	
Governance arrangements in place to meet the statutory requirements and functions for the ICB during the period of transition.		Assurance reported to the Regional governance structure (Regional Transition Group and Regional Transition Board).	Governance arrangements to be reviewed to enable streamlined cluster level arrangements to be established to enable efficient delivery of strategic objectives and statutory duties and priorities.
Transitional executive lead in place overseeing the implementation of the programme and oversight of associated risks to enable the ICB to meet the national timescales.	Assurance reports from the Joint Transition Committee presented to the ICB Board for assurance.	N/A	N/A
Operational Plan and programme of delivery against the Plan in place.		NHS England Quarterly System Review meetings.	A review of the NHS 10 Year Plan to be undertaken to determine medium and long term priorities.
Weekly staff briefings in place to ensure staff are kept abreast of regular updates associated with the transition programme.	Feedback from staff in respect of the effectiveness of the current briefings and information updates. Pulse Survey results and staff survey when available.	N/A	No gaps identified.
Priorities assessed by the Executive Management Team at regular intervals through weekly Joint Executive Team meetings to enable delivery against current / future strategic priorities, whilst considering staff attrition during implementation of management of change policy.		NHS England Quarterly System Review meetings.	No gaps identified.
Working groups established in conjunction with partner organisations to ensure functions transitioning to ‘receiver’ organisations continue to be delivered by the ICB until such a time as the legislative framework is updated and ‘receiver’ organisations have agreed to receive the necessary functions that are transitioning.	Assurance reports to the Joint Transition Committee and the ICB Board.	Assurance reported to the Regional governance structure (Regional Transition Group and Regional Transition Board).	Functional level delivery to be identified.
See also controls and actions detailed under associated BAF risks as above: 1 (partnership), 2 (health inequalities), 4 (finance), 5 (finance) and 6 (EPRR) above.	N/A	N/A	N/A – see BAF risks above

Actions being taken to address gaps in controls and/or assurance					
Detail the actions to be taken *(including What actions are required to bridge the gaps in controls and/or assurance?*	**Action to be completed by (date)**	**Will the action reduce impact of risk score or likelihood or both?**			**Progress on action(s)** *Brief note on updates/progress where appropriate and confirm when action completed.*
		Impact	Likelihood	Impact and likelihood	
Establish streamlined governance arrangements across the Clustered ICBs.	tbc		✓		Tbc – currently under review
A review of the NHS 10 Year Plan to be undertaken to determine medium and long term priorities.	tbc				Tbc – currently under review
Functional level delivery to be identified to enable roadmap for functions to be developed and progress to be reviewed by the Transition Committee at regular intervals.	tbc				Tbc – currently under review

WORKFORCE RISK ASSOCIATED WITH SYSTEM PRIORITIES AND OBJECTIVES (aligned to LLR Integrated Care Strategy)

Principal / strategic risk:
BAF S1 – ICS Workforce
Failure to improve workforce retention, reduce agency use and grow our workforce around new integrated and community based services will result in an inability to deliver care and our strategic aims.

Date risk identified	ICB Executive lead (risk owner)	ICB Committee oversight	Risk category (✓ *one main* category that the risk would impact)		ICB only or system risk (✓ one)		Risk rating (impact x likelihood = risk score)						Risk treatment (*i.e. state whether to terminate, treat, transfer, or tolerate the risk*)	If to be treated confirm frequency of review (e.g. monthly, quarterly)
					ICB	System								
October 2024	**Alice McGee (Chief People Officer)**	System Executive / People and Culture Board	Quality			✓	**Gross/inherent risk score**	5	x	4	=	**20**	Treat	**quarterly**
			Financial				**Risk appetite score**	5	x	2	=	**10**		
			Regulatory				**Net/residual/ current risk score**	5	x	3	=	**15**		
			Reputational				**Residual / current risk score trend since last report:**						⇩ **July 2025 –** reduced residual risk score as a result of positive progress with actions.	
			People	✓			**Next risk review date:**						End September 2025	

Key controls in place and rationale for current / residual risk score	Internal and / or external assurances *Where can we gain evidence that our controls/systems on which we are placing our reliance are effective?*		Gaps in controls and/or assurance *Where are the gaps in our control/systems? Where are we failing to make them effective? Where is the ICB failing to gain evidence that the controls/systems are effective?*
	internal	**external**	
Regular workforce dashboard reports tracking NHS workforce statistics including vacancy rates, WTE growth and agency spend considered at committees for assurances. These include finance committee, Quality Committee, NHS People Executive and System Executive	Trends are being tracked through Organisational committees and oversight through system committees on a monthly basis		No gaps identified at present
Culture Dashboard created in September 2024 to understand the retention, health and well being and inclusion agenda impact on the People Promise. Approval through Equity Committee and tracked through People and Culture Board.	Workforce dashboard presented to the Committee.		No gaps identified at present.
Strategic intent of programmes of work at system level to meet the needs of our population.	People and Culture Board currently reviewing approach in line with national and local strategies.		Formal workforce strategy to be developed for the system.
Annual programme of work at a system level to support organisational people promise implementation and support retention.	People and Culture Board receive quarterly progress reports and impact on interventions at place as a system.		No gaps identified at present.

Actions being taken to address gaps in controls and/or assurance					
Detail the actions to be taken *(including What actions are required to bridge the gaps in controls and/or assurance?*	**Action to be completed by (date)**	**Will the action reduce impact of risk score or likelihood or both?**			**Progress on action(s)** *Brief note on updates/progress where appropriate and confirm when action completed.*
		Impact	Likelihood	Impact and likelihood	
NHS People Board Terms of Reference to be agreed to reflect ownership of risk and escalation through to System Executive.	**June 2025**		✓		**Action complete**
Formal workforce strategy to be developed for the system.	~~**June 2025**~~ **September 2025**		✓		Formal strategy developed and received by People and Culture Board July 2025. Decision to pause strategy pending new 10 Year Workforce Plan and due to NHS Reforms. **Action paused and to be reviewed in September 2025.**

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

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

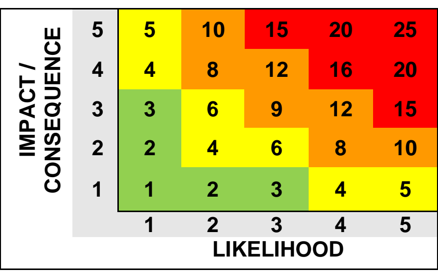
Areas	Definitions
Operational risks	Operational risks are by-products of the day-to-day running of the ICB and includes a broad spectrum of risks including clinical, fraud, security, financial and legal risks arising from employment law of health and safety.
Owner	Either the owner of the risk (risk owner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

Key for Executive Directors:

TS = Toby Sanders, Chief Executive
AM = Alice McGee, Chief People Officer
RT = Robert Toole, Chief Finance Officer
KD = Kay Darby, Chief Nursing Officer
NS = Dr Nil Sanganee, Chief Medical Officer
RV = Rachna Vyas, Chief Operating Officer
PB = Peter Burnett, Chief Strategy Officer

5 x 5 Risk Assessment Matrix (*LLR ICB Risk Management Strategy and Policy, June 2025*)

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

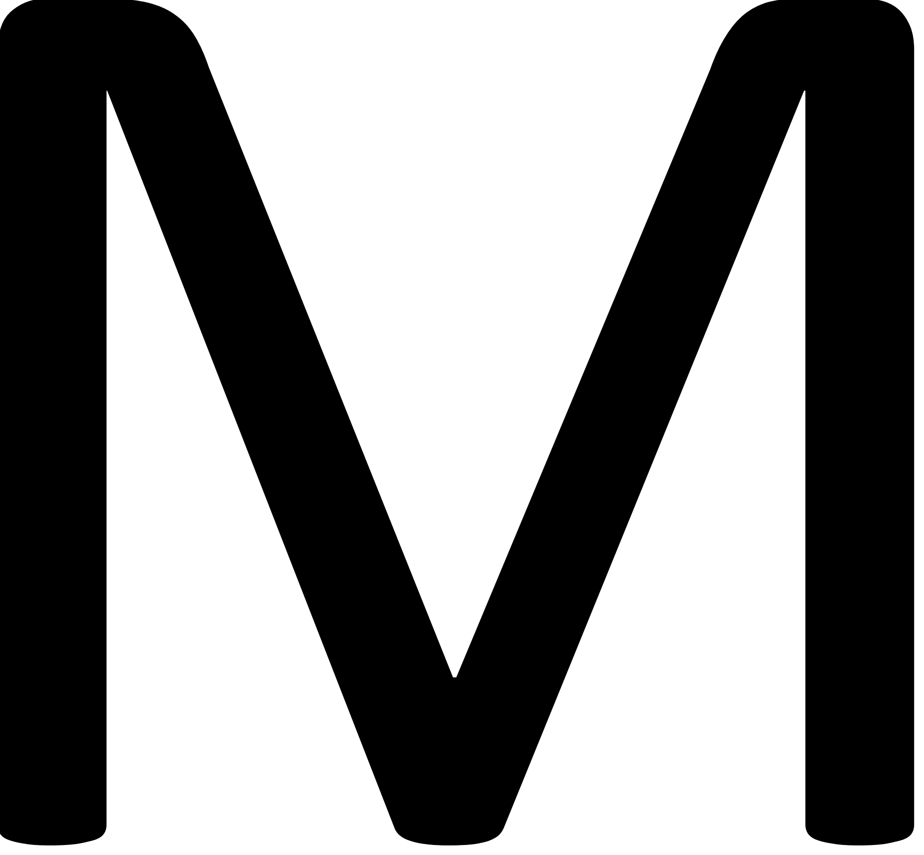


IMPACT / CONSEQUENCE					
5	5	10	15	20	25
4	4	8	12	16	20
3	3	6	9	12	15
2	2	4	6	8	10
1	1	2	3	4	5
	1	2	3	4	5
	LIKELIHOOD				

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

Framework for risk appetite aligned to the revised categories of risk (June 2025)

Risk appetite → **Risk type / category** ↓	**Low (score 1 – 6)** Preference for very safe delivery options that have a low degree of residual risk and only a limited reward potential	**Medium (score 8 – 12)** Willing to consider all potential delivery and innovative options that provide an acceptable level of reward, which may have a greater inherent risk	**High (score 15 – 25)** Confident in setting high levels of risk appetite because controls, forward scanning and responsive systems are robust.
Financial **(how will we use our resources?)**	We are only willing to accept the possibility of very limited financial risk. However, VFM is our primary concern.	We are prepared to invest for the best possible return and accept the possibility of increased financial risk.	We will consistently invest for the best possible return for stakeholders, recognising that the potential for substantial gain outweighs inherent risks.
Regulatory **(how will we be perceived by our regulator?)**	We will avoid any decisions that may result in heightened regulatory challenge.	We are willing to take decisions that will likely result in regulatory intervention if we can justify these and where the potential benefits outweigh the risks.	We are comfortable challenging regulatory practice. We have a significant appetite for challenging the status quo in order to improve outcomes for stakeholders.
Quality **(how will we deliver safe services?)**	Our preference is for risk avoidance. However, if necessary we will take decisions on quality where there is a low degree of inherent risk and the possibility of improved outcomes and appropriate controls are in place.	We will pursue innovation wherever appropriate. We are willing to rake decisions on quality where there may be higher inherent risks but the potential for significant longer-term gains.	We will seek to lead the way and prioritise new innovations, even in emerging fields. We consistently challenge current working practices in order to drive quality improvement.
Reputational **(how will we be perceived by the public and our partners?)**	Our appetite for risk taking is limited to those events where there is limited reputational risk if appropriate controls are in place to limit any repercussions.	We are willing to take decisions that are likely to bring scrutiny of the organisation. We outwardly promote new ideas and innovations where potential benefits outweigh the risks.	We are comfortable to take decisions that may expose the organisation to significant scrutiny or criticism as long as there is a commensurate opportunity for improved outcomes for our stakeholders.
People **(how will we be perceived by the public and our partners?)**	We will avoid all risks relating to our workforce unless absolutely essential. Innovative approaches to workforce recruitment and retention are not a priority and will only be adopted if established and proven to be effective elsewhere.	We are prepared to accept some workforce risk, as a direct result from innovation as long as there is the potential for improved recruitment and retention, and developmental opportunities for staff.	We are willing to take risks which may have implications for our workforce but could improve the skills and capabilities of our staff. We recognise that innovation is likely to be disruptive in the short term but with the possibility of long-term gains.



Name of meeting:	Leicester, Leicestershire and Rutland Integrated Care Board		
Date:	14 August 2025	Paper:	M
Report title:	Assurance Report from the ICB System Executive Committee		
Presented by:	Rachna Vyas, Deputy Chief Executive and Chief Operating Officer		
Report author:	Charlotte Gormley, Corporate Governance Officer		
Sponsor:	Rachna Vyas, Deputy Chief Executive and Chief Operating Officer		

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

Recommendations:

The LLR Integrated Care Board is asked to:

- **RECEIVE** the report for assurance.
- **APPROVE** updated terms of reference for the Strategic Commissioning Group.

Purpose and summary of the report:

This report provides a summary of the key areas of discussion and outcomes following the meetings of the **System Executive Committee** held in June and July 2025**.** The report also covers items for escalation and consideration by ICB Integrated Care Board ensuring that it is alerted to emerging risks and issues.

