NHS

Leicester, Leicestershire and Rutland

Annual Report & Accounts

Leicester, Leicestershire and Rutland Integrated Care Board

1 July 2022 - 31 March 2023

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Contents

Foreword from the Chairman

I am pleased to present the first Annual Report and Accounts for NHS Leicester, Leicestershire and Rutland Integrated Care Board.

Firstly, I must express my gratitude to the Governing Bodies and to the executive leadership and staff of NHS East Leicestershire and Rutland Clinical Commissioning Group, NHS Leicester City Clinical Commissioning Group and NHS West Leicestershire Clinical Commissioning Group for their significant contributions to the local health and care system. As their successor body, the Leicester, Leicestershire and Rutland Integrated Care Board is building on very strong foundations.

We have made considerable progress in our work to improve care for local people over the last year. We have seen positive movements in the numbers of people waiting for planned care, in our ability to respond to emergency care demand, in the number of primary care appointments we offer and in the quality of many of our mental health and learning disability services. Many of our achievements have been delivered as a consequence of better partnership working- with a strong focus on the needs of our citizens and patients. We will build on this integrated approach as we continue to develop our services to become more responsive, personalised and equitable.

As a board, we have grown and developed over the past few months. We are focussing both on our strategic and operational priorities and receiving relevant information to allow us to gauge progress. We are listening to our patients and to local people with engagement events and a patient storey or a relevant case study at each of our meetings.

As an organisation we recognise we still have a lot more to do. Many people are still waiting too long for care and their experience when receiving our services can, on occasions, be unsatisfactory. Perhaps, above all, we need to focus our efforts on the prevention of ill health and on addressing the inequities which currently exist.

In 2023/24 we will be developing our first Leicester, Leicestershire and Rutland Five Year Plan which will set out how we will tackle the many challenges we face. The emphasis will be on integration, innovation and continuous improvement.

I hope this Annual Report conveys some of the great work that we, as an organisation, have led or supported over recent months.

I would also like to take this opportunity to thank and pay tribute to the ICB team- our board members, our executive leaders and our staff. They have all worked with outstanding commitment, compassion and professionalism.

David Sissling
Chair

PERFORMANCE REPORT

Who we are and what we do?

NHS Leicester, Leicestershire and Rutland Integrated Care Board (LLR ICB or the ICB hereafter) was legally established on 1 July 2022 under the provisions of the Health and Social Care Act 2022 and replaced NHS Leicester City Clinical Commissioning Group, NHS East Leicestershire and Rutland Clinical Commissioning Group and NHS West Leicestershire Clinical Commissioning Group.

ICBs were established to work in partnership across health and care to:

- Identify and commission health and care needs of its population;
- To develop service plans to meet those needs, reflecting national and local priorities;
- Support the implementation of those plans and service delivery;
- Evaluate the effectiveness of services and take action to correct or improve these where required; and
- Be accountable to NHS England and our local population for the public funds it spends and the outcomes and outputs of the services it commissions.

The LLR ICB Board is responsible for shaping and commissioning local healthcare for our registered population of 1.1 million patients. The Board of the LLR ICB comprises the Chairman, executive members, non-executive members, sectorial representation from acute, mental health, local authorities and primary care (for further information about the LLR ICB Board please see the Accountability Report or visit our website https://leicesterleicestershireandrutland.icb.nhs.uk/).

For 1 July 2022 – 31 March 2023, the LLR ICB was entrusted with an in-year allocation (our budget) of £1,548m with which to plan and buy the health services needed by people living in Leicester, 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 services, this includes continuing healthcare, continuing care for children, funded nursing care, and mental health after care
- primary medical care services
- mental health services
- learning disability services.

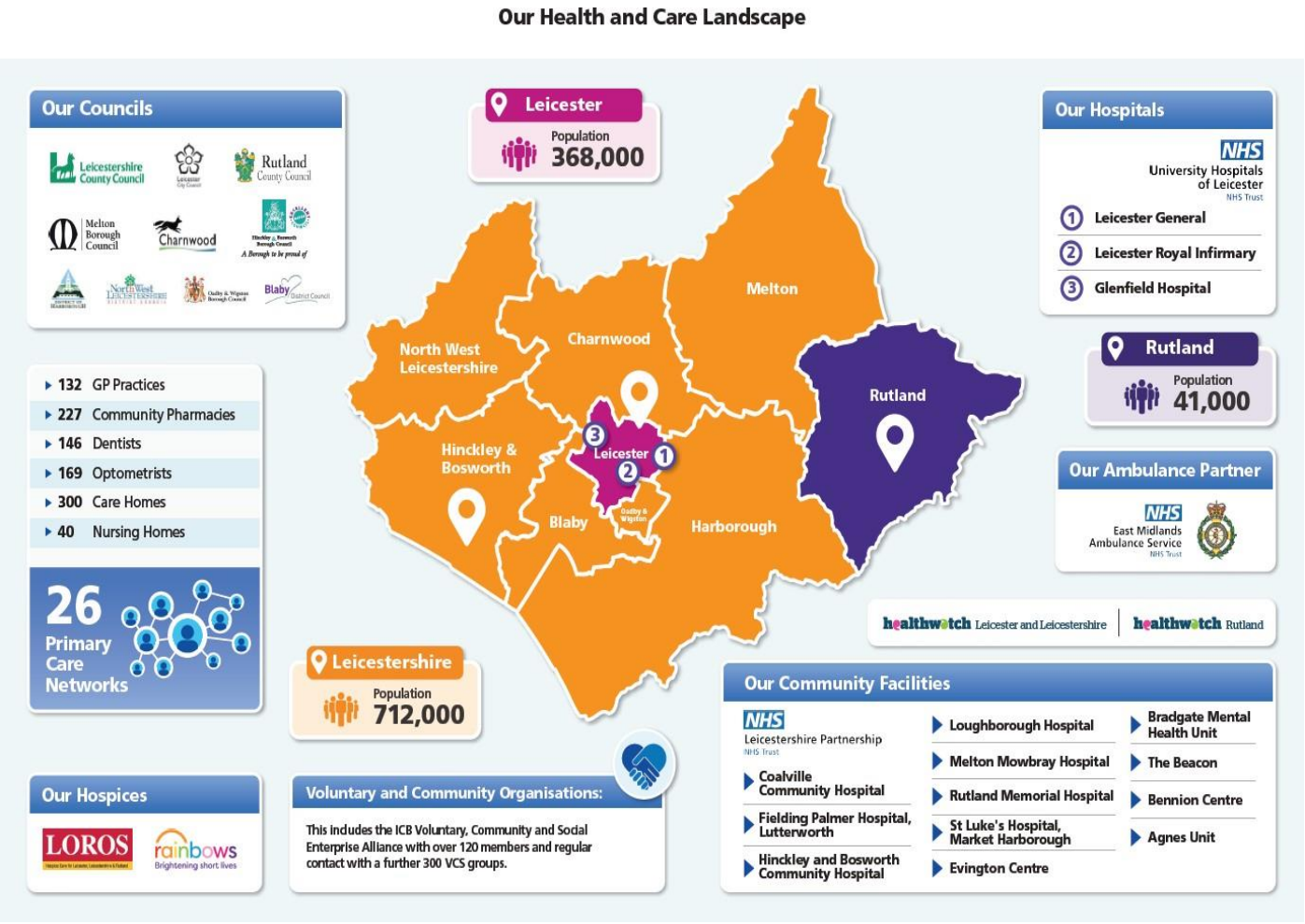
We take pride in the ability to shape our local healthcare and look for opportunities to help our population take greater responsibility for their own health, manage

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.

We do not deliver health care 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. This is achieved by working in collaboration with our partners and 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.

Although the picture of healthcare providers is becoming more complex, we offer patients a wide choice of organisations to provide their care. The population of LLR is served by various services provided by partner organisations across health and social care as outlined in Figure 1.

Figure 1: LLR health and care landscape



Figures accurate as of March 2023

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

We commissioned and funded care providers and, 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 and community sector organisations across Leicester, Leicestershire, and Rutland to support our patient population.

We continued to work with coordinating commissioning bodies outside of Leicester, Leicestershire, and Rutland on a small number of contracts, for instance, Derby and Derbyshire ICB that manages the East Midlands Ambulance Service Contract on behalf of the ICBs across the East Midlands. The health and care services commissioned across Leicester, Leicestershire and Rutland can be found on the ICB's website.

Vison, values and strategic aims

Our vision is to create a health and care system in Leicester, Leicestershire and Rutland that addresses health inequalities and improves the health and wellbeing of local people while delivering value for money. To achieve this, we approved our strategic aims in July 2022 as listed below:

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.

Our ICB values (see Figure 2) underpins and drives the implementation of our strategy and strategic aims of our organisational culture.

Figure 2: LLR ICB Values

Our priorities for 2022/23 focused on managing and improving population health and health outcomes for our population across Leicester, Leicestershire and Rutland through transforming care, restoration and recovery of elective care services, improvements in primary care and achieving financial balance.

Clear lines of accountability and governance arrangements were established to support delivery of our strategic aims and plans. The governance arrangements are outlined in the Accountability Report including an overview of risk management systems and processes. The governance arrangements were regularly reviewed to ensure they remain fit for purpose to support the delivery of our strategic objectives. The ICB governance structure is as at Appendix 1 and also captured within the ICB's Governance Handbook available on the ICB website https://leicesterleicestershireandrutland.icb.nhs.uk/ .

LLR integrated care system (LLR ICS)

Our strategic priorities are also aligned to the priorities agreed with our partners in health and social care across LLR integrated care system.

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 health and care across different organisations and settings; to improve outcomes in population health and healthcare; tackle inequalities in outcomes, experience and access; enhance productivity and value for money.

Further details about the LLR integrated care system and in particular the work of our integrated care partnership called the LLR Health and Wellbeing Partnership (HWP) can be found on our website: https://leicesterleicestershireandrutlandhwp.uk/ .

Our system operates at three levels: system, place and neighbourhood, a description is provided below in Figure 3.

Figure 3

The priorities we have agreed across the LLR ICS are set out in Figure 4. Further engagement with partners during 2023/24 will determine if these remain key areas of focus over the next five years:

Figure 4: LLR integrated care system strategic priorities

- **Best start in life:** we will support our population to have a healthy pregnancy, a safe environment, a nurturing and secure relationship with caregivers, good nutrition and healthcare, and support from birth to adulthood. We will focus on the first 1001 days of life to enable more equity in outcomes as we know this is critical to a child's life chances.

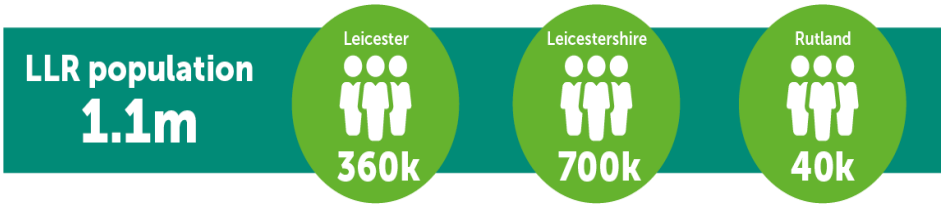
- **Staying healthy and well:** we will help you to live a healthy life, make healthy choices, within safe and strong communities, and maintain a healthy quality of life. We will support our residents to live a health life and make healthy choices to maintain wellbeing and independence within their communities.

- **Living and supported well:** we will support you through your health and care needs to live independently and to actively participate in your care. We will focus on supporting those with multiple conditions and who are frail to manage their health and care needs and live independently.

- **Dying well:** we will ensure you have a personalised, comfortable and supported end of life with personalised support for your carers and families. We will ensure people have a personalised, comfortable, and supported end of life with personalised support for carers and families.

Our population and their health needs

We serve 1.1 million people across the rural, market towns and urban areas of Leicester, Leicestershire and Rutland.



The population of LLR is diverse and health needs and life expectancy vary across each 'place'. 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 and Covid-19.

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. 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). Although it is important to note that health inequity 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.

Leicester City

Leicester is the tenth largest city in England and one of the most populous in the East Midlands. It is ethnically diverse, with over 65% of its 400k population belonging to an ethic minority group. Leicester is ranked as the 32nd most deprived local authority area in the country (out of 152). Just over 35% of the population live in an area classified as being in the most deprived 20% nationally.

This deprivation presents Leicester with significant health challenges, this includes:

- 1 in 10 children and around 38,000 adults with mental health problems,
- 50% of adults who are overweight or obese,
- over 45,000 people living with more than one long term condition,
- over 35% of 65s+ have 2 or more long term conditions, and 1 in 10 have 8 or more.
- Behaviours such as smoking, excessive drinking, drug use, poor diet and inactivity are greater in many parts of our city than they should be. Leading to a poorer quality of life and a shorter life expectancy (a seven-year difference in life expectancy between men living in the most and least deprived areas of the city).

Leicestershire

Leicestershire is a predominantly rural County and comprises of seven local authority districts, each with its own distinctive character. The total population is approximately 700,000, 10% of which are from an ethic minority. Leicestershire is ranked as the 137th most deprived local authority area in the country (out of 152).

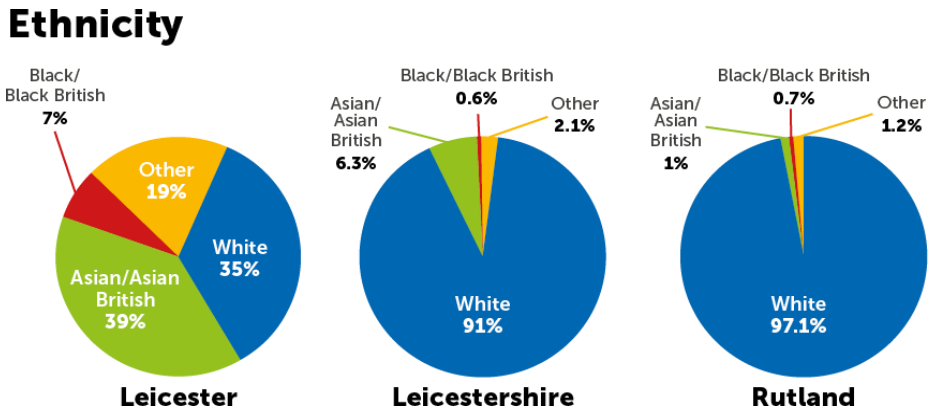
Leicestershire has an aging population with over 26% aged 60 and over. This is expected to grow by 20% by 2043. Leicestershire is a relatively affluent county; however, some pockets of significant deprived areas fall into the 10% most deprived neighbourhoods in England.

There is an eight-year difference in life expectancy at birth between males in the most deprived decile and least deprived decile of the population. The county also underperforms compared to national averages in areas such as immunisations, A&E attendances for children under 18, dementia diagnosis, and fractures in those over 65. Additionally, Leicestershire has a significant population living with chronic and complex conditions, with over 52,000 people having five or more long-term conditions and 16,000 people having eight or more.

Rutland

Rutland is England's smallest historic county, with a population of around 40,000 living in a rural area with two market towns - Oakham and Uppingham. The county has an older population, with almost 24% being over 65. Rutland is ranked as the 148th most deprived local authority area in the country (out of 152).

Although life expectancy at birth for males and females is generally better than the national average, Rutland faces challenges in accessing care services, limited health infrastructure, and community health services. Some groups, such as low-income families children with special educational needs and disabilities, the Armed Forces community, the prison population, carers, people living with learning disabilities, and certain farming communities, have poorer outcomes than the wider population in Rutland.



Legal duties

We have embraced our legal duties in the delivery of our vision and strategic aims. The ICB has a legal responsibility to involve and inform patients and members of the public by ensuring that involving, listening to, and acting on their views are at the heart of delivering our vision for local healthcare. This commitment also extends to other legal duties placed upon the ICB, including duty to improve quality; duty to reduce inequalities and contribute to the delivery of a joint health and wellbeing strategies; 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 available in the equality, diversity and inclusion information and report published on our website https://leicesterleicestershireandrutland.icb.nhs.uk/ .

Wider Partnership Working

Working in partnership, the ICB contributes to the wider health and wellbeing for the Leicester, Leicestershire and Rutland population. The ICB's strategic priorities and priorities across the ICS are consistent with those of the Joint Health and Wellbeing Strategies across Leicester, Leicestershire and Rutland. The focus of these strategies is on the specific challenges in each of the respective 'places' as identified through the respective Joint Strategic Needs Assessments (JSNA). Our three upper-tier Local Authorities (across each 'place') have worked with partners to develop the Joint Health and Wellbeing strategies the details are available on respective Local Authority websites:

- Leicester City Council https://www.leicester.gov.uk/
- Leicestershire County Council https://www.leicestershire.gov.uk/
- Rutland County Council https://www.rutland.gov.uk/

The emphasis across the system is on reducing health inequalities, reducing avoidable admission to hospital, redesign of alternative pathways and prevention of illness.

