LeicesterCity Clinical Commissioning Group
West LeicestershireClinical Commissioning Group
East Leicestershireand Rutland Clinical Commissioning Group

NHS

Annual Report & Accounts

East Leicestershire and Rutland Clinical Commissioning Group

1 April 2022 - 30 June 2022

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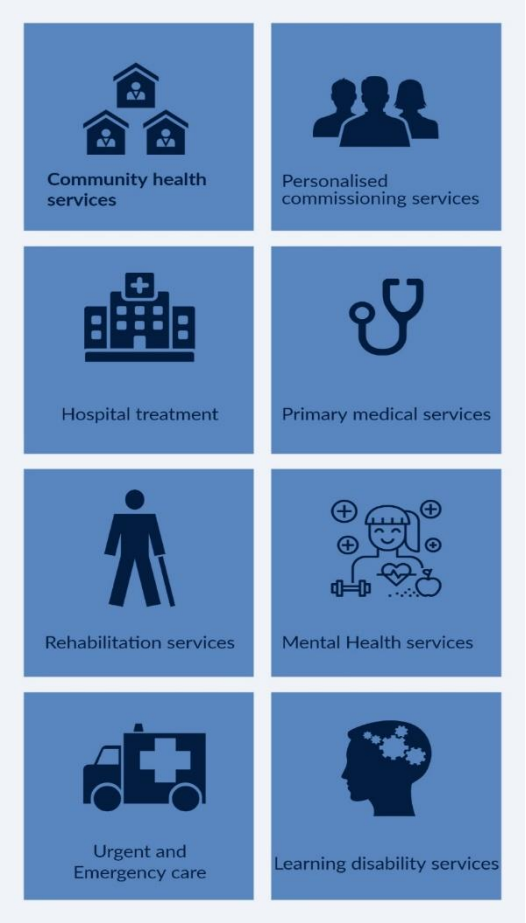
Contents

PERFORMANCE REPORT

Who we are and what we do?

NHS East Leicestershire and Rutland Clinical Commissioning Group (ELR CCG or CCG) was legally established in April 2013 under the provisions of the Health and Social Care Act 2012.



All 30 of our GP practices in East Leicestershire and Rutland are members of the CCG. The CCG Governing Body comprises GPs from member practices who represent their practice and locality to shape local healthcare for our registered population of over 342,300 patients (for further information about the Governing Body please see the Accountability Report).

For April 2022 to June 2022, ELR CCG was entrusted with an in-year allocation (our budget) of £129.4m with which to plan and buy the health services needed by people living in East Leicestershire and Rutland.

The services we are responsible for planning and buying include:

- hospital treatment
- rehabilitation services
- urgent and emergency care
- community health services
- personalised commissioning e.g. continuing healthcare, continuing care for children, funded nursing care, mental health after care
- primary medical services
- mental health services
- learning disability services.

We do not provide these services ourselves; we commission organisations to deliver them for patients on our behalf. We work hard to ensure services are delivered to the standards that we expect for our patients. We work very closely with all of these provider organisations to thoroughly scrutinise the care patients are receiving, identify any concerns at an early stage and help providers to improve the situation where standards may have fallen.

Objectives and strategy

Vision, values, and our strategic aims

Our vision, values and strategic aims are based on the views of our member practices, clinicians, our patients and carers, our staff and partner organisations. Over the years we have spent time talking and listening to people about the changes they would like to see in local healthcare and where we should be focusing our efforts. The development and implementation of our strategic aims and priorities are based on the Joint Strategic Needs Assessment (JSNA) and the Joint Health and Wellbeing strategies compiled in conjunction with Leicestershire County Council and Rutland County Council.

Our strategic aims

During the first quarter of 2022/23 our strategic objectives continue to reflect our alignment and collaboration across the three Leicester, Leicestershire and Rutland CCGs (LLR CCGs) (i.e. East Leicestershire and Rutland CCG, Leicester City CCG and West Leicestershire CCG) and the following strategic objectives were approved by the respective Governing Bodies in January 2021:

a) Increase the health outcomes of the Leicester, Leicestershire and Rutland population.
b) Reduce health inequalities across the Leicester, Leicestershire and Rutland population.
c) Reduce the variation in health outcomes across the Leicester, Leicestershire and Rutland population.
d) Deliver a sustainable system financial plan – ensuring funding is distributed to where services are delivered.
e) Deliver NHS Constitutional requirements.
f) Develop and deliver services with providers that are evidence based and offer value for money.
g) Deliver integrated health and social care.

We have developed comprehensive governance arrangements (see Accountability Report) which support the delivery of our strategic objectives and plans. This includes clear lines of accountability for delivery to ensure progress is made against our strategic aims and plans and risks are identified, monitored, and reviewed. The governance arrangements are regularly reviewed to ensure they remain fit for purpose to support the delivery of our strategic objectives. The CCG governance structure is as at Appendix 2.

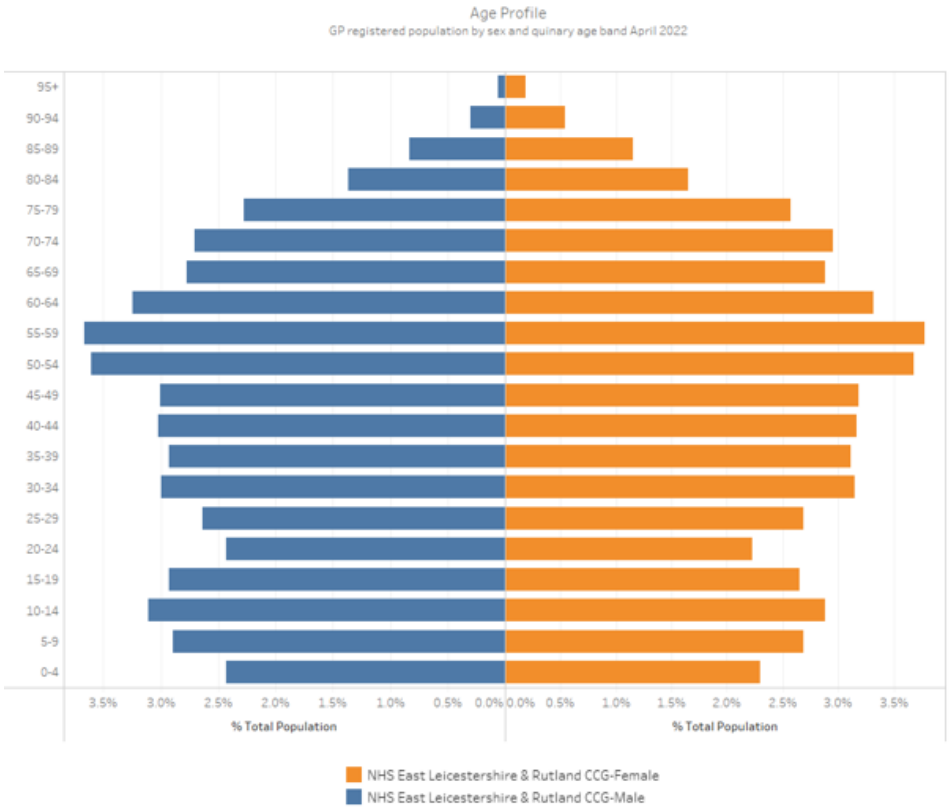
Our strategic priorities are also aligned to the priorities of the LLR integrated care system. Our strategy sets out a shared vision for delivery of integrated care focused on managing and improving population health; community based integrated health and social care; and acute provision no bigger than needed.

The CCG's strategic priorities are also aligned to the Joint Health and Wellbeing Strategies and integrated care system plans across Leicestershire and Rutland with an emphasis across the system on reducing health inequalities, reducing avoidable admission to hospital, redesign of alternative pathways and prevention of illness. We are a partner in the Leicestershire Health and Wellbeing Board and Rutland Health and

Wellbeing Board. Both of these Boards are responsible for overseeing the health and wellbeing of the population from health and social care perspective. Working in partnership, the CCG contributes to the wider health and wellbeing for the East Leicestershire and Rutland population.

Our population and their health needs

The following age profiles are shown for each CCG, with data for the male and female population



Across the area, there is notable variation in age, East Leicestershire and Rutland CCG has a growing and ageing population. Between 2018 and 2043 (25 years) it has been projected that the total population of East Leicestershire and Rutland will grow by 18.9% to 399,101:

- 103.8% increase in people aged 85 years and over
- 39.5% increase in people aged 65-84 years
- 9.7% increase in children and young people aged 0-24 years
- 11.2% increase in people aged 25-64 years

Source: ONS, 2018 based Subnational Population Projections for Clinical Commissioning Groups in England

Population health and life expectancy

The average life expectancy at birth in East Leicestershire and Rutland for 2015- 2019 was 81.2 years for men, and 84.8 years for women, both of which are higher than the England average of 79.7 years and 83.2 years respectively.

In 2020 the proportion of people aged 60 and over in East Leicestershire and Rutland was 28.8%, this is higher than the England average of 24.2%. Our older population is predicted to increase over the next 10 years, with an estimated 21,181 additional people aged 60 years and over. Of these 3,859 people will be aged over 85 years in Leicestershire and Rutland.

The total population of Rutland in 2020 is 40,476. There are more males than females in Rutland. The county has a higher proportion of over 65s and over 85s than the England average. Of the over 65 population 6.25% live alone (2,142) which is higher than the England average.

Just over a quarter of the population (25.6%) are over 65. The working age population makes up 53.3% of the total population. Children and young people in the 0-19-year age bracket make up 21.1% of the population.

The health of our local population is generally better than the overall population of England. However, in 2020/21 there were a large number of people affected by ill health, including GP diagnosed diabetes (19,381 people); which is a similar prevalence to England. Coronary heart disease (10,808 people) and hypertension (54,015 people) and cancer (12,587 people); all have a significantly higher prevalence than England.

Causes of death

E04a - Under 75 mortality rate from all cardiovascular diseases 2017 - 19 — Directly standardised rate - per 100,000

Area	Recent Trend	Count	Value	95% Lower CI	95% Upper CI
England	–	102,225	70.4	70.0	70.9
LLR	–	-	-	-	-
Leicester	–	684	101.6	94.0	109.6
Leicestershire	–	1,212	60.4	57.0	63.9
Rutland	–	53	43.6	32.5	57.2

Under 75 mortality rate from heart disease (Persons) 2017 - 19 — Directly standardised rate - per 100,000

Area	Recent Trend	Count	Value	95% Lower CI	95% Upper CI
England	–	54,258	37.5	37.1	37.8
LLR	–	-	-	-	-
Leicester	–	396	59.3	53.6	65.5
Leicestershire	–	627	31.2	28.8	33.7
Rutland	–	24	19.2	12.2	28.6

Under 75 mortality rate from stroke (Persons, 3 year range) 2017 - 19 — Directly standardised rate - per 100,000

Area	Recent Trend	Count	Value	95% Lower CI	95% Upper CI
England	–	17,804	12.3	12.1	12.4
LLR	–	-	-	-	-
Leicester	–	118	17.7	14.6	21.3
Leicestershire	–	212	10.6	9.2	12.1
Rutland	–	11	9.4	4.6	17.1

E05a - Under 75 mortality rate from cancer 2017 - 19

Directly standardised rate - per 100,000

Area	Recent Trend	Count	Value	95% Lower CI	95% Upper CI
England	–	187,314	129.2	128.6	129.8
LLR	–	-	-	-	-
Leicester	–	954	141.7	132.7	151.1
Leicestershire	–	2,344	117.3	112.6	122.2
Rutland	–	141	110.1	92.5	130.1

Under 75 mortality rate from breast cancer (3 year range) 2017 - 19

Directly standardised rate - per 100,000

Area	Recent Trend	Count	Value	95% Lower CI	95% Upper CI
England	–	15,060	20.3	19.9	20.6
LLR	–	-	-	-	-
Leicestershire	–	200	20.1	17.4	23.1
Leicester	–	67	18.8	14.5	23.9
Rutland	–	10	16.3	7.8	30.0

Under 75 mortality rate from colorectal cancer (Persons, 3 year range) 2017 - 19

Directly standardised rate - per 100,000

Area	Recent Trend	Count	Value	95% Lower CI	95% Upper CI
England	–	17,083	11.8	11.6	12.0
LLR	–	-	-	-	-
Leicester	–	82	12.4	9.8	15.4
Leicestershire	–	241	12.1	10.6	13.7
Rutland	–	12	9.4	4.8	16.5

Under 75 mortality rate from liver disease (Persons, 3 year range) 2017 - 19

Directly standardised rate - per 100,000

Area	Recent Trend	Count	Value	95% Lower CI	95% Upper CI
England	–	27,293	18.8	18.6	19.0
LLR	–	-	-	-	-
Leicester	–	146	20.3	17.1	23.9
Leicestershire	–	291	15.0	13.3	16.8
Rutland	–	17	13.9	8.1	22.3

Under 75 mortality rate from respiratory disease (Persons, 3 year range) 2017 - 19

Directly standardised rate - per 100,000

Area	Recent Trend	Count	Value	95% Lower CI	95% Upper CI
England	–	48,773	33.6	33.3	33.9
LLR	–	-	-	-	-
Leicester	–	284	43.3	38.4	48.7
Leicestershire	–	518	25.6	23.4	27.9
Rutland	–	20	14.6	8.8	22.6

Under 75 mortality rate from injuries (Persons) 2018 - 20

Directly standardised rate - per 100,000

Area	Recent Trend	Count	Value	95% Lower CI	95% Upper CI
England	–	21,435	14.4	14.2	14.6
LLR	–	-	-	-	-
Leicester	–	149	17.5	14.7	20.6
Leicestershire	–	253	13.3	11.7	15.0
Rutland	–	11	10.1	5.0	18.0

Source: Office for Health Improvement & Disparities. Public Health Profiles. [09/05/2022] https://fingertips.phe.org.uk © Crown copyright

Mortality rate for deaths involving COVID-19, under 75s (Persons) 2020

Directly standardised rate - per 100,000

Area	Recent Trend	Count	Value	95% Lower CI	95% Upper CI
England	–	19,353	39.2	38.6	39.7
LLR	–	-	-	-	-
Leicester	–	209	90.8	78.8	104.0
Leicestershire	–	189	27.5	23.7	31.7
Rutland	–	5	*	-	-

Source: Office for Health Improvement and Disparities, based on Office for National Statistics (ONS) data [11/05/22] https://fingertips.phe.org.uk © Crown copyright

There are variations for mortality rates from differing causes across the LLR area with Leicester City having significantly worse mortality compared to Leicestershire and Rutland for the following causes:

- Cardiovascular diseases
- Heart disease
- Stroke
- Cancer
- Respiratory disease
- Injuries
- Covid-19

Nationally and locally, there is variation across life expectancy for males and females. Males have higher mortality rates across all causes compared to females (breast cancer mortality only examines females).

There are variations for life expectancy across the Leicester, Leicestershire and Rutland area, with Leicester City having significantly lower life expectancy compared to the national average of Leicestershire and Rutland. Although it is important to note that health inequality is relative and exists on a gradient in all parts of the region. There are examples of inequality of outcomes in the counties as well as the city.

A01b - Life expectancy at birth (Male, 1 year range) 2020

Life expectancy - Years

Area	Recent Trend	Count	Value	95% Lower CI	95% Upper CI
England	–	-	78.7	78.6	78.7
LLR	–	-	-	-	-
Rutland	–	-	83.3	81.7	85.0
Leicestershire	–	-	79.9	79.5	80.3
Leicester	–	-	75.0	74.3	75.7

A01b - Life expectancy at birth (Female, 1 year range) 2020

Life expectancy - Years

Area	Recent Trend	Count	Value	95% Lower CI	95% Upper CI
England	–	-	82.6	82.6	82.7
LLR	–	-	-	-	-
Rutland	–	-	84.9	83.3	86.5
Leicestershire	–	-	83.7	83.4	84.1
Leicester	–	-	80.4	79.8	81.0

Source: Office for Health Improvement & Disparities. Public Health Profiles. [09/05/2022] https://fingertips.phe.org.uk © Crown copyright

Further information can be found within the Rightcare Health Equality and Inequality report:
https://www.england.nhs.uk/about/equality/equality-hub/equality-and-health-inequalities-rightcare-packs/

The Public Health England review of disparities in the risk and outcomes of Covid-19 shows that there is an association between belonging to some ethnic groups and the likelihood of testing positive and dying with Covid-19. Genetics were not included in the scope of the review.

An analysis of survival among confirmed Covid-19 cases showed that, after accounting for the effect of sex, age, deprivation and region, people of Bangladeshi ethnicity had around twice the risk of death when compared to people of White British ethnicity. People of Chinese, Indian, Pakistani, Other Asian, Caribbean, and Other Black ethnicity had between 10 and 50% higher risk of death when compared to White British. Death rates from Covid-19 were higher for Black and Asian ethnic groups when compared to White ethnic groups. This is the opposite of what is seen in previous years, when the all-cause mortality rates are lower in Asian and Black ethnic groups.

In summary identified at risk groups include:

- Age – over 80s more likely to die
- Males higher risk
- Black and Asian Minority Ethnic (BAME) groups
- Those working in certain professions – caring/transport/security guards
- Deprivation – higher diagnosis and health rates in areas of high deprivation
- People experiencing homelessness and living in care homes
- People with multiple long-term conditions
- People with a learning disability
- Geography – London has highest death rate.

Within Leicester, Leicestershire, and Rutland

- Within LLR, the area with the highest rate of cumulative COVID-19 cases for the whole of the pandemic is Leicester (34,090.6 per 100,000 population), reflecting higher levels of deprivation, BAME population and care home/nursing beds and higher rates of respiratory conditions. The rate is 33,192.5 per 100,000 population for Leicestershire and 29,128.4 per 100,000 population for Rutland.
- Although Leicestershire and Rutland have higher proportions of older people within their populations, these areas also have lower levels of deprivation, smaller proportions of BAME residents and lower rates of respiratory diseases.
- Across LLR there was variation in the mortality rate for deaths involving COVID-19 in 2020. Leicester City had a significantly higher (worse) COVID-19 related mortality rate (210.6 per 100,000 population) compared to Leicestershire (122.0 per 100,000 population) and Rutland (68.2 per 100,000 population) (as referenced above).
- The number of COVID-19 related deaths occurring in care homes between 10th April 2020 and 13th May 2022 are higher in Leicestershire (407) than Leicester (203) or Rutland (26). This is expected, given the larger older population present in Leicestershire.

Deprivation
Leicestershire as a whole is not particularly deprived being ranked 137 out of 152 upper tier authorities. Despite this there are some pockets of significant deprivation for a small proportion of the overall population. In ELR CCG only a small proportion of people live in deprivation when compared to other parts of England. Within the CCG, there are areas that have poorer health outcomes. The main area affected is Oadby and Wigston. In one small area of Oadby and Wigston for example, residents have a higher rate of mortality from all causes and a significantly higher rate of mortality from respiratory diseases when compared to the England average. The CCG is working with the Public Health Team within the local authorities and local stakeholders, including Oadby and Wigston Borough Council, to identify collectively how to reduce the health inequalities.

Evidence suggests that the most effective way to reduce the gap in life expectancy in the short term is to improve the management of diseases (including cardiovascular disease (CVD) and chronic obstructive pulmonary disease (COPD) and their risk factors, including smoking, alcohol, hypertension and diabetes that disproportionately affect people who are socially excluded. There were 5,568 deaths in Leicestershire in under 75s, between the years of 2017-2019, covering all causes. Cancer, CVD, and respiratory disease accounted for 73.3% of these deaths. Many of these deaths could have been avoided through earlier diagnosis and better treatment. This has directly influenced our clinical work in relation to diabetes, cardiovascular disease, COPD, dementia, access to primary care services and mental health.

Legal duties

We have embraced our legal duties in the delivery of our vision and strategic aims. The CCG has a legal responsibility to involve and inform patients and members of the public by ensuring that involving, listening to, and acting on the views of local people are at the heart of delivering our vision for local healthcare. This commitment also extends to other legal duties placed upon the CCG, including duty to improve quality; duty to reduce inequalities and contribute to, and delivery of joint, the health and wellbeing strategy; and compliance with the Equality Act 2010. Further information detailing how we have complied with some of our key legal duties is available within this Annual Report and through our Governing Body reports.

Our role

Our key role is to commission, or buy, health services on behalf of our local population. As a clinically-led organisation we take pride in the ability to shape our local healthcare and look for opportunities to help our population take greater responsibility for their own health, manage existing conditions better and reduce the impact that factors such as smoking, poor diet and lack of exercise may have on their health in the future. We want our patient population to receive the best possible quality of care.

As we do not deliver health care services ourselves, it means we are able to make sure that those services are delivered to the standards that we expect for our patients, independently. We work very closely with all of the provider organisations to thoroughly scrutinise the care patients are receiving, identify any concerns at an early stage and help providers to improve the situation where standards may have fallen. The feedback that patients provide is extremely valuable to us in being able to carry out this element of our role.

The CCG works with partner organisations to agree an approach for an area of work for the benefit of patients and the entire health and social care system. Although the picture of healthcare providers is becoming more complex, we offer patients a wider choice of organisations to provide their care. The local services we commission are mainly provided by the following providers:

- **Primary medical care and General Practitioners**
  Since April 2015 our CCG has had full delegated authority from NHS England for funding the core activities of GP Practices for primary medical care commissioning. Primary care is the corner stone of the NHS and it is where the majority of the public make first contact with the NHS. It is recognised that despite the increasing pressures in primary care, our general practices have delivered and continue to deliver an excellent service and quality of care for our patient population, this is evident in our achievements during 2021/22 and continued in quarter one of 2022/23.

- **Primary Care Networks (PCNs)**
  From 1st July 2019, GP practices began working in groups with other GP practices in the local area, as well as other health, social care, and voluntary sector organisations. These groups are known as primary care networks. Together they decide what services they are going to provide for their local patients to prevent and manage ill-health. One of the key successes during 2021/22 has been the successful implementation of the Covid-19 vaccination programme with support from the PCNs, which continued into 2022/23.

- **University Hospitals of Leicester NHS Trust (UHL)**, which provides acute hospital services at three sites in Leicester and in local community hospitals. UHL provides secondary care to a catchment area of approximately one million people and specialised services for up to three million people. It is one of the largest acute trusts in the country.

- **Leicestershire Partnership NHS Trust (LPT)**, which provides mental health and learning disability services and manages most of the community-based teams serving ELR CCG and is a key provider at the six community hospitals.

- **East Midlands Ambulance Service NHS Trust**, which provides emergency 999 and urgent care crews across Derbyshire, Leicestershire, Rutland, Lincolnshire (including North and North East Lincolnshire), Northamptonshire and Nottinghamshire.

- **Derbyshire Health United,** which provides the NHS 111 service, out of hours service and some evening and weekend GP cover, urgent care services.

- **Vita Health Group**, which has provided our Improving Access to Psychological Therapies (IAPT) provision since 1 April 2021.

We also commission acute services from out-of-county NHS trusts and a range of independent sector providers such as Spire Leicester Hospital, Nuffield Leicester Hospital and Circle Nottingham Treatment Centre.

We continued to commission and fund personalised packages of care where our patients were eligible for mental health aftercare and continuing health for adults and children.

Furthermore, we awarded a number of grants to various voluntary sector organisations across Leicester, Leicestershire, and Rutland to support our patient population.

We continued to work with our colleagues from Leicester City CCG and West Leicestershire CCG in the management of these contracts. We also work collaboratively with other coordinating commissioning bodies outside of Leicester, Leicestershire, and Rutland on a small number of contracts, for instance, Derby and Derbyshire CCG that manages the East Midlands Ambulance Service Contract on behalf of the CCGs across the East Midlands.

Wider Partnership Working

In LLR, we have a long history of working together, as a system. During April to June 2022 this continued to grow from strength to strength as we progressed in earnest our transitional programme towards becoming an integrated care system (ICS) and preparing to establish an Integrated Care Board as a legal body and also establishing an integrated care partnership in conjunction with our Local Authority partners.

Our experience from the Covid-19 pandemic has shown us that, when we all act together, as health and care partners, we can achieve much more. We plan to work even closer together, in order to improve health and care outcomes, as well as reduce health inequalities in Leicester, Leicestershire and Rutland. We have developed plans to do this as an ICS and we have agreed a system-wide vision, as follows:

The CCGs have developed nine design groups. One of the main areas where non-face to face work has been beneficial for the LLR performance position is in elective care. The reduction in travel will support the NHS Green agenda and the NHS ambition to provide high quality care for all, now, and for future generations. One of the key areas of focus has been on restoration and recovery of services following the pandemic, particularly in relation to elective care. The elective care design group has evolved into operating as a

collaborative to enable partners across Leicester, Leicestershire and Rutland to work together to reduce waiting lists for elective care.

We continue to implement shared priorities for health and social care integration through Better Care Funds in conjunction with West Leicestershire CCG, Leicestershire County Council and Rutland County Council. This work is strengthening our joint commissioning and working arrangements to deliver integrated care for older people and supporting people with long term conditions (LTCs). This is particularly crucial if our CCG is to meet its financial challenges through the transformation of care systems and improve the quality of healthcare across all our providers.

Partnership working is vital to East Leicestershire and Rutland CCG and it is the best way to bring about many of the changes we wish to see implemented. We actively engaged with partner organisations to build on existing relationships, and developed new and improved relations with clinicians, patients and carers, public members, staff, partner organisations, including local authorities, and other commissioning agencies.

Better Care Fund

The Better Care Fund continues to be a critical enabler to take forward the integration of health and care services. From April 2022 to June 2022 our contribution to the Leicestershire Better Care Fund (£4.8m) and Rutland Better Care Fund (£0.7m) enabled care to be jointly commissioned locally on health and care to drive better integration of health services and improve outcomes for patients, service users and carers.

Health and Wellbeing Boards

We are an active member of both the Leicestershire Health and Wellbeing Board and the Rutland Health and Wellbeing Board which provide leadership and champion opportunities to improve health and wellbeing outcomes for everybody in Leicestershire and Rutland. Key areas for improvement are detailed within the Performance Analysis section of this report.

Public Health

We work closely with our public health colleagues, who are based within the local authority, to implement the actions within the Health and Wellbeing Strategy. A member of the public health team also sits on our Governing Body to further enhance our collaborative working.

Healthwatch

We have strong links with Healthwatch Leicester and Leicestershire and Healthwatch Rutland, the statutory organisations created to gather and represent the views of the public.

A representative is invited to join our Governing Body meetings and representatives are involved in project groups to support the review, development and implementation of programmes and projects, to support service changes. Representatives of the CCG attend Healthwatch meetings to give presentations and provide updates on priorities.

Emergency Preparedness, Resilience and Response (EPRR)

The CCG is heavily involved in the wider public-sector resilience requirements as a core member of the Leicestershire and Rutland Local Resilience Forum (LRF) “LLR Prepared,” the Local Health Resilience Partnership Executive Group (LHRP), and the Strategic

Coordinating Group (SCG). These groups were established to support the requirements of the Civil Contingencies Act 2004 (CCA) to identify local risks to public services, ensure that the appropriate contingency plans and control measures are in place, and to assure aligned communications and actions across geographies at times of extreme pressure and/or major incidents.

System resilience and incident response for LLR is managed through clear command and control structures. Health planning and resilience arrangements are led by the Health Economy Strategic Co-ordinating Group and the wider Local Resilience Forum response including police, fire, public health, and local government

We have presented regular reports to the Governing Body in relation to our response to Covid-19 and actions taken and being taken.

Priorities for 2022/23

In 2022/23, will we ensure a seamless and robust transition into the new statutory body, NHS Leicester, Leicestershire and Rutland Integrated Care Board commencing from July 2022.

Our commissioning priorities for 2022/23 will include restoration and recovery of services following the Covid-19 pandemic and a focus on supporting our workforce.

As a new statutory body, we will endeavour to continue our commitment to delivering the pledges in the NHS Constitution and enhancing opportunities to achieve this by working in close partnership with our colleagues and stakeholders across LLR. We will learn from our experiences following the pandemic to support continuous quality improvements in the services we commission. 2022/23 will bring more opportunities to work with our partners and providers to collectively gain a deeper understanding of the root causes of underperformance and to support appropriate and targeted corrective action as a system. We will also continue to work hard to reduce health inequalities, improve the health outcomes for our population, and improve patient experience.

Andy Williams
Accountable Officer

Performance Overview

This performance overview is designed to provide you with enough information to understand more about our organisation, our purpose, the key risks, and challenges to the achievement of our objectives and how we have performed during the first quarter of 2022/23. Further information is available in this section of the Annual report, in the section on Performance Analysis, and within reports presented to the Governing Body. It is impossible to highlight all our key achievements and successes and also areas that require further improvement, a detailed review was contained within our Governing Body papers as was published on the CCG website.

The last year has been a challenging one, with continued focus on the NHS response to the Covid-19 pandemic, successful implementation of the national vaccination programme across Leicester, Leicestershire, and Rutland (LLR) and restoration and recovery programme for elective care. We have continued to ensure we keep patients firmly at the centre of our plans, and we have been focused on doing what is best for our patients and ultimately to save lives by working in partnership through a multi-agency approach.

The extraordinary effort and sustained response from the NHS has been admirable. However, we have recognised that this has come at a cost including disruption in elective care and the extreme pressure on our staff and staff across partner organisations. The health and care system partners have worked and continue to work together, to maintain as many services as possible and create capacity to manage the care of people with Covid, while minimising the impact on routine care and those with urgent non-Covid treatment needs. This has involved rapid transformation, integration and innovation including online and video consultations to support patients to safely access advice and treatment, redesign of clinical pathways, and the rapid mobilisation of the vaccination programme.

Our staff have continued to embrace working remotely throughout the last year and worked incredibly hard to ensure we continued to support the response to Covid-19 as a system across Leicester, Leicestershire and Rutland (LLR), and to operate business as usual the best we could during these difficult times.

Collaboration amongst the three CCGs across LLR has grown from strength to strength with strong emphasis on collaborative clinical leadership, enhanced scrutiny from our lay members, and strong executive leadership from our executive management team. Our ability to respond to the pandemic would not have been possible without the continued effort and effective collaboration and partnership working both within the NHS and with other public, private, and voluntary sector organisations. Thank you to all our NHS colleagues and local partners across LLR for their continued contributions, commitment, and support through these challenging circumstances.

Although we have not met all the performance standards and targets expected over the last year and in the first three months of 2022/23, the achievements we have made, some of which are highlighted in our Annual Report, are a testament to the continued efforts and commitment of our staff and clinicians.

The impact of Covid will be felt well after the immediate pressures have abated. During the year we saw extra demands on health services, and this is being factored into our

operational planning as we continue to implement the NHS Long Term Plan next year and beyond. The ongoing restoration and recovery work will be critical to defining priorities going forward and, while some of the strategic clinical and financial priorities will continue as before, some may need to be re-orientated as changing needs and inequalities become clearer. The impact of Covid on waiting time for services, for example, elective acute, mental health and screening services waiting times will all need to be assessed and prioritised. As the system implements its restoration and recovery programme, we have been considering how, as partners, we best work together to deliver on aim of population health management and also deliver on our locally agreed strategic principles and objectives.

In 2021/22 and during April to June 2022, there was broad progress in delivering the NHS Long Term Plan, despite continuing and intense operational pressure. Some of the key areas to highlight this year include the following:

a) **Integrated Care System (ICS) and Integrated Care Board (ICB) -** in March 2021, NHS England approved our application for Leicester, Leicestershire, and Rutland to be authorised as an integrated care system. In preparation for this authorisation, we secured support from our system partners and established system-wide governance arrangements and appointed an independent Chair for our integrated care board. Integrated care systems are partnerships that bring together providers and commissioners of NHS services across a geographical area with local authorities and other local partners to collectively plan health and care services to meet the needs of their population. The central aim of ICSs is to integrate care across different organisations and settings, joining up hospital and community-based services, physical and mental health, and social care.

b) **Implementation of the national Covid vaccination programme -** the COVID-19 vaccination programme is the largest in British history and was established and implemented with unprecedented speed thanks to effective partnership working across the local health system. Locally we led on the successful implementation and roll-out of the vaccination programme. Vaccine centres were set up rapidly across LLR at GP practices, Leicester's hospital sites, community pharmacies, local leisure and community centres, places of worship and other local venues.

c) **Building Better Hospitals for the Future** – the three LLR CCGs led on the public consultation, in conjunction with University Hospitals of Leicester NHS Trust, proposing £450 million improvements to transform our acute and maternity services at Leicester's hospitals. During 2021/22 we reviewed the outcome of the public consultation and approved the plans to move forward with this transformational programme. Further details can be found on our website.

d) **'Step Up to Great' Mental Health services** – in conjunction with Leicestershire Partnership NHS Trust, the three LLR CCGs led on the public consultation which focused on improving the way adult mental health care is delivered across Leicester, Leicestershire and Rutland. The public consultation commenced in May 2021 for a period of three months. Details of the consultation can be found on the CCG website. Following the consultation, a number of improvements have been proposed to improve the services and outcomes for our patients, including an increase in the number of Crisis Cafes in community locations to offer a safe space where people can get help if they are experiencing a mental health crisis.

e) **Communication and engagement** - during 2021/22 and the first quarter of 2022/23, we have continued to engage with our communities with key information and updates supporting the response to the Covid pandemic, including leading a system-wide communications strategy across Leicester, Leicestershire and Rutland (LLR). The CCGs' played a pivotal role in supporting public health messaging on the importance of vaccinations as the programme gradually unfolded, promoting eligibility, information on where to get vaccinated, and other changes to Covid restrictions. This involved close collaboration with local partners such as the Leicestershire Local Resilience Forum (LRF) and leaders of diverse communities, ensuring messaging was through a variety of media including social media campaigns, public-facing webinars and regular updates and by issuing corporate information in various languages and formats. These ranged from weekly stakeholder newsletters to digital video content, social media graphics and the promotion of daily Covid vaccination walk-in clinics.

   During the last year, the focus has also been on supporting system restoration and recovery. Complementing the prolific activities around the pandemic and vaccination programme, we continued to provide regular support across other programmes, including cancer concerns and highlighting the importance of screening. A major challenge was urgent and emergency care. Attendances at A&E reached record levels at times throughout the year, and we worked in conjunction with NHS England / Improvement to target communications through a leaflet drop raising awareness of NHS 111. The aim was to promote the service as the first point of contact for urgent care needs.

f) **Agile working arrangements**
   As a direct response to the Coronavirus pandemic and to ensure the ongoing safety of our workforce, the CCG asked all staff to work from home. In April 2021 we commenced a consultation process with staff about proposals to change the majority of employees' contractual base to home and the likely closure of two of three CCGs' bases. We received over 400 lines of feedback which was summarised into six themes. In August 2021, we confirmed the outcome of the consultation process which was to promote agile working rather than being based at home and retain a contractual office base with the flexibility to work from home, with no requirement to travel to work for routine meetings and meetings that can happen remotely. We continue to embrace agile working and attend a work location for business activities that cannot be carried out remotely which includes connecting with colleagues, team development and project working.

g) **Office accommodation** – as staff embraced working remotely and with our commitment to the NHS Green Plan, we reviewed our office accommodation across the three CCGs and agreed to vacate two of the three offices and retain a single office co-located with the Leicestershire County Council at County Hall in Glenfield in Leicestershire. Going forward as an ICB and as an integrated care system we aim to build on our draft NHS Green Plan to ensure we have a comprehensive plan on building on our current achievements and delivering our commitments including estates and facilities, medicines, digital transformation etc.

There have also been a number of key challenges:

i. **Covid-19 Pandemic (Coronavirus)** - in early March 2020, the World Health Organisation declared a global pandemic as the number of confirmed cases began to rise rapidly outside China and across the world. Across the UK a level four national emergency was declared, and this led to increased levels of planning and operational activity in all regions across the country, with a particular emphasis placed on preparing the NHS for increased demand. Across LLR, a multi-agency response team was established, and preparations began with the mobilisation of our emergency planning, resilience and response systems and processes. During April to June 2022, the CCG continued to play a key role in leading and coordinating the local NHS response in accordance with national guidance and response efforts.

ii. **We continued implementation of our home working arrangements** for our staff and we continued to work from home to support the national response to the pandemic and embraced the new ways of working. Working from home presented some challenges whilst continuing to ensure continuity of operational business, however we continued to provide services for our patients. In addition, many of our clinical staff were mobilised to support partners and the front line in areas of infection control, testing centres and other clinical roles as required.

iii. **Performance against national targets and standards** - there is no doubt that this past year continues to present us with unprecedented challenges. The Covid-19 pandemic has had a major impact on the NHS resulting in unprecedented emergency response, impact on elective services for our patients and also delayed ambulance handover times. Detailed reports on our performance are presented to the Governing Body on a regular basis and can be found in our Board papers on our website. An example of the report is as at Appendix 1 which provides more detail on the standards and targets we have achieved and areas that require more work over the next year.

iv. **Financial performance and risk** – we continued to work across the integrated care system which has enabled a more collaborative approach to financial management and value for money. Specific details on financial performance are detailed within the Performance Analysis section of the report.

Looking ahead to 2022/23

During the last year we have learnt a lot from adopting and embracing different ways of working remotely; and delivering through better and robust systems and processes and testing them as we have done through our emergency planning processes. Our achievements and successes have been a result of better and stronger collaborations with our partners, including GP Practices, NHS providers, Local Authorities, and voluntary sector organisations to enable delivery of improved outcomes for our patients and population and reducing health inequalities.

It has been a privilege to have worked alongside, and to have been part of, a Governing Body with dedicated and passionate clinicians, lay members and executives. I would also express my gratitude to all our staff and clinicians who have worked incredibly hard to ensure that we continue to strive towards improving the quality of care and better outcomes for our patients even during the most challenging of times.

We have used lessons learnt from the previous year and also some of the transformational opportunities such as better use of digital innovation and technology, changes to clinical pathways and alternative ways of working to enable us to efficiently work through the plans for restoring and recovering our services with our partners.

Collaboration and partnerships continued to drive the approach across our system for the first quarter of 2022/23 until the CCGs disestablished. On establishment the Integrated Care Board will continue this approach and work closely with partners within the integrated care system, and with neighbouring integrated care systems, to deliver joined up care and better outcomes for our patient population. Striving for better clinical outcomes for our patients will remain at the heart of the Integrated Care Board's priorities going forward.

In 2022/23 we will continue to strengthen our relationship with our partners and build on the developments of the CCG as we transition towards becoming an Integrated Care Board and continuing to operate within an Integrated Care System.

There is no doubt about the significant scale of challenge in front of us in 2022/23 as we work to enable our services to restore and recover from the pandemic, and also as we transition into the new legal body, ensuring business as usual and improving the services for our patients whilst achieving better value for money. Being part of our integrated care system means that there are many exciting opportunities to develop the health and social care of our population. We will also be exploring opportunities for commissioning at scale on a regional footprint with neighbouring integrated care boards and integrated care systems.

As we continue through these challenging times, we commend all our staff, NHS colleagues and local partners across LLR for their continued contributions, commitment and support for it is a testament to their continued commitment that we have been able to achieve the improvements and tackle the challenges outlined in our Annual Report.

Andy Williams
Accountable Officer
26 June 2023

Performance Analysis

This section describes how the CCG's performance is measured and analysed. It describes some of our key performance achievements and challenges over the last year. Monitoring our performance and identifying and mitigating risks are key in enabling the CCG to achieve its strategic objectives and legal duties.

Strategic risk management

The CCG is committed to commissioning safe and effective care and leading the organisation to deliver its objectives. We have used our risk management strategy and policy to lead the organisation forward to deliver our objectives. Risk management is a core organisational process and is integral part of our philosophy, practices and business planning and that responsibility for its implementation is accepted at all levels of the organisation.

Risk can bring with it positive advantages, benefits, and opportunities. We have aimed to create an environment where risk is considered as a matter of course and appropriately identified and managed. A culture of open reporting has been promoted throughout the CCG to ensure risks are identified, evaluated, documented, and managed by all who may encounter them.

We have continued to work closely with our partners across the integrated care system in involving them with identifying, prioritising, mitigating and controlling shared risks. This will be a critical aspect to build on for the new Integrated Care Board when it is established in July 2022.

The Accountability Report provides further detail about how we identify and manage risks currently and Appendix 7 details the strategic risks as at 30 June 2022.

Our performance

National and local standards

One of the key areas of focus for the CCG is to make sure the resilience of the local health and care system is maintained, while meeting national and local standards. The NHS Constitution established the principles and values of the NHS in England. It sets out rights to which patients, public and staff are entitled, and pledges which the NHS is committee to achieve. The national standards are outlined in the NHS System Oversight Framework 2021/22 and includes measures such as the time it takes to get treatment, waiting times in the emergency department and cancer waiting time standards.

We continue to be committed to delivering the pledges in the NHS Constitution and to enhancing opportunities to achieve this by working in close partnership with our partners and stakeholders across LLR. This commitment is evident in our strategic objectives and in our pursuit for performance improvement as detailed in the Performance Analysis section of this report.

In our pursuit to achieve these standards, we have a duty to improve the quality of the services we commission, to provide information on the safety of services provided and to reduce health inequalities. Our mechanism for regularly reviewing our performance is through our performance framework that identifies standards that we have achieved and standards where further actions are required into to meet the requirements. Appendix 1 illustrates the types of reports we generate, once we have analysed the data, to take a closer look at our performance across specific areas of risk.

We have contracts in place with our providers, including a series of performance and quality indicators, to ensure that delivery against priorities can be measured and accounted for. During 2021/22 and quarter 1 of 2022/23 performance has not been at the level that the CCG expects across a number of areas in the main due to the impact of the Covid-19 pandemic. The main provider where performance has been a challenge is University Hospitals of Leicester NHS Trust (UHL) where we commission the majority of acute services for our patient population. The challenges faced by UHL have also seen an impact on the performance of East Midlands Ambulance Service (EMAS) across our region with the increase in ambulance handover delays.