Appendices:	• Appendix 1 - Terms of reference for the Strategic Commissioning Group
Report history (date and committee / group the content has been discussed / reviewed prior to presenting to this meeting):	• Minutes for the meeting held on 27 June 2025 approved at the System Executive meeting on 25 July 2025

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.*	BAF 01 – Partnership BAF 02 – Health Inequalities BAF 03 – Demand and Capacity BAF 04 – Finance BAF 05 – Quality & Safety
b) Does the report highlight any resource and financial implications? If so, provide which page / paragraph this can be found within the report.	Yes, highlighted in summary table
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

Assurance Report from the ICB System Executive Committee

1. A summary of the key areas of assurance and escalation are detailed in the table below:

Key area discussed at the Committee meeting	Level of risk	Detail – Alert / Advise / Assure (to include mitigations to reduce risk)	Action required (where necessary)
1. System Finance	High	**Alert –** • M2 finance report, noting an adverse variance of £(4.62)m from plan. • The finance plan is phased, and the required efficiencies will increase month on month. **Assure –** • System Executive confirmed commitment to work through the difficult decisions list and service development fund (SDF) at an upcoming development session.	Note the significant level of risk associated with the delivery of the required level of efficiencies across the system.
2. Priorities Performance Report 2025/26	Amber	**Advise –** • System Executive received a summary of key performance indicators and escalations from partnerships and collaboratives whilst a formal reporting structure was being developed. • Escalations included the need to improve discharge metrics across the system to inform winter planning, concerns regarding the complications from excess weight (CEW) service, and the risk to sustaining the East Midlands Maternal Medicines Network due to funding prioritisation decisions.	
3. Hinckley Day Case Unit (DCU) Update	Green	**Advise –** • A full planning application was submitted to Hinckley and Bosworth Borough Council on 1 May 2025 with an outcome anticipated by mid-July. • NHS Property Services are in discussion with UHL to agree the terms of the lease, with the aim to reach an agreement by September 2025.	
4. System Green Plan Annual Report and Refresh of Plan	Green	**Advise –** • System Executive noted progress on delivery of the Green Plan 2022-2025 and timeframe to refresh the System Green Plan as per NHSE direction.	**Full report to be presented to the LLR ICB Board.**
5. Elective Reform Programme Board UHL/UHN/LNR and LLR Commissioning Plan 2025/26	Green	**Advise –** • System Executive received an update on the structure and governance for delivering the planned care aspects of the Elective Reform Plan. **Assure –** • Any strategic commitments would require approval from the LLR ICB Board.	

Key area discussed at the Committee meeting	Level of risk	Detail – Alert / Advise / Assure (to include mitigations to reduce risk)	Action required (where necessary)
6. East Midlands Cancer Alliance (EMCA) – Program Funding Schedule 2025/26	Amber	**Advise –** • LLR ICB received formal correspondence of reductions that were greater than anticipated due to the overall EMCA funding being reduced nationally. • A cost pressure had been identified due to new schemes which were unfunded. **Assure –** • The EMCA Investment Committee had reviewed and supported the bids submitted by LLR ICB.	
7. Strategic Commissioning Plan – 2025/26 Planned Care Contracts	Green	**Advise –** • Plans were in place to remove activity not required to deliver the 2025/26 operational plan.	
8. 10-Year Plan update	Green	**Advise –** • System Executive received an update on the 10 Year Health Plan for England following publication by NHSE. • The item would return for further discussion at a future meeting to set clear priorities.	
9. Neighbourhood models of care briefing	Green	**Advise –** • System Executive received a briefing note on key national and regional policy developments for neighbourhood health, and an update against the commitments of the 2025/26 neighbourhood health programme.	**Full update to be provided to the LLR ICB Board.**
10. Assurance report from the Strategic Commissioning Group	Green	**Assure –** **Assurance received on** • Mental Health Wellbeing Recovery and Support Services. • System Executive supported the updated terms of reference for the Strategic Commissioning Group for onward approval by the Board. • Learning Disabilities Venepuncture. • Primary Care Allocation for Enhanced Service Advice and Guidance including proposed cap. • Premises Project Revenue Increase. • Primary Care Transformation Board (PCTB) Highlight Report and Assurance Report from the LLR ICB Pharmaceutical, Optometry and Dental (PODs) Steering Group. • LLR Policy for Post-Operative Support for Self-Funded Bariatric Surgery and NHS England 3-Year Long Term Condition Pilot: Hypertension. • LLR Combined AHC Pilot Specification.	**The updated SCG terms of reference are at Appendix 1 for approval.**
11. Assurance report from Clinical Executive	Green	**Assure –** **Assurance received on** • Clinical Executive Effectiveness survey – actions.	No items escalated to System Executive

Key area discussed at the Committee meeting	Level of risk	Detail – Alert / Advise / Assure (to include mitigations to reduce risk)	Action required (where necessary)
		• Progress on delivery of the LeDeR high impact actions 2025/26. • ADHD medication reviews for clinically stable patients within Primary Care. • Establishment of a task and finish group to improve discharge letters and processes. • Integrated Neighbourhood Teams approach. • Oral Nutritional Supplement Replacement in Care Homes. • 2025/26 Planned Care Contracts.	
12. Assurance report from the People and Culture Board	Green	**Assure –** **Assurance received on** • Strategic direction and WorkWell Programme. • NHS Workforce Report (M1 and M2) and Equality, Diversity and Inclusion (EDI) progress. • LLR Health and Care People Plan and Adult Social Care Workforce Strategy.	
13. Assurance report from the Recovery and Sustainability Group	Red	**Assure –** **Assurance received on** • Key Plan Delivery Metrics M1 2025/26. • UHL Urgent and Emergency Care impact. • Workforce. • Intervention and Improvement. • Continuing Healthcare.	Financial position at month 2 escalated to System Executive
14. System Capital Planning Group Update	Green	**Advise –** • System Executive received and approved the updated terms of reference for the System Capital Planning Group.	

Definitions:

Alert	What are the key issues/risks that you need to alert the Board? These are issues/risks that require action/escalation in order to aid or support decision/actions to mitigate or manage. The report needs to be clear about what action we are asking the Board to take.
Assure	What are the key areas where you need to provide assurance on where progress is being made but may not yet have achieved the trajectories set or met the milestones anticipated. The report needs to be clear about the mitigations that are in place to address the gaps in assurance.
Advise	What are the key areas/items you want to advise the board/meeting on where key achievements have been made that have had an impact – benefits/outcomes.

Key for level of risk:

Green	**No risks identified:** there are no gaps identified.
Amber	**Risks identified:** there are some gaps in assurance, although assured that appropriate plans are in place / being developed to address the gaps.
Red	**Unmitigated risks:** there are significant gaps in assurance and not assured as to the adequacy of the plans.

Recommendations

The LLR Integrated Care Board is asked to:

- **RECEIVE** the report for assurance.

Appendix 1

NHS Leicester, Leicestershire and Rutland Integrated Care Board

Strategic Commissioning Group
Terms of Reference (v3 June 2025)

1. CONSTITUTION

The Strategic Commissioning Group (the Group) is established by the NHS Leicester, Leicestershire and Rutland Integrated Care Board (the Board or ICB) as a sub-group of the System Executive Committee, which is a Committee of the ICB, in accordance with the Constitution of the ICB.

These terms of reference set out the membership, the remit, responsibilities and reporting arrangements of the Group and may only be changed with the approval of the Board following recommendation from the System Executive Committee.

The Group will be chaired by the Chief Strategy Officer. It is a Group established by the Board and its members are bound by the Standing Orders and other policies of the ICB.

2. STATUTORY FRAMEWORK

In line with the Statutory Framework governing the primary medical services arrangements are as follows:

> The Health and Care Act 2022 amends the NHS Act 2006 by inserting the following provisions:
> ***13YB Directions in respect of functions relating to provision of services***
> *(1) NHS England may by direction provide for any of its relevant functions to be exercised by one or more integrated care boards.*
> *(2) In this section "relevant function" means—*
> *(a) any function of NHS England under section 3B(1) (commissioning functions);*
> *(b) any function of NHS England, not within paragraph (a), that relates to the provision of—*
> *(i) primary medical services,*
> *(ii) primary dental services,*
> *(iii) primary ophthalmic services, or*
> *(iv) services that may be provided as pharmaceutical services, or as local pharmaceutical services, under Part 7;*
> *(c) any function of NHS England by virtue of section 7A or 7B (exercise of Secretary of State's public health functions);*
> *(d) any other functions of NHS England so far as exercisable in connection with any functions within paragraphs (a) to (c).*
> ***82B Duty of integrated care boards to arrange primary medical services***
> *(1) Each integrated care board must exercise its powers so as to secure the provision of primary medical services to such extent as it considers necessary to meet the reasonable requirements of the persons for whom it has responsibility.*
> *(2) For the purposes of this section an integrated care board has responsibility for— (a) the group of people for whom it has core responsibility (see section 14Z31), and (b) such other people as may be prescribed (whether generally or in relation to a prescribed service).*

In exercising its functions, the ICB must comply with the statutory duties set out in NHS Act, as amended by the Health and Care Act 2022, including:

a) Having regard to and acting in a way that promotes the NHS Constitution (section 2 of the Health Act 1989 and section 14Z32 of the 2009 Act);
b) Exercising its functions effectively, efficiently and economically (section 14Z33 of the 2006 Act);
c) section 14Z34 (improvement in quality of services),
d) section 14Z35 (reducing inequalities),
e) section 14Z38 (obtaining appropriate advice),
f) section 14Z40 (duty in respect of research),
g) section 14Z43 (duty to have regard to effect of decisions)
h) section 14Z44 (public involvement and consultation),
i) sections 223GB to 223N (financial duties), and
j) section 116B(1) of the Local Government and Public Involvement in Health Act 2007 (duty to have regard to assessments and strategies).

In addition, the Procurement, Patient Choice and Competition (no") Regulations 2013 and any subsequent procurement legislation that applies to the ICB will also be adhered to.

3. PURPOSE OF THE GROUP

The Group has been established to provide the ICB Board, through the System Executive Committee, with assurance on review, planning and procurement in respect of commissioning / de-commissioning of and investment / disinvestment in healthcare services across the ICB area. This includes primary care services (i.e. primary medical care, pharmacy, optometry and dental services) and secondary care dental (where required, noting in the main these functions have been delegated to the East Midlands ICBs' Joint Committee). The Group has been established in accordance with the statutory framework to enable collective decision making. The Group will be the decision-making body for the management of the delegated functions and will exercise the delegated powers in accordance with the delegation agreement(s) entered into between the ICB and NHS England.

The focus of the Group will be commissioning across the ICB area and ensuring focus at place-level to support equity of access and warranted health inequity.

The Group will provide regular assurance updates to the Board through the System Executive Committee in relation to activities and items within its remit.

4. DELEGATED AUTHORITY

The Group is a formal sub-group of the System Executive Committee as established by the ICB. The Board has delegated authority to the Group as set out in the Scheme of Reservation and Delegation and may be amended from time to time.

The Group holds only those powers as delegated by the Board of the ICB and is subject to any directions made by NHS England in line with the delegation agreement.

5. MEMBERSHIP AND ATTENDANCE

Membership

The members shall be appointed by the Board in accordance with the ICB Constitution.

The Board will appoint no fewer than five members of the Group (from the ICB). Other attendees of the Group need not be members of the ICB, but they may be.

When determining the membership of the Group, active consideration will be made to equality, diversity and inclusion.

The Chair may ask any or all of those who normally attend, but who are not members, to withdraw to facilitate open and frank discussion of particular matters.

Members

- ICB Chief Strategy Officer (Chair) or named deputy
- ICB Chief Nursing Officer ~~or named deputy (vice Chair)~~
- ICB Chief Operating Officer ~~or named deputy~~ (vice Chair)
- ICB Chief Finance Officer ~~or named deputy~~
- ICB Chief Medical Officer ~~or named deputy~~
- ICB Chief People Officer ~~or named deputy~~
- ICB Clinical Adviser

Only members of the Group have the right to attend these meetings. Other individuals may be invited to attend all or part of any meeting as and when appropriate. Attendees do not have voting rights.

Chair and vice chair

In accordance with the Constitution, this meeting will be chaired by the Chief Strategy Officer of the ICB and another member will be nominated as the vice Chair of the Group.

The Group shall satisfy itself that the ICB's policy, systems and processes for the management of conflicts (including gifts and hospitality, and bribery) are effective.

If the Chair of the meeting has a conflict of interest then the vice Chair or, if necessary, another member of the Group will be responsible for deciding the appropriate course of action.

6. MEETING QUORACY AND DECISIONS

The Group shall meet on a monthly basis. Additional meetings may be convened on an exceptional basis at the discretion of the Group's Chair.

Quoracy

For a meeting to be quorate a minimum of four members will be required with the following being present: meeting Chair or vice Chair, plus the Chief Finance Officer, and the Chief Nursing Officer or the Chief Medical Officer (or their respective named deputies).

If any member of the Group has been disqualified from participating in an item on the agenda, by reason of a declaration of conflicts of interest, then that individual shall no longer count towards the quorum.

Where members are unable to attend they should ensure that a named and briefed deputy is in attendance who is able to participate on their behalf.

If the quorum has not been reached, then the meeting may proceed if those attending agree, but no decisions may be taken.

Decision making and voting

Decisions will be taken in accordance with the Standing Orders. The Group will ordinarily reach conclusions by consensus. When this is not possible the Chair may call a vote.

Only members of the Group may vote. Each member is allowed one vote and a majority will be conclusive on any matter.

Where there is a split vote, with no clear majority, the Chair of the Group will hold the casting vote. The result of the vote will be recorded in the minutes.

The Group may conduct its business on a 'virtual' basis through the use of appropriate technological support including telephone, email or other electronic communication. Where meetings are held in person, if a decision is needed which cannot wait for the next scheduled meeting, the Chair may conduct business on a 'virtual' basis through the use of telephone, email or other electronic communication.

7. RESPONSIBILITIES OF THE GROUP

The responsibilities of the Group will be authorised by the Board of the ICB. Responsibilities of the Group vary for each element of primary care, this is dependent upon the timing and level of functions delegated.

a) in relation to **overarching commissioning / de-commissioning and investment / dis-investment** decisions the Group will:

- Provide oversight and make decisions in relation to healthcare commissioning including but not limited to primary care delegated functions, other direct and specialised delegated functions, personalisation of care (e.g. continuing healthcare), prescribing, mental health and acute commissioning.
- To approve business cases for healthcare procurement (for commissioning or decommissioning and/or investment or disinvestment) with a total financial value up to £10,000,000 in total over the period of the contract (or three years if the investment is not time limited) for the ICB.
- Develop final proposals for the procurement process and approve these proposals in line with delegated authority.
- Monitor progress of procurement processes for healthcare services within the remit of the Strategic Commissioning Group and provide assurance and recommendations to the System Executive Committee and / or the ICB Board as appropriate.
- Subject to the delegated authority, make recommendations to the System Executive / ICB Board on the outcome of the procurement evaluation or approve the award of contracts to the preferred bidder, if within the level of authority delegated to the Strategic Commissioning Group.
- Keep under review progress made with commissioning and procurement activity, and other activity which should inform commissioning plans including finance and performance. Where necessary, report to the System Executive any such information which they should be aware of, particularly where it suggests that plans should be amended and escalation of risks identified.
- To approve contract award for healthcare procurements for a total financial value up to £10,000,000 in total over the period of the contract (or three years if the investment is not time limited) for the ICB.
- Where required, approve any contract variation to health care contracts for the ICB, including any changes to funding arrangements subject to the overall contract value not exceeding £10,000,000 in total for the ICB.
- Ensure that suitable policies and procedures are in place to comply with relevant regulatory, legal and code of conduct requirements.

b) In relation to commissioning of **primary medical services** it is expected that the Group will:

- To oversee the development of a system-wide Primary Care Strategy and make recommendation to the Board of the ICB for approval.

