Leicestershire County Council

Meeting: **Leicester, Leicestershire and Rutland Joint Health Scrutiny Committee**

Date/Time: **Monday, 18 December 2023 at 2.00 pm**

Location: **Sparkenhoe Committee Room, County Hall, Glenfield**

Contact: **Euan Walters (0116 3056016)**

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Membership

Mr. J. Morgan CC (Chairman)

Cllr. S. Bonham	Cllr R. Ross
Mr. M. H. Charlesworth CC	Cllr. L. Sahu
Cllr. J. Gopal	Mrs B. Seaton CC
Mr. D. Harrison CC	Cllr L. Stephenson
Mr. R. Hills CC	Cllr. P. Westley
Cllr. M. March	Cllr. G. Whittle
Ms. Betty Newton CC	Cllr. S. Zaman
Mr. T. J. Pendleton CC	

Please note: this meeting will be filmed for live or subsequent broadcast via You Tube at https://www.youtube.com/playlist?list=PLrlN4_PKzPXhBilOPZvqU4lDm7DiSlntJ

AGENDA

Item		Report by
1.	Minutes of the previous meeting.	(Pages 5 - 10)
2.	Question Time.	
3.	Questions asked by Members.	
4.	Urgent items.	
5.	Declarations of interest.	
6.	Presentation of Petitions.	

7.	Care Quality Commission report into maternity services at the University Hospitals of Leicester NHS Trust.	University Hospitals of Leicester NHS Trust	(Pages 11 - 20)
8.	Restoration and Recovery of Elective Care.	University Hospitals of NHS Trust and Integrated Care Board	(Pages 21 - 30)
9.	NHS Workforce in Leicester, Leicestershire and Rutland.	University Hospitals of NHS Trust and Integrated Care Board	(Pages 31 - 76)
10.	Integrated Care Board Medium Term Financial Plan.	Integrated Care Board	(Pages 77 - 80)
11.	UHL - Our Future Hospitals Programme update.	University Hospitals of Leicester NHS Trust	(Pages 81 - 88)

12. Date of next meeting.

The next meeting of the Committee is scheduled to take place on Wednesday 27 March 2024 at 2.00pm.

QUESTIONING BY MEMBERS OF OVERVIEW AND SCRUTINY

The ability to ask good, pertinent questions lies at the heart of successful and effective scrutiny. To support members with this, a range of resources, including guides to questioning, are available via the Centre for Governance and Scrutiny website www.cfgs.org.uk. The following questions have been agreed by Scrutiny members as a good starting point for developing questions:

- Who was consulted and what were they consulted on? What is the process for and quality of the consultation?
- How have the voices of local people and frontline staff been heard?
- What does success look like?
- What is the history of the service and what will be different this time?
- What happens once the money is spent?
- If the service model is changing, has the previous service model been evaluated?
- What evaluation arrangements are in place – will there be an annual review?

Members are reminded that, to ensure questioning during meetings remains appropriately focused that:

(a) they can use the officer contact details at the bottom of each report to ask questions of clarification or raise any related patch issues which might not be best addressed through the formal meeting;

(b) they must speak only as a Councillor and not on behalf of any other local authority when considering matters which also affect district or parish/town councils (see Articles 2.03(b) of the Council's Constitution).

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Agenda Item 1

Minutes of a meeting of the Leicester, Leicestershire and Rutland Joint Health Scrutiny Committee held at County Hall, Glenfield on Monday, 18 September 2023.

PRESENT

Mr. J. Morgan CC (in the Chair)

Cllr. S. Bonham
Mr. D. Harrison CC
Ms. Betty Newton CC
Cllr R. Ross
Cllr. L. Sahu
Mrs B. Seaton CC
Cllr. G. Whittle

In attendance
Sarah Prema, Chief Strategy Officer, Integrated Care Board (Item 7 refers)
Amit Sammi, Integrated Care Board (Item 7 refers)
Yasmin Sidyot, Integrated Care Board. (Item 8 refers)
Jean Knight, Managing Director, Leicestershire Partnership NHS Trust (Item 9 refers)
Tanya Hibbert, Executive Director – Mental Health Services, Leicestershire Partnership NHS Trust (Item 9 refers)
Anne Scott, Director of Nursing, Leicestershire Partnership NHS Trust, (Item 9 refers)
David Williams, Group Director of Strategy & Partnerships, Leicestershire Partnership NHS Trust (Item 9 refers)
Susannah Ashton, Divisional Director, EMAS (Item 10 refers)

1. Minutes of the previous meeting.

The minutes of the meeting held on 6 February 2023 were taken as read, confirmed and signed.

2. Question Time.

The Chairman reported that no questions had been received under Standing Order 34.

3. Questions asked by Members.

The Chairman reported that no questions had been received under Standing Order 7(3) and 7(5).

4. Urgent items.

There were no urgent items for consideration.

5. Declarations of interest.

The Chairman invited members who wished to do so to declare any interest in respect of items on the agenda for the meeting.

Mrs. M. E. Newton CC and Mrs. B. Seaton CC both declared non-registerable interests in all agenda items as they had close relatives that worked for the NHS.

The Chairman Mr. J. Morgan CC declared a non-registerable interest in agenda item 7: NHS Leicester, Leicestershire and Rutland Integrated Care Board 5-year Plan, and agenda item 9: Leicestershire Partnership NHS Trust, as his wife was the Chair of Trustees of the Loughborough Wellbeing Café project.

6. Presentation of Petitions.

The Chief Executive reported that no petitions had been received under Standing Order 35.

7. NHS Leicester, Leicestershire and Rutland Integrated Care Board 5-year Plan.

The Committee considered a report of the Integrated Care Board (ICB) which provided an overview of the Leicester, Leicestershire and Rutland (LLR) ICB 5-Year Plan (5YP). A copy of the report, marked 'Agenda Item 7', is filed with these minutes.

The Committee welcomed to the meeting for this item Sarah Prema, Chief Strategy Officer, and Amit Sammi, both of the Integrated Care Board.

Arising from discussions the following points were noted:

(i) In response to a question from the Chairman as to what made the LLR ICB 5-Year Plan different to Plans in other parts of the country, it was explained that whilst the core pledges were relevant to most areas, the delivery of the Plan would be adapted according to the different areas of LLR. For example, cancer screening would be carried out in a different way in Rutland compared to Leicester City.

(ii) A member observed that that the LLR ICB 5-Year Plan made no reference to cross border provision and neither did the Plans of the areas that shared borders with Leicestershire and Rutland. In response reassurance was given by the ICB that work was taking place in this regard and meetings between representatives of the LLR health system and representatives of bordering health systems did take place. One of the key issues was the interoperability of IT systems which required further work to make them compatible.

(iii) Members welcomed that Pledge 13 in the LLR ICB 5-Year Plan was to improve workforce retention, reduce agency usage and grow the ICB's own workforce. The ICB also had a People Plan which contained a range of indicators for monitoring staffing levels and agency use. A specific report on workforce retention and recruitment across the LLR Health and Care System was to come to a future Committee meeting.

(iv) From October 2022 to April 2023 the number of people waiting for elective care decreased by 7,118 to 133,514. Members raised concerns that although the number of appointments available was increasing, demand was also increasing. In response to a request for more detail about the types of procedures patients were waiting for, and concerns about absenteeism it was agreed that a report covering these issues would be brought to a future meeting of the Committee.

(v) In response to a suggestion from a member that the ICB should arrange for external efficiency reviews to take place, it was explained that external agencies did come into the NHS and carry out reviews, and NHS England also undertook scrutiny.

(vi) Reassurance was given around the good partnership working that was taking place across the system and the ICB confirmed that they were satisfied that all the necessary partners were involved. For example, the mental health partnership included representatives from Leicestershire Partnership NHS Trust, Primary Care, and Public Health.

(vii) In response to concerns raised about ICB finances, the deficits in each year and how much health services had been affected by inflation, it was agreed that a report on the ICB Medium Term Financial Strategy, which was about to be finalised, would be brought to a future meeting of the Committee.

(viii) At the previous Committee meeting, as part of a UHL reconfiguration agenda item, it had been noted that the seven community hospitals in Leicestershire were not fully used and UHL were exploring how to increase usage. The ICB was in support of this work and intended to make community hospitals the hubs of communities. The NHS strategy was to deliver as many services as possible locally, however there were times where this was not possible and therefore larger hospitals had to be built which would deal with patients from a larger area.

(ix) In response to concerns raised about a lack of reference in the LLR ICB 5-Year Plan to children's mental health, the ICB confirmed that Child and Adolescent Mental Health Services were a priority for them and would be part of the 5-year Plan.

RESOLVED:

(a) That the contents of the LLR ICB 5-Year Plan be noted;

(b) That officers be requested to provide reports for future meetings regarding the elective care waiting list, the ICB Medium Term Financial Strategy, and Child and Adolescent Mental Health Services (CAMHS).

8. Delivery Plan for recovering access to Primary Care - LLR System Level Access Improvement Plan

The Committee considered a report of the Integrated Care Board (ICB) which provided an overview of the approach to the development of, and the content and scope of, the LLR "System-level Access Improvement Plan" that was required by NHS England from all ICBs as per the NHSE Primary Care Access Recovery Plan. A copy of the report, marked 'Agenda Item 8', is filed with these minutes.

The Committee welcomed to the meeting for this item Yasmin Sidyot, Integrated Care Board.

Arising from discussions the following points were noted:

(i) In response to concerns raised by members about the variation in service offered between different GP Practices, even within the same Primary Care Network, some reassurance was given that work had taken place to tackle this issue. Progress had

been made in reducing the variations and Primary Care Networks were supporting each other in this regard.

(ii) The Royal College of General Practitioners had run a peer-to-peer programme where managers and clinicians visited GP Practices and shared knowledge and experience with the managers and clinicians that worked there. The programme had visited Leicestershire in 2022 and there had been positive results. Some Practices which had been struggling were now on a more stable footing and some Practices had been able to reopen their patient list.

(iii) In response to concerns about the difficulties patients were having booking an appointment at their GP Practice it was explained that increasing use was now being made of digital alternatives for booking such as the NHS app. Whilst it was acknowledged that not all patients would be able to use digital methods, if some patients were using the app this would free up the telephone lines for those that preferred calling.

(iv) Some GP Practices had a system where if you made a phonecall to the Practice and were unable to get through to somebody you could register for a callback. Members welcomed this system and recommended that it be used by more Practices.

(v) A member suggested that were it easier for patients to book an appointment this could reduce the amount of no shows as patients would be more selective about which appointments they accepted.

(vi) Members emphasised the importance of clearly communicating to the public any changes to the way GP Practices operated. In particular it needed to be made clear to patients in advance whether their appointment was with a GP, a nurse or a pharmacist. In response it was explained that the ICB's Engagement Team was carrying out work in this regard and it was acknowledged that websites were not accessible to everyone and other methods of communication needed to be used. The Clinical Pharmacist and Social Prescriber roles were becoming more well known amongst the public.

RESOLVED:

That the update regarding the LLR System-level Access Improvement Plan be noted.

9. <u>Leicestershire Partnership NHS Trust - Creating high quality compassionate care and wellbeing for all.</u>

The Committee considered a report of Leicestershire Partnership NHS Trust (LPT) which provided an update on delivery of their vision, outlined progress being made against the agreed actions following the 'Better Mental Health for All' public consultation of 2021, and provided an update on LPTs engagement with the Care Quality Commission (CQC) and improvements. A copy of the report, marked 'Agenda Item 9', is filed with these minutes.

The Chairman welcomed to the meeting for this item Jean Knight, Managing Director, Tanya Hibbert, Executive Director – Mental Health Services, Anne Scott, Director of Nursing and David Williams, Group Director of Strategy & Partnerships, all from LPT.

Arising from discussions the following points were noted:

(i) Members were aware of the issues there had been in the past with LLR mental health services and welcomed the improvements that had been made.

(ii) A member raised concerns about Child and Adolescent Mental Health Services (CAMHS) and children facing long waits for mental health support. In response LPT stated that they shared those concerns and acknowledged that more work needed to be done to tackle CAMHS waiting lists. It was explained that for many years in Leicestershire data regarding people with neurodevelopmental issues was collated along with mental health data therefore it had been difficult to gain a true understanding of the extent of the problem. LPT made members aware of preventative mental health work taking place in schools and the Intensive Outreach Service which aimed to prevent children from being admitted to an inpatient unit.

(iii) There were 25 Neighbourhood Mental Health Cafes across LLR run by 12 different providers. Partnership arrangements were in place with charities and the voluntary sector to help the running of the cafes. The cafes had trained staff who listened to people that needed immediate help with their mental health and provided practical support. The cafes were able to offer advice regarding other issues such as the cost of living and overcrowding in accommodation. In response to a question from a member about the consistency of training received by the staff at the cafes it was explained that there was not a uniform approach to all of the cafes; bespoke arrangements were in place depending on the provider and the staff involved. Members strongly welcomed the development of the Mental Health Cafes particularly the way they signposted people to other services.

(iv) The Joy App was available in LLR which people could download to their mobile phone and which would connect people to services for tackling social isolation and other mental health issues, foodbanks and housing services.

RESOLVED:

That the update from Leicestershire Partnership NHS Trust be welcomed.

10. <u>EMAS - Additional investment for category 2 response performance improvement and workforce plan.</u>

The Committee considered a report of East Midlands Ambulance Service (EMAS) regarding additional investment made available to ambulance services to support increasing capacity and improvement in category 2 response performance. A copy of the report, marked ‘Agenda Item 10’, is filed with these minutes.

The Chairman welcomed to the meeting for this item Susannah Ashton, Divisional Director, EMAS.

Arising from discussions the following points were noted:

(i) In 2022/23 the Leicestershire and Rutland average time for attending Category 2 calls was 01:11:24. Since the Category 2 performance recovery plan had been implemented the Category 2 average in Leicester, Leicestershire and Rutland was 00:32:37 for April to August 2023, which was a 45% improvement on 2023/24 performance. Members welcomed this improvement in performance.

(ii) In response to a question about hospital handover delays it was explained that whilst capacity in the system was good, the main barrier to improving performance was flow of patients through the hospital and being able to discharge them when they were ready to leave. Work was taking place to improve pathways.

(iii) EMAS used Private Ambulance Services (PAS) to support frontline operations and contribute additional responding resource. The private crews came with their own ambulances. As a result of the additional investment there would be an increase of 18 PAS crews a day across the region. In response to a question from a member it was confirmed that there were plans to reduce the number of PAS in the long term and increase the numbers of EMAS own staff. However, there were concerns that some paramedics might prefer to work for PAS as they received better terms and conditions. In response to a question from a member about whether in future the PAS would only be used at times of peak demand it was explained that it was difficult to be certain about this at the current time. However, EMAS did know when the peak times were, for example during school holidays. Schools had holidays at different times across the region therefore, EMAS was able to ensure that capacity was in place during those dates. As EMAS covered the whole region it was able to move crews around the region to where the highest demand was.

RESOLVED:

That the update regarding the additional investment made available to EMAS and the improvement in performance be welcomed.

11. Date of next meeting.

RESOLVED:

That the next meeting of the Committee take place on Monday 18 December 2023 at 2.00pm.

2.00 - 4.00 pm CHAIRMAN
18 September 2023

LEICESTER, LEICESTERSHIRE AND RUTLAND JOINT HEALTH SCRUTINY COMMITTEE: 18 DECEMBER 2023

NATIONAL THEMATIC REVIEW - MATERNITY CARE QUALITY COMMISSION INSPECTION UPDATE

(including S29a Warning Notice)

REPORT OF THE CHIEF NURSE AND DIRECTOR OF MIDWIFERY

Purpose of the Report

1. The purpose of this report is to brief the committee on the outcome of the Care Quality Commission (CQC) inspection of maternity services at University Hospitals of Leicester (UHL). The inspection formed part of a national thematic review of maternity services.

Summary

2. The CQC carried out focussed inspections of UHL's maternity services in February and March 2023, looking at the 'safe' and 'well-led' domains.

3. The CQC published its findings on 20 September, rating the overall service as 'Requires Improvement', a move down from 'Good'. Services at the LGH and LRI were rated inadequate for the 'safe' domain.

4. We take the report and its findings very seriously and will use them to drive further improvements for women and families.

5. The service is not yet at the standard we want or need it to be, but prior to the CQC visits we had already identified many of the challenges raised, with plans in place to tackle them. These changes – including a significant strengthening of our maternity leadership and staffing - are now embedding.

6. The golden thread running through the CQC's report is not having enough people to safely staff our units – and this is a challenge we share with Trusts across the country. We have made real improvements on this over the last 12-18 months and are working hard to attract and retain the colleagues we need to provide an exceptional service in the future.

7. A total of 57 Midwives have now commenced working with us during 2023, which included, during November, 17 x Band 5 and Band 6 Midwives and the arrival of four international midwives. A further 15 midwives are due to start by Spring 2024. Since April last year, 35 new neonatal nurses have joined us.

8. We have strengthened the maternity leadership team, bringing in a new Director of Midwifery this year. Our turnover rate remains low and below the national average. We will therefore see a real reduction in the vacancy rate when these colleagues join. The CQC report notes the progress we have made in this area.

9. We have also made improvements to the way the service is run, to reduce delays and improve safety. This includes improvements to our triage systems, daily safety checking of our equipment, and progressing plans to separate the theatre space we use for planned and emergency caesareans at the Leicester General.

10. Overall, we are in a very different place today than we were in February and March and have invited the CQC back to see the impact of the changes we have made.

11. We are encouraged by the positives in the report, not least recognition for our dedicated maternity staff, who continue to put the needs of women and birthing people at the centre of everything they do.

12. Leicester remains a safe place for people to give birth, and anyone with concerns is encouraged to raise them. We promise to listen to you and take your concerns seriously.

The Inspection and Outcome

13. The CQC conducted a planned inspection to maternity services; the visit excluded Gynaecology, Termination of Pregnancy Services, and Neonatal Services and was as follows:
    - Leicester General Hospital 28 February 2023 (team of eight);
    - Leicester Royal Infirmary 1 March 2023 (team of eight);
    - St Mary's Birth Centre 2 March 2023 (team of four).

14. In line with normal practice, we received immediate feedback on three areas for improvement and three areas of good practice. These were as follows:

    1. three improvement areas which require attention:
        a. Staffing medical and midwifery;
        b. Triage – staffing and processes;
        c. Oversight of systems and processes;

    2. three areas of good practice:
        a. Development of the JANAM app (a mobile phone application which provides information on pregnancy, labour and postnatal care including looking after a baby in the first few weeks of birth);
        b. Empowering Voices programme;
        c. Leadership - receptive and responsive to concerns raised by the CQC team during the visit.

Warning Notice

15. On 12th June 2023 the Trust was notified that the CQC had formed the view that the quality of health care provided by the maternity services required significant improvement and a regulation 29A (warning notice) was issued to UHL. The warning notice covered five areas. The subsequent section outlines the measures already taken or underway to address these notices.

Effective governance

16. Governance systems are not operating effectively to ensure risk and performance issues are identified, escalated appropriately, and addressed with timely action. *Significant Improvement Required by 30 September 2023*

Treatment delays

17. Delays in treatment including induction of labour were evident. This meant some service users experienced delayed inductions and some did not receive induction of labour as planned for clinical reasons. *Significant Improvement Required by 30 November 2023*

Staffing levels

18. There were not enough midwives to provide safe care and treatment to service users. *Significant Improvement Required by 30 November 2023*

Equipment checks

19. Some equipment, safety checks, and documentation were out-of-date or not fit for purpose, and daily checks were not always completed. *Significant Improvement Required by 31 July 2023*

Risk documentation

20. Staff did not adequately document and respond to ongoing risks to the safety of service users, in line with national guidance *Significant Improvement Required by 30 September 2023#*

Overall report breakdown

21. The final report was published on 20th September 2023 the overall rating for UHL remains at requires improvement. The overall rating for maternity reduced to requires improvement with site breakdown as follows:

	Safe	Effective	Caring	Responsive	Well-led	Overall
LRI	Good 2019	Good 2019	Good 2019	Good 2019	Good 2019	Good 2019
	Inadequate 2023	Domain Not Inspected			Requires Improvement 2023	Requires Improvement 2023
LGH	Requires Improvement 2017	Good 2017	Good 2017	Good 2017	Good 2017	Good 2017
	Inadequate 2023	Domain Not Inspected			Requires Improvement 2023	Requires Improvement 2023
St Mary's	Good 2017	Good 2017	Good 2017	Good 2017	Good 2017	Good 2017
	Good 2023	Domain Not Inspected			Requires Improvement 2023	Good 2023

Response - progress made to date

22. We have made progress over the last seven months and, while we have more to do, it is important to recognise the significant improvements so far, these include:

Effective governance

1. Maternity & Neonatal Improvement Programme Launched September 2023 supported by new Quality Improvement team including 2 New Lead Midwives for Quality Improvement commencing August 2023;
2. Executive-Led Maternity Assurance Committee (MAC) in place May 2023;
3. Perinatal Mortality Deep Dive & Peer Review (NHSE Public Health input August 2023);
4. External Independent Review of Governance arrangements commissioned May 2023; Governance Team Development Session June 2023 & September 2023;
5. Plans in place to transition complaint function to Corporate Team (October 2023) and increase capacity for PMRT;
6. Obstetric Consultant job plan review to ensure dedicated input into quality and safety (August 2023);
7. Audit Programme refreshed and approved August 2023;
8. Implementation of 2x Daily Tactical Operational Calls (seven days a week);
9. Refreshed Daily SitReps to encompasses all parts of the service;
10. Implementation of refreshed Escalation Policy to improve oversight of risks and performance;
11. New Perinatal Surveillance Scorecard;
12. Safe Staffing Policy updated March 2023;
13. 3 New Safety Champions recruited (July 2023);
14. Quality Improvement Projects- Post-partum Haemorrhage / Perineal Trauma / Induction of Labour (IOL) Working Group re-established;
15. Introduction of Surgical Site surveillance programme;
16. Utilisation of Microsoft Forms for ultrasound scan referrals.

Treatment delays

Reduce delays to the induction of labour pathway:

1. Induction of Labour (IOL) Working Group re-established;
2. Manager on Call (MoC) onsite presence seven days per week;
3. Recruitment to increase the number of Labour Suite / Maternity Coordinators 24/7;
4. Change in process in relation to communication with women on day of IOL;
5. IOL prioritisation tool developed for use within unit and on tactical huddles;
6. Decision made to book IOLs using gestational ranges; notable increase in the number of IOLs during July and August 2023 in response to a change in guidance for Post Dates IOL following HSIB recommendations;
7. New QI Lead Midwife initiated IOL project (August 2023) working with Regional QI NHSE Team - sharing of resources, tools and guidance in relation to successful IOL QI projects across the region;
8. Working with Birmingham Women's Hospital to gain insight regarding successful IOL service project;
9. Engagement - Walkarounds completed across both sites to gain staff insight and feedback including meeting with delivery suite coordinators. Meeting held with MNVP (23 August) to discuss IOL project and to gain service user involvement. Patient feedback survey relating to IOL developed in multiple languages and UHL's Engagement Officer has commenced daily walk-arounds at both sites (from 11/09/23) to collate completed surveys;
10. Formal review of the current IT systems used for monitoring IOL referrals, bookings and on-going IOLs has taken place. Online digital prioritisation tool developed;
11. Audit of all IOLs performed in July 2023, to create a baseline for improvement;
12. Review of the IOL pathway coordinator role providing recommendations to improve effectiveness and flow;
13. Draft SOP in development in relation to delayed IOL to enable knowledge of clear process/escalation routes to provide safety and effectiveness;
14. Pop-up' DAU in place since June 2023 to ensure safety and monitoring of delayed IOLs.

Staffing levels

1. Workforce Plan focused on recruitment, retention, and wellbeing;
2. Safe Staffing Matron in post;
3. Recruitment, Retention, and Pastoral Midwives x three in post, and one for Maternity Support Workers, International Recruit Pastoral Midwife in post to support onboarding;
4. Staffing Summit (December 2022 and June 2023);
5. Leadership Development Opportunities –e.g., LEO, Connect, RCN Leadership, Chief Nurse Fellowships;
6. Recognition –e.g., Long Service, Daisy Award;
7. Launch of the Microsite to support recruitment;
8. BirthRatePlus Awareness and Education;
9. Twice-Weekly Skill-Mix Reviews led by Heads of Midwifery;

10. Launch of Self Rostering Pilot;
11. Incentive Schemes;
12. Collaboration with Universities to improve conversion rate and support packages;
13. Empowering Voices Culture Programme;
14. RCM/RCOG Professional Behaviour & Safety Pilot;
15. Strengths & Motivators Profiling for Labour suite Coordinators;
16. Preceptorship programme for Band 2-8 and updated Career pathways.