Our experience from the Covid-19 pandemic and more recently facing some of the most challenging times including cost of living crisis, the continuing financial constraints and challenges faced by the organisation 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, which we look forward to building on through engagement with our population.

We continue to implement shared priorities for health and social care integration through Better Care Funds in conjunction with Leicester City Council, 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 ICB 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 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 develop new and improved relations with clinicians, patients and carers, public members, staff, partner organisations, including local authorities, and other commissioning agencies.

Establishing stronger partnerships across system boundaries with other integrated care systems and at regional level will be pivotal to enable the ICB to effectively and efficiently deliver its strategic objectives and priorities going forward. Particularly in light of further delegated functions devolved from NHS England from 1 April 2023 in relation to pharmacy, optometry and dental primary care commissioning.

Better Care Fund

The Better Care Fund (BCF) continues to be a critical enabler to take forward the integration of health and care services. From 1 July 2022 to 31 March 2023 our contribution to the BCFs were as follows:

- Leicester City Better Care Fund £21.316m
- Leicestershire Better Care Fund £34.355m
- Rutland Better Care Fund £1.998m

This investment 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 all three Health and Wellbeing Boards across Leicester, Leicestershire and Rutland which provide leadership and champion opportunities to improve health and wellbeing outcomes for everybody in LLR. 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 Strategies. Three Board members are drawn from the across the three Local Authorities to bring a sectoral perspective to the Board, one of whom has lead responsibility for public health. This role enables a perspective on public health and prevention to remain at the forefront of the Board's considerations and decision-making.

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 attend our Board 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 ICB attend Healthwatch meetings to give presentations and provide updates on priorities.

Emergency Preparedness, Resilience and Response (EPRR)

The ICB 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), as well as the Strategic Coordinating Group (SCG). These groups were established both under and 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 the annual report on EPRR to the Board which can be found on our website at www.leicesterleicestershireandrutland.icb.nhs.uk .

Priorities for 2023/24

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 partners and stakeholders across LLR, including the district councils at neighbourhood level to develop community health and wellbeing plans. The continued emphasis on collaboration and partnership working will be pivotal to the ICB and the local health and care system delivering on our organisational and system level priorities and addressing the continued challenges.

Our commissioning priorities for 2023/24 will include delivery of our operational plan, delivery of our collective system-wide priorities aligned to the LLR Integrated Care Strategy and also a focus

on supporting our workforce. We will be finalising our vision for the next five years in our Five Year Plan which will be focusing on the 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.

We will learn from our experiences to support continuous quality improvements in the services we commission and collectively gain a deeper understanding of the root causes of underperformance 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.

A Williams

Andy Williams
Accountable Officer
26 June 2023

Performance Overview

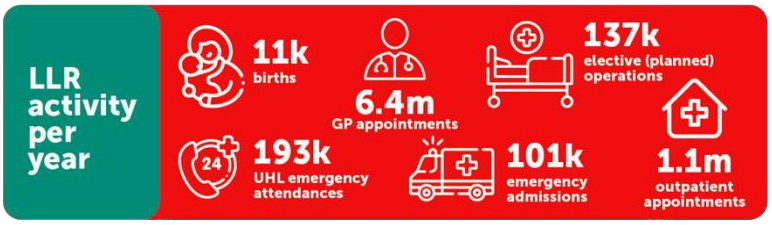
Purpose

The Performance Overview is the section with the overarching Performance Report chapter that provides a brief summary of the performance and financial pressures we have faced during the last year, and also highlights some areas of progress made on prevention and health inequalities; care quality, access and outcomes; ensuring NHS staff are supported; and using taxpayers' investment to maximum effect. Further information is available in this section of the Annual Report, in the section on Performance Analysis, and within reports presented to the Board available on our website. It is not possible to highlight all of our key achievements and successes and also areas that require further improvement, however a detailed review is contained within our Board papers as published on the ICB website at:
www.leicesterleicestershireandrutland.icb.nhs.uk .

This overview is designed to provide you with enough information to understand a bit more about our organisation, our purpose, the key risks, and challenges to the achievement of our objectives and how we have performed during 2022/23.

Overview of our performance

The last year has been a challenging one. Our ability to respond to the in-year financial pressures and working towards restoration of elective care and mental health services following the Covid-19 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 and community 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 of the national constitutional performance standards and targets expected over the last year, 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.

During 2022/23, 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) **Resilience through winter across LLR** – the ICB, in conjunction with partners organisations across LLR, implemented a Winter Plan in 2022/23 based on demand model and capacity needed for a 'safe winter'. This built upon the approach adopted through the Covid-19 pandemic, which identified the expected demand across health and care and then matched capacity-enabling schemes to create flow across the system. Performance against the LLR Winter Plan has been positive, with the majority of schemes delivering at 75-100% of expected impact. Despite the challenges of significant demand across all

health and care services in LLR, the two key system aims of winter were met – ambulance handover significantly improved and our 104 week elective trajectory was met.

Further details can be found on the ICB website in the report to the ICB Board in April 2023. Work continues to embed transformative changes over the coming 26 weeks in readiness for winter 2023/24.

b) Elective care recovery and significant improvements in elective care performance – following the Covid-19 pandemic waiting lists for elective care were increasing and patient care was being impacted. In conjunction with our acute and community / mental health providers (University Hospitals of Leicester NHS Trust and Leicestershire Partnership NHS Trust respectively) and our primary care partners across LLR, we successfully reduced the waiting times for elective care. Further details are available within the ICB Board papers available on the ICB website.

In particular, we made significant progress in 2022/23 to reduce the 104 week waits across LLR and stabilised overall waiting lists and made significant improvement in cancer wait times. Notwithstanding the improvements, the overall picture for elective care remains significantly challenged.

Whilst the challenge remains significant there continues to be good progress on the reduction of those patients waiting longest for definitive treatment. University Hospitals of Leicester NHS Trust's ambition is to reach zero 78-week waiters by the end of quarter one 2023/24. This will enable the focus to shift to reducing the 65-week waiters during 2023/24 in line with national targets of zero by end March 2024.

c) **'Step up to Great' Mental Health services** – the ICB has continued to support and work in conjunction with Leicestershire Partnership NHS Trust and our local communities to focus on improving the way adult mental health care is delivered across Leicester, Leicestershire and Rutland. Following the consultation, a number of improvements have been proposed to improve the services and outcomes for our patients. Since the establishment of the ICB, these improvements continue, 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.

d) **Learning disabilities services** - our Learning Disability services also go from strength to strength. Our LLR Learning Disabilities (LD) Collaborative is one of the first of its kind nationally whereby all partners across health and care come together under the leadership of a single organisation to deliver transformative change across the system.

This collaborative has been led by LPT and encompasses a full system team. As a result of this work, LLR has moved from being a 'failing' system to one of the top systems in England. We have seen an improving take up of LD Annual Health checks from 52% to 79%, with almost 200 people reached who had not had a check for over 2 years.

The Learning from lives and deaths – people with a learning disability and autistic people Programme (or the LeDeR programme) performance has been transformed, having shared no learning up to April 2020, to being top performers in the Midlands with a consistent achievement of 100% of reviews delivered within 6-month target, and over 400 actions shared. Our inpatient numbers have reduced to within target for the first time in several years and most importantly, we have noted an increase in average age at death

for people with LD to above the national LeDeR mean of 59 years; in LLR in 2021/22 it is 64 years.

e) **Development of a Clinical Strategy** - the purpose of this clinical strategy is to set out the principles that should underpin the development, establishment, and maintenance of clinical and care services for people in LLR and thereby delivering the key health objectives. The ICB clinical strategy aligns with the LLR health and wellbeing partnership strategy but also extends the broad objectives set out in that document by providing specific and enduring clinical values which we believe will maintain a clear direction for the work of the ICB in the coming years.

f) **Clinical and place-based leadership –** through the leadership of our Medical Directorate we have established a strong and robust clinical and place-based leadership model across LLR through the appointment of clinical leads, promoting collaboration and multidisciplinary working, with a focus on patient care being at the heart of decision-making.

Clinical leadership at each place has ensured that care is delivered within each place and neighbourhoods in a way that meets the needs of our local community. Place-based leaders work closely with Public Health teams, voluntary and community organisations, and other stakeholders to address the health and social care needs of the local population. This approach has led to significant improvements in health outcomes and helped reduce health inequalities. Currently, the focus is on key projects such as increasing childhood immunisations and improving bowel screening uptake to support early detection of cancer. including improving primary care access, service delivery, workforce, primary care resilience and sustainability, and reducing unwarranted variation. To achieve these goals, the Directorate has worked closely with Primary Care Networks, identifying opportunities for innovation and improvement, such as the use of new technologies, changes to workforce models, and improvements to care coordination.

The establishment of the Clinical and Care Professional Leadership forum (CCPL) provides multi-professional leadership, direction, and promotes multidisciplinary working and collaboration between health and social care providers across LLR.

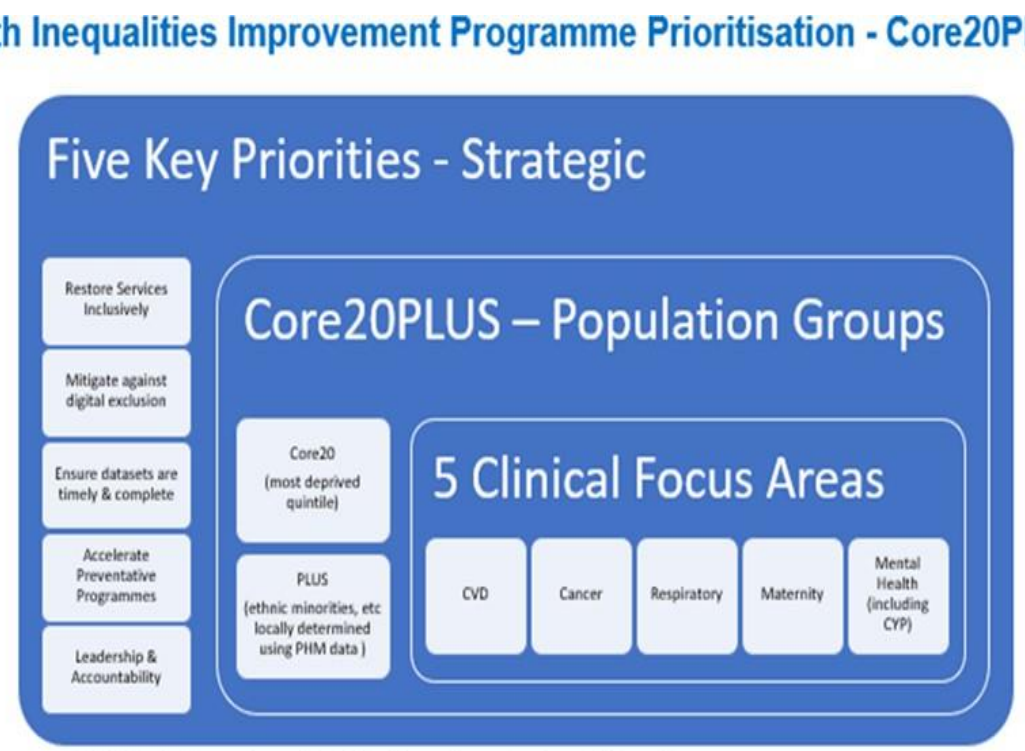
In 2023/24, the priorities will be to improve patient outcomes by facilitating GP direct access to diagnostics, overseeing quality and performance in pharmacy, optometry, and dentistry, managing primary care complaints and quality, addressing the backlog of elective procedures, and developing integrated pathways for long-term conditions.

e) Promoting research and development – the ICB has positively promoted research and development across LLR in conjunction with partners across healthcare and academic institutions. This will continue to be a key area of focus in 2023/24.

f) Establishment of the LLR Health and Wellbeing Partnership – in partnership with the three local authorities across LLR, we jointly established the LLR Health and Wellbeing Partnership (i.e. the integrated care partnership which is a statutory committee of the ICB) in August 2022. This forum aims to integrate care across different organisations and settings, joining up hospital and community-based services, physical and mental health, and social care and will be responsible for approving an integrated care strategy for Leicester, Leicestershire and Rutland during 2023/24.

g) **Established "Better Care For All"** – over the last year we developed a framework called *Better Care For All* to help reduce health inequalities in Leicester, Leicestershire and Rutland. Our programme of work to reduce health inequalities has been guided by the 2022/23 NHS Operational Planning Guidance and the CORE20PLUS5 approach (Figure 5). Details are available on the ICB website and within our Equality and Inclusion Annual Report https://leicesterleicestershireandrutland.icb.nhs.uk/equality-statement/ .

Figure 5*: The five priorities in the 2021/22 and 2022/23 NHS Operational Planning Guidance and the CORE20PLUS5 approach*



2021/22 priorities and operational planning guidance: Implementation guidance
https://www.england.nhs.uk/wp-content/uploads/2021/03/B0468-implementation-guidance-21-22-priorities-and-operational-planning-guidance.pdf

h) **Establishment of a system wide Health Inequalities Support Unit (HISU)** – the purpose of which is to provide a range of dedicated support and expert advice to enable drive, focus and delivery of the health inequalities reduction programme across the system and ensure training and education is provided for system leaders and decision-makers on issues relating to health inequalities and health equity.

i) **Primary medical care services** – since 1 July 2022, the LLR ICB has had full delegated authority from NHS England for funding the core activities of GP Practices for primary medical care commissioning for core services and for certain additional services. It is acknowledged that shifting services from hospital settings into the community closer to patients has increased the work pressures in primary care, in particular, for general practitioners. 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 2022/23. Notably, our practices delivered between 500-600,000 appointments each month during the year, which far exceeds many systems around the

country based on head of population. Despite workforce challenges, primary care colleagues also delivered additional appointment for respiratory diseases over winter, supporting both our patients and the wider winter plan.

j) **ICB's Primary Care Strategy** – the Board approved the Primary Care Strategy with an aim to prioritise investment in primary care, ensuring it is resilient and transformative in line with the ambitions of the NHS Long Term Plan. Implementation of the Strategy will commence in 2023/24, with a view to monitoring outcomes against the commitment over the next three years. These commitments include:

   a. Working collaboratively with our system partners across System, Place and Neighbourhood to deliver on the key health and wellbeing challenges our people face.
   b. Implementing Population Health Management and personalised care approaches to improve health outcomes and address health inequalities (Core20Plus5 in particular).
   c. Tackle variation, restoring and improving the parity of access to Primary Care services – ensuring this meets the needs of patients at place and neighbourhood.
   d. Supporting the health and wellbeing of Primary Care workforce, in line with the People Plan, which includes promoting recruitment, retention, supervision, mentoring and coaching opportunities as well as training and development.
   e. Care closer to home: Transforming community services and improving discharge, including implementation and delivery of Virtual Wards supported by primary care, which allows patients to get the care they need at home safely and conveniently, rather than being in hospital.

k) **Pharmacy, optometry and dental primary care services** – we demonstrated the ability, preparedness and robust governance arrangement to successfully be delegated further primary care delegated functions from NHS England relating to pharmacy, optometry and dental primary care services with effect from 1 April 2023.

l) **Regular communication and engagement activities -** we have continued to engage with our communities with key information and updates. The ICB 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. During 2022/23, we continued to support the NHS's local Covid-19 vaccination programme in Leicester, Leicestershire and Rutland, promoting the importance of getting vaccinated and assisting system restoration and recovery. We did so through our work with local partners, primary care colleagues and through delivery of innovative campaigns targeting our local population, to ensure they receive the right care for their needs, whilst easing pressure from our busy Emergency Department (ED) at the Leicester Royal Infirmary (LRI).

Building on the success of the previous year, working with local partners such as the LLR Local Resilience Forum (LRF) and leaders of diverse communities and our local GPs, the Communications team ramped up creative messages through a series of video messages,

offering advice in a range of languages to encourage awareness and uptake from all sections of our diverse communities, including those who were more likely to be hesitant to take up the vaccination offer.

In July 2022, the ICB Communication team's work on Covid was recognised by NHS England. We won an award for delivering the best campaign on Covid, which included our online and offline activities encouraging our communities to get vaccinated. Our vibrant and eye-catching digital content and simple strapline – 'Get Vaxxed Stay on Track' became popular with our patients as we achieved impressive uptake of Covid vaccinations in the groups we targeted.

In November 2022, the ICB launched its *Get in the Know* campaign to help educate people about using local services to get the right care, as quickly as possible. The campaign was introduced in phases promoting individual themes including: the launch of an online information hub to provide information about local services in one place, mental health services, looking after minor ailments and what to do when it's urgent. The campaign was promoted organically via the ICB and system partners and supplemented by advertising on Facebook, Instagram, Snapchat, Spotify and Google Search and Display. To date, the campaign has achieved 11.5 million impressions via advertising. This campaign will be built upon during 2023/24.