- Seek assurance that the Primary Medical Services Contracts are managed and varied in accordance with the terms of the Primary Medical Services Contracts, including District Valuer endorsed rent reviews.

- Approve contractual action such as issuing branch/remedial notices, removing a contract, boundary changes etc in accordance with the terms of the Primary Medical Services Contracts.

- Ensure appropriate action is taken in response to escalation of quality and safety risks and issues from the Risk Panel to secure improvement in the quality of services and improve efficiency in the provision of the services, which may

include taking timely action to enforce contractual breaches, serve notices or provide discretionary support.

- Ensure value for money is achieved under any Primary Medical Services Contracts.
- Agree local prices, managing agreements or proposals for local variations and local modifications.
- Seek assurance of compliance with any relevant Mandated Guidance issued from time to time.
- Manage the design (where applicable) and commissioning of any Enhanced Services, including re-commissioning these services annually where appropriate, in line with the delegation agreement.
- Have oversight of development of primary care networks
- Seek assurance from the relevant sub-group in the design of any Local Incentive Schemes for Primary Medical Services providers, ensuring the design is sensitive to the differing needs of the population, where appropriate (in line with delegation agreement).
- Approve Primary Medical Services provider mergers and closures in line with the delegation agreement.
- Make decisions in relation to management of poorly performing primary medical services providers in line with delegation agreement.
- Be responsible for making decisions in relation to the Premises Cost Directions Functions. This will include applications for new payments and revisions to existing payments under the Premises Costs Directions.
- Subject to the delegated authority, be responsible for procurement and new contracts. To approve the outcome of the procurement evaluation and approve the award of contracts to the preferred bidder, if above level of authority then to make recommendation to the System Executive or the Board as appropriate in line with Scheme of Delegation.
- To approve decisions within the delegated financial authority. Make recommendations to the System Executive Committee and or the Board, as appropriate, in relation to decisions above delegated authority.
- To co-ordinate a common approach to the commissioning and delivery of primary care services.
- Provide the System Executive Committee with an accurate understanding of the current and forecast performance position. Oversee the recovery plans to address and mitigate any risks.

c) In relation to commissioning of **primary care dental, optometry and pharmacy services, secondary care dental, specialised acute and specialised pharmacy services** the Group will:

- develop a framework in line with national requirements and have oversight of the pre-delegation assessment in preparation for delegation to be authorised by NHS England.
- Seek assurance through the governance arrangements established on a regional footprint for primary care commissioning (e.g. Tier 1 and Tier 2 committees) to ensure the LLR ICB is fulfilling its duties in line with the Delegation Agreements.
- Consider and make recommendations to the System Executive Committee or the LLR ICB Board for decisions outwith the remit of the Tier 1 and Tier 2 Committees.

d) Additional responsibilities across all areas of primary care will be:

- Oversight of its programme of work and monitor delivery and ensure that any identified risks have associated mitigations in place.

- Ensure appropriate interface with the Clinical Executive Group and the Quality and Safety Committee for oversight of clinical prioritisation and assurance of quality and patient safety respectively.

- Oversee the development of the estates and premises programme for primary care services and seek assurance from the Primary Care Premises and Estates Review Group.

- Oversight of primary care workforce and resilience.

- Ensure that suitable policies and procedures are in place to comply with relevant regulatory, legal and code of conduct requirements. Approve policies aligned to the delegated functions.

- Seek assurance from sub-groups:
  - Primary Care Transformation Board
  - Primary Care Premises and Estates Review Group
  - High Risk and Complex Care Panel
  - Childrens' Continuing Care Panel

8. ACCOUNTABILITY and REPORTING ARRANGEMENTS

The Group is directly accountable to the ICB through the System Executive Committee. The minutes of meetings shall be formally recorded. The Chair of the Group shall report to the System Executive Committee after each meeting and provide a report on assurances received, escalating any concerns where necessary.

Budget and resource accountability arrangements and the decision-making scope of the Group are as delegated. In the event of any conflict between the ICB Scheme of

Reservation and Delegation in respect of functions delegated from NHS England, the Delegation Agreement will prevail.

The Group will advise the Audit Committee on the adequacy of assurances available and contribute to the Annual Governance Statement

The Group may establish working groups and other such time-limited groups. However, it cannot delegate its functions to any such groups. The Group will receive scheduled assurance report from its working groups.

9. BEHAVIOURS AND CONDUCT

ICB values

Members will be expected to conduct business in line with the ICB values and objectives. Members of, and those attending, the Group shall behave in accordance with the ICB's Constitution, Standing Orders, and Standards of Business Conduct / Conflicts of Interest Policy.

Equality and diversity

Members must demonstrably consider the equality and diversity implications of decisions they make.

10. DECLARATIONS OF INTEREST

All members and those in attendance must declare any actual or potential conflicts of interest which will be recorded in the minutes. Anyone with a relevant or material interest in a matter under consideration will be excluded from the discussion at the discretion of the Chair of the Group.

11. SECRETARIAT AND ADMINISTRATION

The Group shall be supported by the Corporate Governance Team this will include ensuring that:

- The agenda and papers are prepared and distributed in accordance with the Standing Orders having been agreed by the Chair with the support of the relevant executive lead;
- Attendance of those invited to each meeting is monitored and highlighted to the Chair those that do not meet the minimum requirements;
- Good quality minutes are taken in accordance with the Standing Orders and agreed with the Chair and a record of matters arising, action points and issues to be carried forward are kept;
- The Chair is supported to prepare and deliver reports to the Board;
- The Group is updated on pertinent issues/ areas of interest/ policy developments;
- Action points are taken forward between meetings and progress against those actions is monitored.

12. REVIEW

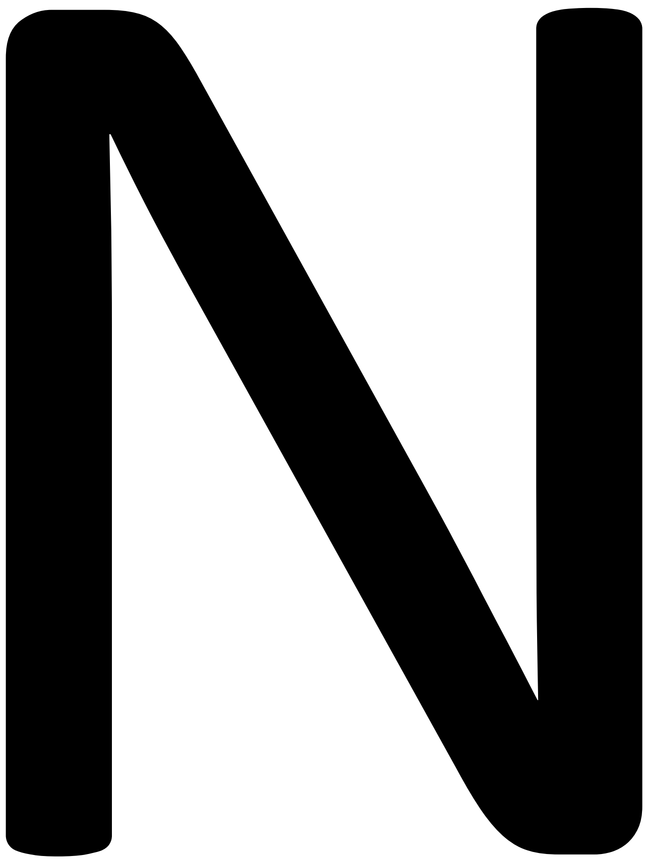
The Group will review its effectiveness at least annually and complete an annual report submitted to the Board.

These terms of reference will be reviewed at least annually and more frequently if required. Any proposed amendments to the terms of reference will be submitted to the Board for approval following consideration by the System Executive Committee.

The Group will utilise a continuous improvement approach in its delegation and all members will be encouraged to review the effectiveness of the meeting at each sitting.

Date of approval: XX by the LLR Integrated Care Board

Date of review: April 2026



Name of meeting:	Leicester, Leicestershire and Rutland Integrated Care Board		
Date:	14 August 2025	Paper:	N
Report title:	Assurance Report from the ICB Audit Committee		
Presented by:	Darren Hickman, Non-Executive Member and Chair of Audit Committee		
Report author:	Tamara Hazell, Corporate Governance Officer		
Sponsor:	Darren Hickman, Non-Executive Member and Chair of Audit Committee		

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

Recommendations:

The LLR Integrated Care Board is asked to:

- **RECEIVE** the Assurance Report from the ICB Audit Committee held June 2025.

Purpose and summary of the report:

This report provides a summary of the key areas of discussion and outcomes following the meeting of the **ICB Audit Committee** held in **June 2025.** The main focus of the meeting was to review and approve the year end governance documentation in line with the authority delegated to the Committee by the LLR ICB Board.

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:	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 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 risk	Detail – Alert / Advise / Assure (to include mitigations to reduce risk)	Action required (where necessary)
1. Service Auditor Reports (SARs) Controls Exceptions Summary 2024/25	**GREEN**	**Assure** The Committee received the 2024/25 Service Auditor Reports (SARs) Controls Exceptions Summary and was assured that all identified actions had been appropriately mitigated.	**Not required.**
2. Counter Fraud, Bribery and Corruption Annual Report	**GREEN**	**Assure** The Committee received the 2024/25 Counter Fraud, Bribery and Corruption Annual Report, noting that all twelve requirements of the Counter Fraud Functional Standards (CFFSR) were sufficiently evidenced, providing assurance over compliance.	**Not required.**
3. Head of Internal Audit Opinion 2024/25	**GREEN**	**Assure** The Committee received the Head of Internal Audit Opinion for 2024/25, noting that the ICB had received an overall opinion of Significant Assurance at year-end. This is a positive outcome confirming that there is generally a sound framework of governance, risk management, and internal controls across the organisation.	**Not required.**
4. Internal Audit Annual Report 2024/25	**GREEN**	**Assure** The Committee received the 2024/25 Internal Audit Report, confirming that the auditors had implemented the internal audit plan in line with the Public Sector Internal Audit Standards (PSIAS).	**Not required.**
5. Summary of External Auditors Annual Report year ending 31 March 2025	**GREEN**	**Assure** The Committee received the Auditor's Annual Report summary for the year ending 31 March 2025, which reviewed external audit work for the ICB during 2024/25, focusing primarily on Value for Money arrangements. Whilst the overall findings were positive, one area of concern related to the slower than anticipated advancement of efficiency plans. The Auditors observed that this was a common challenge across NHS organisations, reflecting the complexities involved in producing detailed financial plans within national deadlines.	**Not required.**
6. Summary of External Audit Findings year ending 31 March 2025	**GREEN**	**Assure** The Committee received the summary of Audit Findings, where it was confirmed that an unqualified opinion was expected to be issued. This was recognised as a positive outcome, although the Committee noted that the final LLR ICB Annual Report and Accounts was yet to be submitted.	**Not required.**
7. The Statement by the Accountable Officer, Annual Governance Statement 2024/25 and the LLR ICB Annual Report 2024/25	**GREEN**	**Assure** The Committee welcomed the final version of the LLR ICB Annual Report, including the Statement by the Accountable Officer and the Annual Governance Statement. In line with the authority delegated to the Committee, the Committee approved the LLR ICB Annual Report in its entirety thanking all involved for their contribution and effort in capturing the successes	**Not required.**

		and challenges over the last year. It was anticipated that the LLR ICB Annual Report and Accounts would be submitted by 20 June 2025 ahead of the national deadline of 23 June 2025.	
8. The Annual Accounts 2024/25	**GREEN**	**Assure** In line with the authority delegated to the Committee, the Annual Accounts for LLR ICB 2024/25 were approved following a detailed discussion and review of the content.	**Not required.**
9. Letter of Representation	**GREEN**	**Assure** The Committee approved the Letter of Representation for signing by the Chief Finance Officer.	**Not required.**

Definitions:

Alert	What are the key issues/risks that you need to alert the Committee? These are issues/risks that require action/escalation in order to aid or support decision/actions to mitigate or manage. The report needs to be clear about what action we are asking the Committee to take.
Assure	What are the key areas where you need to provide assurance on where progress is being made but may not yet have achieved the trajectories set or met the milestones anticipated. The report needs to be clear about the mitigations that are in place to address the gaps in assurance.
Advise	What are the key areas/items you want to advise the board/meeting on where key achievements have been made that have had an impact – benefits/outcomes.