Equipment checks and documentation

1. Daily Assurance Ward Checks integrated into Tactical Calls;
2. Scoped automated and digital solutions for ward level checks, interim solution in development;
3. Matron Weekly Spot checks;
4. A customised Microsoft Power App developed (30 August 2023) currently undergoing testing in live environments, specifically the Maternity Assessment unit at the Leicester Royal Infirmary and the neonatal service. Aim is for go live by 1 November 2023;
5. Trust-Wide scoping audit tools for potential purchase and implementation across the entire organisation to support the ward Exemplar programme and consistent safety checks;
6. Communication Campaigns with teams;
7. Head of Clinical Engineering work programme to service all equipment, 100% compliance achieved by 31 July 2023 with future plan under development for monitoring;
8. Invested in new IT equipment (laptops, IPads and phones) for staff working in the community and upgraded IT systems and processes;
9. Maternity EPR Options Appraisal complete and funding identified;
10. Immediate attention and resolution of all equipment issues / concerns identified by CQC.

Risk documentation:

1. Mobile phones delivered to both sites and are in use, NerveCentre alerting is built and in LIVE environment and alerts in place for Medical Baton phones;
2. NerveCentre permissions adjusted (30 August) to allow midwifery sign off of results; live dynamic blood results lists in place for ward areas;
3. Neonatal observations: Audit proforma designed, plans to integrate as part of the ATAIN program. Latest evidence reviewed and unit decision made to move to the latest tool - new guideline being produced with plans to adopt NEWTT2 with appropriate training to support;
4. Maternal observations. Observations collected in NerveCentre for >18 months in Maternity, tracker developed. Digital system has been implemented, optimisation is key;
5. UHL Fetal Monitoring in Labour Guidelines (May 2021) suggests where stickers are not available all elements of pneumonic DRCBRAVADO are used and

completed - Deep Dive Audit commenced around fresh eyes/ classification and embedding of the stickers in practice. Spot check audit from yearly fetal monitoring audit currently ongoing to monitor baseline;

6. Sepsis: eAssessments Live (July 2023), amendment to rules requested, data extraction underway, once testing has been produced this will provide a daily report. SBAR Maternity Sepsis Action Tool disseminated 31 May 2023;
7. Review & Update of Guidelines: Latent Phase, Caesarean Section, Fetal Monitoring, Water Birth (particular focus on evacuation), and a SOP for babies who are not medically fit for discharge;
8. Plans to increase infrastructure to support guidelines and audit team – greater scrutiny around derogations and best practice.

Improving access to Maternity Assessment Unit (MAU) services

1. Separation of MAU and telephone triage helpline, now known as single point of contact (SPOC);
2. Implementation of NetCall digital, which diverts unanswered calls to the MAU to a new Telephone Triage team, with protected staff to answer calls;
3. Monitoring of call volume in place including average time to answer and number of abandoned calls, to ensure adequate cover is in place, managed via eRostering;
4. A crib sheet has been developed with a pathway showing to whom external calls should be diverted;
5. Daily tactical Women's and Maternity Calls to include SPOC and MAU activity are in place, with checks to confirm that the MAU / TT is discussed three times per day;
6. Development of NerveCentre reports into the Daily Tactical calls and the Trust has fully implemented BSOTS and conducted subsequent audits to check it remains embedded.

Response – governance structure, workstreams and action plan

23. The maternity and neonatal improvement programme has been developed and is included in appendix 1. This brings together compliance actions for CQC, Maternity Incentive Scheme, Ockenden immediate and essential actions and the NHS England 3 year plan.

24. A 'three lines of defence' assurance process is being established within the CMG to ensure actions are delivered, embedded and checked robustly. The first line of defence is workstream level; these meet weekly for planning as well as confirm and challenge sessions. These report to the programme group (second line of defence), which examines the completion evidence and decides whether the action has been delivered or assured or needs further work. Those that pass scrutiny are presented to the Maternity Assurance Committee, which has final say on whether the action has been delivered and assured to an acceptable level.

25. The CMG plans to introduce a 'reverse RAG' (red, amber, green) method to ensure that the CQC actions have been delivered and assured in full. All CQC recommendations have been marked as 'not yet delivered' (red) by default, until

sufficient evidence has been produced to prove otherwise. Once concrete action has been taken to deliver the recommendation, and evidenced, this will move to green.

26. Typical delivery evidence might be the installation of new software or processes, an update to an SOP, or co-produced information improvements made in partnership with the MNVP. Typical assurance evidence would be audit or survey findings which prove (to pre-agreed parameters) that the changes are having the desired effect and are resulting in significant improvement.

27. The forum that takes the decision as to whether an action has been delivered and then assured is the Maternity Assurance Committee. This group will also provide guidance and direction for follow-up audits (sample size, regulatory of repetition and standards to be achieved) to ensure that the standard remains embedded.

28. The CMG has set up a fully resourced QI team who will be responsible for updating the CQC response plan. The CMG is also forming the four workstreams mentioned above, each of which have clinical leadership and triumvirate representation and are assigned specific tasks from the plan.

Response - Next Steps

29. The next steps are as follows:
    - Progress Actions to address Significant Improvement Requirements as per S29A Warning Notice
    - Action Plan being developed to address Must & Should Do's from the CQC findings aligning with MNIP / MIS / 3 Year Plan / Ockenden / Empowering Voices
    - Proactive Engagement & Staff Support as part of publication
    - Engage in Post-Inspection Survey

Background papers

Care Quality Commission reports 20 September 2023: https://www.cqc.org.uk/press-release/improvements-needed-university-hospitals-leicester-nhs-trusts-maternity-services

Persons to contact

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Appendix 1

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Agenda Item 8

LEICESTER, LEICESTERSHIRE AND RUTLAND JOINT HEALTH SCRUTINY COMMITTEE – 18 DECEMBER 2023

RESTORATION AND RECOVERY OF ELECTIVE CARE

REPORT OF LEICESTER, LEICESTERSHIRE AND RUTLAND HEALTH SYSTEM

Purpose of the Report

1. The purpose of this report is to provide the Committee with an update on the elective care recovery progress for the patients of Leicester, Leicestershire and Rutland (LLR) with a specific focus on the scale of the impact for those people living in within the Leicestershire County boundary who are on the University Hospitals of Leicester NHS Trust (UHL) list for elective care, diagnostics and/or treatment.

Context

2. Before the Covid-19 pandemic (March 2020), Leicester, Leicestershire and Rutland's (LLR's) health providers had a total of 66,000 on its waiting list. The UHL waiting list includes patients with a physical health need, diagnostics and/or treatments including cancer, for both paediatrics and adults.

3. The size of the wating list more than doubled following the pandemic with 130,835 patients waiting by October 22. UHL has the 10th largest RTT (Referral to Treatment) waiting list nationally based on September 23 published data.

4. Nationally, the overall waiting list is continuing to grow and is at a record high, despite the reduction in the longest waits.

5. However, UHL has seen a reduction in the overall waiting list since the start of the year (April 23 117,318) and is on track to achieve the waiting list target within the operational plan of 103,000 by the end of March 24.

6. UHL has also seen significant progress made on reducing waiting times for those patients waiting the longest for definitive treatment. UHL has virtually eliminated all patients waiting longer than 2 years for treatment. With a forecast to get to zero patients waiting 78 weeks by the end of February 2024.

7. Whilst the impact of cumulative Industrial Action has been significant, we have still managed to improve the waiting times for patients across the board. Patients, in general, are receiving their care sooner now than they were 12 months ago. With the plans we have in place, we believe we will be able to say this again in 12 months' time.

8. The three key principles of the elective improvement plan are: improving our **processes and productivity**; increasing **capacity** in the right areas; and having the **support of partners** to help us improve.

9. The ambitions and actions in the plan are clinically led and are informed by evidence and feedback from across UHL.

Elective Recovery

78-week wait position and forecast

Table 1 78week wait trajectory- Route to zero

Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24
143 actual	92 actual	96	54	25	0	0

10. The end of October position was 92 for UHL. This is an improvement of 51 from the end of September. The cumulative impact of repeated Industrial Action (IA) is having a significant effect on the speed of recovery, this is most notable on the admitted pathways where the capacity lost cannot be re-created. The capacity that is available is prioritised for specialities with large cancer backlogs which means that non cancer patients may have to wait longer.

11. Furthermore, in October winter pressures have started to impact and there has been a growing increase in cancellations, particularly within paediatrics. Therefore, the trajectory to get to zero for 78-week waits has deteriorated from a forecasted zero position by the end of December to zero by February 24.

65-week wait position and forecast

12. Modelling suggests that UHL 65-week position remains ahead of the national target for most specialities and we continue to make progress towards this target of 0 by the end of March 2024. There is risk to achieving this target, particularly with winter pressures and industrial action, and we will do all we can to mitigate this risk.

13. Focus remains on driving down the number of patients waiting for their first Outpatient appointment (OPA) in the 65-week cohort. As of 4/12/23, 713 patients are waiting their first OPA within the 65-week cohort. 48% of these patients have a first OPA before the 31st December.

52-week wait position and forecast

14. The 52-week actual position as at 13/11/23 is 5,010 and March 24 cohort is 21,190. Ten specialities make up 82% of the March 24 cohort, see table 3 below. Performance is currently better than our operational plan, with continued improvement forecast based on current activity levels.

Table 2 Top speciality waits, March 24, 52-week cohort

Adult Specialties	Combined	Admitted	Non-Admitted	% Total Cohort
Gynaecology	3,321	357	2,964	16%
Ophthalmology	2,489	563	1,926	12%
Gastroenterology	1,915	180	1,735	9%
ENT	2,053	216	1,837	10%
Cardiology	2,032	439	1,593	10%
Maxillofacial Surgery	1,312	157	1,155	6%
Urology	1,363	292	1,071	6%
Orthopaedic Surgery	1,414	791	623	7%
Gen Surg incl.	930	238	692	4%
Spinal Surgery	515	160	355	2%

Total waiting-list

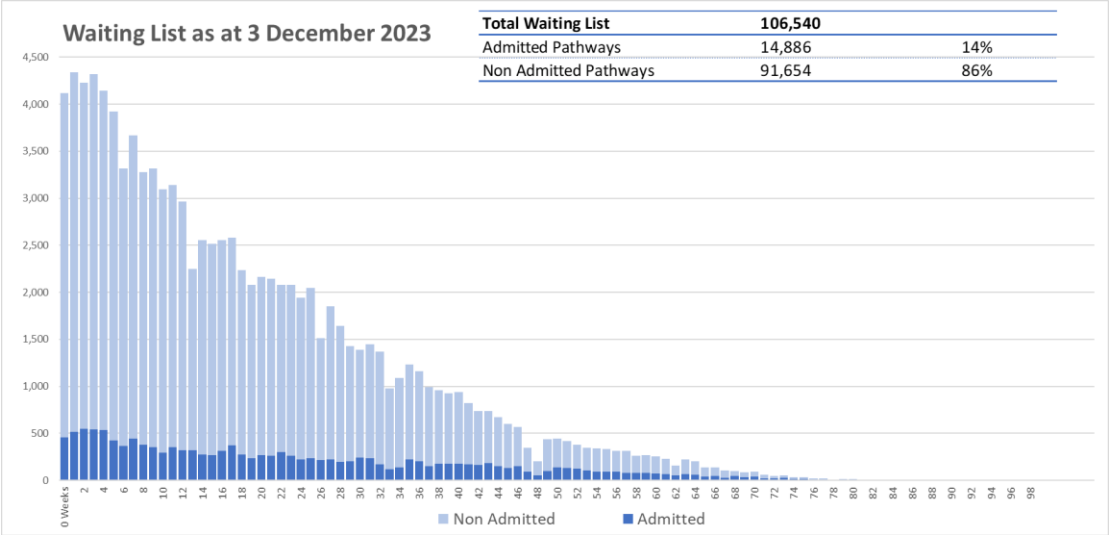
15. The total waiting list continues to buck the national trend showing a reduction in overall waiting list size, making a significant improvement in October due to a number of focused interventions. Such as, the focus on the first outpatient appointments by 31st October for patients within the 65week wait cohort; a new 12-week validation cycle to enable text messaging every two weeks to commencing 2nd October, the first cycle resulted in circa 1,600 patients being appropriately removed from the waiting list; a technical validation exercise commenced 4th October addressing data quality errors in lower waiting pathways.

16. The number of patients being added to the waiting list has started to increase and so far for 2023/24 has a higher monthly average than pre-pandemic of 2019/20. See table 4 below.

Table 3 Clock starts- how many new patients are joining the waiting list each year

Year	Clock Starts Total	Average Monthly
2019/20	291,418	24,285
2020/21	204,417	17,035
2021/22	238,908	19,909
2022/23	257,320	21,443
2023/24 (7 mo Apr - Oct)	173,249	24,750

Shape of waiting list



Productivity Objectives and Interventions:

There are two core streams: Theatre Productivity and Outpatient Improvement.

17. Key interventions include:

- Focus on daycase utilisation;
- GIRFT (Getting it Right First Time) Further Faster Engagement- implementing best practice in the management of elective care;
- Digital validation e.g. improving our communications with patients through 2-way text messaging;
- Digital pre-operative questionnaires (aim to reduce clinical on the day cancellations);
- My pre-op programme (electronic pre-assessment, avoiding the need for face to face pre-operative assessment where clinically appropriate)
- Strengthened governance;
- Outpatient DNA Florey's (a florey is a questionnaire sent by text message, to collect structured data) identified opportunity of 23% reduction in DNAs possible;
- PIFU (Patient Initiated Follow-up) focus, with additional admin training provided. The aim being that this will release capacity to see patients who need to be seen, reducing waiting times for clinic appointments.

18. Outcomes so far include:

- Improvement in Average Case per List year to date;
- Theatre utilisation improved from 70% to 75% overall;

- Daycase rates for TURBT (Urology) have gone from 16% in 20/21 to 42% in 22/23. Over 100 patients not requiring an admission.
- High Volume Low Complexity- orthopaedics 'LEAP' pathway launched which has led to a significant reduction in length of stay for knees from 4.8 in 22/23 to 3.0 in Oct 23 and for hips 5.4 in 22/23 to 3.2 in Oct 23. The first day case hip procedure was carried out in November.
- PIFU (Patient Initiated Follow-up) delivering 3.3% in October 23 from 2.1% in April 23. Stretch targets have recently been introduced for each speciality based on GIRFT best practice.
- Overall follow-ups are significantly below plan (greater than 25% reduction), increasing clinic capacity for patients waiting to be seen.

Diagnostics

Hinckley Community Diagnostic Centre

19. £24.6m of National capital investment secured. Currently in the process of agreeing the phasing of the spend over the remainder of this year and next year with NHSE.

20. Will include services such as CT, MRI, X-ray and ultrasound facilities, as well as providing clinical rooms for phlebotomy, endoscopy, and outpatient procedures.

21. When fully operational the CDC will provide capacity for up to 89,000 tests or appointments each year – noting this is not all new activity as some services are currently provided from Hinckley.

22. Construction is due to begin in early 2024 with the unit set to be built around December 2024 and operational from January 2025.

23. There will be disruption to services whilst the ground works and building works take place. Daycase services and Endoscopy will be accommodated in other facilities as locally as possible.

24. An Outline Planning application has been submitted - Planning Committee to take place on 16/01/24.

Summary

1. There continues to be good progress made on the reduction of those patients waiting longest for definitive treatment. Please see appendix 2 RTT (Referral To Treatment) graphs.

2. There is significant improvement work underway to improve productivity and efficiency across a suite of indicators. Outcomes so far show the progress being made, whilst acknowledging the is further opportunity to explore.

Officers to Contact

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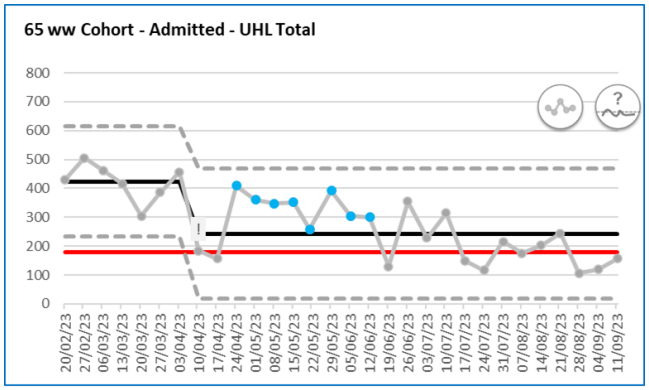
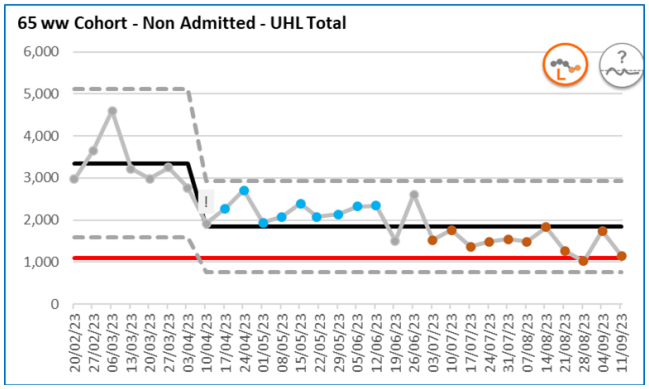
Operational Leads	Siobhan Favier, Deputy Chief Operating Officer, UHL siobhan.favier@uhl-tr.nhs.uk

Appendix 1: Impact of Industrial Action:

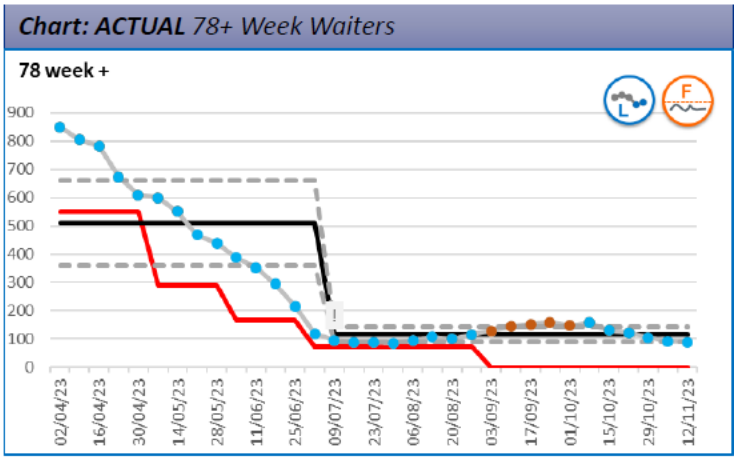
Industrial action has had a significant impact on elective activity, including:

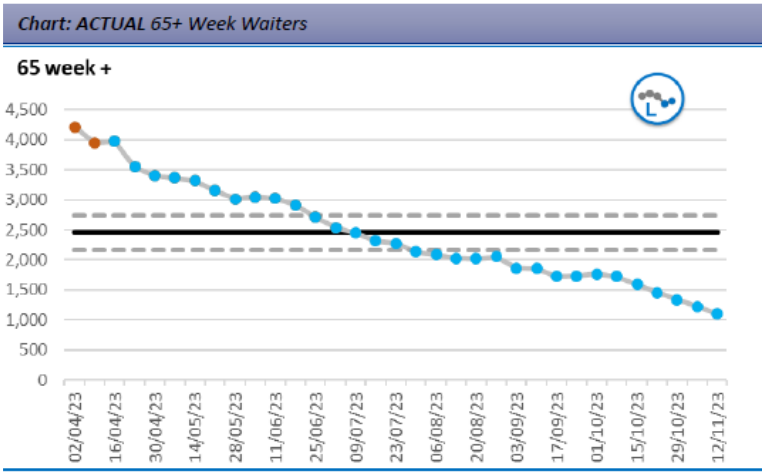
Reduction in 65 week wait clearance rate: Charts 1 and 2 (below) show our average reductions in 65ww cohorts for the year, and you can see a reduction in clearance rate in July and August (the orange dots). We monitor on a specialty level in weekly performance meetings. Despite this, all specialties are currently still managing to continue to reduce their long waiter cohorts.

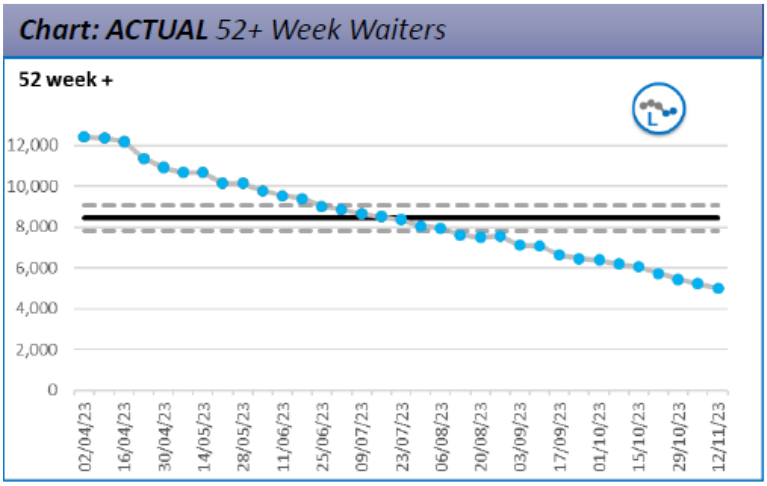




Appendix 2 RTT graphs







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Appendix 3 Elective Care Glossary of Terms

Elective Care Glossary of Terms June 2023

Active monitoring
A waiting time clock may be stopped where it is clinically appropriate to start a period of monitoring in secondary care without clinical intervention or diagnostic procedures at that stage. A new waiting time clock would start when a decision to treat is made following a period of active monitoring (also known as watchful waiting). Where there is a clinical reason why it is not appropriate to continue to treat the patient at that stage, but to refer the patient back to primary care for ongoing management, then this constitutes a decision not to treat and should be recorded as such and also stops a waiting time clock If a patient is subsequently referred back to a consultant-led service, then this referral starts a new waiting time clock.

Active monitoring can also be applied, following clinical review and agreement, when a patient has declined or cancels two previously agreed appointments or admission offers.

Admission
The act of admitting a patient for a day case or inpatient procedure.

Admitted pathway
A pathway that ends in a clock stop for admission (day case or inpatient).

Bilateral (procedure)
A procedure that is performed on both sides of the body, at matching anatomical sites. For example, removal of cataracts from both eyes.

Care Professional
A person who is a member of a profession regulated by a body mentioned in section 25(3) of the National Health Service Reform and Health Care Professions Act 2002.

Clinical decision
A decision taken by a clinician or other qualified care professional, in consultation with the patient, and with reference to local access policies and commissioning arrangements.

Consultant
A person contracted by a healthcare provider who has been appointed by a consultant appointment committee. He or she must be a member of a Royal College or Faculty. Consultant-led waiting times exclude non-medical scientists of equivalent standing (to a consultant) within diagnostic departments.

Consultant-led
A consultant retains overall clinical responsibility for the service, team or treatment. The consultant will not necessarily be physically present for each patient's appointment, but he/she takes overall clinical responsibility for patient care.

Convert(s) their UBRN
When an appointment has been booked via the NHS e-Referral Service, the UBRN is converted. (Please see definition of UBRN).

DNA – Did Not Attend

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Agenda Item 9

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LEICESTER, LEICESTERSHIRE AND RUTLAND JOINT HEALTH SCRUTINY COMMITTEE: 18 DECEMBER 2023

A SUMMARY OF THE NHS WORKFORCE IN LEICESTER, LEICESTERSHIRE AND RUTLAND 2023

REPORT OF THE CHIEF PEOPLE OFFICER, LEICESTER, LEICESTERSHIRE AND RUTLAND INTEGRATED CARE BOARD

Purpose of report

1. The purpose of this report is to provide the LLR Joint Health Scrutiny Committee with a summary of the NHS workforce in Leicester, Leicestershire and Rutland, and the approach to joint working for the People agenda across health and social care. To also outline the programmes of work underway to deliver our strategic priorities and, address the workforce challenges.

Background

Summary

2. Two national publications have created the strategic framework for health and social care to consider transformation of our workforce collectively; 'Next Steps to put People at the heart of care' (DH&SC April 2023), and NHS Long term Workforce Plan (NHSE June 2023).

3. In Leicester, Leicestershire and Rutland (LLR we have a board specifically set up to consider the integration of the People agenda across health and social care. The LLR people and Culture Board recognises that in LLR, focussing the approach to integrated health and social care workforce will ensure that the ICS has a holistic approach to a sustainable workforce that meets the needs of our population and supports the delivery of the national policy documentation.

4. The LLR People and Culture Board has been in place since 2018 and has focussed on how we train, retain and transform our workforce to ensure a sustainable future for health and care. The People and Culture Board focussed on strategic direction, and where doing pieces of work once together can achieve better outcomes.