The ICB Communications team also worked with a range of media including BBC East Midlands Today and ITV Central News on coverage relating to GP pressures, how this was impacting patients and highlighting the various services available for our patients. We supported people to access the right services for their clinical needs through widespread promotion of NHS 111, which should be the first point of contact when a person's condition is not a life-threatening emergency. We have also produced a guide on urgent care services available in LLR to support our patients: https://leicesterleicestershireandrutland.icb.nhs.uk/your-guide-to-local-nhs-urgent-care-services/

We have worked closely with our GPs and practices too providing support on issues they have needed to communicate with their patients and media such as changes to services, different ways to book an appointment and other services available, including community pharmacies. Our promotion of information in different formats and languages produced in partnership with our local clinicians, such as our videos on Strep A, has been very popular on our social media channels.

Our social media channels have also been enhanced with greater use of creative, digital content through various channels. We regularly post and share information daily. All of our social media handles are on our website. Simply click on the icons to follow: https://leicesterleicestershireandrutland.icb.nhs.uk/

In February 2023, we supported the first ever NHS England tour of a cancer bus-ting double-decker bus to Leicester. The bus aimed to help raise awareness of the signs and symptoms of cancer, to encourage people to visit their GP for potentially lifesaving checks if they have a symptom. From the bus, teams of NHS staff, alongside nurses from Cancer Research UK, provided expert advice to help make passers-by aware of common cancer signs and symptoms, the importance of earlier diagnosis, and where they can go for support or further advice. We are pleased to have supported this excellent initiative, attracting scores of local people who attended for potentially life-saving advice. You can view a short video about the bus tour to Leicester on our website:

https://leicesterleicestershireandrutland.icb.nhs.uk/newsroom/?playlist=19964c9&video=359c3d3

We launched our first ever series of podcasts in March 2023, focusing on the work of our health and social care staff in LLR who work on integrated care helping improve the lives of our local population. Over 70,000 people work in health and social care and we highlighted some of the great work taking place across the area.

The podcast series includes features on supporting frail or older patients who have suffered from falls; young people who have been victims of violent crime and virtual wards – caring for people in their own home. Our podcasts can be accessed from our LLR Health and Wellbeing Partnership website:

https://leicesterleicestershireandrutlandhwp.uk/news/podcasts/ .

m) **LLR Green Plan** - in February 2023, we launched the LLR Green Plan, committing to our journey to net zero. Our Green Plan sets out a collective vision and the actions that we will take over the next three years, to support national and regional NHS targets for carbon reduction; prioritising interventions which simultaneously improve patient care and community wellbeing while tackling climate change and broader sustainability issues across LLR. The Plan also sets out collaborative efforts by the ICB and LLR partners to achieve desired outcomes in a cost-effective and efficient manner. For further information and to watch video content showcasing some of our green case studies visit The Green Space – a dedicated webpage for our Green Plan: https://leicesterleicestershireandrutland.icb.nhs.uk/our-work/green-plan/

There have also been a number of key challenges during the last year, the key challenges being:

i. **Performance against national targets and standards** - there is no doubt that this past year presented 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 Board on a regular basis and can be found in our Board papers on our website. These reports provide further information about the standards and targets we have achieved and areas that require more work over the next year.

ii. **Financial performance and risk** – ensuring financial sustainability and achieving financial balance has been challenging over the last year as described in our regular reports presented at the ICB Board meetings. A collaborative approach to financial management and achieving value for money with our NHS partners across LLR has enabled actions to be taken collectively to manage our financial performance risks. Specific details on financial performance are detailed within the Performance Analysis section of the report.

Looking ahead to 2023/24

Our focus for 2023/24 will build on what we have achieved during the last year, as we continue to work closely with our partners, to deliver the high-quality, joined-up health and social care services that our patients expect and deserve.

During the last year we have learnt a lot from adopting and embracing different ways of working following the Covid-19 pandemic. Our achievements and successes have been a result of better and stronger collaborations with our partners, including GP Practices, NHS providers, Local Authorities, voluntary and community sector organisations to enable delivery of improved outcomes for our patients and population and reducing health inequalities.

We have used lessons learnt from the predecessor organisations 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 will continue to drive the approach across our system. In 2023/24 we will endeavour to build and enhance on partnerships with and across neighbouring integrated care systems, to deliver joined up care and better outcomes for our patient population. This will be pivotal to the delivery of future commissioning functions, such as pharmacy, optometry, primary care dental services and specialised commissioning services which NHS England delegated to the ICB with effect from 1 April 2023 onwards.

There is no doubt about the significant scale of challenge in front of us in 2023/24 as we work to enable our services to restore business as usual and improve and evolve 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

Purpose

This section describes how the ICB'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 is key in enabling the ICB to achieve its strategic objectives and legal duties.

Strategic risk management

The ICB 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 an 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 ICB 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 during 2023/24.

The Accountability Report provides further detail about how we identify and manage risks currently and Appendix 5 details the strategic risks as of 31 March 2023.

Our performance

National and local standards

One of the key areas of focus for the ICB 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 committed to achieve. The national standards are outlined in the NHS System Oversight Framework 2022/23 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. The types of reports we generate can be found within our Board papers on our website: https://leicesterleicestershireandrutland.icb.nhs.uk/about/board-meetings/ which details the analysis of the data and the specific areas of risk identified, including actions to mitigate the 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 2022/23 performance has not been at the level that the ICB 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 ICB 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 5.

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 2022/23 informs the assessment of ICBs. It is intended as a focal point for joint work, support and dialogue between NHS England, ICB, 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 2022/23 is available on NHS England's website. 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 on a monthly basis to the System Executive Committee, then onwards to the Board. The report usually outlines key performance indicators which are currently the critical areas of focus for Leicester, Leicestershire, and Rutland (LLR). The performance usually covers a selection of key performance indicators taken from local priorities such as ambulance handovers, as well as the System Oversight Framework (SOF).

Highlight reports may include the following areas:

- Urgent Care including 6 winter plan metrics and ambulance handovers.
- Primary Care.
- Elective Long Waiters.
- Cancer.
- Learning Disabilities and Autism.
- Mental Health.
- Maternity.

Performance intelligence at system level is provided around:

- Performance against national targets (performance against plan is reviewed elsewhere within the system although these are due to come together through a new System Delivery Group meeting).
- Risk and mitigations.
- Benchmarking.

There are summaries presented to System Executive Committee illustrating where LLR is ranked within the highest and lowest quartiles compared to all 42 Integrated Care Board (ICB) areas in the country. In March 2023 this showed that there are 11 areas where LLR appear in the top five ICBs in the country (up from 9 last month) as shown in the table below.

Figure 6: *2022/23 NHS System Oversight Framework – data provided by NHS England for a number of key metrics from the 2022/23 NHS Oversight Framework (SOF). For LLR ICB the table provides indicators where LLR is in the* ***highest*** *quartile (25 rank position) compared to all ICBs in the Country.*

	Indicator	Aggregation Source	Latest Period	Previous	Latest		Target / Nat Ave*	National Value	Rank
S063c	Proportion of staff who say they have personally experienced harassment, bullying or abuse at work from patients/service users, ...	ICB	2022	22.8%	23.1%	↗			1/42
S086a	Inappropriate adult acute mental health placement out of area placement bed days	ICB	Nov 2022 - Jan 2023	0	0		0		1/42
S116a	Proportion of adult inpatient settings offering tobacco dependence services	ICB	2023 Q1	50.0%	100.0%	↘	100%	24.5%	1/42
S001a	Number of general practice appointments per 10,000 weighted patients	ICB	2023 Q2	5,863.8	5,368.3	↘	443.2*	4,432.2	2/42
S053a	% of atrial fibrillation patients with a record of a CHA2DS2-VASc score of 2 or more who are treated with anticoagulation drug th...	SubICB	2021-22	91.3%	92.1%	↗	90%	89.0%	2/42
S051a	Number of people supported through the NHS diabetes prevention programme as a proportion of patients profiled	ICB	22-23 Q3	66.2%	101.5%	↘	41.5%*	41.5%	3/42
S074a	FTE doctors in General Practice per 10,000 weighted patients	ICB	2023 Q2	6.7	6.6	↘	5.8*	5.8	3/42
S084a	Number of children and young people accessing mental health services as a % of LTP trajectory	ICB	2023 Q1	116.3%	117.0%	↗	100%		3/42
S085a	Proportion of people with severe mental illness receiving a full annual physical health check and follow-up interventions	ICB	2022 12	86.0%	94.5%	↗	100%	77.2%	4/42
S110a	Access rates to community mental health services for adult and older adults with severe mental illness	ICB	2023 Q1	330.2%	333.9%	↗	100%		4/42
S106a	Number of Completed Referrals to Community Pharmacist Consultation Service (CPCS) from a general practice	ICB	2023 Q1	230.6	150.9	↘	76.*	76	5/42
S123a	Adult general and acute type 1 bed occupancy (adjusted for void beds)	Provider	2023 Q2	95.4%	93.5%	↘	95.8%*	95.8%	6/42
S053b	% of hypertension patients who are treated to target as per NICE guidance	SubICB	2021-22	50.0%	62.9%	↗	80%	60.4%	7/42
S013c	Diagnostic activity levels: Endoscopy	Provider	2023 Q2	113.6%	125.9%	↗	120%	96.3%	8/42
S067a	Leaver rate	ICB	2023 Q1	8.17%	8.14%	↘	8.7%*	8.71%	9/41
S007b	Elective Activity : Completed pathway elective activity growth	ICB	2023 Q2	115.5%	119.4%	↗	110%		9/42
S013b	Diagnostic activity levels: Physiological measurement	SubICB	2023 Q2	120.9%	126.8%	↗	120%	106.7%	9/42
S013c	Diagnostic activity levels: Endoscopy	SubICB	2023 Q2	101.4%	112.7%	↗	120%	96.7%	10/42
S106b	Number of Completed Referrals to Community Pharmacist Consultation Service (CPCS) from NHS111 per 100,000 population	ICB	2023 Q1	165.1	104.9	↘	94.8*	94.8	10/42
S013d	Diagnostic activity levels: Total	SubICB	2023 Q2	107.1%	111.1%	↗	120%	108.5%	11/42
S040a	Methicillin resistant Staphylococcus aureus (MRSA) bacteraemia infection rate	Provider	2023 Q2	4	3	↘	0	295	11/42
S109a	Units of Dental Activity delivered as a proportion of all Units of Dental Activity contracted	ICB	2023 Q3	95.9%	112.0%	↗	100%	101.3%	11/42
S117a	Proportion of patients who have a first consultation in a post covid service within six weeks of referral	Provider	2023 Q3	44.9%	51.1%	↗	50.8%*	50.8%	12/24
S053c	% of patients identified as having 20% or greater 10-year risk of developing CVD are treated with statins	SubICB	22-23 Q2	59.2%	60.0%	↗	45%	57.9%	12/42
S044a	Antimicrobial resistance: total prescribing of antibiotics in primary care	SubICB	Feb 2022 - Jan 2023	87.5%	89.8%	↗	87.1%	95.5%	13/42

Figure 7: *2022/23 NHS System Oversight Framework – data provided by NHS England for a number of key metrics from the 2022/23 NHS Oversight Framework (SOF). For LLR ICB the table provides indicators where LLR is in the* ***lowest*** *quartile (25 rank position) compared to all ICBs in the Country.*

	Indicator	Aggregation Source	Latest Period	Previous	Latest		Target / Nat Ave*	National Value	Rank
S009b	Total patients waiting more than 78 weeks to start consultant led treatment	SubICB	2023 02	3,014	1,940	↘	641.8*	26,955	41/42
S009b	Total patients waiting more than 78 weeks to start consultant led treatment	Provider	2023 02	3,082	1,914	↘	677.4*	28,450	40/42
S107a	Percentage of 2-hour Urgent Community Response referrals where care was provided within two hours	ICB	2023 01	68.4%	66.7%	↘	70%		40/42
S022a	Stillbirths per 1,000 total births	ICB	2020	2.67	4.1	↗	3.3*	3.29	39/42
S042a	E. coli bloodstream infection rate	Provider	2023 02	129.4%	130.1%	↗	100%	110.9%	39/42
S044b	Antimicrobial resistance: proportion of broad-spectrum antibiotic prescribing in primary care	SubICB	Feb 2022 - Jan 2023	9.6%	9.4%	↘	10%	7.9%	39/42
S009a	Total patients waiting more than 52 weeks to start consultant led treatment	Provider	2023 02	16,237	13,969	↘	8,253.9*	346,664	38/42
S009a	Total patients waiting more than 52 weeks to start consultant led treatment	SubICB	2023 02	15,692	13,814	↘	7,868.8*	330,489	38/42
S009c	Total patients waiting more than 104 weeks to start consultant led treatment	Provider	2023 02	85	53	↘	0	924	38/42
S009c	Total patients waiting more than 104 weeks to start consultant led treatment	SubICB	2023 02	77	49	↘	0	964	37/42
S037a	Percentage of patients describing their overall experience of making a GP appointment as good	ICB	2022	67.9%	52.8%	↘	56.2%*	56.2%	36/42
S041a	Clostridium difficile infection rate	Provider	2023 02	147.3%	137.6%	↘	100%	119.0%	35/42
S031a	Rate of personalised care interventions	ICB	22-23 Q3	57.9	74.5	↗	97.3*	97.33	33/42
S013a	Diagnostic activity levels: Imaging	Provider	2023 02	103.6%	104.3%	↗	120%	111.0%	32/42
S013b	Diagnostic activity levels: Physiological measurement	Provider	2023 02	85.4%	94.3%	↗	120%	107.5%	32/42
S013d	Diagnostic activity levels: Total	Provider	2023 02	102.7%	104.9%	↗	120%	109.8%	29/42
S050a	Cervical screening coverage : % females aged 25 : 64 attending screening within the target period	SubICB	22-23 Q2	70.6%	69.9%	↘	75%	69.7%	29/42
S106a	Available virtual ward capacity per 100k head of population	ICB	2023 03	10.3	10.8	↗	40 per 1...	16.3	29/42
S115a	Proportion of diabetes patients that have received all eight diabetes care processes	ICB	21-22 Q4	35.9%	45.7%	↗	0.5*	46.7%	29/42
S101a	Outpatient follow up activity levels compared with 2019/20 baseline	ICB	2023 02	105.8%	102.7%	↘	75%		28/42
S060a	Aggregate score for NHS staff survey questions that measure perception of leadership culture	ICB	2022	6.81	6.92	↗			27/42
S081a	Access rate for IAPT services	ICB	2022 12	54.4%	60.6%	↗	100%		27/42
S047a	Proportion of people over 65 receiving a seasonal flu vaccinatio	SubICB	2023 02	80.4%	80.8%	↗	85%	79.9%	25/42
S125a	Adult Acute LoS Over 60 Days % of total discharges	MH Provider	2023 01	24.4%	28.9%	↗	22.1%*	22.1%	25/35
S012a	Proportion of patients meeting the faster cancer diagnosis standard	ICB	2023 02	68.0%	73.5%	↗	75%	75.0%	24/42

In March 2023 there was one area (diagnostic activity levels: physiological measurement) where LLR ranked lowest of all ICBs. Elective Care is one of the most challenging areas for LLR when benchmarking ourselves to other systems but there are commitments for ongoing improvements throughout 2023/2024 with an aim to have:

- zero 104 week waits by 31/3/2023 and
- zero 65-week elective waits by 31/3/2024
- ongoing monthly reductions for 52 week waits throughout 2023/2024.

This is based on the current starting position which became challenged throughout Covid with the extended lockdown in Leicester compared to other areas of the Country.

- The total LLR waiting list size at the end of December 2022 was 138,299 a reduction of over 700 LLR patients from November 2022 which stood at 139,063.
- At the end of December 2022, 52+ week waiters stood at 18,116. 78+ week waiters stood at 3677, which is an increase of over 300 patients from November 2022.
- 104+ week waiters continue to steadily decline and stood at 103 at the end of December 2022.

Performance in relation to urgent and emergency care has been challenging over the last year, in particular across the following metrics / standards: A&E 4 hour wait and cancer two week wait target for people referred with suspected breast cancer, 62 day cancer wait performance and backlogs, and ambulance handover waiting times. Detailed performance figures and actions to

help identify root causes and apply corrective action to improve performance were reported to the ICB Board (see ICB website for further details).

As performance deteriorates across specific standards and targets, the ICB 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 mechanisms 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 key risks to performance improvement alongside the mitigations and how they are being managed can be seen in the table below.