The quality and safety of the care the CCG commissions is pivotal to achieving our strategic objectives and therefore the risk of being non-compliant with specific standards such as ambulance handovers was escalated to the Board Assurance Framework as detailed in Appendix 7,

We have continued to challenge performance below expected standards through a number of routes, including contractual meetings. A more collaborative approach has been favoured during the last year to enable performance risks and mitigations to be explored and reviewed in conjunction with partner organisations in our integrated care system. This has enabled actions and mitigations to be explored across both health and social care.

Assurance on how well we are doing

The NHS System Oversight Framework 2021/22 informs the assessment of CCGs. It is intended as a focal point for joint work, support and dialogue between NHS England, NHS Improvement, CCGs, providers and partners across integrated care systems.

The NHS System Oversight Framework comprises a set of indicators and metrics aligned to priority areas in the NHS Long Term Plan. NHS England / Improvement Regional teams use data from these metrics, as well as local information and insight, to identify where commissioners may need support. The NHS System Oversight Framework 2021/22 is available on the NHS England's website at https://www.england.nhs.uk/publication/system-oversight-framework-2021-22/ . There are other performance metrics that are not within the NHS System Oversight Framework, relating to cancer and mental health services waiting times, which are also reviewed to ensure the health outcome of our patients continues to improve.

The performance against these metrics have been reported to the Governing Body and the system Quality, Performance Improvement and Assurance Committee. Through these meetings we have identified high risk indicators and the mitigations needed to improve quality, performance and outcomes. In addition, reports are also considered by the Local Authority Health Overview and Scrutiny Committees particularly where there may be a high risk to achieving the metrics.

Information available on *My NHS* www.nhs.uk/mynhs/services.html gathers data from across the system into one place so professionals and the public can easily compare performance of health and care services over a range of measures, including improving access to psychological therapies (IAPT), cancer standards, dementia, mental health and learning disability standards, antibiotic quality premium for CCGs amongst many standards and metrics.

Other requirements and metrics relating to our workforce and organisation systems and processes are also used as an indicator to understand and measure our performance. In April to June 2022 we continued to review a number of our **workforce policies** to enable consistent policies to be drafted across the three CCGs as a result of the development of single staffing structure across the three organisations. The workforce policies were reviewed to ensure they were applicable across the three organisations, updated to reflect changes in regulation and reviewed in line with the Equality Act 2010. These policies cover the recruitment, selection and appointment process as well as all aspects of working across the CCGs. **Workforce metrics** are reviewed on a regular basis by the Executive Management Team to ensure we implement our workforce policies appropriately and are able to support our staff.

Improve quality

Under Section 14R of the Health and Social Care Act 2012 we have a duty to continuously improve the quality of services that we commission and improve outcomes for patients and ensuring that care provided to our patients is as safe as possible. We consider the components of quality (patient safety, clinical outcomes, effectiveness, and patient experience) to be central to our function as an effective commissioning body. The

contribution from our clinicians and teams throughout the last year has enabled the CCG to have continued focus on quality improvement and quality assurance.

Underpinning the assurance domains are our statutory duties that each CCG has to meet and the need for NHS England to comply with guidance issued by the Secretary of State for Health under 14Z16 (performance assessment of the CCG) or 14Z8 (guidance of commissioning) of the NHS Act 2006 (as amended by the Health and Social Care Act 2012). We certify that the CCG has complied with the statutory duties laid down in the National Health Service Act 2006 (as amended).

Over the last year, performance improvement across Leicester, Leicestershire and Rutland (LLR) has been set within the context of the COVID-19 pandemic and the impact this has had on our population health. Performance improvement has moved away from monthly trend analysis to reviewing our performance as a wider system across Leicester, Leicestershire and Rutland to enable the development of a more comprehensive system-wide overview. Reports have been presented to the Governing Body on a regular basis detailing the impact of COVID-19 on performance and an analysis of COVID-19 expenditure all available on the CCG website.

We continued to discharge our duty to improve the quality of services combining quality of care alongside performance improvement at system, place and neighbourhood levels as the driver to delivering assurance. Placing performance and quality at the centre of our plans to transform services within our nine Design Groups, as part of the system wide governance arrangements, is crucial to delivering long term and meaningful change.

The Design Groups are models of care developed at system level for transformation, service delivery and quality thus enabling the CCG to move away from individual organisation performance monitoring to a culture of performance improvement, inclusivity and collaboration across our partners to deliver improved outcomes for our patients. The nine Design Groups are listed here.

The elective care design group has data at place level around speciality treatments which is supporting the health inequalities work as well as reviewing priority areas for transformation and performance improvement. In 2022/23 it is anticipated that further information will be sourced from social care to provide more wider intelligence to inform the transformation and improvement of services.

Elective care continued to be directly impacted by Covid-19 causes and restrictions with the numbers waiting continuing to increase. By end of February 2022 there were 1701 patients waiting 104 weeks or more across LLR, which means that some patients were waiting for over a year for their elective (planned) care treatment.

Performance in relation to urgent and emergency care deteriorated, in particular across the following metrics / standards: A&E 4 hour wait, cancer two week wait target for people referred with suspected breast cancer, 62 day cancer wait performance and

backlogs, and ambulance handovers. Detailed performance figures and actions to help identify root causes and apply corrective action to improve performance are provided in Appendix 1.

As performance deteriorates across specific standards and targets, the CCG is cognisant of the impact on health inequalities. For instance, as cancer services recover from the impact of the pandemic, through the cancer design group we continued to work to develop a better understanding of this impact on black and minority ethnic groups in particular.

Over the last year, we continued to develop our performance reporting demonstrating progress against the national and other metrics. The reports were aligned to Design Group themes, highlighting the successes and challenges and further actions either underway or required. The performance across the LLR CCGs as a system is captured in Appendix 1 which describes the position as at April 2022, including the challenges faced. Our reports describe key metrics that have been achieved and areas that fall short despite significant effort. Exception reports on underachieving indicators, including trends, actions being taken and assurance to address performance issues are provided, also at Design Group level.

The following section highlights some areas of improvement and positive developments over the last year:

- Following the **'Step Up to Great' Mental Health** consultation in 2021/22, a number of improvements have been proposed to improve the services and outcomes for our patients. This included an increase in the number of Crisis Cafes in community locations to offer a safe space where people can get help if they are experiencing a mental health crisis. The plan is to increase from the current 3 and have 25 cafes serving local communities across Leicester, Leicestershire and Rutland.

- **Transforming Care Programme** we continue to make positive progress in transforming care for people with a learning disability or autism across LLR, supporting care closer to home for those who have high levels of complex need and the minimal use of restrictive hospital placements.

- **Children and Young People (CYP)** - we have continued to work across the system with our partners to implement a CYP Palliative Care Network in line with the East Midlands region. We worked with system partners to create a joint risk register in line with wider system recovery following the pandemic and the CYP Transformation Programme, including mitigating actions.

- **Primary and Community Care –** the Design Group focusing on primary and community care has three main functions of design, delivery and assurance, and is looking at ways to improve services working closely with place-based groups to enable delivery at neighbourhood level through Primary Care Networks (PCNs). The priorities for the group as agreed are resilience in primary and community care, coordinated care for patients with multi-morbidity (linking to personalisation of care), and reducing health inequalities.

- **Special Educational Needs and Disabilities (SEND) -** the SEND Code of Practice 2014 and the Children and Families Act 2014 give guidance to health and social care, education, and local authorities to make sure that children and young people with SEND are properly supported. We have continued to work collaboratively with our local authority colleagues and community health providers on improvement work and the development of a joint commissioning strategy for SEND with quality assurance frameworks in place for educational and health care plans. We have increased the capacity within the CCG team by recruiting a SEND Senior Officer who has been working closely with partners, parents, and carers to ensure operationally we meet the individual needs of children with SEND.

  With the regional funding we secured we continue to explore models of transition for young people moving into adult services and are currently piloting the Rix Wikki software to capture children and young people's voice. Going forward, as an Integrated Care Board, we will be looking to strengthen these arrangements and to continue to support children with speech, language and communication needs.

- **Safeguarding** – we continued to have a strong focus on safeguarding vulnerable people in accordance with the NHS England Safeguarding Vulnerable People in the NHS: Accountability and Assurance Framework 2015. The Quality and Performance Committee of the Governing Body has oversight and scrutiny of the safeguarding arrangements for the CCG and also seeks assurance in relation to safeguarding arrangements across our commissioned services. The Executive Director for Nursing, Quality and Performance is the Executive Lead for safeguarding and is a member of the Leicestershire and Rutland Local Safeguarding Children Board (LSCB) and Safeguarding Adult Board (SAB). The CCG is supported in its statutory duties by Designated Clinical GP Leads and Designated Nurses for safeguarding. In 2021/22 we focused on:
  - ensuring all our staff and clinical staff undertake the relevant level of safeguarding training.
  - Embedding lessons from local children and adult safeguarding reviews e.g. serious case reviews, domestic homicide reviews in conjunction with our GP Practices.

- **Continuing Health Care -** the National Framework for NHS Continuing Healthcare and NHS-funded Nursing Care sets out the principles and processes of NHS Continuing Healthcare and NHS-funded Nursing Care. At the heart of the National Framework is the process for determining whether an individual is eligible for NHS Continuing Healthcare or NHS-funded Nursing Care. An individual is eligible for NHS Continuing Healthcare if they have a 'primary health need' and if eligible the NHS is responsible for commissioning a care package that meets the individual's health and associated social care needs. Due to COVID-19 pandemic continuing healthcare assessments had had to be deferred. During the last year these assessments were prioritised.

As a commissioner of services, we have balanced this collaborative approach with the requirement to assure ourselves and others of the quality of our provider organisations and their ability to provide safe, high quality healthcare to our populations. A Quality and Performance Improvement strategy is in place that describes how the LLR CCGs collectively discharge this responsibility through system and its leadership.

Annual assessment ratings are usually published by NHS England to enable CCGs to benchmark their progress, however at the point of writing this report these have not been published for the previous year. CCG ratings for previous years are contained within previous Annual Reports.

Engaging people and communities

Under Section 14Z2 of the Health and Social Care Act 2012 we have a duty to involve the public in our commissioning plans and decisions that we make as a commissioning organisation. The CCG has a clear vision for engagement and patient experience. We want our patients, public and stakeholders to be among the most involved, informed and empowered when it comes to local healthcare.

We recognise the fundamental importance and benefit of ensuring that our decisions are shaped through effective communication and engagement with the local population and we use The Engagement Cycle as part of our commissioning and engagement planning. The Engagement Cycle is a strategic tool that helps to identify who needs to do what, in order to engage communities, patients and the public at each stage of commissioning.

As a CCG we have a duty and a commitment to listen and engage with patients and members of the public to ensure we understand their views on healthcare, the areas of healthcare about which they are satisfied or dissatisfied, and how they would like to be engaged or informed going forward. The National Health Service Act 2006 (as amended) states that NHS organisations must 'make arrangements' to involve the public in the commissioning of services for NHS patients ('the public involvement duty'). For CCGs this duty is outlined in section 14Z2 of the Act. To fulfil the public involvement duty, the arrangements must provide for the public to be involved in:

- the planning of services,
- the development and consideration of proposals for change which, if implemented,
- would have an impact on services and
- decisions which, when implemented, would have an impact on services.

Annual reporting on the legal duty to involve patients and the public in commissioning

The CCG is required once a year to report on how patients and the public have been engaged and involved in the commissioning and developing of health services. The report outlines what engagement activity took place, the objective and any changes made as a result. Since 2019 we are required to formally submit additional evidence to NHS England for an assessment.

The range of methods we use is shown in the diagram below:

How we support staff to embed involvement into their work
To involve people effectively throughout the commissioning cycle we work closely with our staff in other teams, to identify opportunities early. We offer an 'account management' approach to support, advise and guide our staff wherever possible. Teams are allocated a member of the communications and engagement team throughout the project cycle to ensure engagement activities stay on track and the objectives are met.

The communications and engagement team acts as an 'insight hub' of information on communities, stakeholders, and networks as well as patient, carer's views, and experiences of our services.

Communicating with our patients and partners
We continued to play a significant role supporting the response to the Covid pandemic, leading a system – wide communications strategy across Leicester, Leicestershire and Rutland (LLR).

The COVID-19 vaccination programme is the largest in British history and was established at unprecedented speed thanks to effective partnership working across the local health system. Vaccine centres were set up rapidly across LLR at GP practices, Leicester's Hospitals' sites, community pharmacies, local leisure and community centres, places of worship and other local venues.

The CCGs' Communications team played a pivotal role in supporting public health messaging on the importance of vaccinations as the programme gradually unfolded,

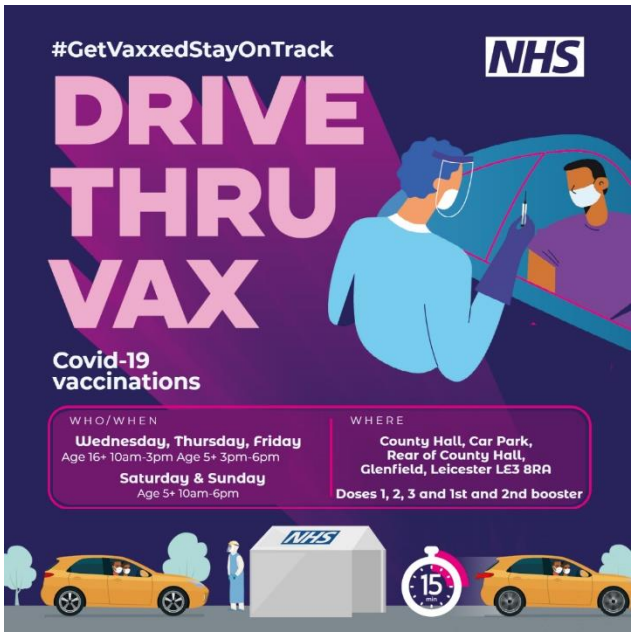
promoting eligibility, where to get vaccinated, lockdown rules and other changes to Covid restrictions.

Working with local partners such as the LLR Local Resilience Forum (LRF) and leaders of diverse communities, the Communications team kept patients informed of latest NHS and Government guidance on Covid-19, through effective media engagement, social media campaigns, public-facing webinars and regular updates and by issuing corporate information in various languages and formats. These ranged from weekly stakeholder newsletters to digital video content, social media graphics and the promotion of daily Covid vaccination walk-in clinics on the CCG website.

The CCGs' communications activities have helped deliver a successful Covid vaccination campaign in LLR. By March 2022, 91% of people aged 12+ had been vaccinated with the first dose, more than 85% had been vaccinated with both doses and more than 66% had been vaccinated with their booster or third dose.

To ensure vaccine uptake is maximised within all groups in the community, we have continued to apply our strong understanding of the cultural and language needs of the local population. We have developed excellent relationships with all sections of our diverse local communities, working with them to promote and deliver our vaccination programme at a real grassroots level.

Similarly, we worked in effective partnership with Leicestershire County Council to promote the opening of the Midland's first drive-through vaccination centre. The provision makes it simple for people from all walks of life to get vaccinated from the comfort of their car.



Through regular, clear, and transparent messaging about the importance of vaccinations, the public have been able to access the latest information to support their awareness and enable them to protect themselves, their families, and the wider community by getting vaccinated.

The Communications team has produced innovative and striking vaccination assets promoting vaccination clinic sites, which have been shared on a weekly basis with local partners and stakeholders. This strong partnership approach with consistent messaging has been a major contributory factor to the success of our local vaccination programme.

In 2021/22 and during the first quarter of 2022/23, the team's focus was also on supporting system restoration and recovery. Complementing the prolific activities around the pandemic and vaccination programme, the Communications team continued to provide regular support to other CCG functions and services including primary care; keeping patients informed of health services, encouraging people to contact their practice with any health concerns - including cancer concerns and highlighting the importance of screening.

The team also embarked on a multilingual cancer awareness campaign, in partnership with local South Asian radio station Sabras Sound, targeting various communities that are more likely to be affected by certain cancers, but less likely to come forward to seek help. Reducing health inequalities and securing better health outcomes for patients is a matter the CCGs are fully committed to, and this particular campaign is just one of many examples of our work to fulfil this commitment.

Research insight and behavioural theory is constantly used by the team to develop a well-informed communications approach that meets the needs of the local population. Through tailored communication, the CCGs' Communication team has been responsible for informing and engaging local people on a range of health issues, providing trusted advice and signposting to the most relevant services. An example of this was our campaign 'Get vaxxed stay on track' targeted at young people. We also used insight on vaccination uptake to develop a more targeted approach to our communications to certain communities and areas.

We are constantly looking at new ways of engaging and communicating with the people we serve and going forward. We worked closely with local partners in the Local Resilience Forum (LRF) to co-ordinate our communications on covid vaccinations.

Effective communications will also be essential as we move to becoming an Integrated Care System. Communications will be at the heart of explaining integrated care and how it will improve health and care for the people of LLR.

One of our key areas of work over the last year has been primary care. During the year we focussed on supporting our GPs to promote access, in particular promoting alternatives to GPs. These included raising awareness of self-care and in particular the role of the community pharmacist as a source of help and support for health care needs.

We continued to provide support to practices facing challenges following Care Quality Commission Reviews and the CCGs' response to safeguarding reviews.

A major challenge in 2021/22 was urgent and emergency care. Attendances at A&E reached record levels at times throughout the year, and we worked in conjunction with NHSE to target communications at specific areas in Leicester City through a leaflet drop raising awareness of NHS 111. The aim was to promote the service as the first point of contact for urgent care needs.

Reducing health inequality

Under Section 14T of the Health and Social Care Act 2012 we have a duty to reduce health inequalities for patients across Leicestershire and Rutland. Health inequalities are not a problem we can tackle in isolation. Our approach has been to work in partnership with public health teams, our local authorities, our GP member practices, the Voluntary and Community Sector and patients to co-produce relevant plans and initiatives.

Population Health Management

All three Clinical Commissioning Groups have been undertaking elements of population health management (PHM) since 2012. PHM involves using existing data from various sources for two purposes:

a) To identify people who have more complex health needs to ensure that they get the right level of support and monitoring of their condition. This data can only be seen by your own doctor or nurse. In some cases, this leads not just to extra medical care but to increased support from the local council or community health services. This is important as we know that people often need extra help if they are dealing with several health conditions (including mental ill health) at one time. Getting help with some problems that are not directly to do with your health can sometimes make it easier to take better care of your health – or to take care of a loved one who is ill. In 2021-22 more than 13,000 people in LLR had extra support thanks to population health management schemes.

b) To help the CCG plan services based on the needs of the population and to measure how services are being used. Knowing what kinds of diseases are most common and the numbers of people with several conditions at once, helps us create services that are going to be most helpful to people.

One of the key purposes of taking a population health approach in LLR is to reduce the differences in health outcomes between different groups of people living in the area. These outcomes can include how long people live on average, how many years they may expect to live in good health or how long they have to wait for treatments. Reducing health inequalities means identifying and removing the unfair and avoidable causes of these differences in outcomes. Some of the causes lie outside of the NHS – issues such as the quality of housing or access to jobs and education – and some issues require changes in how the NHS offers its services. In 2021-22 the CCGs took a number of successful steps to make sure that people from all communities and parts of the area could have their COVID vaccine as soon as they were eligible.

Having created the Health Inequalities Reduction Plan (Framework) in conjunction with partners and stakeholders over the last couple of years, we will be aiming to implement the actions going forward. This plan lays out why reducing health inequalities across LLR is a central purpose for us as we operate within the integrated care system. It sets out some principles of how we will do this work and identifies a small number of key actions we will be doing with our partners to give everyone in LLR a fair opportunity to live a long and healthy life.

Improving health

In addition to planning and buying healthcare, our role is also to help people to live long and healthy lives, to prevent ill health where possible and reduce health inequalities. We encourage people to take greater responsibility for their own health, manage existing conditions better and reduce the impact that factors such as smoking, drinking alcohol, poor diet and lack of exercise may have on their health in the future. The LLR CCGs implemented the LLR System Health Inequalities Framework to improve healthy life expectancy across LLR by reducing health inequalities across LLR.

"*Health inequalities are the preventable, unfair and unjust differences in health status between groups, populations or individuals that arise from the unequal distribution of social, environmental and economic conditions within societies*" (NHS England) "Health inequalities" is the commonly used term, however we are actually referring to health equity and inequities. Therefore, the terms are used interchangeably within this document and in the LLR system.

Equality means treating everyone the same/providing everyone with the same resource, whereas **Equity** means providing services relative to need. This will mean some *warranted* variation in services for different groups. It is important to note the difference in terminology between this work and those stated in the Equality Act 2010, although the terms relate to the same concept of equity.

The Equality Act defines specific protected characteristics that require explicit consideration in any decision-making process, but this framework recognises the importance of identifying vulnerable groups that are not well reflected within these definitions (such as homeless people or those with caring responsibilities). The health and wellbeing of people is an asset to individuals, to communities, and to wider society. Good mental and physical health is a basic precondition for people to take an active role in family, community, and work life. Although there is growing concern about stalling life expectancy, the existing wide inequalities in health outcomes tend to be overlooked. Improving healthy life expectancy enables people to live in better health for longer. Ensuring they can contribute to society. A workforce that remains fit, healthy, and working for longer can contribute to a productive economy and decrease the costs of supporting an ageing society. However, health inequalities undermine these benefits.

Health inequalities can be found along a social gradient, with those living in the most deprived areas having the worst outcomes. Inequalities can be found even within areas that might be regarded as affluent. Therefore, using a 'levelling up' approach will have an impact on the majority of the population. Evidence shows that having a more equitable society benefits the whole population, not just those living in the most deprived areas or currently experiencing the worst outcomes.

Those living in the most disadvantaged areas often have poorer health outcomes, as do some ethnic minority groups and vulnerable/socially excluded people. These inequalities are due to a combination of factors including income, education and the general conditions in which people are living. In addition, the most disadvantaged are not only more likely to get ill, but less likely to access services when they are ill. This is known as the inverse care law.

Health inequalities have been further exposed by the Covid-19 pandemic, which has taken a disproportionate toll on groups already facing the worst health outcomes. The mortality rate from the virus in the most deprived areas has been more than double that of the least deprived. In addition, some ethnic minority communities and people with disabilities have seen significantly higher Covid-19 mortality rates than the rest of the population. The economic and social consequences of measures to contain the virus have worsened these inequalities further, with people in crowded housing, on low wage, unstable and frontline work experiencing a greater burden and transmission of the virus.

There are always going to be differences in health, some are unavoidable e.g. as result of age or genetics but many differences in health are avoidable, unjust and unfair – it is

these that LLR CCGs are concerned about and a Health Inequalities Framework has been developed to seek to address some of these issues.

A detailed analysis of local demographic and health data demonstrating the extent of inequality is available through local JSNA (Joint Strategic Needs Assessment) reports produced by each Public Health Team. Local JSNAs are available on the local authority websites.

Some key areas of focus during 2021/22 aligned to the work of the Design Groups as referred to earlier in the Performance Analysis section of this report.

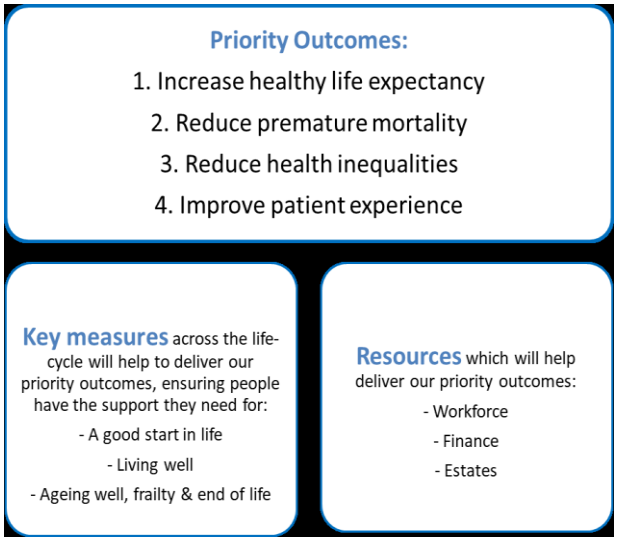
Outcomes framework across the ICS

As an Integrated Care Board, we will further develop the Outcomes Framework which we have been developing across the integrated care system with our partners. The importance of making a difference to people's lives through integration is a central objective of the Outcomes Framework. The work which has been supported by design group system partners aims to achieve tangible improvements to outcomes for people and to the quality of services across health and social care. This Framework places the person at the centre with integration as the pinnacle. Having an Outcomes Framework helps to shift the focus from transactional care to personalised care with a shift from performance improvement (which still has a place through our governance structures) to success around meeting personal outcomes for those patients and their carers.

An ICS Outcomes Framework provides the shape against which System, Place and Neighbourhood groups can plan, transform, innovate, and review their priorities. When reviewing performance and looking at the improvement challenges, it is clear the challenges to performance have been exacerbated during the covid-19 pandemic has further exposed health inequalities at every level of the system. NHS England /Improvement have stated that the virus itself has had “a disproportionate impact on certain sections of the population, including those living in most deprived neighbourhoods. That is to say those from Black, Asian and minority ethnic communities, older people, men, those who are obese and who have other long-term health conditions and those in certain occupations”. Recovery and quality and performance improvement going forward needs to be planned in a way that inclusively supports those in greatest need. This requires collaborative working within communities at Neighbourhood level to reduce health inequalities, and regularly assess progress.

Our model of care across LLR is summarised using a life course model broken down into:

- Increase healthy life expectancy,
- Reduce premature mortality,
- Reduce health inequalities and
- Improve patient experience.



Achieving these outcomes will be driven at the Place level and it will take time to measure the improvements in these outcomes. Outcomes can be structured around the life-cycle approach to ensure ‘A good start in life’, ‘Living well’ and ‘Ageing

well, frailty and end of life'. Alongside the key measures, other elements of the oversight themes and quintuple aim will be reviewed as crucial for improvement such as the workforce, finance, and estates. The ICS governance structure is designed to be a vehicle to enable closer collaboration with enabling governance and simplified structures to ensure the system and NHS partners can work effectively together. It is not replacing the statutory responsibilities of each organisation.

Transformation and delivery will be driven through Design Groups, which will work on an integrated pathway basis and through the Place Based Groups ensuring we are able to improve quality and the health outcomes of our population through delivery and integration at a place level as an Integrated Care Board in 2022/23 ensuring the patient voice is at the centred of this approach.

Equality, inclusion, and human rights

This section of the report sets out how the CCG has been demonstrating 'due regard' to the Public Sector Equality Duty (equality duty). In the past year, equality and diversity and human rights have been central to the work of the CCG, in making sure that there is equality of access and treatment within the services we commission, particularly in light of the pandemic.

There has been much focus on delivering on our duty through effective partnership work on reducing health inequalities by engaging with the local community, patients, and the public. Another key area of progress has centred around embedding the Equality Impact and Risk Analysis process. We are committed to ensuring that Equality, Inclusion and Human Rights is a central core to business planning, staff and workforce experience, service delivery and community and patient outcomes.

Workforce

The CCG's workforce details are contained within the Staff Report. We have robust policies and procedures in place which help to ensure that all staff are treated fairly and with dignity and respect and are committed to promoting equality of opportunity for all current and potential employees. We are aware of the legal equality duties as a public sector employer and service commissioner and have equality and diversity training in place for all staff.

We are committed to improving equality and respect to the whole of the community as well as patients, CCG employees and potential employees. We are committed to treating everyone who we come into contact with fairly and not discriminate against anyone because of their age, disability, gender, gender reassignment, pregnancy and maternity, race, religion or belief, sexual orientation or whether they are married or in a civil partnership. Our aim is to ensure that we commission accessible, high-quality health services, working on prevention and intervention initiatives aimed at reducing health inequalities and establishing a culture of inclusion that enables us to meet the needs of all our diverse communities within the organisation's culture, employment practices and commissioning systems.

The CCG aims to meet the requirements of the Public Sector Equality Duty (PSED) and the 'three aims' of the duty. The 'three aims' are to have due regard to the need to:

- **eliminate unlawful discrimination, harassment, victimisation,** and any other conduct that is prohibited by or under act
- **advance equality of opportunity** between people who share a relevant protected characteristic and those who do not share it, and
- **foster good relations** between persons who share a relevant protected characteristic and persons who do not share it. The Equality Act 2010 also outlines specific duties on public bodies to meet the PSED more effectively.

During 2021/22 we reflected on the progress we have made against the goals within the Equality Delivery System (EDS2), details of which are available on the CCG website. The Equality, Diversity and Inclusion (EDI) Annual Report for the period 2021/22 is also available on the CCG website. The report includes an update on all the equality actions and objectives. It also includes the work we have undertaken in terms of inclusive working practices and engagement activities.

Equality, Health Inequality Impact and Risk Assessments (EHIIRA) - considering due Regard

We have a well-established process in place to give due regard to the needs of communities, patients, and staff. The CCGs carefully consider the potential impacts of decisions regarding services and involves communities in decision making in line with 'Brown and Bracking principles.' During the time of the reporting period 26 Equality Health Inequality Impact and Risk Assessments (outcomes) were completed collectively across the LLR CCGs.

LLR inclusive decision-making framework (IDMF)

In conjunction with our local health care system partners we created an Inclusive Decision-Making Framework (IDMF) which forms part of our LLR System People Plan. The framework is based around six steps in which equality and health inequality considerations are embedded within each stage of decisions being made. The IDFM will help to:

- Foster a culture of Inclusive Decision Making across LLR system
- Provide a shared EDI resource across different partners
- Provide practical steps to ensure that the needs of different communities and staff are considered in the decision plans
- Meet the challenges of delivering the NHS Long Term Plan across LLR
- Meet our legal duties – in terms of equality, reducing health inequalities and Human Rights.

The purpose of the IDMF is to promote equality, diversity and inclusion when developing and implementing strategy, plans, programmes, projects, and commissioning and procuring services. The IDMF will enable us to enhance our consideration of the diverse needs of our workforce, our patients, and the wider community in our decision-making processes. The successful application of this framework will ensure that we can integrate equality analyses into our decision-making behaviours and processes to reduce health inequalities and attract, retain, and develop diverse talent. Implementation of the IDMF commenced during 2021/22 with our system wide Design Groups. The IDMF should ensure that information that is currently documented within Equality Impact Assessments will be included within project planning documentation and assurance should be in place to ensure this meets the equality duty and other legislative requirements. The IDMF is an innovative approach that should embed equality, address bias, and improve decision

making from the outset of decisions / proposals. Its successful implementation will require support from all partners and staff involved in decision making.

The CCG Equality and Inclusion Strategy and Objectives were refreshed and dovetail with the system wide approach to equality and inclusion.

Workforce Race Equality Standard (WRES)
In September 2020, the LLR CCGs published a 5-year action plan to deliver the Workforce Race Equality Standard (WRES) and relevant elements of 'We are the NHS People Plan 20/21'/ Model Employer. This will be reviewed and updated regularly and at least annually to meet the Workforce Race Equality Standard (WRES) reporting cycle. The review of the 2021/22 outcomes will take place in the summer of 2022.

Health and wellbeing strategy

The CCG's strategic aims and policies are aligned to the Joint Health and Well Being Strategies and Better Care Fund (BCF) Plans across Leicester, Leicestershire and Rutland with an emphasis across the system on reducing health inequalities, variation in health outcomes, reducing avoidable admission to hospital, redesign of alternative pathways and prevention of illness.

Better Care Fund

The Better Care Fund continues to be a critical enabler to take forward the integration of health and care services. In April 2022 to June 2022 our contribution to the Leicestershire Better Care Fund (£4.8m) and Rutland Better Care Fund (£0.7m) enabled care to be jointly commissioned locally on health and care to drive better integration of health services and improve outcomes for patients, service users and carers.

Performance against the Better Care Fund metrics was not formally reported this year as it was recognised by NHS England that the changes in services in response to the pandemic made comparisons with previous years not useful. Instead, the focus was on how well our system was able to meet the needs of our residents as it responded to the pandemic, as well as meeting the needs of people not related to COVID-19.

We are responsible for improving the health and wellbeing of people in East Leicestershire and Rutland and hence have worked closely with both Leicestershire County Council and Rutland County Council to produce the Joint Health and Wellbeing Strategies.

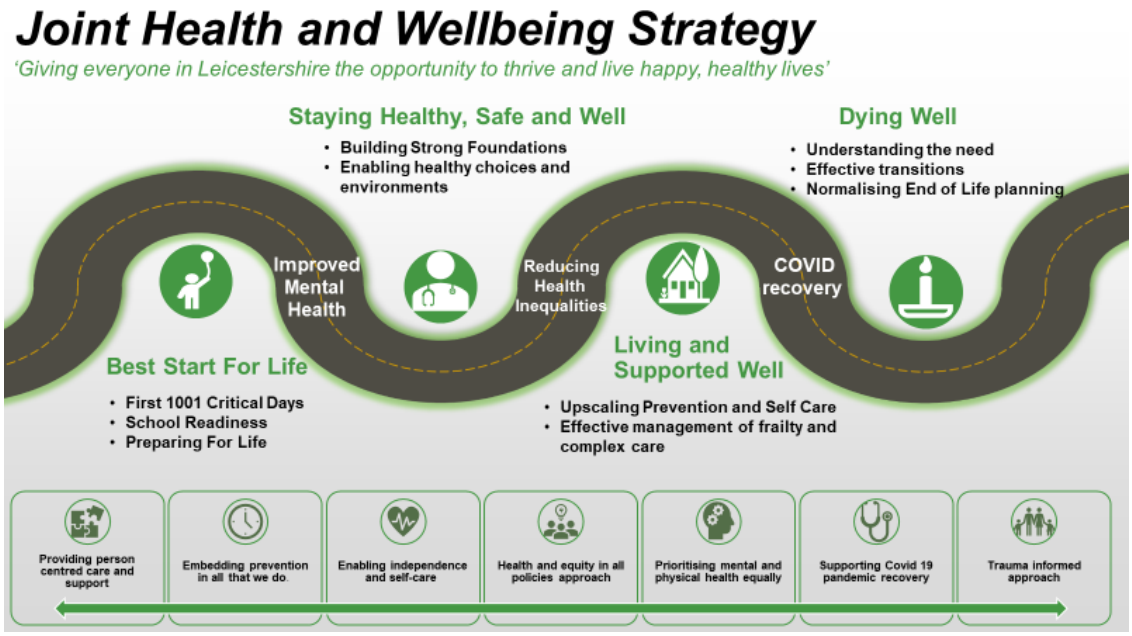
The CCG's strategic aims and policies are aligned to the Joint Health and Well Being Strategies and Better Care Fund (BCF) Plans across Leicester, Leicestershire and Rutland with an emphasis across the system on reducing health inequalities, variation in health outcomes, reducing avoidable admission to hospital, redesign of alternative pathways and prevention of illness.

We are responsible for improving the health and wellbeing of people in East Leicestershire and Rutland and hence have worked closely with both Leicestershire County Council and Rutland County Council to produce the Joint Health and Wellbeing Strategies. The strategies are aligned to our strategic objectives and have been reviewed

recently. The updated strategies for Leicestershire and Rutland are available at the following respectively:
https://politics.leics.gov.uk/ieListDocuments.aspx?CId=1038&MId=6942&Ver=4

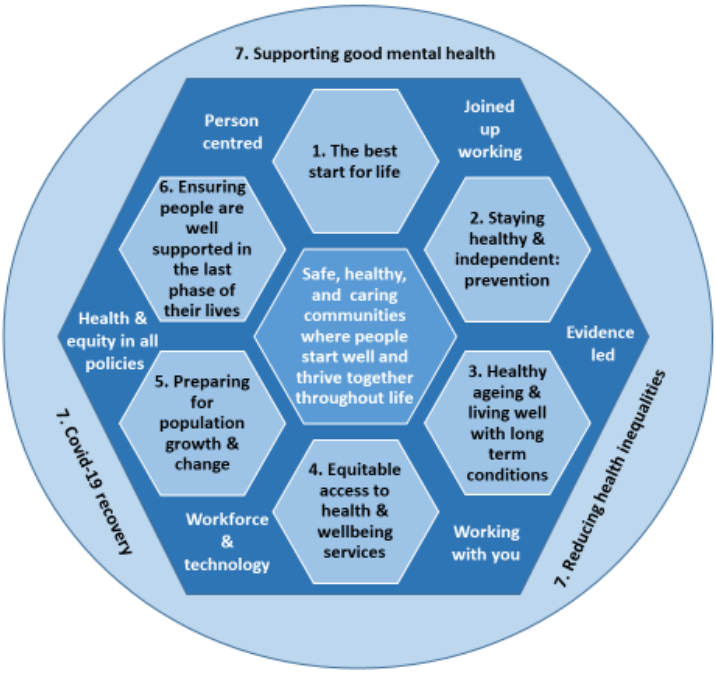
https://rutlandcounty.moderngov.co.uk/ieListDocuments.aspx?CId=213&MId=2407&Ver=4

The key areas for improvement for Leicestershire as detailed within the updated strategy are:



The key areas for improvement for Rutland as detailed within the updated strategy are:

Rutland Joint Health and Wellbeing Strategy: The Rutland Place based Plan 2022-27



The essence of the strategy's goal is *'people living well in active communities'*.

Through the Health and Wellbeing Board we work closely with our partner organisations on the delivery of these key priorities. By working together, we are able to develop a holistic picture and shape services and support to meet the needs of our different communities.

There are a number of key achievements during the last year, some specific examples are as follows:

- **Children and young people.** We work together with a range of system partners to improve outcomes for children and young people around issues such as reducing infant mortality, delivery of the LLR, health baby strategy reducing youth offending meeting the needs of children and young people (CYP) with special educational needs and disabilities (SEND) and emotional health and well-being issues. The three Children and Families Partnership Group has agreed to become the place-based planning groups for the system and have recently agreed to come together as a system to deliver the 1001 critical days agenda which looks at improving outcomes from conception to age 2.

Sustainable Development

Sustainability in this context is about the smart and efficient use of natural resources, to reduce both immediate and long term social, environmental, and economic risks. The cost of all natural resources is rising and there are increasing health and wellbeing impacts from the social, economic, and environmental costs of natural resource extraction and use.

Sustainability has been recognised at a national level as an integral part of delivering high quality healthcare efficiently.

The Department of Health Manual for Accounts states that all NHS bodies are required to produce a Sustainability Report as part of their wider Annual Report, to cover their performance on greenhouse gas emissions, waste management, and use of finite resources, following HM Treasury guidance. The key principle behind this type of reporting is that it provides NHS organisations with an opportunity to demonstrate how sustainability has been used to drive continuous environmental, health and wellbeing improvements in their organisation, and in doing so, unlock money to be better spent on patient treatment and care.

Published sustainability reporting also enables organisations to showcase their achievements with staff, patients, and other stakeholders, providing an opportunity to inspire positive behaviours in the wider community. Furthermore, once established across the board, organisation wide reporting can constitute a transparent, comparable, and consistent framework for assessing their own environmental impact and benchmark it against that of other NHS organisations and public sector bodies, a commonplace practice in the private sector.

As an NHS organisation, and as a spender of public funds, we have an obligation to work in a way that has a positive effect on the communities we serve. Sustainability means spending public money well, the smart and efficient use of natural resources and building healthy, resilient communities. By making the most of social, environmental, and

economic assets we can improve health both in the immediate and long term even in the context of rising cost of natural resources. Demonstrating that we consider the social and environmental impacts ensures that the legal requirements in the Public Services (Social Value) Act (2012) are met.

We acknowledge this responsibility to our patients, local communities, and the environment by working hard to minimise our footprint.

In order to embed sustainability within our business it is important to explain where in our process and procedures sustainability features. Sustainability is considered as part of our procurement processes (in terms of environmental and social impact). One of the ways in which an organisation can embed sustainability is through the use of a Sustainable Development Management Plan (SDMP). We have been developing a SDMP recognising the impact of COVID-19 and as we move forward and transition into working more closer with our partners across the integrated care system.

Sustainability has become increasingly important as the impact of peoples' lifestyles and business choices are changing the world in which we live. We acknowledge this responsibility to our patients, local communities and the environment and are committed to minimising our footprint. Sustainable actions undertaken during the year are integral to this Annual Report, although outlined below we have pulled out some key themes and actions that we have worked towards meeting during the last year:

- **Office accommodation:** as staff embraced working remotely and with our commitment to the NHS Green Plan, we reviewed our office accommodation across the three CCGs and agreed to vacate two of the three offices and retain a single office co-located with the Leicestershire County Council at County Hall in Glenfield in Leicestershire. Going forward as an ICB and as an integrated care system we aim to build on our draft NHS Green Plan to ensure we have a comprehensive plan on building on our current achievements and delivering our commitments including estates and facilities, medicines, digital transformation etc. We also consider all relevant sustainability issues in the design and operation of our office including the need to reduce waste, energy, and resource. In the office space that we occupy we have and continue to promote recycling facilities, reduction in use of paper and printing where possible.

- **Travel*:*** we have previously identified opportunities to reduce car usage, encouraging active travel. During the last couple of years, due to the pandemic, our staff have been working remotely at home which has encouraged a greater use of remote communication which replaced face-to-face meetings thus dramatically reducing our travel time and car usage

- **Procurement*:*** we commission health services which are environmentally, socially, and economically sustainable. Through the contracting processes we ensure that the providers of services commissioned by the CCG are complying with national and local requirements on sustainability, including carbon reduction.

- **Workforce*:*** We respond to local employment conditions and needs and proactively build a skilled local workforce, promoting the health and wellbeing of employees through our HR policies.

- **Community engagement:** We understand the local community and involve its members in decision making and scrutiny, planning and delivery of healthcare and supporting a strong and sustainable local economy.

- **Models of care:** We collaborate with cross-sector partners to prevent illness, promote health, and develop sustainable joint service plans e.g. care plans, work to support self management of long-term conditions, integrated locality teams and 'home first' principles.