5. The information contained within this report has been produced using the standard NHS reporting tools and collated for the LLR People and Culture Board. The data is used for planning and assurance purposes across the NHS and is used to priority set the programmes of work.

6. The social care workforce data is produced by Skills for Care. In July 2023 Skills for Care published the 'The size and structure of the adult social care sector and workforce in England' which has detailed analysis of trends of the workforce in 2022/23 which will inform the future prioritisation of the People Board programmes of work.

Size and Structure of the NHS Workforce

7. In 2023, the LLR Integrated Care System (ICS) has approximately 70,000 staff and workers delivering health and social care. Table 1 below summarises the headcount across all sectors and providers within LLR ICS.

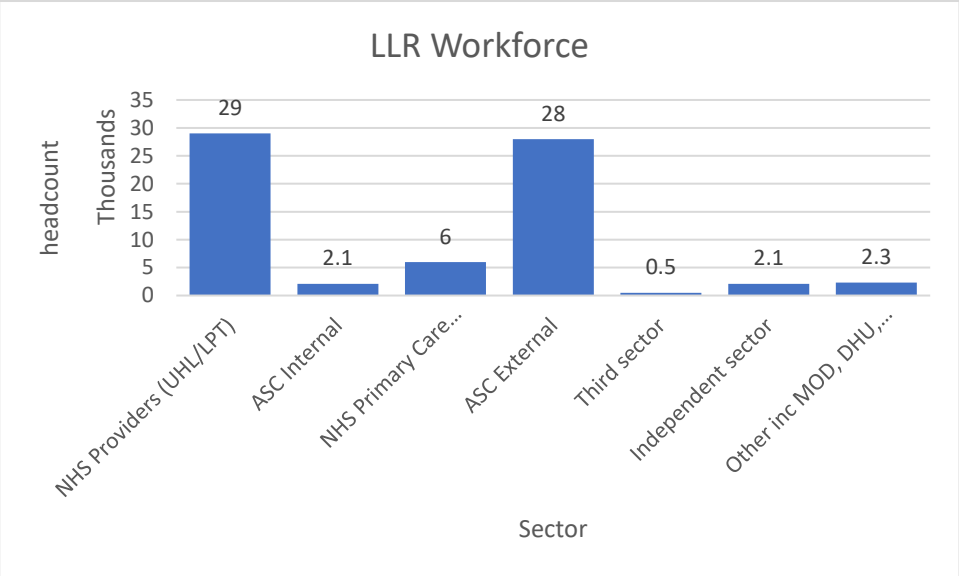

Table 1

8. Since 2019 the NHS has seen a growth across the majority of providers with the headline growth being 7.7% growth in employed health (NHS) staff which includes 26% growth in overall General Practice staff across 15 professional groups since 2019. In the local authority and independent sector there was a drop of 1000 filled posts (-3%) since 2021/22.

9. The data for the NHS is predominately viewed at LLR level however some data is segmented by Place, this is particularly important for Primary Care where in 2023 the growth rates are 1.7% in Leicester City and 0.3% in Leicestershire and Rutland. However, the growth rate in 2022 saw the County and Rutland outgrow City.

10. Sickness absence rates are reported at Organisational level and used to address staff availability. The average sickness rate in August 2023 was 6.04%. The average number of sickness days taken in the local authority and independent sector was 5.8 in 2022/23.

11. Whilst the overall staff numbers have grown, the NHS still holds a significant number of vacancies, in August 2023 this vacancy number was 2,855 (11.7%), with the largest vacancy professional groups in Nursing and Healthcare support workers.

12. NHS leaver rates are a key metric for understanding the NHS retention challenge and since 2019 the national leaver rate has reduced from 8.2% to 7.2% in the NHS. The NHS Leaver rate is not the same as turnover by organisation. The NHS leaver

rate is those who leave an NHS organisation and do not take up NHS employment elsewhere. The average vacancy rate in the local authority and independent sector was 8% in 2022/23. The number of leavers in that sector was 7,100 in 2022/23.

13. Across the two main NHS providers in LLR the Turnover rate has been a declining trend since January across all professional groups. As a system the turnover rate has declined from 10.9% turnover rate in January 2023 to 9.8% in September 2023.

14. The average Turnover rate in the local authority and independent sector was 27.5% in 2022/23.

Strategic Intent

15. Within the ICS, the approach to an integrated and sustainable workforce is not a new concept. The People Board has been working across health and social care to attract, retain and train our workforce in the best way for several years. The publication of the NHS Workforce Plan offers an opportunity to the LLR People and Culture Board and its constituent organisations to continue to build on the successes of working together to deliver a sustainable workforce.

16. On 9th October 2023 a 'think tank' workshop for leaders across LLR took place with the aim of bringing together leaders and staff from across partner organisations to explore the themes in the recently published NHS Workforce Plan (Recruit, Retain and Transform) and create a localised plan across health and social care.

17. The event asked participants to consider the strategic context of the national documents and how this relates to LLR across health and social care. The aim of the workshop was creating space to collectively consider and discuss how we might integrate, develop and support our staff and develop the common ambition for LLR to be a great place to work.

18. The outcome of the Think Tank event will be a strategic document setting out the ambitions of what health and social care will do together to create a sustainable workforce, considering the national strategic documents and our local organisation aims.

19. At present, the ICS has a number of priorities that it is working on together, whilst the strategic approach is designed and agreed. These priorities and programmes of work are listed in the table below:

Programme	Summary	Impact area
Oliver McGowan Training	System wide approach to Learning Disability and Autism	Staff Development
System Induction principles	A single approach to setting the approach to working in LLR – Values Proposition	Retention and integration of workforce
Active Bystander	Training, Development, and sustainable approach to an inclusive workforce and addressing deep rooted incivilities in the workplace	Retention and inclusion

Reverse Mentoring	An ongoing learning through experience and mentoring focussing on the experiences of Global Majority and those staff with a disability	Retention and Inclusion
Talking Therapies staff access pathway	A bespoke referral pathway for staff into Talking Therapies, removing stigma and ensuring access for all staff	Retention and Health and Well Being
Menopause pathway and support	A bespoke referral pathway for staff into Menopause support and system wide training for managers and staff to support and understand Menopause	Retention and Health and Well Being
One Workforce Principles	An approach to support career development, movement between organisations and parity of esteem across sectors	Recruitment, retention and well being
Health and Well Being for all	A range of products, pod casts, support and events across health and well being for mental and physical well being	Retention and well being
Culture and Leadership Programme	Understanding of individual culture, leadership and inclusion agendas to put collective interventions and support in once to staff and cultures thrive	Retention
WorkWell Programme (DWP)	Joint bid for WorkWell programme funding to support people to get into work, stay in work and thrive in work across health and social care	Recruitment, Retention and Anchor Institutions

20. Alongside the outputs from the Think Tank event, the People and Culture Board will consider how the impact of its work achieves the expectations from the NHS Long Term Workforce Plan to work at system to improve or implement work across 11 areas of work:

- Apprentices' expansion;
- Anchor Institution responsibilities;
- Volunteer Workforce expansion;
- Attraction into health and social care campaigns;
- Equality, Diversity, and Inclusion for all;
- Implementing Leadership Competencies;
- Setting an Employee Values Proposition;
- Improving and supporting health and wellbeing for all staff;
- Improved and consistent access to Occupational Health;
- Recruitment reforms for the NHS;
- Development and transformation of career pathways for health and social care.

Appendices

The following documents are attached to this report:

Appendix A: LLR ICS Workforce Update – Month 7
Appendix B: LLR Adult Social Care 22/23 – Skills for Care workforce intelligence

Officer(s) to Contact

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Leicester, Leicestershire and Rutland
Integrated Care Board

Appendix A: LLR ICS Workforce Update - Month 7

October Update. FY 23/24 / Retention stats Q1 / Public health

Produced by Workforce (P&I Directorate) Rajesh Thanki
Provider data sources are PWR and PFR. PC data sources are NHS digital. Public health data provided by NHSE Midlands

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Workforce Overview M7 2023

vs. M6: Substantive ↑ | Bank ↑ | Agency ↑ | Total ↑

- Overall UHL/LPT are above plan with growth of 6.7% vs planned growth of 2.1%.
- WTE position is above plan due to substantive and bank growth.
- Infrastructure support in UHL remains over plan by 445 WTE in M7. However approx. 45% of the excess figure is due to recoding of staff into infrastructure support from areas like ward assistants etc..
- Agency use has reduced by 20% since March 23. UHL has strengthened the agency controls across the organisation. There is a weekly agency oversight group in place (chaired by an Exec Director) to oversee transition from agency use with a focus on substantive recruitment.
- Month on month bank usage is increasing. Bank is now 527 WTE above plan. UHL bank has grown by 71% from March 23 (536 WTE)
- LPT are below plan for substantive and agency.
- LPT continue to control agency costs through their planned agency reduction.

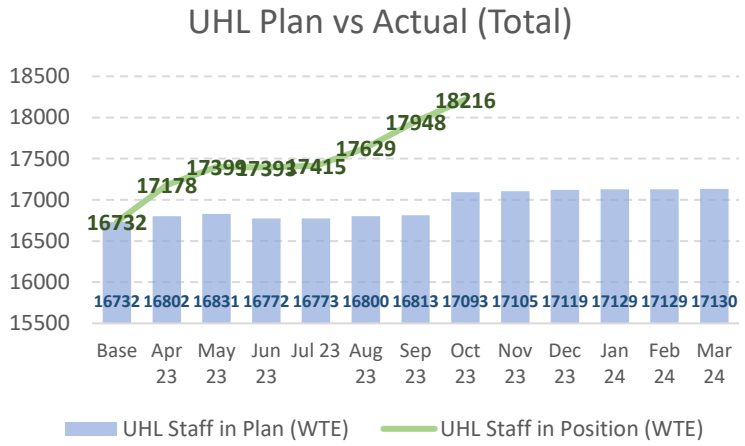
UHL/LPT Workforce Risks/Mitigations

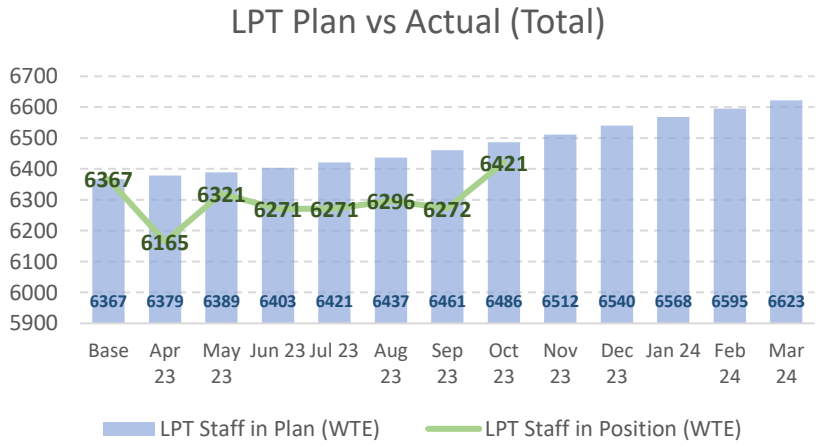
Risk	Mitigation
Substantive staff above submitted plan (by 637 FTE) i.e 4% above plan	UHL also continues to strengthen all elements of workforce utilisation and spend in line with the NHSE pay controls and this month we have moved to a refined vacancy oversight process with a key focus on non-clinical posts
LPT substantive is currently below plan on WTE per month YTD	LPT have an improved position, from 93fte behind plan at M6 to 49fte behind plan at M7. Time to hire is improving enabling us to process the recruitment pipeline quicker. Medical and Dental is below plan due to trainees which fluctuates across the year.
LPT agency price cap breach per WTE exceed region	LPT are looking to address price cap overrides with a review on current policies around price cap overrides and existing agreements.

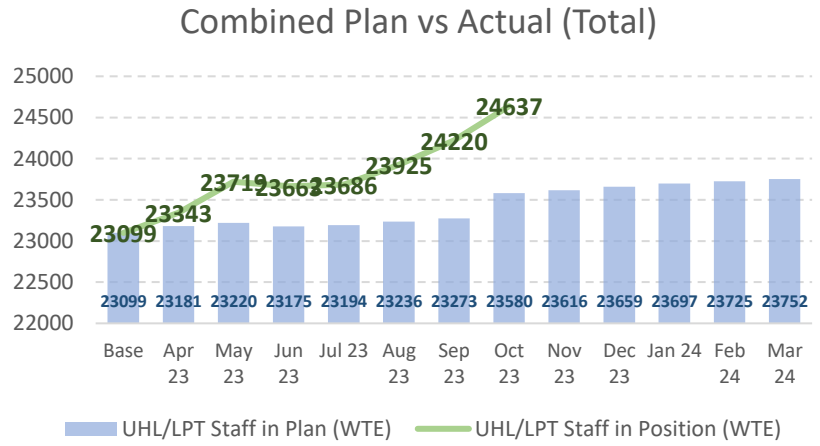
WF Overview (UHL/LPT WTE) M7

VARIANCE WTE				
Variance to Plan (WTE) oct 23	**Plan**	**Total**	UHL	LPT
Nursing, Midwifery	6137	86	75	11
Scientific, Therapeutic, Technical	2656	2	38	-36
Clinical Support	4520	-61	-36	-25
Infrastructure Support	5514	465	445	20
Medical, Dental	2544	133	151	-17
Total Substantive	**21408**	**588**	**637**	**-49**
Total Bank	**1383**	**527**	**536**	**-9**
Total Agency	**789**	**-58**	**-50**	**-8**
Total (Excl. Overtime)	**23580**	**1058**	**1123**	**-65**
Growth (cumulative)	**2.1%**	**6.8%**	**8.9%**	**0.9%**

- Substantive above plan for M7 by 588 WTE (down from 633 WTE above plan in M6). The above plan staff groups are predominantly from UHLs Infrastructure support and Medical, Dental.
- LPT are below plan for bank, agency and substantive and have recruitment plans in place to increase substantive. Staffing levels are monitored monthly via the Safer Staffing paper received at Trust Board each month
- UHL bank is above plan by 527 WTE (up from M6 of 517 WTE above plan). Areas above plan are primarily in Nursing, Midwifery and Clinical Support

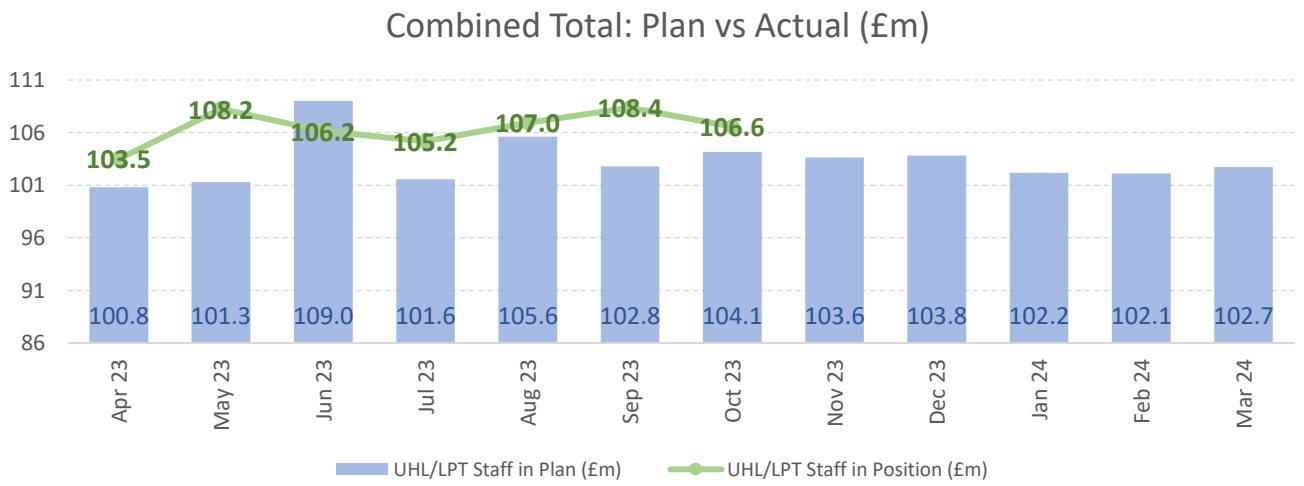






Finance Overview (UHL/LPT £m) M7

VARIANCE (Cost £m)	In Month Variance				Variance	Variance
Variance to Plan (£m) oct 23	**Plan**	**Total**	UHL	LPT	YTD Total	YE Run Rate
Nursing, Midwifery	£28.1m	-£3.0m	-£2.0m	-£1.0m	-£17.9m	-£35.7m
Scientific, Therapeutic, Technical	£12.5m	£1.4m	£2.1m	-£0.7m	**£10.7m**	**£21.3m**
Clinical Support	£12.1m	£1.2m	£0.8m	£0.4m	**£6.4m**	**£12.7m**
Infrastructure Support	£13.9m	£1.8m	£1.3m	£0.6m	**£9.5m**	**£19.0m**
Medical, Dental	£27.5m	-£0.5m	-£0.3m	-£0.2m	£1.0m	£2.1m
Total Substantive	**£94.3m**	**£1.0m**	**£2.1m**	**-£1.1m**	**£10.0m**	**£20.0m**
Total Bank	**£5.4m**	**£1.1m**	**£1.4m**	**-£0.4m**	**£7.4m**	**£14.8m**
Total Agency	**£4.5m**	**£0.6m**	**£0.4m**	**£0.2m**	**£4.3m**	**£8.6m**
Total	**£104.1m**	**£2.7m**	**£3.9m**	**-£1.2m**	**£21.7m**	**£43.5m**



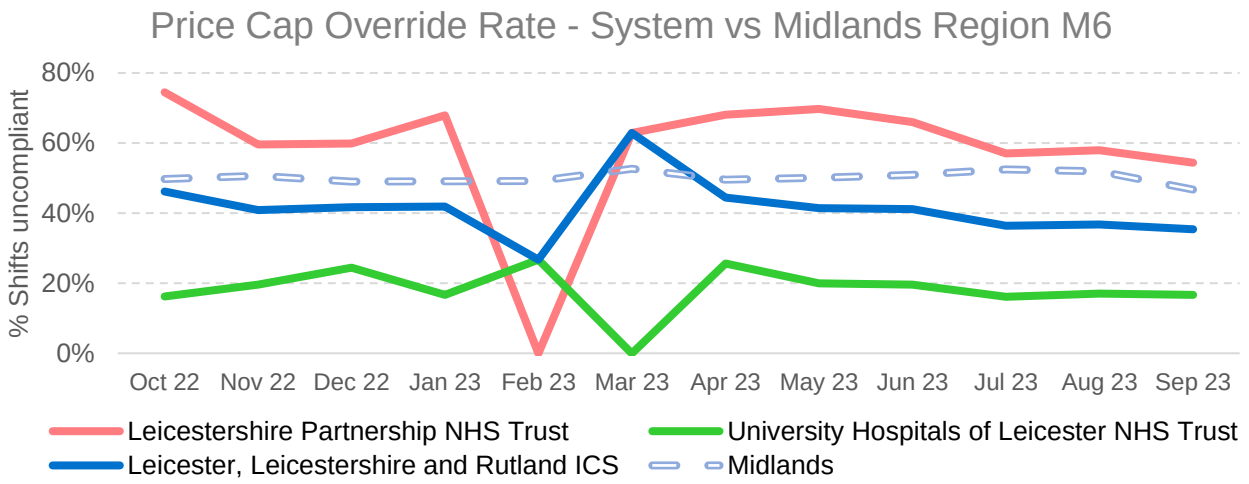
Note: Due to staff group coding variance in the PWR and PFR, costs may not correlate to WTE changes at staff group level. UHL are currently working on aligning staff groups in the PFR with the PWR.

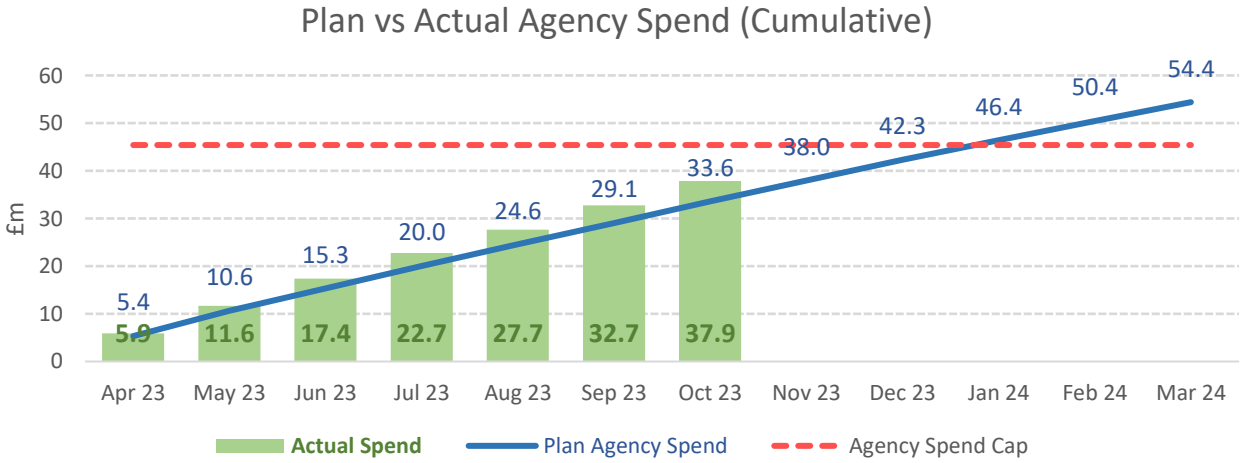
- Combined UHL/LPT are £2.7m over budget in M7 and £21.7m over budget YTD.
- YTD Biggest areas of overspend are:
  Scientific/Therapeutic/Technical (+£10.7m)
  Clinical support (+£6.4m)
  Infrastructure Support (+£9.5m)
- Agency is £4.3m over budget YTD with M7 £0.6m over budget (remains static from M6)

Agency Overview (UHL/LPT £m) M7

Agency VARIANCE							
UHL/LPT Variance to Plan (WTE)	**Base**	May 23	Jun 23	Jul 23	Aug 23	Sep 23	**Oct 23**
Nursing, Midwifery	288	10	21	72	96	45	63
Scientific, Therapeutic, Technical	66	11	0	-2	15	-2	4
Clinical Support	382	115	34	-18	-45	-50	-36
Infrastructure Support	112	-36	-29	-48	-56	-65	-60
Medical, Dental	72	1	18	2	-1	-25	-29
Other staff	0						
Total		**100**	**44**	**5**	**9**	**-97**	**-58**
Variance to Plan %		**11.6%**	**5.1%**	**0.6%**	**1.1%**	**-12.3%**	**-7.3%**

- Agency is 13% overspent YTD combined (UHL being 33% over budget and LPT is 13% under budget)
- At current run rate Agency overspend for 23/24 will be +£8.6m. Below agency reduction plans will further reduce final overspend figure.
- LPT remain above region in agency price cap breaches but have decreased from peak in May of 70% of shifts uncompliant to September of 54% of shifts uncompliant. LPT are continuing to address price cap overrides with a review on current policies around price cap overrides and existing agreements.
- UHL are successfully reducing down their agency use through a recruitment drive for substantive staff in areas of high agency use.
- Since May LPTs price cap breaches have decreased. UHL has remained (circa) static since May although far below midlands average





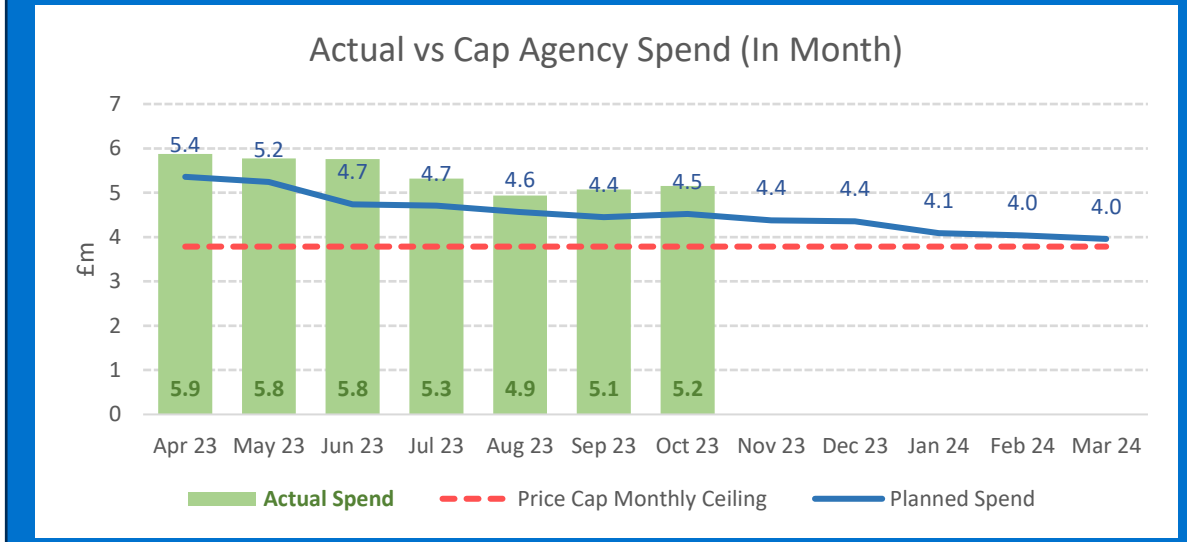
Agency continued. "Moving in the right direction"

YTD Spend against spend ceiling

Cumulative Agency Spend	Apr 23	May 23	Jun 23	Jul 23	Aug 23	Sep 23	Oct 23
Price Cap Spend (Cumulative)	3.8	7.6	11.3	15.1	18.9	22.7	26.5
Actual Spend (Cumulative)	5.9	11.6	17.4	22.7	27.7	32.7	37.9
% Over price cap celling	55%	54%	53%	50%	46%	44%	43%

Agency usage has decreased 20% from base (Mar23). Agency use has been under plan for Q2 after Q1 being over plan. LPT have consistently been under plan for agency with UHL drastically reducing agency to be under plan in Q2 and beyond.