Performance risk and mitigations

Report Summary – Challenges (1)

Performance challenges :	What is the key issue?	Mitigations
Ambulance waits : over 30 minutes not met national target	• Crowding in ED due to chronic and sustained lack of flow. • High inflow of walk-in patients (sick patients walking in due to inability to get an ambulance)	• Implementation of pre-transfer unit at LRI • The opening of the BUS/POD this has seen a significant improvement reducing the average time. • Extension of discharge lounge at LRI
Discharges: targets routinely not being met – resulting in risk of harm and deconditioning	System needs to grow and sustain community capacity to support discharge so patients do not occupy acute beds and result in risk of harm and deconditioning	Continue to work with health and social care system partners to: • Embed the new shortened referral/transfer process of patients transferring from UHL-LPT • Change administrative process for processing Home First Forms Work with Clinical Management groups (CMGs) • Continue to raise awareness of the impacts of hospitalised deconditioning and promote the National reconditioning games. • Track patients with a discharge outcome today/in the future to reduce lost discharges • Develop the therapy led approach to filling therapy led capacity and reducing P2 allocations

Report Summary – Challenges (2)

Performance challenges :	What is the key issue?	Mitigations
Elective: Long waiters (52+weeks and 78+ weeks)	• Significant operational pressures due to emergency demand • Workforce challenges in admin and anesthetics leading to theatre cancellations • Continued growth in demand against significant number of specialties	• The trust have fortnightly meetings in place to monitor performance. • Mutual Aid requests submitted on DMAS (Digital Mutual Aid System) • Increase numbers sent to Nuffield IS provider and BMI park • Establish future mutual aid requirements • Agreement with IS providers to transfer whole pathway (from first OPA to surgery) • Elective Care Strategy developed with eight key Elective Recovery Interventions aligned to the National Elective Recovery Framework. • Validation plan has been developed and is underway to ensure a 'clean waiting' list is in place. • Demand and Capacity modelling being commissioned to support future planning.

Report Summary – Challenges (3)

Performance challenges :	What is the key issue?	Mitigations
Cancer: 2WW and 62 day not met the national target	• Two week despite pathway improvements this standard remains at risk due to the sustained increase in demand, predominantly in out-patients and endoscopy and workforce challenges in both admin and clinical areas. • 62 day - Urology, LOGI & Skin remain a key area on concern	• Head & Neck additional capacity introduced • LOGI 50+FIT pathway implemented 04/01/23 • Non Site Specific Symptoms pathway implemented 04/01/23 • Continuation of Breast pain pathway & insourcing of under 35s • Continuation of AI teledermatology provider into 23/24 • The Trust continue to clinically prioritise all cancer patients • Weekly PTL review meetings • Review national timed pathways • Share dynamic backlog report tool, including next steps, to support focussed actions for recovery.

In order to ensure high quality of care for patients and service users and performance improvements there have been summits in 2022 around:

- Urgent and Emergency Care.
- Cancer.

There are further summits planned in 2023/2024 for:

- Children and Young People.
- Cancer.

Areas of performance improvement

Areas that have shown improvement in performance include:

- Primary care: number of GP appointment and face-to-face appointments:
    - ICB ranks 2/42 for number of GP appointments per 10,000 weighted patients however 36/42 for a "good" experience of making an appointment.

- Ambulance handover waiting times have improved over the last few months.

- Elective: long waiters (52+ weeks) - there has been a reduction in the number of patients waiting over 52weeks, 78 weeks and 104 weeks
    - 52+ weeks - ICB ranks 38/42 for the number of patients currently waiting for care
    - 78+ weeks -ICB ranks 41/42
    - 104+ weeks - ICB ranks 37/42

- Cancer: improvement in performance for 2 week wait – there has been a marginal improvement in performance for the 2 week wait standard, however it remains under the national target of 93%.

Further updates on performance against the national standards is available in the ICB's Board papers available at the following:
https://leicesterleicestershireandrutland.icb.nhs.uk/about/board-meetings/

A number of the design group / collaborative areas also have quality and performance subgroups where further analysis of performance intelligence can be reviewed in more depth taking into account place data, benchmarking, progress against annual operational plan and population health management data to support patient outcomes. 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.

Within the annual operational plan for 2023/2024 there are zero performance indicators that the ICB are not planning to achieve based on the 31 performance indicators which came from NHS England (NHSE). Collaboration with health and social care colleagues have supported improvements in care for our population throughout the year across pathways and in areas of challenge there is a commitment to further improve.

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.

Workforce policies were in place across the organisation and continue to be reviewed to ensure they remain applicable, up to date with changes in regulation including the Equality Act 2010. These policies cover the recruitment, selection and appointment process as well as all aspects of working across the ICB.

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 14Z34 of the Health and Social Care Act 2022 we have a duty to continuously improve the quality of services that we commission and improve outcomes for patients as well as ensuring that care provided to our patients is as safe as possible. We certify that the ICB has complied with the statutory duties laid down in the National Health Service Act 2006 (as amended). 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 ICB to have continued focus on quality improvement and quality assurance.

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 collaborative and comprehensive system-wide overview. Reports have been presented to the Board on a regular basis detailing our progress on performance and quality including the impact of COVID-19 on performance and an analysis of COVID-19 expenditure all available on the ICB website.

We continued to discharge our duty to improve the quality of services combining quality of care and 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 is crucial to delivering long term and meaningful change.

Our approach to quality and performance improvement is underpinned by our Quality and Performance Improvement Strategy as well as NHS England's Quality Functions and Responsibilities of Integrated Care Systems, which summarises how quality functions are expected to be delivered. These functions are:

i. Establishing quality governance arrangements, including a System Quality Group.
ii. Putting in place quality systems and assurance.
iii. Implementing arrangements to ensure patient safety.
iv. Improving people's experience of care.
v. Ensuring clinical effectiveness.
vi. Safeguarding arrangements.
vii. Enacting new duties (abuse and violence, mental health, and quality improvement programmes) and
viii. Sustainability.

Key areas of priority during 2022/23

Quality, safety and effectiveness has been pivotal to all functions across the ICB. Our main focus in 2022/23 has been on promoting a collaborative and integrated approach to improving quality of our services. Specific areas where we have concentrated our efforts are described below.

a) Patient Safety: Whilst our individual healthcare providers are accountable for their learning responses to patient safety incidents, we work collaboratively, across LLR, to facilitate and provide supportive oversight, including in the implementation of the new Patient Safety Incident Response Framework (PSIRF). The PSIRF sets out the NHS's revised approach to developing and maintaining effective systems and processes for responding to patient safety incidents for the purpose of learning and improving patient safety.

b) Infection Prevention and Control: We work collaboratively with our healthcare providers, bringing oversight, leadership, support, and guidance to ensure effective management in the prevention and control of infections.

c) Serious Violence duty: We work as a member of the LLR Strategic Partnership Board (SPB) with local authorities, police, the justice system, fire and rescue and other partners to share information and collaborate on interventions to prevent and reduce serious violence and crimes. In order to discharge our duties under the Police, Crime, Sentencing and Courts Act 2022, the SPB will develop and implement a Strategy to prevent and reduce serious violence across LLR. At a more local level, we are members of Community Safety Partnerships (CSPs) which provide a multi-agency approach to tackling local issues with the aim of making communities safer.

d) Safeguarding: It is the responsibility of each of our Partner organisations to ensure that people in vulnerable circumstances are safe and receive the highest possible standard of care. We are committed to promoting the safety and wellbeing of children, young people and adults who may be at risk of abuse or neglect. We continued to work closely with our local authorities, healthcare providers, safeguarding partnerships and networks of professionals to support this work which includes, but is not limited to:

- Child Protection-Information Sharing.
- Serious Violence duty.
- Female Genital Mutilation.
- Prevent.
- Modern Slavery and Human Trafficking.
- Domestic Abuse.
- Deprivation of Liberty Safeguards / Liberty Protection Safeguards.

e) Medicine Optimisation and Safety: We will enable transformation and support the pharmacy workforce to:

- Reduce health inequalities through improving access and optimisation of medicines.
- Tackle antimicrobial resistance.
- Tackle overprescribing and reduce the prescribing of drugs of dependence.
- Reduce the environmental impact of medicines and dispensing.
- Transform community pharmacy to support acute and elective care pathways.
- Develop an integrated system workforce approach driven by the pharmacy faculty; and
- Reduce patient harm from medicines.

f) Maternity: We will respond to the NHS England Single Delivery Plan for Maternity by listening to our women, growing, and supporting our workforce and supporting the positive leadership culture. This will be underpinned by our approach to safety and delivering a personalised, equitable service. Specific focus will be on:

- Improving the Maternity Voices Partnership.
- Integrating 1001 days into our maternity transformation programme
- Embedding the learning from national maternity reviews including Ockenden and Kirkup.
- Implementing the Saving Babies Lives Care Bundle.
- Increasing personalisation and choice.
- Improving access to the perinatal mental health service.
- Improving the safety culture across our services.

g) 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 ICB 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.

h) Personalisation and 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.

Quality assurance: measuring and monitoring quality

The success of our approach to quality improvement will be measured against the three pillars of quality:

i. **Effectiveness** - Clear quality improvement priorities based on a sound understanding of quality issues within the context of our local residents' needs, variation, and inequalities. This also includes sharing data and intelligence across the system in a transparent and timely way.

ii. **Patient and Public Experience -** Meaningful engagement ensures that people using services, the public and staff shape how services are designed, delivered, and co-evaluated. This includes working together in an open way with clear accountabilities for quality decisions, including ownership and management of risks, particularly relating to serious quality issues.

iii. **Safety** – Sharing data and intelligence across the system in a transparent and timely way and moving to a culture of shared learning, review and understanding of care. The safety agenda includes recognising the impact of decisions made at system level given the financial constraints the system may experience. In order to do this effectively, LLR is developing a joint equality and quality impact assessment framework to support the assurance of our decision making which is clinically led.

We have robust quality assurance arrangements in place; the key elements being:

- **Quality and Safety Committee** – receives intelligence from the System Quality Group and provides assurance to the ICB.

- **System Quality Group** – membership from across our NHS, primary care and local authority partners, this group has responsibility for sharing quality intelligence, learning, engagement.
- **Clinical Executive Group** – this Group provides clinical leadership to the ICB.

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 ICB discharges this responsibility through the system and its leadership.

Annual assessment ratings are usually published by NHS England to enable the ICB to benchmark progress, however at the point of writing this report this has not been published.

Engaging people and communities

Under Section 14Z45 of the Health and Social Care Act 2022 and as set out in the NHS Constitution we have a duty to involve the public in our commissioning plans and decisions that we make as a commissioning organisation. The ICB 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.

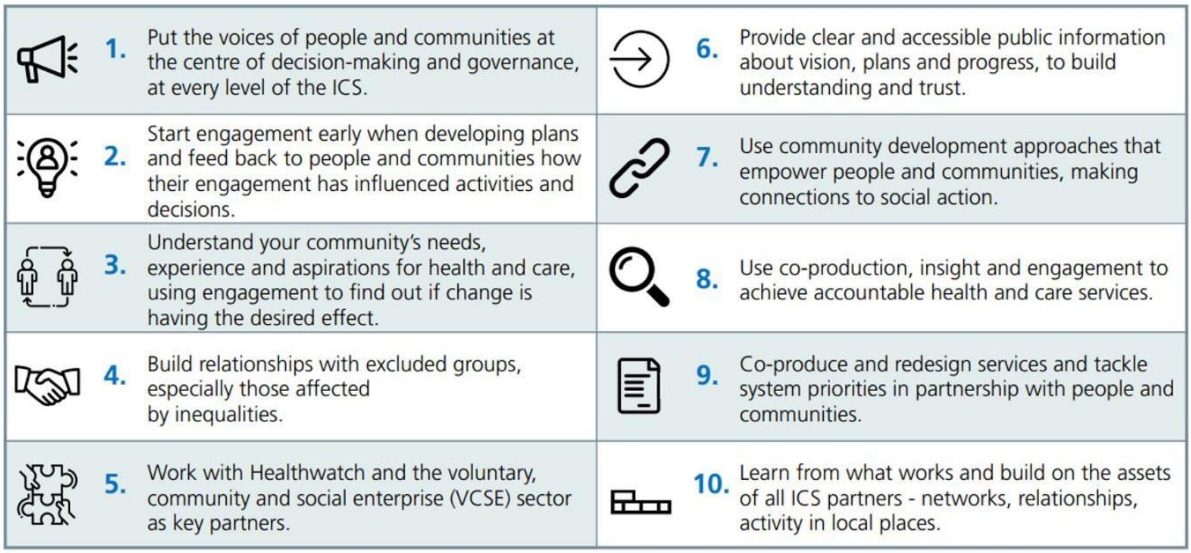
In 2022/23 NHS Leicester, Leicestershire and Rutland Integrated Care Board (LLR ICB) built on the firm foundations of participation, involvement and engagement over many years in LLR organisations – commissioners, providers and partners. Building on an inclusive learning culture, that values partnerships with people and communities, we have recognised what has worked well and what can be done better - reflected on it and implemented improvements through the delivery of our ICB People and Communities Strategy 2022/24.

We have combined our strong track record with effective and innovative ways of engagement, linking individual and community data and insights into the heart of the ICB through good governance and discharged our legal public involvement duties.

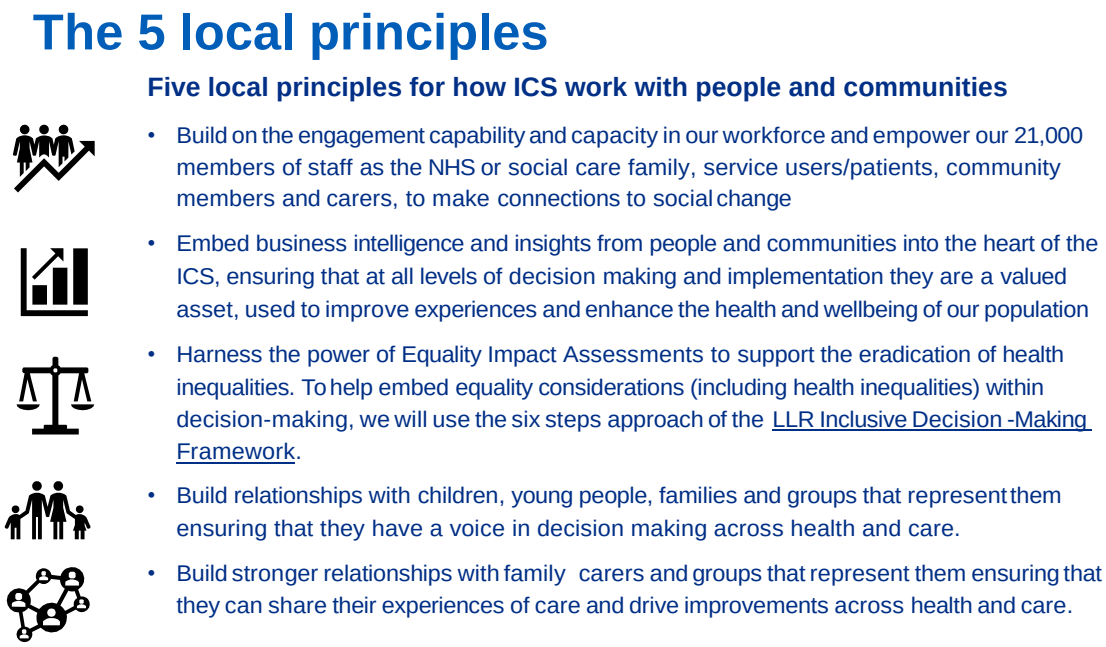
Principles for working with people and communities

The principles that underpin our work with people and communities align with 10 national principles for how ICSs should collaborate with people and communities, are shown below:

Figure 8: Ten national ICS principles for engagement



In addition to the ten national principles, we added 5 local principles:



Our work with the public and communities discharges our public involvement duty, as set out in the NHS constitution. It also takes account of the range of legislation that relates to involvement and decision making including:

i. Section 14Z2 of the NHS Act 2006, as amended by the Health and Social Care Act 2012 (current guidance)
ii. Brown and Gunning Principles
iii. Human Rights Act 1998
iv. NHS Act 2006
v. NHS Constitution
vi. Communities Board Principles for Consultation

The LLR ICB is also subject to legal duties to give due regard or regard to addressing health inequalities and advancing equality of opportunity. These separate duties are the Public Sector Equality Duty (PSED), section 149 (1) of the Equality Act 2010 and the health inequalities duties set out as section 13G of the National Health Service Act 2006 as amended.

Structures and process that support collaborating with people and communities

We have placed the voice and experience of people and communities in LLR at the heart of the work of the ICB and as a golden thread through the governance structure with establishment of the Patient and Public Involvement Assurance Group (see Appendix 1 outlining the ICB governance structure) and the System Engagement Group. This is supporting the system and all partners to understand what people need, what is working, what can be improved and how we can work together to deliver what matters to the people we serve.

Evidenced based insights and business intelligence, based on the experiences of people into the delivery of safe, high quality and compassionate care is reported into the ICB board through the Quality and Safety Committee, which assures that the data is being acted upon.