Financial review

System finance

One of our key strategic objectives relates to delivery of a sustainable system financial plan. The LLR CCGs have broken even during the period April to June 2022. This has been achieved in a revised financial regime as the NHS moves away from the reliance on non recurrent allocations to support additional costs as a result of the Covid pandemic. The previous Covid financial regime came to an end during 2021/22.

We created and agreed with system partners an LLR System Financial Strategy for 2022/23 to manage finances across the system. The ambition is to deliver recurrent system balance through an allocative strategy that targets resources to system transformation. The intention is to shift the focus of investment to primary care, prevention, community, and mental health with less emphasis on growth in secondary care. This will sustainably improve the health and wellbeing of the LLR population providing greater value for money.

Finance performance and risk

Financial performance and risk

The CCG operated for the period April to June 2022 and all financial information contained within this report relates solely to that period. The responsibilities of the CCG transferred to the Leicester, Leicestershire and Rutland Integrated Care Board (ICB) on 1 July 2022 and the CCG was dissolved. Financial results for the period 1 July 2022 to 31 March 2023 are contained within the ICB Annual Report and Accounts for that period, available separately.

The CCG had an in-year allocation of £129.4m (our budget). This allocation is received in three allocations as follows:

- Programme: £114.3m
- Primary Care Co-Commissioning: £13.6m
- Running Costs: £1.5m

The total allocation for April to June 2022 was £200.4m. As the NHS is emerging from the Coronavirus (Covid-19) Pandemic, a number of elements of the NHS financial regime and planning processes were returning to pre-pandemic arrangements. Additional Covid financial support and reimbursement processes have greatly reduced and the focus of

the NHS increasingly switches to restoration of services and Elective (planned care) recovery.

For 2022/23 the three LLR CCGs continued to plan collectively, working as a system and agreed a breakeven plan for year. The financial regime for CCGs ensured that the outturn position of CCGs at the time of their cessation would be brought into balance by an allocation adjustment and that any resultant variance would be transferred to the successor ICB. By 30th June 2022, the LLR CCGs had delivered a collective £3.6m surplus, largely due to slippage in non recurrent investments. Allocation adjustments were undertaken to account for this slippage and effectively defer the surplus into the subsequent ICB allocations. Within this total the East Leicestershire and Rutland CCG position was a £1.5m surplus due to being the system lead on a number of investment areas that had encountered slippage. An allocation reduction was processed for this value to ensure financial balance.

The financial performance of the CCG has been monitored on a monthly basis by the Executive Management Team with regular reports to the Governing Body. The key financial risks that the CCG and the successor ICB faced throughout the year were as follows:

- Failure to assure local health economy financial viability over the next 5 years.
- Failure to maintain control of the LLR financial position and deliver sufficient efficiencies to ensure compliance with the statutory duty to break-even in 2022/23.

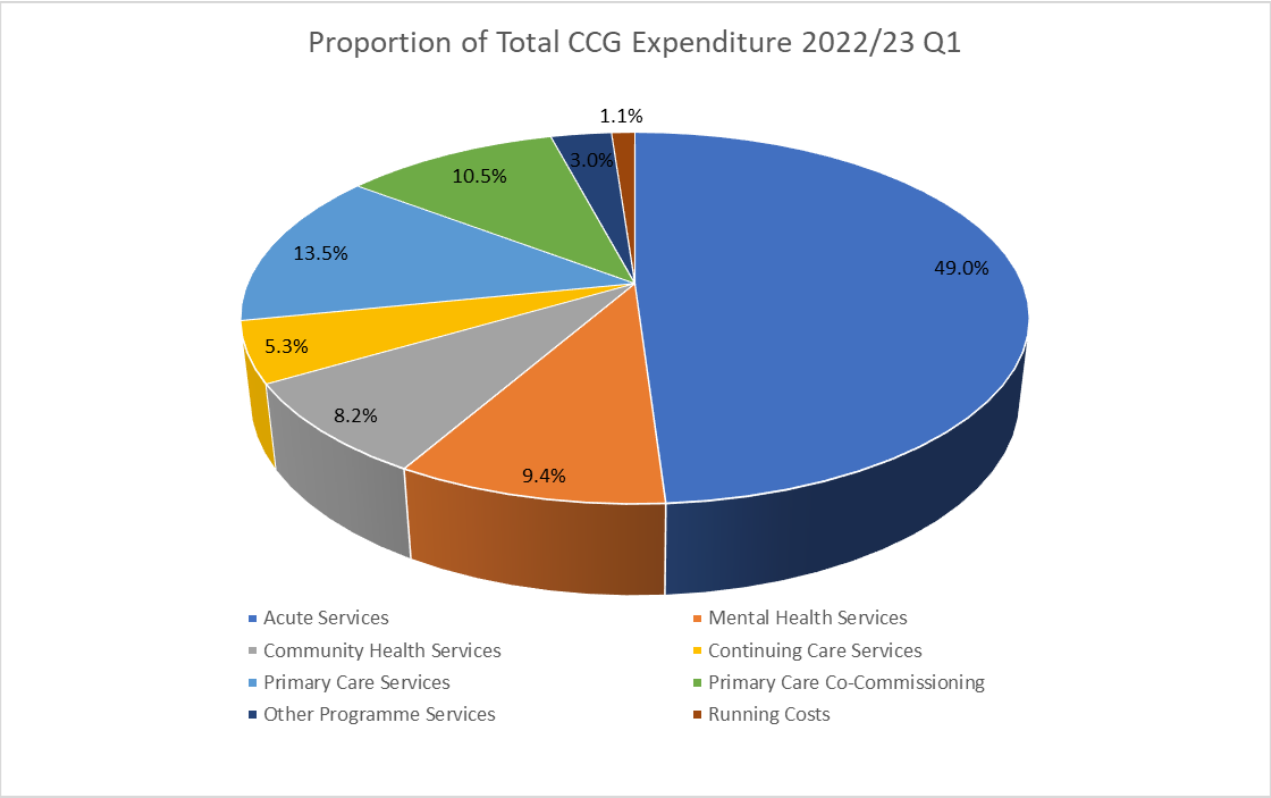
Mitigation of these risks was monitored by the Executive Management Team (EMT) Mitigations included the identification of further in-year efficiencies and review of planned investments.

The final £3.3m allocation adjustments referenced above included a split of programme, Primary Care Co-commissioning and Running cost allocations to ensure the CCG recorded a breakeven position against all three allocations.

How we spend our money

Expenditure Profile

In April to June 2022 the CCG spent £129.37m on healthcare and running costs for the local population. This was allocated as is shown on the chart below (including running costs and primary care co-commissioning expenditure):



Running Cost Allowance

The CCG had an allocation for April to June 2022 of £1.7m (0.8% of total CCG allocation) to spend on administrative costs i.e. staff costs and administrative non pay costs. Administrative costs incurred by the CCG must not exceed this allocation and were £1.5m for the period.

- Running costs (£m) £1.5m
- Weighted population (number) 345,140
- Running costs per head of weighted population £4.29

Capital Expenditure

The CCG received no capital allocation from NHS England for the period April to June 2022.

Cash Balance

NHS England guidance specified that the CCG's bank balances as at 30 June 2022 should be less than £0.51m. The actual bank balance was £0.12m and therefore the target has been achieved.

Principles of remedy

Our CCG's policy on managing complaints is guided by the Principles of Good Complaints Handling published by the Parliamentary and Health Service Ombudsman for public bodies. We always aim to conform with the Parliamentary and Health Service

Ombudsman's 'Principles for Remedy' which defines good practice in dealing with complaints, specifically it ensures that we are:

- getting it right
- being customer focussed being open and accountable
- acting fairly and proportionately
- putting things right
- seeking continuous improvement.
- This is how we interpret the principles and how we will handle complaints:
    - complaints are dealt with efficiently and confidentially
    - complaints are properly investigated, monitored, and recorded
    - complainants receive, so far as reasonably practicable, assistance to enable them to understand the procedure or advice on where assistance should be available
    - complainants receive a timely and appropriate response
    - complainants are told of the outcome of the investigation of their complaint and action is taken, if necessary, in the light of the outcome of a complaint
    - the process for dealing with complaints should be, and be seen to be, impartial and fair to both staff and complainant alike
    - complainants will be treated with respect and courtesy
    - complainants will not be discriminated against for making a complaint and making a complaint will not adversely affect future treatment
    - information will be provided to senior management to help services to be reviewed and improved
    - all complainants will receive a sympathetic and caring response and, where appropriate, an apology given or an expression of regret
    - staff will receive appropriate training in handling complaints.

During April 2022 - June 2022 we received a total of 5 complaints, this includes complaints received from patients and the public, and via Members of Parliament on behalf of their constituents. These complaints included both complaints in relation to CCG commissioning decisions and complaints in relation to the care and treatment provided by the providers that the CCG commissions services from.

ACCOUNTABILITY REPORT

The Accountability Report describes how we meet key accountability requirements and embody best practice to comply with corporate governance norms and regulations.
It comprises three sections:

- The **Corporate Governance Report** sets out how we have governed the organisation during the last year and during 1 April to 30 June 2022, including membership and organisation of our governance structures and how they supported the achievement of our objectives. The report includes the Members of the Governing Body report, the Statement of Accounting Officer's Responsibilities and the Governance Statement and starts from page 44.

- The **Remuneration and Staff Report** describes our remuneration polices for executive and non-executive directors, including salary and pension liability information. It also provides further information on our workforce, remuneration and staff policies and starts from page 67.

- The **Parliamentary Accountability and Audit Report** brings together key information to support accountability, including a summary of fees and charges, remote contingent liabilities, and an audit report and certificate. This report starts from page 87.

Corporate Governance Report

Members Report

NHS East Leicestershire and Rutland Clinical Commissioning Group (ELR CCG or CCG) is led by a Governing Body comprising elected GP members, a lead nurse, executive leads and independent lay members as detailed below as at 30 June 2022.

Name	Position
Dr Vivek Varakantam	Chair
Mr Andy Williams	LLR CCGs' Chief Executive (Accountable Officer)
Ms Fiona Barber	Deputy Chair and Independent Lay Member (Patient and Public Involvement)
Mr Warwick Kendrick	Independent Lay Member (Audit, Conflicts, Governance and Finance)
Mr Clive Wood	Independent Lay Member (collaborative commissioning and health inequalities)
Dr Andy Ahyow	Member Practice Representative and Clinical Vice Chair (GP Governing Body Member)
Dr Graham Johnson	Member Practice Representative (GP Governing Body Member)
Dr Girish Purohit	Member Practice Representative (GP Governing Body Member)
Dr Nicholas Glover	Member Practice Representative (GP Governing Body Member)
Dr Nikhil Mahatma	Member Practice Representative (GP Governing Body Member)
Ms Sarah Prema	LLR CCGs' Executive Director of Strategy and Planning
Dr Caroline Trevithick	LLR CCGs' Executive Director of Nursing, Quality and Performance
Ms Nicci Briggs	LLR CCGs' Executive Director of Finance, Contracting and Corporate Governance
Mrs Rachna Vyas	LLR CCGs' Executive Director of Integration and Transformation
Mrs Alice McGee	LLR CCGs' Executive Director of People and Innovation

Dr Vivek Varakantam
Chair
Dr Vivek Varakantam was appointed Clinical Chair in August 2020. He previously represented the East Leicestershire and Rutland CCG member practices on the Governing Body and also served as the locality lead for Oadby and Wigston and provided clinical leadership in supporting the cancer workstream across Leicester, Leicestershire and Rutland. He has been a partner at the Croft Medical Centre in Oadby since 2009. He is a GP Registrar Associate and Foundation Year Trainer.

Mr Andy Williams
LLR CCGs' Chief Executive (Accountable Officer)
Andy Williams' role covers the three Clinical Commissioning Groups in Leicester, Leicestershire and Rutland (LLR). He was Sustainability Transformation Partnership (STP) lead for the LLR area and recently appointed Chief Executive Officer designate for the LLR Integrated care Board.

An experienced and hugely respected NHS senior leader, Andy possesses a wealth of experience in both NHS commissioning and provider organisations – both in his native Wales and in England. He previously led Sandwell and West Birmingham CCG since its inception in 2013. During his tenure, that organisation was twice awarded the prestigious CCG of the Year accolade at the industry-wide Health Service Journal (HSJ) Awards.

Ms Fiona Barber
Deputy Chair and Independent Lay Member
Fiona Barber was appointed as the Deputy Chair and Independent Lay Member with responsibility for patient and public involvement in August 2019. Fiona joins the CCG with a wealth of experience in patient and public involvement across health, social care and the voluntary sector. This includes her current roles in supporting NHS England as a Patient Public Advisor, as a member of the Primary Care Oversight Group, and a member of the Clinical Priorities Advisory Group. Previously, Ms Barber was a Chief Superintendent in the Lincolnshire Police. In the CCG, Fiona chairs the CCG's Primary Care Commissioning Committee; and she is a member of the Remuneration Committee.

Mr Warwick Kendrick
Independent Lay Member

Warwick Kendrick was appointed an Independent Lay Member of East Leicestershire and Rutland Clinical Commissioning Group in 2011 and reappointed in 2019. He is the lay member with responsibility for audit, conflicts, governance and finance. He chairs the Audit Committee and the Competition and Procurement Group across the three CCGs; and is a member of the Remuneration Committee. He is the CCG Conflicts of Interest Guardian, and also the Freedom to Speak Up Guardian. He was previously a Non-Executive Director of Leicestershire County and Rutland PCT and held senior finance appointments throughout his career. Warwick is a fellow of the Chartered Institute of Management Accountants established and ran his own consultancy business.

Mr Clive Wood
Independent Lay Member

Clive Wood was appointed as an Independent Lay Member in October 2015 and reappointed in 2019. His particular focus in East Leicestershire and Rutland Clinical Commissioning Group Governing Body is on collaborative commissioning and health inequalities. Clive chairs the CCG's Remuneration Committee and is a member of the Primary Care Commissioning Committee and Audit Committee. He also has commitments to support collaborative working across the three CCGs, including: chairing the High Risk and Complex Care Panel; chairing the Children's Panel; and he is the lay member lead for emergency planning. Clive is a retired police detective superintendent, following a successful 30-year career in the Leicestershire Police.

Dr Andy Ahyow
Member Practice Representative and Clinical Vice Chair

Dr Andy Ahyow represents the East Leicestershire and Rutland CCG member practices on the Governing Body and joined the CCG in January 2020. His responsibilities expanded in November 2020 to include the clinical vice chair role. Since graduating from Leicester University in 2003, Andy has worked in the local healthcare economy, first as a junior doctor, and then as a vocational training scheme trainee. He is a GP partner at the Forest House Medical Centre in Leicester Forest East for the past 11 years, and he is currently the senior partner. Prior to becoming a member of the Governing Body, Andy supported the CCG in an advisory role as the clinical lead for IM&T for the CCG. Andy is currently providing clinical leadership across a number of clinical work streams across LLR.

Dr Girish Purohit
Member Practice Representative

Dr Girish Purohit represents the East Leicestershire and Rutland CCG member practices on the Governing Body, previously he was the locality Lead for Melton, Rutland, and Harborough. Girish has taken a keen interest in and provided clinical leadership across the dementia work streams for the three CCGs in Leicester, Leicestershire and Rutland. He is a GP Principal at the Jubilee Medical Practice in Syston, which he joined in July 2012.

Dr Graham Johnson
Member Practice Representative
Dr Graham Johnson represents the East Leicestershire and Rutland CCG member practices on the Governing Body. Graham's previous roles within the CCG included Clinical Lead for Mental Health and Finance, and he was previously one of the locality leads for Blaby and Lutterworth. Graham continues to provide clinical leadership in relation to mental health workstreams and has developed strong relationships and collaboration with partner organisations in mental health commissioning. He is the GP Principal at Wycliffe Medical Centre.

Dr Nick Glover
Member Practice Representative
Dr Nick Glover represents the East Leicestershire and Rutland CCG member practices on the Governing Body, previously he was the locality lead for South Blaby and Lutterworth. His main area of responsibility is primary care and he is a member of the primary care commissioning committee, and the primary care quality delivery group. Dr Glover became a GP partner at Northfield Medical Centre in Blaby in 1997 and has been training doctors coming into general practice since 2005. Nick has previously worked as a Clinical Assistant in Dermatology.

Dr Nikhil Mahatma
Member Practice Representative
Dr Nikhil Mahatma was appointed in April 2020 and is one of the Member Practice Representatives representing the East Leicestershire and Rutland CCG member practices on the Governing Body. Nikhil is a GP Partner at Kingsway Surgery.

Ms Nicci Briggs
LLR CCGs' Executive Director of Finance, Contracting and Corporate Governance
Nicci has worked across the public sector in very senior roles in a period of financial instability, challenging efficiency targets and increased scrutiny. She spent the last 10 years at Kettering General Hospital NHS Foundation Trust, four of those years as the Director of Finance and prior to that as the Director of Transformation, and a number of finance roles from Business Partner to Deputy Director of Finance. She spent nearly two years at Northamptonshire Police where she led the financial management functions and consolidated three teams into one alongside project management of the introduction of shared financial service. Nicci started her post graduate career at Cambridgeshire County Council spending five years across various roles and departments including Adult Social Care finance, Financial Systems and Corporate Finance and Planning.

Dr Caroline Trevithick
LLR CCGs' Executive Director of Nursing, Quality and Performance
Caroline Trevithick has worked as a registered nurse for the last 30 years. Her experience includes caring for patients in acute hospitals and community settings and has been working in commissioning organisations since 2009. In the past she has also worked for the Department of Health and the Strategic Health Authority, leading on the reduction of healthcare associated infections and the implementation of clinical governance frameworks in NHS Trusts.

Caroline worked for West Leicestershire CCG since its inception in shadow form in 2012. In her time with West Leicestershire CCG she led on end of life, community hospital redesign, medicine's optimisation and other clinical issues. Since 2017, Caroline was Deputy Managing Director for the CCG. Her work in the CCG has enabled her to ensure that continuous quality improvement stays at the forefront of the organisation but has also given her the opportunity to develop the nursing agenda within the organisation and across the LLR CCGs as the Executive Director of Nursing, Quality and Performance since January 2020. During 2021, Caroline was awarded an Honorary Doctorate of Science from Loughborough University recognising her exceptional contribution to the Covid-19 vaccine programme for Leicester, Leicestershire and Rutland (LLR).

Ms Rachna Vyas
LLR CCGs' Executive Director of Integration and Transformation
Rachna began her NHS career in Leicester City in 2005. Since then, she has had a variety of single commissioner posts working in the Leicester City area, most recently as the Deputy Director of Strategy for Leicester City CCG. She has also held a number of commissioner posts covering elective and non-elective services within the Leicester, Leicestershire and Rutland footprint. Rachna returned to the LLR CCGs from University Hospitals Leicester NHS Trust where she was Deputy Director of Strategy since 2017, leading the strategic and operational planning function as well as delivering service transformation and improvement across the Trust. Since June 2020, Rachna has held the position of Executive Director for Integration and Transformation for the three CCGs in Leicester, Leicestershire and Rutland. In this role she is responsible for the design and delivery of transformed models of care at system level for urgent care, elective care, children's services, maternity services, all age mental health and learning disability services, as well as integration of services at place and neighbourhood level.

Ms Sarah Prema
LLR CCGs' Executive Director of Strategy and Planning
Sarah has had a career in the public sector since leaving school. Prior to 2001 this was in local authorities and since then she worked in various roles in the NHS mainly within commissioning organisations. She has past experience in strategic planning and estates and has previously managed a £40million LIFT programme for the city. Sarah held the role of deputy director of primary care for NHS Leicester City from 2007 and went on to join the CCG in October 2011 where she is responsible for strategic planning of services in Leicester City and developing the annual business plan. From 2015 she has also been responsible for medicines optimisation and primary medical care across the city.

Mrs Alice McGee
LLR CCGs' Executive Director of People and Innovation
Alice began her NHS career in 2007 as an NHS Graduate Management Trainee (HR). During her career she has worked across a number of People Leadership roles in the NHS, predominately in Birmingham and the Black Country. Alice has spent the last 5 years as a HR Director in a CCG and held a Senior Responsible Officer role for the people agenda in the Black Country and West Birmingham STP, which became an ICS. In June 2020, Alice joined Leicester, Leicestershire and Rutland as the Executive Director for People and Innovation for the three CCGs. In this role she is responsible for the People agenda for the CCGs, including the development of the primary care workforce, the digital strategy, and the innovation agenda.

Members of committees of the Governing Body

Members of the committees of the Governing Body are detailed within the Annual Governance Statement and their respective declarations of interest are appended to this report.

Appendix 2 provides the committee / governance structure and Appendix 3 provides the Register of Interests as at 30 June 2022.

Personal data related incidents

There have been no serious untoward incidents relating to data security breaches, including any that would be reported to the Information Commissioner.

Modern Slavery Act

East Leicestershire and Rutland fully supports the Government's objectives to eradicate modern slavery and human trafficking. Our Slavery and Human Trafficking Statement for the period ending 30 June 2022 was published on our website.

Andy Williams
Accountable Officer
26 June 2023

Statement of Accountable Officer's Responsibilities

The National Health Service Act 2006 (as amended) states that each Clinical Commissioning Group shall have an Accountable Officer and that Officer shall be appointed by the NHS Commissioning Board (NHS England). NHS England has appointed the Chief Executive to be the Accountable Officer of NHS East Leicestershire and Rutland CCG.

The responsibilities of an Accountable Officer are set out under the National Health Service Act 2006 (as amended), Managing Public Money and in the Clinical Commissioning Group Accountable Officer Appointment Letter. They include responsibilities for:

- The propriety and regularity of the public finances for which the Accountable Officer is answerable,
- For keeping proper accounting records (which disclose with reasonable accuracy at any time the financial position of the Clinical Commissioning Group and enable them to ensure that the accounts comply with the requirements of the Accounts Direction),
- For safeguarding the Clinical Commissioning Group's assets (and hence for taking reasonable steps for the prevention and detection of fraud and other irregularities).
- The relevant responsibilities of accounting officers under Managing Public Money,
- Ensuring the CCG exercises its functions effectively, efficiently and economically (in accordance with Section 14Q of the National Health Service Act 2006 (as amended)) and with a view to securing continuous improvement in the quality of services (in accordance with Section14R of the National Health Service Act 2006 (as amended)),
- Ensuring that the CCG complies with its financial duties under Sections 223H to 223J of the National Health Service Act 2006 (as amended).

Under the National Health Service Act 2006 (as amended), NHS England has directed each Clinical Commissioning Group to prepare for each financial year a statement of accounts in the form and on the basis set out in the Accounts Direction. The accounts are prepared on an accruals basis and must give a true and fair view of the state of affairs of the Clinical Commissioning Group and of its income and expenditure, Statement of Financial Position and cash flows for the financial year.

In preparing the accounts, the Accountable Officer is required to comply with the requirements of the Government Financial Reporting Manual and in particular to:

- Observe the Accounts Direction issued by NHS England, including the relevant accounting and disclosure requirements, and apply suitable accounting policies on a consistent basis;
- Make judgements and estimates on a reasonable basis;
- State whether applicable accounting standards as set out in the Government Financial Reporting Manual have been followed, and disclose and explain any material departures in the accounts; and,
- Prepare the accounts on a going concern basis; and
- Confirm that the Annual Report and Accounts as a whole is fair, balanced and understandable and take personal responsibility for the Annual Report and

Accounts and the judgements required for determining that it is fair, balanced and understandable.

As the Accountable Officer, I have taken all the steps that I ought to have taken to make myself aware of any relevant audit information and to establish that NHS East Leicestershire and Rutland CCG's auditors are aware of that information. So far as I am aware, there is no relevant audit information of which the auditors are unaware.

I also confirm that:

- as far as I am aware, there is no relevant audit information of which the CCG's auditors are unaware, and that as Accountable Officer, I have taken all the steps that I ought to have taken to make myself aware of any relevant audit information and to establish that the CCG's auditors are aware of that information.

Andy Williams
Accountable Officer
26 June 2023

Governance Statement

Introduction and context

East Leicestershire and Rutland Clinical Commissioning Group (CCG) is a body corporate established by NHS England on 1 April 2013 under the National Health Service Act 2006 (as amended).

The Clinical Commissioning Group's statutory functions are set out under the National Health Service Act 2006 (as amended). The CCG's general function is arranging the provision of services for persons for the purposes of the health service in England. The CCG is, in particular, required to arrange for the provision of certain health services to such extent as it considers necessary to meet the reasonable requirements of its local population.

As at 1 April 2022, the clinical commissioning group is not subject to any directions from NHS England issued under Section 14Z21 of the National Health Service Act 2006.

NHS East Leicestershire and Rutland Clinical Commissioning Group (ELR CCG) is a clinically led membership organisation which comprises 30 GP member practices across: Melton Mowbray, Rutland, Market Harborough, Oadby and Wigston, North Blaby, and South Blaby and Lutterworth.

ELR CCG is responsible for commissioning healthcare services for patients across the CCG area. Information about the commissioning priorities and the population the CCG serves can be found in the Performance Report. There is a need to demonstrate probity and governance commensurate with our considerable responsibilities for our patients' healthcare and taxpayers' money. This means ensuring that we have open, robust and transparent processes which will give the communities we service the confidence that, through the appropriate governance arrangements, we can demonstrate how we will play our part in ensuring that the services our patients receive are safe and delivered with care and compassion.

Scope of responsibility

As Accountable Officer, I have responsibility for maintaining a sound system of internal control that supports the achievement of the clinical commissioning group's policies, aims and objectives, whilst safeguarding the public funds and assets for which I am personally responsible, in accordance with the responsibilities assigned to me in Managing Public Money. I also acknowledge my responsibilities as set out under the National Health Service Act 2006 (as amended) and in my Clinical Commissioning Group Accountable Officer Appointment Letter.

I am responsible for ensuring that the clinical commissioning group is administered prudently and economically and that resources are applied efficiently and effectively, safeguarding financial propriety and regularity. I also have responsibility for reviewing the effectiveness of the system of internal control within the clinical commissioning group as set out in this governance statement.

Governance arrangements and effectiveness

The main function of the governing body is to ensure that the group has made appropriate arrangements for ensuring that it exercises its functions effectively, efficiently and economically and complies with such generally accepted principles of good governance as are relevant to it.

The clinical commissioning group has in place a Constitution, which provides its corporate governance framework, as agreed by its member practices. The CCG's Constitution consists the following: information about the membership, Standing Orders, Scheme of Reservation and Delegation and Prime Financial Policies. The Scheme of Reservation and Delegation clearly details matters reserved to the membership and authority delegated to the Governing Body, its committees and officers. The Prime Financial Policies and the Scheme of Reservation and Delegation are underpinned by Detailed Financial Policies and an Operational Scheme of Delegation respectively.

There have been no amendments to the Constitution during the period of this report.

The clinical commissioning group is led by a Governing Body comprising elected GP members, lead nurse and independent lay members. The overall responsibility for the management of internal control lies with me as the Accountable Officer. The Governing Body, in line with authority delegated to it by the Membership, collectively and individually ensured that robust systems of internal control and management were in place. This responsibility was supported through an effective committee structure, which includes joint committees established with the local authorities.

The governance arrangements across LLR were reviewed and strengthened further to ensure the collaboratives arrangements remained fit for purpose and was robust to support the transitional phase as we began establishing the foundations for the governance across the LLR system. The statutory committees have continued to meet in common and some of the internal facing joint committees have been stood down to enable joint committees with a system focus to be established. The three clinical commissioning groups remain statutory bodies in their own right, with individual Constitutions with alignment across the Scheme of Reservation and Delegation to reflect the new collaborative governance arrangements. Appendix 5 provides details of committees and members of each committee up until 30 June 2022. The committee structure underpinning the CCG and Governing Body has supported the identification and management of internal controls and risks as detailed below.

a) **Audit Committee** – the Audit Committee (statutory committee), which is accountable to the group's Governing Body is chaired by an independent lay member. The Audit Committee has responsibility for reviewing and ensuring that the organisation has established and is maintaining robust and effective systems of integrated governance, risk management and internal control across all areas of its business. It is responsible for providing assurance to the Governing Body that the Executive Management Team has appropriate and adequate systems in place to ensure links between financial risk, corporate and clinical governance. The Audit Committee terms of reference were reviewed in March 2022 and approved in April 2022. The committee continue to meet in common with the Audit Committees of both Leicester City CCG and West Leicestershire CCG.

The Audit Committee reviewed the Board Assurance Framework throughout the year to provide assurance to the Governing Body that the organisation's risk management processes are effective, and risks are being effectively controlled.

The Committee received regular reports on the work and findings of the internal and external auditors; reports from counter fraud team and an update against the NHS Counter Fraud Functional Standard requirements; reports from management in relation to follow-up and progress in relation to implementation of audit recommendations.

The Audit Committee received an opinion of significant assurance from the Head of Internal Audit on the degree of assurance that can be derived from the system of internal control.

The Committee has a schedule to meet at least six times a year. The Audit Committee held seven meetings in total during 2021/22: six regular meetings in common, and one meeting in common to conduct the end of year approvals. A further couple of meetings were held in May 2022 and June 2022. All meetings, with the exception of one, were quorate, well attended and supported by the Head of Corporate Governance. The Committee produced a summary report for the Governing Body following Committee meetings.

b) Auditor Panel – the CCG Auditor Panel (statutory group) was established in March 2016 in line with the Department of Health's and Healthcare Financial Management Association's (HFMA) guidance; and is accountable to the group's Governing Body. The model terms of reference were adopted, and existing members of the Audit Committee formed the membership of the Auditor Panel. It is an advisory panel and the actual procurement and appointment of the external auditors remains within the remit of the Governing Body. The Governing Body approved the appointment of Grant Thornton for a further four years during 2021/22.

c) Remuneration Committee – the Remuneration Committee (statutory committee), is accountable to the group's Governing Body and is responsible for considering the Remuneration policies appropriate to the CCG and in accordance with national guidance. In addition, the Governing Body has delegated the approval of arrangements for identifying the group's proposed accountable officer as detailed within the Scheme of Reservation and Delegation. The Remuneration Committee is chaired by an Independent Lay Member. The Committee convened as required during the year with all meetings being quorate and supported by the Head of Corporate Governance in relation to corporate governance matters, and by the Assistant Director of People for employment related matters. The terms of reference were refreshed and approved in July 2020 by the Governing Body to enable the Committee to meet in common with the Remuneration Committees of both Leicester City CCG and West Leicestershire CCG.

d) Primary Care Commissioning Committee – the Primary Care Commissioning Committee is a committee established by the Clinical Commissioning Group in January 2015 to exercise the primary care commissioning functions that have been delegated from NHS England as of 1 April 2015. The Committee held regular meetings in common in public during 2021/22 and in the first quarter of 2022/23, in conjunction with Leicester City CCG and West Leicestershire CCG. The meetings are chaired by an independent lay member. A summary report from the Primary Care

Commissioning Committee is presented to the Governing Body at its next meeting. The terms of reference were approved by the Governing Body.

e) **Quality, Performance Improvement and Assurance Committee (system focused)** was established to provide oversight and assurance for the development and delivery of a System Quality and Performance Improvement Strategy; assurance processes to monitor quality, safety, patient experience and performance risks across the System; and aid the implementation of the System Quality and Performance Improvement plan. The Committee has an oversight of these core areas of assurance and risk in particular through the transition period to becoming an Integrated Care Board.

f) **Finance Committee (system focused) –** the purpose of this Committee is to provide oversight and assurance in the development and delivery of a robust, viable and sustainable system financial plan; and processes which meet the health and care needs of the population of LLR and aid the implementation of the LLR vision and finance strategy. The Committee has a strategic focus on seeking assurance of delivery against the financial plans and efficiency / transformational delivery plans, and where activity is not on track assurance is sought and advice offered in respect of remedial actions required. The Committee reviews risks and impact of the system financial plans on the CCGs and escalates risks to the Governing Bodies and to the interim integrated care board arrangements.

g) **Executive Management Team meetings (group reporting to the Governing Bodies)** – in October 2020, the Governing Bodies established the Executive Management Team meetings as a formal group reporting into the Governing Bodies. The purpose of EMT is to provide effective leadership that oversees all aspects of operational activities of the LLR CCGs on a day-to-day basis. It is the primary executive decision-making and operational delivery body of the LLR CCGs and is accountable to the respective CCG Governing Bodies for the management of LLR CCGs and delivery of strategic objectives. In July 2021 the remit of the Group was enhanced to include further delegations in relation to non-health and healthcare procurement and commissioning.

h) **Clinical Reference Group (joint committee)** – this is an advisory Committee established by the three CCGs in October 2019 to help improve clinical outcomes, patient experience and reduce health inequalities across the LLR CCGs by providing clinical input and advice in the development and review of commissioning plans and strategies, including service design and redesign.

i) **Competition and Procurement Group** – advises the CCGs on the risks and issues relating to competition and procurement law in respect of its commissioning responsibilities and potential procurements. It is an advisory group with final decisions being made by either the respective CCG Governing Bodies or the Executive Management Team.

The clinical commissioning group has established Integration Executive meetings as a joint partnership groups with each respective local authority (i.e. Leicestershire County Council and Rutland Council Council), via a section 75 partnership agreement. The two Integration Executive meetings advise the Health and Wellbeing Board on matters relating to the management of the Better Care Fund and delivers the health and care

integration programme on behalf of the Health and Wellbeing Board. CCG representatives are members of both Integration Executive partnership groups.

During 2021/22 and up until 30 June 2022, the Governing Body members have continued to evaluate their own performance through development sessions, in collaboration with Leicester City CCG and West Leicestershire CCG, to support focus on individual and collective roles, responsibilities, enhancing leadership skills. These sessions are aimed to support members of the Governing Body to function more effectively as a Governing Body in its own right and also collaboratively with Leicester City CCG and West Leicestershire CCG. In addition, information sessions have also taken place for members of the Governing Body providing them with an opportunity to, for example, review national guidance / initiatives in greater depth and its implications on the clinical commissioning group's business; develop further insight into performance issues with key providers; enhance their knowledge on a specific topics; and receive detailed information on key national requirements.

Governing Body members' attendance record at both the Governing Body development / information sessions and the public meetings of the Governing Body are positive. All meetings of the Governing Body have been quorate with all or the majority of the of the Governing Body members being present (see Appendix 6).

UK Corporate Governance Code

NHS Bodies are not required to comply with the UK Code of Corporate Governance. However, we have reported on our Corporate Governance arrangements by drawing upon best practice available, including those aspects of the UK Corporate Governance Code we consider to be relevant to the CCG and best practice. For the financial year ended 31 March 2022 and the first quarter of 2022/23, and up to the date of signing this statement, the CCG has applied the principles of the Code as we have considered relevant to the CCG including drawing on other best practice available. This is evident, for example through the following:

- there was clear division of responsibilities between the Membership Body, the Governing Body, and the executive responsibilities for running the organisation. The Chairman was responsible for leading the Governing Body and ensuring it is effective in its role, and organising appropriate development and support for the Governing Body's role
- the Committees of the Governing Body consisted of a balance of skill, knowledge, independence, and experience for them to carry out duties and responsibilities
- in the main, information was supplied to the Governing Body and its committees in advance of meetings and of a quality that enables the clinical commissioning group to discharge its duties
- the Governing Body assessed the nature and extent of the significant risks it is willing to take in achieving the strategic objectives of the clinical commissioning group; and it maintains a sound system of risk management and internal control; and
- The Remuneration Committee had oversight of the arrangements in relation to policy on the Remuneration of members of the Governing Body.

Discharge of statutory functions

In light of recommendations of the 1983 Harris Review, the clinical commissioning group has reviewed and will continue to review the statutory duties and powers conferred on it by the National Health Service Act 2006 (as amended) and other associated legislative and regulations. As a result, I can confirm that the clinical commissioning group is clear about the legislative requirements associated with each of the statutory functions for which it is responsible, including any restrictions on delegation of those functions. Responsibility for each duty and power has been clearly allocated to a lead executive within the clinical commissioning group. Directorates have confirmed that their structures provide the necessary capability and capacity to undertake all of the clinical commissioning group's statutory duties and where potential gaps are highlighted these are escalated accordingly for immediate action.

Risk management arrangements and effectiveness

Risk management is an integral part of good management processes; the proactive and continuous management of risk is essential to the efficient and effective delivery of an organisation's objectives. The organisation's Risk Management Strategy and Policy was reviewed and approved in July 2020 setting the strategic and operational frameworks of successful management and evaluation of risk across the Leicester, Leicestershire and Rutland CCGs. The chosen method of risk scoring is based on the ISO 31000 2009 – Risk Management Principles and Guidelines, which are a widely adopted set of principles and guidelines. The clinical commissioning group adopted a common framework for the assessment and analysis of all risks whether they are clinical, financial, information or organisational. The actions required to manage the risks were documented on the risk registers, which were updated as risks continued to be assessed and treated.

A two-tier process involving local directorate-based registers and a corporate register (Board Assurance Framework) have been implemented to reflect the organisation's risk profile. The aim of the two tier approach was to ensure that the strategic picture did not become clouded by the day to day risk management issues that can and were dealt with as a matter of course at local level, whilst still providing a clear route for significant local issues to influence the strategic risk profile. The Board Assurance Framework (corporate risk register), which aligned to the clinical commissioning group's strategic aims and objectives, provided the organisation with a comprehensive method for the effective and focused management of the principal risks with action plans in place to mitigate risks identified. Risk appetite has been determined for each risk in line with the Risk Management Strategy and Policy. The content of the Board Assurance Framework has been reviewed and updated on a regular basis. Key corporate risks identified are detailed in Appendix 7.

All committees of the clinical commissioning group have been critical to the review and management of risks. The Audit Committee, Governing Body and the Executive Management Team have been integral in the review of the Board Assurance Framework; and in the review of the risk profile and oversight of individual risks and action plans. The Executive Management Team has been and continues to be responsible for ensuring corporate risks facing the CCG are current; have been captured and evaluated appropriately; and actions undertaken in a timely manner.

Each directorate had a directorate (operational) risk register where they monitored their local risks. Risks were linked to strategic aims / objectives and the likelihood and impact were assessed to ascertain risk appetite depending on the category of risk, the inherent

risk and residual risk and individual leads were assigned to actions. The CCG's risk appetite is expressed as a boundary above which the level of risk will not be accepted, and further action must be taken. The Audit Committee and the Governing Body reserve the right to vary the amount of risk the CCG is willing to tolerate on an individual risk basis. The Board Assurance Framework was built around the proactive and reactive assessment of risks that may have an impact on the achievement of corporate objectives. This simplified reporting and the prioritisation of action plans which, in turn, allowed for more effective performance management.

Strategic and operational risks on the corporate and local risk registers were regularly reviewed by the Executive Management Team with the objective of ensuring risks were effectively managed. These registers were used to record risks using the 5 x 5 risk scoring matrix. Risks were reported and escalated in line with the CCG's Risk Management Strategy and Policy.

Summary updates and reports on the status of key risks were presented to the Executive Management Team (EMT) via the EMT meetings and at agreed intervals at both the Audit Committee and the Governing Body. Whilst the CCG considered risks to the organisation in meeting its objectives and to its staff, it also considered those to whom a service is provided, the organisations and also the patients themselves. The CCG received risk reports and, where appropriate, assurances and mitigation plans from those organisations from which it commissioned a service. The Internal Audit programme of work has been completed and the Head of Internal Audit has provided an opinion of significant assurance.

Capacity to handle risk

As stated above, the overall responsibility for the management of risk lies with me as the Accountable Officer and operational implementation with the Executive Management Team. The Governing Body collectively and individually ensured that robust systems of internal control and management were in place. This responsibility was supported through an effective Governing Body and committee structure as detailed earlier. Specialist advice on risk assessment and management has been available to the organisation through the organisation's Head of Corporate Governance, Health and Safety Adviser (external), the Information Security lead (external); information Governance support (external), and the Local Counter Fraud specialist (external).

Over the last year there has been continued increase in awareness at all levels of the organisation of the importance and relevance of risk management to operational processes. This has been through team meetings, one-to-one meetings with individuals, the requirement for all staff to complete the e-learning and on-line training modules covering all aspects of risk (for example information, health and safety), circulation of a variety of policies for example finance budget manual, prime and operational financial policies, information security and information governance policies, clinical policies, policy on Fraud, Corruption and Bribery, Conflicts of Interest, Gifts and Hospitality and Sponsorship Policy; Risk Management Strategy and Policy etc.

Risk assessment

The Executive Management Team and members of the Governing Body in the main identified the risks considering the political, economical, social, technological, legal and environmental (PESTLE analysis) in which the CCG operates. In the regular review of the Board Assurance Framework, risks identified from "bottom-up" are also considered,

for example, review of directorate level risk registers, cluster of incidents, cluster of complaints, through performance management arrangements. Risk identification and management had been incorporated into key processes within East Leicestershire and Rutland CCG ensuring embeddedness of the principles of risk management and encouraging a proactive approach to identifying risks. The core business processes, for instance, included the review of risk and the impact on strategic decision making. The organisation's business cases required leads to identify the risk of not implementing a scheme and the benefits realisation of the scheme. In addition, it includes the requirement to undertake equality analysis for each case of need.

The principal risks identified are captured within the Board Assurance Framework are detailed in Appendix 7.

Other sources of assurance

Internal Control Framework

A system of internal control is the set of processes and procedures in place in the clinical commissioning group to ensure it delivers its policies, aims and objectives. It is designed to identify and prioritise the risks, to evaluate the likelihood of those risks being realised and the impact should they be realised, and to manage them efficiently, effectively and economically. The system of internal control allows risk to be managed to a reasonable level rather than eliminating all risk; it can therefore only provide reasonable and not absolute assurance of effectiveness. The system of internal control has been in place in the clinical commissioning group for the period ending 30 June 2022 and up to the date of the approval of the Annual Report and Accounts.