The plan was agreed and submitted before the price cap threshold was made aware to the ICB. The spend was tracking 53% above priced cap ceiling in Q1 and that percentage dropped to 44% in Q2 through various agency reduction actions carried out by providers.

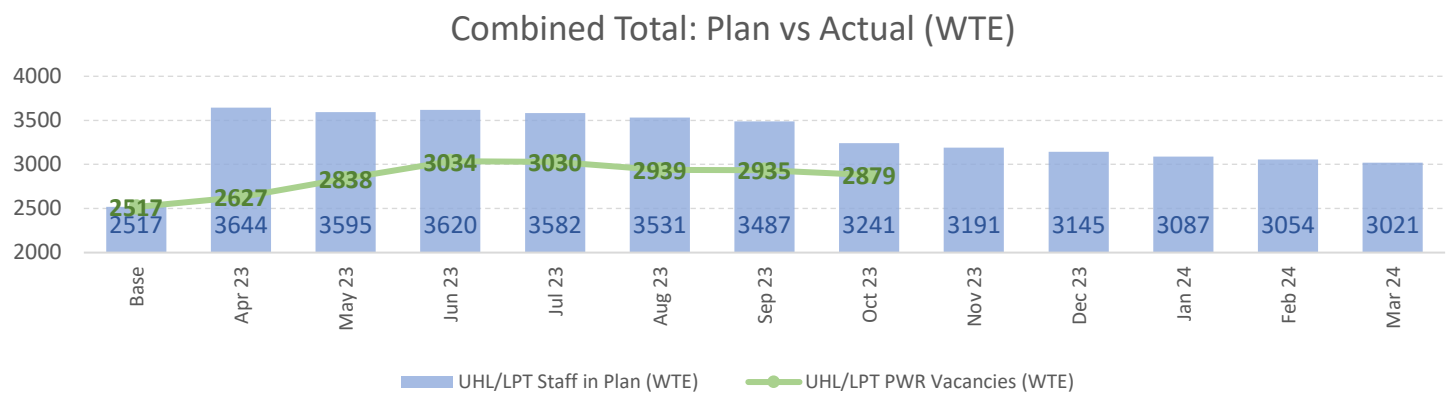


Although spend is tracking 13% above plan YTD, that figure decreased to 12% above plan in the last 3 months. And the run rate overspend for agency forecasted at £8.6m takes YTD behaviour into account. If LLR continue to drive down agency costs, the £8.6m will reduce further.

The graph above shows that LLR (although above plan) are reducing in line with planned agency costs.

Vacancy Overview M7

ACTUAL			
Vacancy (WTE) oct 23	**Total**	UHL	LPT
Nursing, Midwifery	876	344	532
Scientific, Therapeutic, Technical	426	299	127
Clinical Support	442	161	281
Infrastructure Support	883	614	268
Medical, Dental	220	185	34
Total WTE	**2879**	**1636**	**1242**
Vacancy Rate	**11.6%**	**9.1%**	**18.1%**



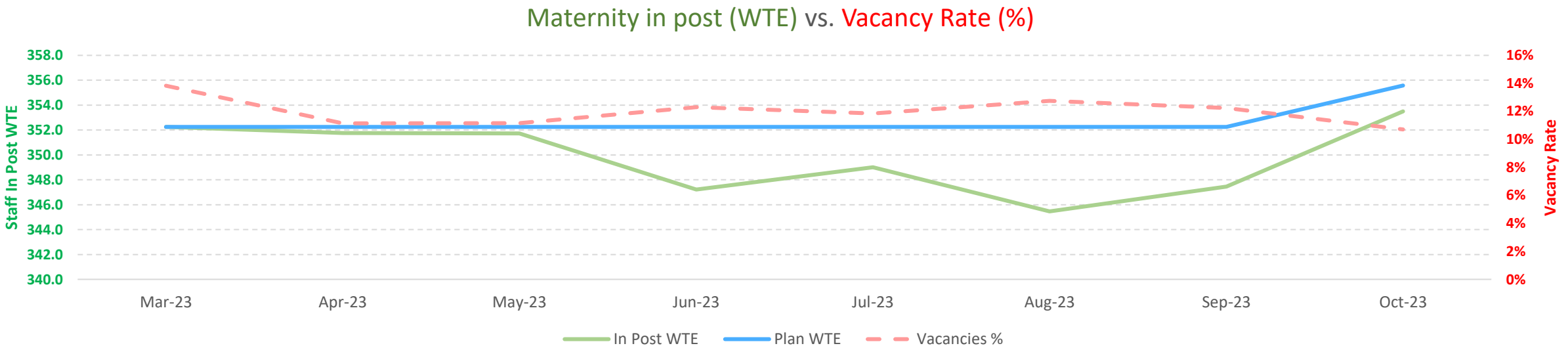
Combined vacancy rate remains the same as M6. From M6, UHL's vacancy increased 0.5% and LPT's vacancy have decreased by 1.2%

- Nursing makes up 30% of total vacancies 876 WTE out of 2879 WTE. UHL nursing vacancies have decreased month on month YTD. LPTs nursing vacancies decreased this month for the first time this FY.
- Infrastructure Support makes up 31% of vacancies and have been averaging 850 WTE month on month in UHL. The same staff group's vacancies in LPT have slightly decreased from M6

Why is vacancy so high in LPT and what plans are in place to reduce down the vacancy rate?

LPT's vacancy rate has increased during 2023/24 due to the addition of 560fte posts to the budgeted establishment. Those posts predominantly relate to safer staffing following inpatient establishment reviews, MH investment and additional bed capacity in Community Hospitals (which was agreed in-year and not accounted for in the workforce plan). Pace of recruitment continues to be a high priority for the Trust. An incident structure put in place around recruitment checks processing including: Senior level risk summit held 01/09/23; Separate ORR risk relating to recruitment checks in development; Twice weekly Recruitment Gold Calls to deal with immediate priorities, identify and resolve blockages, work through immediate change ideas, review capacity and prioritise; existing QI work has been integrated into this approach

M7 Maternity WF update



- UHLs midwives' increased by 6 WTE in M7 from M6. This means UHLs growth YTD is now +0.4% (M6s growth was -1.4% YTD)
- Vacancy rate in M7 is at 10.7% which is a decrease on M6 rate of 12.2%.
- M7 establishment is 396 WTE with vacancies at 42 WTE. This means 354 WTE are currently in post. UHL plan submitted in March 23 gives an establishment of 415 WTE by year end (March 24)

Maternity Risks and Mitigations

Improved position for October compared to previous months, however, remain above target of 10%.

Midwifery still remain below plan due to release of Ockenden funding in April 2022, there has been an uplift to reflect expected staffing numbers; in turn this gave a stretch target and achievement of this has been a challenge and retention of midwives remains below national average

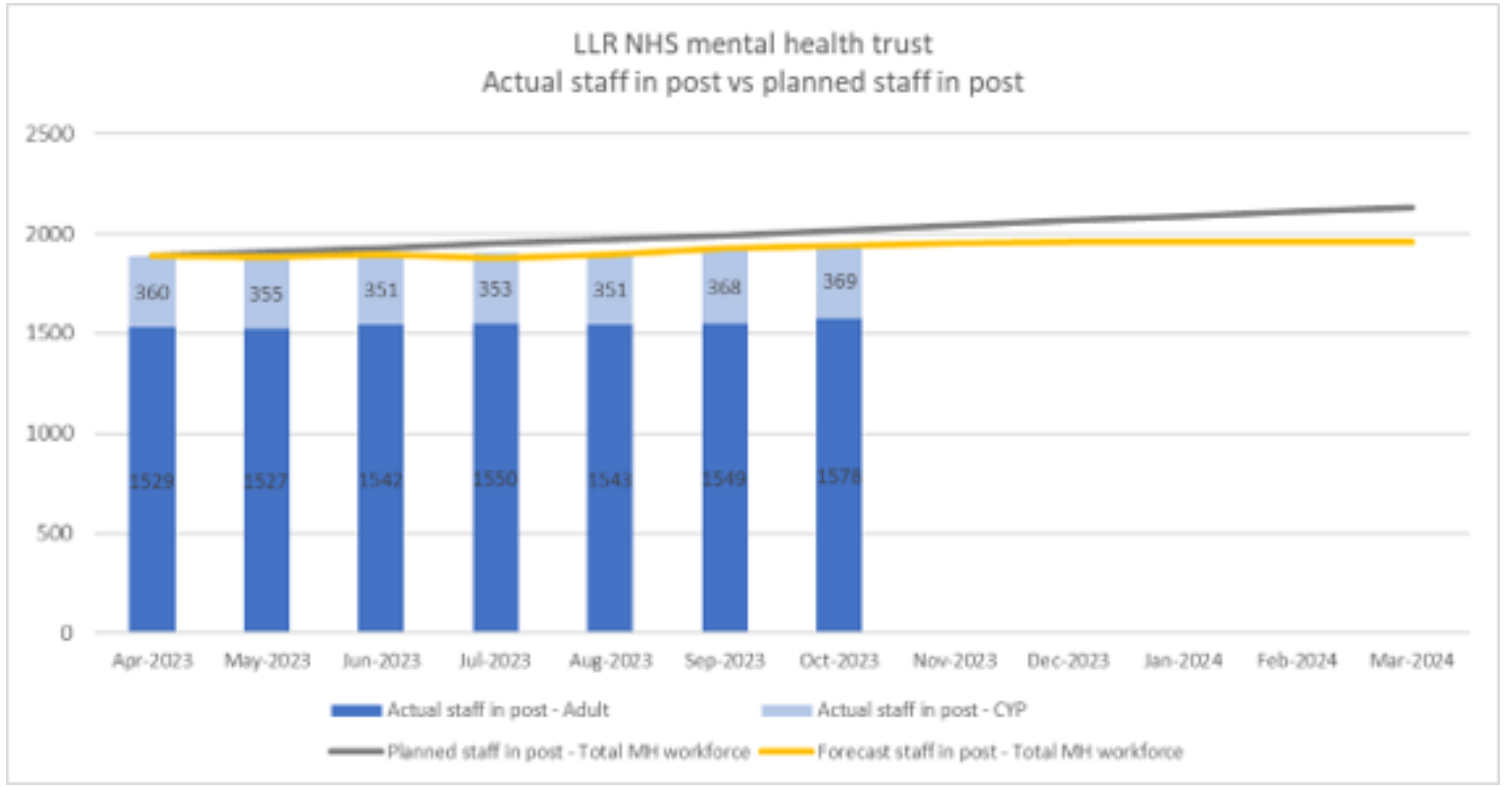
Mitigations

- Rolling 4weekly advert for Band 5 & 6 midwife roles to support timely recruitment into workforce
- International midwife recruitment
- Established regular engagement with both UoL and DMU students to improve communication and promotion of working at UHL, advertising the Recruitment, Retention and Pastoral opportunities
- Continue to conduct and report feedback from ‘stay conversations’
- RRP midwives undertaking strengths based recruitment training to support recruitment processes.

Overview NHS mental health services M7

- The LPT mental health workforce is 1,947fte against a plan of 2017fte (a variance of 70fte behind plan).
- The forecast for the end of the financial year is 1922fte against a plan of 2132fte (a variance of 210fte behind plan).
- The 12-month turnover rate for the mental health workforce is 8.9% This is below the Trust target of 10%.
- Rolling 12m sickness absence rate is 6.4%.
- Reducing reliance on agency staffing to fill gaps in establishment contains to be a high priority for the Trust. A range of actions are in place through the Trust's Workforce, Agency and Recruitment Plan.

Progress against plan



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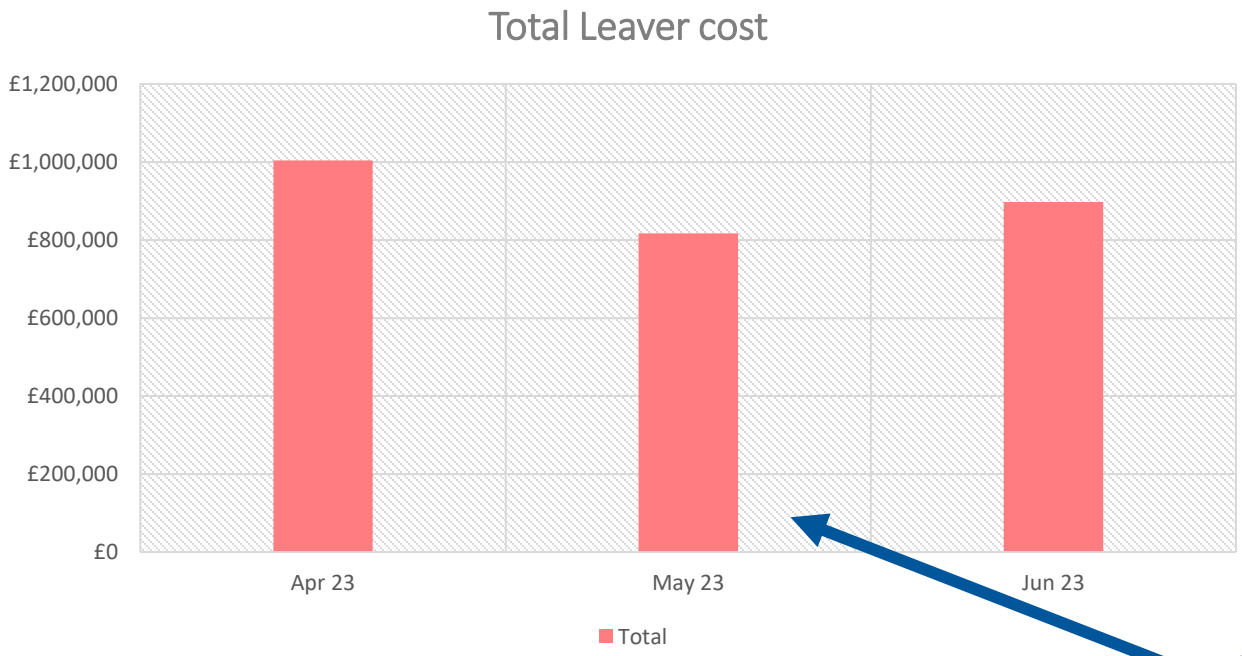
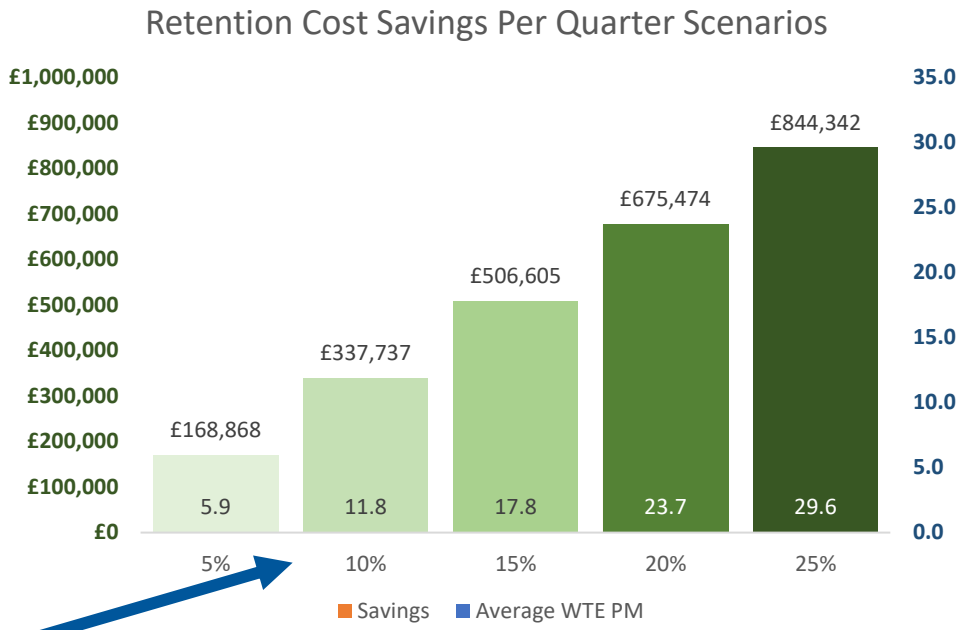
LLR Retention Dashboard Q1

Data Shown is from the NHS Provider Orgs, but the ambition is to expand data collection to other H&SC orgs in LLR

Cost of recruitment





An analysis was completed to understand the true cost of replacing staff that leave the organisation. Using the analysis it was calculated that in Q1 23 that an additional £3.4m cost to replace leavers

The graph on the left shows WTE reduction scenarios and what the savings would equate to over Q1 if we retained X% of WTE per month over Q1 (cost is total for Q1 while WTE is per month)

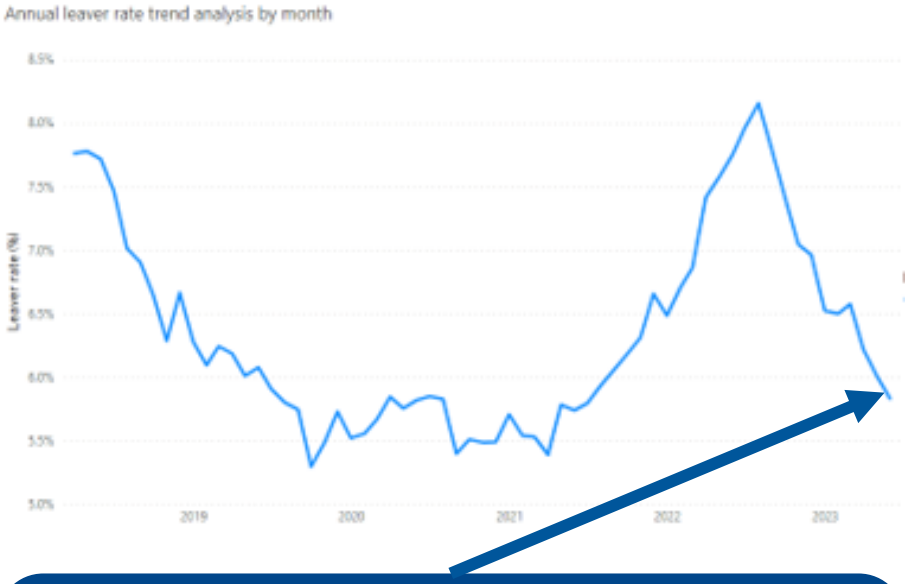
*TBC

NHS Leaver Rate*

NHS Leaver rate is the key metric considered by NHSE at Regional and National Level

the NHS Leaver rate is those who leave an NHS organisation and do not take up NHS employment elsewhere (not found on ESR in subsequent months)

*data from NHSE Retention Dashboard (currently not available outside of NHSE)

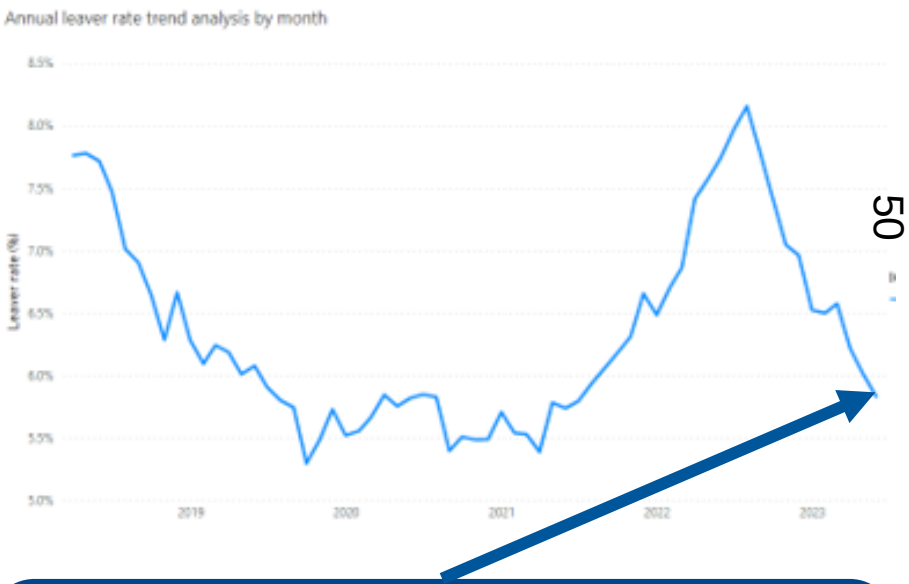


All Staff NHS Leaver Rate

7.2% in June 2023

Below regional rate

Declining trend since **December 2022** from **8.2%**



N50k NHS Leaver Rate

5.8% in June 2023

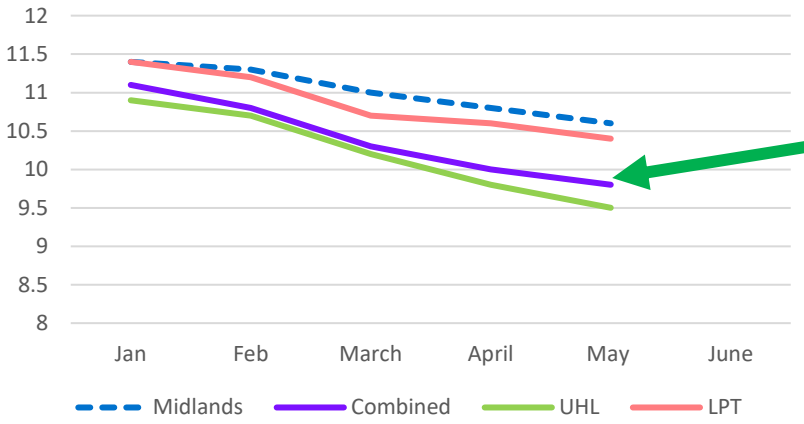
Below regional rate

Declining trend since **March 2023** from **6.6%.**

Turnover*

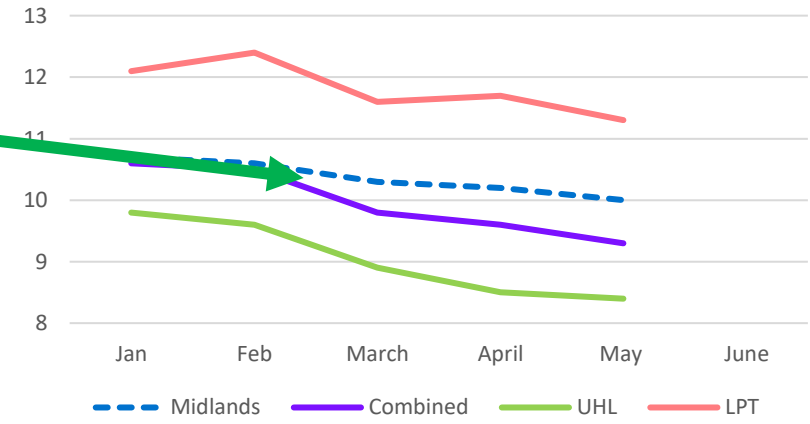
*data from eProduct. There will be variations between eProduct and internal Trust turnover analysis. The value of this data is to monitor trends and variations over long periods, and it is not intended to challenge or replace internal Trust reporting.