In addition, the Public and Patient Involvement Assurance Group (PPIAG), a group of independent people using service in LLR:

- Reviews and assures the health system that appropriate engagement and involvement has been undertaken across all communities yielding high quality insights.
- Reviews the impact that the insights have had on decision making and service redesign.

The PPIAG had an extensive programme of work in 2022/23, through this forum we have reviewed and received assurance on the following nine programmes of work:

a) Involvement of people and communities in the development of the People and Communities Strategy 2022/24.

b) Involvement of services users in the redesign of Non-Urgent Patient Transport Services.

c) Involvement of people and communities in the future of community and primary care services in Melton Mowbray.

d) Involvement of people and communities in the design of enhanced access of primary care across 26 Primary Care Network.

e) Proposed model of care for involving children and young people.

f) Involvement of people and communities in Hinckley and Bosworth in the design of proposed improvement of community health services. (Mid-point Review of public engagement).

g) Approach to reinvigoration of Patient Participation Groups.

h) Alignment of insights and data reviewed between PPIAG and Quality and Safety Committee.

i) Approach to the development of the VCSE Alliance.

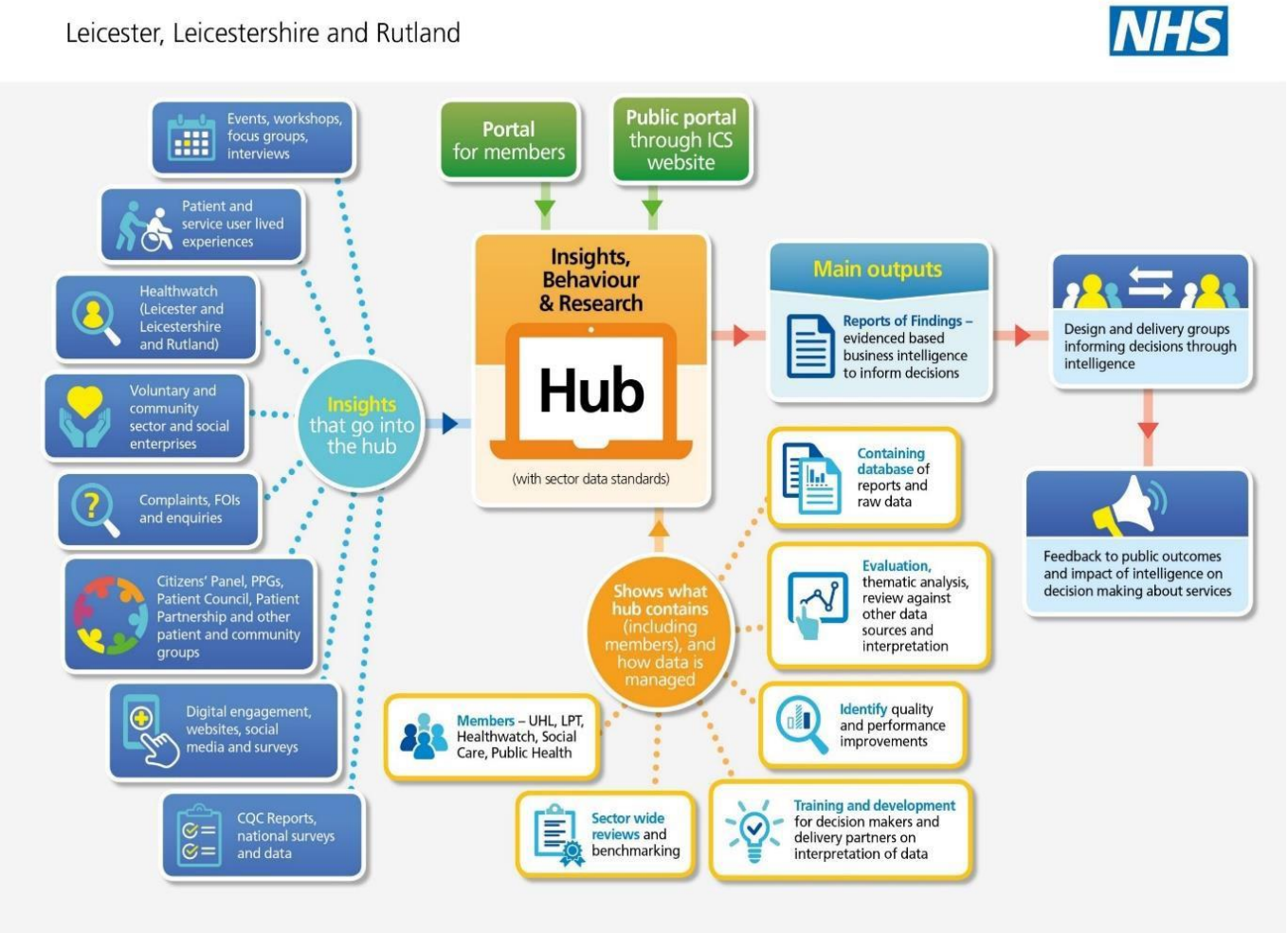
The group also reviewed patient experiences of GP practices from local research and the national GP patient survey. While the group understand that a range of plans are progressing, they could not provide assurance that the insights were yet having an impact on the decisions being made and the patient experience was improving. The PPIAG will continue to review experiences to provide assurance in the future.

Managing and using insights

Insights and data collected from patients, services users, carers, staff and public is managed through the Insights, Behaviour and Research Hub. This places the voice of people and communities on an equal footing with other key operational data including population health management and business intelligence.

The hub contains raw data and Reports of the Findings produced by local NHS bodies and other local organisations including Healthwatch Leicester and Leicestershire and Healthwatch Rutland. The hub is an engagement architecture for hearing from patients, public, staff and carers, as well as key organisations and groups, who provide valuable information about experiences of health and care. Figure 9 shows how the hub is evolving. It also outlines the hub partners, data retrieval system and management system, publication schemes, both with partners and the public and the feedback mechanisms.

Figure 9: the Hub



Having good analysis is important, but the ability to interpret and use the information effectively is an essential element in any learning health care system. We ensure that insights are interpreted and utilised in planning and decision-making across the ICB meetings and also in programmes of work with our partner organisations.

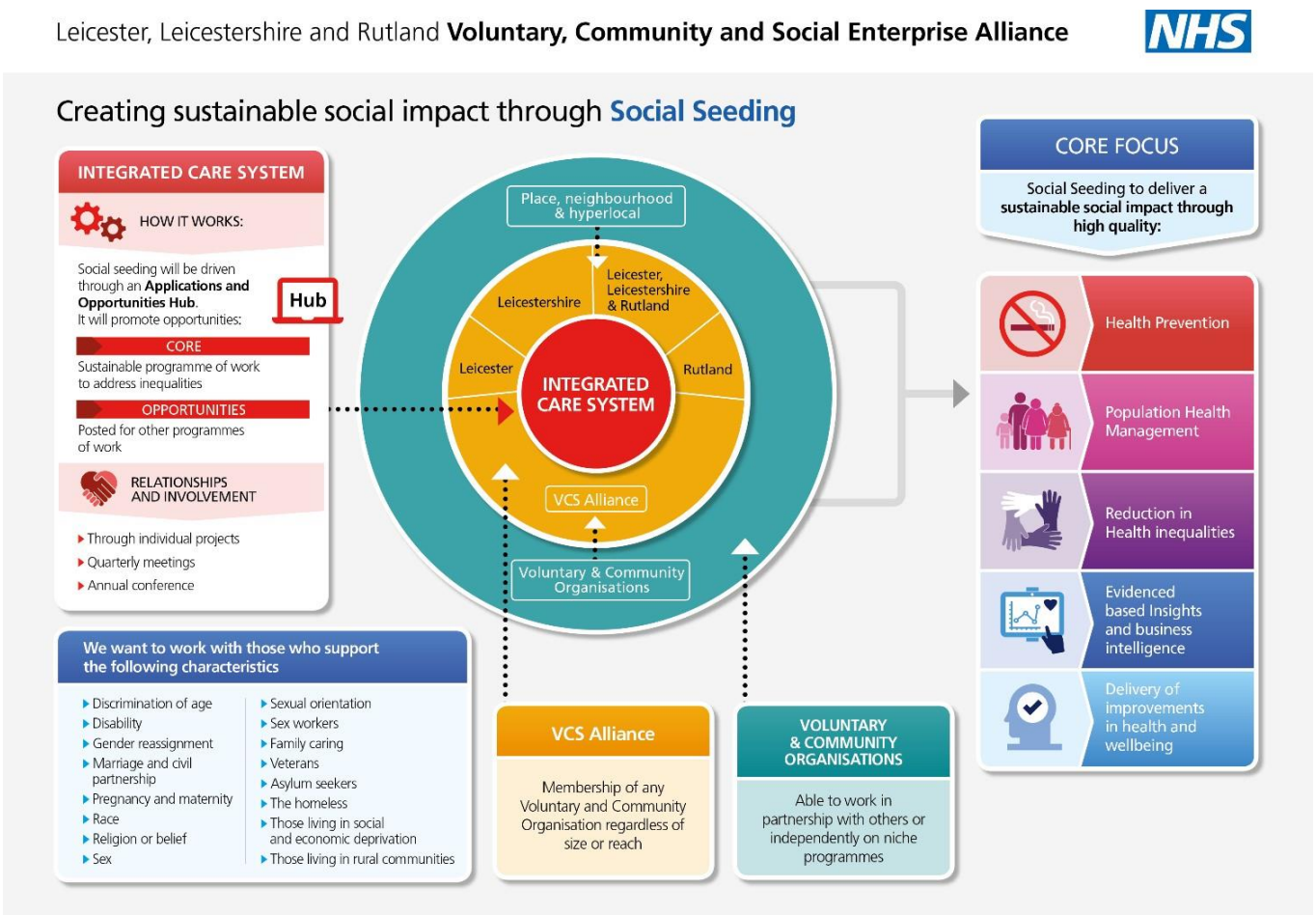
We also ensure that we feedback to people and communities, so that they can see how their voice has impacted on services and redesign.

Voluntary, Community and Social Enterprise Collaboration to reduce inequality

The Voluntary, Community and Social Enterprise (VCSE) contribute to shaping, improving and delivering healthcare services. They also support the development and implementation of plans that tackle the wider determinants of health.

Figure 10 shows a model of how we effectively include this diverse and creative sector through a co-designed Alliance, launched in November 2022, that ensures the sector influences decision making, whilst remaining resilient and an effective part of the health system. This work where appropriate, is financially recompensed recognising that the sector needs to maintain financial resilience through longer term income sources.

Figure 10:



Since the VCSE Alliance launched on 23 November 2022 we have invested circa £112,000 through the Opportunities Hub, via 32 VCSE organisation, supporting the delivery of 5 strategic projects. The projects include:

- Engaging women and families through the Maternity Voices Partnership to improve maternity and neonatal services.
- Engaging South Asian communities to improve outpatient clinics at University Hospitals of Leicester.
- Engaging diverse communities within a 1-mile proximity of A&E Leicester and on main arterial routes into Leicester, involving people in making better decisions about their health, preventing illness and caring for themselves, thus avoiding the A&E department.
- Engaging people to actively volunteer to shape and improve services at their local GP practice.
- Engaging people to shape the future of community services in Hinckley and Bosworth.

These projects have yet to report fully their outcomes for patients. We will report on population health outcomes when each programme of work comes to fruition.

In addition, we also have:

- 511 VCSE subscribers to the online Alliance Forum
- 152 VCSE Alliance members who are signed up to the VCSE Directory and the Opportunities Hub

Our work and achievements in 2022/23

During 2022/23 we have maximised our engagement with patient, carers, service users, staff, stakeholders and communities by building stronger foundations by working with local authorities at the city, county, district and parish council level, driving out organisational boundaries. This is supporting us to tackle the inequalities agenda, where joint working has considered the wider determinants of health such as housing, education, transport, employment and the environment. Full details of our programme of engagement can be found on our website (https://leicesterleicestershireandrutland.icb.nhs.uk/be-involved/). Here are some of our key initiatives:

Maximising partnerships

System engagement partners meet monthly comprising of engagement professionals from health organisations (commissioners and providers), Healthwatch Leicester and Leicestershire and Healthwatch Rutland, to discuss strategy and operational issues. In addition, both Healthwatch organisations meet the LLR ICS Chief Executive every six weeks and sit on the ICB Board and on a range of collaboratives and design groups.

Communications and Engagement specialists from across the Health and Wellbeing Partnership meet weekly and through this group have developed a joint approach to many campaigns and initiatives, particularly relating to improving access to services and reducing pressures.

In addition to the PPIAG, we have a network of 240 Patient Participation Group (PPG) members that meeting monthly either online or face-to-face. This network has traditionally had the ability

to network on behalf of the NHS, amplifying messages to their local communities and provide insights.

During the pandemic many PPGs have been less active, but we are working with our 136 practices to reinvigorate their PPG and have launched a campaign in February 2023 to recruit volunteers to engage in their practice. We have also produced a Practice Toolkit for Practice Managers with tips and processes to develop and manage their PPG and overall engagement of people and communities. The toolkit reduces duplication of effort for practices at a time of significant pressure.

Working with children and young people

We have a joint engagement post for the ICS, dedicated to the engagement of children, young people and families.

During the last year, we have introduced a new Children and Young People's Engagement policy, embedding the Lundy Model into its practice. The model helps us to meaningfully and effectively implement a child's right to participate.

We have also engaged children and young people, gaining insights and understanding that have contributed to business cases. They include redesign of our Asthma Hub, Neurodevelopment and the Mental Health Pathways. We are currently engaging with young people to find out their view on GP remote consultations and their appetite to use digital services to support social prescribing.

We also co-chair Leicestershire Partnership Trust's Youth Advisory Board. This is a group of eight young people that also links with University Hospitals of Leicester's Youth Forum. Both groups support young people to present their lived experience.

In 2022/23 we have engaged 22 organisations that work with children and young people, including, youth clubs, schools for Special Educational Needs and local authority children and young people groups including Family Lifestyle Club and a Youth Parliament. We have also engaged with 145 children, young people and parents/carers, many in a variety of settings.

Providing insights to inform decision making and shape services

Through our Behaviour, Insights and Research Hub we store and retrieve data and insights from people and communities and work with collaboratives, neighbourhood-led plan groups and design cells to ensure the business intelligence informs plans and decision-making.

In 2022/23 we have supported the development of Health and Wellbeing Plans in the counties of Rutland and Leicestershire and in the city of Leicester.

We have also provided thematic insights to support the development of plans for neighbourhoods including Charnwood, Melton and Hinckley and Bosworth.

Engaging support to family carers

At the beginning of 2023, in partnership with organisations across the health and care system, a Carers Strategy was developed, which is now being implement. The vision for all carers is to identify them early, and ensure they feel valued and respected. They will be offered appropriate support wherever possible to enable them to continue their caring role and maintain their own health and wellbeing'.

Engagement and consultation

We have supported four practices in 2022/23 to undertake consultation and engagement activities supporting improvements, efficiencies, procurements and mergers to take place at a practice population level.

We have undertaken six engagement programmes. This has included proposals for enhanced community services in Hinckley. 3,364 people participated sharing their views and what matters most. In addition, prior to the introduction of enhanced access 44,000 people participated in work to improve local access. This engagement was undertaken jointly across the ICB and Primary Care Networks.

In 2022 we also looked at the future healthcare needs of people in Melton Mowbray and asked people to join a conversation on plan for services provided within general practices in the area. 3,214 people participated and their insights helped shape future services in the area. We also talked to 206 service users, carers and staff all in healthcare setting to hear their experiences of Non-Urgent Patient Transport Services to inform a redesign of the service.

After detailed analysis of the national GP patient survey, we provided hyperlocal work to 10 practices where experience of access was poor. This work reviewed practice engagement across a range of mechanisms and make recommendations for improvement.

Online Citizens' Panel

The online Citizens' Panel provides a systematic approach to gathering insight and feedback, while people are on the go – commuting or with little time. A range of health and care issues are discussed by a representative sample of our 1.1 million population. The panel comprising of 1,186 members, who we endeavour to ensure are demographically and attitudinally representative of our populate provide views on a range of services and have supported all our engagement activities.

Engagement case study

Our Hinckley Community Health Services which closed in March 2023 involved people in a discussion about a range of services based in central Hinckley. The very local consultation received 3,364 responses.

We asked people about proposals to invest in more care closer to home and improve existing building with the development of a Clinical Diagnostic Hub, Day Care Centre and Physiotherapy Hub.

We used a multi-channel approach, both online and offline tools and techniques. Among the many different activities carried out, we built on previous work and commissioned 12 voluntary, community and social enterprise organisations to reach out to seldom heard and often overlooked communities, gained extensive media coverage, used organic and paid for social media to reach out to 400,000 Facebook in the local area.