The organisation continued to operate through its comprehensive committee structure which ensures identification, robust management, reporting and accountability for risk management. The Governing Body sought assurance at regular intervals of the review of the Board Assurance Framework; outcomes from the Executive Management Team meetings and the Audit Committee (for example in relation to effectiveness of internal control mechanisms). The Quality, Performance Improvement and Assurance Committee, received assurance reports to monitor areas of risk, including, safeguarding, patient safety, serious incidents, patient complaints, performance risks, planning, procurement and commissioning of services, including instances of whistle-blowing in line with the Freedom to Speak Up Policy as appropriate. The Finance Committee, received assurance, reports in respect of finance and activity. Regular summary reports from these Committees were presented to the Governing Body drawing the Governing Body's attention to key financial, performance, and patient safety and quality risks.

In addition, reports on specific updates and areas of risk were directly reported to the Governing Body including reports on safeguarding adults and children and serious incident reports. The Governing Body reviewed these reports and sought assurance to demonstrate that providers are learning from incidents. All these groups had a role to provide regular monitoring to identify themes and trends for learning and sustained improvements. Where provider performance risks were considered significant and escalated to the Governing Body action was taken by the Governing Body to ensure delivery and a robust mitigation plan. In addition, the Governing Body received assurance reports demonstrating compliance with statutory obligations including compliance with the Public Sector Duty of Equality.

Delivery of the Risk Management Strategy and Policy was also achieved through the implementation of associated policies and procedures, for example, health and safety policies / procedures, incident reporting, claims policy, Counter Fraud Policy, HR policies etc. Progress and performance in achieving the aims of the strategy and adherence to the policy was monitored by the Executive Management Team; the Executive Director of Finance, Contracting and Corporate Governance; the Executive Director of Nursing, Quality and Performance; and ultimately the Governing Body via the Audit Committee. The policies and procedures in place across the CCG aimed to, as far as possible, prevent the identified risks from arising; policies, procedures and codes of conduct were made available to staff through various mechanisms including through the CCG newsletter. Statutory and mandatory training included raising awareness about countering fraud, identifying potential risks and also identifying where risks may have materialised (for example, through the incident reporting process).

Equality analysis is integral to core business processes, policies and processes across the organisation. Relevant systems and processes were implemented to support the policies and procedures, for instance the CCG's Constitution (which includes the Standing Orders, Scheme of Reservation and Delegation and Prime Financial Policies) clearly stipulated the delegations to budget holders which were then reflected within the Shared Business Service system to ensure appropriate level of authorisation is obtained for approval of invoices. Where risks have materialised the Executive Management Team would review the controls in place to determine how the controls need to be improved and whether assurances need to be sought from alternative sources. Control measures are in place to ensure that all the clinical commissioning group's obligations under pensions, sustainable development and equality, diversity and human rights legislation are complied with.

Annual audit of conflicts of interest management

The revised statutory guidance on managing conflicts of interest for CCGs (published June 2017, NHS England) requires CCGs to undertake an annual internal audit of conflicts of interest management. To support CCGs to undertake this task, NHS England has published a template audit framework. The clinical commissioning group has carried out the annual internal audit of conflicts of interest in 2021/22. The objectives of the audit was to evaluate the design and operating effectiveness of the arrangements the CCG has in place to manage conflicts of interest and gifts and hospitality, including compliance with NHS England's updated *Managing Conflicts of Interest: Revised Statutory Guidance for CCGs 2017*, published in June 2017.

These scope areas are derived from the framework published by NHS England and the following areas were reviewed:

- **Governance arrangements** – including whether policies/procedures comply with legal requirements and statutory guidance, an appropriate number of lay members and a conflicts of interest guardian is/are appointed and required training has been provided.
- **Declarations of Interests and Gifts and Hospitality** - including whether declarations are being made and recorded in accordance with legal requirements and statutory guidance.
- **Registers of Interests, Gifts and Hospitality and Procurement Decisions** - including, whether each of these registers is maintained and published in accordance with legal requirements and statutory guidance.

- **Decision making processes and contract monitoring** – including whether there are mechanisms for the management of conflicts within meetings, when making procurement decisions and in relation to contract management.
- **Reporting concerns and identifying and managing breaches/non-compliance** – including whether processes are in place for managing breaches and for the publication of anonymised details of breaches on the CCG's website.
- **Counter Fraud Review** – due consideration of policies with reference to fraud, bribery and corruption and detect any undeclared conflicts of interest for review.

The auditors provided an opinion of "significant assurance" noting that the risk management activities and controls are suitably designed, and were operating with sufficient effectiveness, to provide reasonable assurance that the control environment was effectively managed during the period under review. The audit identified the following actions:

- The Staff Declarations of Interest Register will be reviewed to ensure that all decision making staff interests or nil declarations are received and recorded.
- At the next review of the Register of Procurement Decisions, the projects / procurement recorded within the LLR Procurement Work Programme will be reviewed and added.
- The date of approval for any gifts, hospitality and sponsorship will be recorded within the register.
- The CCG will obtain the conflicts of interest declaration forms completed by staff involved in the Improving Access to Psychological Therapies Service and Anticoagulation Housebound Service procurement to be assured that any conflicts declared have been managed appropriately.
- The CCGs will communicate to all staff the requirement of the Conflicts of Interest, Gifts and Hospitality and Sponsorship Policy to declare interests, gifts or hospitality within 28 days of being aware of them.
- The Head of Corporate Governance will review the interests of some individuals to ascertain if further relevant information is required.

Data Quality

Good information underpins sound decision making within the CCG. The CCG is committed to improving data quality and information flows throughout the organisation and in particular through its committees to the Governing Body and to the membership. Following feedback throughout the year from Governing Body members and its committees the quality of both qualitative and quantitative data and information has improved. This has enabled information in relation to performance monitoring and consideration of future commissioning of services to be based on more current information. Internal audit has undertaken various audits throughout the year where the quality of both data and information was reviewed to provide assurance to the Audit Committee and the Governing Body.

Information Governance

The NHS Information Governance Framework sets the processes and procedures by which the NHS handles information about patients and employees, in particular personal identifiable information. The NHS Information Governance Framework is supported by the Data Security and Protection Toolkit and the annual submission process provides assurances to the clinical commissioning group, other organisations and to individuals that personal information is dealt with legally, securely, efficiently and effectively. In

response to the coronavirus crisis, NHS Digital extended the submission deadline from 31 March to 30 June 2022.

We place high importance on ensuring there are robust information governance systems and processes in place to help protect patient and corporate information. We have established an information governance management framework and have developed and continue to further develop information governance processes and procedures in line with the Data Security and Protection Toolkit. We have ensured all staff undertake annual information governance training and have implemented a staff information governance handbook / leaflets to ensure staff are aware of their information governance roles and responsibilities.

There are processes in place for incident reporting and investigation of serious incidents. We are developing information risk assessment and management procedures and a programme will be established to fully embed an information risk culture across the three LLR CCGs. The CCG had in place an Information Governance Strategy and Policy. The final year end self-assessment for 2021/22 was approved by the Executive Management Team at its meeting in April 2022 and the CCG assessed itself as compliant with the requirements. Specific requirements were submitted to Internal Audit and a final opinion "significant assurance" has been provided with one action to be completed which have a low risk score. Information risks are clearly defined within the Risk Management Strategy and Policy including the role of the Senior Information Risk Officer and the Information Asset Owners, which supports the requirements for identifying and managing information risk. In addition, the CCG can report that there have been no information governance incidents reported in 2021/22 and none reported in the period April to June 2022.

The NHS Data Mapping exercise was undertaken during 2021/22 in line with GDPR and Data Protection regulations and involved identification of personal identifiable information data flows into and out of the organisation. Systems and processes are in place to ensure the security of data; and to ensure encryption of all electronic personal identifiable information data transfers, e.g. via email and personal and confidential data held on mobile devices such as laptops. All staff are required to complete the annual e-learning training module on information governance.

Business critical models and third-party assurances

An appropriate framework and environment is in place to provide quality assurance of business-critical models, in line with the recommendations in the Macpherson report. All business-critical models have been identified and information about quality assurance processes for those models. This framework is informed by the role of the Audit Committee and internal audit programme to review systems of internal control to identify areas for improvement. The CCG has a rigorous performance management framework which it uses to monitor delivery of services from its third-party contractors, this includes collaborative arrangements across the three local CCGs.

The CCG also has business continuity arrangements which will identify those business processes which need to recover as a priority in the event of business disruption. In addition, the CCG has sought assurance from GP Practices and from the health informatics service provider in respect of their business continuity plans and processes to enable the CCG in performing its duties and supporting its business continuity arrangements. Furthermore, in line with the annual Data Security and Protection Toolkit requirements we have produced and maintained an information asset register which

defines business critical models and their asset owners in the organisation. Data mapping flows have been conducted which enables an understanding of the flows of information related to these key business critical models.

Control issues

During the period no significant control issues have been identified that would prejudice the achievement of the CCG's priorities or impact the delivery of the standards expected by the Accountable Officer.

The internal auditors have not advised the Audit Committee of any such control issues. The Head of Internal Audit Opinion from the internal auditors is detailed later in this report.

Review of economy, efficiency and effectiveness of the use of resources

The effectiveness of the use of resources and financial performance of the clinical commissioning group was monitored on a monthly basis by the Governing Body and the Executive Management Team. Corporate risks in respect of financial performance and use of resources are captured in the Board Assurance Framework and directorate level risk registers and reported to the Audit Committee regularly and the Governing Body at least on an annual basis.

In addition, performance of providers and commissioned services was monitored in the main through the Finance Committee and the Quality, Performance Improvement and Assurance Committee. The main financial risks that the CCG faced throughout the year, and immediately after the year-end, are highlighted in the Performance Report. The Audit Committee included within the internal audit plan for 2021/22 an audit to review integrity of the general ledger and financial systems. This audit was given an opinion of significant assurance and the contents shared with the Audit Committee and relevant teams within the CCG to ensure action is taken where recommendations have been highlighted by the auditors.

Delegation of functions

The CCG was awarded delegated authority from 1 April 2015 from NHS England for commissioning and contracting of primary medical services. The delegated functions form the remit of the Primary Care Commissioning Committee which oversees and ensures the CCG adheres to and carries out the functions delegated to it. The CCG's internal controls in respect of managing conflicts of interest have been enhanced as a result of this to ensure robust systems are in place to manage conflicts of interest. In particular, as the GP members of the Governing Body are members of the Primary Care Commissioning Committee, a committee level conflicts of interest register has been maintained to monitor declarations of interest and the action taken to mitigate actual and perceived conflicts.

The Audit Committee and the Conflicts of interest Guardian provides a level of scrutiny and challenge in reviewing the processes for decision making, in particular decisions made by the Primary Care Commissioning Committee and how it manages conflicts of interest.

In 2021/22 conflicts of interest formed part of the CCG's annual internal audit programme and the auditors reviewed the CCG's systems and processes in line with the NHS England's guidance. The outcome of the review was a "significant assurance" opinion.

Furthermore, the internal auditors have reviewed the CCG's process for quarterly self-certification returns to NHS England in relation to the delegation functions and have confirmed they are supportive of the approach taken. The CCG submits the quarterly self-certification returns to NHS England, which has aligned with the CCG's quarterly assurance meeting with NHS England where issues and queries can be raised in respect of the CCG's performance of the delegated functions and the management of conflicts of interest.

Counter fraud arrangements

The CCG commissions counter fraud services from 360 Assurance who have assigned to the CCG an Accredited Counter Fraud Specialist to undertake counter fraud work proportionate to identified risks. The Executive Director of Finance, Contracting and Corporate Governance is a member of the Governing Body and is proactively and demonstrably responsible for tackling fraud, bribery and corruption. There is executive support and direction from the Executive Director of Finance, Contracting and Corporate Governance for a proportionate proactive work plan to address identified risks. The CCG Audit Committee receives a report against the work plan and the NHS Counter Fraud Functional Standard requirements at least annually to ensure appropriate action is being taken to mitigate risks identified. A detailed action plan is in place to ensure compliance with the NHS Counter Fraud Functional Standard requirements and to address any recommendations that are identified through the review process.

Head of Internal Audit Opinion

Following completion of the planned audit work for the financial year for the clinical commissioning group, the Head of Internal Audit issued an independent and objective opinion on the adequacy and effectiveness of the clinical commissioning group's system of risk management, governance and internal control. The Head of Internal Audit has provided the following opinion for the period April to June 2022:

> *I am providing an interim opinion of **significant assurance** that there is a generally sound framework of governance, risk management and control designed to meet the organisation's objectives, and that controls are generally being applied consistently.*
>
> *As at 30 June the CCG had 9 internal audit actions outstanding, 6 of which related to previous years, providing a first follow up rate of 40%. All actions have been given a revised implementation date and will be handed over to the ICB for monitoring through to implementation.*
>
> *Throughout the period we have continued to provide transition support to the CCG, including attendance at the LLR ICB Transition Committee.*

During the period no audit reports were issued other than the Head of Internal Audit Opinion for 2021/22.

I am not aware of any risks that have materialised resulting in deficiencies in internal control systems. I confirm that there have been no serious incidents in the last year involving personal data where the incident is attributable to the CCG. The CCG continues

to monitor risks at both operational and corporate level, including review of systems, processes and policies to ensure ongoing continuous improvement in systems.

Where the CCG receives third party support for financial services from another organisation, they receive a Service Auditor Report (SAR) from the organisation's auditors confirming the level of assurance they can provide over the controls in place. The CCG has not received any further SARs for the period April to June 2022. Where SARs are received, they are reviewed and either take sufficient assurance from the SAR itself or is assured that for any weakness in control contained within the SAR the CCG has suitable additional processes in place to mitigate any resultant risk.

Review of the effectiveness of Governance, Risk Management and Internal Control

As the Accountable Officer I have responsibility for reviewing the effectiveness of the system of internal control within the clinical commissioning group. My review of the effectiveness of the system of internal control is informed by the work of the internal auditors and the executive managers (the Executive Management Team) and clinical leads within the clinical commissioning group who have responsibility for the development and maintenance of the internal control framework. I have drawn on performance information available to me. My review is also informed by comments made by the external auditors in their annual audit letter and other reports.

Our Board Assurance Framework provides me with evidence that the effectiveness of controls that manage risks to the clinical commissioning group achieving its principle objectives have been reviewed.

I have been advised on the implications of the result of my review of effectiveness of the system of internal control by the following:

- The Governing Body.
- The Audit Committee.
- The Quality, Performance Improvement and Assurance Committee
- The Finance Committee
- the Primary Care Commissioning Committee.
- The Executive Management Team
- and internal audit.

A plan to address weaknesses and ensure continuous improvement of the system is in place. The processes and committees that have been integral to maintaining and reviewing the effectiveness of the system of internal control, and in addition to the reviews undertaken by internal audit; and quarterly checkpoint assurance meetings with the NHS England. The specific role of the Governing Body and its committees in reviewing effectiveness of systems of internal control and risk management is provided earlier.

Conclusion

There are no significant internal control issues that have been identified.

Remuneration and Staff Report

Remuneration Report

The Remuneration Report and Staff Report set out the CCG's remuneration policy for directors and senior managers (i.e. executives) and how that policy has been implemented. The disclosure also includes information on those persons in senior positions having authority or responsibility for directing or consulting major activities within the CCG. This means those who influence the decisions of the entity as a whole rather than the decisions of individual directorates or departments. The CCG has interpreted this to mean the Chief Officers (i.e. the executives), the lay members (i.e. the non-executives), and GP members of the Governing Body (i.e. representatives from the CCG GP member practices).

Remuneration Committee

The Remuneration Committee is made up of the following members:

Name	Position
Mr. Clive Wood	Independent Lay Member, Remuneration Committee Chair
Mr. Warwick Kendrick	Independent Lay Member
Ms. Fiona Barber	CCG Deputy Chair and Independent Lay Member

The Remuneration Committee, which comprises of the three Lay Members, reviews the remuneration arrangements of its most senior managers including the sessional rates for GP members of the Governing Body, taking into account market rates and agenda for change pay awards determined nationally. The Committee held meetings as required during the period April to June 2022 in line with its terms of reference all of which were quorate. This included holding meetings of Remuneration Committees in common with the Remuneration Committees of Leicester City CCG and West Leicestershire CCG.

Policy on the remuneration of senior managers

All Senior Managers (excluding the Accountable Officer and Executive Directors) are employed under the agenda for change terms and conditions.

Remuneration of Very Senior Managers

The Remuneration of the Accountable Officer and Executive Directors on Very Senior Managers' (VSM) contracts is reviewed annually by the Remuneration Committee, taking into account any national guidance, and agreed by the Governing Body.

Senior Manager performance is monitored through the formal appraisal process, based on organisational and individual objectives.

The Remuneration Committee has access to professional advisors as required to support the Committee's work programme. In setting policy for current and future years, the Committee has access to guidance, best practice and benchmarking information from NHS Employers, NHS England and comparative CCGs.

Account is also taken of the pay and conditions of service that apply to other employees in the CCG.

Remuneration of the ICB Accountable Officer was determined by NHS England and agreed by ministers.

Remuneration of the ICB Directors has not been determined at the time of writing, however, this will be in line with the ICB Executive Pay Framework.

Policy on senior managers' contracts

Agenda for Change, the current NHS grading and pay system for all NHS staff (excluding doctors, dentists and some senior managers), was used to determine other senior managers' pay and conditions of employment which also determines other employees pay and employment conditions.

The Accountable Officer and Executive Directors are permanent employees of the CCG, employed on Very Senior Manager contracts.

The Accountable Officer and Executive Directors are required to give six months' notice, in writing, in respect of any decision to leave the organisation.

All other senior managers are required to give 12 weeks' notice, in writing, in respect of any decision to leave the organisation.

No employment contracts include an entitlement to a termination payment other than by reason of redundancy outside of their contractual entitlement to the notice period.

The ICB will continue to set remuneration in accordance with the latest available national guidance and local benchmarking information.

Senior managers' service contracts

GP Member Practices elected the GP members of East Leicestershire and Rutland CCG's Governing Body to their posts for a period of three years and the appointment is made on the understanding that they subscribe to the 'Codes of Conduct and Accountability in the NHS' and accept the terms and conditions of their appointment. They are also asked to comply at all times with the 'Standards for members of NHS Boards and CCG Governing Bodies in England'. Three months' prior notice must be given in writing by either party to terminate the agreement early. On termination of the appointment, the Member will only be entitled to accrue fees at the date of termination together with reimbursement of any expenses properly incurred prior to that date.

There is no provision for compensation for early termination of the contract. The Clinical Chair was appointed to their position following expressions of interest put forward by GPs from Member Practices and an interview process. The independent lay members are appointed for a term of three years from when they commenced in post. The secondary care clinician position on the Governing Body was appointed to the role following an open recruitment process, and over the last year this position has been vacant.

Senior manager remuneration / salaries and allowances

The table below shows the remuneration (excluding any employer's National Insurance contributions) for all Governing Body members irrespective of their employment status with the CCG.

Salary includes:

- all amounts paid or payable by the NHS body including recharges from any other health body
- the gross cost of any arrangement whereby a senior manager receives a net amount and an NHS body pays income tax on their behalf
- any financial loss allowances paid in place of Remuneration
- geographical allowances such as London weighting, and
- any other allowances which is subject to UK taxation and any ex-gratia payments.

Salary excludes:

- recharges to any other health body
- reimbursement of out-of-pocket expenses
- reimbursement of "travelling and other allowances" (paid under determination order) including home to work travel costs
- taxable benefits
- employers' superannuation and National Insurance contributions
- performance related bonuses (these are recorded separately)
- golden hellos and compensation for loss of office (these are recorded separately), and
- any amount paid which the director must subsequently repay.

Andy Williams
Accountable Officer
26 June 2023

Remuneration and Allowances report April to June 2022 (subject to audit)

Name & Title	(a) Salary (bands of £5,000) £'000	(b) Expense Payments (taxable to the nearest £100) *1 £	(c) Performance pay and bonuses (Bands of £5,000) £'000	(d) Long term performance pay bonuses (Bands of £5,000) £'000	(e) All pension related benefits (Bands of £2,500) £'000	(f) TOTAL (a to e) (bands of £5,000) £'000
Andrew Williams, Chief Executive	10 - 15	0	0	0	20 - 22.5	30 - 35
Caroline Trevithick, Executive Director of Nursing, Quality and Performance	10 - 15	0	0	0	20 - 22.5	30 - 35
Nicola Briggs, Exec Director Finance, Contracting & Corporate Governance	10 - 15	0	0	0	7.5 - 10	15 - 20
Sarah Prema, Executive Director of Strategy and Planning	10 - 15	0	0	0	12.5 - 15	25 - 30
Alice McGee, Executive Director of People and Innovation	10 - 15	0	0	0	0 - 2.5	10 - 15
Rachana Vyas, Executive Director of Integration & Transformation	10 - 15	0	0	0	2.5 - 5	10 - 15
Dr Vivek Varakantam, CCG Clinical Chair	20 - 25	0	0	0	0 - 0	20 - 25
Dr Nicholas Glover, Member Practice Representative	15 - 20	0	0	0	0 - 0	15 - 20
Dr Nikhil Mahatma, Member Practice Representative	15 - 20	0	0	0	0 - 0	15 - 20
Dr Girish Purohit, Member Practice Representative	15 - 20	0	0	0	0 - 0	15 - 20
Dr Andy Ahyow, Member Practice Representative	35 - 40	0	0	0	0 - 0	35 - 40
Dr Graham Johnson, Member Practice Representative	15 - 20	0	0	0	0 - 0	15 - 20
Warwick Kendrick, Independent Lay Member	0 - 5	0	0	0	0 - 0	0 - 5
Fiona Barber, Deputy Chair and Independent Lay Member	0 - 5	0	0	0	0 - 0	0 - 5
Clive Wood, Independent Lay Member	0 - 5	0	0	0	0 - 0	0 - 5

*1: Taxable expenses and benefits in kind are expressed to the nearest £100. The values and bands used to disclose sums in this table are prescribed by the through Employer Pension Notices and replicated in the HM Treasury Financial Reporting Manual Cabinet Officer

The Salary payments for Board members includes all pay including extra clinical work for non-Board membership remuneration.

Andrew Williams is the Accountable Officer for NHS Leicester City Clinical Commissioning Group; NHS East Leicestershire and Rutland Clinical Commissioning Group; and NHS West Leicestershire Clinical Commissioning Group.

The Remuneration Committee makes recommendations to the Board on proposed remuneration and terms of condition for Board members. It also advises the Board on appropriate remuneration and terms of service for the Accountable Officer and senior officers who report to the Accountable Officer, in accord with relevant national pay frameworks and other guidance as appropriate.

The salaries of the members identified below, were allocated over Leicester, Leicestershire and Rutland Clinical Commissioning Groups. The allocation share of 30.06% to NHS East Leicestershire and Rutland Clinical Commissioning Group is shown above. Their total remuneration is shown below (subject to audit):

Total Remuneration for members allocated over a number of LLR CCGs	(a) Salary (bands of £5,000) £'000	(b) Expense Payments (taxable to the nearest £100) *1 £	(c) Performance pay and bonuses (Bands of £5,000) £'000	(d) Long term performance pay bonuses (Bands of £5,000) £'000	(e) All pension related benefits (Bands of £2,500) £'000	(f) TOTAL (a to e) (bands of £5,000) £'000
Andrew Williams, Chief Executive	45 - 50	0	0	0	65 - 67.5	110 - 115
Caroline Trevithick, Executive Director of Nursing, Quality and Performance	40 - 45	0	0	0	67.5 - 70	110 - 115
Nicola Briggs, Exec Director Finance, Contracting & Corporate Governance	40 - 45	0	0	0	25 - 27.5	65 - 70
Sarah Prema, Executive Director of Strategy and Planning	35 - 40	0	0	0	47.5 - 50	80 - 85
Alice McGee, Executive Director of People and Innovation	35 - 40	0	0	0	7.5 - 10	40 - 45
Rachana Vyas, Executive Director of Integration & Transformation	35 - 40	0	0	0	10 - 12.5	45 - 50

Remuneration and Allowances report 2021/22

Name & Title	(a) Salary (bands of £5,000) £'000	(b) Expense Payments (taxable to the nearest £100) *1 £	(c) Performance pay and bonuses (Bands of £5,000) £'000	(d) Long term performance pay bonuses (Bands of £5,000) £'000	(e) All pension related benefits (Bands of £2,500) £'000	(f) TOTAL (a to e) (bands of £5,000) £'000
Andrew Williams, Chief Executive	50 - 55	0	0	0	32.5 - 35	80 - 85
Caroline Trevithick, Executive Director of Nursing, Quality and Performance	30 - 35	0	0	0	5 - 7.5	40 - 45
Nicola Briggs, Exec Director Finance, Contracting & Corporate Governance	40 - 45	0	0	0	10 - 12.5	50 - 55
Sarah Prema, Executive Director of Strategy and Planning	30 - 35	0	0	0	5 - 7.5	35 - 40
Alice McGee, Executive Director of People and Innovation	30 - 35	0	0	0	7.5 - 10	40 - 45
Rachana Vyas, Executive Director of Integration & Transformation	30 - 35	0	0	0	7.5 - 10	40 - 45
Dr Vivek Varakantam, CCG Clinical Chair	90 - 95	0	0	0	0 - 0	90 - 95
Dr Nicholas Glover, Member Practice Representative	70 - 75	0	0	0	0 - 0	70 - 75
Dr Nikhil Mahatma, Member Practice Representative	60 - 65	0	0	0	0 - 0	60 - 65
Dr Girish Purohit, Member Practice Representative	60 - 65	0	0	0	0 - 0	60 - 65
Dr Andy Ahyow, Member Practice Representative	65 - 70	0	0	0	0 - 0	65 - 70
Dr Graham Johnson, Member Practice Representative	65 - 70	0	0	0	0 - 0	65 - 70
Warwick Kendrick, Independent Lay Member	15 - 20	0	0	0	0 - 0	15 - 20
Fiona Barber, Deputy Chair and Independent Lay Member	15 - 20	0	0	0	0 - 0	15 - 20
Clive Wood, Independent Lay Member	10 - 15	0	0	0	0 - 0	10 - 15

*1: Taxable expenses and benefits in kind are expressed to the nearest £100. The values and bands used to disclose sums in this table are prescribed by the through Employer Pension Notices and replicated in the HM Treasury Financial Reporting Manual Cabinet Officer

Andrew Williams is the Accountable Officer for NHS Leicester City Clinical Commissioning Group; NHS East Leicestershire and Rutland Clinical Commissioning Group; and NHS West Leicestershire Clinical Commissioning Group.

The Remuneration Committee makes recommendations to the Board on proposed remuneration and terms of condition for Board members. It also advises the Board on appropriate remuneration and terms of service for the Accountable Officer and senior officers who report to the Accountable Officer, in accord with relevant national pay frameworks and other guidance as appropriate.

The salaries of the members identified below, were allocated over Leicester, Leicestershire and Rutland Clinical Commissioning Groups. The allocation share of 30.06% to NHS East Leicestershire and Rutland Clinical Commissioning Group is shown above. Their total remuneration is shown below (subject to audit):

Total Remuneration for members allocated over a number of LLR CCGs	(a) Salary (bands of £5,000) £'000	(b) Expense Payments (taxable to the nearest £100) *1 £	(c) Performance pay and bonuses (Bands of £5,000) £'000	(d) Long term performance pay bonuses (Bands of £5,000) £'000	(e) All pension related benefits (Bands of £2,500) £'000	(f) TOTAL (a to e) (bands of £5,000) £'000
Andrew Williams, Chief Executive	165 - 170	0	0	0	112.5 - 115	280 - 285
Caroline Trevithick, Executive Director of Nursing, Quality and Performance	110 - 115	0	0	0	22.5 - 25	135 - 140
Nicola Briggs, Exec Director Finance, Contracting & Corporate Governance	140 - 145	0	0	0	35 - 37.5	175 - 180
Sarah Prema, Executive Director of Strategy and Planning	110 - 115	0	0	0	17.5 - 20	130 - 135
Alice McGee, Executive Director of People and Innovation	110 - 115	0	0	0	25 - 27.5	135 - 140
Rachana Vyas, Executive Director of Integration & Transformation	110 - 115	0	0	0	25 - 27.5	135 - 140

Pension benefits as at 30 June 2022 (subject to audit)

Name & Title	(a) Real Increase in pension at pension age (bands of £2,500) £'000	(b) Real Increase in pension lump sum at pension age (bands of £2,500) £'000	(c) Total accrued pension at pension age at 30 June 2022 (bands of £5,000) £'000	(d) Lump sum at pension age related to accrued pension at 30 June 2022 (bands of £5,000) £'000	(e) Cash Equivalent Transfer Value at 01 April 2022 £'000	(f) Real Increase in Cash Equivalent Transfer Value £'000	(g) Cash Equivalent Transfer Value at 30 June 2022 £'000	(h) Employers Contribution to stakeholder pension £'000
Andrew Williams, Chief Executive	2.5 - 5	5 - 7.5	85 - 87.5	212.5 - 215	1758	75	1895	0
Caroline Trevithick, Executive Director of Nursing, Quality and Performance	2.5 - 5	7.5 - 10	50 - 52.5	142.5 - 145	983	70	1088	0
Nicola Briggs, Exec Director Finance, Contracting & Corporate Governance	0 - 2.5	0 - 0	27.5 - 30	0 - 0	258	14	285	0
Sarah Prema, Executive Director of Strategy and Planning	0 - 2.5	5 - 7.5	60 - 62.5	132.5 - 135	1161	53	1255	0
Alice McGee, Executive Director of People and Innovation	0 - 2.5	0 - 0	2.5 - 5	0 - 0	34	1	41	0
Rachana Vyas, Executive Director of Integration & Transformation	0 - 2.5	0 - 0	7.5 - 10	0 - 0	83	6	93	0

Pension benefits are applicable to all senior managers unless they wish to opt out of membership of the NHS pension scheme. The GP members of the governing body are not subject to this disclosure as, for those that have opted to join the NHS Pension scheme, they make their NHS pension scheme contributions via their GP practices. Similarly the Lay Members of the governing body do not contribute to the NHS pension scheme and so are not subject to the disclosure

The pension table above gives detail of the total pension values for members, including those shared across Leicester, Leicestershire and Rutland Clinical Commissioning Groups. Therefore while the shared members are also reported in the other Clinical Commissioning Group Annual reports, these are not additional pensions but reflect the same total pension values.

Pension benefits as at 31 March 2022

Name & Title	(a) Real Increase in pension at pension age (bands of £2,500) £'000	(b) Real Increase in pension lump sum at pension age (bands of £2,500) £'000	(c) Total accrued pension at pension age at 31 March 2022 (bands of £5,000) £'000	(d) Lump sum at pension age related to accrued pension at 31 March 2022 (bands of £5,000) £'000	(e) Cash Equivalent Transfer Value at 01 April 2021 £'000	(f) Real Increase in Cash Equivalent Transfer Value £'000	(g) Cash Equivalent Transfer Value at 31 March 2022 £'000	(h) Employers Contribution to stakeholder pension £'000
Andrew Williams, Chief Executive	5 - 7.5	7.5 - 10	75 - 80	200 - 205	1592	134	1758	0
Caroline Trevithick, Executive Director of Nursing, Quality and Performance	0 - 2.5	0 - 0	45 - 50	130 - 135	933	31	983	0
Nicola Briggs, Exec Director Finance, Contracting & Corporate Governance	2.5 - 5	0 - 0	25 - 30	0 - 0	225	11	258	0
Sarah Prema, Executive Director of Strategy and Planning	0 - 2.5	0 - 0	55 - 60	125 - 130	1108	32	1161	0
Alice McGee, Executive Director of People and Innovation	0 - 2.5	0 - 0	0 - 5	0 - 0	15	3	34	0
Rachana Vyas, Executive Director of Integration & Transformation	0 - 2.5	0 - 0	5 - 10	0 - 0	60	6	83	0

Notes

Pension benefits are applicable to all senior managers unless they wish to opt out of membership of the NHS pension scheme. The GP members of the governing body are not subject to this disclosure as, for those that have opted to join the NHS Pension scheme, they make their NHS pension scheme contributions via their GP practices. Similarly the Lay Members of the governing body do not contribute to the NHS pension scheme and so are not subject to the disclosure.

The pension table above gives detail of the total pension values for members, including those shared across Leicester, Leicestershire and Rutland Clinical Commissioning Groups. Therefore while the shared members are also reported in the other Clinical Commissioning Group Annual reports, these are not additional pensions but reflect the same total pension values.

Cash equivalent transfer values
A cash equivalent transfer value (CETV) is the actuarially assessed capital value of the pension scheme benefits accrued by a member at a particular point in time. The benefits valued are the member's accrued benefits and any contingent spouse's (or other allowable beneficiary's) pension payable from the scheme.

A CETV is a payment made by a pension scheme or arrangement to secure pension benefits in another pension scheme or arrangement when the member leaves a scheme and chooses to transfer the benefits accrued in their former scheme. The pension figures shown relate to the benefits that the individual has accrued as a consequence of their total membership of the pension scheme, not just their service in a senior capacity to which disclosure applies.

The CETV figures and the other pension details include the value of any pension benefits in another scheme or arrangement which the individual has transferred to the NHS pension scheme. They also include any additional pension benefit accrued to the member as a result of their purchasing additional years of pension service in the scheme at their own cost. CETVs are calculated within the guidelines and framework prescribed by the Institute and Faculty of Actuaries.

Real increase in CETV
This reflects the increase in CETV that is funded by the employer. It does not include the increase in accrued pension due to inflation or contributions paid by the employee (including the value of any benefits transferred from another scheme or arrangement).

Compensation on early retirement of for loss of office (subject to audit)
No payments were made during the year in respect of early retirement or for loss of office.

Payments to past directors (subject to audit)
No such payments have been proposed or paid during the year.

Fair Pay Disclosure (subject to audit)
Pay ratio information concerning the highest paid director and all other employees is detailed below.

Percentage change in remuneration of highest paid director

	Salary and allowances (22/23)	Performance pay and bonuses (22/23)	Salary and allowances (21/22)	Performance pay and bonuses (21/22)
The percentage change from the previous financial year in respect of the highest paid director	4.32%	0.00%	-5.13%	0.00%
The average percentage change from the previous financial year in respect of employees of the entity, taken as a whole	-3.97%	0.00%	13.68%	0.00%

These figures are based on total renumeration paid to the highest paid director vs the total gross renumeration paid to all remaining employees in June 2022.

The increase in highest paid director relates to additional sessions worked in preparation for ICB transition.

The reduction in the average pay reflects a reduced agency spend in the period

Pay ratio information

Reporting bodies are required to disclose the relationship between the remuneration of the highest-paid director / member in their organisation against the 25th percentile, median and 75th percentile of remuneration of the organisation's workforce. Total remuneration of the employee at the 25th percentile, median and 75th percentile is further broken down to disclose the salary component.

The banded remuneration of the highest paid director / member in East Leicestershire and Rutland CCG in the financial period was £96.5 (2021-22, £92.5). The relationship to the remuneration of the organisation's workforce is disclosed in the below table.

2022	25th percentile	Median	75th percentile
Total remuneration (£)	39,027	47,126	75,921
Salary component of total remuneration (£)	39,027	47,126	75,921
Pay ratio information	2.47	2.05	1.27
2021-22			
Total remuneration (£)	39,027	53,219	77,000
Salary component of total remuneration (£)	39,027	53,219	77,000
Pay ratio information	2.37	1.74	1.20

In the financial period, 18 employees (2021-22, 23 employees) received remuneration in excess of the highest-paid director / member. Annualised gross Remuneration ranged from £190k to £21.6k (2021-22, £190k to £21.6k) based on Annualised Gross Pay.

Total remuneration includes salary, non-consolidated performance-related pay, benefits-in-kind, but not severance payments. It does not include employer pension contributions and the cash equivalent transfer value of pensions.

The salary of the highest paid director reflects the Actual pay, whereas the comparison is to the calculated Gross Annualised Cost.

Due to this convention, several employees (including other directors) who are part time, are showing as receiving renumeration in excess of the highest paid director as we are comparing the actual part time salary of the Highest paid Director with the hypothetical full time salary of all remaining staff.

Total remuneration includes salary, non-consolidated performance-related pay, benefits-in-kind, but not severance payments. It does not include employer pension contributions and the cash equivalent transfer value of pensions.

This comparison is based on a total of 101 staff (2021/22 108).

The 25th percentile has remained at the same value, resulting in a deterioration in the ratio, when compared to the slight increase for the highest paid Director

Due to the loss of several agency staff members the median and 75th Percentile values have decreased, this is resulting in a deterioration in the ratios.

Staff Report

Number of senior managers

The senior managers (i.e., executives) and details about their salary by band, with further detail available in the Remuneration and Allowance table within the Remuneration Report section of this report.

Title	First Name	Last Name	Band
Mr	Andy	Williams	VSM
Ms	Caroline	Trevithick	VSM
Mrs	Nicola	Briggs	VSM
Mrs	Alice	McGee	VSM
Ms	Rachna	Vyas	VSM
Ms	Sarah	Prema	VSM

Staff numbers and costs (subject to audit)

	30-Jun-22								
	ADMIN			PROGRAMME			TOTAL		
	Perm	Other		Perm	Other		Perm	Other	
	Permanent Employees £'000	Other £'000	Total £'000	Permanent Employees £'000	Other £'000	Total £'000	Permanent Employees £'000	Other £'000	Total £'000
	N4A	N4B	N4C	N4D	N4E	N4F	N4G	N4H	N4I
Salaries and wages	615	22	637	255	136	391	870	158	1,028
Social security costs	75	-	75	41	-	41	116	-	116
Employer contributions to the NHS Pension Scheme	147	-	147	34	-	34	180	-	180
Other pension costs	-	-	-	-	-	-	-	-	-
Apprenticeship Levy	1	-	1	-	-	-	1	-	1
Other post-employment benefits	-	-	-	-	-	-	-	-	-
Other employment benefits	-	-	-	-	-	-	-	-	-
Termination benefits	-	-	-	-	-	-	-	-	-
Gross Employee Benefits Expenditure	**839**	**22**	**861**	**330**	**136**	**466**	**1,168**	**158**	**1,326**
Less: Recoveries in respect of employee benefits (note 4.1.2)	(17)	-	(17)	(79)	-	(79)	(96)	-	(96)
Net employee benefits expenditure including capitalised costs	**821**	**22**	**843**	**251**	**136**	**387**	**1,072**	**158**	**1,230**
Less: Employee costs capitalised	-	-	-	-	-	-	-	-	-
Net employee benefits expenditure excluding capitalised costs	**821**	**22**	**843**	**251**	**136**	**387**	**1,072**	**158**	**1,230**

Average Number of People Employed

	30-Jun-22		
	Permanent Employees Number	Other Number	Total Number
	N4Y	N4Z	N4AA
Total Entity	**68.54**	**6.02**	**74.56**
Of the above:			
Number of whole time equivalent people engaged on capital projects			-

Staff composition

The employed workforce, plus office holders and appointments, at 30 June 2022 was 98 (headcount).

In terms of grade-mix, the chart below provides a visual representation of the shape of the workforce in terms of pay reward. The vast majority of staff are paid under Agenda for Change (AfC) terms and conditions. For the Non-agenda for Change groups, Medical (Non-AfC) includes the CCG Clinical Leads and the CCG Member Practice Representatives. The VSM (Non-AfC) group includes the Executive Directors. The other (Non-AfC) group includes the CCG Lay Members.

Staff Analysis by Gender (based on staffing at 30 June 2022)

	Headcount by Gender			% by Gender	
Staff Grouping	**Female**	**Male**	**Totals**	**Female**	**Male**
Governing Body	6	9	**15**	40.0%	60.0%
Other Senior Management (Band 8C+)	4	3	**7**	57.1%	42.9%
All Other Employees	57	19	**76**	75.0%	25.0%
Grand Total	**67**	**31**	**98**	**68.37%**	**31.63%**

Staff Analysis by Band (based on staffing at 30 June 2022)

Pay Band	Headcount
Apprentice	0
Band 1	0
Band 2	0
Band 3	2
Band 4	2
Band 5	13
Band 6	15
Band 7	16
Band 8 - Range A	18
Band 8 - Range B	10
Band 8 - Range C	3
Band 8 - Range D	1
Band 9	0
Medical	9
VSM	9
Gov Body (off payroll)	0
Grand Total	**98**

Sickness absence data

The sickness absence data for the CCG in 2022 was whole time equivalent (WTE) days available of 17715 and WTE days lost to sickness absence of 516.42 and average working days lost per employee was 6.56 which was managed through the absence management policy.

Staff sickness absence 2022	2022 Number
Total Days Lost	516.42
Total Staff Years	78.73
Average Working Days Lost	6.56

Staff turnover percentages

The CCG staff turnover rate for the financial period has been calculated by dividing the total FTE Leavers in-year by the average FTE Staff in Post during the year. The CCG's Total FTE Leavers in year was 5.05. The CCG's Average FTE Staff in Post during the year was 77.81. The CCG Staff Turnover Rate for the year was 6.49%.

CCG Staff Turnover 2022	2022 Number
Average FTE Employed 2022	77.81
Total FTE Leavers 2022	5.05
Turnover Rate	6.49%

Staff engagement percentages

East Leicestershire and Rutland CCG participated in the National Staff Opinion Survey in conjunction with Leicester City CCG and West Leicestershire CCG collectively to gain the views of the employees. The results are analysed, and an action plan created. The CCGs' overall staff engagement score was 7.0 which is unchanged from 2020. The score of 7 is slightly higher than the average score nationally and slightly lower than average for comparator CCGs which was 7.2. The CCG also undertook a quarterly Pulse Survey.

Staff policies

All staff policies are reviewed as part of a rolling programme to ensure they are up to date and reflect best practice guidance and legislation.