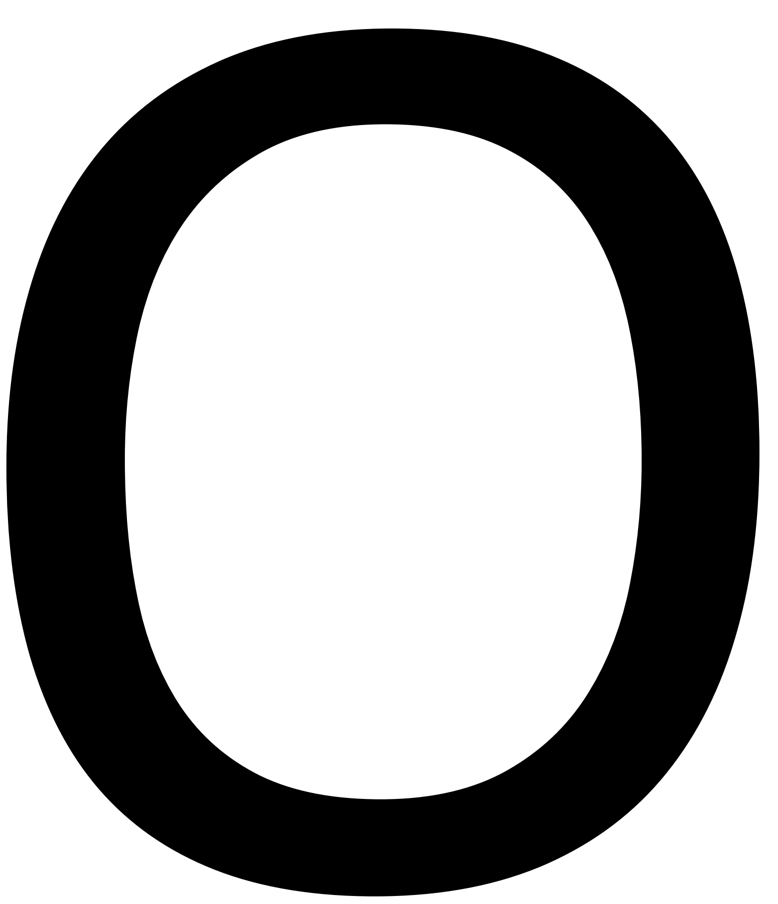
Key for level of risk:

Green	**No risks identified:** there are no gaps identified.
Amber	**Risks identified:** there are some gaps in assurance, although assured that appropriate plans are in place / being developed to address the gaps.
Red	**Unmitigated risks:** there are significant gaps in assurance and not assured as to the adequacy of the plans.

Recommendations

The LLR Integrated Care Board is asked to:

- **RECEIVE** the Assurance Report from the ICB Audit Committee held June 2025.



Name of meeting:	Leicester, Leicestershire and Rutland Integrated Care Board meeting		
Date:	14 August 2025	Paper:	O
Report title:	Assurance Report from the LLR ICB Health Equity Committee		
Presented by:	Anil Majithia, Non-Executive Member – Health Inequalities, Public Engagement, Third Sector and Carers		
Report author:	Claire Middlebrook, Corporate Governance Officer		
Sponsor:	Rachna Vyas, Chief Operating Officer		

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

Recommendations:

The LLR ICB Board is asked to:

- **RECEIVE** the report for assurance.

Purpose and summary of the report:

This report provides a summary of the key areas of discussion and outcomes following the meeting of the **Health Equity Committee** held in June 2025**.**

This report also covers items for escalation and consideration by the 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.*	• BAF 2 – health inequalities • Interdependencies with BAF risks relating to partnership working, finance and quality and safety.
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 Health Equity Committee

1. A summary of the key areas of assurance and escalation are detailed in the table below:

Key area discussed at the Committee meeting	Level of risk	Detail – Alert / Advise / Assure (to include mitigations to reduce risk)	Action required (where necessary)
1. Equality Delivery System (EDS) Grading Report 2024	**Green**	**Advise** – the Committee received the content of the EDI Grading Report 2024/25. It was recognised that the ICB had an obligation under the Public Sector Equality Duty to produce this report. The Committee suggested that some elements of the report needed to be made more user friendly, prior to publication.	**Report to be made more public facing prior to publication on website.**
2. Draft LLR ICB Equality Delivery System (EDS) 2024-25 Report	**Green**	**Advise** – the Committee received the content of the Equality Deliver System report 2024/25 and supported the report for onward circulation to the Board.	
3. Workshop to align on collective areas of focus and prioritisation for this year.	**Amber**	**Advise -** There is a good alignment of priorities and areas of focus. Several areas of collaboration have been identified and will be progressed through, keeping in mind the transition to the model ICB.	

Definitions:

Alert	What are the key issues/risks that you need to alert the Committee? These are issues/risks that require action/escalation in order to aid or support decision/actions to mitigate or manage. The report needs to be clear about what action we are asking the Committee to take.
Assure	What are the key areas where you need to provide assurance on where progress is being made but may not yet have achieved the trajectories set or met the milestones anticipated. The report needs to be clear about the mitigations that are in place to address the gaps in assurance.
Advise	What are the key areas/items you want to advise the board/meeting on where key achievements have been made that have had an impact – benefits/outcomes.

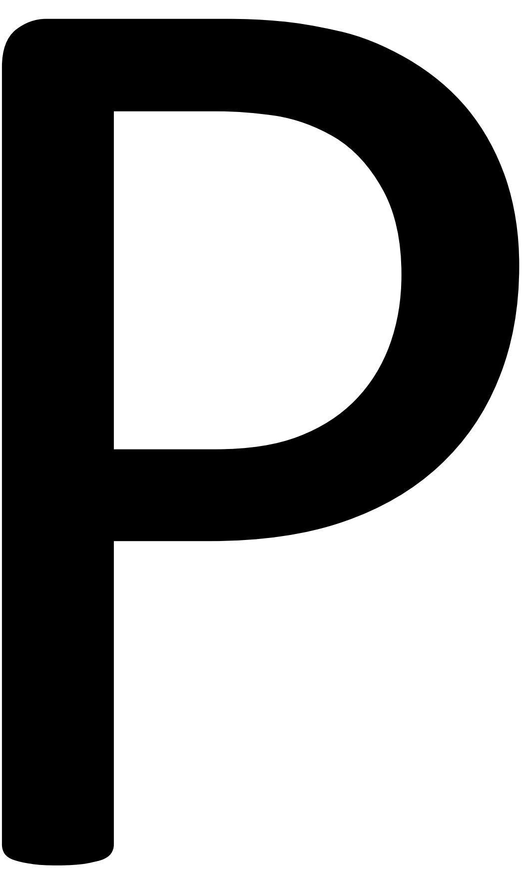
Key for level of risk:

Green	**No risks identified:** there are no gaps identified.
Amber	**Risks identified:** there are some gaps in assurance, although assured that appropriate plans are in place / being developed to address the gaps.
Red	**Unmitigated risks:** there are significant gaps in assurance and not assured as to the adequacy of the plans.

Recommendations

The LLR ICB Board is asked to:

- **RECEIVE** the report for assurance.



Name of meeting:	Leicester, Leicestershire and Rutland Integrated Care Board meeting		
Date:	14 August 2025	Paper:	P
Report title:	Assurance Report from the LLR ICB Quality and Safety Committee		
Presented by:	Pauline Tagg, Non-Executive Member – Quality, Safety and Transformation		
Report author:	Claire Middlebrook, Corporate Governance Officer		
Sponsor:	Kay Darby, Chief Nursing Officer		

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

Recommendations:

The LLR ICB Board is asked to:

- **RECEIVE** the report for assurance.

Purpose and summary of the report:

This report provides a summary of the key areas of discussion and outcomes following the meeting of the **Quality and Safety Committee** held in July 2025.

This report also covers items for escalation and consideration by the 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.*	• BAF 5 – quality and safety • Interdependencies with BAF risks relating to partnership working, finance and health inequality.
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 Quality and Safety Committee

1. A summary of the key areas of assurance and escalation are detailed in the table below:

Key area discussed at the Committee meeting	Level of risk	Detail – Alert / Advise / Assure (to include mitigations to reduce risk)	Action required (where necessary)
1. Looked after Children – Deep dive	**AMBER**	**Assure** – the committee received an update on Looked After Children, noting the good work that has already taken place and challenges that remain. The committee discussed the continuing risk to a small number of Looked after children waiting for Neuro development assessments and potential mitigations.	**N/A**
2. Assurance and Review of Cardiac Surgery at UHL	**AMBER**	**Advise –** the committee were advised that concerns remain around cardiac surgery in UHL. This has been appropriately escalated to region, and no harm has been identified. CQC visited and the report is awaited. Cardiac surgery remains under Rapid Quality Review, whilst further assurance is sought and assurance actions completed.	**Further assurance being sought by the committee.**
3. Insightful Board - Quality Assurance Report	**AMBER**	**Advise** – the committee received the revised Quality Assurance report and positive feedback was received on the new format. The committee received an alert for information relating to a H M Coroners ruling in relation to a prescribing incident. The GP practice is being appropriately supported by the ICB and other agencies. The committee were advised that a GP Surgery have been identified as outsourcing administration to India in breach of GDPR and this has been raised by the CQC. Remedial action has been taken. The committee were informed that nationally healthcare acquired infections are increasing and whilst UHL CDIFF and MRSA numbers compare favourably they are increasing. The committee were advised that Maternity Voices work was due to be picked up by Healthwatch, however, in light of recent announcements this will have to be further reviewed. This has added to the System Quality Risk Log.	
4. System Quality Risk (SQG) Log	**GREEN**	**Assure** - the risk log from the SQG was received. The committee were informed that there are 19 current risks, of which 7 are historically high-level risks. The SQG were asked to review the risks and consider if they fairly represented the highest system quality risks.	**N/A**
5. Quality Strategy Implementation Plan 2024/25	**GREEN**	**Assure** – the committee received an update on the plan for 2024/25, noting the backlog of POD complaints and the risks for the future, which include team capacity and robustness of mechanisms to support surveillance and share learning.	**N/A**

Key area discussed at the Committee meeting	Level of risk	Detail – Alert / Advise / Assure (to include mitigations to reduce risk)	Action required (where necessary)
		The committee were assured around the progress made against priorities for 2024/25 and the successes achieved.	
6. Quality and Equality Impact Assessments	**AMBER**	**Advise** – the committee received assurance that EQIAs are taking place and were advised that one EQIA was noted to be high scoring in relation to Tier2+ weight management services a pilot service which has been discontinued by LPT. Children and Young people in this cohort will now be seen in Tiers 2 and 3, and this could result in longer waiting times and poorer health outcomes for this cohort of patients. A review of weight management pathways is being carried out	
7. Outcomes and recommendations from LLR LMNS Full Quality Insight Visit: Maternity & Neonatal Services (UHL) 8th and 9th April 2025	**GREEN**	**Assure** – the committee received the report and the action plan produced by UHL in response. It was noted that significant progress had been made on the maternity improvement plan and services were now rated Green on the regional heatmap. Oversight continues to ensure progress is embedded and improvements are sustainable with a further touch point meeting in September. **Advise** – during a confidential meeting, the Committee was advised of the proposed pause to births and postnatal care at St Mary's Birth Centre from the 7 July 2025. The Committee understood the rationale for this decision and supported the Trust's proposal.	**N/A**
8. Leicestershire Partnership Trust Quality Review Meetings Highlight Report	**AMBER**	**Advise** – The committee were informed that following some quality concerns, a series of assurance deep dives had taken place. Significant assurance was received in relation to the Crisis & Home Treatment Team, Learning from Incidents and Quality Governance Structures. It was noted that further assurance was needed in relation to the sustainability of improvements in the safeguarding team capacity and function	**Continued assurance to be sought.**
9. Complaints Annual Report 2024/25	**GREEN**	**Assure** – the Committee received the ICB's annual complaints report for 2024/25. The Committee noted the seven-fold increase in the number of complaints received by the ICB in comparison to the previous year. Positive assurance was received in respect of the 108 unresolved complaints, handed over to the ICB from NHS England as part of the delegation of GP complaints function, had all now been resolved.	**N/A**
10. Update on the Board Assurance Framework (BAF)	**GREEN**	**Assure** – The Committee received an updated BAF, noting the ICB Board had recently approved a new risk appetite framework. The Committee supported the risk appetite level of "medium" with a risk appetite score of 12 for BAF risk 5 (quality and safety). .	

Definitions:

Alert	What are the key issues/risks that you need to alert the Committee? These are issues/risks that require action/escalation in order to aid or support decision/actions to mitigate or manage. The report needs to be clear about what action we are asking the Committee to take.
Assure	What are the key areas where you need to provide assurance on where progress is being made but may not yet have achieved the trajectories set or met the milestones anticipated. The report needs to be clear about the mitigations that are in place to address the gaps in assurance.
Advise	What are the key areas/items you want to advise the board/meeting on where key achievements have been made that have had an impact – benefits/outcomes.

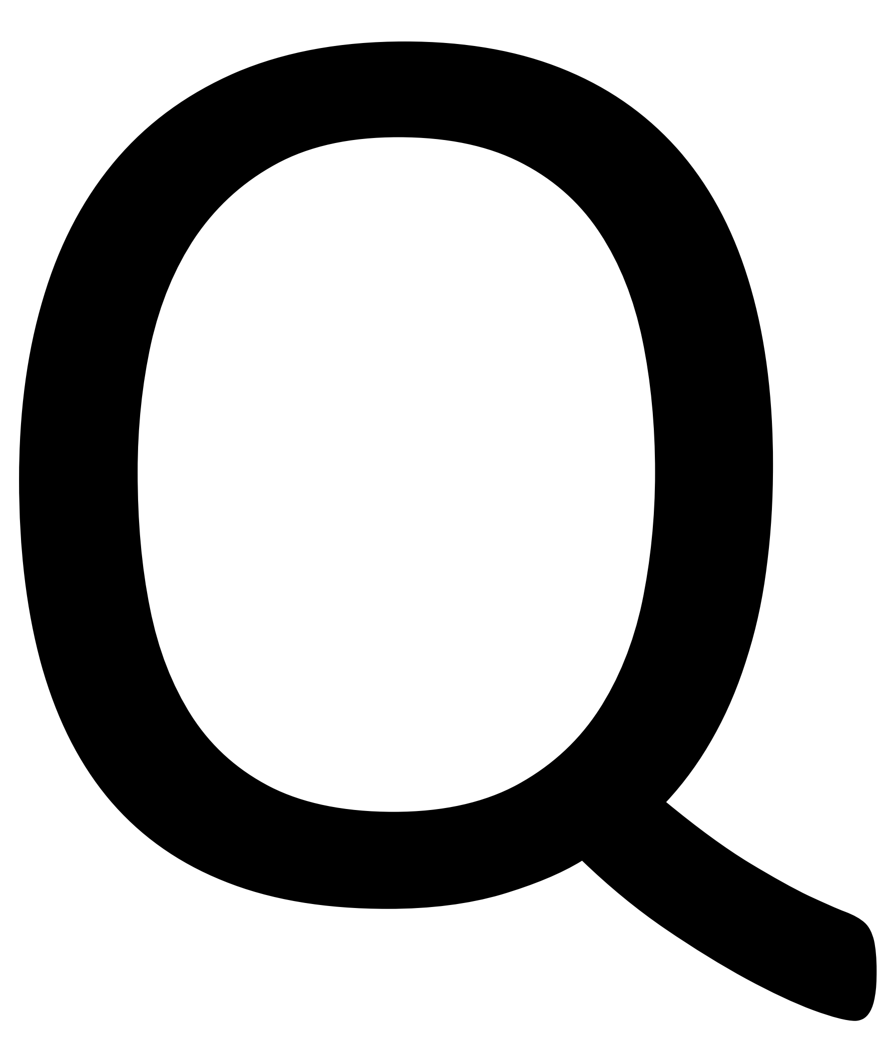
Key for level of risk:

Green	**No risks identified:** there are no gaps identified.
Amber	**Risks identified:** there are some gaps in assurance, although assured that appropriate plans are in place / being developed to address the gaps.
Red	**Unmitigated risks:** there are significant gaps in assurance and not assured as to the adequacy of the plans.