All Staff Turnover (leavers from ICS)

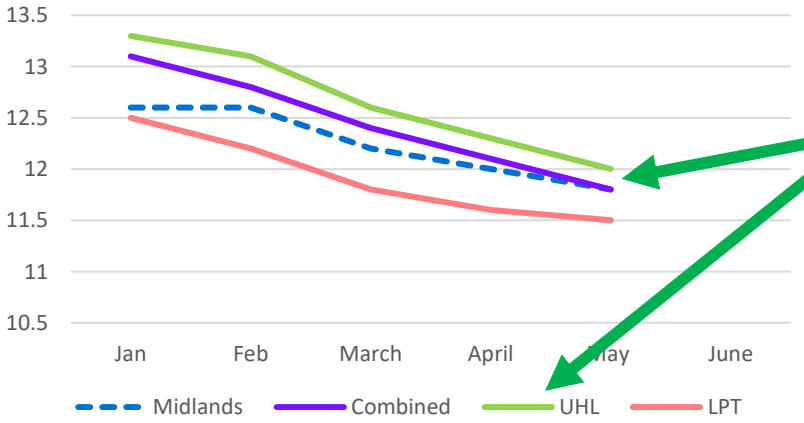


There has been a **declining trend** in turnover at both NHS Provider Trusts since January 2023.

N&MW Turnover (leavers from ICS)

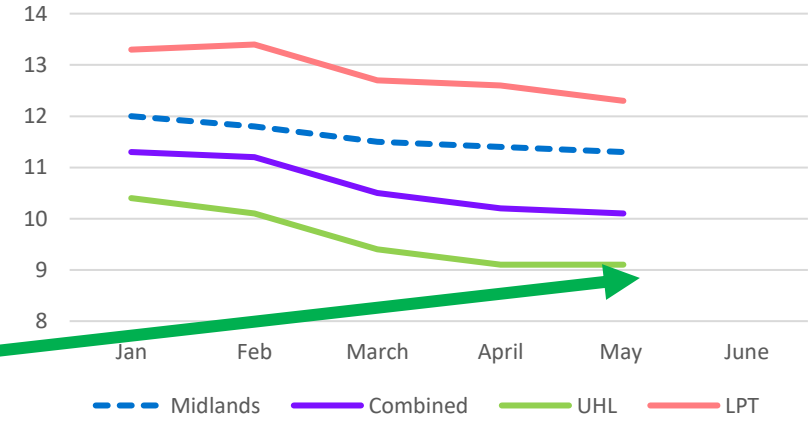


All Staff Turnover (leavers from Trusts)

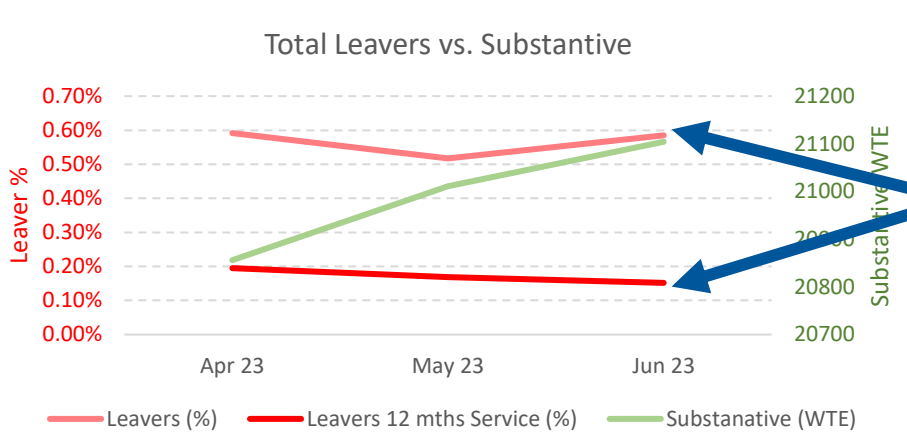


At Trust level, UHL have the highest turnover for 'All Staff', indicating that many UHL leavers stay within the ICS and move to LPT. However, for N&MW staff, UHL have the lowest turnover rate.

N&MW Turnover (leavers from Trusts)

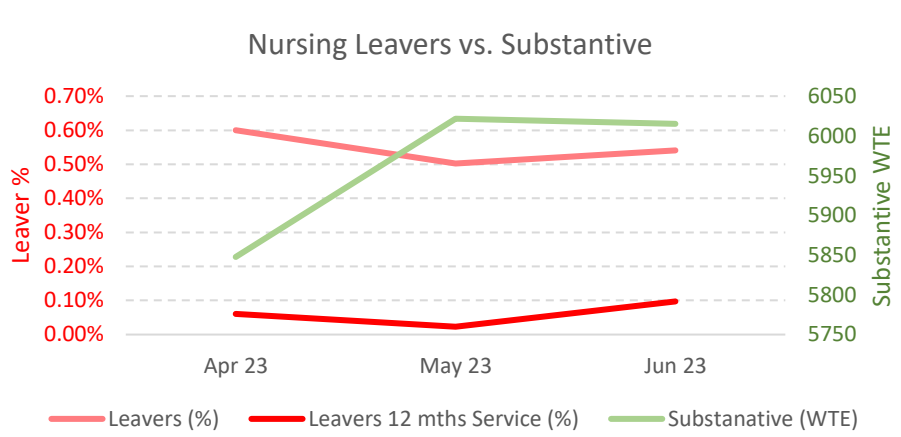


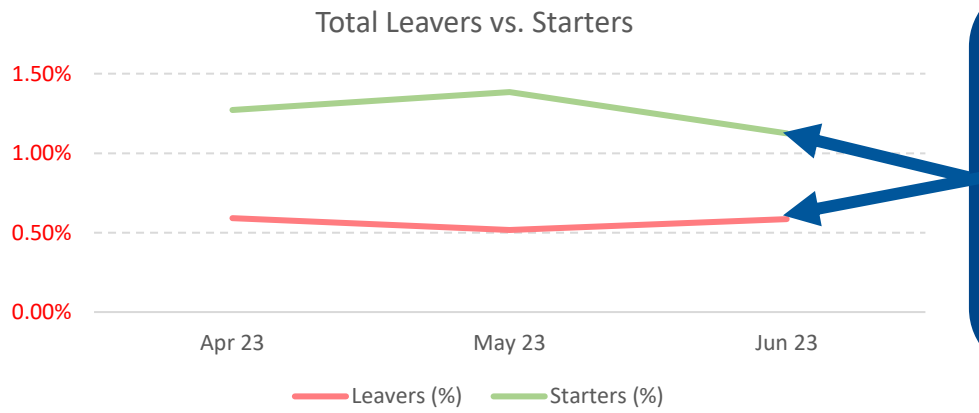
Leaver data against substantive WTE and new starters*



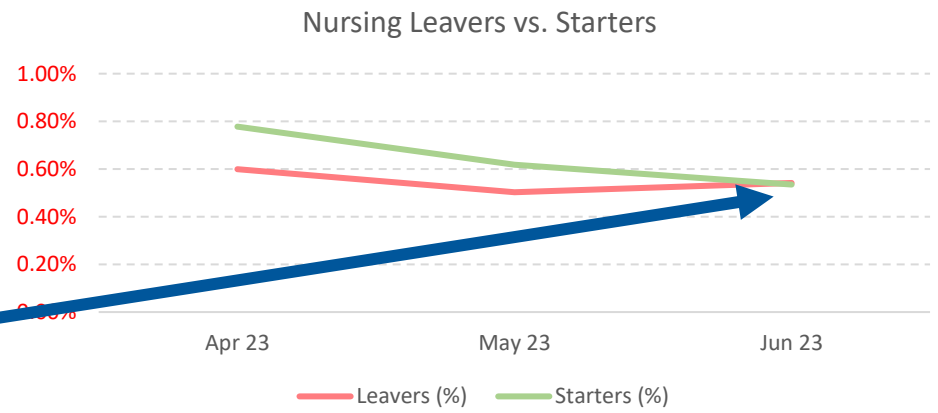
The % leavers and 12 months leavers rate is the number of WTE leavers / Total WTE.

This is plotted against the WTE over the same period.





For 'All Staff' the starter rate is higher than the leaver rate, generating overall growth in the workforce. For N&MW in June, the numbers of leavers was equal to the starters.



*combined data from Trusts

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Public Health

NHS England Midlands – Improvement & Value Analytics Support (LLR)

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Demographic Change & Trends

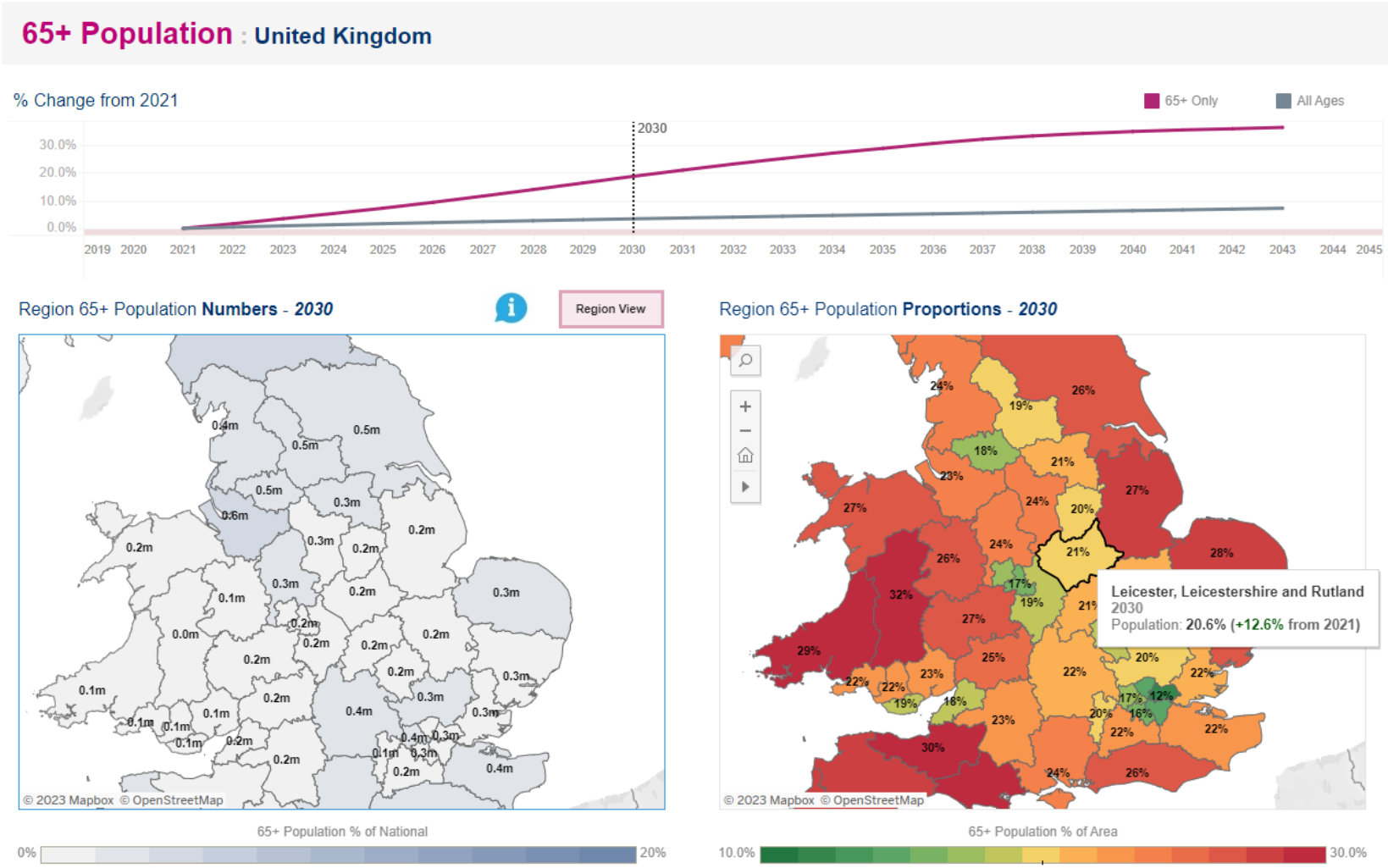
Leicester, Leicestershire, and Rutland shows a below-average number for its 65+ population segment, but this is projected to increase by 2030 to approximately 21%, reflecting a 12.6% rise from 2021.

Can we use population forecasts and models to support understand this further?

HEE workforce and demand model by local system to estimate population changed based on ONS data. (top chart)

Across the region there is wide variation in use of virtual wards, respiratory hubs, and care coordination – The Black Country seen as good practice.

Nationally – there are useful models from [World Population Prospects]



Cancer Screening Support

Cancer screening is highlighted due to higher rates of mortality, and practices with low screening rates.

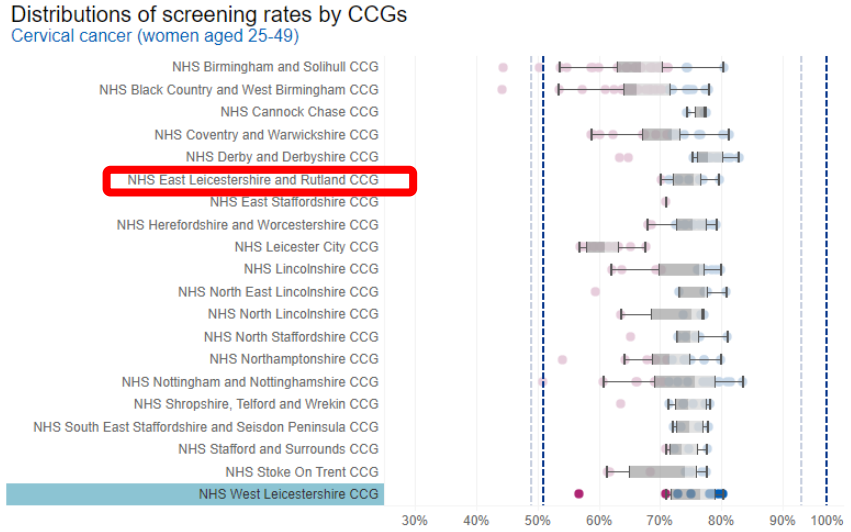
NHSE Midlands, with support from the Cancer Alliance and primary care, has developed the regional cancer screening tool: this includes links to evidence based good practice.

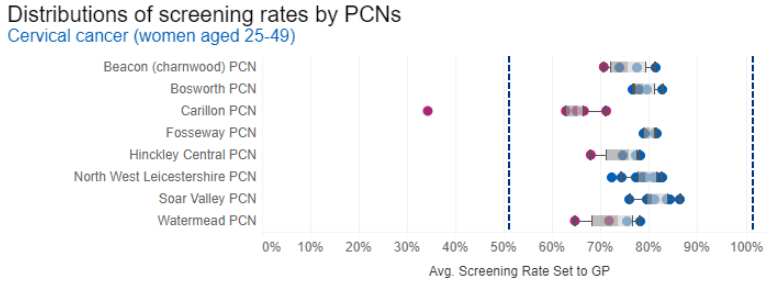
Using it in general practice can identify areas of good screening practice, increase cancer detection and reduce mortality.

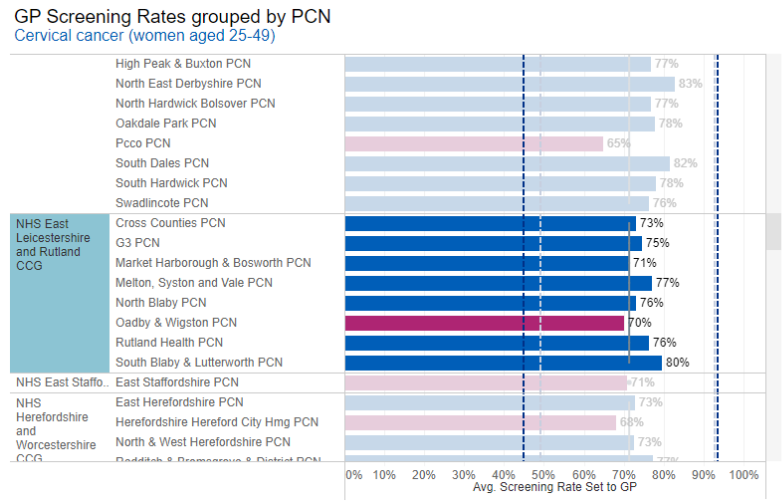
The example on the right shows 20/21 data, featuring average screening rates for cervical cancer (women aged 25 - 49) Overall, 59,000 patients have not been screened, with lower rates in more deprived population.

This highlights instances of good practice across GPs with similar deprivation levels, while also pinpointing areas that require additional support. The dashboard offers a comprehensive view, allowing comparison of deprivation scores and the influence of ethnicity across four common cancer pathways, with data on emergency admissions and hospital activity.

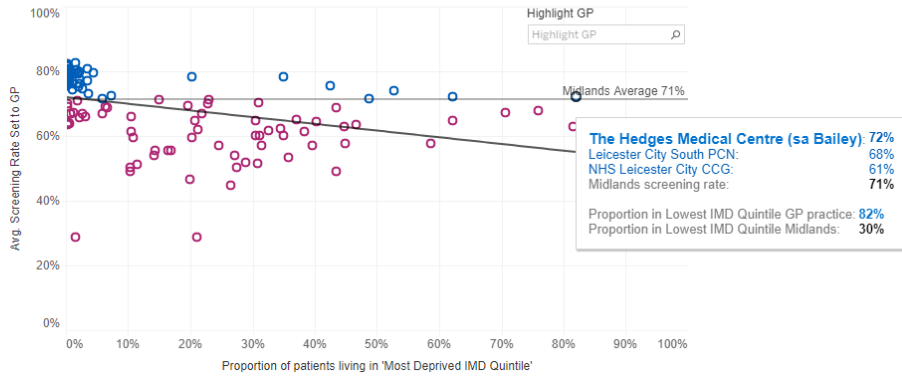
[Cancer tool](#) available here.







Eligible for Screening	Number Screened	Screening Gap	Midlands Eligible	Midlands Screened	Midlands Screening Gap
188,814	130,192	59,173	1,824,303	1,284,950	552,001



Cardiac Prevention

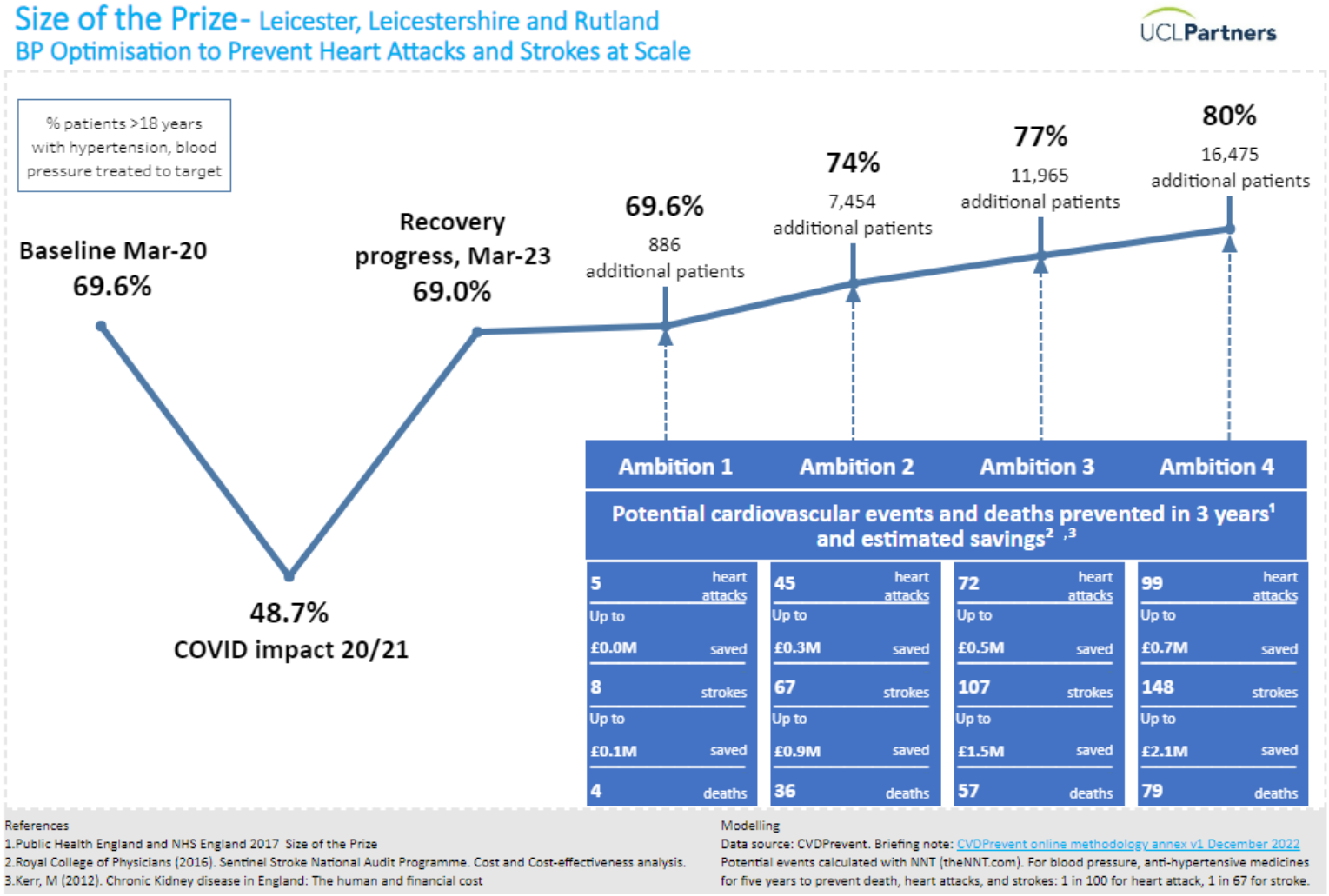
Small improvements may add up to big benefits to patients

This tool shows the potential benefits to patients and cost savings to the ICB by treating more hypertensive patients.

It is estimated that meeting the 80% target would lead to 79 fewer deaths and save up to £2.8m.

Systems such as Bradford have achieved improvement in detection to improve outcomes.

Upon request, we can also provide a copy of Bradford's full resource pack which includes an evaluation of the improved patient outcomes they achieved within two years of implementing their programme.



Cardiac Prevention

CVD is the primary cause of premature mortality within the Midlands though this varies across ICBs.

The under 75 mortality rate for all cardiovascular diseases per 100,000 population is 81.9 in the East Midlands and 83.5 in the West Midlands, directly age standardised (Mortality Profile - Data - OHID (phe.org.uk))

The CVD Prevent audit provides quarterly updates on key measures of cardiac prevention. We built this exploration tool with the regional cardiac network to identify outliers and review practice data.

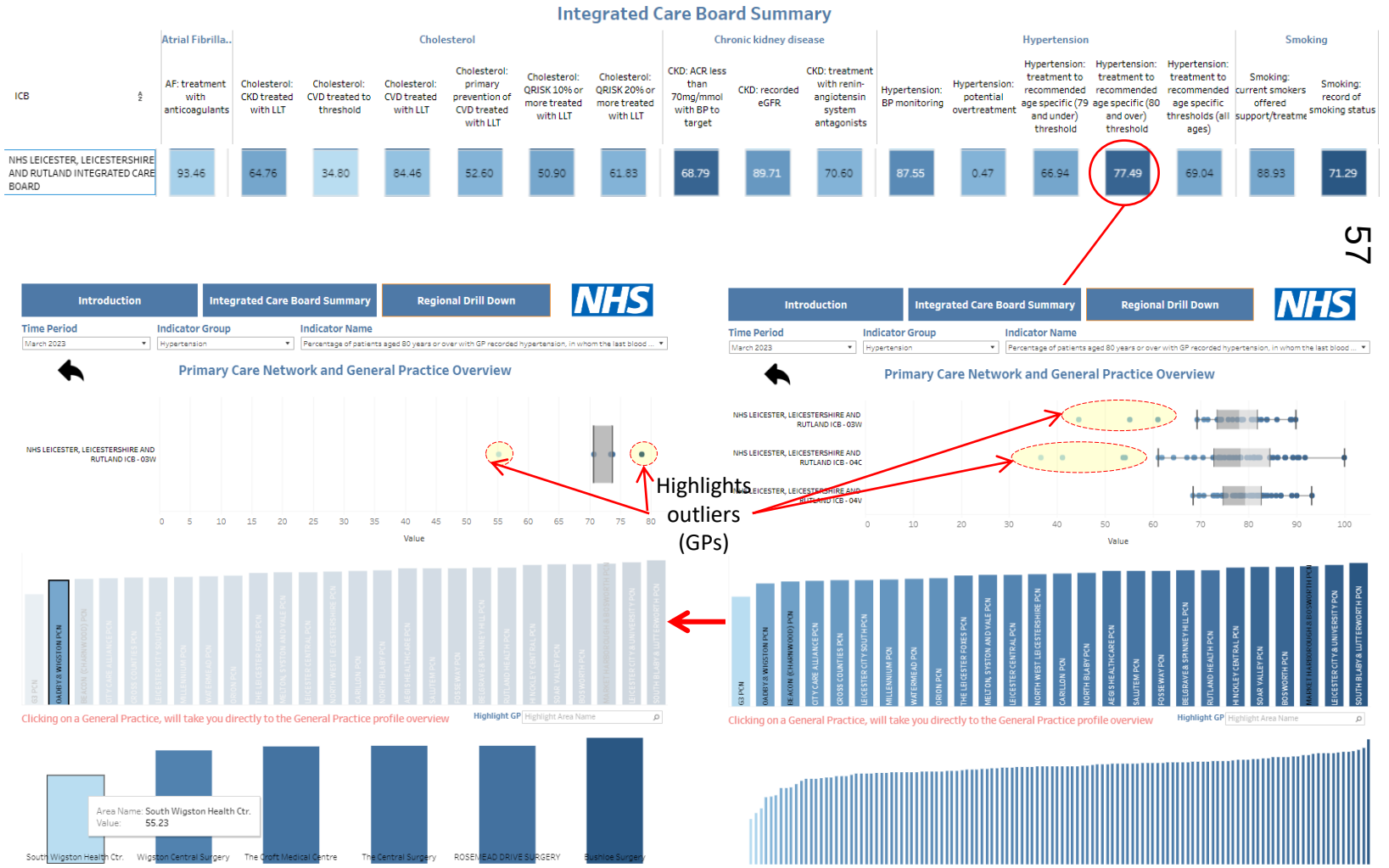
77% of patients aged 80+ treated to recommended threshold with variation at PCN/Practice level. Practice variation ranges from 36.6% to 100%.