The CCG promotes equality and diversity. Our policies were developed in accordance with our Equality and Diversity Strategy, taking into account the provisions of the Equality Act 2010 and we endeavour to advance equal opportunities for all. We do not discriminate, either directly or indirectly, on the grounds of age, disability, gender reassignment, marriage or civil partnership, pregnancy and maternity, race, religion or belief or sex. Within recruitment, we offer a guaranteed interview for any disabled candidate who meets the essential criteria and consider reasonable adjustments throughout the process. Into employment, reasonable adjustments are made in relation to continued employment, access to training, career development and promotion.

The LLR CCGs have produced a separate Equality Diversity and Inclusion (EDI) Annual Report for 2021-22. It sets out how we fulfil our responsibilities arising from the Equality

Act 2010 and NHS mandated standards. The Act requires all CCGs to publish appropriate information which demonstrates how we are meeting the Public-Sector Equality Duty 2011 (PSED, specific duties) and addressing any significant gaps which may adversely impact on local people who are protected by equalities law. This will be found on the CCG websites once approved.

The following is a summary of some employment initiatives and achievements relating to equalities. More information can be found within the main EDI Annual Report 2021-22 previously noted.

Equality, Diversity and Inclusion (EDI) Strategy 2021-25

One of our main drivers, is the overarching EDI strategy which was approved in May 2021 and sets out LLR CCGs' strategic approach to delivering equality, diversity and inclusion for the benefit of the local population and staff in line with the aims and objectives of the Equality Act 2010, the Public Sector Equality Duty and NHS mandated duties.

The strategy presents our new equality objectives for service delivery and employment practices based on the Equality Delivery System (EDS). We have reported progress on all our targets including our workforce as part of Equality Objective 3 (EDS Goal 3). We have also listed all our Equality Impact Assessments which have taken place over the past year which includes our employment policies and practices. This helps to identify and mitigate against any possible barriers that for staff with protected characteristics.

Workforce Race Equality Standard (WRES)

The LLR CCGs have developed a 5-year action plan to deliver the Workforce Race Equality Standard (WRES) and relevant elements of 'We are the NHS People Plan 2020/21'/ Model Employer.

In May 2021, the NHSE/I Midlands WRES team launched their Workforce Race Equality and Inclusion Strategy (WREI). Whilst primarily focussed on addressing inequality for Black, Asian and minority ethnic staff it also covers all protected characteristics. Subsequently, in June 2021, the main local NHS providers and CCGs were asked to gather evidence against six high impact actions as part of delivering the WRES/WREI strategy. Most of the actions are incorporated into the CCGs WRES Action Plan and are very much about developing an inclusive and diverse workforce.

The EDI Annual report also contains examples of WRES actions we are progressing and our subsequent performance. Some of these are listed below. Movements quoted below are between financial years 2019/20 and 2020/21.

1. The proportion of BAME staff employed by the CCGs increased from 29.4% to 32.8%. The number of BAME staff employed by the CCGs is more representative of the local population by approximately 11%.

2. There has been an increase in BAME staff representation across all grouped pay bands.

3. The relative likelihood of appointment for BAME applicants from shortlisting has increased from 18.75% to 25.64% (6.89% increase).

4. The total number of BAME members on the combined Governing Bodies is 43.2% (and voting) which is more than representative of the workforce and local demographic profile. This is an increase of 3.2%.

One of the actions in the WRES Action Plan was to enable an understanding / appreciation of the negative effects of discrimination experienced by underrepresented groups. VSMs and Board members were set a target to mentor / reverse mentor at least five talented BAME staff members at band 8D or below. During the reporting period LLR CCGs have matched eight mentors and eight mentees which exceeded the target set.

More information on these and further actions can also be found in the WRES Action Plan: LLR-CCGs-WRES-Action-Plan-2021-Final.pdf (netdna-ssl.com)

Disability

Future consideration will be given to undertaking the Workforce Disability Equality Standard on a voluntary basis. We are also signing up to the Disability Confident Scheme which supports employers like the LLR CCGs make the most of the talents disabled people in the workplace.

Collaboration

The LLR systemwide Equality, Diversity and Inclusion (EDI) Group recently identified seven priority areas such as continuing the reverse mentoring, implementing the six high impact actions and the development of staff networks. More information on all the priorities together with progress can be found in the WRES Action plan and the EDI Annual Report both noted above.

The EDI Annual Report also contains the workforce profile for each CCG broken down by protected characteristic. This will be particularly useful when the new Census data is available later in 2022 so we can compare this with the local community profile.

Policy

The CCG takes the health and safety of its employees seriously and has sought the expertise of an external specialist to fulfil the role of the competent person for the CCG and conduct comprehensive risk assessments on at least an annual basis. In addition, all staff undertake health and safety training as part of their mandatory training programme.

The CCG receives human resource services via a commissioning support unit, Midlands and Lancashire Commissioning Support Unit (ML CSU), who also engage and consult with recognised trade unions as required. An example of this is the development of staff policies, all of which are considered and reviewed by the trade unions to ensure that they are both fit for purpose and meet the requirements of HR best practice and employment legislation.

Employee engagement and internal communications has been an important focus for each of the three LLR CCGs and has been pivotal during our transition into the ICB.

Throughout April to June 2022 we continued to hold regular virtual staff briefings across the three CCGs which the Accountable Officer, or an Executive Director, has led and this provides them with opportunity to hear from staff.

The fortnightly LLR wide staff newsletter 'LLR Connect' brings together news from across the organisation.

Trade Union Facility Time Reporting Requirements

The CCG does not employ anyone who undertakes relevant union official duties as outlined in the Trade Union (Facility Time Publication Requirements) Regulations 2017 and therefore no time is released from this employer in relation to official duties. The CCG liaises and works with Trade Union representatives and area/regional representatives from those recognised unions whose time will be recorded with their employing authority.

Other employee matters

Equality Impact Assessments are undertaken as an integral part of HR Policy reviews, and employment changes, such as the Senior Leaders Management of Change and the Transfer to the ICB. All reasonable adjustments are considered, and any currently agreed will transfer with employees to the ICB.

As part of the Recruitment to the ICB Board, the importance of diversity in leadership was shared with all Recruitment Panel members.

In response to the COVID pandemic, we consulted with our workforce and have subsequently implemented agile working and rationalised our office estate. Equipment was provided to facilitate working from home and any reasonable adjustments considered and facilitated where possible. Agile working provides staff with greater flexibility to achieve work life balance. The CCG has paid employees for COVID related absences in line with Agenda for Change Terms and Conditions.

The CCG continues to engage with the local / regional Trade Union Representatives during times of change and / or consultation with staff.

Expenditure on consultancy

The was no expenditure on consultancy for the period April to June 2022 for the Clinical Commissioning Group.

Off-payroll engagements

In line with HM Treasury guidance the CCG is required to disclose information about 'Off payroll engagements'. The information relating to the Clinical Commissioning Group is provided in the following tables:

Table 1: Length of all highly paid off-payroll engagements

For all off-payroll engagements as at 30 June 2022 for more than £245* per day:

	Number
Number of existing engagements as of 30 June 2022	5
Of which, the number that have existed:	
for less than one year at the time of reporting	3
for between one and two years at the time of reporting	1
for between 2 and 3 years at the time of reporting	1
for between 3 and 4 years at the time of reporting	0
for 4 or more years at the time of reporting	0

* The £245 threshold is set to approximate the minimum point of the pay scale for a Senior Civil Servant.

Table 2: Off-payroll workers engaged at any point during the financial year

For all off-payroll engagements between 1 April 2022 and 30 June 2022, for more than £245 per day:

	Number
Number of temporary off-payroll workers engaged between 1 April 2022 and 30 June 2022	6
Of which...	
Number not subject to off-payroll legislation **	0
Number subject to off-payroll legislation and determined as in-scope of IR35 **	0
Number subject to off-payroll legislation and determined as out of scope of IR35 **	6
Number of engagements reassessed for compliance or assurance purposes during the year	0
Of which, number of engagements that saw a change to IR35 status following review	0

* The £245 threshold is set to approximate the minimum point of the pay scale for a Senior Civil Servant.

** A worker that provides their services through their own limited company or another type of intermediary to the client will be subject to off-payroll legislation and the department must undertake an assessment to determine whether that worker is in-scope of Intermediaries legislation (IR35) or out-of-scope for tax purposes.

Table 3: Off-payroll board members / senior official engagements

For any off-payroll engagements of Board members and / or senior officials with significant financial responsibility, between 1 April 2022 and 30 June 2022:

Number of off-payroll engagements of board members, and/or senior officers with significant financial responsibility, during the financial year *	0
Total number of individuals on payroll and off-payroll that have been deemed 'board members, and/or, senior officials with significant financial responsibility', during the financial year. This figure must include both on payroll and off-payroll engagements **	15

* There should only be a very small number of off-payroll engagements of board members and/or senior officials with significant financial responsibility, permitted only in exceptional circumstances and for no more than 6 months.

** As both on payroll and off-payroll engagements are included in the total figure, no entries here should be blank or zero. In any cases where individuals are included within the first row of this table the department should set out:

- details of the exceptional circumstances that led to each of these engagements
- details of the length of time each of these exceptional engagements lasted

Exit packages, including special (non-contractual) payments

No exit package was agreed during April to June 2022.

Parliamentary Accountability and Audit Report

NHS East Leicestershire and Rutland CCG is not required to produce a Parliamentary Accountability and Audit Report. Disclosures on remote contingent liabilities, losses and special payments, gifts, and fees and charges are included as notes in the Financial Statements (Annual Accounts) of this report at note XX. An audit certificate and report is also included in this Annual Report at page 88.

Independent auditor's report to the members of the Board of NHS Leicester, Leicestershire and Rutland Integrated Care Board in respect of NHS East Leicestershire & Rutland Clinical Commissioning Group

Report on the audit of the financial statements

Opinion on financial statements

We have audited the financial statements of NHS East Leicestershire & Rutland CCG (the 'CCG') for the period ended 30 June 2022, which comprise the Statement of Comprehensive Net Expenditure, the Statement of Financial Position, the Statement of Changes in Taxpayers Equity, the Statement of Cash Flows and notes to the financial statements, including a summary of significant accounting policies. The financial reporting framework that has been applied in their preparation is applicable law and international accounting standards in conformity with the requirements of the Accounts Directions issued under Schedule 15 of the National Health Service Act 2006, as amended by the Health and Social Care Act 2012 and interpreted and adapted by the Department of Health and Social Care Group Accounting Manual 2022-23.

In our opinion, the financial statements:

- give a true and fair view of the financial position of the CCG as at 30 June 2022 and of its expenditure and income for the period then ended;
- have been properly prepared in accordance with international accounting standards as interpreted and adapted by the Department of Health and Social Care Group Accounting Manual 2022-23; and
- have been prepared in accordance with the requirements of the National Health Service Act 2006, as amended by the Health and Social Care Act 2012.

Basis for opinion

We conducted our audit in accordance with International Standards on Auditing (UK) (ISAs (UK)) and applicable law, as required by the Code of Audit Practice (2020) ("the Code of Audit Practice") approved by the Comptroller and Auditor General. Our responsibilities under those standards are further described in the 'Auditor's responsibilities for the audit of the financial statements' section of our report. We are independent of the CCG in accordance with the ethical requirements that are relevant to our audit of the financial statements in the UK, including the FRC's Ethical Standard, and we have fulfilled our other ethical responsibilities in accordance with these requirements. We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our opinion.

Emphasis of matter – Demise of the organisation

In forming our opinion on the financial statements, which is not modified, we draw attention to note 1.1 to the financial statements, which indicates that the Health and Care Bill allowed for the establishment of Integrated Care Boards (ICBs) and abolished Clinical Commissioning Groups (CCGs). The functions, assets, and liabilities of NHS East Leicestershire & Rutland CCG transferred to NHS Leicester, Leicestershire and Rutland ICB on 1 July 2022. When NHS East Leicestershire & Rutland CCG ceased to exist on 1 July 2022, its services continued to be provided by NHS Leicester, Leicestershire and Rutland ICB.

Conclusions relating to going concern

We are responsible for concluding on the appropriateness of the Accountable Officer's use of the going concern basis of accounting and, based on the audit evidence obtained, whether a material uncertainty exists related to events or conditions that may cast significant doubt on the CCG's ability to continue as a going concern. If we conclude that a material uncertainty exists, we are required to draw attention in our report to the related disclosures in the financial statements or, if such disclosures are inadequate, to modify the auditor's opinion. Our conclusions are based on the audit evidence obtained up to the date of our report.

In our evaluation of the Accountable Officer's conclusions, and in accordance with the expectation set out within the Department of Health and Social Care Group Accounting Manual 2022-23 that the CCG's financial statements shall be prepared on a going concern basis, we considered the inherent risks associated with the continuation of services provided by the CCG. In doing so we have had regard to the guidance provided in Practice Note 10 Audit of financial statements and regularity of public sector bodies in the United Kingdom (Revised 2022) on the application of ISA (UK)

570 Going Concern to public sector entities. We assessed the reasonableness of the basis of preparation used by the CCG and the CCG's disclosures over the going concern period.

In auditing the financial statements, we have concluded that the Accountable Officer's use of the going concern basis of accounting in the preparation of the financial statements is appropriate.

Based on the work we have performed, we have not identified any material uncertainties relating to events or conditions that, individually or collectively, may cast significant doubt on the CCG's ability to continue as a going concern for a period of at least twelve months from when the financial statements are authorised for issue.

Our responsibilities and the responsibilities of the Accountable Officer with respect to going concern are described in the relevant sections of this report.

Other information

The other information comprises the information included in the annual report, other than the financial statements and our auditor's report thereon. The Accountable Officer is responsible for the other information contained within the annual report. Our opinion on the financial statements does not cover the other information and, except to the extent otherwise explicitly stated in our report, we do not express any form of assurance conclusion thereon.

Our responsibility is to read the other information and, in doing so, consider whether the other information is materially inconsistent with the financial statements or our knowledge obtained in the audit or otherwise appears to be materially misstated. If we identify such material inconsistencies or apparent material misstatements, we are required to determine whether there is a material misstatement in the financial statements themselves. If, based on the work we have performed, we conclude that there is a material misstatement of this other information, we are required to report that fact.

We have nothing to report in this regard.

Other information we are required to report on by exception under the Code of Audit Practice

Under the Code of Audit Practice published by the National Audit Office in April 2020 on behalf of the Comptroller and Auditor General (the Code of Audit Practice) we are required to consider whether the Governance Statement does not comply with the guidance issued by NHS England or is misleading or inconsistent with the information of which we are aware from our audit. We are not required to consider whether the Governance Statement addresses all risks and controls or that risks are satisfactorily addressed by internal controls.

We have nothing to report in this regard.

Opinion on other matters required by the Code of Audit Practice

In our opinion:

- the parts of the Remuneration and Staff Report to be audited have been properly prepared in accordance with the requirements of the Department of Health and Social Care Group Accounting Manual 2022-23; and
- based on the work undertaken in the course of the audit of the financial statements the other information published together with the financial statements in the annual report for the financial period for which the financial statements are prepared is consistent with the financial statements.

Opinion on regularity of income and expenditure required by the Code of Audit Practice

In our opinion, in all material respects the expenditure and income recorded in the financial statements have been applied to the purposes intended by Parliament and the financial transactions in the financial statements conform to the authorities which govern them.

Matters on which we are required to report by exception

Under the Code of Audit Practice, we are required to report to you if:

- we issue a report in the public interest under Section 24 of the Local Audit and Accountability Act 2014 in the course of, or at the conclusion of the audit; or
- we refer a matter to the Secretary of State under Section 30 of the Local Audit and Accountability Act 2014 because we have reason to believe that the CCG, or an officer of the CCG, is about to make, or has made, a decision which involves or would involve the body incurring unlawful expenditure, or is about to take, or has begun to take a course of action which, if followed to its conclusion, would be unlawful and likely to cause a loss or deficiency; or

- we make a written recommendation to the CCG under Section 24 of the Local Audit and Accountability Act 2014 in the course of, or at the conclusion of the audit.

We have nothing to report in respect of the above matters.

Responsibilities of the Accountable Officer

As explained more fully in the Statement of Accountable Officer's responsibilities set out on pages 51 and 52, the Accountable Officer, is responsible for the preparation of the financial statements in the form and on the basis set out in the Accounts Directions, for being satisfied that they give a true and fair view, and for such internal control as the Accountable Officer determines is necessary to enable the preparation of financial statements that are free from material misstatement, whether due to fraud or error.

In preparing the financial statements, the Accountable Officer is responsible for assessing the CCG's ability to continue as a going concern, disclosing, as applicable, matters related to going concern and using the going concern basis of accounting unless they have been informed by the relevant national body of the intention to dissolve the CCG without the transfer of its services to another public sector entity.

The Accountable Officer is responsible for ensuring the regularity of expenditure and income in the financial statements.

Auditor's responsibilities for the audit of the financial statements

Our objectives are to obtain reasonable assurance about whether the financial statements as a whole are free from material misstatement, whether due to fraud or error, and to issue an auditor's report that includes our opinion. Reasonable assurance is a high level of assurance but is not a guarantee that an audit conducted in accordance with ISAs (UK) will always detect a material misstatement when it exists.

We are also responsible for giving an opinion on the regularity of expenditure and income in the financial statements in accordance with the Code of Audit Practice.

Misstatements can arise from fraud or error and are considered material if, individually or in the aggregate, they could reasonably be expected to influence the economic decisions of users taken on the basis of these financial statements. Irregularities, including fraud, are instances of non-compliance with laws and regulations. The extent to which our procedures are capable of detecting irregularities, including fraud is detailed below:

- We obtained an understanding of the legal and regulatory frameworks that are applicable to the CCG and determined that the most significant which are directly relevant to specific assertions in the financial statements are those related to the reporting frameworks (international accounting standards and the National Health Service Act 2006, as amended by the Health and Social Care Act 2012 and interpreted and adapted by the Department of Health and Social Care Group Accounting Manual 2022-23).

- We enquired of management and the Audit Committee, concerning the CCG's policies and procedures relating to:
  - the identification, evaluation and compliance with laws and regulations;
  - the detection and response to the risks of fraud; and
  - the establishment of internal controls to mitigate risks related to fraud or non-compliance with laws and regulations.
- We enquired of management, internal audit and the Audit Committee, whether they were aware of any instances of non-compliance with laws and regulations or whether they had any knowledge of actual, suspected or alleged fraud.
- We assessed the susceptibility of the CCG's financial statements to material misstatement, including how fraud might occur, evaluating management's incentives and opportunities for manipulation of the financial statements. This included the evaluation of the risk of fraud in expenditure recogniture and the risk of management override of controls. We determined that the principal risks were in relation to:
  - Journals with a specific focus on those relating to the 'Fair Shares' arrangement and those which altered the financial performance of the CCG for the year
  - significant accounting estimates related to the prescribing accrual and the 'Fair Shares' arrangements.
  - the risk of fraud in expenditure, except for block contract payment and prescribing costs
- Our audit procedures involved:

- evaluation of the design effectiveness of controls that management has in place to prevent and detect fraud;
- journal entry testing, with a focus on unusual journals which included journals posted by senior finance officers, large value journals, journals posted in June and post period-end that might relate to advance payments, and journals relating to the 'Fair Share' arrangements for the system CCGs.
- challenging assumptions and judgements made by management in its significant accounting estimates in respect of prescribing accrual and the 'Fair Shares' arrangements
- agreeing expenditure transactions, on a sample basis, to supporting evidence; and
- evaluating and challenging the estimates and the judgments made by management at year end.

- These audit procedures were designed to provide reasonable assurance that the financial statements were free from fraud or error. The risk of not detecting a material misstatement due to fraud is higher than the risk of not detecting one resulting from error and detecting irregularities that result from fraud is inherently more difficult than detecting those that result from error, as fraud may involve collusion, deliberate concealment, forgery or intentional misrepresentations. Also, the further removed non-compliance with laws and regulations is from events and transactions reflected in the financial statements, the less likely we would become aware of it.
- The team communicated with management and the Audit Committee in respect of potential non-compliance with relevant laws and regulations, including the potential for fraud in revenue and/or expenditure recognition, and the significant accounting estimates related to the prescribing accrual and the 'Fair Shares' arrangements.
- Our assessment of the appropriateness of the collective competence and capabilities of the engagement team included consideration of the engagement team's:
  - understanding of, and practical experience with audit engagements of a similar nature and complexity through appropriate training and participation
  - knowledge of the health sector and economy in which the CCG operates
  - understanding of the legal and regulatory requirements specific to the CCG including:
    - the provisions of the applicable legislation
    - NHS England's rules and related guidance
    - the applicable statutory provisions.
- In assessing the potential risks of material misstatement, we obtained an understanding of:
  - The CCG's operations, including the nature of its other operating revenue and expenditure and its services and of its objectives and strategies to understand the classes of transactions, account balances, expected financial statement disclosures and business risks that may result in risks of material misstatement.
  - The CCG's control environment, including the policies and procedures implemented by the CCG to ensure compliance with the requirements of the financial reporting framework**.**

A further description of our responsibilities for the audit of the financial statements is located on the Financial Reporting Council's website at: www.frc.org.uk/auditorsresponsibilities. This description forms part of our auditor's report.

Report on other legal and regulatory requirements – the CCG's arrangements for securing economy, efficiency and effectiveness in its use of resources

Matter on which we are required to report by exception – the CCG's arrangements for securing economy, efficiency and effectiveness in its use of resources

Under the Code of Audit Practice, we are required to report to you if, in our opinion, we have not been able to satisfy ourselves that the CCG made proper arrangements for securing economy, efficiency and effectiveness in its use of resources for the period ended 30 June 2022.

We have nothing to report in respect of the above matter.

Responsibilities of the Accountable Officer

As explained in the Governance Statement, the Accountable Officer was responsible for putting in place proper arrangements for securing economy, efficiency and effectiveness in the use of the CCG's resources.

Auditor's responsibilities for the review of the CCG's arrangements for securing economy, efficiency and effectiveness in its use of resources

We are required under Section 21(1)(c) of the Local Audit and Accountability Act 2014 to be satisfied that the CCG has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources. We are not required to consider, nor have we considered, whether all aspects of the CCG's arrangements for securing economy, efficiency and effectiveness in its use of resources were operating effectively during the three month period ended 30 June 2022..

We have undertaken our review in accordance with the Code of Audit Practice, having regard to the guidance issued by the Comptroller and Auditor General in January 2023. This guidance sets out the arrangements that fall within the scope of 'proper arrangements'. When reporting on these arrangements, the Code of Audit Practice requires auditors to structure their commentary on arrangements under three specified reporting criteria:

- Financial sustainability: how the CCG planned and managed its resources to ensure it could continue to deliver its services;
- Governance: how the CCG ensured that it made informed decisions and properly managed its risks; and
- Improving economy, efficiency and effectiveness: how the CCG used information about its costs and performance to improve the way it managed and delivered its services.

We have documented our understanding of the arrangements the CCG had in place for each of these three specified reporting criteria, gathering sufficient evidence to support our risk assessment and commentary in our Auditor's Annual Report. In undertaking our work, we have considered whether there is evidence to suggest that there were significant weaknesses in arrangements.

Report on other legal and regulatory requirements – Certificate

We certify that we have completed the audit of NHS East Leicestershire & Rutland CCG in accordance with the requirements of the Local Audit and Accountability Act 2014 and the Code of Audit Practice.

Use of our report

This report is made solely to the members of the Board of NHS Leicester, Leicestershire and Rutland ICB, as a body, in respect of the CCG, in accordance with Part 5 of the Local Audit and Accountability Act 2014. Our audit work has been undertaken so that we might state to the members of the Board of NHS Leicester, Leicestershire and Rutland ICB those matters we are required to state to them in an auditor's report in respect of the CCG and for no other purpose. To the fullest extent permitted by law, we do not accept or assume responsibility to anyone other than NHS Leicester, Leicestershire and Rutland ICB and the CCG and the members of the Boards of both entities, as bodies, for our audit work, for this report, or for the opinions we have formed.

Laurelin Griffiths

Laurelin Griffiths, Key Audit Partner

for and on behalf of Grant Thornton UK LLP, Local Auditor

Birmingham

27 June 2023

ANNUAL ACCOUNTS

Andy Williams
Accountable Officer
26 June 2023

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The Primary Statements:

Notes to the Accounts

Statement of Comprehensive Net Expenditure for the year ended 30 June 2022

	Note	**2022-23 30/06/2022 £'000**	2021-22 31/03/2022 £'000
Income from sale of goods and services	2	(403)	(4,041)
Total operating income		**(403)**	**(4,041)**
Staff costs	4	1,326	5,000
Purchase of goods and services	5	128,181	510,059
Depreciation and impairment charges	5	27	41
Provision expense	5	119	339
Other Operating Expenditure	5	123	539
Total operating expenditure		**129,776**	**515,978**
Net Operating Expenditure		**129,373**	**511,937**
Finance expense		1	-
Net expenditure for the Year		**129,374**	**511,937**
Comprehensive Expenditure for the year		**129,374**	**511,937**

Due to this Financial Year duration being 3 months, the year on year figures are not comparable.

Statement of Financial Position as at 30 June 2022

	Note	2022-23 £'000	2021-22 £'000
Non-current assets:			
Property, plant and equipment	8	82	91
Right-of-use assets	8a	253	-
Intangible assets	9	-	-
Total non-current assets		335	91
Current assets:			
Trade and other receivables	10	10,935	10,940
Cash and cash equivalents	11	120	5
Total current assets		**11,055**	10,945
Total assets		**11,390**	11,036
Current liabilities			
Trade and other payables	12	(23,667)	(29,650)
Lease liabilities	8a.3	(70)	-
Provisions	13	(251)	(321)
Total current liabilities		**(23,988)**	(29,971)
Non-Current Assets plus/less Net Current Assets/Liabilities		**(12,598)**	(18,935)
Non-current liabilities			
Lease liabilities	8a.3	(184)	-
Total non-current liabilities		(184)	-
Assets less Liabilities		**(12,781)**	(18,935)
Financed by Taxpayers' Equity			
General fund		(12,781)	(18,935)
Total taxpayers' equity:		**(12,781)**	(18,935)

The notes on pages 99 to 124 form part of this statement

The financial statements on pages 95 to 124 were approved by the Audit Committee (as delegated by the ICB Board),on 20/06/2023 and signed on its behalf by:

Chief Accountable Officer
Andrew Williams

Statement of Changes In Taxpayers Equity for the year ended 30 June 2022

	General fund £'000	Revaluation reserve £'000	Other reserves £'000	Total reserves £'000
Changes in taxpayers' equity for 2022-23				
Balance at 01 April 2022	(18,935)	0	0	**(18,935)**
		0	**0**	**(18,935)**
Changes in NHS Clinical Commissioning Group taxpayers' equity for 2022-23				
Net operating expenditure for the financial year	(129,374)			**(129,374)**
Net Recognised NHS Clinical Commissioning Group Expenditure for the Financial year	**(129,374)**	**0**	**0**	**(129,374)**
Net funding	135,528	0	0	**135,528**
Balance at 30 June 2022	**(12,781)**	**0**	**0**	**(12,781)**

	General fund £'000	Revaluation reserve £'000	Other reserves £'000	Total reserves £'000
Changes in taxpayers' equity for 2021-22				
Balance at 01 April 2021	(28,371)	0	0	**(28,371)**
		0	**0**	**(28,371)**
Changes in NHS Clinical Commissioning Group taxpayers' equity for 2021-22				
Net operating costs for the financial year	(511,937)			**(511,937)**
Net Recognised NHS Clinical Commissioning Group Expenditure for the Financial Year	**(511,937)**	**0**	**0**	**(511,937)**
Net funding	521,373	0	0	**521,373**
Balance at 31 March 2022	**(18,935)**	**0**	**0**	**(18,935)**

The notes on pages 99 to 124 form part of this statement

Statement of Cash Flows for the year ended 30 June 2022

	Note	**2022-23 30/06/2022 £'000**	2021-22 31/03/2022 £'000
Cash Flows from Operating Activities			
Net operating expenditure for the financial year		(129,374)	(511,937)
Depreciation and amortisation	5	27	41
(Increase)/decrease in trade & other receivables	10	5	(7,777)
Increase/(decrease) in trade & other payables	12	(5,983)	(1,788)
Provisions utilised	13	(189)	(338)
Increase/(decrease) in provisions	13	119	412
Net Cash Inflow (Outflow) from Operating Activities		**(135,395)**	(521,387)
Cash Flows from Investing Activities			
(Payments) for property, plant and equipment		0	(11)
Net Cash Inflow (Outflow) from Investing Activities		**0**	(11)
Net Cash Inflow (Outflow) before Financing		**(135,395)**	(521,398)
Cash Flows from Financing Activities			
Grant in Aid Funding Received		135,528	521,373
Repayment of lease liabilities		(18)	0
Net Cash Inflow (Outflow) from Financing Activities		**135,510**	521,373
Net Increase (Decrease) in Cash & Cash Equivalents	11	**115**	(25)
Cash & Cash Equivalents at the Beginning of the Financial Year		**5**	30
Cash & Cash Equivalents (including bank overdrafts) at the End of the Financial Year		**120**	5

Due to this Financial Year duration being 3 months, the year on year figures are not comparable.

The notes on pages 99 to 124 form part of this statement

Notes to the financial statements

1 **Accounting Policies**

NHS England has directed that the financial statements of clinical commissioning groups shall meet the accounting requirements of the Group Accounting Manual issued by the Department of Health and Social Care. Consequently, the following financial statements have been prepared in accordance with the Group Accounting Manual 2021-22 issued by the Department of Health and Social Care. The accounting policies contained in the Group Accounting Manual follow International Financial Reporting Standards to the extent that they are meaningful and appropriate to clinical commissioning groups, as determined by HM Treasury, which is advised by the Financial Reporting Advisory Board. Where the Group Accounting Manual permits a choice of accounting policy, the accounting policy which is judged to be most appropriate to the particular circumstances of the clinical commissioning group for the purpose of giving a true and fair view has been selected. The particular policies adopted by the clinical commissioning group are described below. They have been applied consistently in dealing with items considered material in relation to the accounts.

1.1 **Going Concern**

These accounts have been prepared on a going concern basis ***[despite the issue of a report to the Secretary of State for Health and Social Care under Section 30 of the Local Audit and Accountability Act 2014].***

The Health and Social Care Bill was introduced into the House of Commons on 6 July 2021. The Bill allows for the establishment of Integrated Care Boards (ICB) across England and abolishes clinical commissioning groups (CCG). ICBs will take on the commissioning functions of CCGs. Under the terms of the Bill the CCG functions, assets and liabilities will therefore transfer to an ICB.

Public sector bodies are assumed to be going concerns where the continuation of the provision of a service in the future is anticipated, as evidenced by inclusion of financial provision for that service in published documents.

Where a clinical commissioning group ceases to exist, it considers whether or not its services will continue to be provided (using the same assets, by another public sector entity) in determining whether to use the concept of going concern for the final set of financial statements. If services will continue to be provided the financial statements are prepared on the going concern basis. The statement of financial position has therefore been drawn up at 30th June 2022 on a going concern basis.

1.2 **Accounting Convention**

These accounts have been prepared under the historical cost convention modified to account for the revaluation of property, plant and equipment, intangible assets, inventories and certain financial assets and financial liabilities.

1.3 **Movement of Assets within the Department of Health and Social Care Group**

As Public Sector Bodies are deemed to operate under common control, business reconfigurations within the Department of Health and Social Care Group are outside the scope of IFRS 3 Business Combinations. Where functions transfer between two public sector bodies, the Department of Health and Social Care GAM requires the application of absorption accounting. Absorption accounting requires that entities account for their transactions in the period in which they took place, with no restatement of performance required when functions transfer within the public sector. Where assets and liabilities transfer, the gain or loss resulting is recognised in the Statement of Comprehensive Net Expenditure, and is disclosed separately from operating costs.

Other transfers of assets and liabilities within the Department of Health and Social Care Group are accounted for in line with IAS 20 and similarly give rise to income and expenditure entries.

1.4 **Joint arrangements**

Arrangements over which the clinical commissioning group has joint control with one or more other entities are classified as joint arrangements. Joint control is the contractually agreed sharing of control of an arrangement. A joint arrangement is either a joint operation or a joint venture.

A joint operation exists where the parties that have joint control have rights to the assets and obligations for the liabilities relating to the arrangement. Where the Clinical Commissioning Group is a joint operator it recognises its share of, assets, liabilities, income and expenses in its own accounts. The substance of each programme that forms part of the pooled budgets has been assessed under IFRS 11: 'Joint arrangements'. These have been assessed as joint commissioning arrangements under which each pool partner is deemed to have joint control and in accordance with IFRS 11, accounts for their share of expenditure and balances with the end provider. For these arrangements, the parties are judged by management to meet the criteria for joint control. A joint operation is in place and the parties have the power, exposure and the rights to variable returns from their involvement and the ability to use their powers to affect the returns.

A joint venture is a joint arrangement whereby the parties that have joint control of the arrangement have rights to the net assets of the arrangement. Joint ventures are recognised as an investment and accounted for using the equity method.

1.5 **Pooled Budgets**

The Clinical Commissioning Group has entered into a number of pooled budget arrangements with various organisations in accordance with Section 75 of the NHS Act 2006 and accounts for its share of the expenditure arising from the activities of the pooled budgets, identified in accordance with the pooled budget agreements. Details of the pooled budgets are contained in the note to the accounts, Joint arrangements - interests in joint operations.

Assets and liabilities of the pooled budgets have a minimal value and are therefore not recorded. The Clinical Commissioning Group receives no income from the pooled budgets.

1.6 **Operating Segments**

Income and expenditure are analysed in the Operating Segments note and are reported in line with management information used within the clinical commissioning group.

1.7 **Revenue**

In the application of IFRS 15 a number of practical expedients offered in the Standard have been employed. These are as

• As per paragraph 121 of the Standard the clinical commissioning group will not disclose information regarding performance obligations part of a contract that has an original expected duration of one year or less,

• The clinical commissioning group is to similarly not disclose information where revenue is recognised in line with the practical expedient offered in paragraph B16 of the Standard where the right to consideration corresponds directly with value of the performance completed to date.
• The FReM has mandated the exercise of the practical expedient offered in C7(a) of the Standard that requires the clinical commissioning group to reflect the aggregate effect of all contracts modified before the date of initial application.

The main source of funding for the Clinical Commissioning Group is from NHS England. This is drawn down and credited to the general fund. Funding is recognised in the period in which it is received.
Revenue in respect of services provided is recognised when (or as) performance obligations are satisfied by transferring promised services to the customer, and is measured at the amount of the transaction price allocated to that performance

Where income is received for a specific performance obligation that is to be satisfied in the following year, that income is

Payment terms are standard reflecting cross government principles.
The value of the benefit received when the clinical commissioning group accesses funds from the Government's apprenticeship service are recognised as income in accordance with IAS 20, Accounting for Government Grants. Where these funds are paid directly to an accredited training provider, non-cash income and a corresponding non-cash training expense are recognised, both equal to the cost of the training funded.

1.8 **Employee Benefits**

1.8.1 **Short-term Employee Benefits**

Salaries, wages and employment-related payments, including payments arising from the apprenticeship levy, are recognised in the period in which the service is received from employees, including bonuses earned but not yet taken.

The cost of leave earned but not taken by employees at the end of the period is recognised in the financial statements to the extent that employees are permitted to carry forward leave into the following period.

1.8.2 **Retirement Benefit Costs**

Past and present employees are covered by the provisions of the NHS Pensions Schemes. These schemes are unfunded, defined benefit schemes that cover NHS employers, General Practices and other bodies allowed under the direction of the Secretary of State in England and Wales. The schemes are not designed to be run in a way that would enable NHS bodies to identify their share of the underlying scheme assets and liabilities. Therefore, the schemes are accounted for as if they were a defined contribution scheme; the cost recognised in these accounts represents the contributions payable for the year. Details of the benefits payable under these provisions can be found on the NHS Pensions website at www.nhsbsa.nhs.uk/pensions.

For early retirements other than those due to ill health the additional pension liabilities are not funded by the scheme. The full amount of the liability for the additional costs is charged to expenditure at the time the clinical commissioning group commits itself to the retirement, regardless of the method of payment.
The schemes are subject to a full actuarial valuation every four years and an accounting valuation every year.

1.9 **Other Expenses**

Other operating expenses are recognised when, and to the extent that, the goods or services have been received. They are measured at the fair value of the consideration payable.

1.10 **Property, Plant & Equipment**

1.10.1 **Recognition**

Property, plant and equipment is capitalised if:

- It is held for use in delivering services or for administrative purposes;
- It is probable that future economic benefits will flow to, or service potential will be supplied to the clinical commissioning group;
- It is expected to be used for more than one financial year;
- The cost of the item can be measured reliably; and,
- The item has a cost of at least £5,000; or,
- Collectively, a number of items have a cost of at least £5,000 and individually have a cost of more than £250, where the assets are functionally interdependent, they had broadly simultaneous purchase dates, are anticipated to have simultaneous disposal dates and are under single managerial control; or,
- Items form part of the initial equipping and setting-up cost of a new building, ward or unit, irrespective of their individual or collective cost.

Where a large asset, for example a building, includes a number of components with significantly different asset lives, the components are treated as separate assets and depreciated over their own useful economic lives.

1.10.2 **Measurement**

All property, plant and equipment is measured initially at cost, representing the cost directly attributable to acquiring or constructing the asset and bringing it to the location and condition necessary for it to be capable of operating in the manner intended by management.

Assets that are held for their service potential and are in use are measured subsequently at their current value in existing use. Assets that were most recently held for their service potential but are surplus are measured at fair value where there are no restrictions preventing access to the market at the reporting date

Revaluations are performed with sufficient regularity to ensure that carrying amounts are not materially different from those that would be determined at the end of the reporting period. Current values in existing use are determined as follows:

- Land and non-specialised buildings – market value for existing use; and,
- Specialised buildings – depreciated replacement cost.

Properties in the course of construction for service or administration purposes are carried at cost, less any impairment loss. Cost includes professional fees but not borrowing costs, which are recognised as expenses immediately, as allowed by IAS 23 for assets held at fair value. Assets are re-valued and depreciation commences when they are brought into use.

IT equipment, transport equipment, furniture and fittings, and plant and machinery that are held for operational use are valued at depreciated historic cost where these assets have short useful economic lives or low values or both, as this is not considered to be materially different from current value in existing use.

An increase arising on revaluation is taken to the revaluation reserve except when it reverses an impairment for the same asset previously recognised in expenditure, in which case it is credited to expenditure to the extent of the decrease previously charged there. A revaluation decrease that does not result from a loss of economic value or service potential is recognised as an impairment charged to the revaluation reserve to the extent that there is a balance on the reserve for the asset and, thereafter, to expenditure. Impairment losses that arise from a clear consumption of economic benefit are taken to expenditure. Gains and losses recognised in the revaluation reserve are reported as other comprehensive income in the Statement of Comprehensive Net Expenditure.

1.10.3 **Subsequent Expenditure**

Where subsequent expenditure enhances an asset beyond its original specification, the directly attributable cost is capitalised. Where subsequent expenditure restores the asset to its original specification, the expenditure is capitalised and any existing carrying value of the item replaced is written-out and charged to operating expenses.

1.11 Intangible Assets

1.11.1 Recognition

Intangible assets are non-monetary assets without physical substance, which are capable of sale separately from the rest of the Clinical Commissioning Group's business or which arise from contractual or other legal rights. They are recognised only:

- When it is probable that future economic benefits will flow to, or service potential be provided to, the Clinical Commissioning Group;
- Where the cost of the asset can be measured reliably; and,
- Where the cost is at least £5,000.

Software that is integral to the operating of hardware, for example an operating system, is capitalised as part of the relevant item of property, plant and equipment. Software that is not integral to the operation of hardware, for example application software, is capitalised as an intangible asset. Expenditure on research is not capitalised but is recognised as an operating expense in the period in which it is incurred. Internally-generated assets are recognised if, and only if, all of the following have been demonstrated:

- The technical feasibility of completing the intangible asset so that it will be available for use;
- The intention to complete the intangible asset and use it;
- The ability to sell or use the intangible asset;
- How the intangible asset will generate probable future economic benefits or service potential;
- The availability of adequate technical, financial and other resources to complete the intangible asset and sell or use it; and,
- The ability to measure reliably the expenditure attributable to the intangible asset during its development.

1.11.2 Measurement

Intangible assets acquired separately are initially recognised at cost. The amount initially recognised for internally-generated intangible assets is the sum of the expenditure incurred from the date when the criteria above are initially met. Where no internally-generated intangible asset can be recognised, the expenditure is recognised in the period in which it is incurred.

Following initial recognition, intangible assets are carried at current value in existing use by reference to an active market, or, where no active market exists, at the lower of amortised replacement cost or the value in use where the asset is income generating. Internally-developed software is held at historic cost to reflect the opposing effects of increases in development costs and technological advances. Revaluations and impairments are treated in the same manner as for property, plant and equipment.

1.12 **Depreciation, Amortisation & Impairments**

Freehold land, properties under construction, and assets held for sale are not depreciated.
Otherwise, depreciation and amortisation are charged to write off the costs or valuation of property, plant and equipment and intangible non-current assets, less any residual value, over their estimated useful lives, in a manner that reflects the consumption of economic benefits or service potential of the assets. The estimated useful life of an asset is the period over which the clinical commissioning group expects to obtain economic benefits or service potential from the asset. This is specific to the clinical commissioning group and may be shorter than the physical life of the asset itself. Estimated useful lives and residual values are reviewed each year end, with the effect of any changes recognised on a prospective basis. Assets held under finance leases are depreciated over the shorter of the lease term and the estimated useful life.

At each reporting period end, the clinical commissioning group checks whether there is any indication that any of its property, plant and equipment assets or intangible non-current assets have suffered an impairment loss. If there is indication of an impairment loss, the recoverable amount of the asset is estimated to determine whether there has been a loss and, if so, its amount. Intangible assets not yet available for use are tested for impairment annually.