Recommendations

The LLR ICB Board is asked to:

- **RECEIVE** the report for assurance.



Briefing Summary of the East Midlands ICBs Joint Committee Meeting held on Tuesday 17 June 2025

1. Purpose

1.1. This **ADVISORY** report is presented to provide a summary of the East Midlands Joint Committee meeting held on Tuesday 17 June 2025.

2. Summary of Agenda Items

2.1. Primary Care Finance and Assurance Report

The Committee received the report for **ASSURANCE**. Confirmation was received that:

- a review exercise had been undertaken into the aborted Intermediate Minor Oral Surgery procurement and lesson learnt had been carried forward into the new process, and that a collaborative steering group (inclusive of legal support) is now operating to co-ordinate activity.
- ICBs will be required to purchase additional in year activity for urgent dental appointments, with targeted activity initially focusing on the most pressing areas in Lincolnshire and Northamptonshire.
- it is anticipated the Community Pharmacy Strategy will be agreed by Q3 2025/26, this allowing individual ICB Operational Plans to be developed in response.

2.2. Specialised Commissioning Services Assurance Report

The Committee received the following for **ASSURANCE**:

- requirements for return to Level 2 LNU (Local Neonatal Unit) had been met at Kettering General Hospital. It was anticipated that this would have a positive effect on other units in the region.
- the regionally commissioned Mental Health and Learning Disability services Operational Plan was agreed at the May meeting of the Tier 2 co-ordination group.

The Committee also:

- **NOTED** concerns regarding the Midlands Diving Chamber service and the external independent review being undertaken
- **DISCUSSED** the transfer of staff associated with delegated services and the challenges this may have with co-ordinated activity/ delivery of outcomes.
- **APPROVED** enacting the contract option to extend the current 2-year NHS Led Specialised MHLDA Provider Collaborative Contract for an additional 1 year, to end 31 March 2027, and **NOTED** the publishing of the Provider Selection Regime Transparency Notice.

2.3. East Midlands 3 Year Dental Commissioning Plans

The Committee received the report for **ASSURANCE** inclusive of the updated financial position, planned year 1 procurements, and potential procurement pipeline capacity concerns, recognising the focus of current activity being urgent dental care appointments, Intermediate minor Oral Surgery, and commissioning Offender Health

General Dental Services. Further **DISCUSSION** was had on the potential to balance increase rates for Units of dental Activity whilst recognising the need to demonstrate additional Value for Money, and the available recurrent / non-recurrent in year funding available.

2.4. Specialised Commissioning Strategic Report

The Committee **NOTED** updates on the following:

- update on the technical delegation process and National Commissioning Review
- transition programme actions reflecting policy direction, inclusive of service and staff transfers
- NHS contracting assurance and escalations
- Key service issues and actions

2.5. Deep Dive Mechanical Thrombectomy

The Committee **NOTED** the comprehensive update on Mechanical Thrombectomy inclusive of the good progress made on improving collaboration across providers to make the most effective use of workforce / facilities, and the ongoing ask of University Hospitals Birmingham and University Hospitals Coventry & Warwick to develop joint rotas to facilitate 24/7 service coverage.

2.6. National Rehabilitation Centre update

The Committee **NOTED** the update actions inclusive of action taken to establish a rapid review of neurorehabilitation and in consideration of the inpatient bedded provision at the National Rehabilitation Centre.

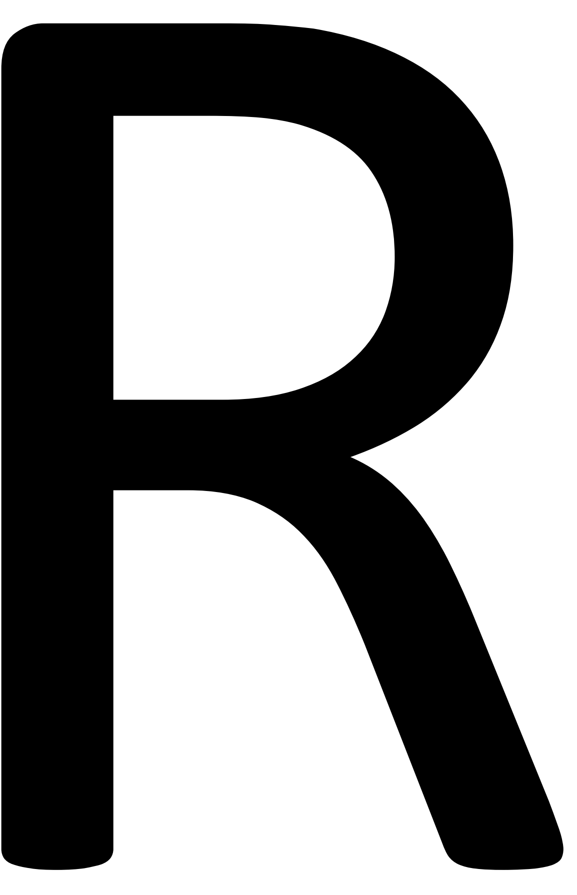
2.7. AOB - 111/999 Services

The Committee **AGREED** that further progress with collaborative commissioning for 111/999 services should be considered as part of the ICB Transition Programme in response to the Model Blueprint.

2.8. The ICB Chairs and Chief Executives reconvened to have an informal discussion on the NHS Reforms

3. Recommendation

3.1. This Board is asked to **NOTE** this briefing summary.



Name of meeting:	**Leicester, Leicestershire and Rutland Integrated Care Board** (public)		
Date:	14 August 2025	**Paper:**	**R**
Report title:	**System Green Plan Annual Report and Refresh of Plan**		
Presented by:	Lorna Simpson, Head of Strategic Estates, LLR ICB		
Report authors:	Nigel Bond, SRO, Chair of Green Board, Interim Director of Estates, Facilities & Sustainability, UHL Lorna Simpson, Head of Strategic Estates, LLR ICB Amit Sammi, Head of Strategy and Planning, LLR ICB		
Executive Sponsor:	Pete Burnett, 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:

- **RECEIVE and NOTE** the progress in delivery of the Green Plan 2022-2025.
- **RECEIVE and NOTE** the plans and timeframe to refresh the System Green Plan as per NHSE direction.

Purpose and summary of the report:

1) The report provides the final annual report on the Green Plan 2022-2025, identifying progress and challenges towards delivery.
2) The report then outlines the plan and timescale for the refreshing of the Green Plan.

Appendices:	• Appendix 1 – Green Action Plan – Actions on Target or In Delay
Report history (date and committee / group the content has been discussed / reviewed prior to presenting to this meeting):	• System Executive 27th June 2025

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

5. NHS Constitution	Deliver NHS Constitutional and legal requirements.	☒

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

System Green Plan Annual Report and Refresh of Plan

Background and Context

1. The Health and Care Act 2022 places a duty on ICB's and Trusts to consider statutory emissions and environmental targets in their decisions, and NHSE expects these duties to be met through the delivery of a board-approved green plan.

2. The ICS Green Plan 2022–2025 was formally adopted by the Integrated Care Board in Dec 2022 and is reaching the end of its term and requires refreshing. The full plan can be viewed here: LLR Green Plan

3. It was developed through a series of meetings, workshops and engagement sessions and built upon the foundations of existing UHL and LPT green plans specific to their operations and forward plans. Wider elements were built into the plan taking into account the role and supporting collaborative actions of other Green Board members.

4. Annual reports on delivery of the Green Plan 2022-25 have been provided for assurance, and below is the 2024/2025 annual report.

5. The process and timeline for refreshing the Green Plan is provided below (Item 16).

Annual report on the Green Plan 2022-2025

6. The Green Plan follows the framework set out in the June 2021 guidance based on the following 9 domains, alongside key actions to be taken:

- Workforce and system leadership
- Sustainable models of care
- Digital transformation
- Sustainable Travel and transport
- Estates and facilities sustainability
- Medicines
- Supply chain and procurement
- Food and nutrition
- Adaptation to Climate Change

7. Progress has been achieved since the last annual report of April 2024. At that time 20 actions were reported as delivered, (noting that some requiring ongoing monitoring). A further 15 are now complete.

Abbrev.	Work Area	No. of actions	Actions Completed/ Ongoing	On Target	Action Delayed
WFL	Workforce and System leadership	4	4	0	0
SMC	Sustainable models of care	4	3	0	1
DT	Digital transformation	4	4	0	0
TT	Sustainable travel and transport	12	8	3	1
EF	Estates and facilities sustainability	8	6	2	0

M	Medicines	8	3	2	3
P	Supply chain and procurement	12	2	0	10
FN	Food and nutrition	6	1	0	5
CCA	Adaptation to climate change	4	4	0	0
	Totals	62	35	7	20

8, Of the actions that are in delay (see App 1 which includes the actions on target), some are because data is not readily available from all partners, but progress continues. Others are being reported via new NHSE reporting requirements, reducing capacity to report consistently to the Green Board. Others are parked as new legislation and requirements have come into effect, requiring the workstream to focus on implementing legislation. For example, the original actions for procurement and supply chain did not consider national requirements for sustainable procurement (by the inclusion of a 10% weighting for social value in every tender, and through the requirement for a Carbon Reduction Plan (CRP)/ Net Zero Commitment (NZC) for new procurements). The Trusts and ICB are now managing and shaping their supply chains through these actions thus superseding some of the original actions.

9. Resourcing continues to be the main challenge across all work areas and is key to the delayed actions in the Food and Nutrition workstream;

   a. The limits on recruitment are resulting in sustainability posts remaining vacant, thus inhibiting system engagement and participation.
   b. The limited availability of subject matter experts to support the Green Board, as they are focussed on operational delivery within their own organisations.
   c. The absence of a GP lead during the previous period to act as clinical advocate and spearhead engagement with general practice.
   d. The impact of planned sustainability targets in the Estates and Facilities work area will increase the capital cost of schemes. From Q3 2025 new developments and refurbishments are to achieve BREEAM standards Very Good and Good respectively.
   e. The duplication of reporting to organisation, system and to NHSE, and attendance at organisational, system and regional meetings has increased demands on staff.

10. There has been notable success in bidding for external funding which has been helpful, and recent awards include:
   a. UHL was awarded around £440k to install building management systems and sub-metering, which will help to monitor, track and ultimately reduce their energy consumption.
   b. LPT was awarded approx. £100k for the installation of solar panels on the roof of Loughborough Community hospital. 346 panels will generate 200kw of clean energy and will reduce the energy bill by £50k pa. Further works are planned at the Hinckley and Bosworth Community Hospital.
   c. UHL has secured nitrous oxide waste mitigation funding (as nitrous oxide is responsible for the largest overall volume of emissions from anaesthetic and medical gases in the NHS with audits undertaken in trusts indicating significant amounts of piped nitrous oxide can be wasted in some settings).

11. We are further waiting for an announcement about an award for EV charging points for EMAS and UHL and hope that too will be successful.

Refresh of the Green Plan

12. In Feb this year, NHSE provided guidance and instructed systems to each produce a new 3 year plan.

13. The system Green Board, led by the SRO for the Green Plan, will undertake engagement with system partners and develop a plan that facilitates system working through sharing knowledge and best practice, supports partner trusts to achieve their green plan goals and supports primary care providers in their carbon reduction activity.

14. The plan will contain an agreed set of system-level priority actions across the 9 areas of focus, like the workstreams of the current Green Plan.

15. Oversight and delivery of the refreshed Green Plan will be by the established ICS Green Board, who will provide annual progress reports to the system. The annual reports will include narrative updates on progress, risks to future delivery and a quantitative assessment of progress against defined targets.

16. NHSE has advised that the adoption of the refreshed Green Plan should be by end Oct 2025. The indicative timeline for completion is as below:

Date	Action
14th May 2025	Green Board initial view of requirements and timelines
27th Jun 2025	System Executive to receive and note for awareness and comment
16th July 2025	Green Board to have received and provided feedback on the first draft - discussion and review
Jul - Aug	Engagement sessions planned with partners and stakeholders, socialising of plan.
10th Sep 2025	Green Board to receive plan for approval
Sep 2025	System Executive to receive final version for approval and to recommend to ICB for adoption
Oct 2025	Present to ICB for adoption
Oct 2025	Supply to NHSE

17. It is anticipated that during this process the TOR of the System Green Board will require review, and that these will be appended to the planned Sept 2025 paper for approval by System Executive.

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

- **RECEIVE and NOTE** the progress made to date with the action points from the ICS Green Plan.
- **RECEIVE and NOTE** the plans and timeframe to refresh the System Green Plan as per NHSE direction.