Data from:

https://www.cvdprevent.nhs.uk/

Business case / cost benefit tool

CVD tool



Cancer, Pain & Prescribing?

Sizeable variations in non-elective admissions, mainly in cancer cases.

The system has some of the highest rates for non-elective cancer admissions in the country.

This gap widens when looking at non-elective tariff activity when compared to peer systems as shown on the right.

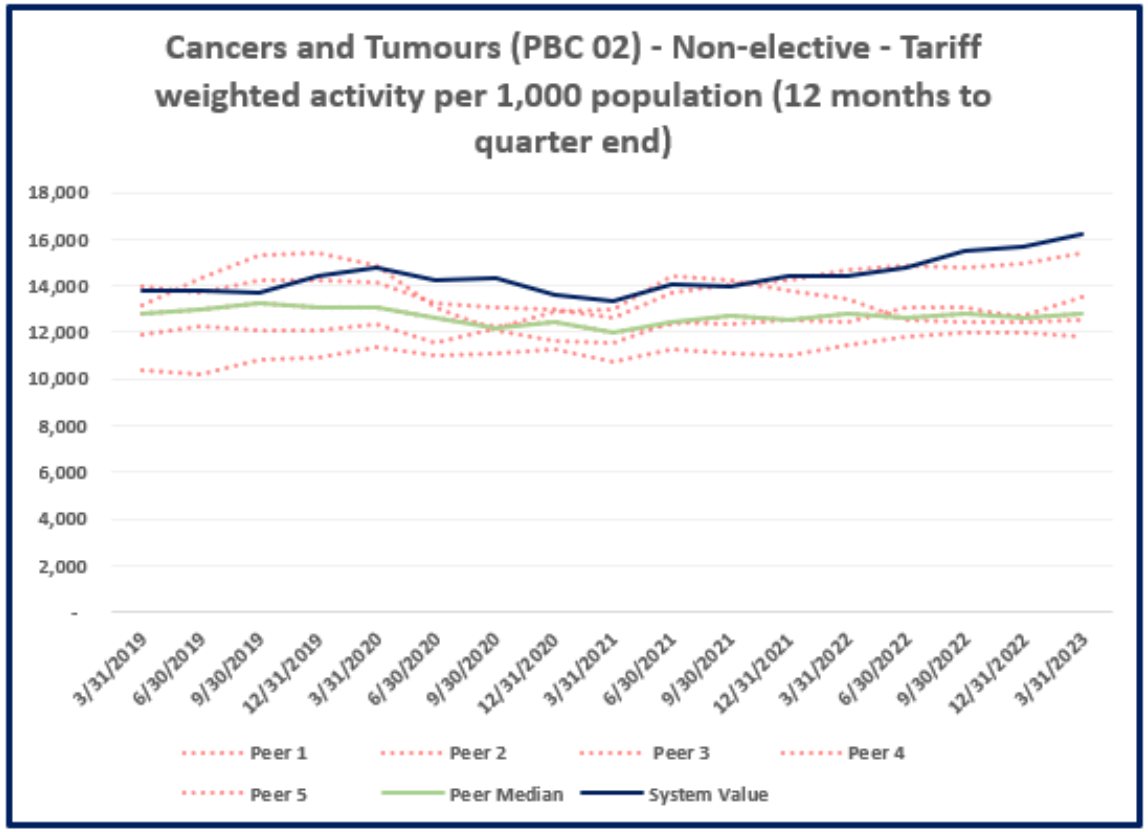
Are these patients coded through SDEC and become 0 LOS?

Analysis of primary care prescriptions for cancer indicates that the system's value remains below both peer and national medians.

A more detailed inspection of the data reveals a trend of higher-than-average prescription rates for pain management associated with bone.

How do we understand this population need & variation?

- Data from PAPI – population health tools to help identify risk, demographics etc.
- Prevention data and clinical quality measures – prescribing etc.
- PCN data – are there opportunities to improve local places?
- Burden of disease tool – premature deaths to smoking, hypertension, alcohol, diet.



Potential opportunity from improving to average of demographic peers – expressed in £s (12 months to quarter end) - £3,722,872 | Alert: This metric has been highlighted because performance is in the highest-performing quartile.

Inequalities of Access

Inequalities in non-elective, elective, outpatient and ED attendance are available in a new national HIID dashboard & regional data. It uses data from the past 12m that are age-sex standardised.

Users can drill down and combine deprivation and ethnicity, gender, elective and non-elective attendance, and split by clinical speciality.

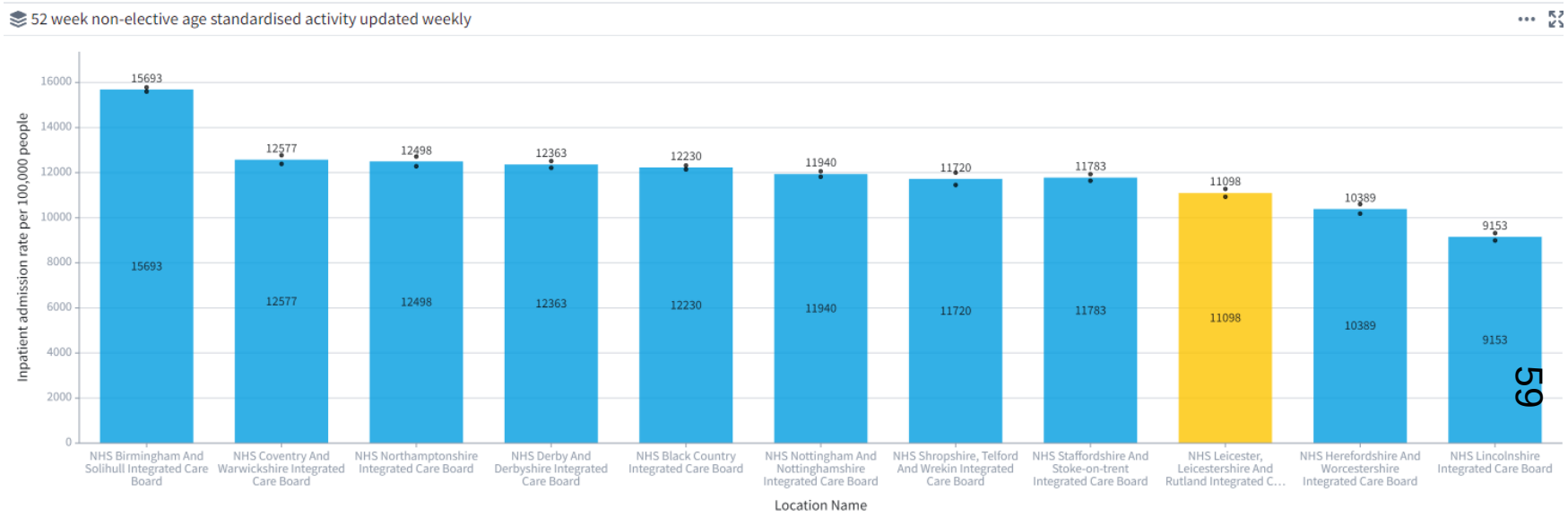
The example on the right shows clear variation in admissions based on ethnic groups and deprivation.

The initial chart highlights that the system exhibits one of the lowest rates of non-elective admissions among the most deprived quintile of the population.

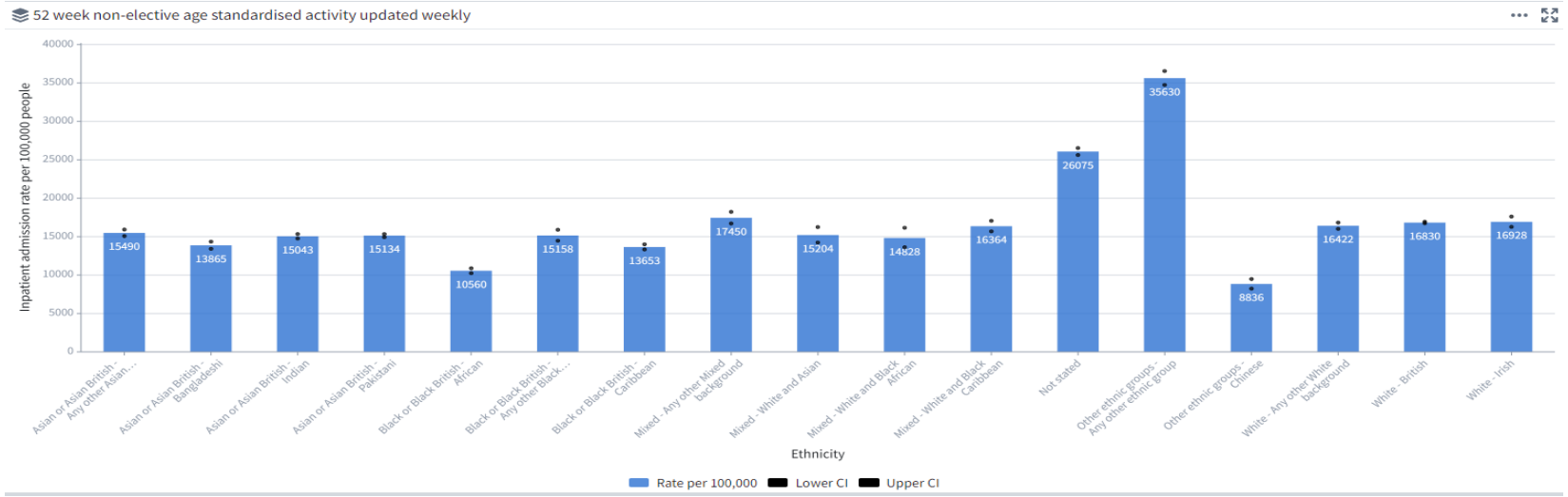
Further work on waiting list inequalities analysis by regional team can be shared if a priority. Available on Foundry via Health Inequalities workspace.

https://ppds.palantirfoundry.co.uk/

Non-Elective Standardised rates for most deprived 20% of population



Variation in standardised rates of non-elective admission by ethnicity



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Primary Care

M6 Workforce Update

Exploring Opportunities by PCN

Non-elective PCN opportunities are compared to twenty demographically similar PCNs (peers) using age-sex standardised 21/22 data.

An opportunity indicates the potential gained by performing at the average level of the ten lowest spending peers.

North West Leicestershire (£5.3m) and Melton, Syston & Vale (£3.2m) have the greatest total opportunities – although data not adjusted for PCN size.

Circulation (£11.5m), respiratory (£7.3m), gastro (£6.2m) stand out across PCNs.

May indicate where to focus on prevention and management of LTCs

[Full PCN packs available here]

GeographyName	Cancer	Endocrine	Neuro	Circulation	Respiratory	Gastro	MSK	T&I	GU	Total
NORTH WEST LEICESTERSHIRE PCN	£487,910	£72,060	£430,575	£1,469,327	£1,180,850	£655,878	£307,177	£428,059	£333,080	£5,364,916
MELTON, SYSTON AND VALE PCN	£345,580	£48,965	£312,847	£973,648	£600,979	£100,242	£224,138	£236,929	£385,073	£3,228,403
OADBY & WIGSTON PCN	£259,814	£125,414	£404,963	£492,559	£185,211	£491,061	£69,525	£224,340	£179,102	£2,431,990
FOSSEWAY PCN	£431,222	£40,388	£192,837	£248,891	£396,761	£299,275	£103,992	£436,342	£125,255	£2,274,963
SOUTH BLABY & LUTTERWORTH PCN	£109,412	£40,018	£408,831	£251,087	£455,394	£407,086	£51,850	£122,693	£268,715	£2,115,087
NORTH BLABY PCN	£117,177		£143,566	£740,700	£295,602	£383,070		£189,540	£158,023	£2,027,678
SOAR VALLEY PCN	£162,592	£44,941	£50,112	£673,610	£253,019	£314,680	£89,772	£148,593	£220,331	£1,957,649
CARILLON PCN	£144,317	£91,043	£213,036	£694,496	£84,737	£336,051	£64,590	£197,957	£93,762	£1,919,987
MARKET HARBOROUGH & BOSWORTH PCN	£158,670	£92,151	£176,290	£425,814	£289,740	£262,772	£39,275	£60,568	£199,030	£1,704,309
BEACON (CHARNWOOD) PCN	£221,052	£17,969	£169,222	£600,510	£62,593	£389,334	£14,530	£90,664	£123,562	£1,689,437
LEICESTER CITY SOUTH PCN	£179,081	£48,842	£194,425	£152,558	£590,230	£142,178		£284,964	£73,135	£1,665,412
SALUTEM PCN	£55,888	£19,053	£276,959	£683,608	£236,609	£298,356	£147	£40,529	£45,906	£1,657,054
RUTLAND HEALTH PCN	£137,079	£36,572	£90,752	£405,366	£318,009	£354,961	£107,837	£13,873	£51,295	£1,515,743
WATERMEAD PCN	£36,627	£49,874	£53,307	£687,298	£408,819	£141,288	£16,029		£4,389	£1,397,630
MILLENNIUM PCN	£24,399	£51,118	£182,543	£300,901	£250,899	£239,797	£2,917	£82,771	£66,598	£1,201,943
LEICESTER CENTRAL PCN		£156,952	£114,065	£539,717		£157,960	£23,525		£139,648	£1,131,867
BOSWORTH PCN	£103,890	£46,994	£18,974	£84,969	£307,816	£182,285	£46,388	£104,616	£133,239	£1,029,172
G3 PCN	£162,942		£47,475	£144,600	£172,516	£182,753	£83,015		£215,149	£1,008,450
LEICESTER CITY & UNIVERSITY PCN	£94,062	£86,683		£162,995	£314,521	£156,531	£14,093	£109,204	£49,550	£987,640
ORION PCN	£1,329	£2,638	£213,238	£144,883	£256,169	£145,828	£60,268	£38,365	£97,072	£959,792
CITY CARE ALLIANCE PCN	£24,212	£62,149	£72,898	£449,827	£93,752	£253,541				£956,380
CROSS COUNTIES PCN	£107,165		£17,037	£506,699	£111,624	£17,882	£5,048		£86,541	£851,996
THE LEICESTER FOXES PCN	£20,317	£50,871		£286,576	£201,044	£193,029	£13,760		£43,406	£809,003
AEGIS HEALTHCARE PCN	£64,471	£38,618	£91,242	£249,050	£102,667	£112,166		£48,951	£15,080	£722,246
HINCKLEY CENTRAL PCN	£229,461			£52,928	£186,361	£69,718	£58,966		£116,074	£713,507
BELGRAVE & SPINNEY HILL PCN	£6,846			£82,249					£118,080	£207,176

Highest

Lowest

PCN Data – Opportunity summary tools: Heart Conditions

RightCare PCN packs were created to benchmark every PCN on a number of measures including prevention, diagnosis, admissions, bed day use.

For example, areas for cardiac improvement, management of CHD and BP in CHD patients. Data includes QOF and LTC areas.

The methodology incorporates age/sex standardization where relevant and draws comparisons with PCNs of similar demographics including ethnicity, urbanisation, size, and deprivation levels.

Starting with opportunity summary show where biggest opportunities can be – Note, not adjusted for PCN size.

[NHS Leicester, Leicestershire and Rutland ICB PCN Summary]

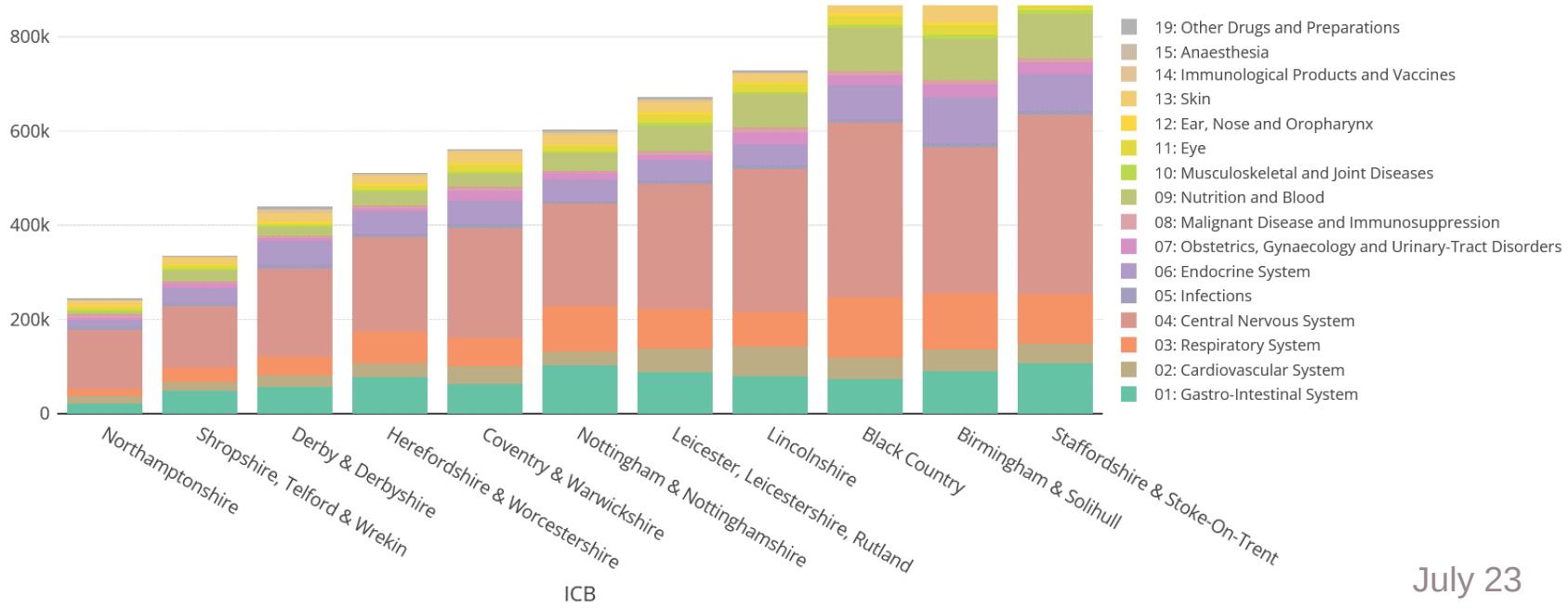
GeographyName	AF Reported to Est.	AF assessment Chads2	Treated with Anticoag	BP recorded last 5 yrs	CHD reported /expected	CHD treated antiplatelet/coag	BP<140 under 79	BP<150 over 80
AEGIS HEALTHCARE PCN	79 Patients		2 Patients	332 Patients	148 Patients	18 Patients		
BEACON (CHARNWOOD) PCN	56 Patients	7 Patients		517 Patients	99 Patients	21 Patients	47 Patients	26 Patients
BELGRAVE & SPINNEY HILL PCN	332 Patients		5 Patients	886 Patients	307 Patients	31 Patients	161 Patients	55 Patients
BOSWORTH PCN	12 Patients	45 Patients			249 Patients		12 Patients	
CARILLON PCN		42 Patients			156 Patients	4 Patients		8 Patients
CITY CARE ALLIANCE PCN	119 Patients			655 Patients	297 Patients	8 Patients	54 Patients	2 Patients
CROSS COUNTIES PCN	130 Patients	31 Patients		741 Patients	344 Patients	35 Patients	119 Patients	35 Patients
FOSSEWAY PCN	95 Patients			393 Patients	396 Patients			2 Patients
G3 PCN	60 Patients	22 Patients	5 Patients	518 Patients	37 Patients		133 Patients	79 Patients
HINCKLEY CENTRAL PCN	82 Patients	15 Patients	23 Patients	472 Patients	286 Patients	16 Patients	13 Patients	15 Patients
LEICESTER CENTRAL PCN	134 Patients	1 Patients		305 Patients	268 Patients	15 Patients		
LEICESTER CITY & UNIVERSITY PCN				305 Patients	59 Patients	13 Patients		
LEICESTER CITY SOUTH PCN	5 Patients	25 Patients		494 Patients	162 Patients	21 Patients	74 Patients	13 Patients
MARKET HARBOROUGH & BOSWORTH PCN	29 Patients		6 Patients	1,006 Patients	198 Patients	5 Patients	60 Patients	63 Patients
MELTON, SYSTON AND VALE PCN		83 Patients		759 Patients	243 Patients		13 Patients	7 Patients
MILLENNIUM PCN	100 Patients			357 Patients	88 Patients	22 Patients	94 Patients	16 Patients
NORTH BLABY PCN	128 Patients	20 Patients			322 Patients	3 Patients	44 Patients	
NORTH WEST LEICESTERSHIRE PCN	92 Patients	156 Patients		131 Patients	783 Patients		106 Patients	
OADBY & WIGSTON PCN	96 Patients	6 Patients	7 Patients	646 Patients	227 Patients	52 Patients	90 Patients	43 Patients
ORION PCN	58 Patients				135 Patients	7 Patients		3 Patients
RUTLAND HEALTH PCN					148 Patients	58 Patients	98 Patients	48 Patients
SALUTEM PCN	81 Patients				368 Patients	40 Patients		4 Patients
SOAR VALLEY PCN	57 Patients				380 Patients	40 Patients	10 Patients	13 Patients
SOUTH BLABY & LUTTERWORTH PCN	114 Patients	4 Patients		42 Patients	359 Patients			
THE LEICESTER FOXES PCN	142 Patients	8 Patients		77 Patients	44 Patients	5 Patients		1 Patients
WATERMEAD PCN	48 Patients	18 Patients	6 Patients	83 Patients	176 Patients	44 Patients	47 Patients	20 Patients

PC Prescribing – Price per unit savings

Using methodology developed by OpenPrescribing that identifies very large cost-saving opportunities of between £100m and £400m a year for GP practices and ICBs across the Midlands. This is more than any previous advice such as “always prescribe generically”. The tool identifies the drugs with the biggest cost saving opportunities for each practice and ICB, every month; and then helps them choose cheaper options.

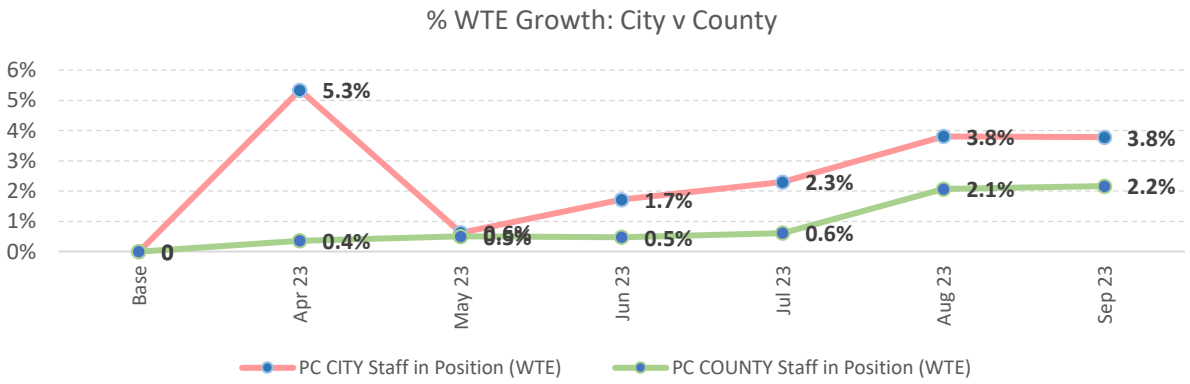
LLR has an opportunity to save more than 600k per month.