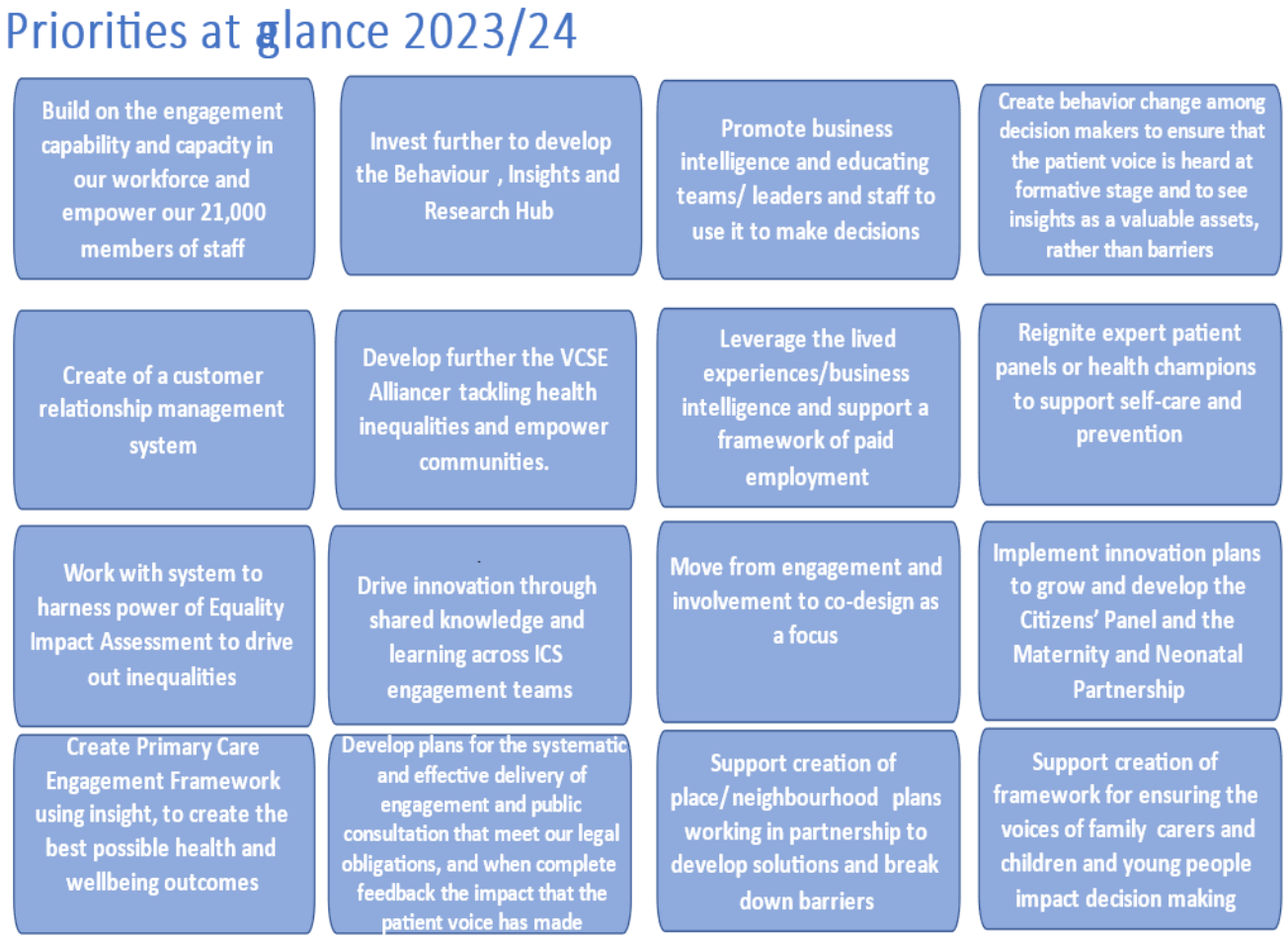
We held 67 events, most of which were hyperlocal hosted by voluntary and community groups. Separately we hosted bespoke focus groups with children and young people. We carried out email marketing to schools, and engaged local businesses. The local PPGs supported the engagement, as did the local authority.

The insights from this engagement have been captured in a Report of Findings which has been published. The insights have been continually fed through to commissioners and providers throughout the engagement and the Report of Findings is influencing the planning and implementation of the new services.

Future planning

Outlined below are our priorities for 2023/24, which will enable us to deliver on the second year of our ICB People and Communities Strategy.

Figure 11:



Improving health and reducing health inequality

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.

Under Section 14Z35 of the Health and Social Care Act 2022 we have a duty to reduce health inequalities for patients across Leicester, 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.

The ICB 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 ICB are concerned about and a Health Inequalities Framework has been developed to seek to address some of these issues.

In February 2023, the ICS held a workshop on health inequalities analysis. The objectives of this session were to:

- Bring together analysts across LLR to build our shared understanding of the breadth and depth of work that is taking place around health inequalities;
- Build knowledge around the datasets that are being used to explore health inequity;
- Share learning around techniques and tools that are being used to analyse health inequity.

Population health management

Population health management (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 ICB 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 2022-23 the ICB 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.

During 2022/23 we established the health inequalities support hub (HISU) to support the delivery of our statutory duty to reduce health inequalities by initial establishing an understanding of the current health inequalities data and information across LLR and then monitor delivery. The HISU will be responsible for developing a reporting framework for Core20Plus5 for adults and other specific areas of health inequalities, it will develop a knowledge management strategy for health inequalities work across the ICB and develop a data quality improvement work programme for health inequalities data across LLR.

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.

Equality, inclusion, and human rights

This section of the report sets out how the ICB 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 ICB, 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 ICB'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, ICB 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 ICB 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 2022/23 we reflected on the progress we have made against the goals within the Equality Delivery System (EDS2), details of which are available on the ICB website. The Equality, Diversity & Inclusion (EDI) Annual Report for the period 2022/23 is available on the ICB 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 ICB carefully considers the potential impacts of decisions regarding services and involves communities in decision making in line with 'Brown and Bracking principles.'

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 ICB Equality and Inclusion Strategy and Objectives were refreshed and dovetail with the system wide approach to equality and inclusion. Further details can be found on our website.

Workforce Race Equality Standard (WRES)

During 2022/23, the LLR ICB developed an action plan to deliver the Workforce Race Equality Standard (WRES). This will be reviewed and updated regularly and at least annually to meet the WRES reporting cycle. The WRES is published on the ICB website https://leicesterleicestershireandrutland.icb.nhs.uk/ .

Health and wellbeing strategy

The ICB's strategic aims and policies are aligned to the Joint Health and Wellbeing 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 July 2022 to March 2023 our contribution to the Leicester, Better Care Fund (£21.3m) Leicestershire Better Care Fund (£34.4m) and Rutland Better Care Fund (£2.0m) 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 non-Covid-19 related needs of people.

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 ICB'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 Leicester, Leicestershire and Rutland and hence have worked closely with both Leicester City Council, 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:

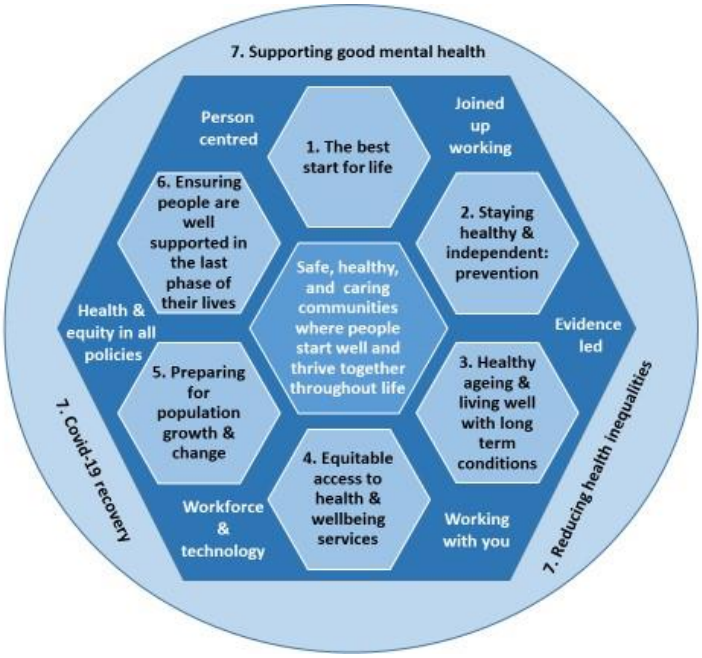
https://politics.leics.gov.uk/ieListDocuments.aspx?CId=1038&MId=6942&Ver=4

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. One specific example relates to 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, healthy 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 former clinical commissioning groups and agreed to vacate two of the three offices and retain a single office co-located with Leicestershire County Council at County Hall in Glenfield in Leicestershire. This reduced the CCG / ICB office footprint by 74% to just 641sqm at County Hall.

  In December 2022, the ICB approved the LLR Green Plan, which builds on the achievements of the ICB and other partners, and sets our commitments, in areas 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 ICB 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. Our new starter pack and induction process highlights climate change and the aims of the system Green Plan to all newcomers, to embed a culture of responsible and sustainable practice.

- **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.

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

Following the dissolution of the three predecessor CCGs on 30 June 2022, the LLR ICB was formed on 1 July 2022, operating with the same Commissioning responsibilities and overall financial regime of the former CCGs. The financial results in this report cover the period 1 July 2022 to 31 March 2023. The Annual Report and Accounts for the predecessor CCGs for the period to 30 June 2022 are available separately.

The total funding for ICB from July 2022 to March 2023 was £1,547.5m (£1.548bn). This allocation is received in three parts:

- Programme: £1,384.9m
- Primary Care Co-Commissioning: £145.6m
- Running Costs: £17.0m

As the NHS is emerging from the Covid-19 pandemic, 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, as the focus of the NHS increasingly switches to restoration of services and Elective (planned care) recovery.

For 2022/23 the three LLR predecessor CCGs continued to plan collectively, working as a system and agreed a breakeven plan for year, managed by the three CCGs for April to June 2022 and then by the ICB until March 2023. 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 30 June 2022, the LLR CCGs had delivered a collective £3.6m surplus, largely due to slippage in non-recurrent investments. Net negative allocation adjustments were undertaken to account for this slippage and effectively transfer the surplus into the ICB. The split of this adjustment per CCG was:

- East Leicestershire and Rutland CCG £1.542m
- Leicester City CCG £3.284m
- West Leicestershire CCG £(1.190)m
- Total adjustment £3.636m

Prior to the allocation adjustment, the West Leicestershire CCG was in deficit at the end of June, largely due to leading on a range of expenditure areas on behalf of the system including Covid-

19 vaccination centres. The other two CCGs surpluses were largely due to slippage in investments they were hosting on behalf of the system.

Financial planning for 2022/23 confirmed the LLR system was facing significant financial challenges. The underlying position of the CCGs being a recurrent deficit when exiting 2021/22, was exacerbated by a reduction in Covid-19 support funding, when many of the services put in place or enhanced to respond to the pandemic, were still required to maintain current demand and restore elective (planned care) performance.

A breakeven plan for the year was produced which contained a challenging savings (efficiency) requirement and a number of further risks that would require mitigation.

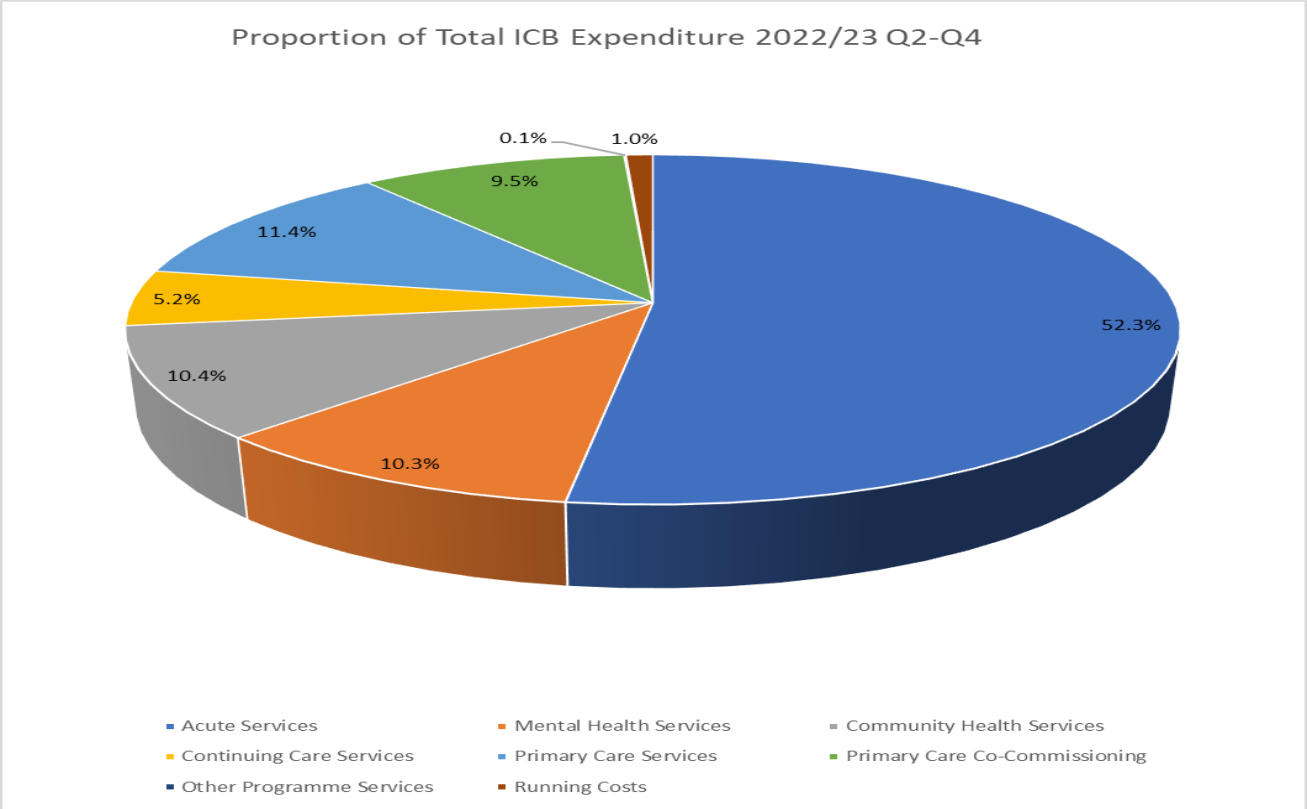
The financial performance of the CCGs and then ICB has been monitored on a monthly basis by the Executive Management Team (EMT) with regular reports to the Finance Committee and Governing Body. The key financial risks that the CCG and the successor ICB faced throughout the year were as follows:

- assure local health economy financial viability over the next 5 years.
- 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 EMT and included the identification of further in-year efficiencies and review of planned investments.

During the summer of 2022, the LLR system recognised that they did not have enough identified efficiencies and other mitigations to assure a breakeven forecast was still deliverable and embarked on a Financial Recovery programme. This programme resulted in the identification of a potential £48m of additional mitigations and cost control actions required by the ICB and the two local NHS Trusts, UHL and LPT to identify further savings plans. These actions were allocated to Senior Responsible Owners (SROs) and performance managed through the System Executive Group.

Figure 12:



As the year continued, progress was made on these and other mitigations but system discussions with NHSE confirmed a likely aggregate deficit of £20m for the year. Following receipt of additional allocations at the end of the year this was reduced to £14.9m and agreed as a revised in year target for the system. Within this net target, the two Trusts would overspend as they were not able to fully control their costs and the ICB would be set a target of a surplus of £0.6m.

The final results of the ICB show that the target has been achieved and a surplus of £0.62m has been declared. This represents a significant achievement by the ICB and its staff despite the significant pressures faced when considering the additional work involved in dissolving the three CCGs and establishing the ICB.

How we spend our money

Expenditure Profile

In July 2022 to March 2023 the ICB spent £1,546.88m (£1.55bn) 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 ICB had an allocation for July 2022 to March 2023 of £17.0m (1.1% of total CCG allocation) to spend on administrative staff costs and non-pay. Administrative costs incurred by the ICB must not exceed this allocation and were £14.7m for the period. This underspend of £2.3m arose from maintaining several staff vacancies throughout the year and delaying redevelopment of the Corporate HQ in order to direct more resource to front line patient care. The following analysis shows the Running Cost spend per head of population:

- Running costs £14.7m.
- Weighted population (number) 1,146,595.
- Running costs per head of weighted population £12.85.

Capital Expenditure
The ICB received no capital allocation from NHS England for the period July 2022 to March 2023

Cash Balance
NHS England guidance specified that the ICB's bank balances as at 31 March 2023 should be less than £2.1m. The actual bank balance was £0.39m and therefore the target has been achieved.

Principles of remedy

Our ICB'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 focused 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 July 2022 – March 2023 we received a total of 108 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 ICB commissioning decisions and complaints in relation to the care and treatment provided by the providers that the ICB commissions services from.