Appendix 1

Appendix 1 – Green Action Plan – Actions on Target or In Delay

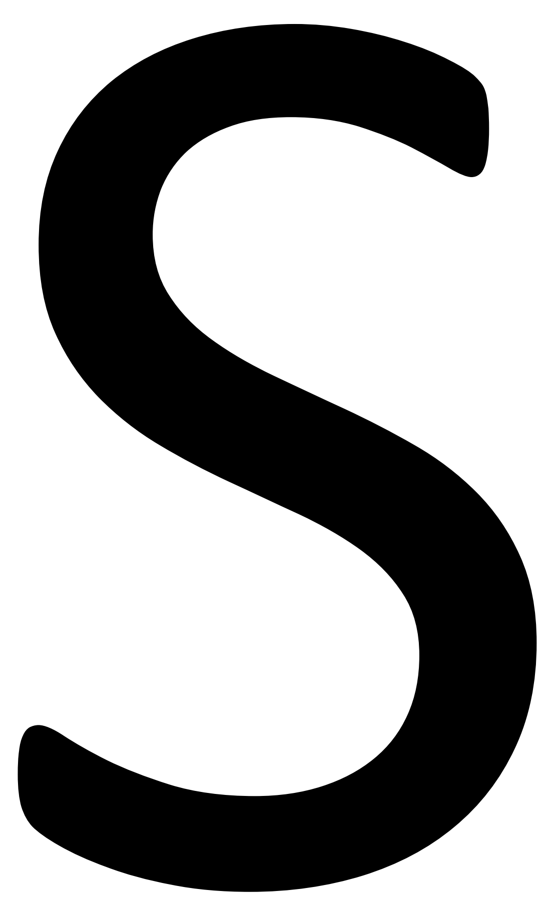
Green Plan Area	Action Number	Action	Commentary	Target Date	RAG	% complete
Sustainable Models of Care	SMC1	Identify and report 2021/22 Virtual appointments and set targets for 2022/23 onwards - review progress annually and ensure capacity to deliver is adequate.	Primary Care - Aim for 30% non face to face appointments. UHL - Target 20% non face to face appointments. LPT - Target awaiting advise. These targets are considered clinically sound and data is awaited to ensure targets are met for future years.	By Q2 2023	Delayed	75%
Travel and Transport	TT1	Each member of the ICS to determine its carbon emissions related to travel and transport and set an action plan – sign up for a free green fleet review where possible	This is still under review. We do now have fleet data but this does not cover all activity. UHL Head of Sustainability and Travel scheduled to join the team from October 2025 and will be supporting this.	Q1 2024	Delayed	not reported
Travel and Transport	TT2	Reduce carbon emissions associated with business mileage by 20% by Jan 2025 against individual baseline (per own target if greater).	Working internally to gain the baseline. New Head of Sustainability and Travel scheduled to join the team from October 2025 and will be supporting this.	Q1 2025	On Target	not reported
Travel and Transport	TT4	UHL will establish an online travel portal for staff and public – review/consider if this can be extended across the LLR ICS	UHL pay for the travel portal -and updated portal is under development for staff and patients - it is our ambition to use this platform going forward website details - www.choosehowyoumove.co.uk. New intranet (UHL Connect) now up and running. Meeting with comms team scheduled to look at the overall strategy for sustainability including travel.	Q1 2022 – Q1 2025	On Target	not reported

Travel and Transport	TT6	Review salary sacrifice policy for Electric Vehicles where company car policy applies (City and County Councils already have in place a scheme for ULEVs).	ICB - no salary sacrifice schemes - UHL's Car Scheme allows employees to access petrol vehicles as well as electic.ULEVs and ZEVs account for around 90% of the cars we authorise.	Q1 2025	On Target	66%
Estates and Facilities	EF7	Car parking and Traffic Management – on and offsite opportunities to help alleviate traffic congestion and air pollution	There are P&R solutions, and off site car parking for LRI & GH. No pollution measures at this stage. New Head of Sustainability and Travel scheduled to join the team from October 2025 and will be supporting this.	Q3 2025	On Target	75%
Estates and Facilities	EF8	Implement waste reduction programmes incl. behavioural change framework following the waste hierarchy, undertake waste analysis where required and follow the reduce, reuse, recycling approach	UHL has implemented a robust segregation program and is now a zero-waste-to-landfill organisatation.	Q3 2025	On Target	80%
Supply Chain	P3	Identify Sustainable Procurement Champions across the system	Delays in identifying a workstream lead has caused delays in reporting progress.	Q1 2025/26	Delayed	not reported
Supply Chain	P4	Undertake 'NHS Carbon Footprint Plus' to understand the impact of carbon emissions within procurement and supply chain.	Delays in identifying a workstream lead has caused delays in reporting progress.	Q1 2025/26	Delayed	not reported
Supply Chain	P5	Develop a road map to embedding sustainability and carbon reduction in decision-making	Delays in identifying a workstream lead has caused delays in reporting progress.	Q1 2025/26	Delayed	not reported
Supply Chain	P6	Review the training and development requirements with regards to Sustainable Procurement awareness across the ICS	Delays in identifying a workstream lead has caused delays in reporting progress.	Q1 2025/26	Delayed	not reported

Supply Chain	P7	Support the development of a 2023/24 Annual Procurement Carbon Reduction Schemes plan (product and transport) arising from use, and waste reduction potential	Delays in identifying a workstream lead has caused delays in reporting progress.	Q1 2025/26	Delayed	not reported
Supply Chain	P8	Develop the Business case to review the carbon reduction of “last mile” deliveries to the ICS	Delays in identifying a workstream lead has caused delays in reporting progress.	Q1 2025/26	Delayed	not reported
Supply Chain	P9	Review progress against the 2023/24 Annual Procurement Carbon Reduction Schemes	Delays in identifying a workstream lead has caused delays in reporting progress.	Q1 2025/26	Delayed	not reported
Supply Chain	P10	Finalise the 2024/25 Annual Procurement Carbon Reduction Schemes	Delays in identifying a workstream lead has caused delays in reporting progress.	Q1 2025/26	Delayed	not reported
Supply Chain	P11	Review progress against the 2024/45 Annual Procurement Carbon Reduction Schemes	Delays in identifying a workstream lead has caused delays in reporting progress.	Q1 2025/26	Delayed	not reported
Supply Chain	P12	Plastics project – identifying top 200 items going through trusts and looking at ways to reduce, swap and adapt what we buy and how we process the waste. This will also highlight areas where we need innovation and technology to help us bridge the gap	Delays in identifying a workstream lead has caused delays in reporting progress.	Ongoing	Delayed	not reported
Food and Nutrition	FN2	Work with Sustainable Procurement Lead (at Trust or ICS Level) to focus on catering and retail suppliers and low carbon goals.	Delays in identifying a workstream lead has caused delays in reporting progress.	Q1 2025/26	Delayed	not reported

Food and Nutrition	FN3	Sustainable Procurement Working Group established – focus stream on Food and Nutrition and Packaging.	Delays in identifying a workstream lead has caused delays in reporting progress.	Q1 2025/26	Delayed	not reported
Food and Nutrition	FN4	Deeper dive across ICS into the 'NHS Carbon Footprint Plus' to understand the impact of carbon emissions within procurement and supply chain related to Food and Nutrition	Delays in identifying a workstream lead has caused delays in reporting progress.	Q1 2025/26	Delayed	not reported
Food and Nutrition	FN 5	Improve waste segregation and recycling and part of new waste contracts – monitor progress annually. Look for opportunities across the LLR for food waste management including composting, food banks, donations to homeless shelters etc.	Delays in identifying a workstream lead has caused delays in reporting progress.	Q1 2025/26	Delayed	not reported
Food and Nutrition	FN 6	Collaboration on healthy and sustainable food offerings and promotion of healthy diets – engagement with Council's Sustainable Food Partnership	Delays in identifying a workstream lead has caused delays in reporting progress.	On-going	Delayed	not reported
Medicine	M2	Support PCNs to meet the respiratory and sustainable national targets going forward, in order to contribute to greener inhaler prescribing	National target for 2023-24 to reduce total CO2e from inhalers by 25% compared to baseline data from 2019/20. System Ambition TBC. National target for 2023-24 to reduce total CO2e from inhalers by 25% compared to baseline data from 2019/20. System Ambition TBC.	Ongoing delivery of target or better	On Target	not reported
Medicine	M4	Take steps to increase staff awareness of the green medicine strategy, and provide training to staff	See Item 9 - re absence of GP lead has presented delays	Q4 2022	Delayed	75%
Medicine	M5	Clinical plastics: explore alternative options for specific single-use items, disposable, unused or expired equipment associated with medicines or medical devices	1. PenCycle insulin pen recycling pilot in community pharmacy (5 pharmacies). For PenCycle across LLR, estimated 12,000 used pre-filled insulin pens returned via community pharmacy or post.	Q2 2025	On Target	40%

Medicine	**M7**	**Implement key recommendations of the NHS Overprescribing Review**	Im**plement a training program for General Practice to include medication reviews and avoiding/ addressing overprescribing.**	**Q4 2023**	**Delayed**	**80%**
Medicine	**M8**	**Support Care Homes to reduce wastage associated with medicines**	**Direct dressing process implemented in nursing homes to avoid wastage.**	**Q4 2023**	**Delayed**	**40%**



Name of meeting:	Leicester, Leicestershire and Rutland Integrated Care Board (public)		
Date:	**14 August 2025**	**Paper:**	**S**
Report title:	**Briefing note: Neighbourhood Health programme**		
Presented by:	Rachna Vyas, Deputy Chief Exec / Chief Operating Officer, NHS LLR ICB		
Report author:	Rachel Dewar / Debra Mitchell / Helen Mather – NHS LLR ICB Place representatives		
Executive Sponsor:	Rachna Vyas, Deputy Chief Exec / Chief Operating Officer, NHS LLR ICB		

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

Recommendations:

The LLR ICB (public) board is asked to:

RECEIVE and NOTE the progress made thus far

Purpose and summary of the report:

This paper provides a precis of the progress of the LLR Neighbourhood Health Programme, a collaborative programme across all health and care providers in the sub-region.

The focus of the Board in June 2025 has been three-fold;

1. To articulate a vision across health and care
2. To understand the short- and medium-term work required to deliver the vision
3. To report against the immediate 2526 deliverables agreed through health planning

Outputs from each of these focus areas were agreed through the programme board, with a brief description included in this paper.

The paper also includes an appendix, outlining the response against the six priorities outlined in the policy documents released in Jan 2025. Delivery against outcomes has been positive, with each place engaged and actively working together to understand what / how infrastructure across health and care should be structured to best meet the needs of each of our populations.

Appendices:	Appendix A – place based neighbourhood health reports
Report history (date and committee / group the content has been discussed / reviewed prior to presenting to this meeting):	System Executive Neighbourhood health programme board

The report is helping to deliver the following strategic objective(s) – *please tick all that apply*:		
1. Improve outcomes	Improve outcomes in population health and healthcare.	☒
2. Health inequalities	Tackle inequalities in outcomes, experience and access.	☒
3. Value for money	Enhance productivity and value for money.	☒

4. Social and economic development	Help the NHS support broader social and economic development.	☒
5. NHS Constitution	Deliver NHS Constitutional and legal requirements.	☒

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

Implications:	
a) Does the report provide assurance against a corporate risk(s) e.g. risk aligned to the Board Assurance Framework, risk register etc? *If so, state which risk and also detail if any new risks are identified.*	BAF 1 – Partnership BAF 2 – Health Inequalities BAF 3 – Demand and Capacity BAF 4 – Finance BAF 5 – Quality and Safety
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 has been identified
c) Does the report highlight quality and patient safety implications? If so, provide which page / paragraph this is outlined in within the report.	The outputs of the neighbourhood health programme will support quality and safety of service outcomes across multiple pathways
d) Does the report demonstrate patient and public involvement? If so, provide which page / paragraph this is outlined in within the report.	The vision document has been co-produced following an all-partner workshop, with patient and public representatives
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.	As services develop, all due regard processes will be followed across health and care

Briefing note: Neighbourhood Health programme
July 2025

Introduction

1. This briefing note provides a precis of key national and regional policy developments for neighbourhood health, an update against the commitments of the 2526 neighbourhood health programme for the LLR sub-region for M3 and outlines key development areas for consideration across and within the ICS.

National and regional policy developments

2. The 10-year plan has now been published with a significant focus on Neighbourhood Health. A Place based implementation programme is also being launched, inviting places to be one of 46 early implementers, with national coaching, learning groups, and workshops to support the implementation of new ways of working. We will work with partners to agree which place/places for LLR will be nominated for this programme.

3. The 10-year plan describes 3 key shifts:

   a. Hospital to Home
   b. Analogue to digital
   c. Sickness to prevention

   Describing that at its core, neighbourhood services should ensure that care is delivered:

   a. as locally as it can be.
   b. digitally by default
   c. in a patient's home if possible
   d. in a neighbourhood health centre (NHC) when needed
   e. in a hospital if necessary

   Key expectations include development of one stop shop health and care hubs on a neighbourhood footprint, which are open at least 12 hours a day 6 days of the week, the delivery of more urgent care services in peoples homes, or via community hubs, expansion of SDEC and co-located UTC's, development of the NHS app to enable patients to book appointments, seek advice, view their care plan and self-refer to local tests and services, incentive schemes to encourage healthier choices, increase vaccination update and expand mental health support in schools, colleges and young futures hubs.

Leicester, Leicestershire & Rutland – local context

4. We have now developed our vision for a neighbourhood model of care across LLR and have strengthened our links with Northamptonshire to enable us to share good practice and opportunities. An easier to read version is being co-produced with expert input, with a particular focus on health literacy. Both versions will be presented to Boards across LLR in August.

5. In line with the ethos of subsidiarity, each Place (Leicester City, Leicestershire, and Rutland) have processes in place to develop the neighbourhood model, In Rutland, through the Integration Delivery Group, in County through the Integrated Delivery and Commissioning Group and in City via the Leicester City Integrated Health and Care Group. Each of these groups have representation from all partner agencies. These place groups are supporting and overseeing the development of Integrated Neighbourhood teams. An update from each place is attached to this paper as Appendix A for interest.