A revaluation decrease that does not result from a loss of economic value or service potential is recognised as an impairment charged to the revaluation reserve to the extent that there is a balance on the reserve for the asset and, thereafter, to expenditure. Impairment losses that arise from a clear consumption of economic benefit are taken to expenditure. Where an impairment loss subsequently reverses, the carrying amount of the asset is increased to the revised estimate of the recoverable amount but capped at the amount that would have been determined had there been no initial impairment loss. The reversal of the impairment loss is credited to expenditure to the extent of the decrease previously charged there and thereafter to the revaluation reserve.

1.13 **Leases**

A lease is a contract, or part of a contract, that conveys the right to control the use of an asset for a period of time in exchange for consideration.
The clinical commissioning group assesses whether a contract is or contains a lease, at inception of the contract.

1.13.1 **The Clinical Commissioning Group as Lessee**

A right-of-use asset and a corresponding lease liability are recognised at commencement of the lease.
The lease liability is initially measured at the present value of the future lease payments, discounted by using the rate implicit in the lease. If this rate cannot be readily determined, the prescribed HM Treasury discount rates are used as the incremental borrowing rate to discount future lease payments.
The HM Treasury incremental borrowing rate of 0.95% is applied for leases commencing, transitioning or being remeasured in the 2022 calendar year under IFRS 16.
Lease payments included in the measurement of the lease liability comprise
-Fixed payments;
-Variable lease payments dependent on an index or rate, initially measured using the index or rate at commencement;
-The amount expected to be payable under residual value guarantees;
-The exercise price of purchase options, if it is reasonably certain the option will be exercised; and
-Payments of penalties for terminating the lease, if the lease term reflects the exercise of an option to terminate the lease.

Variable rents that do not depend on an index or rate are not included in the measurement the lease liability and are recognised as an expense in the period in which the event or condition that triggers those payments occurs.

The lease liability is subsequently measured by increasing the carrying amount for interest incurred using the effective interest method and decreasing the carrying amount to reflect the lease payments made. The lease liability is remeasured, with a corresponding adjustment to the right-of-use asset, to reflect any reassessment of or modification made to the lease.

The right-of-use asset is initially measured at an amount equal to the initial lease liability adjusted for any lease prepayments or incentives, initial direct costs or an estimate of any dismantling, removal or restoring costs relating to either restoring the location of the asset or restoring the underlying asset itself, unless costs are incurred to produce inventories.

The subsequent measurement of the right-of-use asset is consistent with the principles for subsequent measurement of property, plant and equipment. Accordingly, right-of-use assets that are held for their service potential and are in use are subsequently measured at their current value in existing use.
Right-of-use assets for leases that are low value or short term and for which current value in use is not expected to fluctuate significantly due to changes in market prices and conditions are valued at depreciated historical cost as a proxy for current value in existing use.
Other than leases for assets under construction and investment property, the right-of-use asset is subsequently depreciated on a straight-line basis over the shorter of the lease term or the useful life of the underlying asset. The right-of-use asset is tested for impairment if there are any indicators of impairment and impairment losses are accounted for as described in the ‘Depreciation, amortisation and impairments’ policy.

Peppercorn leases are defined as leases for which the consideration paid is nil or nominal (that is, significantly below market value). Peppercorn leases are in the scope of IFRS 16 if they meet the definition of a lease in all aspects apart from containing consideration.
For peppercorn leases a right-of-use asset is recognised and initially measured at current value in existing use. The lease liability is measured in accordance with the above policy. Any difference between the carrying amount of the right-of-use asset and the lease liability is recognised as income as required by IAS 20 as interpreted by the FReM.

Leases of low value assets (value when new less than £5,000) and short-term leases of 12 months or less are recognised as an expense on a straight-line basis over the term of the lease.

1.14 **Cash & Cash Equivalents**

Cash is cash in hand and deposits with any financial institution repayable without penalty on notice of not more than 24 hours. Cash equivalents are investments that mature in 3 months or less from the date of acquisition and that are readily convertible to known amounts of cash with insignificant risk of change in value.

In the Statement of Cash Flows, cash and cash equivalents are shown net of bank overdrafts that are repayable on demand and that form an integral part of the clinical commissioning group's cash management.

1.15 **Provisions**

Provisions are recognised when the clinical commissioning group has a present legal or constructive obligation as a result of a past event, it is probable that the clinical commissioning group will be required to settle the obligation, and a reliable estimate can be made of the amount of the obligation. The amount recognised as a provision is the best estimate of the expenditure required to settle the obligation at the end of the reporting period, taking into account the risks and uncertainties. Where a provision is measured using the cash flows estimated to settle the obligation, its carrying amount is the present value of those cash flows using HM Treasury's discount rate as follows:

All general provisions are subject to four separate discount rates according to the expected timing of cashflows from the Statement of Financial Position date:

- A nominal short-term rate of 3.27% (2021-22: 0.47%) for inflation adjusted expected cash flows up to and including 5 years from Statement of Financial Position date.
- A nominal medium-term rate of 3.20% (2021-22: 0.70%) for inflation adjusted expected cash flows over 5 years up to and including 10 years from the Statement of Financial Position date.
- A nominal long-term rate of 3.51% (2021-22: 0.95%) for inflation adjusted expected cash flows over 10 years and up to and including 40 years from the Statement of Financial Position date.
- A nominal very long-term rate of 3.00% (2021-22: 0.66%) for inflation adjusted expected cash flows exceeding 40 years from the Statement of Financial Position date.

When some or all of the economic benefits required to settle a provision are expected to be recovered from a third party, the receivable is recognised as an asset if it is virtually certain that reimbursements will be received and the amount of the receivable can be measured reliably.

A restructuring provision is recognised when the clinical commissioning group has developed a detailed formal plan for the restructuring and has raised a valid expectation in those affected that it will carry out the restructuring by starting to implement the plan or announcing its main features to those affected by it. The measurement of a restructuring provision includes only the direct expenditures arising from the restructuring, which are those amounts that are both necessarily entailed by the restructuring and not associated with on-going activities of the entity.

1.16 **Clinical Negligence Costs**

NHS Resolution operates a risk pooling scheme under which the clinical commissioning group pays an annual contribution to NHS Resolution, which in return settles all clinical negligence claims. The contribution is charged to expenditure. Although NHS Resolution is administratively responsible for all clinical negligence cases, the legal liability remains with clinical commissioning group.

1.17 **Non-clinical Risk Pooling**

The clinical commissioning group participates in the Property Expenses Scheme and the Liabilities to Third Parties Scheme. Both are risk pooling schemes under which the clinical commissioning group pays an annual contribution to the NHS Resolution and, in return, receives assistance with the costs of claims arising. The annual membership contributions, and any excesses payable in respect of particular claims are charged to operating expenses as and when they become due.

1.18 **Contingent liabilities and contingent assets**

A contingent liability is a possible obligation that arises from past events and whose existence will be confirmed only by the occurrence or non-occurrence of one or more uncertain future events not wholly within the control of the clinical commissioning group, or a present obligation that is not recognised because it is not probable that a payment will be required to settle the obligation or the amount of the obligation cannot be measured sufficiently reliably. A contingent liability is disclosed unless the possibility of a payment is remote.

A contingent asset is a possible asset that arises from past events and whose existence will be confirmed by the occurrence or non-occurrence of one or more uncertain future events not wholly within the control of the clinical commissioning group. A contingent asset is disclosed where an inflow of economic benefits is probable.

Where the time value of money is material, contingent liabilities and contingent assets are disclosed at their present value.

1.19 **Financial Assets**

Financial assets are recognised when the clinical commissioning group becomes party to the financial instrument contract or, in the case of trade receivables, when the goods or services have been delivered. Financial assets are derecognised when the contractual rights have expired or the asset has been transferred.

Financial assets are classified into the following categories:

- Financial assets at amortised cost;
- Financial assets at fair value through other comprehensive income and ;
- Financial assets at fair value through profit and loss.

The classification is determined by the cash flow and business model characteristics of the financial assets, as set out in IFRS 9, and is determined at the time of initial recognition.

1.19.1 **Financial Assets at Amortised cost**

Financial assets measured at amortised cost are those held within a business model whose objective is achieved by collecting contractual cash flows and where the cash flows are solely payments of principal and interest. This includes most trade receivables and other simple debt instruments. After initial recognition these financial assets are measured at amortised cost using the effective interest method less any impairment. The effective interest rate is the rate that exactly discounts estimated future cash receipts through the life of the financial asset to the gross carrying amount of the financial asset.

1.19.2 **Financial assets at fair value through other comprehensive income**

Financial assets held at fair value through other comprehensive income are those held within a business model whose objective is achieved by both collecting contractual cash flows and selling financial assets and where the cash flows are solely payments of principal and interest.

1.19.3 **Financial assets at fair value through profit and loss**

Financial assets measure at fair value through profit and loss are those that are not otherwise measured at amortised cost or fair value through other comprehensive income. This includes derivatives and financial assets acquired principally for the purpose of selling in the short term.

1.19.4 **Impairment**

For all financial assets measured at amortised cost or at fair value through other comprehensive income (except equity instruments designated at fair value through other comprehensive income), lease receivables and contract assets, the clinical commissioning group recognises a loss allowance representing the expected credit losses on the financial asset.

The clinical commissioning group adopts the simplified approach to impairment in accordance with IFRS 9, and measures the loss allowance for trade receivables, lease receivables and contract assets at an amount equal to lifetime expected credit losses. For other financial assets, the loss allowance is measured at an amount equal to lifetime expected credit losses if the credit risk on the financial instrument has increased significantly since initial recognition (stage 2) and otherwise at an amount equal to 12 month expected credit losses (stage 1).

HM Treasury has ruled that central government bodies may not recognise stage 1 or stage 2 impairments against other government departments, their executive agencies, the Bank of England, Exchequer Funds and Exchequer Funds assets where repayment is ensured by primary legislation. The clinical commissioning group therefore does not recognise loss allowances for stage 1 or stage 2 impairments against these bodies. Additionally Department of Health and Social Care provides a guarantee of last resort against the debts of its arm's lengths bodies and NHS bodies and the clinical commissioning group does not recognise allowances for stage 1 or stage 2 impairments against these bodies.

For financial assets that have become credit impaired since initial recognition (stage 3), expected credit losses at the reporting date are measured as the difference between the asset's gross carrying amount and the present value of the estimated future cash flows discounted at the financial asset's original effective interest rate. Any adjustment is recognised in profit or loss as an

1.20 **Financial Liabilities**

Financial liabilities are recognised on the statement of financial position when the clinical commissioning group becomes party to the contractual provisions of the financial instrument or, in the case of trade payables, when the goods or services have been received. Financial liabilities are de-recognised when the liability has been discharged, that is, the liability has been paid or has

1.21 **Value Added Tax**

Most of the activities of the clinical commissioning group are outside the scope of VAT and, in general, output tax does not apply and input tax on purchases is not recoverable. Irrecoverable VAT is charged to the relevant expenditure category or included in the capitalised purchase cost of fixed assets. Where output tax is charged or input VAT is recoverable, the amounts are stated net of VAT.

1.22 **Losses & Special Payments**

Losses and special payments are items that Parliament would not have contemplated when it agreed funds for the health service or passed legislation. By their nature they are items that ideally should not arise. They are therefore subject to special control procedures compared with the generality of payments. They are divided into different categories, which govern the way that individual cases are handled.

Losses and special payments are charged to the relevant functional headings in expenditure on an accruals basis, including losses which would have been made good through insurance cover had the clinical commissioning group not been bearing its own risks (with insurance premiums then being included as normal revenue expenditure).

1.23 **Gifts**

Gifts are items that are voluntarily donated, with no preconditions and without the expectation of any return. Gifts include all transactions economically equivalent to free and unremunerated transfers, such as the loan of an asset for its expected useful life, and the sale or lease of assets at below market value.

1.24 **Adoption of new standards**

On 1 April 2022, the clinical commissioning group adopted IFRS 16 'Leases'. The new standard introduces a single, on statement of financial position lease accounting model for lessees and removes the distinction between operating and finance leases.

Under IFRS 16 the group will recognise a right-of-use asset representing the group's right to use the underlying asset and a lease liability representing its obligation to make lease payments for any operating leases assessed to fall under IFRS 16. There are recognition exemptions for short term leases and leases of low value items.

In addition, the group will no longer charge provisions for operating leases that it assesses to be onerous to the statement of comprehensive net expenditure. Instead, the group will include the payments due under the lease with any appropriate assessment for impairments in the right-of-use asset.

1.24.1 **Impact assessment**

The clinical commissioning group has applied the modified retrospective approach and will recognise the cumulative effect of adopting the standard at the date of initial application as an adjustment to the opening retained earnings with no restatement of comparative balances.
IFRS 16 does not require entities to reassess whether a contract is, or contains, a lease at the date of initial application. HM Treasury has interpreted this to mandate this practical expedient and therefore the group has applied IFRS 16 to contracts identified as a lease under IAS 17 or IFRIC 4 at 1 April 2022.
The group has utilised three further practical expedients under the transition approach adopted:
a) The election to not make an adjustment for leases for which the underlying asset is of low value.
b) The election to not make an adjustment to leases where the lease terms ends within 12 months of the date of application.
c) The election to use hindsight in determining the lease term if the contract contains options to extend or terminate the lease.

The most significant impact of the adoption of IFRS 16 has been the need to recognise right-of-use assets and lease liabilities for any buildings previously treated as operating leases that meet the recognition criteria in IFRS 16. Expenditure on operating leases has been replaced by interest on lease liabilities and depreciation on right-of-use assets in the statement of comprehensive net expenditure.
As of 1 April 2022, the group recognised £273k or right-of-use assets and lease liabilities of £271k. The weighted average incremental borrowing rate applied at 1 April 2022 is 0.95% and on adoption of IFRS 16 there was an £0k impact to tax payers' equity.
The following table reconciles the group's operating lease obligations at 31 March 2022, disclosed in the group's 21/22 financial statements, to the lease liabilities recognised on initial application of IFRS 16 at 1 April 2022.

	Total £000
Operating lease commitments at 31 March 2022	-277
Impact of discounting at 1 April 2022 using the weighted average incremental borrowing rate of 0.95%	5
Operating lease commitments discounted used weighted average IBR	-272
Add: Finance lease liabilities at 31 March 2022	0
Add: Peppercorn leases revalued to existing value in use	0
Add: Residual value guarantees	0
Add: Rentals associated with extension options reasonably certain to be exercised	0
Less: Short term leases (including those with <12 months at application date)	0
Less: Low value leases	1
Less: Variable payments not included in the valuation of the lease liabilities	0
Lease liability at 1 April 2022	**-271**

1.25 **New and revised IFRS Standards in issue but not yet effective**

● IFRS 17 Insurance Contracts – Application required for accounting periods beginning on or after 1 January 2021. Standard is not yet adopted by the FReM which is expected to be April 2023: early adoption is not therefore permitted.

2 Other Operating Revenue

	2022-23 30/06/2022 Total £'000	2021-22 31/03/2022 Total £'000
Income from sale of goods and services (contracts)		
Education, training and research	**1**	1
Non-patient care services to other bodies	**167**	1,231
Other Contract income	**139**	2,574
Recoveries in respect of employee benefits	**96**	235
Total Income from sale of goods and services	**403**	**4,041**
Total Operating Income	**403**	**4,041**

Due to this Financial Year duration being 3 months, the year on year figures are not comparable.

3.1 Disaggregation of Income - Income from sale of good and services (contracts)

	Education, training and research	Non-patient care services to other bodies	Other Contract income	Recoveries in respect of employee benefits
	£'000	£'000	£'000	£'000
Source of Revenue				
NHS	-	132	8	79
Non NHS	1	35	132	17
Total	**1**	**167**	**140**	**96**

	Education, training and research	Non-patient care services to other bodies	Other Contract income	Recoveries in respect of employee benefits
	£'000	£'000	£'000	£'000
Timing of Revenue				
Point in time	1	167	139	96
Total	**1**	**167**	**139**	**96**

3.2 Transaction price to remaining contract performance obligations

The Clinical Commissioning Group had no contract revenue to be recognised in future periods relating to contract performance obligations not yet completed at the reporting date.

4. Employee benefits and staff numbers

4.1.1 Employee benefits	**Total 01/04/2022 - 30/06/2022**		**2022-23**
	Permanent Employees £'000	**Other £'000**	**Total £'000**
Employee Benefits			
Salaries and wages	871	158	1,029
Social security costs	116	-	116
Employer Contributions to NHS Pension scheme	180	-	180
Apprenticeship Levy	1	-	1
Gross employee benefits expenditure	1,168	158	1,326
Less recoveries in respect of employee benefits (note 4.1.2)	(96)	-	(96)
Net employee benefits excluding capitalised costs	1,072	158	1,230

4.1.1 Employee benefits	Total		2021-22
	Permanent Employees £'000	Other £'000	Total £'000
Employee Benefits			
Salaries and wages	3,360	528	3,888
Social security costs	366	-	366
Employer Contributions to NHS Pension scheme	668	-	668
Apprenticeship Levy	5	-	5
Termination benefits	73	-	73
Gross employee benefits expenditure	4,472	528	5,000
Less recoveries in respect of employee benefits (note 4.1.2)	(235)	-	(235)
Net employee benefits excluding capitalised costs	4,237	528	4,765

4.1.2 Recoveries in respect of employee benefits			**2022-23**	2021-22
	01/04/21 - 31/03/2022			
	Permanent Employees £'000	**Other £'000**	**Total £'000**	Total £'000
Employee Benefits - Revenue				
Salaries and wages	(96)	-	(96)	(235)
Total recoveries in respect of employee benefits	(96)	-	(96)	(235)

Due to this Financial Year duration being 3 months, the year on year figures are not comparable.

4.2 Average number of people employed

	2022-23			2021-22		
	Permanently employed Number	Other Number	Total Number	Permanently employed Number	Other Number	Total Number
Total	**69**	**6**	**75**	**72**	**5**	**77**

4.4 Exit packages agreed in the financial year

	2022-23 Compulsory redundancies		2022-23 Other agreed departures		2022-23 Total	
	Number	£	Number	£	Number	£
£100,001 to £150,000	-	-	-	-	-	-
Total	**-**	**-**	**-**	**-**	**-**	**-**

	2021-22 Compulsory redundancies		2021-22 Other agreed departures		2021-22 Total	
	Number	£	Number	£	Number	£
£100,001 to £150,000	1	106,438	-	-	1	106,438
Total	**1**	**106,438**	**-**	**-**	**1**	**106,438**

There were no non-contractual severance payments made following judicial mediation, and nil settlements valued at £nil relating to non-contractual payments in lieu of notice.

As a single exit package can be made up of several components each of which will be counted separately in this table, the total number will not necessarily match the total number in the table above, which will be the number of individuals.

These tables report the number and value of exit packages agreed in the financial year. The expense associated with these departures may have been recognised in part or in full in a previous period.

Redundancy and other departure costs have been paid in accordance with the provisions of the NHS Redundancy scheme (the remuneration report includes the disclosure of exit payments paid to these individuals).

Exit costs are accounted for in accordance with relevant accounting standards and at the latest in full in the year of departure.

The Remuneration Report includes the disclosure of exit payments payable to individuals named in that Report.

4.5 Pension costs

Past and present employees are covered by the provisions of the two NHS Pension Schemes. Details of the benefits payable and rules of the Schemes can be found on the NHS Pensions website at www.nhsbsa.nhs.uk/pensions. Both are unfunded defined benefit schemes that cover NHS employers, GP practices and other bodies, allowed under the direction of the Secretary of State for Health and Social Care in England and Wales. They are not designed to be run in a way that would enable NHS bodies to identify their share of the underlying scheme assets and liabilities. Therefore, each scheme is accounted for as if it were a defined contribution scheme: the cost to the NHS body of participating in each scheme is taken as equal to the contributions payable to that scheme for the accounting period.

In order that the defined benefit obligations recognised in the financial statements do not differ materially from those that would be determined at the reporting date by a formal actuarial valuation, the FReM requires that "the period between formal valuations shall be four years, with approximate assessments in intervening years". An outline of these follows:

4.5.1 Accounting valuation

A valuation of scheme liability is carried out annually by the scheme actuary (currently the Government Actuary's Department) as at the end of the reporting period. This utilises an actuarial assessment for the previous accounting period in conjunction with updated membership and financial data for the current reporting period, and is accepted as providing suitably robust figures for financial reporting purposes. The valuation of the scheme liability as at 31 March 2022, is based on valuation data as 31 March 2021, updated to 31 March 2022 with summary global member and accounting data. In undertaking this actuarial assessment, the methodology prescribed in IAS 19, relevant FReM interpretations, and the discount rate prescribed by HM Treasury have also been used.

The latest assessment of the liabilities of the scheme is contained in the report of the scheme actuary, which forms part of the annual NHS Pension Scheme Accounts. These accounts can be viewed on the NHS Pensions website and are published annually. Copies can also be obtained from The Stationery Office.

4.5.2 Full actuarial (funding) valuation

The purpose of this valuation is to assess the level of liability in respect of the benefits due under the schemes (taking into account recent demographic experience), and to recommend contribution rates payable by employees and employers.

The latest actuarial valuation undertaken for the NHS Pension Scheme was completed as at 31 March 2016. The results of this valuation set the employer contribution rate payable from April 2019 to 20.6% of pensionable pay.

The 2016 funding valuation also tested the cost of the Scheme relative to the employer cost cap that was set following the 2012 valuation. There was initially a pause to the cost control element of the 2016 valuations, due to the uncertainty around member benefits caused by the discrimination ruling relating to the McCloud case.

HMT published valuation directions dated 7 October 2021 (see Amending Directions 2021) that set out the technical detail of how the costs of remedy are included in the 2016 valuation process. Following these directions, the scheme actuary has completed the cost control element of the 2016 valuation for the NHS Pension Scheme, which concludes no changes to benefits or member contributions are required. The 2016 valuation reports can be found on the NHS Pensions website at https://www.nhsbsa.nhs.uk/nhs-pension-scheme-accounts-and-valuation-reports.

5. Operating expenses

	2022-23 30/06/2022 Total £'000	2021-22 31/03/2022 Total £'000
Purchase of goods and services		
Services from other CCGs and NHS England	786	3,015
Services from foundation trusts	6,307	21,245
Services from other NHS trusts	70,963	272,764
Purchase of healthcare from non-NHS bodies	19,025	90,308
Purchase of social care	469	1,649
Prescribing costs	14,096	55,157
General Ophthalmic services	-	1
GPMS/APMS and PCTMS	15,263	62,102
Supplies and services – clinical	262	1,217
Supplies and services – general	309	(1,881)
Consultancy services	-	9
Establishment	74	1,176
Transport	452	2,449
Premises	38	363
Audit fees	38	51
Other non statutory audit expenditure		
· Other services	16	-
Other professional fees	19	33
Legal fees	32	81
Education, training and conferences	32	320
Total Purchase of goods and services	**128,181**	**510,059**
Depreciation and impairment charges		
Depreciation	27	41
Total Depreciation and impairment charges	**27**	**41**
Provision expense		
Provisions	119	339
Total Provision expense	**119**	**339**
Other Operating Expenditure		
Chair and Non Executive Members	122	513
Clinical negligence	1	5
Research and development (excluding staff costs)	-	20
Expected credit loss on receivables	-	1
Total Other Operating Expenditure	**123**	**539**
Total operating expenditure	**128,450**	**510,978**

Due to this Financial Year duration being 3 months, the year on year figures are not comparable.

The auditor's liability for external audit work carried out for the three months ending 30 June 2022, is limited to £2,000,000.

6.1 Better Payment Practice Code

Measure of compliance	**2022-23 Number**	**2022-23 £'000**	2021-22 Number	2021-22 £'000
Non-NHS Payables				
Total Non-NHS Trade invoices paid in the Year	1,329	18,515	6,040	85,889
Total Non-NHS Trade Invoices paid within target	1,329	18,515	6,023	85,735
Percentage of Non-NHS Trade invoices paid within target	**100.00%**	**100.00%**	**99.72%**	**99.82%**
NHS Payables				
Total NHS Trade Invoices Paid in the Year	108	80,137	364	299,986
Total NHS Trade Invoices Paid within target	107	80,136	360	299,915
Percentage of NHS Trade Invoices paid within target	**99.07%**	**100.00%**	**98.90%**	**99.98%**

Due to this Financial Year duration being 3 months, the year on year numbers and values are not comparable.

6.2 The Late Payment of Commercial Debts (Interest) Act 1998

The Clinical Commissioning Group incurred £nil charges relating to claims made under this legislation (2021-22 £nil).

7.1 Finance costs

	2022-23 £'000	2021-22 £'000
Interest		
Interest on lease liabilities	1	-
Total interest	**1**	**-**
Total finance costs	**1**	**-**

Lease liabilities are accounted for by IFRS13 from 1st April. The 22/23 charge relates to 3 months interest

8 Property, plant and equipment

2022-23	Buildings excluding dwellings £'000	Plant & machinery £'000	Information technology £'000	Furniture & fittings £'000	Total £'000
Cost or valuation at 01 April 2022	111	86	343	26	566
Additions purchased	-	-	-	-	-
Cost/Valuation at 30 June 2022	**111**	**86**	**343**	**26**	**566**
Depreciation 01 April 2022	67	86	302	20	475
Charged during the year	2	-	6	1	9
Depreciation at 30 June 2022	**69**	**86**	**308**	**21**	**484**
Net Book Value at 30 June 2022	**42**	**-**	**35**	**5**	**82**
Purchased	42	-	35	5	82
Total at 30 June 2022	**42**	**-**	**35**	**5**	**82**
Asset financing:					
Owned	42	-	35	5	82
Total at 30 June 2022	**42**	**-**	**35**	**5**	**82**

8.1 Cost or valuation of fully depreciated assets

The cost or valuation of fully depreciated assets still in use was as follows:

	2022-23 £'000	2021-22 £'000
Plant & machinery	86	86
Information technology	224	224
Total	**310**	**310**

8.2 Economic lives

	Minimum Life (years)	**Maximum Life (Years)**
Buildings excluding dwellings	4	4
Information technology	0	0
Furniture & fittings	1	1

8a Leases

8a.1 Right-of-use assets

2022-23	Buildings excluding dwellings £'000
Cost or valuation at 01 April 2022	-
IFRS 16 Transition Adjustment	271
Cost/Valuation at 30 June 2022	**271**
Depreciation 01 April 2022	-
Charged during the year	18
Depreciation at 30 June 2022	**18**
Net Book Value at 30 June 2022	**253**

8a.2 Lease liabilities

2022-23	2022-23 £'000
Lease liabilities at 01 April 2022	-
IFRS 16 Transition Adjustment	271
Repayment of lease liabilities (including interest)	1
Lease remeasurement	(18)
Lease liabilities at 30 June 2022	**254**

8a.3 Lease liabilities - Maturity analysis of undiscounted future lease payments

	2022-23 £'000
Within one year	(72)
Between one and five years	(186)
After five years	-
Balance at 30 June 2022	**(258)**
Effect of discounting	4
Included in:	
Current lease liabilities	(70)
Non-current lease liabilities	(184)
Balance at 30 June 2022	**(254)**

8a.4 Amounts recognised in Statement of Comprehensive Net Expenditure

2022-23	2022-23 £'000
Depreciation expense on right-of-use assets	18
Interest expense on lease liabilities	1

8a.5 Amounts recognised in Statement of Cash Flows

	2022-23 £'000
Total cash outflow on leases under IFRS 16	(18)

8a Leases cont'd

Nature of lessee's leasing activities

The lease disclosed in these accounts relates to lease of Space from Leicester County Council and is used as headquarters / Office Space

Future cash outflows to which the lessee is potentially exposed that are not reflected in the measurement of lease liabilities. This includes exposure arising from

- variable lease payments
- extension and termination options
- residual value guarantee
- leases not yet commenced to which the lessee is committed

The current lease is due to terminate on 31st January 2026. At this point we will either need to renew the lease, or move to other premises.

Restrictions or covenants imposed by leases

There are no Restrictions and covenants impossed by the lease, however, modifications need to be approved by Leicester County Council, and may be subject to restoration / Delapidation charges upon termination

Sale and leaseback transactions

There are no sale and leaseback transactions

9 Intangible non-current assets

2022-23	Computer Software: Purchased £'000
Cost or valuation at 01 April 2022	114
Cost / Valuation At 30 June 2022	**114**
Amortisation 01 April 2022	114
Charged during the year	-
Amortisation At 30 June 2022	**114**
Net Book Value at 30 June 2022	**-**

9.1 Cost or valuation of fully amortised assets

The cost or valuation of fully depreciated assets still in use was as follows:

	2022-23 £'000	2021-22 £'000
Computer software: purchased	114	114
Total	**114**	**114**

9.2 Economic lives

	Minimum Life (years)	Maximum Life (Years)
Computer software: purchased	0	5

10.1 Trade and other receivables	**Current 30/06/2022 2022-23 £'000**	Current 31/03/2022 2021-22 £'000
NHS receivables: Revenue	127	638
NHS prepayments	-	2
NHS accrued income	10,061	9,328
Non-NHS and Other WGA receivables: Revenue	64	200
Non-NHS and Other WGA prepayments	449	416
Non-NHS and Other WGA accrued income	259	336
Expected credit loss allowance-receivables	(48)	(48)
VAT	23	68
Total Trade & other receivables	**10,935**	**10,940**
Total current and non current	**10,935**	**10,940**

There are no prepaid pension contributions included in note 10.1 (£nil 2021-22).

Due to this Financial Year duration being 3 months, the year on year figures are not comparable.

10.2 Receivables past their due date but not impaired

	2022-23 DHSC Group Bodies £'000	**2022-23 Non DHSC Group Bodies £'000**	2021-22 DHSC Group Bodies £'000	2021-22 Non DHSC Group Bodies £'000
By up to three months	-	3	23	47
By three to six months	-	8	-	-
Total	**-**	**11**	**23**	**47**

10.3 Loss allowance on asset classes	**Trade and other receivables - Non DHSC Group Bodies**	**Other financial assets**	**Total**
	£'000	**£'000**	**£'000**
Balance at 01 April 2022	(48)	-	**(48)**
Total	**(48)**	**-**	**(48)**

11 Cash and cash equivalents

	2022-23 30/06/2022 £'000	2021-22 31/03/2022 £'000
Balance at 01 April 2022	5	30
Net change in year	115	(25)
Balance at 30 June 2022	**120**	**5**
Made up of:		
Cash with the Government Banking Service	120	5
Cash and cash equivalents as in statement of financial position	**120**	**5**
Balance at 30 June 2022	**120**	**5**

The Clinical Commissioning Group does not hold patients monies (£nil 2021-22).
Due to this Financial Year duration being 3 months, the year on year figures are not comparable.

12 Trade and other payables	**Current 2022-23 30/06/2022 £'000**	Current 2021-22 31/03/2022 £'000
NHS payables: Revenue	217	211
NHS payables: Capital	3	3
NHS accruals	3,382	4,391
Non-NHS and Other WGA payables: Revenue	742	1,939
Non-NHS and Other WGA accruals	18,572	22,234
Non-NHS and Other WGA deferred income	-	187
Social security costs	77	64
Tax	67	40
Other payables and accruals	607	581
Total Trade & Other Payables	**23,667**	**29,650**
Total current and non-current	**23,667**	**29,650**

The Clinical Commissioning Group does not have any liabilities included above for arrangements to buy out the liability for early retirement over 5 years (£nil at 31 March 2022).

Other payables include £422k outstanding pension contributions at 30 June 2022 (£401k as at 31st March 2022).
Other Payables includes GP Pensions

Due to this Financial Year duration being 3 months, the year on year figures are not comparable.

13 Provisions

	Current 2022-23 £'000	Current 2021-22 £'000
Redundancy	18	125
Continuing care	233	183
Other		13
Total	**251**	**321**
Total current and non-current	**251**	**321**

	Redundancy £'000	Continuing Care £'000	Other £'000	Total £'000
Balance at 01 April 2022	**124**	**183**	**13**	**320**
Arising during the year	-	132	-	**132**
Utilised during the year	(106)	(82)	(1)	**(189)**
Reversed unused	-	-	(12)	**(12)**
Balance at 30 June 2022	**18**	**233**	**-**	**251**
Expected timing of cash flows:				
Within one year	18	233	-	**251**
Balance at 30 June 2022	**18**	**233**	**-**	**251**

One Redundancy was finalised during the period with a payment of £106k, leaving one outstanding provision remaining

The continuing healthcare retrospective claims and disputes have been reviewed with £82k utilised in year and an additional £132k arising in year.

The Clinical Commissioning Group "Other" Provision related to fees in relation to a service transfer and TUPE pension claims. This has now been resolved

Legal claims are calculated from the number of claims currently lodged with the NHS Resolution and the probabilities provided by them. As at 30 June 2022, NHS Resolution was providing £11,230 under the Clinical Negligence scheme, on behalf of the Clinical Commissioning Group (£11,230 as at 31 March 2022).

14 Contingencies

The Clinical Commissioning Group had no contingent liabilities as at 30th June 2022 (£nil 31 March 2022).

15 Commitments

15.1 Capital commitments

The Clinical Commissioning Group had no capital commitments as at 30th June 2022 (£nil 31 March 2022).

15.2 Other financial commitments

The Clinical Commissioning Group had no other contracted financial commitments as at 30th June 2022 (£nil 31

16 Financial instruments

16.1 Financial risk management

Financial reporting standard IFRS 7 requires disclosure of the role that financial instruments have had during the period in creating or changing the risks a body faces in undertaking its activities.

Because NHS clinical commissioning group is financed through parliamentary funding, it is not exposed to the degree of financial risk faced by business entities. Also, financial instruments play a much more limited role in creating or changing risk than would be typical of listed companies, to which the financial reporting standards mainly apply. The clinical commissioning group has limited powers to borrow or invest surplus funds and financial assets and liabilities are generated by day-to-day operational activities rather than being held to change the risks facing the clinical commissioning group in undertaking its activities.

Treasury management operations are carried out by the finance department, within parameters defined formally within the NHS clinical commissioning group standing financial instructions and policies agreed by the Governing Body. Treasury activity is subject to review by the NHS clinical commissioning group and internal auditors.

16.1.1 Currency risk

The NHS clinical commissioning group is principally a domestic organisation with the great majority of transactions, assets and liabilities being in the UK and sterling based. The NHS clinical commissioning group has no overseas operations. The NHS clinical commissioning group and therefore has low exposure to currency rate fluctuations.

16.1.2 Interest rate risk

The clinical commissioning group borrows from government for capital expenditure, subject to affordability as confirmed by NHS England. The borrowings are for 1 to 25 years, in line with the life of the associated assets, and interest is charged at the National Loans Fund rate, fixed for the life of the loan. The clinical commissioning group therefore has low exposure to interest rate fluctuations.

16.1.3 Credit risk

Because the majority of the NHS clinical commissioning group and revenue comes parliamentary funding, NHS clinical commissioning group has low exposure to credit risk. The maximum exposures as at the end of the financial year are in receivables from customers, as disclosed in the trade and other receivables note.

16.1.4 Liquidity risk

NHS clinical commissioning group is required to operate within revenue and capital resource limits, which are financed from resources voted annually by Parliament. The NHS clinical commissioning group draws down cash to cover expenditure, as the need arises. The NHS clinical commissioning group is not, therefore, exposed to significant liquidity risks.

16.1.5 Financial Instruments

As the cash requirements of NHS England are met through the Estimate process, financial instruments play a more limited role in creating and managing risk than would apply to a non-public sector body. The majority of financial instruments relate to contracts to buy non-financial items in line with NHS England's expected purchase and usage requirements and NHS England is therefore exposed to little credit, liquidity or market risk.

16 Financial instruments cont'd

16.2 Financial assets

	Financial Assets measured at amortised cost	
	2022-23	2021-22
	£'000	£'000
Trade and other receivables with NHSE bodies	10,013	9,898
Trade and other receivables with other DHSC group bodies	435	404
Trade and other receivables with external bodies	64	200
Cash and cash equivalents	121	5
Total at 30 June 2022	**10,633**	10,507

16.3 Financial liabilities

	Financial Liabilities measured at amortised cost	
	2022-23	2021-22
	£'000	£'000
Trade and other payables with NHSE bodies	912	3,927
Trade and other payables with other DHSC group bodies	2,689	678
Trade and other payables with external bodies	20,177	24,755
Total at 30 June 2022	**23,778**	29,360

17 Joint arrangements - interests in joint operations

CCGs should disclose information in relation to joint arangements in line with the requirements in IFRS 12 - Disclosure of interests in other entities.

17.1 Interests in joint operations

Scheme	Area	Category	Accounting Treatment	CCG Expenditure for each scheme in 2021-22 (£000s)	CCG Expenditure for each scheme in 2022-23 (£000s) Month 3
Better Care Fund	Adult Social Care	BCF (s.75 agreement)	Resources transferred to Leicestershire County Council who act as host.	11,361	2,991
Better Care Fund	Adult Social Care	BCF (s.75 agreement)	Resources transferred to Rutland County Council who act as host.	1,731	463
Community Equipment (ICES)	Social Care	Support to live at home	Leicester City Council who act as host.	1,875	469
Learning Disabilities Pool	Social Care	LD	Leicestershire County Council who act as host.	3,081	770
				18,048	**4,693**
Better Care Fund	Learning Disabilities	Leics County BCF	Resources controlled and expended by the CCG	278	71
Better Care Fund	Community Health	Leics County BCF	Resources controlled and expended by the CCG	4,454	1,152
Better Care Fund	Community Health	Rutland County BCF	Resources controlled and expended by the CCG	748	187
Better Care Fund	Step Down Beds	Leics County BCF	Resources controlled and expended by the CCG	277	76
Better Care Fund	Urgent Care/Out of Hours	Leics County BCF	Resources controlled and expended by the CCG	2,310	584
				8,067	**2,070**
Total				**26,115**	**6,763**

This table summarises the Clinical Commissioning Group share of expenditure incurred for each of the pooled budgets of which it is a partner. Details of the pooled budget arrangements follow.

17.2 Interests in joint operations - Integrated Community Equipment Services (ICES) Pooled Budget
The Clinical Commissioning Group had entered into a pooled budget with Leicester City Council, Leicestershire County Council, Rutland County Council, NHS Leicester City Commissioning Group and
Under the arrangement funds are pooled under Section 75 of the NHS Act 2006 for Integrated Community Equipment Services (ICES). As a commissioner of healthcare services, the Clinical

17.3.1 Interests in joint operations - Better Care Fund Pooled Budget (Leicestershire)
On 1st April 2015 the Adults and Communities Department of Leicestershire County Council entered into a pooled budget arrangement under s.75 of the NHS Act 2016 with NHS West Leicestershire

17.3.2 Interests in joint operations - Better Care Fund Pooled Budget (Rutland)
Rutland County Council has entered into a pooled budget arrangement under s75 of the NHS Act 2006 with NHS East Leicestershire and Rutland Clinical Commissioning Group for the Better Care Fund.

17.4 Interests in joint operations - Learning Disabilities Pooled Budget
The Clinical Commissioning Group has a pooled budget arrangement with Leicestershire County Council and NHS West Leicestershire Clinical Commissioning Group, for Learning Disabilities (LD)

18 Related party transactions

Details of related party transactions with individuals are as follows:

Related Party	Payments to Related Party	Receipts from Related Party	Amounts owed to Related Party	Amounts due from Related Party
	£'000	£'000	£'000	£'000
Executive Directors for NHS Leicester City CCG (Andy Williams; Caroline Trevithick; Nicci Briggs; Sarah Prema; Alice McGee; Rachna Vyas)	75	(84)	674	(1,074)
Executive Directors for NHS West Leicestershire CCG (Andy Williams; Caroline Trevithick; Nicci Briggs; Sarah Prema; Alice McGee; Rachna Vyas)	180	(48)	181	(8,914)
GP Partner of Practice (The Croft Medical Centre) (Dr Vivek Varakantam)	672	0	(43)	(28)
GP Partner of Practice (Forest House Medical Centre) (Dr Andrew Ahyow)	83	0	0	0
GP Partner of Practice (Warren Lane Surgery) (Dr Andrew Ahyow)	448	0	0	(4)
GP Partner of Practice (Northfield Medical Centre)(Dr Nicholas Glover)	811	0	0	(0)
GP Partner of Practice (The Jubilee Medical Practice) (Dr Girish Purohit)	538	0	0	(59)
GP Partner of Practice (Kingsway Surgery) (Dr Nikhil Mahatma)	307	0	0	0
GP Partner of Pratice (Wycliffe Medical Practice) (Dr Graham Johnson)	56	0	0	(50)
Total	**3,170**	**(132)**	**813**	**(10,129)**

All transactions have been at arm's length as part of the Clinical Commissioning Group's healthcare commissioning.
The Department of Health is regarded as a related party. During the year the Clinical Commissioning Group has had a significant number of material
- University Hospitals of Leicester NHS Trust
- Leicestershire Partnership NHS Trust
- East Midlands Ambulance Service NHS Trust
- Nottinghamshire Healthcare NHS Trust
- NHS West Leicestershire Clinical Commissioning Group
- NHS Leicester City Clinical Commissioning Group
- NHS Midlands and Lancashire Commissioning Support Unit
- NHS England and NHS Improvement

The Clinical Commissioning Group also has material transactions with all the GP Practices within its locality and membership.
In addition, the Clinical Commissioning Group has had a number of material transactions with other Government departments and other central and local
- Leicester City Council
- Leicestershire County Council

19 Events after the end of the reporting period

Following the end of the reporting period, the Health and Care Act 2022 was enacted. The Clinical Commissioning Group was dissolved 30 June 2022, as were NHS Leicester City Clinical Commissioning Group; and NHS West Leicestershire Clinical Commissioning Group. All assets and liabilities of the three Clinical Commissioning Groups transferred to the new Leicester, Leicestershire and Rutland Integrated Care Board, 1 July 2022.

20 Losses and Special Payments

There were no losses in year (2021-22, nil cases, £nil). There were no special payments made in year (2021-22, nil cases, £nil).