ACCOUNTABILITY REPORT

Andy Williams
Accountable Officer
26 June 2023

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 period 1 April to 30 June 2022, including membership and organisation of our governance structures and how they supported the achievement of our objectives.

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.

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.

Corporate Governance Report

Members Report

The Board of LLR ICB comprises the following members:

Member	ICB Board role	Role in partner organisation
Mr David Sissling	ICB Independent Chair	N/A
Mr Andy Williams	ICB Chief Executive	N/A
Ms Caroline Gregory (from August 2022)	Chief Finance Officer	N/A
Dr Nil Sanganee	Chief Medical Officer	N/A
Dr Caroline Trevithick	Chief Nursing Officer	N/A
Ms Sarah Prema	Chief Strategy Officer	N/A
Sir Mayur Lakhani CBE	Clinical Executive Lead	GP and Chair of the ICB Clinical Executive Meeting
Ms Simone Jordan	Non-Executive Member – Remuneration and People	N/A
Mr Darren Hickman	Non-Executive Member – Audit and Conflicts of Interest	N/A
Mrs Pauline Tagg, MBE	Non-Executive Member – Quality, Safety, Performance and Transformation	N/A
Prof Azhar Farooqi	Non-Executive Member – Health Inequalities, Public Engagement, Third Sector and Carers	N/A
Mr Richard Mitchell	Acute sector representative	Chief Executive Officer, University Hospitals of Leicester NHS Trust
Ms Angela Hillery	Community / Mental Health sector representative	Chief Executive Officer, Leicestershire Partnership NHS Trust
Mr Mike Sandys	Local authority sectoral representative (with children's and adult's social care and / or public health)	Director of Public Health, Leicestershire County Council
Mr Martin Samuels	Local authority sectoral representative (with children's and adult's social care and / or public health)	Strategic Director, Social Care and Education, Leicester City Council
Mr Mark Andrews	Local authority sectoral representative (with children's and adult's social care and / or public health)	Chief Executive, Rutland County Council
Dr Nainesh Chotai (from September 2022)	Primary Care sector representative	GP

David Sissling, Independent Chair

David lives in Leicestershire and started his career in the NHS some 30 years ago. He has wide-ranging leadership experience at organisational, regional and national level. He was Chief Executive of the Leicester Royal Infirmary, Northamptonshire Health Authority, Leicestershire, Northamptonshire and Rutland Strategic Health Authority and Kettering General Hospital. David also held prominent roles in the devolved administrations: Chief Executive of the Northern Ireland Health and Social Care Authority, Chief Executive of the Welsh NHS and Director General of the Welsh Government Department of Health, Social Care and Children. He was also Programme Director for Healthcare for London - a major transformation programme across the capital city; and up until March 2023 he was a Senior Leadership Advisor for NHS England, offering coaching and mentoring support to those in leadership roles. David's areas of particular interest include leadership development, integration, prevention, research and clinically-led service change. He currently works as the Independent Chair of the Leicester, Leicestershire and Rutland Integrated Care Board.

Andy Williams, Chief Executive

Andy Williams is the CEO of the Integrated Care Board, Andy will work with colleagues, communities and partners to deliver a long-term strategy to achieve these ambitions whilst continuing to focus on shorter-term priorities including the continued vaccine rollout and elective waiting list recovery. 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 ICB since its inception in 2013. During his tenure, that organisation was twice awarded the prestigious ICB of the Year accolade at the industry-wide Health Service Journal (HSJ) Awards. Since arriving in Leicester in November 2019, Andy has worked with clinical leaders to bring the CCGs together and promoted partnership working within the NHS as part of the journey to forming the new Integrated Care Board. He has also worked with local government to reset relationships leading to significant investment in health and social care as part of a partnership plan for LLR.

Dr Caroline Trevithick, Chief Nursing Officer and Deputy Chief Executive

Caroline has a wealth of experience gained over many years and in a variety of healthcare settings, at local, regional and national level. She has worked in NHS quality management/clinical governance since 1995. Caroline brings extensive knowledge of the NHS from the frontline services to senior and strategic level and her primary focus has always been quality, safety and patient experience. She has an extensive background in nursing management and leadership, most recently in 2020 she was appointed as the single Executive Director of Nursing, Quality & Performance and Deputy Chief Executive for all three CCGs in Leicester, Leicestershire & Rutland and retains her responsibility for all aspects of high quality, safe patient care. In July 2021 Caroline was delighted to be awarded an Honorary Doctorate by Loughborough University for her leadership of the LLR COVID Vaccination Programme. She believes that high quality, safe care should be the basis of all we do, to improve outcomes for patients and improve the cost effectiveness of the NHS, both of which are essential. Outside of work, Caroline has a range of hobbies including dog walking, motorbiking and wild swimming.

Sarah Prema, Chief Strategy Officer

Sarah has had a career in the public sector since leaving school. Prior to 2001 this was in local authorities and since then she has worked in various roles in the NHS mainly within commissioning organisations. She joined Leicester City ICB in 2011 as Director of Strategy and Implementation where she had corporate responsibility for strategic development; operational planning; service redesign commissioning; and medicines optimisation. In 2020, Sarah was appointed as Executive Director of Strategy and Planning for the Leicester, Leicestershire and Rutland CCGs where she has corporate responsibility for strategic development; operational planning; strategic estates; strategic Business Intelligence; place planning; population health management; and health inequalities. In February 2022 Sarah was appointed to the role of Chief Strategy Officer in the Leicester, Leicestershire and Rutland Integrated Care Board.

Caroline Gregory, Interim Chief Finance Officer

Caroline has over 20 years of NHS experience and has spent more than 80 per cent of that period at senior management and board level. Her extensive career with numerous provider and commissioner organisations has provided her with an in-depth knowledge across a range of key NHS areas including mental health, community, learning disabilities, primary care groups and most recently CCG. She initially worked in the NHS across Oxfordshire, Berkshire and Buckinghamshire and has spent the last 10 years in the Bath, Northeast Somerset, Swindon and Wiltshire health system. As a highly experienced financial director, Caroline has a passion for achieving results and better outcomes for service users.

Dr Nil Sanganee, Chief Medical Officer

Dr Sanganee has been a GP since 2004, working as a Partner at Castle Medical Group in Ashby. Being passionate about medical education, he has also worked as a GP Trainer, Medical Student Tutor, GP Appraiser and Examiner for the Royal College of GPs. He has been a longstanding Board Member for West Leicestershire ICB (WLICB) and since 2020, was the Vice Chair of the ICB, leading on a wide range of clinical pathways and driving improvements in the quality of care. In his role as Medical Director for the LLR Integrated Care Board, Dr Sanganee will oversee the Clinical Strategy and priorities for the transformation of high quality, accessible services within primary, community and hospital sectors to ensure that we are delivering the highest standards of care and achieving the best outcomes for our patients. He is keen to champion the role of a broad range of health and care professionals both at the frontline of patient care and in leadership roles across the system. Using his experience as a clinical leader in LLR, he will continue to listen and respond to patients' views to improve the service that our citizens experience locally and to optimise the health of our population overall, whilst driving down inequalities in health and care outcomes.

Sir Mayur Lakhani CBE, Clinical Executive Lead

Sir Mayur Lakhani CBE, FRCP, FRCGP, SFFMLM, RCPathME, is a practicing GP and experienced medical leader. He is Chair Designate of the ICS Clinical Executive team where his role is to spearhead excellence in clinical leadership, coordinate and represent the voice of health and care and professionals. He has been a GP partner at Highgate Medical Centre in South Charnwood, Leicestershire, since 1991. He was a senior clinician on the national covid clinical assessment service (CCAS-1) and has recently completed training to be a Medical Examiner (RCPathME). Mayur led work leading to the publication of the 10 principles for recovery and restoration post COVID in Leicester, Leicestershire and Rutland. He is former Chairman and President of the Royal College of General Practitioners, roles in which he promoted high quality general practice. He was also Chair of the National Council for Palliative Care from 2008 to 2015. He is currently Chair of the Faculty of Medical Leadership and Management (FMLM).

Professor Azhar Farooqi, Non-Executive Member

Professor Azhar Farooqi qualified from the University of Manchester Medical School in 1983 and has been a GP at the East Leicester Medical Practice since 1987. He was elected a Fellow of the Royal College of General Practitioners (RCGP) in 1991. Professor Farooqi's main research interests have been in diabetes and ethnic minority health issues. He has published around 100 peer reviewed papers, as well as a book on diabetes in primary care and several book chapters. National work has included advisory work for Diabetes UK, the British Heart Foundation and the Department of Health. In 2007, Professor Farooqi was awarded an OBE for services to medicine and health services. In 2011 he was elected by Leicester GPs to chair the Leicester City Clinical Com-missioning Group. He was re-elected three times and served in this role up to the formation of the LLR ICS in 2022. His other roles include Clinical Director of the EM CRN (NIHR) and co-Clinical Di-rector of the NHSE Midlands Diabetes and Vascular clinical network.

Darren Hickman, Non-Executive Member

Darren was the Finance and Relationship Director for the Insurance Company of Santander Bank, until December 2019. During his 37 years at the bank, he gained a broad experience, holding a variety of executive positions including Operational Management, Marketing,IT and Change Management. Since, January 2014, he has served as a Non-Executive Director (NED) and Audit & Risk Chair for Leicestershire Partnership NHS Trust. Stepping down from this position to become the NED and Audit & Risk Chair for ICB. Since finishing his substantive career he has focused on NED and board advisory roles. The majority of these have been centred in the Midlands region, working for the Earl Shilton Building Society and Northampton Children's Trust.

Pauline Tagg, MBE, Non-Executive Member

Pauline has had a long and successful career in the NHS and In 2022, celebrated her 50-year anniversary of working in the NHS. She worked in the acute sector for over 35 years as a nurse, midwife, and senior leader. During this time, she held executive nurse director posts in three NHS hospital trusts, the most recent being the University Hospitals of Leicester NHS Trust from November 2000, until she retired from her Executive career at the end of July 2008. Then followed a brief period of consultancy in the then Trent Region and Lay member roles in primary care in Leicestershire. In January 2009, Pauline was awarded an MBE for her contribution to healthcare in Leicestershire. Pauline joined East Midlands Ambulance NHS trust Board as a Non-Executive Director in 2011 and was appointed to the role of Chairman in November 2013 and will complete her last term of office at the end of July 2022. Pauline also held a Trustee role at LOROS for seven years until she joined VISTA (the local LLR charity for people with Visual impairment) as the Chairman of Trustees from January 2020 to March 2023.

Simone Jordan, Non-Executive Member

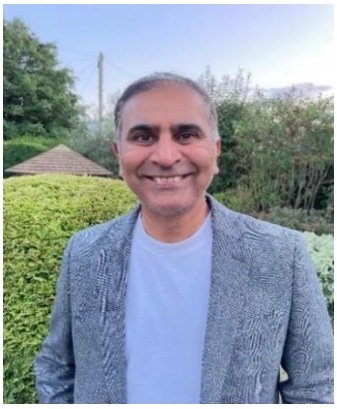
Simone is an experienced Executive working at Board, system and national levels for almost thirty years in the NHS – as a Chief Executive, Executive and Non-Executive Director. She also has significant Board development and governance expertise. Her other UK experience includes service and hospitality sectors, manufacturing, health, higher and further education and other public sector organisations. She has also worked internationally advising government on healthcare reform and has been a speaker at international conferences on change and improvement. Simone now works independently as a consultant and coach. With professional qualifications in HR and OD, an MBA and significant expertise in quality improvement, Simone has led major organisational change programmes and is passionate about workforce and staff experience and wellbeing.

Angela Hillery, Partner Member - Community / Mental Health sector representative

Angela is the shared Chief Executive of two NHS Trusts, providing Mental Health and Community health services in Leicester, Leicestershire and Rutland (Leicestershire Partnership NHS Trust) and Northamptonshire (Northamptonshire Healthcare NHS Foundation Trust). She was appointed to LPT in July 2019, when NHFT provided a buddy trust support relationship to LPT. In April 2020 both trusts formed a group model recognising mutual opportunities to continue to learn together. Angela's NHS career spans 33 years and she has led many leadership positions, including Director of Operations. She has also been listed in the HSJ Top 50 rated CEOs three times and was a finalist for 'Chief Executive of the Year' at the HSJ Awards. In July 2019 Angela was awarded an Honorary Doctorate from the University of Northampton for her leadership contribution. Alongside other CEOs, Angela is part of a pioneering East Midlands Alliance for mental health and learning disabilities, working together to improve the quality and effectiveness of services. Angela is committed to working in collaboration with system partners to create high quality, compassionate care and wellbeing for all.

Richard Mitchell, Partner Member - Acute sector representative

Richard re-joined UHL as Chief Executive in October 2021 having worked as the chief executive of Sherwood Forest Hospitals NHS Foundation Trust for four years. In 2020, SFHNFT was voted HSJ Acute/ Specialist Trust of the Year and its Acute site was rated Outstanding by the CQC. In 2021 the Trust finished third out of 119 NHS Acute Trusts in the NHS Staff Survey. Richard previously worked as deputy chief executive and chief operating officer for four years at UHL and before that, he worked at Imperial College Healthcare NHS Trust and Guy's and St Thomas' NHS Foundation Trust in senior management roles. Richard is married with two children and is the Chair of the East Midlands Cancer Alliance and Midlands Regional and Talent Leadership Board.



Dr Nainesh Chotai, Partner Member - Primary Care Partner Member

Dr Nainesh Chotai has been a county GP since 1995. He continues in full-time practice working as executive partner, GP trainer and medical student tutor at a large sub-urban practice. He is also clinical director of G3 PCN. Over the last seven years he has been chair of the Leicester, Leicestershire and Rutland Local Medical Committee (LLR LMC) and will continue in this role until his term comes to an end. The Local Medical Committee represents the interests of GPs in LLR and Dr Chotai has formed constructive relationships with leaders across the system in his role with the LMC. He is honoured to have been put forward by his GP colleagues for his position with the LLR ICB and hopes to use his personal experience to further the seamless care of patients by realising true cohesion with system partners.

Mark Andrews, Partner Member - Local authority sectoral representative

Mark Andrews became the permanent Chief Executive for Rutland County Council in in June 2021, after taking on the interim role in August 2020. He has worked in local government for 20 years, with over 14 years in senior leadership roles. He has successfully led a wide range of services in his career, predominantly in the Children's and Adult's sectors, and has held the position of Vice Chair for the Association of Directors of Adult Social Services in the East Midlands. In his spare time, Mark coaches the local U16 Rugby team, as well as being a keen trail runner.

Mike Sandys, Partner Member - Local authority sectoral representative

Mike Sandys is Director of Public Health (DPH) for Leicestershire County Council and Rutland County Council, being appointed to the post in February 2014. Mike has worked in public health since the early 90s in a number of public health intelligence, research and development, manager and consultant roles for both the NHS, local government and academia. Mike moved to the East Midlands in 2005. Before that he spent most of his career working across Greater Manchester and Merseyside. Mike's public health interest lies in the health improvement capability of asset-based community development approaches, moving public health from a focus on disease and illness to one that recognises the context in which people live their lives. Mike is a passionate advocate for physical activity and is vice chair of the LLR Active Together partnership and a trustee of the national active partnerships body. During the COVID pandemic Mike played a leading role in the response from LLR organisations.

Martin Samuels, Partner Member - Local authority sectoral representative

Martin has responsibility for the full range of adult social care, children's social care and education services. He has been with Leicester City Council since March 2020 and has had a varied career, having started his working life in the Civil Service, with a number of years spent working in Whitehall. Martin then worked in the NHS for almost a decade, undertaking roles at national, regional and local level, including as Director of Commissioning for a PCT. Martin moved to Local Government in 2011 and has been a statutory Director of Adult Social Services (DASS) since 2015 and a statutory Director of Children's Services (DCS) since 2018. He is active both regionally and nationally with the Association of Directors of Adult Social Services (ADASS).

Board participants

Rachna Vyas, Chief Operating Officer

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. She has also held a number of system lead posts covering elective and non-elective services within the Leicester, Leicestershire and Rutland footprint. As the LLR health and care system has developed, her transformation portfolio has developed into whole system transformation, across all sectors. Since June 2020, Rachna held the position of Executive Director for Integration and Transformation for the three CCGs in Leicester, Leicestershire and Rutland. In this role she was responsible for the design and delivery of transformed models of care at system level for urgent care, elective care, children's services, all age mental health and learning disability services, as well as integration of services at place and neighbourhood level and Emergency preparedness for the LLR system. Rachna also holds an Honorary Lecturer position at the University of Leicester in recognition of ongoing work around health equity, and is also a Trustee for Growing Points, a charity focused on social mobility.