6. Six priority areas have been identified from the workshop held in June and working groups are being developed to support our focus on:

   a. Data Pack Development – a holistic data pack for each neighbourhood combining data and intelligence from primary and secondary health services, Social care, public health and local voluntary and asset based services, to inform and provide baseline data against which outcome impact & return on investment can be measured.

   b. PNG Implementation – to support robust and meaningful processes to identify patient need group prevalence, set priorities and develop multi-disciplinary care across all facets of primary, community, social and secondary care partners.

   c. Care Planning MDT plan development – to enhance care planning processes to multi-disciplinary care plans which involve and are easily accessible to patients and those delivering care, and which are reviewed and updated appropriately at the point of care delivery.

   d. Single Point of Access – to ensure that all pathways for urgent and same day care are triaged and accessed via a single point, ensuring the right care first, and supporting ED attendance and avoidance.

   e. Patient Activation – to empower patients in managing their health conditions and making healthy choices and supporting individual autonomy in care planning.

   f. Scoping Neighbourhood contracting & delivery infrastructure – in line with the population sizes in the ten-year plan, to begin to understand local ambitions around delivery infrastructure at scale.

   Leadership of each of these groups will be by the appropriate discipline (system wide), with participation open to all willing to contribute. Nominations have been requested through the neighbourhood programme board and we expect to launch each in August 2025. Each will be requested to co-create their own delivery plan, with metrics and outcomes co-crated in line with system and patient need.

Headline progress against the NHS England guidelines

7. UEC demands and the ongoing financial challenges have influenced the 2526 plan for neighbourhood health which specifically targets interventions that will support admission and attendance avoidance, and/or support flow across provider services. Progress against the key deliverables is detailed below:

Population health management

8. The roll out of our ACG risk stratification model is complete. 100% of practices have access to the data, with a ‘how to’ guide developed and published. A further 5 GP practices are

trialling the use of Patient Need Group data to manage long term conditions and their daily workflow. This will provide local, clinical evidence to support a cultural change in our local practices. Work is underway to include ethnicity data on ACG reports, currently expected Sept 2025.

9. Our 2526 plan includes delivery of an additional 15,984 plans, largely in our higher risk and therefore higher impact PNG's. The Q1 target for patients enrolled onto the Integrated Care Pathway (including care plans) is 3,996, with 2,652 achieved by June 2025 and therefore behind trajectory. 9,000 new patients are expected to have had care plans in place by March 2026; whilst the Q1 trajectory is off-track, confidence in delivery is high, with mitigation plans in place.

Modern General Practice

10. This programme has two components – contact and single workflow. Our local programme also includes workforce growth, in recognition of local GP shortages.

a. Contact – All contact standards for 2526 have already been met, including upgrading of phone systems & implementation of online services. Focus has now shifted to the efficacy of each of these, with standards being trialled for impact. Practices which have updated websites and NHS app utilisation have received positive feedback for patients in terms of finding access to appropriate pathways easier. We are utilising this feedback to encourage all practices to implement these changes.

b. Single workflow – Rapid Health and KLINIK AI tool trials continue. Early feedback is positive, however structured evaluation and analysis will not be available until Q3.

c. For 2526, The ICB continue to support practices and PCN's, through dedicated webinars, to develop and enact workforce plans. The plan for 25/26 is to recruit 8 new GP's into the system and maximise ARRS funding through recruitment of appropriate skill mix for practice/PCN population need.

Community health services – Home First / Urgent community services

11. Our Pre-transfer clinical decision assessment service saw 277 patients in June. The clinical team have assessed 219 of these as ED attendance avoidance and 149 of these as admissions avoided. These figures are higher than May and continue to sit above trajectory. The PTCDA consultant staffing is fragile, and short term resolution is in place, however a longer term solution to sustain the service delivery is required and a business case in in development to secure appropriate workforce levels to continue and hopefully expand the service. The annual plan for 25/26 is to support 3,520, to save 2762 ED attendances and 1,878 emergency admissions.

12. Our frailty virtual wards saw an occupancy of 79.68%, against a standard of 80%. Whilst below trajectory this is an improvement from May. The service had 34 admissions in June with 302.2 bed days saved.

13. Redirection of patients presenting at the ED front door continues, with 3,292 patients streamed away to neighbourhood care in the first 3 months of 2526, compared to 2,717 in the same period 24/25. The plan was to increase redirections by circa 10 per week, excluding the additional Merlyn Vaz capacity. We are above target for this.

Integrated Neighbourhood Teams

14. Integrated Neighbourhood Teams have been in place in various guises for some time across LLR. We are working to strengthen and develop the MDT elements of these teams, linking the outcomes to PNG implementation and care planning, particularly initially for PNG groups that sit in the 9,10, 11 categories of need.
15. Rutland continue to develop their model which has been embedded for some time; County initially identified 2 neighbourhood areas, but other neighbourhoods have come forward expressing desire to commence developing their MDT model and therefore engagement work is underway to agree actions, outcomes and trajectories in these areas. City have held engagement events to agree the footprints of their INT's. The model will include MDT sessions to identify patients from specific health need categories within PNG 9,10, 11. Public health are working with Local authority and health analysts to create data packs to support this caseload mapping which will include health contact data, LA contact data and data related to age, ethnicity and wider determinants linked to housing/benefits etc. These will include baseline data to enable the impact of the INT MDTs related to Acute care, Social care, Primary care and Community care contacts.
16. Many colleagues have expressed a lack of understanding of what INT's will practically do to support patient care – to support this, our clinical and practitioner teams across health and care are preparing a short webinar, open to all, to deepen this understanding. This should also begin our partnerships and collaboratives to begin to think about how they can 'dock into' to concepts of the INT and further strengthen our offer to our patient groups.

Integrated Intermediate care

17. For 2526, the aspiration is to ensure our complex patients are discharged as soon as possible to optimise outcomes, by having no more than 100 patients awaiting a care plan in UHL by July 2025. For M3, the average numbers of patients awaiting a care plan in UHL was 96 and for Q1 the range of patients has been a high of 136 and a low of 77.

Overall programme deliverables for 2526

18. M3 overall reporting shows the cumulative impact of these workstreams:

    a. Ambulance conveyances to ED in June were 5,941 against a plan of 6,248 which is 307 under plan

    b. ED attendances were at 23,938 for June 25, a reduction of 256 attendances when compared to 24/25 data, Plan was 23,809, however we also saw an increase in patients redirected from ED to an alternative UTC/UCC setting from 865 in June 24/25 to 1,128 in 25/26, an increase of 263 patients, these redirection figures are not subtracted from the attendance numbers given in the report. When redirections are considered net attendances were 22,810, 999 under plan.

    c. Emergency admissions via ED saw an increase of 214 from 9,559 24/25 to 9,773 in June 25/26, this is against a plan of 9,623.

Priorities for July/August

19. Outline neighbourhood contribution to LLR winter plan

20. Submission of our system Maturity Matrix on 24th July 2025

21. Nominations for Neighbourhood implementation programme, signed and agreed by all partners by 8th August

22. Development of working groups for agreed LLR priorities of
   a. Data Pack Delivery
   b. PNG Implementation
   c. Care Planning reform
   d. Single point of access
   e. Patient activation
   f. Scoping Neighbourhood contracting & delivery infrastructure

23. Confirmation of City Neighbourhood footprint

Recommendations

The ICB Board is asked to:

RECEIVE and NOTE the progress made thus far

Appendix 1

Rutland’s Neighbourhood Model of Health & Care Update

Rutland’s Integrated Delivery Group (IDG) have been working to align the projects and programmes being delivered as part of the Joint Health & Wellbeing Strategy (2022-2027), and Health Plan (2022-2027), to the 6 components of a Neighbourhood Model of Health, as described in NHSE’s, “Neighbourhood Health Guidelines 2025/26”.

The below provides a high-level overview of the priorities for 2025/26, aligned to the 6 components of the Neighbourhood Model of Health. These are current plans, however it is expected that further activity will develop throughout the year.

The expected outcomes outlined in this paper still require further discussion through local governance channels and confirming.

Neighbourhood Component	Action in 25/26 plans	Expected Outcomes	Time Frames
1. Population Health Management (PHM)	Updating Patient Need Group (PNG) population modelling (initially completed in November 2023).	• Understanding of the complexity of our population • Enables mapping service provision to Patient Need Groups.	End of Q1 2025
	Rutland’s Integrated Neighbourhood Team (INT) to begin using PNGs to proactively identify residents in the upper PNGs, those who are multi-morbid, frail and with complex health and care needs, to wrap holistic support around them and their carers.	• Increase in the Care Plans being completed for PNGs 9, 10 and 11 • Minimise unnecessary admissions • Where an admission is necessary, a reduction in bed days.	End of Q3 2025
	A Customer Journey Mapping task to support development of the INT, Local Link Hub and other Rutland County Council transformation projects.	• Identifying, and addressing gaps and areas of duplication in current pathways.	End of Q1 2025
	Implementation of the Smoke Free Generation programme. Recruitment to the Smoking Advisor role (April 2024). Leading on community engagement and outreach, supporting people into Quit Ready programmes.	• Supporting primary prevention of diseases and illnesses related to smoking. • Increase in referrals to Quit Ready Programme • Increase in community engagement around smoking prevention and quitting.	Funding until 2029
	Continuation of the Healthy Weight Programme, including a health and wellbeing event aligned to the “Know Your Numbers” campaign	• Supporting prevention of conditions associated with unhealthy weight.	September 2025

2. Modern General Practice	Ensure alignment of Modern General Practice programme and plans to the neighbourhood plans	• Ensures Rutland Neighbourhood programme involves all major health and care providers.	June 2025
	Development of the PCN Enhanced Access Clinics to ensure optimum useage.	• Improving access to secondary prevention activity for more of the population.	Ongoing
	Continued development of the use of the Joy App as a link between our community teams and clinical systems	• Improved case management ability across partner organisations. • Joy outcomes dashboard can demonstrate key outcomes measures from residents with cases in the case management system.	Ongoing
	Scope how Patient Need Groups can be used to support a single workflow.	• Improved patient flow • Improved understanding of patient need • Align with ICB support for PNGs as a "clinical currency" for talking about complexity	End of Q2 2025
3. Community Health Services	Development of Rutland's end of life pathway.	• Increased early identification of residents who may be toward the end of their lives. • Increased ReSPECT planning activity and care planning conversations • Early identification of carers	Q4 2025
	MediTech Centre plans (Levelling up Fund Project lead by Rutland County Council) and milestones: includes an enhanced procedure suite (EPS), consulting rooms and community/research facilities.	TBC	Elective commissioning decision required by end of Q2 2025, go live from October 2026

	Design and implementation of the Local Link[1] hub as a community asset and team working location for health, care and VCSE partners.	• Increase communication and team-working between provider partners.	End of Q4 2025
4. Neighbourhood MDTs	INT development sessions focused on priority cohorts (inc. end of life, frailty and carers).	• Identify, and address, gaps/challenges faced by our INT in delivery of support to priority cohorts. • Improved experience of health and care for Rutland residents. • Develop streamlined pathways for our priority cohorts.	Q3 24 – Q4 2025
	Progress the development of MDTs for the above cohorts, learning from the Mental Health Neighbourhood MDTs already in place.	• Improved care planning activity for our most vulnerable and complex patients, who require an MDT approach. •	Q3 2025
5. Integrated Intermediate care with a "Home First" approach	Scoping development of Step-Up and Step-Down services within Rutland, with the intention of trialling improvements at Neighbourhood. • Complete Customer Journey Mapping to identify gaps. • Launch trial solutions for gaps ahead of Winter 2025.	• Identifying pathway improvement with a focus on preventing deterioration where possible.	End of Q1 2025
6. Urgent Neighbourhood Services	Continue plans for developing a Same Day Access service in Rutland by combining the Minor Injuries and UCC to develop a minor injuries and illness service. • Public consultation on the Same Day Access plans. • Independent evaluation of the consultation results. • Dependent on outcomes of consultation, confirm available resources and clinical safety of proposed model of care. • New service operational	• Increased local appointments • Avoid unnecessary ED visits • Simplified pathway for public to navigate • Improvement in available accommodation to bring the service up to modern standards.	• Consultation completed April 25. • Independent evaluation end of May25 • End of Q2 • April 2026.

[1] The Local Link hub includes the Mobi Hub element of the Levelling Up Fund projects. Meditech is the second.

	• Capital Scheme (funded by SIL monies)		• End of October 2026.
7. Underpinning Governance - Rutland's Neighbourhood Collaborative	The Rutland Neighbourhood Leadership team is working closely with senior partners provider organisations to implement the first Place-based Collaborative. The Collaborative will be established to formalise the relationship between health, social care, voluntary, and community sector partners in Rutland. The purpose being, to foster integrated working across partners delivering health and care services in Rutland. The overall aim being to improve the overall health and wellbeing of Rutland's population through simpler to access health and care, and a focus on prevention at all levels.	• Ensure multi-agency buy-in and support for the Rutland programme of work. • Possible conduit for ICB functions moved to Neighbourhood providers.	Sep25 – First Collaborative meeting.

Better Care Fund Metrics

It is expected that the actions outlined above will positively influence the metrics outlined in the Better Care Fund (BCF) 25/26. These are listed below with available data populated.

It is to be noted that the Rutland Health & Wellbeing Integration Manager has raised concerns with the National BCF Team regarding their accuracy and consistency of data for Rutland, due to population size. Work around developments are ongoing, including Rutland's Business Intelligence Team building a dedicated BCF data dashboard.

The National BCF Team are taking case examples from Rutland's MiCare Team, Fall's prevention, Integrated Neighbourhood Team and the wider development and learning regarding Rutland's BCF and it's delivery.