Greater detail available here: https://future.nhs.uk/RCME/view?objectId=42090640



PC M6 (Non ARRS)

	ACTUAL						
PC Staff in Position (WTE)	**Base**	Apr 23	May 23	Jun 23	Jul 23	Aug 23	Sep 23
GPs excluding registrars	529	525	516	515	515	514	516
GP Registrars	175	191	188	185	182	218	212
Nurses	284	289	284	285	286	288	286
DPC roles (ARRS funded)	522	561	571	575	579	629	591
DPC roles (not ARRS funded)	345	350	347	342	342	346	356
Other – admin and non-clinical	1426	1448	1433	1450	1458	1456	1453
Total PMC	**2758**	**2802**	**2768**	**2776**	**2783**	**2823**	**2822**
Total ARRS	**522**	**561**	**571**	**575**	**579**	**629**	**591**
Total	**3280**	**3362**	**3338**	**3351**	**3362**	**3452**	**3413**
PMC Growth (cumulative)		**1.6%**	**0.4%**	**0.7%**	**0.9%**	**2.4%**	**2.3%**
ARRS Growth (cumulative)		**7.4%**	**9.3%**	**10.1%**	**10.9%**	**20.4%**	**13.2%**
Total Growth (cumulative)		**2.5%**	**1.8%**	**2.2%**	**2.5%**	**5.2%**	**4.1%**



Growth in PMC in LLR is at 2.3%. Which is below expectation. However between City and County, County (excluding Rutland) has grown 2.2%, City at 3.8%, Rutland decreased by -3.8%

City

- GPs in city have remained mostly static in June, August 2023 and September.
- Growth is at 3.8% since March 2023. Growth is above of County
- All other staff groups with the exception of DPC roles (non ARRS) (increased) and ARRS roles (decreased) have remained static or only deviated slightly from March 2023.

County

- Growth has been 2.2% since March 23 and is below city growth.
- Most staff groups have remained mainly static barring GP registrars which has decreased by 4 WTE, ARRS roles has decreased by 16 WTE and DPC roles (non ARRS) which increased by 6 WTE.

Rutland

- Growth is at -3.8% since March 23. All staff groups have remained mainly static barring Nurses which decrease by 2 WTE.

PC M6 ARRS

ARRS Staff Groups	Apr 2023	Sep 2023	WTE Growth	% Growth
Advanced Clinical Practitioner Nurse	6.2	18.4	12.1	195%
Advanced OT Practitioner	0.0	0.0	0.0	0%
Advanced Paramedic Practitioner	5.1	5.5	0.4	8%
Advanced Pharmacist Practitioner	3.6	10.2	6.5	179%
Advanced Physiotherapist Practitioner	0.0	0.5	0.5	0%
Advanced Practitioner	2.0	0.0	-2.0	-100%
Apprentice Physician Associate	0.0	1.5	1.5	0%
Care Coordinator	58.9	69.0	10.1	17%
Clinical Pharmacist	185.1	189.8	4.6	3%
Dietician	0.0	0.0	0.0	0%
Digital and Transformation Lead	16.7	15.7	-1.0	-6%
First Contact Physiotherapist	28.6	25.1	-3.5	-12%
General Practice Assistant	36.5	39.0	2.5	7%
Health and Wellbeing Coach	13.7	11.5	-2.2	-16%
Mental Health Practitioner Band 6	3.0	3.0	0.0	0%
Mental Health Practitioner Band 7	14.1	11.0	-3.1	-22%
Mental Health Practitioner Band 8a	1.9	1.0	-0.9	-48%
Nursing associate	19.6	21.9	2.3	12%
Occupational therapist	1.0	1.0	0.0	0%
Paramedic	32.4	29.0	-3.4	-10%
Pharmacy Technician	39.0	41.0	2.0	5%
Physician Associate	36.6	33.0	-3.6	-10%
Podiatrist	0.0	0.0	0.0	0%
Social Prescribing Link Worker	52.8	53.7	0.9	2%
Trainee nursing associate	3.8	10.2	6.4	168%
Total	560.7	590.9	30.2	5%
Agency based	89.4	74.2	-15.2	-17%

Please note that the ARRS data is claims to finance for each WTE that is approved or pending approval. All rejected claims are removed.

Based on plans submitted to NHSEI Primary Medical care and ARRS is on plan. This is mainly due to substantial growth in all staff groups.

Top 5 ARRS roles for City, County and Rutland (Claims Data August)

City (growth since April 23- 1%)

- Clinical Pharmacists – 68.0 WTE
- General Practice Assistant – 25.4 WTE
- Care Coordinator– 24.1 WTE
- Pharmacy Technician– 12.6 WTE
- Physician Associate – 12.3 WTE

County (growth since April 23- 9%)

- Clinical Pharmacists – 111.2 WTE
- Care Coordinator – 40.9 WTE
- Social Prescribing Link Worker – 40.4 WTE
- Pharmacy Technician– 28.4 WTE
- Paramedic– 28 WTE

Rutland (growth since April 23- -8%)

- Clinical Pharmacists – 10.6 WTE
- Care Coordinator – 4.0 WTE
- First Contact Physiotherapist – 1.3 WTE
- Social Prescribing Link Worker, Mental Health Practitioner Band 7, Digital and Transformation Lead WTE

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NHS
Leicester, Leicestershire and Rutland
Integrated Care Board

Appendix B: LLR Adult Social Care 22/23

Skills for Care workforce intelligence

A proud partner in the:

Leicester, Leicestershire and Rutland
Health and Wellbeing Partnership

Key Findings 22/23

In the **local authority and independent sector:**

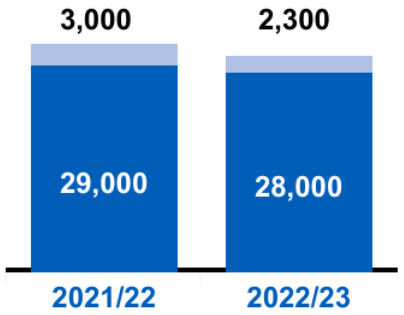
31,000 total posts

28,000 filled posts

20,500 FTE filled posts

(full-time equivalent filled posts)

Change in **filled posts** and **vacancies**



There was a change of

-1,000 filled posts (-3%)

since 2021/22 in **local authority and independent sectors**

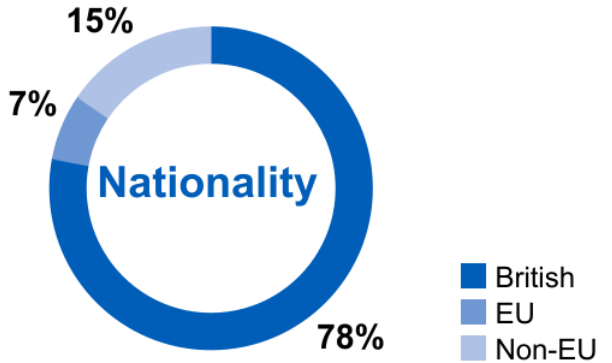
Average hourly pay for care workers

Local authority

£10.94

Independent sector

£10.11



32% of workers were on **zero-hours contracts**

8.0% average **vacancy rate** in 2022/23

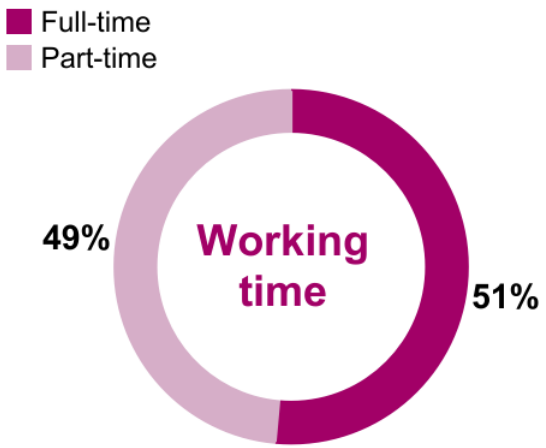
The average **turnover rate** was **27.5%**

23% were **aged 55 or above**

This page contains information about **local authority** and **independent** sectors only

Employment overview 22/23

Number of filled posts
28,000



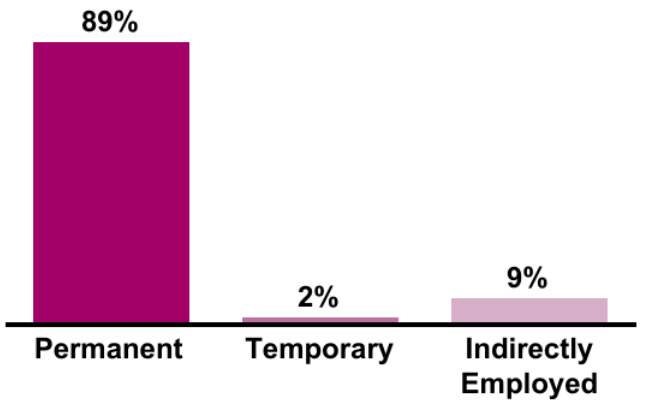
Full-time equivalent filled posts

The **FTE filled posts ratio** in

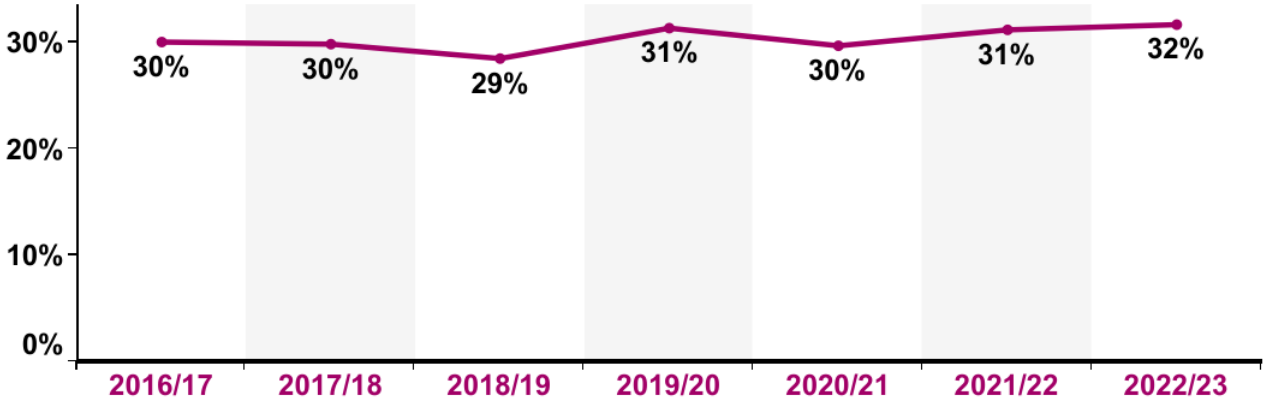
Leicester, Leicestershire and Rutland

is **0.71**

Employment status



Zero-hours contracts trend



In 2022/23

32%

of filled posts were **zero-hours contracts** (or **9,000 filled posts**)

This page contains information about **local authority** and **independent** sectors only

Recruitment and retention 22/23

8.0%
vacancy rate
(or 2,300 vacant posts)
in 2022/23

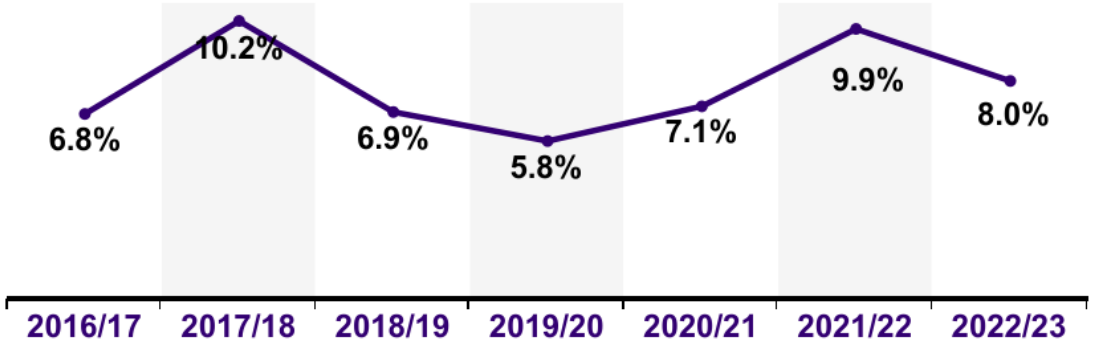
27.5%
turnover rate
(or 7,100 leavers)
in 2022/23

59%
of **recruitment** is from **within adult social care**

5.8
average **sickness days** taken in 2022/23

Select a view:
- (●) Vacancy rate
- ( ) Turnover rate

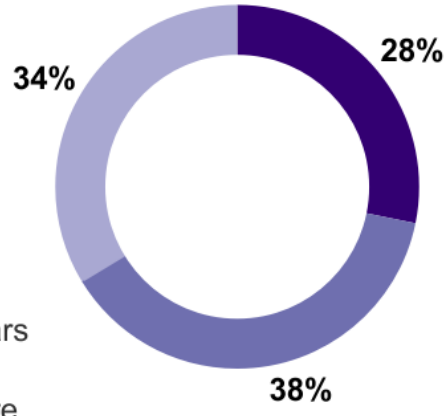
Vacancy rate trend



Experience in sector

Select a view:
- (●) Experience in sector
- ( ) Experience in role

Average:
8.6 years



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Demographics 22/23

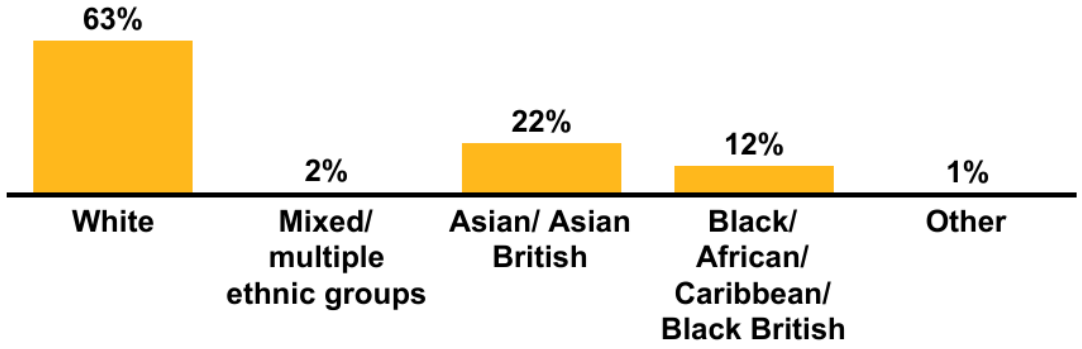
Gender

81% of the workforce were **female**

19% of the workforce were **male**

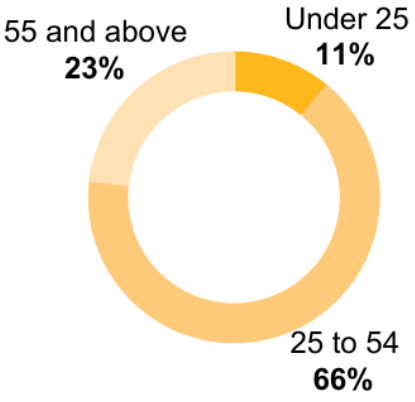
'Other' gender is collected but not yet included in analysis. Press the report for more information:

Ethnicity

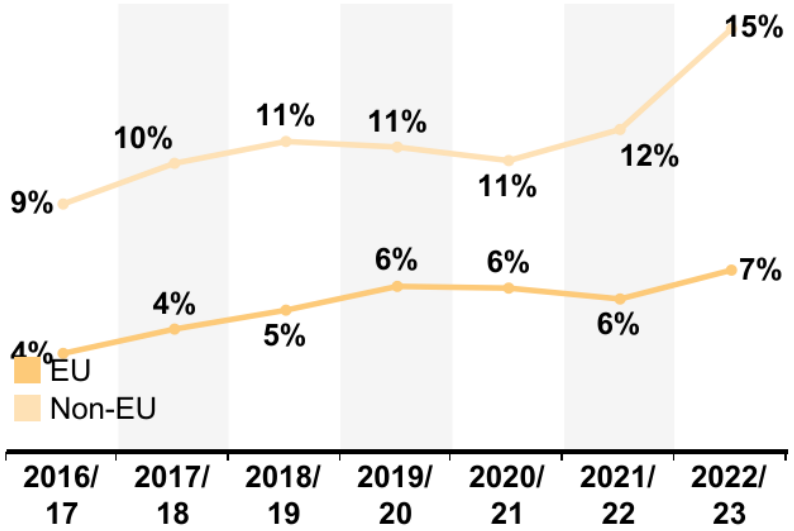


Age

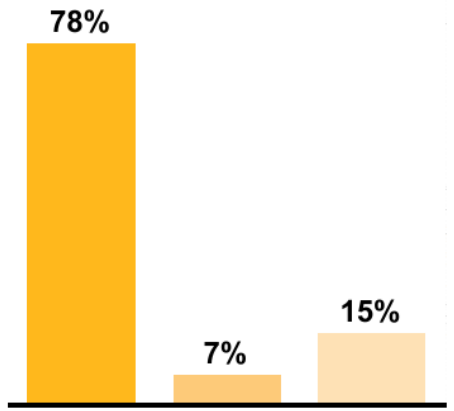
The average **age** was **42 years old**



Nationality trend



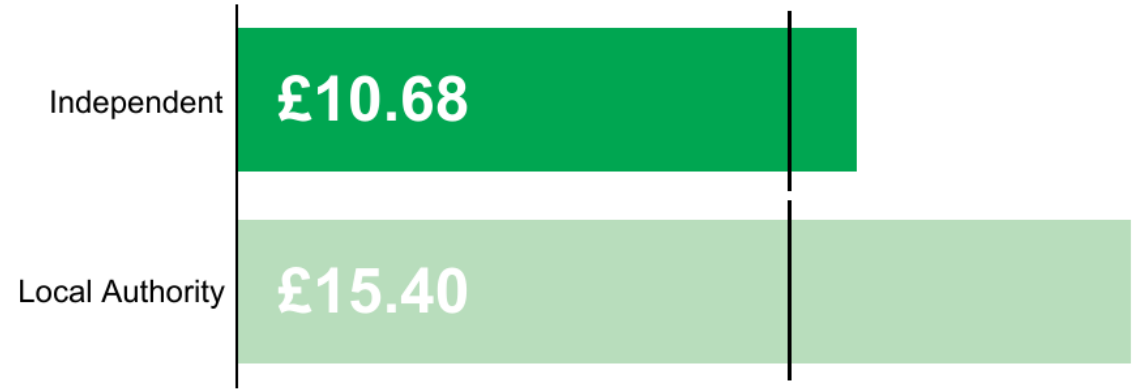
Nationality (2022/23)



This page contains information about **local authority** and **independent** sectors only

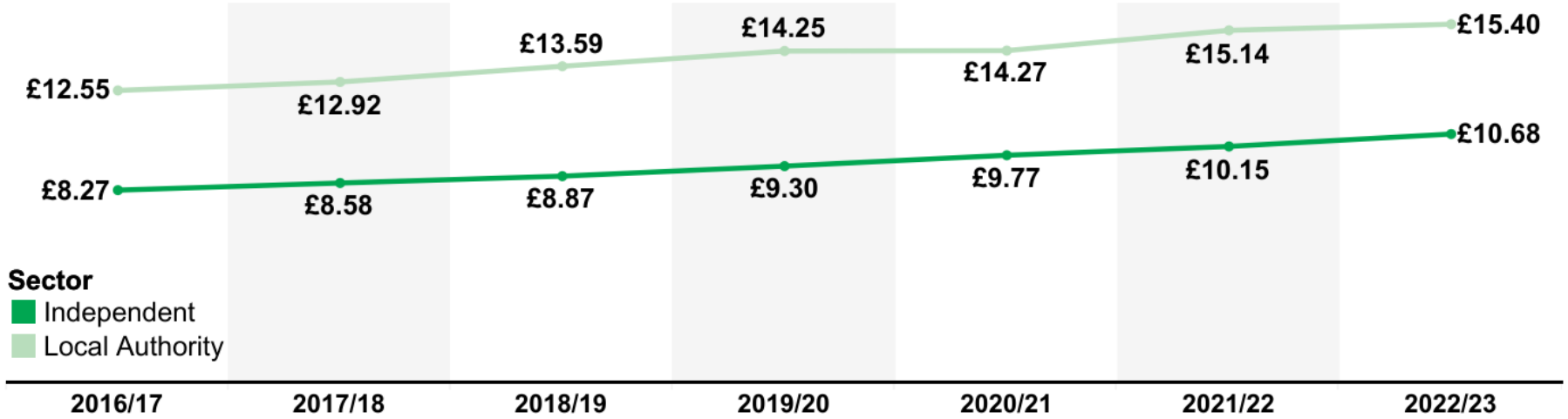
Pay (Hourly) 22/23

Average hourly pay rate



The National Living Wage was £9.50
(April 2022 - March 2023)

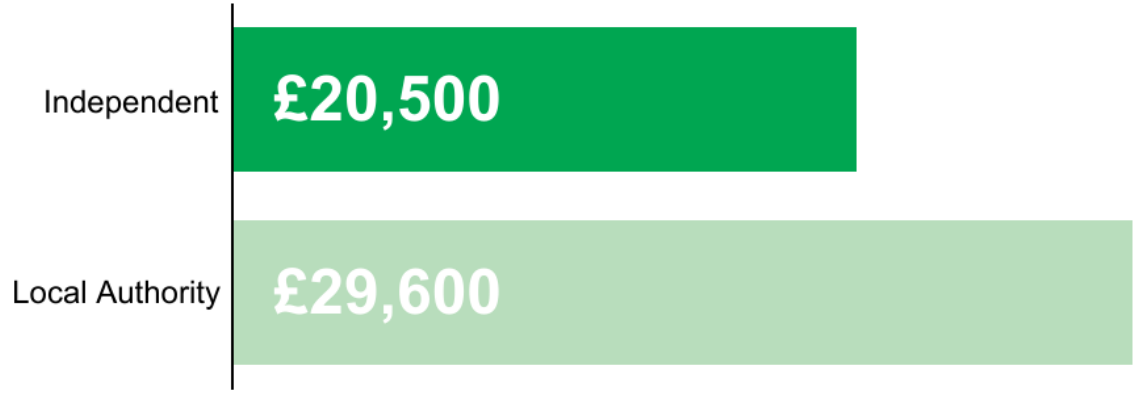
Average hourly pay rate trend



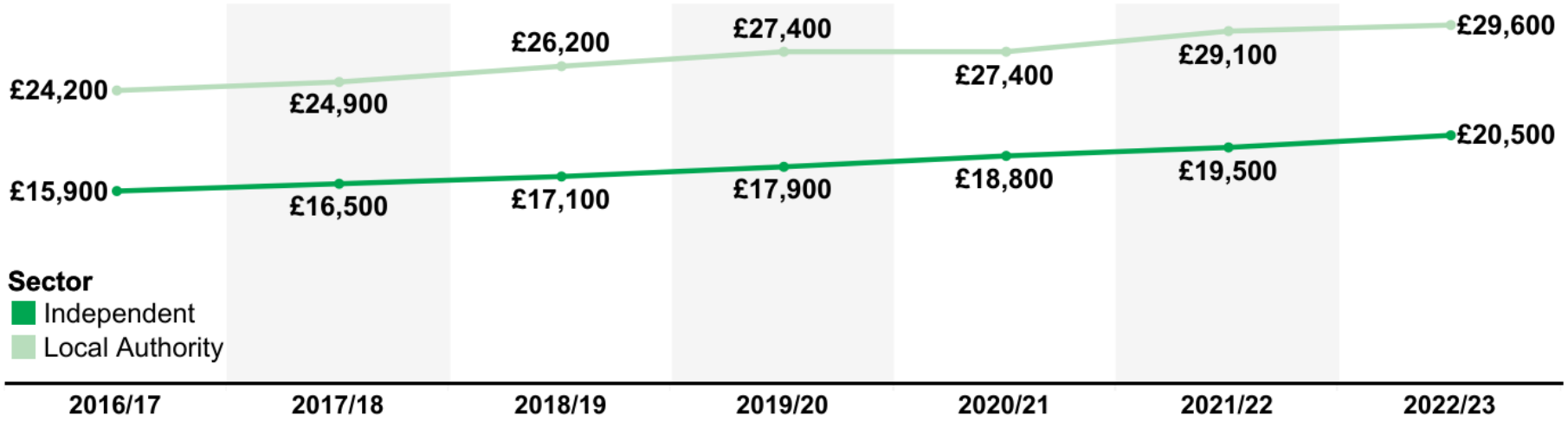
This page contains information about **local authority** and **independent** sectors only

Pay (FTE Annual) 22/23

Average FTE annual pay rate



Average FTE annual pay rate trend



This page contains information about **local authority** and **independent** sectors only