21 Financial performance targets

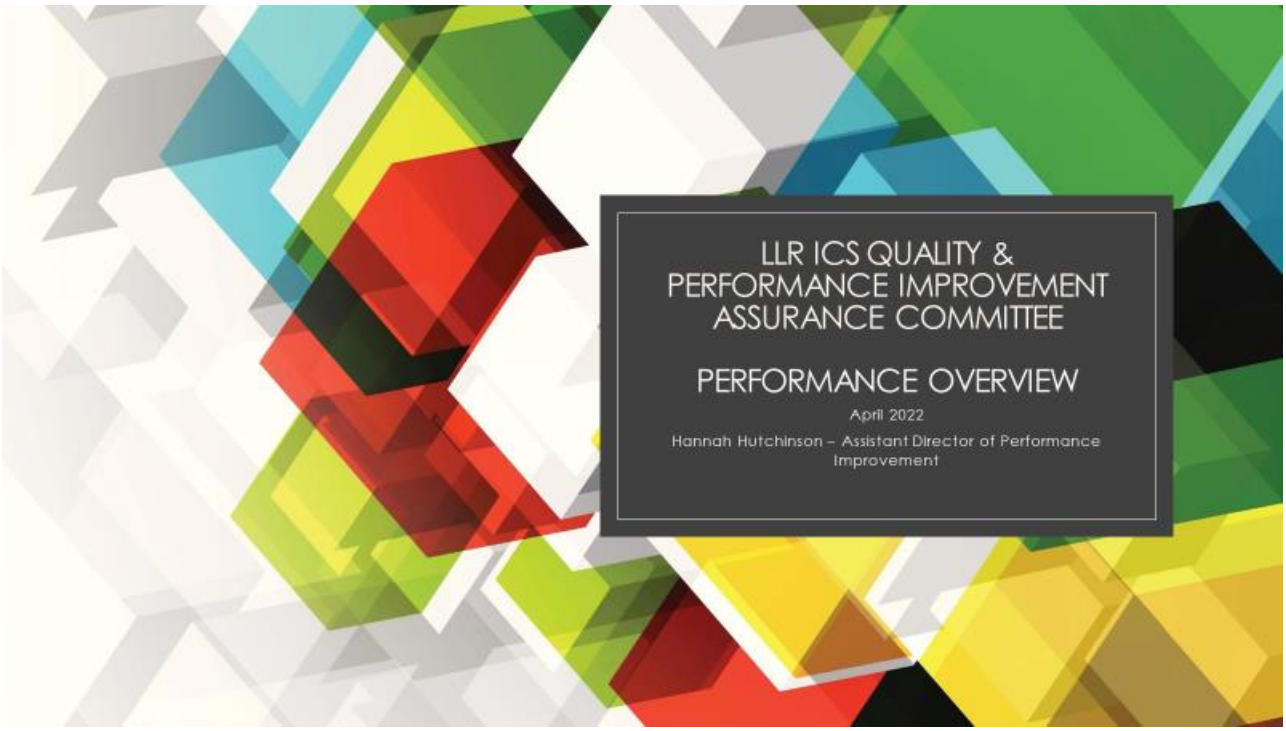
NHS Clinical Commissioning Group have a number of financial duties under the NHS Act 2006 (as amended).
NHS Clinical Commissioning Group performance against those duties was as follows:

	2022-23 Target	**2022-23 Performance**	2021-22 Target	2021-22 Performance
Expenditure not to exceed income	129,777	129,777	517,311	515,978
Capital resource use does not exceed the amount specified in Directions	-	-	75	13
Revenue resource use does not exceed the amount specified in Directions	129,374	129,374	513,270	511,937
Capital resource use on specified matter(s) does not exceed the amount specified in Directions	-	-	-	-
Revenue resource use on specified matter(s) does not exceed the amount specified in Directions	-	-	-	-
Revenue administration resource use does not exceed the amount specified in Directions	1,479	1,479	6,299	5,698

APPENDICES

- Appendix 1 – LLR CCGs' Performance overview as at June 2022
- Appendix 2 – LLR CCGs' Governance Arrangements
- Appendix 3 – LLR CCGs' Governing Body Members' Register of Interests
- Appendix 4 – ELR CCG GP Member Practices
- Appendix 5 – Members of CCG Committees
- Appendix 6 – Attendance at Governing Body meetings
- Appendix 7 – Key corporate risks: LLR CCGs' Board Assurance Framework
- Appendix 8 – contact details

Appendix 1 - LLR CCGs' Performance Overview (as at April 2022)



PERFORMANCE OVERVIEW

KEY NUMBERS

PERFORMANCE AGAINST PLAN

RECOVERY TIMES FOR LLR

The aim of this PowerPoint is to provide a high-level overview around the areas which are most under scrutiny by our regulators. It focuses on Primary care, learning disabilities, Urgent Care including Ambulance Handovers, elective long waiters, Priority 2 patients, cancer and the uptake of covid vaccinations in LLR.

Within this presentation, we have included an Out of County performance snapshot on key metrics for six Out of County Acute Providers.

Areas of Improvement

Primary Care - GP appointments & face - to-face appointments

Long waiters (+52 weeks and +104 weeks) at UHL in Feb

Areas of Deterioration

A&E 4hour wait

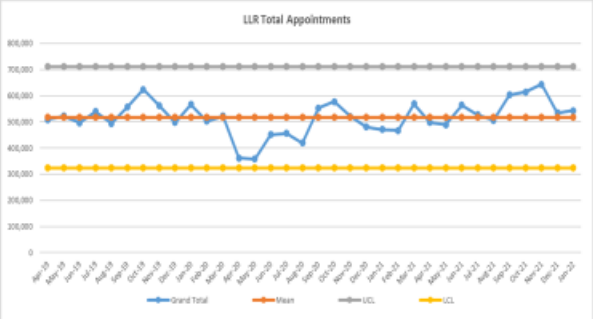
Priority 2 patient numbers

Cancer 2 week wait breast

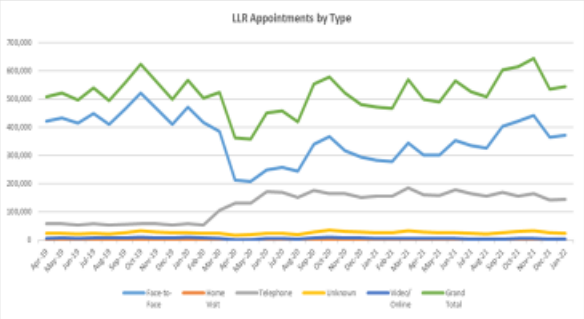
62day Cancer wait performance and backlogs

Primary Care – GP Appointments

LLR Total Appointments
Apr 2019 –Jan 2022



LLR Appointments by Appointment Type
Apr 2019 – Jan 2022



Pressure on primary care continues, with the total appointment types showing an increase of 1.6% between December (535,049) and January (543,435). The number of face-to face appointments has also increased by 2.0% for the same time period and stands at 371,286 for January and 363,995 for December.

Although the Jan 22 position is higher than in Jan 21, there were fewer appointments than in Jan 20. Funding to support the winter resilience programme endeavours to see the numbers return to the Jan 20 position.

Learning Disabilities

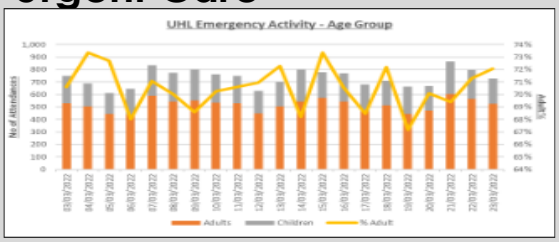
Number of Annual Health Checks carried out for persons aged 14+ on GP Learning Disability Register

CCG Name	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	21/22 HC's Year to date	Q1-Q4 21/22 Plan
NHS East Leicestershire and Rutland CCG	0	25	52	45	29	47	54	142	59	89	542	922
NHS Leicester City CCG	35	72	90	70	125	107	167	130	127	171	1094	1703
NHS West Leicestershire CCG	24	34	51	40	34	58	67	103	130	134	675	1188
LLR	**59**	**131**	**193**	**155**	**188**	**212**	**288**	**375**	**316**	**394**	2311	**3813**

Annual Health Checks (AHCs)- Due to the impact of Covid the numbers are not quite as high as expected. The above is based on national data to end of January 2022. Based on local data as of 14 March 2022, LLR are at 65% achievement and have another 242 AHCs to complete by end of March 2022 to reach target.

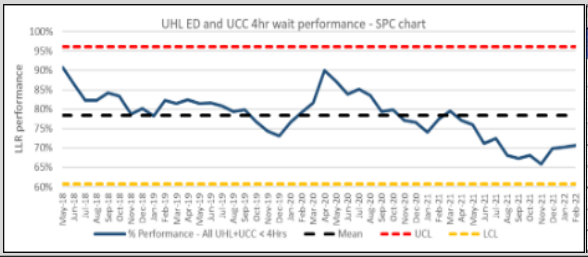
The following measures have been taken to try to support practices to continue to offer AHCs:
-Primary Care Liaison Nurses (PC LNs) continue to support practices in completing their AHCs.
-PC LNs have raised awareness of LD AHCs and offer of support at Primary Care webinars and Practice Learning Time (PLT) event during the month of February and March.
-Support for GP practices to develop plans to ensure all people on their learning disability register are invited for a health check (documented on the NHS futures platform) by end of March 2022

Urgent Care



There has been an overall reduction in ED activity compared to the previous 7 days. Overall children's has seen a slight increase (0.8%) and adults have reduced (2.6%)

A&E activity for LLR residents is around 80% at the Leicester Royal Infirmary Emergency Department. The remaining 20% will access A&E hospital services outside of Leicestershire (Coventry & Warwick, Derby & Burton, Nottingham, Peterborough etc etc).
February's 4hr A&E wait performance continues to be below the required standards across all local providers but has been increasing slightly since December 2021.



Out of County Provider A&E Performance

Provider (All Patients)	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	21_22 YTD
UH Derby & Burton FT	77.1%	75.3%	73.3%	69.9%	70.4%	67.9%	67.0%	64.6%	63.6%	65.7%	62.2%	68.9%
Nottingham University Hospital	CRS Trial Site											
George Eliot Hospital	91.8%	92.2%	91.7%	87.4%	85.8%	83.0%	84.1%	78.3%	76.5%	78.0%	79.6%	84.7%
UH Coventry & Warwick	85.9%	80.8%	78.1%	74.0%	74.3%	69.2%	69.4%	70.5%	71.8%	70.7%	71.5%	74.0%
Kettering	CRS Trial Site											
Northampton	86.3%	88.8%	84.4%	78.4%	71.3%	73.3%	69.7%	70.0%	69.5%	67.6%	65.8%	74.9%
NW Anglia FT	80.1%	72.5%	65.2%	63.3%	55.9%	58.7%	64.3%	60.1%	55.4%	58.4%	56.9%	62.7%
UHL	68.7%	67.5%	62.8%	62.9%	56.8%	56.8%	57.0%	53.9%	57.1%	57.0%	57.5%	59.8%

Ambulance Handovers

Urgent Care	20-Feb	27-Feb	06-Mar	13-Mar	20-Mar	Variation from prev wk (n)	% change from previous wk	% change from 4wks ago
EMAS UHL Handover: Cases	1,071	1,055	1,086	1,073	1,072	-1	-0.1%	1.6%
EMAS UHL Handover: Queueing >2hr	146	142	157	300	141	-159	-53.0%	-0.7%
EMAS UHL Handover: Queueing >60mins	290	254	319	430	303	-127	-29.5%	19.3%
EMAS UHL Handover: Queueing 30-59mins	221	159	213	153	232	79	51.6%	45.9%
<4hr wait performance - UHL ED & UCC*	69.4%	72.7%	70.1%	64.9%	66.3%	1.3%	2.0%	-8.8%

Monthly number of Ambulance Handovers- The graph shows the monthly number of Handovers at UHL, and shows an overall reduction from the 2021 summer months to February 2022.

Ambulance handover waiting times continue to be a concern both within LLR and regionally.

Rapid handover issues have been escalated, and clear process needs to be assured to manage both Cat1 responses and significant Cat2 waits requiring crews to handover patients.

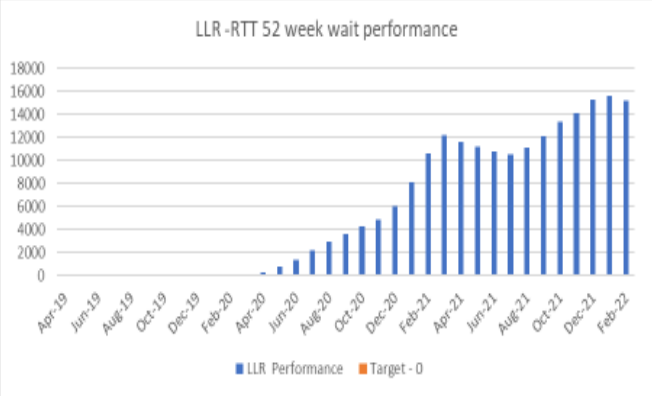
Work is being undertaken with partners to review this issue.

ED Consultants continue to have access to the EMAS stack to assist with triage of calls during peak times.

Elective - 52 week waits (LLR patients at all LLR providers)

The total LLR waiting list size at the end of February was 122,246, an increase of just over 3000 LLR patients from January which stood at 119,238.

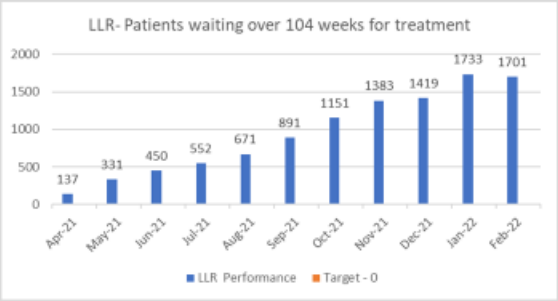
52-week waiters stands at **15,158** at the end of Feb 22, a reduction of 412 patients between Jan 22 and Feb 22. This is for LLR patients at all LLR providers.

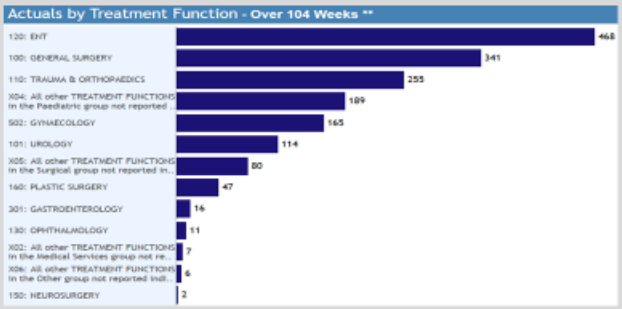


Further actions in place to reduce long waiters on next slide

Elective Long Waiters 104+ Weeks (LLR patients at all LLR Providers)

In February 22 there were **1701** 104+ week breaches within LLR, a reduction of 32 patients from January 22. This is for LLR patients at all LLR providers





Elective capacity is recovering, however, is still being impacted on by theatre and recovery staff sickness.

Actions in place:
- Capital bid (Targeted Investment Fund) has been successful for Elective hub at LGH. Business Plan to be completed.
- Spire are supporting Urology and Dermatology for Cancer patients
- Continued utilisation of the independent sector

Elective Long Waiters– Weekly UHL position, all patients

The following table provides the latest weekly position on the total number of patients at UHL only , waiting over 52weeks and over 104 weeks for elective treatment.

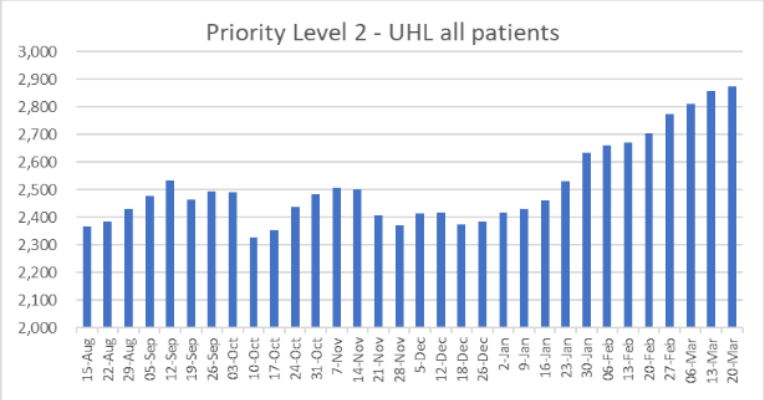
There has been a reduction in the number of long waiters from a peak at the end of January 22. This is in the main due to the Vanguard being on site from February 22.

	week ending (2022)						
UHL - Elective care	27-Feb	06-Mar	13-Mar	20-Mar	Variation from prev wk	% change from previous wk	% change from 4wks ago
52+ wks	15,836	15,942	15,959	15,920	-39	-0.2%	0.5%
104+ weeks	1,877	1,854	1,827	1,695	-132	-7.2%	-9.7%

Priority 2 Patients at UHL only

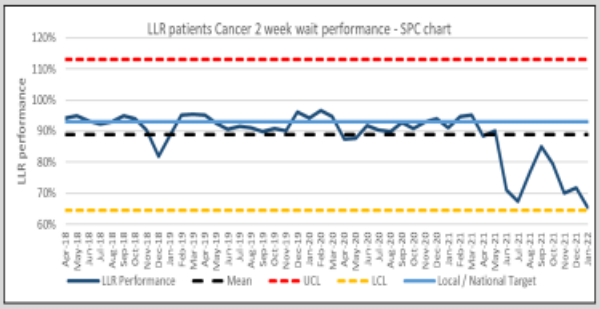
Definition of Priority Level 2: Surgery that can be deferred for up to 4 weeks.

The number of P2 patients has continued to increase from mid-December 2021 and most recently by 15 patients between 13th - 20th March 2022 (unvalidated UHL data)

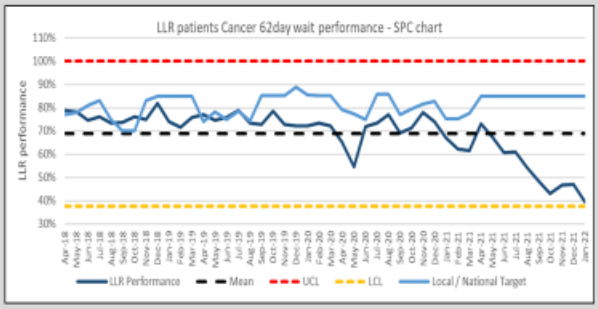


Cancer

2 week wait Cancer Performance for LLR patients at all providers



62day wait Cancer Performance for LLR patients at all providers



2ww position remains challenged and backlogs remain high in ENT at circa 296.
The 2ww referrals have continued to increase and remain consistently above pre-pandemic levels (20 – 25%). Capacity issues, workforce challenges, increased waiting list volumes, diagnostic capacity issues in Endoscopy and bed reductions due to overall system pressures continue to put at risk improvements in performance.

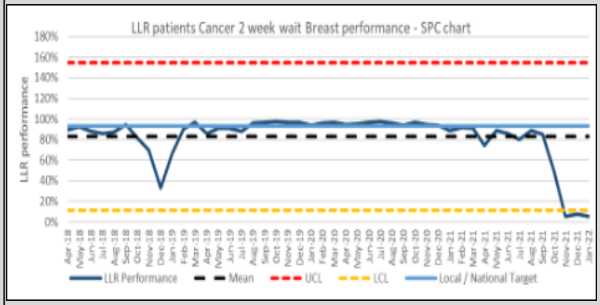
All backlog patients are reviewed on a weekly basis and escalated appropriately to ensure a timely next step is in place or each patient.

There was a system Cancer Summit on 8th April 2022 to enable the system to review the plans in place and identify gaps and risks to delivery.

Cancer 2 week wait Breast

Number of 2WW Referrals received (UHL)

	Aug 2021	Sep 2021	Oct 2021	Nov 2021	Dec 2021	Jan 2022
Breast Care	546	1072	1055	994	836	905
Weekly Average	137	268	264	249	209	226



UHL Performance	Target	Jan position	SCR Position February*	SCR Position March*
2WW Breast	93%	4.1%	11.5%	49.0%

**as at 21/03/22- subject to validation*

The increase in referrals received in October and November had a significant impact on performanceand this further impacted on the 62 day cancer standard.

UHL are booking within 2 weeks now for all breast appointments.

Backlogs have now been cleared with an improvement in performance forecasted through March and April and achievement of the standard from April onwards.

Actions in place (UHL):

- Breast pain pathway
- Independent Sector(IS) provision of capacity for patients under 35yrs
- Your World insourcing- Plan to run an all-day clinic every weekend (24 slots per clinic) throughout February, March with a completely insourced team
- Continue to provide additional in week slots as and when staffing and capacity allows ensuring no impact on the diagnostic pathway for both symptomatic and screening service.

Out of County Performance

The table below provides an overview of the most recent performance data available *for LLR patients* receiving care at UHL and 6 Out of County Acute Providers (Kettering, Nottingham University Hospital, North West Anglia NHS Foundation Trust, University Hospital Derby & Burton, George Eliot and University Hospitals Coventry & Warwickshire)

Indicator	Target	Date of data	UHL	Kettering	Nottingham University Hospitals	North West Anglia NHS Foundation Trust	University Hospitals of Derby and Burton	George Eliot	University Hospital Coventry and Warwickshire	Spire Leicester	Nuffield Leicester	Newmedica Community Ophthalmology, Leicester
A&E Four Hour Wait (excl UCCs)	>95%	Feb-22	57.5%	CRS Trial Site	CRS Trial Site	56.9%	62.2%	79.6%	71.5%			
Cancer 2 Week Wait from GP referral	>93%	Jan-22	65.80% 2134/3253	91.67% 33/36	78.95% 15/19	53.51% 61/114	54.93% 78/142	93.10% 27/29	65.63% 21/32			
Cancer 31 day first definitive treatment	>96%	Jan-22	77.36% 287/371	100% 4/4	100% 5/5	72.73% 8/11	90.91% 20/22	100% 6/6	100% 9/9			
Cancer 62 day GP referral to first definitive treatment	>85%	Jan-22	37.79% 82/217	50.00% 1/2		22.22% 2/9	50.00% 7/14	75.00% 3/4	85.71% 6/7			
Cancer- 28 Day FDS two week referral	>75%	Jan-22	62.21% 1946/3128	82.14% 23/28	85.71% 12/14	59.78% 55/92	56.82% 75/132	48.35% 13/27	56.82% 25/44			
RTT-18 Weeks Incompletes	>92%	Feb-22	48.3%	69.8%	59.8%	62.8%	58.2%	67.3%	52.5%	46.8%	37.5%	57.4%
RTT-Overall size of the waiting list		Feb-22	102335	949	1604	1505	4164	1255	2281	910	379	927
RTT -Patients waiting over 52 weeks for treatment	0	Feb-22	14,065	7	143	52	207	30	132	29	146	1
RTT -Patients waiting over 104 weeks for treatment	0	Feb-22	1,609	0	7	4	15	1	5	4	31	0
Patients waiting six weeks or more for a diagnostic test	<=1%	Feb-22	44.09% 14,561/33,033	43.58% 146/335	41.49% 161/388	40.92% 178/435	30.11% 237/787	3.60% 5/139	6.30% 24/381	1.22% 1/82	0.00% 0/34	

Data source- Aristotle

**Note for RTT, Diagnostic tests & Cancer metrics, the data relates to LLR patients only.*

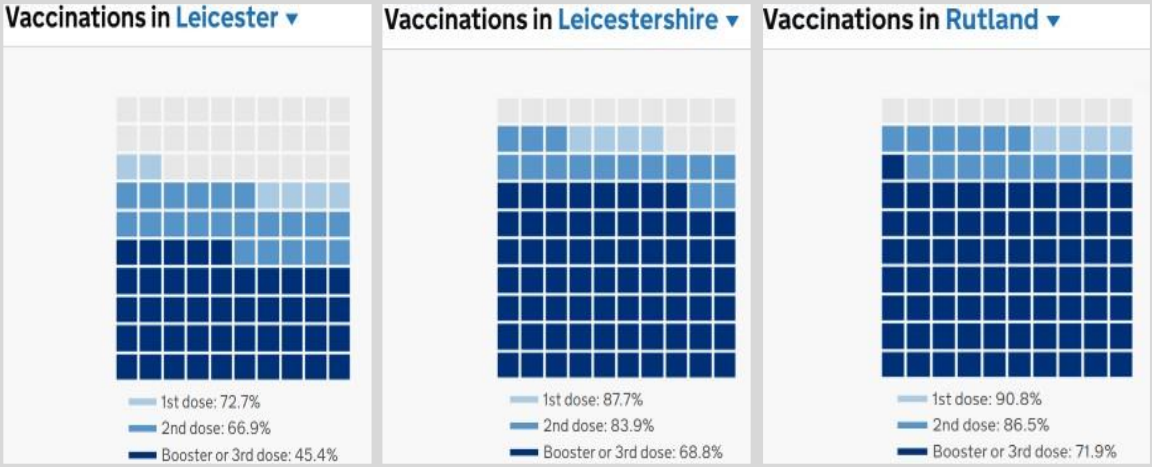
Note:

- A&E 4 hour wait remains at Provider level only
- For RTT, Diagnostic tests and Cancer metrics, data is shown for LLR patients only at these providers.
- Metrics have been RAG rated for LLR patients. In some circumstances a metric may be rated red for LLR patients but green as a whole provider position.

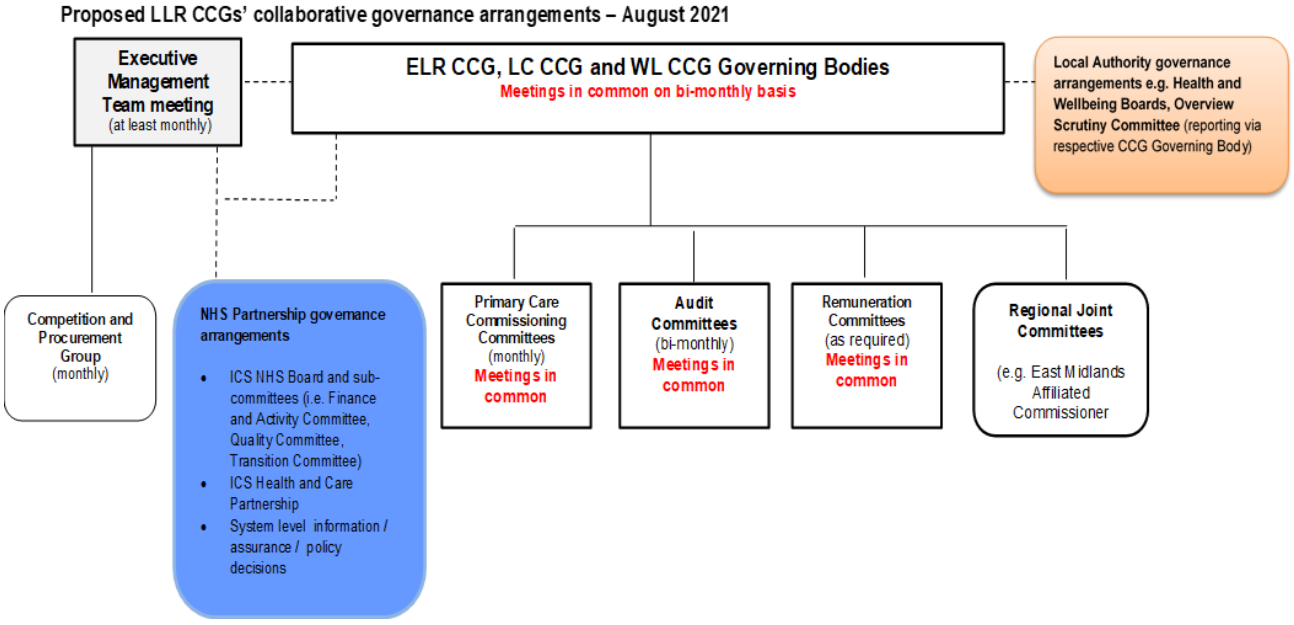
Covid Vaccinations – Published Data

COVID Vaccinations Position, 28-March-22:

Latest total percentage of people aged 12 and over who have received a COVID-19 vaccination, by dose.



Appendix 2– LLR CCGs' Governance Arrangements



Appendix 3 – LLR CCGs' Register of Interests as at 30 June 2022

EAST LEICESTERSHIRE AND RUTLAND CLINICAL COMMISSIONING GROUP, LEICESTER CITY CLINICAL COMMISSIONING GROUP, and WEST LEICSTERSHIRE CLINICAL COMMISSIONING GROUP						
Declarations of Interest - 2021 - 2022 (v7, 31 March 2022)						
N.B. including dates "to", "from" or both as per guidance relating to the interest where new or circumstances have changed through the year.						

Name	Job Title / Role	Financial Interests	Non-financial professional interests	Non-financial personal interest	Indirect Interests	Actions to be taken to mitigate the risks (see Conflicts of Interest Policy for details)
Across all three LLR CCGs:						
Mr Andy Williams (from 11 November 2019)	LLR CCGs' Accountable Officer (Chief Executive)	N/A	Trustee of brap - charity working in the rights and equality field. Director of Jupiter Phase 3 Management Company (not remuenrated). .	Warden of Birmingham Cathedral - non remunerated position. Foundation Governor of St Matthews Primary School, Smethick - non remunerated position.	Wife is Acting Director at Dudley and Walsall Mental Health Partnership NHS Trust.	If consultancy firm required Andy would not be part of the procurement process. Remaining interests are non-financial interests. However, if a direct potential or actual conflict of interest arises then appropriate action to be taken in line with the Policy.
Dr Caroline Trevithick (from 13 January 2020)	LLR CCGs' Executive Director of Nursing, Quality and Performance / Deputy AO	NICE Expert Advisor Panel.	Royal College of Nursing Nurse & Midwifery Council. Awarded the title and status of Honorary Doctorate of Science from Loughborough University.	N/A	N/A	Appropriate actions to be taken as necessary and dependent on the nature of the conflict.
Ms Nicci Briggs (from 14 September 2020)	LLR CCGs' Executive Director of Finance, Contracting and Corporate Governance	N/A	Chair of HFMA Digital council Member of HFMA Policy & Research Cttee	Finance Committee Independent Member for Brooke Weston Trust - non remunerated position. Volunteer Blind Veterans.	N/A	N/A
MrsAlice McGee (from 1 June 2020)	LLR CCGs' Executive Director of People and Innovation	N/A	N/A	N/A	N/A	N/A
Mrs Rachna Vyas (from 1 June 2020)	LLR CCGs' Executive Director of Integration and Transformation	N/A	Awarded the title and status of Honorary Lecturer at the University of Leicester from 19 July 2021 to 18 July 2024.	Trustee on the Board of a national charity called Growing Points, helping refugees and those from disadvantaged backgrounds into professional careers.	Registered as a patient at Evington Medical Centre a Practice in Leicester City CCG. No financial interest in Practice.	Note that interest in GP Practice is not a direct financial interest for the individual, and as a member of the LLR CCGs' Executive Management Team and a member of the LLR CCGs' Governing Bodies it may not be possible for the individual not to participate in the decision-making process in committee meetings relating to this Practice. However, if a direct potential or actual conflict of interest arises then appropriate action to be taken in line with the Policy.
Ms Sarah Prema (from 13 January 2020)	LLR CCGs' Executive Director of Strategy and Planning	Local Public Sector Director at Leicester LIFT Co.	N/A	N/A	Registered as a patient at Birstall Medical Practice which is a Member Practice of WL CCG.	Appropriate actions to be taken as necessary and dependent on the nature of the conflict.
Mr David Sissling (from 11 January 2021)	Independent Chair of Leicester, Leicestershire and Rutland Integrated Care System	N/A	Work for NHS England / Improvement (Midlands Region) as a senior Leadership Advisor 2 days per week in the main providing coaching and mentoring support to NHS leaders (current). Member of the National Senior Salaries Review Body (work circa 25 days a year). Advising Ministers of salaries of senior public sector leaders including NHS (current)..		Wife is a manger at University Hospitals of Leicester NHS Trust (current).	Appropriate actions to be taken as necessary during system-wide meetings and during conduct of business, dependent on the nature of the conflict.

Name	Job Title	Financial Interests	Non-financial professional interests	Non-financial personal interest	Indirect Interests	Actions to be taken to mitigate the risks (see Conflicts of Interest Policy for details)
East Leicestershire and Rutland CCG:						
Dr Vivek Varakantam	GP Governing Body Member, Member Practice Representative CCG Interim Chair (from 1 August 2020)	GP Partner and associate GP trainer at The Croft Medical Centre, Oadby, Leicester. Director Bushby Lodge Medical Personal Health Services (Out of Hours) Resigned Director - LLR Provider Company. The Practice is also the Jubilee Medical Practice Academy and Training Hub. Undertakes examination of medical students at the University of Leicester. The Croft Medical Centre is a shareholder in the Leicester, Leicestershire and Rutland Provider Company Ltd (LLR Provider Company Ltd). Practice is a member of the East Leicestershire and Rutland GP Federation. Partner at the Practice, Dr Shiraz Makda, is a Board member on the ELR Federation Board (27 August 2020 advised that Dr Makda is no longer a director of the ELR Federation Board). Croft Medical Centre has a contract with Derbyshire Health United for GPs from Croft Medical Centre to deliver urgent care services in the Oadby Walk in Centre (as of April 2019). Practice is a member of the Cross Counties Primary Care Network (from 1 July 2019). Director of RSSSV Holdings Ltd (from 29 April 2020).	FY2 Trainer in general practice (Health Education East Midlands) Fellow of the Royal College of General Practitioners and British Medical Association member. Academic Champion / Research Fellow for University of Leicester.	N/A	Wife is shareholder in Bushby Lodge Medical (medical services company). Wife commenced post in Interserve in care at home (therefore conflicted with e.g. CHC) - March 2015. As from March 2020 wife now works for "Empowering U" a provider of care packages. Indirect interest in respect of discussions and decisions made relating to GP Practice property. Dr Varakantam does not own the Croft Medical Centre premises, the premises are leased.	In relation to financial interests, to ensure individual does not participate in the decision-making process in committee meetings (e.g to absent themselves from meetings at the relevant point on the agenda); during procurement processes individual to seek advice if and up to which part of the process individuals can be involved in, or not involved with at all etc. For other declarations, appropriate actions to be taken as necessary in line with the Policy, dependent on the nature of the interest declared and whether a conflict arises.

Name	Job Title	Financial Interests	Non-financial professional interests	Non-financial personal interest	Indirect Interests	Actions to be taken to mitigate the risks (see Conflicts of Interest Policy for details)
Ms Fiona Barber (from 5 August 2019)	Deputy Chair / Independent Lay Member	Patient Public Voice Advisor NHS England (from 2016) on the following groups: - Primary Care Strategic Oversight Group, NHS England (from 2016). - Clinical Priority Advisory Group, NHS England (from 2016).	Lay Member for General Pharmaceutical Council (Accreditation & Recognition Panel) from 2017. Independent Member Leicester City Council Standards Committee.	Trustee for Royal Air Force Association (from 2018).	Registered as a patient at Greengate Medical Centre which is a Member Practice of WL CCG.	Note that interest is not a direct financial interest. However, if a direct potential or actual conflict of interest arises then appropriate action to be taken in line with the Policy.
Mr Warwick Kendrick	Independent Lay Member	N/A	Member of Chartered Institute of Management Accountants (CIMA).	N/A	N/A	N/A
Mr Clive Wood	Independent Lay Member	N/A	Vice President Section UK, International Police Association (until end May 2018). President Section UK, International Police Association (from 9 June 2018).	N/A	Son is employee of Total Community Care Ltd which provides specialist care services for individuals with spinal cord injury and other neurological conditions (until September 2021).	Note that interest is not a direct financial interest. However, if a direct potential or actual conflict of interest arises then appropriate action to be taken in line with the Policy.
Dr Andrew Ahyow (from 1 January 2020)	GP Governing Body Member, Member Practice Representative / Clinical Vice Chair	Senior Partner at Forest Medical Group (Forest House Medical Centre). GP Trainer, FY2 trainer, Health Education East Midlands. Practice is a member of the ELR GP Federation. Practice is a member of the Jubilee medical Practice Academy and Training Hub. Forest House Medical Centre is a shareholder in the Leicester, Leicestershire and Rutland Provider Company Lrd. (LLR Provider Company Ltd.). Practice is a member of the North Blaby Primary Care Network (from June / July 2019).	Member of the Royal College of General Practitioners.	N/A	Wife is a Public Health Consultant (CCDC) for LLR. Indirect interest in respect of discussions and decisions made relating to GP Practice property relating to the Forest House Medical Centre site as Dr Ahyow does not own these premises, the premises are leased.	In relation to financial interests, to ensure individual does not participate in the decision-making process in committee meetings (e.g to absent themselves from meetings at the relevant point on the agenda); during procurement processes individuals to seek advice if and up to which part of the process individuals can be involved in, or not involved with at all etc. For other declarations, appropriate actions to be taken as necessary in line with the Policy, dependent on the nature of the interest declared and whether a conflict arises.
Dr Nicholas Glover	GP Governing Body Member, Member Practice Representative	GP Partner at Northfield Medical Centre, Blaby. GP Trainer, East Midlands Deanery. Member of the Leicester, Leicestershire and Rutland Local Medical Committee. Practice is a member of the East Leicestershire and Rutland GP Federation. The Northfield Medical Centre is a minor shareholder in Leicester, Leicestershire and Rutland Provider Company Ltd. (LLR Provider Company Ltd). Practice is a member of the South Blaby and Lutterworth Primary Care Network (from 1 July 2019).	Member of the Royal College of General Practitioners and British Medical Association.	N/A	Indirect interest in respect of discussions and decisions made relating to GP Practice property, however does not own the Northfield Medical Centre premises. Dr Glover is one of three partners who lease the building from an independent company.	In relation to financial interests, to ensure individual does not participate in the decision-making process in committee meetings (e.g to absent themselves from meetings at the relevant point on the agenda); during procurement processes individuals to seek advice if and up to which part of the process individuals can be involved in, or not involved with at all etc. For other declarations, appropriate actions to be taken as necessary in line with the Policy, dependent on the nature of the interest declared and whether a conflict arises.

Name	Job Title	Financial Interests	Non-financial professional interests	Non-financial personal interest	Indirect Interests	Actions to be taken to mitigate the risks (see Conflicts of Interest Policy for details)
Dr Girish Purohit	GP Governing Body Member, Member Practice Representative	Director Holiday Club 4 Kids Services Ltd, and Nurseries 'R' Us Ltd - child care and nursery manned by wife. Dr Purohit and his wife are also directors of Smarties Private Day Nursery Ltd (from 28 February 2020), which is also manned by his wife. Dr Purohit and his wife are Directors of Purohit Property Ltd (from 1st May 2018). GP Partner at The Jubilee Medical Practice, Syston Health Centre, Syston, Leicestershire. The Jubilee Medical Practice represents the locality that forms part of the LLR Training Hub. Practice is a member of the East Leicestershire and Rutland GP Federation. Member of the Leicester, Leicestershire and Rutland Local Medical Committee. The Jubliee Medical Practice is a shareholder in The Leicester, Leicestershire and Rutland Provider Company Ltd (LLR Provider Company Ltd). Dementia Lead for East Midlands Clinical Mental Health Network (from 23 May 2018 - November 2020). Practice is a member of the Melton, Syston and Vale Primary Care Network (from June / July 2019).	Member of the Royal College of General Practitioners (from February 2021). Member of the Royal College of Physicians (from August 2020).	N/A	Indirect interest in respect of discussions and decisions made relating to GP Practice property, however does not own the Syston Health Centre as currently leasing the practice premises within the health centre. Registered as a patient at Central Surgery in Oadby which is a Member Practice of ELR CCG. Wife volunteers at the Melton, Syston and Vale COVID Vaccination Centre as a Vaccinator (her honorary employment is with the Jubilee Medical Practice) (from March 2021).	In relation to financial interests, to ensure individual does not participate in the decision-making process in committee meetings (e.g to absent themselves from meetings at the relevant point on the agenda); during procurement processes individuals to seek advice if and up to which part of the process individuals can be involved in, or not involved with at all etc. For other declarations, appropriate actions to be taken as necessary in line with the Policy, dependent on the nature of the interest declared and whether a conflict arises.
Dr Nikhil Mahatma (from 14 April 2020)	GP Governing Body Member, Member Practice Representative	GP Partner at Kingsway Surgery. Practice is a member of the ELR GP Federation. Practice is a minor Shareholder in the Leicester, Leicestershire and Rutland Provider Company Ltd. (LLR Provider Company Ltd). Practice is a member of North Blaby Primary Care Network (from 1 July 2019). Director of N Mahatma Medical Services Ltd, a company through which Dr Mahatma provided medical consultancy as a locum GP . Direct interest in respect of discussions and decisions made relating to GP Practice property relating to Kingsway Surgery, as part owner of premises.	Member of the British Medical Association	N/A	Wife is an optometrist at Vision Express in Hinckley. Father-in-law is a pharmacist in Evington, Leicester. Secretary of M H Trims Ltd which is a textiles company owned by Dr Mahatma's father. Registered as a patient at Forest House Medical Centre which is a Member Practice of ELR CCG.	In relation to financial interests, to ensure individual does not participate in the decision-making process in committee meetings (e.g to absent themselves from meetings at the relevant point on the agenda); during procurement processes individuals to seek advice if and up to which part of the process individuals can be involved in, or not involved with at all etc. For other declarations, appropriate actions to be taken as necessary in line with the Policy, dependent on the nature of the interest declared and whether a conflict arises.