Data sources –
Rutland Health & Wellbeing Board 2025-26 BCF Reporting Template
Rutland Health & Wellbeing Board 24-25 BCF End of Year Report

Headline Metric	Rutland Position	Supporting Indicators	Rutland Position
Emergency Admissions to hospital for people aged 65+ per 100,000 population	Planned Jul25 – 1,318	**Unplanned hospital admissions for chronic ambulator care sensitive conditions per 100,000 population**	Q3 24/25 Planned – 112 Q3 24/25 Actual – 89.7
		Emergency hospital admissions due to falls in people aged 65+ per 100,000 population	24/25 Planned – 1166.9 24/25 Actual – 279.8

Average length of discharge delay for all acute patients	Planned Jul25 – 0.48	**Patients not discharged on their DRD, and discharged withing 1 day, 2-3 days, 4-6 days, 7-13 days and 21 days or more.**	
		Average length of delay by discharge pathway.	
Long-term admissions to residential care homes and nursing homes for people aged 65+ per 100,000 population	Planned Q2 25/26 – 46.7	**Hospital discharges to usual place of residence**	Q3 24/25 Planned – 91.2% Q3 24/25 Actual – 91.46%
		The proportion of people who received reablement during the year, where no further request was made for ongoing support	

Leicestershire’s Neighbourhood Model of Health & Care Update

Leicestershire’s Integrated Delivery and commissioning group, and Place team Group have been scoping projects and programmes being delivered as part of the Joint Health & Wellbeing Strategy (2022-2027), and Health Plan (2022-2027), to the 6 components of a Neighbourhood Model of Health, as described in NHSE’s, “Neighbourhood Health Guidelines 2025/26”.

The below provides a high-level overview of the priorities for 2025/26, aligned to the 6 components of the Neighbourhood Model of Health. These are current plans, however it is expected that further activity will develop throughout the year.

The expected outcomes outlined in this paper still require further discussion through local governance channels and confirming.

Neighbourhood Component	Action in 25/26 plans	Expected Outcomes	Time Frames
8. Population Health Management (PHM)	Updating Patient Need Group (PNG) population modelling with a view to having data available at a neighbourhood hub level as well as PCN level.		End of Q1 2025
	Developing an MDT approach to care planning/Care contracting for PNG groups 9,10,11 in 2025 with a view to optimising community pathways and care closer to home where appropriate	• Increase in the Care Plans being completed for PNGs 9, 10 and 11 • Minimise unnecessary admissions • Where an admission is necessary, a reduction in bed days.	End of Q3 2025
	Implementation of Leicestershire’s Joint Health and Wellbeing Strategy priorities at neighbourhood level. Identifying local population need and focus on prevention, alongside schemes offering support for carers and patients.	• Supporting primary prevention of diseases and illnesses. • Supporting informal carers to minimise risk of care breakdown which could result in admission to health or care facilities.	TBC
9. Modern General Practice	Ensure alignment of Modern General Practice programme and ambition to the neighbourhood plans	• Ensures Leicestershire’s Neighbourhood programme involves all major health and care providers.	July 2025
	Development of the PCN Enhanced Access services to ensure optimum usage.	• Improving access to secondary prevention activity for more of the population.	

10. Community Health Services	Further developing the integration of HART, Community Therapy and Community Nursing, to support efficient care delivery and an integrated approach for delivery of care.	• Reduced duplication and increased efficiency across services. • Improved patient experience and outcomes.	Q4 2025
	Standardising and strengthening MDT links with Local Area coordinators, social prescribers, pharmacy, community nursing etc.	• Improving local access to Services	Q3 2025
11. Neighbourhood MDTs	Introduce INT development sessions focused on priority cohorts (inc. end of life, frailty, and carers).	• Identify, and address, gaps/challenges faced by our INT in delivery of support to priority cohorts. • Improved experience of health and care for Rutland residents. • Develop streamlined pathways for our priority cohorts.	Q3 24 – Q4 2025
12. Integrated Intermediate care with a "Home First" approach	Scoping development of Step-Up and Step-Down services within Leicestershire, with the intention of trialling improvements at Neighbourhood particularly increasing step-up utilisation of Intermediate Care, Virtual Wards, and Community Hospital beds.	• Identifying pathway improvement with a focus on preventing deterioration where possible.	End of Q3 2025
13. Urgent Neighbourhood Services	Implement a Same Day Access service across Leicestershire to improve opportunities for patients to access services for type 4 level need and avoid unnecessary attendance at UTC/ED facilities.	• Increased local appointments • Avoid unnecessary ED visits • Simplified pathway for public to navigate	TBC

Better Care Fund Metrics – metrics are currently unavailable for M1 and M2 of 25/26 – however for 24/25 the below was achieved, we would expect to see further improvement in 25/26

Metric	Target 24/25	Actual 24/25	Commentary
Indirectly standardised rate (ISR) of admissions per 100,000 population	162.6	195.1	The focus for the LLR system will be on the development of community care models particularly in expansion of current good performance to ensure capacity meets demand. Additional investment in neighbourhood models of care and step-up activity should mitigate the increase seen in this financial year.
Percentage of people, resident in the HWB, who are discharged from acute hospital to their normal place of residence	93%	92.1%	For 25-26 an increase in RRR provision from hospital is hoped to increase further the number of people that return to their normal place of residence. This includes care home environments being supported to have residents return. There is a less than 1% variance from target to actual so has been reported as target met.
Emergency hospital admissions due to falls in people aged 65 and over directly age standardised rate per 100,000.	1756.9	1682.9	This metric has met the target. The falls sub-group are looking at proactive models of support in the community for falls reduction pathways along with improved performance within the DHU falls response car
Long-term support needs of older people (age 65 and over) met by admission to residential and nursing care homes, per 100,000 population	494	583.8 (projected)	This metric is off target. Proactive care MDT's will be looking at ensuring people in high need population groups have got a care plan that will aim to support people to remain at home. This includes developing palliative care and VW service and therefore reducing the likelihood of long-term admissions to care homes.

Leicester City Neighbourhood Model of Health & Care Update

Leicester City Integrated Health and Social Care Group, and PLACE Team Group have been scoping projects and programmes being delivered as part of the Joint Health & Wellbeing Strategy (2022-2027), and Health Plan (2022-2027), to the 6 components of a Neighbourhood Model of Health, as described in NHSE's, "Neighbourhood Health Guidelines 2025/26".

The below provides a high-level overview of the priorities for 2025/26, aligned to the 6 components of the Neighbourhood Model of Health. These are current plans, (this is still an emerging / developing process but progress is being made) and updates will be made throughout the year.

The expected outcomes outlined in this paper still require further discussion through local governance channels and confirming.

Neighbourhood Component	Action in 25/26 plans	Expected Outcomes	Time Frames
14. Population Health Management (PHM)	Updating Patient Need Group (PNG) population modelling (initially completed in November 2023).	Updated PNG population modelling shared with general practice and encouraged to promote continuity of care and offer of preferred GP.	Q1 – Q3
	Leicester City PCNs working in collaboration with Public Health and ICB Population Health lead to begin using PNGs to proactively identify residents in the upper PNGs, those who are multi-morbid, frail and with complex health and care needs, to wrap holistic support around them and their carers (2025-6 delivery of the complex care specification).	Increase in the Care Plans being completed for PNGs 9, 10 and 11 Fewer admissions and lower secondary care tariff in those with a care plan from these PNGs compared to a matched cohort without evidence of a care plan Where an admission is necessary, a reduction in bed days.	End of Q4 2026
	A Customer Journey Mapping task to support development of the INT, Local Link Hub and other Leicester City Council transformation projects.	Identifying, and addressing gaps and areas of duplication in current pathways.	TBC
	Improve the uptake of childhood Immunisation and vaccinations	Supporting primary prevention of diseases and illnesses amongst the CORE20 children's cohort.	Q1 – Q4
	Continuation of the Healthy Weight Programme, including a health and wellbeing event aligned to the "Know Your Numbers" campaign	Increase in eligible referrals by city practices to the national Digital	October 2025

Neighbourhood Component	Action in 25/26 plans	Expected Outcomes	Time Frames
		Weight Management Programme (Outturn 2024-5 as baseline).	
	Continuation on delivery against the City priorities; • Increase Childhood immunisation uptake • Tuberculosis (TB) identification and referral • Bowel Cancer - 75% of cancer patients within LLR should be diagnosed at Stage 1 and 2 by 2028. • Hypertension – prevention and early diagnosis/ treatment. • Obesity and weight management.	• Increase screening for Breast, Colorectal, Bowel, Gynae, Lung, Oesophageal, Prostate, Skin in underserved populations • Hypertension: Increase early identification and prevention case findings. • Atrial Fibrillation (AF): identify more undiagnosed AF: March 2024 prevalence 2.2% and December 2024 prevalence increased to 2.46% • Women's Health Hub available in Leicester City which offers cervical screening, menopause sessions and treatment, etc • Childhood Imms data shared with PCNs to support maintenance in uptake against 2024-5 outturn as baseline. Support by PCL to set up roving van, use super vaccinators with targeted populations , etc. • 1400 LTBI tests to be delivered by primary care in the city in 2025-6. Focus on 30-35 yos & those in the UK for 4 years already.	Q1 – Q4 March 2026
15. Modern General Practice	Ensure alignment of Modern General Practice programme and plans to the neighbourhood plans • LLR practices migrated to Cloud Based telephony – 100% • NHS App registration – 647,519 (April 25) 98% • NHS App prescription – 211,837 (April 25) 20%	Ensure Leicester City digital programmes involves all major health and care providers. Increase NHS App registration and prescription ordering by 100%.Ensure patients are informed and aware of	Q1 – Q4

Neighbourhood Component	Action in 25/26 plans	Expected Outcomes	Time Frames
	• GP practices implement Online Consultation – 100% (required to offer these during core hours). Online Consultation activity - 51,466 (M1)	the online consultation options via the website, notice boards, conversations with Social Prescribers, etc.	
	Enhanced Access sessions on Saturday offer an opportunity for PCNs to support digital enablement	Hold focus groups and sessions with patients to improve digital knowledge Collaborate with PPGs/ Patient groups and NHS APP Champions with the practice to improve digital enablement.	Q1 – Q4
	Increase Care Navigation in general practice to ensure patients are referred to the right clinician for the right care	Through CAIP, practices have implemented care navigation which include Clinical triage, AI, SystmOne clinical process, etc Staff trained via Active Signposting Practices obtain pt feedback via Friends and Family test, in-house survey, PPG feedback.	Q1 – Q4
	Tackling 8am Rush – ensure practices have systems in place to manage demand and capacity.	100% of practices on Cloud Based Telephony with a service provider on the NHSE Framework. CBT suppliers provide telephony dashboard information that supports practices to undertake demand and capacity audit and make necessary quality improvements, this includes; ○ Managing workforce rotas to meet demand ○ Updating the website to signpost pts effectively to access online consultation for non-urgent, routine queries and ordering prescription. ○ Use of Care Navigation and auditing the process to ensure	Q1 – Q4

Neighbourhood Component	Action in 25/26 plans	Expected Outcomes	Time Frames
		patients signposted to the right care. Practices piloting automated care navigation process such as Rapid Health, Klink, etc.	
16. Community Health Services	Realigning both LPT and Social Care locality services to our new Neighbourhood footprint to maximise patient care and reduce duplication where appropriate, linking roles such as Social Prescribers, Care Co-Ordinators, Youth Workers etc	• Teams re-aligned to fit Neighbourhood footprints • Joint understanding of roles of team members reducing duplication	Q4 2025/26
	Standardising and strengthening MDT links with Local Area coordinators, social prescribers, pharmacy, community nursing etc.	• Improving local access to Services	Q3 2025/26
17. Neighbourhood MDTs	Following agreement of the Neighbourhoods work with existing MDT Teams, enhancing them where appropriate, to deliver identified programmes of care (eg Best Start in Life, End of Life, locally and nationally agreed priorities	• Identify, and address, gaps/challenges faced by our INT in delivery of support to priority cohorts. • Improved experience of health and care for Leicester City residents. • Develop streamlined pathways for our priority cohorts.	End of Q4 2025/26
18. Integrated Intermediate care with a "Home First" approach	Scoping development of Step-Up and Step-Down services within Leicester City, with the intention of trialling improvements at Neighbourhood particularly increasing step-up utilisation of Intermediate Care and Virtual Wards,	• Identifying pathway improvement with a focus on preventing deterioration where possible.	End of Q3 2025/26
19. Urgent Neighbourhood Services	Implement a Same Day Access service across Leicester City to improve opportunities for patients to access services for type 4 level need and avoid unnecessary attendance at UTC/ED facilities with a focus on LE4 and LE5 postcodes	• Increased local appointments. • GP led service offering 15 min appointment. • Avoid unnecessary ED visits. • Simplified pathway for public to navigate	TBC

Neighbourhood Component	Action in 25/26 plans	Expected Outcomes	Time Frames
		• Multiple locations available for pts to access closer to home. • Use of effective triage to direct pts to the right clinical	

Better Care Fund Metrics – full metrics are currently unavailable for M1 and M2 of 25/26 –for Q1 the below was achieved, we would expect to see further improvement in 25/26

Metric	Target 25/26 Q1	Actual 25/26 Q1	Commentary
Indirectly standardised rate (ISR) of admissions per 100,000 population	2715	Awaiting full Q1 data	The focus for the LLR system will be on the development of community care models particularly in expansion of current good performance to ensure capacity meets demand. Additional investment in neighbourhood models of care and step-up activity should mitigate the increase seen in this financial year.
Average length of discharge delay for all acute adult patients	1.43	1.06 (awaiting June 25 data)	For 25-26 an increase in RRR provision from hospital is hoped to increase further the number of people that return to their normal place of residence. This includes care home environments being supported to have residents return. There is a less than 1% variance from target to actual so has been reported as target met.
Proportion of adult patients discharged from acute hospitals on their discharge ready date	88.5%	88.4% (awaiting June 25 data)	Discharge home activity remains on track, above plan and with a slight improvement between April and May. However, days to discharge have increased as has average delays, work progressing to work towards targets in 25/26.
For those adult patients not discharged on DRD, average	12	9.2 (awaiting June 25 data)	Once full Q1 data confirmed, target should show as met.

number of days from DRD to discharge			
Long-term support needs of older people (age 65 and over) met by admission to residential and nursing care homes, per 100,000 population	55	48	This metric is off target. We are currently on track to meet the BCF targets, after a 'high' start to the quarter. Work continues to secure community solutions where possible; to maximise discharge home on Pathway 1; reduce the use of short term bedded care and access support for mental health crisis at home. Proactive care MDT's will be looking at ensuring people in high need population groups have got a care plan that will aim to support people to remain at home. This includes developing palliative care and VW service and therefore reducing the likelihood of long-term admissions to care homes.