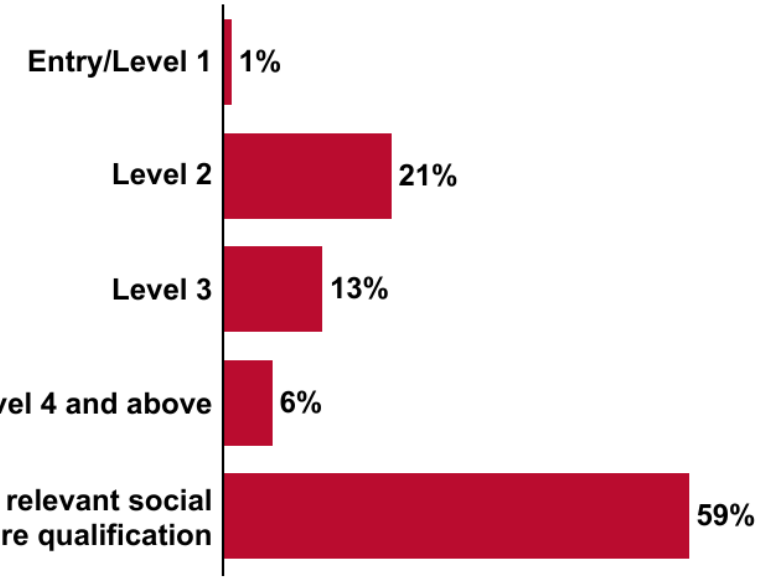
Qualifications & training 22/23

Relevant social care qualification

Select a job role:
All job roles

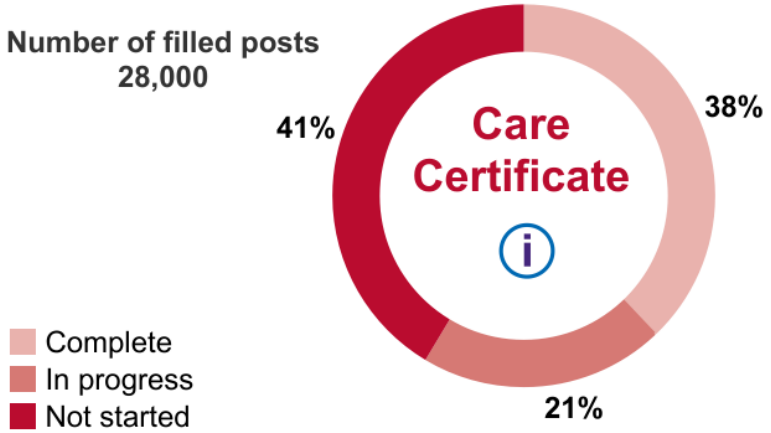
Number of filled posts
28,000

41%
of workers held a qualification relevant to social care

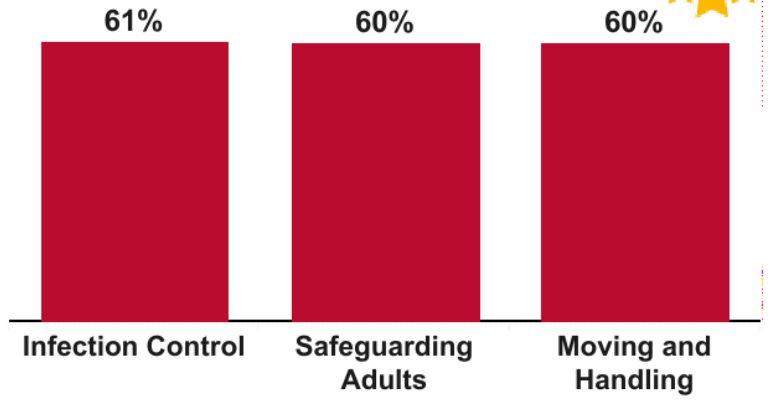


Select a job role:
All job roles

Number of filled posts
28,000



Top 3 training categories



This page contains information about **local authority** and **independent** sectors only

Workforce projections 22/23

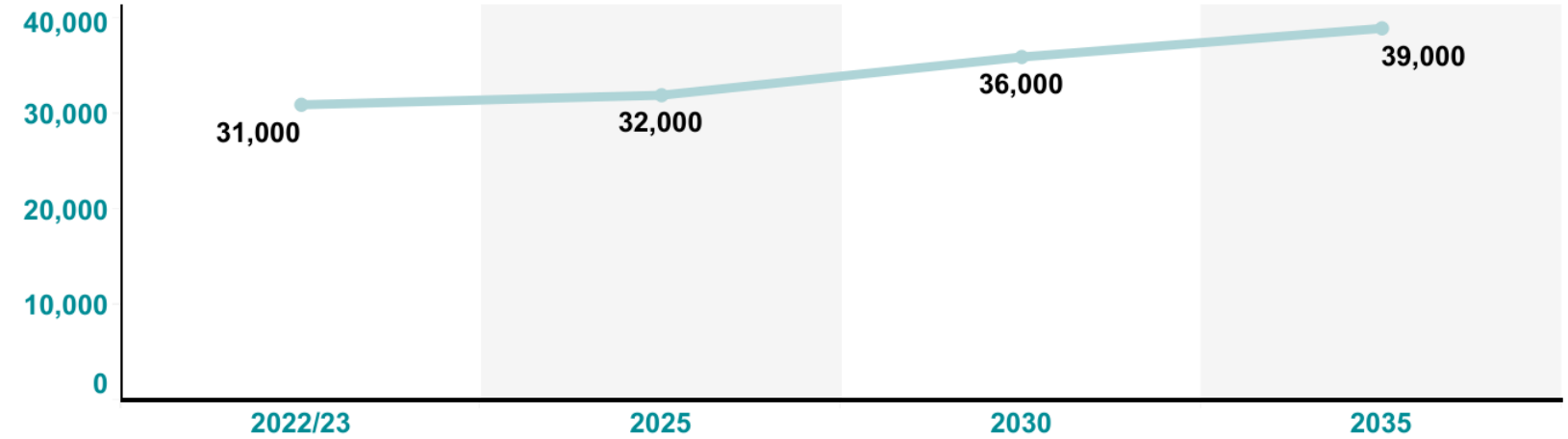
This model projects the size of the workforce if it grows proportionally to the number of people aged 65 and over in the population. Population information has been taken from *poppi.org.uk*. Please note that demand due to replacing leavers will be in addition to the figures shown below.

This workforce includes adult social care total posts employed by local authorities and the independent sector only.

If the adult social care workforce grows proportionally to the projected number of people aged 65 and over in the population then the number of total posts needs to **increase by +26%** (8,000 additional posts).

This would take the number of **total posts in 2035** to around **39,000**.

Projected number of total posts in adult social care required by 2035



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Agenda Item 10

Leicester, Leicestershire and Rutland

LEICESTER, LEICESTERSHIRE AND RUTLAND JOINT HEALTH SCRUTINY COMMITTEE: 18 DECEMBER 2023

LEICESTER, LEICESTERSHIRE AND RUTLAND ICB (LLR ICB) MEDIUM TERM FINANCIAL PLAN

REPORT OF THE LLR ICB CHIEF FINANCE OFFICER

Purpose of report

1. The purpose of this report is to inform the committee about the level of financial pressure facing the NHS in the medium term as published in our five-year plan. It also provides an update on pressures occurring in 2023/24 and outlines the likely impact of those financial pressures going forwards.

Policy Framework and Previous Decisions

2. This paper builds on the work published in the Leicester, Leicestershire and Rutland Integrated Commissioning Board (LLR ICB) 5 Year plan which can be found at the following links:
https://leicesterleicestershireandrutland.icb.nhs.uk/about/leicester-leicestershire-and-rutland-five-year-plan/

https://leicesterleicestershireandrutland.icb.nhs.uk/wp-content/uploads/2023/07/Chapter-6-Our-Finances-21072023.pdf

3. The overall plan was presented to the Leicester, Leicestershire and Rutland Joint Health Scrutiny Committee on 18th September 2023, the committee wanted to understand more about the medium-term financial plan and in particular:
   a. How we will manage our budget over the next few years;
   b. How inflation is applied;
   c. How population growth is accounted for;
   d. How and what level of efficiencies are we working to.

4. This paper attempts to answer all of the questions set out above

Background

Our Published 5 Year Plan:

5. Our strategy is underpinned by the following principles to ensure that a sustainable financial position is achieved:

a. Continuing to strengthen and ensure strong financial control across the health economy, and sharing openly and transparently our financial positions so we can best manage our finances collectively.
b. Ensuring we set aside sufficient funding to support activity growth and to cover the costs of inflation.
c. Productivity and efficiency must deliver at least 3% per year through moving to upper quartile in performance and elimination of waste.
d. Consider the total resource allocation of c.£2bn across LLR and not just the use of new growth funds coming to the system.
e. Evolve the role of partnerships to devolve resource through 'lead provider' collaborative arrangements as agreed for 'Urgent and Emergency Care'.

6. Inflationary costs built into the planning model, as per the following table, are comparable with previous years (although not in line with the increased and high levels of inflation experienced during 23/24).

Cost	Cost weight	Estimate
Pay	68.9%	2.1%
Drugs	2.3%	0.4%
Capital	7.1%	1.3%
Headline CNST*	2.1%	0.0%
Other	19.5%	1.3%
Total weighted		**1.80%**

7. Growth is factored into the model according to national NHS assumptions regarding different levels of growth across different sectors based on expected demographic need E.g. 2.3% Acute, 3.1% Community, 3.2% Mental health,6.2% CHC(incl. Inflation), 2.3% (incl. Inflation) Prescribing.

8. A small amount of funding has been set aside within the plan for investment each year which following appropriate prioritisation, will enable us to:
a. Invest wisely into programmes that can have a positive impact on our overall financial position and give the best value to our patients;
b. Ensure we invest into prevention as well as treatment;
c. Invest the areas where we can make a longer-term impact in terms of both patient /population and financial benefits;
d. Support specific schemes as outlined in each of the portfolios in the Medium Term Financial Plan (MTFP), the process for prioritisation and approval will be consistently applied through a Business Case and Benefits Realisation process;
e. Focus service reconfiguration to enable reduced demand and reliance on acute services with more resilience in out of hospital and community based services.

9. The scale of efficiencies over the next four years covering the medium term is c. £312m, equated to a yearly CIP target of 3% - this needs to be delivered recurrently to achieve financial balance as a system by 2027/28. **All of this is predicated on the 23/24 plan being the start point for planning and therefore requires re validation.**

2023/24 Financial Performance:

10. As the current financial year has progressed, we have faced several challenges to the in-year financial position which has had an adverse impact on the recurrent position going into the medium-term period, of c. £100m per annum.

11. The overall year-to-date (YTD) health system financial position is a deficit of £(70.9)m which is a £(41.3)m adverse variance against plan. We had planned to deliver a £(10)m deficit in this financial year which will not be achieved.

12. The most significant drivers of financial pressure beyond our plans relate to the following:
    a. Inflation; We have significant pressure across the full range of our costs related to inflation, this is most significant in terms of utilities and drugs costs and accounts for more than half of the pressure we are facing. Note: inflation related to pay has been much higher than anticipated but that has largely been funded.
    b. Urgent Care Demand and ensuring appropriate capacity; we have worked hard to improve performance related to urgent care including significantly reducing ambulance handover times at UHL, though the additional service capacity and resources we have needed comes at a significant cost. This includes additional ward capacity across the system (both physical and virtual), opening of additional capacity within the emergency department for swift ambulance handover and assessment, additional costs of patient transport to support discharges, additional capacity in primary care such as extended access.
    c. Demand increases in other services including Continuing HealthCare, prescribing, S117 shared care, and alternative hospital placements.

13. Although we have examined expenditure and considered (and implemented where appropriate) a range of actions, we are presently unable to fully mitigate the pressures we face. This is partly due to the ambitious financial plan we set at the outset; we did not hold a contingency and planned efficiency savings in excess of 5% of our budget (which we do expect to deliver in full).

Impact on our medium term plan

14. The impact of this on our medium-term outlook is that we are likely to need to deliver **at least 5% savings per annum** in order to deliver a return to recurrent balance over the next three years. This is a significant target and greater than the NHS has historically delivered (although it is in line with the level of efficiency savings / cost mitigations we are set to achieve in 23/24 albeit not all recurrent).

15. In order to deliver this level of efficiency on a consistent basis we need to adopt the approach described in the medium-term plan (as set out in paragraphs 5 and 8 above).

Resource Implications

16. The entirety of this report relates to NHS financial resources. It is not directly expected to impact on Local Authorities.

Timetable for Decisions

17. Work is in progress to update our medium-term financial plan as part of refreshing the 5-year plan. We will use plans currently being constructed for the financial year 24/25 as the basis for this plan and it is expected to be finalised in the first half of the 2024 calendar year.

Background papers

18. Our 5 year plan is published at the following link: *https://leicesterleicestershireandrutland.icb.nhs.uk/about/leicester-leicestershire-and-rutland-five-year-plan/*

Circulation under the Local Issues Alert Procedure

19. None

Equality Implications

20. The overall 5-Year Plan has not been subject to an equality impact assessment given its strategic nature. Any detailed service changes set to be undertaken in the planning period will be subject to Equality Impact Assessments (EIA) as necessary.

Human Rights Implications

21. There are no human rights implications arising from the recommendations in this report.

Other Relevant Impact Assessments

22. *Any detailed service changes set to be undertaken in the planning period will be subject to Quality Impact Assessments (QIA) as necessary (in addition to EIA as outlined above).*

Appendices

23. None

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Agenda Item 11

NHS
University Hospitals of Leicester
NHS Trust

LEICESTER, LEICESTERSHIRE AND RUTLAND JOINT HEALTH SCRUTINY COMMITTEE: 18 DECEMBER 2023

REPORT OF UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST

OUR FUTURE HOSPITALS PROGRAMME UPDATE

Purpose of report

1. The purpose of this report is to provide an overview and update of University Hospitals of Leicester NHS Trust's (UHL) 'Our future hospitals programme', a multi-million pound transformation of services that UHL is proud to provide to the diverse communities we serve.

Background

2. Recognising that there are new Committee members, we have provided some background to Our Future Hospitals Programme.

3. UHL is proud to provide high quality healthcare to the people of Leicester, Leicestershire and Rutland, enabling people to live full and fulfilling lives, contributing as they are able to our vibrant, diverse communities. However, healthcare needs are changing, with a growing and aging population, and increasing prevalence of long-term conditions. The Trust cannot continue to operate in its current format.

4. Medical and nursing resources are spread thinly, many buildings are not fit for the needs of modern healthcare and have significant and expensive maintenance requirements. We need to better integrate our services to provide more joined up care, and deliver care that is closer to home. This means we need to rethink how we provide healthcare across Leicester, Leicester and Rutland whilst remaining true to our unshakeable determination to provide care to all who need it.

5. Our ambition is to be leading in healthcare and trusted in communities. To achieve this, two of our priorities are to provide high quality care for all and to make UHL a great place to work. One of the ways we will achieve this is through Our Future Hospitals (previously known as Building Better Hospitals), a multi-million pound transformation of our services with funding from both the national New Hospitals Programme (NHP) and other NHS sources. (Further information on the national New Hospitals Programme can be found in Appendix One). This is a once-in-a-generation opportunity to create world class facilities and transform patient care for people in Leicester.

6. In September 2019, £450m funding was confirmed by the government to progress with this programme; following which a full public consultation process was undertaken in 2020.

A consulted programme of activity

7. The consultation process identified overwhelming public support for the proposals we made, covering the key areas below, which we now aim to complete by 2030:

- a new women's and family health hospital at the Leicester Royal Infirmary;
- a dedicated children's hospital at the Leicester Royal Infirmary;
- expanded intensive care facilities at the Leicester Royal Infirmary and Glenfield Hospital;
- the development of new facilities at Glenfield Hospital including new wards, theatres, and outpatient settings.

8. We remain committed to delivering our services across our three sites, with a main focus of providing complex and acute care at Leicester Royal Infirmary (LRI) and Glenfield Hospital, and high-volume low acuity services at Leicester General Hospital.

9. Further information on the consultation process is available on request.

Hearing and Balance services - Engagement

10. UHL provide Hearing services across 12 community locations (Melton Mowbray, Loughborough, Rutland, Coalville adults and paediatrics, Shepshed, Syston, Hinckley Hospital, Hinckley Lodge, Market Harborough, Braunston and Rutland), as well as Hearing and Balance services at the Leicester Royal Infirmary. Utilisation of community capacity is key to the strategy for the service, in order to ensure patients can receive the care they need closer to home. Patients need to come to the LRI if they require the Balance service, or if they choose to because it is their closest service.

11. The relocation of the LRI Hearing and Balance service was not a part of the acute and maternity Public Consultation completed in 2020, as at that point in time, there were no plans to move the service.

12. Since this time, work has progressed to review the scope of works for the LRI Enabling Project (that being the works required to prepare the LRI Site for the new women's and family health hospital), and it has become clear that there is a requirement to demolish the Hearing and Balance building on the LRI site. It is proposed that the service is moved to the Leicester General Hospital (LGH), forming a part of the East Midlands Planned Care Centre.

13. A patient engagement exercise has been completed, involving a survey of patients attending the LRI Hearing and Balance clinic, with staff proactively distributing questionnaires and supporting people with completion as necessary. The aim was to elicit service user opinion about the proposed service move, and to highlight any concerns.

14. Based on insights gained from this exercise, a number of key actions and recommendations have been noted, as follows:

    1. There is evidence from the survey that service users are not aware of community clinics (possibly due to repeat appointments being offered in the same location). As such, the service will work to publicise the alternative clinic locations for patients, in order to offer patient choice wherever possible and clinically appropriate.
    2. A satellite hearing booth will be built within the LRI ENT clinic, primarily to support inpatients onsite, however this could be accessed by other patients in exceptional circumstances.
    3. Car parking, public transport and the distance to the LGH featured in some patient responses. This has been noted, and will be factored into the Travel and Parking strategy for the LGH site.
    4. The Hearing and Balance service will continue to engage with service users as the project to move to the LGH develops, to allow a process of co-design within an appropriate scope of influence.

15. It should be noted that Balance clinics cannot operate in a community setting due to the fixed, specialist equipment involved, therefore all balance clinic patients will need to attend the LGH.

16. The proposal to move the service has been supported by UHL and Integrated Care Board (ICB) governance, and as such, will be progressed as a part of the LRI Enabling Project.

17. A full copy of the Report of Findings is available upon request.

Digitally enabled services supporting patients and clinicians

18. Digital has a positive impact in people's daily lives, and we aspire to replicate this in our services.

19. Through incorporating digital technology into Our Future Hospitals programme, care will be increasingly tailored to people's individual needs. Modern facilities will lead to more accessible and responsive care that keeps our diverse and growing population healthier for longer. Research will be fully embedded into clinical practice and settings to both ensure that patients benefit from the latest advances, and we grow the next generation of healthcare professionals.

20. Our future hospitals will embed mobile technology that eliminates paper records, enhances safety and saves time - improving patient experience. The new facilities will incorporate smart buildings, remote-monitoring devices and other new technologies that will radically improve care and outcomes.

21. Colleagues will have access to the up-to-date intelligence they need to provide high-quality care for every patient, every time. We will streamline systems, consolidate records and provide teams with comprehensive access to information - including data from connected medical devices and diagnostic equipment.

22. Real-time support from Artificial Intelligence (AI) decision support tools will enhance the care we provide. Patients will be able to access and contribute to their health records and make appointments that suit them through the NHS App.

Progress to date

23. The redevelopment of UHL is well underway, with over £200m investment made in our hospitals since 2017 enabling us to continue to make progress towards achieving the aims of our clinical strategy with the following projects:

- creation of two expanded critical care units at Glenfield Hospital and Leicester Royal Infirmary. The Interim reconfiguration project in summer 2022 moved HPB, Renal and Transplant inpatient services to Glenfield Hospital, and non-elective general surgery to Leicester Royal Infirmary.

- Children's services. All acute children's services are now located at LRI. Further work will consolidate all children's services at LRI into a refurbished Kensington Building.

- planned/emergency split: with the move of specialties to Glenfield Hospital and the provision of more specialist elective surgery there, and the development of the East Midlands Planned Care Centre at Leicester General, work continues to provide a split between emergency and elective work.

A summary of investment into UHL:

Year	Value	Project
- 2017	£13m	Vascular moves from LRI to Glenfield Hospital
2018	£50m	New Emergency Floor at the LRI
2019	£14.5m	East Midlands Congenital Heart Centre moved from GH to the LRI
2022	£31m	Interim ICU scheme: Level 3 ICU beds and associated services moved from the LGH to the LRI andGH
2023	£6.7m	Phase one of the East Midlands Planned Care Centre at LGH opened
2024	£40m	Phase two of the East Midlands Planned Care Centre at LGH to open
2024	£16.7m	New Endoscopy Unit at LGH to open
2024/25	£30m	Three new wards at Glenfield Hospital

Live Projects:

East Midlands Planned Care Centre - Leicester General Hospital

24. UHL has one of the largest and longest waiting lists in the country with a stark difference in health outcomes between the most and least deprived areas in one of the most ethnically diverse cities in the UK. To address this, we have been supported by NHS England to develop the East Midlands Planned Care Centre on the LGH site to offer additional ring-fenced capacity to protect planned care from emergency pressures, support the ongoing elective recovery and reduce long waits. The hub brings with it the flexibility to adapt to the changing needs of the LLR population.

25. Phase One of the Centre opened in May 2023. The development consists of the construction of two modular theatres to see high volume low acuity patients such as gall bladder removals (via key hole surgery), hernia repairs and minor urological procedures.

26. Phase Two is the refurbishment of the Brandon Unit. By the time Phase Two is fully open in late 2024, the Centre will see around 100,000 people each year, further reducing waiting lists and improving care and involves the refurbishment of the former Brandon Unit. This includes development of wards protected for patients on our waiting lists for inpatient and day case procedures. There will be fourteen outpatient rooms and four clean rooms as well as the modular theatres from Phase one.

Endoscopy New Build Unit - Leicester General Hospital

27. Also at the Leicester General and adjacent to the East Midlands Planned Care Centre, we are building a new specialist endoscopy unit. This is a dedicated facility that will see approximately 17,500 patients each year once it is open in late 2024.

28. The planning application has been submitted and is awaiting validation, with demolition work is planned to commence in January 2024.

Enabling works – Leicester Royal Infirmary and Glenfield Hospital

29. Whilst waiting for the NHP to confirm the funding envelope to progress the design of our new buildings, we have received funding from the NHP this year to prepare both the Leicester Royal Infirmary and Glenfield Hospital sites for our large-scale building works. This is an excellent sign of the support we have for our programme.

Leicester Royal Infirmary Enabling scheme: £41.8m

- The preparation of Knighton Street campus on the Leicester Royal infirmary site in readiness for the building of the new Women's/ICU Hospital. The business case will be made up of multiple elements, including:
    - extension of the Windsor Building with a multi-storey new build extension for Pharmacy, Clinical Genetics and Immunology
    - relocation of a range of offices, clinical services and research facilities within the LRI site
    - relocation of Education and Training
    - Hearing and Balance and Medical Records relocation
- Construction will start in 2025 and complete in 2026.

Glenfield Hospital Enabling scheme: £16.7m

- relocation of the ambulance drop off, bus/ cycle shelter
- diversion of main road
- re-provision of displaced car parking

Conclusion

30. Our Future Hospitals is a complex, highly integrated and multi-dependent project. Nonetheless, it represents a once in a lifetime opportunity to transform forever the care of our diverse communities across Leicester, Leicestershire and Rutland. We are relentless in our determination to bring this to fruition and look forward to keeping the Scrutiny Committee involved and informed throughout, and to working with our communities to deliver the care they need and deserve.

Appendix One

The New Hospitals Programme - the national approach

Our Future Hospitals sits within the delivery of a national programme of hospital developments, called the New Hospital Programme (NHP). This constitutes 48 new hospitals in five cohorts. Cohort 1 are already in construction, and Cohort 2 are agile small hospitals that are being expedited. UHL sits in Cohort 3 as one of eight new hospital developments, which are expected to start to deliver a standardised building approach, such as net zero carbon, a digital hospital, optimum space standards e.g. generic rooms and modern methods of construction. It is anticipated that savings can be achieved through this standardised approach, and construction times improved.

Design development on the main new buildings has been slowed down whilst the NHP develop the next iteration of their Programmatic Business Case, to strengthen the case to Treasury in justifying the strategic, financial and economic rationale of the national hospital building programme. The last iteration was approved by the government's major projects review group (MPRG) in March 2023; and is expected to be presented again in March 2024 in order to identify scheme specific detail on individual funding envelopes, and timescales for delivery for cohort 3 and 4 developments.

Since 2019, inflation and the need to deliver a standardised scheme (Hospital 2.0) including net zero carbon has increased the costs of the scheme, and we hope to understand our full funding envelope when this is approved in Spring 2024.

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