Name	Job Title	Financial Interests	Non-financial professional interests	Non-financial personal interest	Indirect Interests	Actions to be taken to mitigate the risks (see Conflicts of Interest Policy for details)
Dr Graham Johnson (from 10 November 2020)	GP Governing Body Member, Member Practice Representative	GP Partner at Wycliffe Medical Practice. Member of the Leicester, Leicestershire and Rutland Local Medical Committee. Practice is a member of the East Leicestershire and Rutland GP Federation. Wycliffe Medical Practice is a minor shareholder in Leicester, Leicestershire and Rutland Provider Company Ltd. (LLR Provider Company Ltd). Practice is a member of the South Blabyand Lutterworth Primary Care Network (from 1 July 2019).	N/A	N/A	N/A	In relation to financial interests, to ensure individual does not participate in the decision-making process in committee meetings (e.g to absent themselves from meetings at the relevant point on the agenda); during procurement processes individuals to seek advice if and up to which part of the process individuals can be involved in, or not involved with at all etc. For other declarations, appropriate actions to be taken as necessary in line with the Policy, dependent on the nature of the interest declared and whether a conflict arises.
Dr Katherine Packham (until January 2021 for ELR CCG and from February 2021 for LC CCG see below)	Public Health Consultant	Public Health Consultant employed by Leicestershire County Council (from 13 August 2018). Was a locum GP for 6 months and then a salaried GP for 18 months at Countesthorpe Health Centre from 2008 to 2010. Was a GP registrar at Countesthopr in 2005 - 2006 and 2008. Was a P registrar at the Limes in Narborough in 2006 - 2008. Was a pre-registration house officer in General Practice at The County Practice, Syston (2004 - 2005).	Fellow of Faculty of Public Health. Member of British Medical Association	N/A	Husband is a Consultant Anaesthetist at University Hospitals of Leicester NHS Trust. He is also the Clinical Lead for Cardio-Pulmonary Exercise Testing and Prehabilitation, and the Clinical Lead for the Fit for Surgery prehabilitation programme since 2019. He is also the Clinical Clinical Lead for Orthopaedics prehabilitation programme.	In relation to financial interests, to ensure individual does not participate in the decision-making process in committee meetings (e.g to absent themselves from meetings at the relevant point on the agenda); during procurement processes individuals to seek advice if and up to which part of the process individuals can be involved in, or not involved with at all etc. For other declarations, appropriate actions to be taken as necessary in line with the Policy, dependent on the nature of the interest declared and whether a conflict arises.

Name	Job Title	Financial Interests	Non-financial professional interests	Non-financial personal interest	Indirect Interests	Actions to be taken to mitigate the risks (see Conflicts of Interest Policy for details)
Leicester City CCG:						
Prof Azhar Farooqi	CCG Chair	GP Partner at East Leicester Medical Practice and part owner. Director of A Farooqi Limited which provides clinical research and quality service. Part owner and share-holdings exceeding 25%. GP Practice (East Leicester Medical Practice) is a member of the LLR GP Provider Company with less than 1% ownership. Honorary Professor, Department of Health Sciences at University of Leicester and Clinical Director Centre of Ethnic Health Research University of Leicester. East Leicester Medical Practice in receipt of NHS England research funding via National Institute of Healthcare Research. East Leicester Medical Practice acts as the lead practice for Across Leicester Academy (a consortium of 7 city practices) providing undergraduate medical teaching to a number of medical schools. Practice was a member of the Aegis Primary Care Network (1 July 2019 - August 2021). From 1 September 2021 Practice is a member of Salutem Primary Care Network. National and international presentations and lectures as part of research or academic and postgraduate education roles including non-promotional educational activity sponsored by charities and pharmaceutical companies. East Midlands Clinical Research Network - Clinical Director appointef from 1 June 2021, Division 5, East Midlands Clinical Research Network hosted by University Hospitals of Leicester NHS Trust on behalf of the National Institute of Health Research (position is remunerated). Co-director of Regional Diabetes and Vascular Clinical Network, NHS England Midlands. Son, Dr Imran Farooqi, is a partner at the East Leicester Medical Practice.	Fellow of the Royal College of General Practitioners. Member of the British Medical Association. Member of the Leicester Medical Society.	N/A	Indirect interest in respect of discussions and decisions made relating to GP Practice property, however does not own the Practice premises as these are leased from NHS Property Services.	In relation to financial interests, to ensure individual does not participate in the decision-making process in committee meetings (e.g to absent themselves from meetings at the relevant point on the agenda); during procurement processes individual to seek advice if and up to which part of the process individuals can be involved in, or not involved with at all etc. For other declarations, appropriate actions to be taken as necessary in line with the Policy, dependent on the nature of the interest declared and whether a conflict arises.

Name	Job Title	Financial Interests	Non-financial professional interests	Non-financial personal interest	Indirect Interests	Actions to be taken to mitigate the risks (see Conflicts of Interest Policy for details)
Dr Avi Prasad	Assistant Clinical Chair	GP Principal partner of Clarendon Park Medical Centre. Clarendon Park Medical Centre is a Member of the Leicester City Health Federation. Leicester City Health Federation formerly known as Across Leicester Federation. Director of Leicester City Health Ltd (from 1/02/2020) - (Dr Prasad advised this is no longer a Federation and acts as a provider arm of Willows Health from February 2020). Director of Clarendon Medical Centre Property Limited. GP Practice (Clarendon Park Medical Centre) is a member of the LLR GP Provider Company with less than 1% ownership. Clarendon Park Medical Centre is a secondary provider of vasectomy services. Clarendon Park Medical Centre is a member of the Aegis Primary Care Network (PCN) (July 2019). GP Partner of Willowbrook Medical Centre. Willowbrook Medical Centre is a member of the Aegis Primary Care Network (July 2019). GP Partner of Pasley Road Health Centre. Pasley Road Health Centre is a member of the Aegis Primary Care Network (July 2019). GP Partner of Heatherbrook Surgery. Heatherbrook Surgery is a member of the Aegis Primary Care Network (July 2019). GP Partner of Williows Medical Centre. Willows Medical Centre is a member of the Aegis Primary Care Network (July 2019). GP Partner of Dishley Grange Medical Practice. Dishley Grange Medical Practice is a member of the (Maxwell Surgery) Beacon PCN, WL CCG (July 2019). GP Partner of Sayeed Medical Centre. Sayeed Medical Centre is a member of the Leicester Central Primary Care Network (July 2019). GP Partner of Al Razi Medical Centre. Al Razi Medical Centre is a member of the City Care Alliance Primary Care Network (March 2022).	Member of the British Medical Association.	N/A	Dr Rishabh Prasad (son) is an honorary professor at DeMontfort University, Tutor at Leicester University; co-founder and Director of the Digital Health and Primary care Research at DeMontfort University. Dr Amba Prasad (daughter) is a qualitified GP in the City. Dr Arushee Prasad (daughter) is a locum GP in Leicester. Dr Neel Somani (son in law) works as a dentist locally.	In relation to financial interests, to ensure individual does not participate in the decision-making process in committee meetings (e.g to absent themselves from meetings at the relevant point on the agenda); during procurement processes individual to seek advice if and up to which part of the process individuals can be involved in, or not involved with at all etc. For other declarations, appropriate actions to be taken as necessary in line with the Policy, dependent on the nature of the interest declared and whether a conflict arises.
		Dr Avi Prasad continued: Director of Willows Health. Willows Health is a consortium of the following Practices: - Clarendon Park Medical Centre (Aegis PCN, LC CCG)) - Willows Medical Centre (Aegis PCN, LC CCG) - Dishley Grange Medical Practice (Maxwell Surgery) (Beacon PCN, WL CCG) - Dishley Grange Medical Practice (Hathern Surgery) (Beacon PCN, WL CCG) - Sayeed Medical Centre (Leicester Central PCN, LC CCG) - Willowbrook Medical Centre (Aegis PCN, LC CCG) - Pasley Road Medical Centre (Aegis PCN, LC CCG) - Heatherbrook Surgery (Aegis PCN, LC CCG). Part own the following Practice premises: Clarendon Park Medical Centre and Hathern Branch of Dishley Grange Medical Practice. Director of Biocatalyst Innovation Ltd (from 12/11/2020). Director of CheetahSpots Ltd (from 9/01/2020). Director of Willows Property Ventures Ltd (from 7/01/2020). Director of Locumbrite Ltd (from 14/1/2020) Director of CPMC Property Ltd (from 23/9/2013). Diector of LLR Locums Ltd (from 29 July 2021). Dr Rishabh Prasad (son) is a partner at the following Practices: - Clarendon Park Medical Centre (Aegis PCN, LC CCG)) - Willows Medical Centre (Aegis PCN, LC CCG) - Dishley Grange Medical Practice (Maxwell Surgery) (Beacon PCN, WL CCG) - Dishley Grange Medical Practice (Hathern Surgery) (Beacon PCN, WL CCG) - Sayeed Medical Centre (Leicester Central PCN, LC CCG) - Willowbrook Medical Centre (Aegis PCN, LC CCG) - Pasley Road Medical Centre (Aegis PCN, LC CCG) - Heatherbrook Surgery (Aegis PCN, LC CCG). Dr Rishabh Prasad (son): - Director and Chair of the Leicester City Health Ltd - the Chair of LLR Provider Company Ltd (from November 2018 until April 2021). - Chair of Willows Health - he previously undertook ad hoc work for Leicester City CCG.				

Name	Job Title	Financial Interests	Non-financial professional interests	Non-financial personal interest	Indirect Interests	Actions to be taken to mitigate the risks (see Conflicts of Interest Policy for details)
Mr Nick Carter	Independent Lay Member	Media consultancy – national and international work on media, communications and cohesion with particular reference to the reporting of diversity and inequality (from 2012) Contract to provide communication advice to the Trustees – Community of St Mary the Virgin, Wantage, Oxfordshire (from 2012 to 31 December 2020). .	Chair of the Leicester Multicultural Advisory Group. Informal, independent body who meet to consider and advise on diversity and cohesion issues. Largely dormant (from 2012). Fellow of the Royal Society for the support of Arts, Manufacturers and Science (FRSA) (from 2012 until 11 June 2021). World Association of Newspapers - Member (from 2012). Emeritus Member of Society of Editors (from 2012). Associate Member of University Court, University of Leicester (from 2012). From April 2022 will be taking up position as Non-Executive Director on the Board of Inclusion Healthcare, pending formal confirmation of appointment. Inclusion Healthcare is a Community Interest Company and a provider of primary medical care services in Leicester City (role is voluntary and not remunerated).	N/A	Registered as a patient at DeMontfort Street Surgery (LC CCG).	In relation to financial interests, to ensure individual does not participate in the decision-making process in committee meetings (e.g to absent themselves from meetings at the relevant point on the agenda); during procurement processes individual to seek advice if and up to which part of the process individual can be involved in, or not involved with at all etc. For other declarations, appropriate actions to be taken as necessary in line with the Policy, dependent on the nature of the interest declared and whether a conflict arises.
Prof Jeffrey Knight	Independent Lay Member	N/A	Fellow of Institute of Mechanical Engineers.	Chair, Board of Trustees, Learning without Limits Academy Trust, Leicester (from 2 September 2021).	Helen Knight (daughter) is Deputy Chief Pharmacist at University Hospitals of Leicester NHS Trust. Dr Nicola Masal (son in law) is Cardiothoracic Surgeon, Cardiac Surgery, Glenfield General Hospital site of University Hospitals of Leicester NHS Trust. Mary Riley (sister) is employed by Honeysuckle Farm Care Home, Newton Unthank (from 2014 - ended January 2020). Marjorie Burbidge (sister) is employed by Honeysuckle Farm Care Home, Newton Unthank (from 2014 - ended July 2020).	Appropriate actions to be taken as necessary and dependent on the nature of the conflict.

Name	Job Title	Financial Interests	Non-financial professional interests	Non-financial personal interest	Indirect Interests	Actions to be taken to mitigate the risks (see Conflicts of Interest Policy for details)
Mr Zuffar Haq (until 31 March 2022)	Independent Lay Member	Trustee of Charity, International Hospital Relief. Owner of Zen Enterprizes. Vice chair of Leicester Children's Hospital Charity Campaign. Director of The Consortium Leicester Ltd.	N/A	Member of the Liberal Democrat Party, East Midlands.	Brother employed as procurement manager at George Eliot Hospital (until May 2021). Brother employed as Head of Procurement at University Hospitals of Coventry (from May 2021). Wife is Deputy Leader of Oadby and Wigston Council.	In relation to financial interests, to ensure individual does not participate in the decision-making process in committee meetings (e.g to absent themselves from meetings at the relevant point on the agenda); during procurement processes individual to seek advice if and up to which part of the process individual can be involved in, or not involved with at all etc. For other declarations, appropriate actions to be taken as necessary in line with the Policy, dependent on the nature of the interest declared and whether a conflict arises.
Dr Tony Bentley	North and East Health Need Neighbourhood Chair	Senior Partner of AJJ Bentley and Partners (GP Practice), Downing Drive (until 30 June 2019).	Honorary Associate Consultant in General Practice at KE Ball and Partners (GP Practice), Downing Drive (not remunerated). Member of the Leicester Medical Society	N/A	N/A	Direct financial interest in this GP Practice has ended thus reducing the level of conflict in primary care related decisions and procurement. However, honorary arrangement in place with the GP Practice on Downing Drive, therefore to ensure individual does not participate in the decision-making process in committee meetings (e.g to absent themselves from meetings at the relevant point on the agenda) for decisions relating specifically to this Practice. During procurement processes individual to seek advice if and up to which part of the process individual can be involved in, or not involved with at all etc.
Dr Gopi Boora (until 31 March 2022)	North and West Health Need Neighbourhood Chair	Senior Partner of Dr Hazeldine and Dr Taylor's Practice. Partner at Westcotes Medical Practice and Brandon Street Surgery. Now WB Medical Group: Cossington Park Surgery, Westend Medical Practice, and branch at Colwell Road Medical Centre. Senior Partner at WB Medical Group 2021). Practices are shareholders in the Leicester, Leicestershire and Rutland Provider Company Ltd. (LLR Provider Company Ltd.). Director of Moonchild Photography. Practice is a member of the Millenium Fderation. Director of Millennium Health Limited from Januray 2022. Director at Rearsbyhome 5 Limited.	N/A	N/A	N/A	In relation to financial interests, to ensure individual does not participate in the decision-making process in committee meetings (e.g to absent themselves from meetings at the relevant point on the agenda); during procurement processes individual to seek advice if and up to which part of the process individual can be involved in, or not involved with at all etc.
Dr Raj Than	Left shift / Integration Lead	GP Principal partner of Humberstone Medical Centre. Partner of PVR Partnership, providing out of hours GP work, appraising and teaching. GP Appraiser for NHS England GP appraisal and revalidation team. Diabetes lead mentor with Leicester City CCG including support to patient diabetes education programme. Practice is a member of the Salutem Primary Care Network (from 1 July 2019).	Member of the Dental Defence Union of Scotland (MDDUS) mutual organisation offering medical and dental legal assistance and professional indemnity. Member of the British Medical Association. Fellow of Royal College of General Practitioners (FRCGPs).	N/A	N/A	In relation to financial interests, to ensure individual does not participate in the decision-making process in committee meetings (e.g to absent themselves from meetings at the relevant point on the agenda); during procurement processes individual to seek advice if and up to which part of the process individual can be involved in, or not involved with at all etc. XX

Name	Job Title	Financial Interests	Non-financial professional interests	Non-financial personal interest	Indirect Interests	Actions to be taken to mitigate the risks (see Conflicts of Interest Policy for details)
Dr Sulaxni Nainani	South Health Need Neighbourhood Chair	GP Partner at DeMontfort Surgery. Director of Bhatia Assosciates Limited and husband (Mr Maneesh Bhatia) is also a Director.. Decision Panel Member for NHS England's Performance Advisory Group and Performers' List. Clinical Reviewer for NHS England's Complaints Committee. DeMontfort Surgery is a member of Leicester City Health Federation (formerly known as Across Leicester Federation). Practice is a member of the Leicester City & Uni Primary Care Network (from 1 July 2019). Independent consultant for Arbonne International providing health and wellness products (until December 2021). Husband, Mr Maneesh Bhatia, is Clinical Director of the LLR Alliance (since Summer 2020).	Member of the General Medical Council. Member of the Dental Defence Union of Scotland (MDDUS)	N/A	Mr Maneesh Bhatia (husband) is Consultant Orthopaedic Surgeon at University Hospitals of Leicester NHS Trust. Director of MSB Investment Ideas Ltd (company manages investment in real estate and property) .	In relation to financial interests, to ensure individual does not participate in the decision-making process in committee meetings (e.g to absent themselves from meetings at the relevant point on the agenda); during procurement processes individual to seek advice if and up to which part of the process individual can be involved in, or not involved with at all etc. For other declarations, appropriate actions to be taken as necessary in line with the Policy, dependent on the nature of the interest declared and whether a conflict arises.
Dr Matthew Trotter	Secondary Care Clinician	Consultant Surgeon at University Hospital Coventry and Warwickshire. Consultant Surgeon - practising privileges at Spire (Little Aston) (until September 2021). Consultant Surgeon - practising privileges at Spire (Parkway). Consultant Surgeon - practising privileges at Nuffield Hospital Warwickshire (from September 2020). Director of Specialist ENT Care Limited. Director of Specialist Health Partnership (until September 2021).	Member of ENT UK. Member of the General Medical Council. Member of Royal College of Surgeons. Member of Royal Society of Medicine. Member of British Society of Otology. Member of British Rhinological Society. Member of Royal Society of Medicine Section of Otology.	N/A	N/A	In relation to financial interests, to ensure individual does not participate in the decision-making process in committee meetings (e.g to absent themselves from meetings at the relevant point on the agenda); during procurement processes individual to seek advice if and up to which part of the process individual can be involved in, or not involved with at all etc.
Dr Katherine Packham (from February 2021)	Public Health Consultant	Public Health Consultant employed by Leicester City Council (from 22 February 2021). Was employed as a Consultant in Public Health by Leicestershire County Council from 13 April 2018 to 7 February 2021. Was a locum GP for 6 months and then a salaried GP for 18 months at Countesthorpe Health Centre from 2008 to 2010. Was a GP registrar at Countesthopr in 2005 - 2006 and 2008. Was a GP registrar at the Limes in Narborough in 2006 - 2008. Was a pre-registration house officer in General Practice at The County Practice, Syston (2004 - 2005).	Fellow of Faculty of Public Health. Member of British Medical Association	N/A	Husband is a Consultant Anaesthetist at University Hospitals of Leicester NHS Trust. He is also the Clinical Lead for Cardio-Pulmonary Exercise Testing and Prehabilitation, and the Clinical Lead for the Fit for Surgery prehabilitation programme since 2019. He is also the Clinical Clinical Lead for Orthopaedics prehabilitation programme.	In relation to financial interests, to ensure individual does not participate in the decision-making process in committee meetings (e.g to absent themselves from meetings at the relevant point on the agenda); during procurement processes individuals to seek advice if and up to which part of the process individuals can be involved in, or not involved with at all etc. For other declarations, appropriate actions to be taken as necessary in line with the Policy, dependent on the nature of the interest declared and whether a conflict arises.

Name	Job Title	Financial Interests	Non-financial professional interests	Non-financial personal interest	Indirect Interests	Actions to be taken to mitigate the risks (see Conflicts of Interest Policy for details)
West Leicestershire CCG:						
Prof Mayur Lakhani	CCG Chair	Chair – FMLM Faculty of Medical Leadership & Management Company Director – The office of Dr Mayur Lakhani CBE Limited Undergraduate teaching - University of Leicester & Nottingham. GP Principal Highgate Medical Centre GMS contract Independent contractor at Highgate Medical Centre (GP), GMS practice Highgate Medical Centre is part of Charnwood Federation and Soar Valley PCN (July 2019). Highgate Medical Centre is a member of LLR Provider Company Visiting Professor, Division of Health Sciences, University of Leicester (Honorary) Spouse is a Practice Manager and non-clinical partner at Highgate Medical Centre and director of Charnwood GP Network Ltd.	Professional Membership Details Royal College of General Practitioners Professional Membership Details British Medical Association Professional Membership General Medical Council Professional Membership Details Medical Defence Union Professional Membership Details Royal College of Physicians Edinburgh Professional Membership Details Royal College of Physicians London Professional Membership Details Fellow of Royal College of GPs Professional Membership Details Member of the Faculty of Medical Management & Leadership. Professional Membership Details Medical Examiner trained and Medical Examiner member of Royal College of Pathologists	N/A	N/A	In relation to financial interests, to ensure individual does not participate in the decision-making process in committee meetings (e.g to absent themselves from meetings at the relevant point on the agenda); during procurement processes individual to seek advice if and up to which part of the process individual can be involved in, or not involved with at all etc.

Name	Job Title	Financial Interests	Non-financial professional interests	Non-financial personal interest	Indirect Interests	Actions to be taken to mitigate the risks (see Conflicts of Interest Policy for details)
Dr Nilesh Sanganee	Locality Lead, North West Leicestershire (until 30 September 2020) Clinical Vice Chair (from 1 October 2020)	GP Partner - Principal at Castle Medical Group. GP appraiser for NHS England. Trustee of Friends for Castle Medical Group - Registered Charity. Director of Sanganee Medical Ltd. Company which includes my non-practice work e.g. GP appraiser work, Selection Centre Assessment for GP trainees and RCGP work. Practice is a member of the LLR Provider Company Director of Ashby Medical Ltd - Ashby Medical Ltd holds the APMS contract for The Surgery in Ashby (APMS contract with The Surgery in Ashby ended October 2019, and from May 2021 Dr Sanganee is no longer director of the Ltd company). Castle Medical Group is a member of the North West Leicestershire GP Ltd. Examiner for the MRCGP with the RCGP.	Professional Membership Details - British Medical Association (BMA). Professional Membership Details - Royal College of General Practitioners. Professional Membership - General Medical Council. Professional Membership Details - Medical Defence Union	N/A	Indirect interest in respect of discussions and decisions made relating to GP Practice property relating to Practice premises, which is under a lease from a third party..	In relation to financial interests, to ensure individual does not participate in the decision-making process in committee meetings (e.g to absent themselves from meetings at the relevant point on the agenda); during procurement processes individual to seek advice if and up to which part of the process individual can be involved in, or not involved with at all etc. For other declarations, appropriate actions to be taken as necessary in line with the Policy, dependent on the nature of the interest declared and whether a conflict arises.
Mr Steve Churton	Independent Lay Member	N/A	Fellow of Royal Pharmaceutical Society and a member of its Fellows Panel 9until September 2021).	Trustee of Psoriasis Association and Chair of its Medical and Research Committee (until September 2021). Member of the Conservative party (until September 2021).	Son is a Registrar Anaesthetist at various hospitals in Derbyshire and Nottingham.	Appropriate actions to be taken as necessary and dependent on the nature of the conflict.
Ms Gillian Adams	Independent Lay Member	Vice Chair and Director of Registration Council for Clinical Physiologists (from 2017, role is remunerated). NHS England Blood & Marrow Transplantation Clinical Reference Group (term ended October 2019, role was remunerated until 31 March 2022). Member of Medicines Repurposing Steering Group, Jointly sponsired by DHSC, MHRA, NINCE, NIHR and NHSE (appointed September 2021 until 31 March 2022). Member of the NHS England Regional Medicines Optimisation Committee (appointed 2017, remunerated). Member of NHS England Medicines Optimisation Priorities Panel (resigned September 2021, remunerated). Director of Gillian Adams Consultancy Ltd. Appointed member of the NHS England / Improvement Blood and Infection National Programme of Care Board (November 2020). This covers specialised services in infection, immunity and haematology and is a 3 year paid appointment. Patient Public Voice member on NHS England's Patient and Public Voice Assurance Group (appointed January 2021, remunerated). Undertook a short term, self-employed consultancy contract with Pfizer between May 2021 and June 2021 advising on their patient information leaflets.	Vice chair of the European Society for Blood &Marrow Transplantation, Patient Advocacy Committee (term ended October 2019, role was not remunerated). Member of the Eurpean Society for Blood &Marrow Transplantation, Clinical Outcomes Working Group. Member of the UK Stem Cell Strategy Oversight Committee. Member of Anthony Nolan National Expert Steering Group - Post Transplant Care. Loughborough University Medical Practice Patient Participation Group member. Member of the Chartered Institute of Personnel and Development (professional body).	Member of the Labour Party.	Prof Steve Rothberg (husband) is employed by Loughborough University as Pro-Vice Chancellor (Research). And is member of the senior leadership team at Loughborough University.	In relation to financial interests, to ensure individual does not participate in the decision-making process in committee meetings (e.g to absent themselves from meetings at the relevant point on the agenda); during procurement processes individual to seek advice if and up to which part of the process individual can be involved in, or not involved with at all etc. For other declarations, appropriate actions to be taken as necessary in line with the Policy, dependent on the nature of the interest declared and whether a conflict arises.
Ms Wendy Kerr	Independent Lay Member	N/A	N/A	Secretary for Austery Village Hall which is a charity organisation, Warwickshire. Unpaid work (from October 2021).	N/A	N/A

Name	Job Title	Financial Interests	Non-financial professional interests	Non-financial personal interest	Indirect Interests	Actions to be taken to mitigate the risks (see Conflicts of Interest Policy for details)
Dr Umar Abdulmajid (until 31 March 2022)	Locality Lead, South Charnwood	GP Partner at Charnwood Surgery. Charnwood Surgery is a member of the Charnwood GP Network Ltd.	N/A	N/A	N/A	In relation to financial interests, to ensure individual does not participate in the decision-making process in committee meetings (e.g to absent themselves from meetings at the relevant point on the agenda); during procurement processes individual to seek advice if and up to which part of the process individual can be involved in, or not involved with at all etc. For other declarations, appropriate actions to be taken as necessary in line with the Policy, dependent on the nature of the interest declared and whether a conflict arises.
Dr Geoff Hanlon (until 31 January 2022)	Locality Lead, North Charnwood	General Practitioner at Charnwood Medical Group, operating as a partnership and as a wholly owned company Charnwood Medical Group is part of Charnwood GP Network Ltd National Clinical Assessment Service Assessor Charnwood Medical Group is a member of LLR Provider Company Clinical Director Elect for Beacon PCN. Direct interest in respect of discussions and decisions made relating to premises of Charnwood Medical Group as Dr Hanlon is a property owning partner. Paul Hanlon son is director of Charnwood GP Network Ltd.	Professional Membership Details Royal College of General Practitioners Professional Membership Details British Medical Association Professional Membership General Medical Council Professional Membership Details Medical Defence Union	N/A	N/A	In relation to financial interests, to ensure individual does not participate in the decision-making process in committee meetings (e.g to absent themselves from meetings at the relevant point on the agenda); during procurement processes individual to seek advice if and up to which part of the process individual can be involved in, or not involved with at all etc. For other declarations, appropriate actions to be taken as necessary in line with the Policy, dependent on the nature of the interest declared and whether a conflict arises.
Dr Ash Kothari (until 31 March 2022)	Locality Lead, Hinckley & Bosworth	GP Partner at Maples Family Medical Practice.	N/A	N/A	N/A	In relation to financial interests, to ensure individual does not participate in the decision-making process in committee meetings (e.g to absent themselves from meetings at the relevant point on the agenda); during procurement processes individual to seek advice if and up to which part of the process individual can be involved in, or not involved with at all etc.

Dr Reema Parwaiz	Locality Lead, Hinckley and Bosworth	GP Principle at Ratby Surgery and part owner of the Ratby Surgery premises. Dr James Ogle (husband) is GP Principal at Ratby Surgery. Dr Asim Parwaiz (brother) is a GP Partner at Ratby Surgery. Dr Paul Parwaiz (father) is a GP Partner at Ratby Surgery. Mother is Practice Manager at Ratby Surgery. Husband is a Member of the Hinckley & Bosworth Medical Alliance Ltd (i.e. GP Federation). Ratby Surgery is part of local GP Federation 'Hinckley and Bosworth Medical Alliance Ltd' and Bosworth PCN.	Member of the Royal College of General Practitioners. Member of the General Medical Council. Member of the British Medical Association.	N/A	Brother is a GP trainee at Leicester Deanery. Two sister in laws work locally as dentists.	In relation to financial interests, to ensure individual does not participate in the decision-making process in committee meetings (e.g to absent themselves from meetings at the relevant point on the agenda); during procurement processes individual to seek advice if and up to which part of the process individual can be involved in, or not involved with at all etc. For other declarations, appropriate actions to be taken as necessary in line with the Policy, dependent on the nature of the interest declared and whether a conflict arises.
Name	**Job Title**	**Financial Interests**	**Non-financial professional interests**	**Non-financial personal interest**	**Indirect Interests**	**Actions to be taken to mitigate the risks (see Conflicts of Interest Policy for details)**
Dr Rowan Sil	Locality Lead, North West Leicestershire	GP Partner at Ibstock & Barlestone Surgeries. Practice is a member of the North West Leicestershire Primary Care Network (from 1 July 2019). Practice is a member of the LLR Provider Company Ltd.	N/A	N/A	N/A	For other declarations, appropriate actions to be taken as necessary in line with the Policy, dependent on the nature of the interest declared and whether a conflict arises.

Dr Fahad Rizvi	Locality Lead, North Charnwood	GP Partner, Dishley Grange and Cross Street Medical Practices (Practices are members of the Beacon Primary Care Network, WL CCG). GP Partner, Heatherbrook Surgery (LC CCG). GP Partner, Clarendon Park Medical Centre (LC CCG). GP Partner, Paisley Road Health Centre (LC CCG). GP Partner at the Willowbrook Medical Centre, Springfield Medical Centre and Willows Medical Centre (LC CCG). GP Partner, Willows Medical Centre (LC CCG). Clarendon Park Medical Centre, Paisley Road Health Centre, Willowbrook Medical Centre, Springfield Medical Centre and Willows Medical Center are members of the Aegis Primary Care Network (LC CCG) (July 2019). GP Partner, Sayeed Medical Centre (Leicester Central PCN, LC CCG). Director of Willows Health and Leicesters City Health Ltd. Willows Health is a consortium of the following Practices: - Clarendon Park Medical Centre (Aegis PCN, LC CCG)) - Willows Medical Centre (Aegis PCN, LC CCG) - Dishley Grange Medical Practice (Maxwell Surgery) (Beacon PCN, WL CCG) - Dishley Grange Medical Practice (Hathern Surgery) (Beacon PCN, WL CCG) - Sayeed Medical Centre (Leicester Central PCN, LC CCG) - Willowbrook Medical Centre (Aegis PCN, LC CCG) - Pasley Road Medical Centre (Aegis PCN, LC CCG) - Heatherbrook Surgery (Aegis PCN, LC CCG). Director, F&M Healthcare (UK) Ltd. Director, ACHE (a group of 5 GPs providing cataract, hand, ENT and dermatology services). Director of Locumbrite Ltd (from 14/01/2020). Director of Willows Property Ventures Ltd (from 7/01/2020). Director of Leicester City Heath Ltd (previously GP Federation in LC CCG). Director of Biocatalyst Innovation Lrd (from 12/11/2020). Director of Heatherbrook Services Ltd (from 15/11/2016). Director of LLR Locums Ltd (from 29 July 2021).	N/A	N/A	Dr Mehar Ahson, wife , Consultant Anaesthetist at UHL since March 2020.	In relation to financial interests, to ensure individual does not participate in the decision-making process in committee meetings (e.g to absent themselves from meetings at the relevant point on the agenda); during procurement processes individual to seek advice if and up to which part of the process individual can be involved in, or not involved with at all etc.

Appendix 4 - List of GP Member Practices

Blaby and Lutterworth area		
Countesthorpe Health Centre Central Street, Countesthorpe, Leicestershire. LE8 5QJ.	Wycliffe Medical Practice Gilmorton Road, Lutterworth, Leicestershire, LE17 4EB.	Kingsway Surgery 23 Kingsway Narborough Road South, Leicester, LE3 2JN.
The Limes Medical Centre 65 Leicester Road, Narborough, Leics LE19 2DU	Glenfield Surgery 111 Station Road, Glenfield, Leicestershire, LE3 8GS.	Forest House Medical Centre 2a Park Drive, Leicester Forest East, Leicester, LE3 3FN.
Northfield Medical Centre Villers Court, Blaby, Leicestershire, LE8 4NS.	Hazelmere Medical Centre 58 Lutterworth Road, Blaby, Leicester, LE8 4DN.	
The Masharani Practice Gilmorton Road, Lutterworth, Leicestershire, LE17 4EB.	Enderby Medical Centre Shortridge Lane, Enderby Leicestershire, LE19 4LY.	
Melton, Rutland and Harborough area		
South Leicester Medical Group: Kibworth Medical Centre Smeeton Road, Kibworth, Leicestershire, LE8 0LG. The Old School Surgery 2a Station Road Kibworth, Leicestershire, LE8 0LN.	Market Harborough Medical Centre 67 Coventry Road, Market Harborough, Leicestershire, LE16 9BX. Long Clawson Medical Practice The Sands, Long Clawson, Melton Mowbray, Leicestershire, LE14 4PA.	Oakham Medical Practice Cold Overton Road Oakham, Rutland, LE15 6NT.
Market Overton Surgery (& Somerby) Thistleton Road, Market Overton, Oakham, Leicestershire, LE15 7PP.	Stackyard Surgery 1 The Stackyard Croxton Kerrial Grantham, NG32 1QS.	Billesdon Surgery 4 Market Place, Billesdon Leicestershire, LE7 9AJ.
Latham House Medical Practice Sage Cross Street Melton Mowbray, Leicestershire, LE13 1NX.	The Jubilee Medical Practice 1330 Melton Road Syston, Leicestershire, LE7 2EQ.	The County Practice Syston Health Centre Melton Road, Syston Leicestershire, LE7 2EQ.
Empingham Medical Centre Main Street, Empingham Oakham, Rutland Leicestershire, LE15 8PR	The Uppingham Surgery Northgate Uppingham, Rutland, Leicestershire, LE15 9EG.	Husbands Bosworth Surgery 1 Marsh Drive Husbands Bosworth Leicestershire, LE17 6JZ.

Oadby and Wigston area		
Bushloe Surgery Two Steeples Medical Centre Abington Close Wigston Leicestershire LE18 2EW	Central Surgery Brooksby Drive, Oadby Leicester, LE2 5AA.	Rosemead Drive Surgery 103 Rosemead Drive Oadby, Leicestershire, LE2 5PP.
The Croft Medical Centre 2 Glen Road, Oadby Leicestershire, LE2 4PE.	Wigston Central Surgery Two Steeples Medical Centre Abington Close Wigston Leicestershire LE18 2EW	South Wigston Health Centre 80 Blaby Road South Wigston Leicestershire, LE18 4SE.
Spectrum Health (previously Severn Surgery) 159 Uplands Road, Oadby, Leicestershire, LE2 4NW.		

Appendix 5 - Members of CCG Committees

Name	Governing Body	Executive Management Team	Audit Committee	Remuneration Committee	Primary Care Commissioning Committee	ICB Quality Performance Improvement and Assurance Committee (from October 2021)	ICB Finance Committee (from September 2021)	Clinical Reference Group (joint advisory group)
Mr Andy Williams	✓	✓						
Dr Caroline Trevithick	✓	✓			✓	✓		
Ms Nicci Briggs	✓	✓			✓		✓	
Ms Alice McGee	✓	✓						
Ms Sarah Prema	✓	✓						
Ms Rachna Vyas	✓	✓			✓			
Dr Vivek Varakantam	✓				✓	✓		
Dr Andy Ahyow	✓				✓			
Dr Girish Purohit	✓				✓			
Dr Nick Glover	✓				✓			
Dr Graham Johnson	✓				✓			
Dr Nikhil Mahatma	✓				✓			
Ms Fiona Barber	✓		✓	✓	✓			
Mr Clive Wood	✓		✓	✓	✓	✓		
Mr Warwick Kendrick	✓		✓	✓			✓	
Prof Mayur Lakhani (Chair, WL CCG)						✓		
Dr Nilesh Sanganee (GP member, WL CCG)								
Ms Wendy Kerr (Independent Lay Member, WL CCG)							✓	
Ms Gillian Adams (Independent Lay Member, WL CCG)								
Prof Azhar Farooqi (Chair, LC CCG)						✓		
Dr Avi Prasad (GP member, LC CCG)								
Dr Sulaxni Nainani (GP member, LC CCG)								
Mr Nick Carter (Independent Lay Member, LC CG)								

Appendix 6 - Attendance at Governing Body meetings held in public (April 2022 – June 2022)

	May 2022	June 2022
LLR CCGs' members		
Mr Andy Williams	✓	✓
Ms Nicci Briggs	✓	✓
Ms Alice McGee	✓	✓
Ms Sarah Prema	✓	✓
Dr Caroline Trevithick	✓	✓
Ms Rachna Vyas	✓	✓
ELR CCG members		
Dr Vivek Varakantam	✓	✓
Dr Andrew Ahyow	✓	✓
Dr Graham Johnson	✓	✓
Dr Nick Glover	✓	✓
Dr Nikhil Mahatma	✓	✓
Dr Girish Purohit	✓	✓
Mr Clive Wood	✓	✓
Ms Fiona Barber	✓	✓
Mr Warwick Kendrick	✓	✓

Appendix 7 - Key corporate risks: LLR CCGs' Board Assurance Framework (BAF) as at 30 June 2022

Risk Ref and Description:
LLR BAF 1: **Risk Description: The quality of care provided by acute providers** There is a risk in relation to the quality of care provided by acute providers, which does not match commissioner's expectations in respect of quality and safety. This may result in reduced health outcome and experience for the LLR population.
LLR BAF 2: **Risk Description: The quality of care provided by non-acute providers** There is a risk in relation to the quality of care provided by non-acute providers, which does not match commissioner's expectations in respect of quality and safety. This may result in reduced health outcome and experience for the LLR population.
LLR BAF 3: Quality of care and service provided by emergency patient transport services (archived).
LLR BAF 4: Quality of care provided by non-emergency patient transport services (TASL) (archived).
LLR BAF 5: **Risk Description: The quality of care provided by primary care providers** There is a risk in relation to the quality of care provided by primary care, which does not match commissioner's expectations in respect of quality and safety. This may result in reduced health outcome and experience for the LLR population.
LLR BAF 7: **Risk Description: Emergency Preparedness, Resilience and Response (EPRR) arrangements** There is a lack of systematic and continuous processes in place for Emergency Preparedness, Resilience and Response (EPRR) and as a result the LLR CCGs are less resilient to respond to an emergency and to provide safe patient care. This may result in financial loss and legal consequences if the LLR CCGs are unable to comply with national NHS EPRR Core Standards.
LLR BAF 8: **Risk Description: Implementation of GPFV and Primary Care Network (PCN) development** There is a risk around resource constraints and the conflicting priorities for LLR and GP Practices that could impact on the implementation of the GPFV / Investment and Evolution framework. This may affect the development and integration of PCNs which then fail to address the challenges faced by General Practice to support the safe and effective delivery of patient care.
LLR BAF 9: **Risk Description: Shortfall in nursing and medical staffing across Community Health Services** There is a risk of unwarranted variations in the quality of care provided by Community Health Services, Mental Health Services and Child and Adolescent Mental Health (CAHMs). This is due to a shortfall in nursing and medical staff along with risks around capacity, capability and skills in the workforce. This will impact on the quality and continuity of care for LLR patients.
LLR BAF 10: LLR CCGs will fail to meet the core standard relating to the 4-hour A&E target (archived).
LLR BAF 11: **Risk Description: Meeting the core standard relating to cancer targets** There is a risk that the CCG will fail to meet core standards in relation to the delivery of the cancer targets especially due to the Covid-19 pandemic where a wide range of activity ceased. This further exacerbated by insufficient capacity within UHL and inadequate systems and processes. This may

Risk Ref and Description:
result in potential risk to patients as a result of any delays in diagnosis, which could lead to patient harm, poor patient experience and reputational impact on the LLR CCG.
LLR BAF 12: **Risk Description: Covid-19 impact on Primary Care Resilience – workforce, estates, IT and PPE** The impact of the Covid-19 pandemic further exacerbates challenges around GP workforce and sustainability, primary care estate, information technology and provision of Personal Protective Equipment (PPE).This will result in patients having reduced access to their GP which impacts on clinical quality, patient safety and addressing health inequalities in primary care.
LLR BAF 13: **Risk Description: Financial viability over next 5 years** There is risk that due to a lack of robust information and tested schemes, the financial viability of the local health economy (over the next 5 years) cannot be assured. As a result, this could impact on the LLR CCGs' organisational reputation, incur possible financial penalties and result in closer regulatory scrutiny.
LLR BAF 14: Failure to break-even (archived).
LLR BAF 15: System leadership to deliver transformation (archived).
LLR BAF 16: Staff morale and productivity during organisational change (archived).
LLR BAF 17: **Risk Description: Cyber Security** There is a risk that due to a significant rise in new and unknown cyber-attacks (locally or nationally) this could make access to IT services unavailable for extended periods of time. This may result in risks to the confidentiality of corporate or patient confidential data, disruption to organisational business continuity and to operational services.
LLR BAF 18: **Ambulance Handover Delays:** Ambulance handover times not being met due to increased pressure across the system, resulting in risks to assessing patients in the community, risks to patients that are delayed on the back of ambulances and risks to patients that require an elective procedure due to cancellations as a result of capacity.

Appendix 8 - Contact Details

NHS East Leicestershire and Rutland CCG was disestablished on 30 June 2022.

NHS Leicester, Leicestershire and Rutland Integrated Care Board (as the successor body) can be contacted in a number of ways:

Telephone: 0116 2953405
Email:
Twitter: @NHSLLRICB
Facebook: https://www.facebook.com/NHSLLRICB/

Alternatively, you can write to us at:

NHS Leicester, Leicestershire and Rutland ICB
Room G30, Pen Lloyd Building
County Hall, Glenfield
Leicester
LE3 8TB

You can find out more about us and the work we are involved in by visiting:

https://leicesterleicestershireandrutland.icb.nhs.uk/

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Leicester City Clinical Commissioning Group
WestLeicestershire Clinical Commissioning Group
East Leicestershire and Rutland Clinical Commissioning Group

NHS