Alice McGee, Chief People Officer

Alice started her NHS career in 2007 as a national NHS Graduate Trainee on the HR programme. She has worked across a range of NHS organisations focusing on the People agenda, predominately in the Black Country and Birmingham. In 2020 Alice joined the Leicester, Leicestershire and Rutland CCGs as the Executive Director of People and Innovation focusing on transformation for our people, our population and the technology we use to deliver care. Alice is passionate about using insights from our population and our staff to drive strategy and decisions about how we deliver care ensuring that our success criteria is focused on experience of working and living in Leicester, Leicestershire and Rutland.

- **Richard Henderson, Chief Executive East Midlands Ambulance Trust**
- **Harsha Kotecha, Representative from Healthwatch Leicester and Leicestershire**
- **Dr Janet Underwood, Representative from Healthwatch Rutland**

Committee(s), including Audit Committee

LLR ICB Board committees and committee members are detailed within the Annual Governance Statement.

Appendix 1 provides the committee / governance structure.

Register of Interests

The LLR ICB Board Register of Interest is updated on a regular basis, the most recent version is available on the ICB's website at www.leicesterleicestershireandrutland.icb.nhs.uk .

Appendix 1 provides the committee / governance structure and Appendix 2 provides the Register of Interests as at 31 March 2023.

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

NHS LLR ICB fully supports the Government's objectives to eradicate modern slavery and human trafficking. Our Slavery and Human Trafficking Statement for the period ending 31 March 2023 will be published on our website at www.leicesterleicestershireandrutland.icb.nhs.uk by June 2023.

Statement of Accountable Officer's Responsibilities

Under the National Health Service Act 2006 (as amended), NHS England has directed each Integrated Care Board 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 NHS Leicester, Leicestershire and Rutland ICB 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.

The National Health Service Act 2006 (as amended) states that each Integrated Care Board shall have an Accountable Officer and that Officer shall be appointed by NHS England.

NHS England has appointed the Chief Executive Officer to be the Accountable Officer of NHS Leicester, Leicestershire and Rutland ICB. The responsibilities of an Accountable Officer, including responsibility 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 Integrated Care Board and enable them to ensure that the accounts comply with the requirements of the Accounts Direction), and for safeguarding the NHS Leicester, Leicestershire and Rutland ICB's assets (and hence for taking reasonable steps for the prevention and detection of fraud and other irregularities), are set out in the Accountable Officer Appointment Letter, the National Health Service Act 2006 (as amended), and Managing Public Money published by the Treasury.

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 Leicester, Leicestershire and Rutland ICB'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.

Andy Williams
Accountable Officer
26 June 2023

Governance Statement

Introduction and context

NHS Leicester, Leicestershire and Rutland ICB (LLR ICB) is a body corporate established by NHS England on 1 July 2022 under the National Health Service Act 2006 (as amended).

The LLR ICB's statutory functions are set out under the National Health Service Act 2006 (as amended).

The ICB's general function is arranging the provision of services for persons for the purposes of the health service in England. The ICB 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 population.

Between 1 July 2022 and 31 March 2023, the Integrated Care Board was not subject to any directions from NHS England issued under Section 14Z61 of the of the National Health Service Act 2006 (as amended).

Scope of responsibility

As Accountable Officer, I have responsibility for maintaining a sound system of internal control that supports the achievement of the LLR ICB'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 the LLR ICB's Accountable Officer Appointment Letter.

I am responsible for ensuring that the LLR ICB 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 ICB as set out in this governance statement.

Governance arrangements and effectiveness

The main function of the Board 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 LLR ICB has in place a Constitution, which provides its corporate governance framework, as agreed by the Board. The ICB's Constitution consists of 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 Board, 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, other than the mandated change as requested by NHS England.

The ICB is led by a Board comprising non-executive and executive members, and sectoral representatives. The overall responsibility for the management of internal control lies with me as the Accountable Officer. The Board, 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.

Appendix 3 provides details of committees and members of each committee. The committee structure underpinning the ICB and Board 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 Board is chaired by a non-executive 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 Board 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 approved in July 2022.

The Audit Committee reviewed the Board Assurance Framework throughout the year to provide assurance to the Board 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 moderate 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. Between July 2022 – March 2023, the Audit Committee held five meetings in total. All meetings were quorate, well attended and supported by the Chief Finance Officer and the Head of Corporate Governance. The Committee produced a summary report for the Board following Committee meetings.

c) Remuneration Committee – the Remuneration Committee (statutory committee), is accountable to the Board and is responsible for considering the Remuneration policies appropriate to the ICB and in accordance with national guidance. In addition, as detailed in the Scheme of Reservation and Delegation, the Board has delegated the:

- approval of all aspects of remuneration, arrangements for terminations of employment and other contractual / non-contractual matters for the Chief Executive, Directors and Very Senior Managers
- approval of the ICB pay policy for staff including contractual arrangements and termination payments.
- approval of all aspects of remuneration and termination of appointment and other contractual / non-contractual arrangements for office holders and individuals not on either Very Senior Manager framework or Agenda for Change.

The Remuneration Committee is chaired by a Non-Executive Member. The Committee convened as required during the year with all meetings being quorate and supported by the Chief People Officer and the Head of Corporate Governance. The terms of reference were approved in July 2022 by the Board.

d) System Executive Committee – is a Committee of the Board and established to provide the Board with assurance on the day to day running of the NHS across LLR. The purpose of the Committee is to:

- Provide assurance on operational resilience and dealing with any escalations.
- Develop and monitor the yearly financial, revenue and capital, plans and the long-term financial plans and regimes for the NHS system for approval by the ICB Board.
- Develop the LLR System Long Term Strategic Plan for approval by the ICB Board.
- Develop the yearly LLR System Operational Plan for approval by the ICB Board.
- Oversee the programme and project assurance arrangements to deliver the yearly financial plan transformation priorities and strategic programme.
- Oversee quality, safety and performance at a system level.
- Oversee the development, implementation and delivery of the LLR System People Plan; Joint Estate Plan and Joint Digital and Data Strategy.
- Commission and oversee the development of the Collaboratives within LLR.
- Oversee the delegated commissioning functions from NHS England
- Approve Business Cases within delegated limits.
- Approve contracts within delegated limits.
- Manage procurement processes and approve preferred bidder within delegated limits.

The System Executive Committee is chaired by the ICB Chief Executive. The Committee convened as required during the year with all meetings being quorate. The terms of reference were reviewed and subsequently approved by the Board in October 2022.

e) Strategic Commissioning Group – the Strategic Commissioning Group is a sub-group of the System Executive Committee established by the Board to exercise the primary care commissioning functions that have been delegated from NHS England as of 1 July 2022. The Group held regular monthly meetings during 2022/23. The meetings are chaired by the Chief Strategy Officer. A summary report from the Group

is presented to the System Executive Committee at its next meeting. The terms of reference were approved by the Board on 1 July 2022.

e) **Quality and Safety Committee** was established to provide the ICB with assurance that it is delivering its functions in a way that secures continuous improvement in the quality of services, against each of the dimensions of quality set out in the Shared Commitment to Quality and enshrined in the Health and Care Act 2022. This includes reducing inequalities in the quality of care. The Committee exists to scrutinise the robustness of, and gain and provide assurance to the ICB, that there is an effective system of quality governance and internal control that supports it to effectively deliver its strategic objectives and provide sustainable, high quality care. The Committee held meeting at agreed intervals and was quorate for all meetings, and ensured regular assurance updates are presented to the Board in relation to activities and items within its remit.

f) **Finance Committee –** the purpose of the Committee is to provide to provide the ICB with assurance that it is delivering its statutory functions in relation to financial planning and management. The Committee exists to scrutinise the robustness of, and gain and provide assurance to the ICB, that there is an effective and sustainable system of financial planning and management and internal control that supports it to effectively deliver its strategic objectives and provide sustainable, high quality care. The Committee is chaired by the Chair of Leicestershire Partnership NHS Trust and met at agreed intervals during the year, providing regular assurance updates to the ICB in relation to activities and items within its remit.

g) **Health Equity Committee** has been established to provide the ICB with assurance that it is delivering its statutory functions in relation to reducing healthcare inequalities and making decisions to enable inclusion, improve overall health outcomes for patients and service users, and reduce unwarranted health inequity. The Committee exists to scrutinise the robustness of, and gain and provide assurance to the ICB, that there is an effective and sustainable system of monitoring our progress in reducing health inequalities that supports effective delivery of the ICB's strategic objectives and provides sustainable, high quality care. The Committee is chaired by a Non-Executive Member and met at agreed intervals during the year. The Committee provided regular assurance updates to the ICB in relation to activities and items within its remit.

h) **Executive Management Team meetings** – the Executive Management Team meets as a formal group reporting into the ICB Board through the various updates and reports. The purpose of EMT is to provide effective leadership that oversees all aspects of operational activities of the ICB on a day-to-day basis. It is the primary executive decision-making and operational delivery body of the ICB and is accountable to the Board for the management of the ICB and delivery of strategic objectives.

i) **Clinical Executive Group** – this is a sub-group of the System Executive Committee established to help improve clinical outcomes by providing clinical input and advice in the development and review of commissioning plans and strategies, including service design and redesign. The Chair of the Group is a member of the ICB Board.

j) **LLR Health and Wellbeing Partnership (LLR HWP)** is a statutory committee jointly formed between the LLR ICB, Leicester City Council, Leicestershire County Council and Rutland County Council. This is referred to as the Integrated Care Partnership

(ICP) within the Health and Social Care Act 2022. The HWP is responsible for producing an integrated care strategy on how to meet the health and wellbeing needs of the population across LLR.

The ICB has established joint partnership groups with each respective local authority at place level (i.e. Leicester City, Leicestershire County and Rutland County Councils), via a section 75 partnership agreement. These groups 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. ICB representatives are members of key partnership groups.

Since establishment, the Board members have a regular opportunity to reflect on and evaluate their own performance through development sessions, to support focus on individual and collective roles, responsibilities, enhancing leadership skills. These sessions are aimed to support members of the Board to function more effectively as a Board in its own right and also collaboratively with partners. In addition, information sessions have also taken place for members of the Board providing them with an opportunity to, for example, review national guidance / initiatives in greater depth and its implications on the ICB's business; develop further insight into performance issues with key providers; enhance their knowledge on specific topics; and receive detailed information on key national requirements.

Board members' attendance record at both the Board development / information sessions and the public meetings of the Board are positive. All Board meetings held in public have been quorate with all or the majority of the of the Board members being present (see Appendix 4).

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 ICB and best practice. For the financial year ended 31 March 2023, and up to the date of signing this statement, the ICB has applied the principles of the Code as we have considered relevant to the ICB including drawing on other best practice available. This is evident, for example through the following:

- there was clear division of responsibilities between the Board and the executive responsibilities for running the organisation. The Chairman was responsible for leading the Board and ensuring it is effective in its role, and organising appropriate development and support for the Board's role
- the Committees of the Board 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 Board and its committees in advance of meetings and of a quality that enables the ICB to discharge its duties
- the Board assessed the nature and extent of the significant risks it is willing to take in achieving the strategic objectives of the ICB; 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 Board.

Discharge of Statutory Functions

NHS LLR ICB has reviewed all of the statutory duties and powers conferred on it by the National Health Service Act 2006 (as amended) and other associated legislation and regulations. As a result, I can confirm that the ICB 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 Director. Directorates have confirmed that their structures provide the necessary capability and capacity to undertake all of the ICB's statutory duties.

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 approved in July 2022 setting the strategic and operational frameworks of successful management and evaluation of risk across the Leicester, Leicestershire and Rutland ICB. 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 ICB 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 ICB'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 5.

All committees of the ICB have been critical to the review and management of risks. The Audit Committee, Board 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 ICB 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 and 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 ICB'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 Board reserved the right to vary the amount of risk the ICB 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 ICB'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 Board. Whilst the ICB 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 ICB 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 Board collectively and individually ensured that robust systems of internal control and management were in place. This responsibility was supported through an effective Board 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 a continued increase in awareness at all levels in 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 Board in the main identified the risks considering the political, economical, social, technological, legal and environmental (PESTLE analysis) in which the ICB 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 Leicester, Leicestershire and Rutland ICB 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 5.

Other sources of assurance

Internal Control Framework

A system of internal control is the set of processes and procedures in place in the ICB 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 ICB for the period ending 31 March 2023 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 Board 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 and Safety Committee, received assurance reports to monitor areas of risk, including, safeguarding, patient safety, serious incidents, patient complaints, planning, procurement and commissioning of services, including instances of whistleblowing in line with the Freedom to Speak Up Policy as appropriate.

The Finance Committee, received assurance, reports in respect of finance and activity for the ICB and the impact across the NHS system partners.

The System Executive Committee received assurance in respect of performance, contracting and procurement risks. Regular summary reports from these Committees were presented to the Board drawing the Board's attention to key financial, performance, contracting, procurement and patient safety and quality risks.

In addition, reports on specific updates and areas of risk were directly reported to the Board including reports on performance and delivery.

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 Board action was taken by the Board to ensure delivery and a robust mitigation plan. In addition, the Board 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 Chief Finance Officer, Contracting and Corporate Governance; the Chief Nursing Officer, Quality and Safety; and ultimately the Board via the Audit Committee.

The policies and procedures in place across the ICB 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 ICB 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. The establishment of the Health Equity Committee has enabled enhanced focus on risks associated with inequalities and ensuring appropriate mitigations are in place.

Relevant systems and processes were implemented to support the policies and procedures, for instance the ICB'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 ICB'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 (published June 2016) requires commissioners to undertake an annual internal audit of conflicts of interest management. To support the ICB to undertake this task, NHS England has published a template audit framework.

The ICB will be carrying out the annual internal audit of conflicts of interest in June / July 2023.

Data Quality

Good information underpins sound decision making within the ICB. The ICB is committed to improving data quality and information flows throughout the organisation and in particular through its committees to the Board and to the membership. Following

feedback throughout the year from Board 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 Board.

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 a Data Security and Protection Toolkit and the annual submission process provides assurances to the ICB, other organisations and to individuals that personal information is dealt with legally, securely, efficiently and effectively. LLR ICB submitted an interim baseline in February 2023 and will be making a final submission on 30 June 2023 in line with the national process.

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 information governance processes and procedures in line with the information governance toolkit. We have ensured all staff undertake annual information governance training and have implemented a staff information governance handbook 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 throughout the organisation against identified risks. We are developing information risk assessment and management procedures and a programme will be established to fully embed an information risk culture across the ICB.

The ICB had in place an Information Governance Strategy and Policy. The final year end self-assessment for 2022/23 will be approved by the Executive Management Team at its meeting in June 2023 and the ICB will assess itself as compliant with the requirements. Specific requirements were submitted to Internal Audit and a final opinion "substantial assurance" and no actions. 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 ICB can report that there have been no information governance incidents reported in 2022/23.

The NHS Data Mapping exercise was undertaken during 2022/23 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 ICB has a rigorous performance management framework which it uses to monitor delivery of services from its third-party contractors.

The ICB 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 ICB has sought assurance from the health informatics service provider in respect of their business continuity plans and processes to enable the ICB 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 ICB'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 & effectiveness of the use of resources

The effectiveness of the use of resources and financial performance of the ICB was monitored on a monthly basis by the Board 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 Board at least on an annual basis.

In addition, performance of providers and commissioned services was monitored in the main through the Finance Committee, System Executive Committee and the Quality and Safety Committee. The main financial risks that the ICB faced throughout the year, are highlighted in the Performance Report. The Audit Committee included within the internal audit plan for 2022/23 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 ICB to ensure action is taken where recommendations have been highlighted by the auditors.

Delegation of functions

The ICB was awarded delegated authority from 1 July 2023 from NHS England for commissioning and contracting of primary medical services. The delegated functions form the remit of the Strategic Commissioning Group, which reports to the System

Executive Committee, which oversees and ensures the ICB adheres to and carries out the functions delegated to it. The ICB'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.

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 and how the organisation manages conflicts of interest.

The conflicts of interest forms part of the ICB's 2023/24 annual internal audit programme and the auditors will review the ICB's systems and processes in line with the NHS England's guidance.

Counter fraud arrangements

The ICB commissions counter fraud services from 360 Assurance who have assigned to the ICB an Accredited Counter Fraud Specialist to undertake counter fraud work proportionate to identified risks. The Chief Finance Officer is a member of the Board and is proactively and demonstrably responsible for tackling fraud, bribery and corruption. There is executive support and direction from the Chief Finance Officer for a proportionate proactive work plan to address identified risks. The ICB 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 period 1 July 2022 to 31 March 2023 for the ICB, the Head of Internal Audit issued an independent and objective opinion on the adequacy and effectiveness of the ICB's system of risk management, governance and internal control. The Head of Internal Audit concluded that:

*I am providing an opinion of **moderate assurance** that there are areas for improvement in the framework of governance, risk management and control and some inconsistent application of controls puts the achievement of the organisation's objectives at risk.*

Board Assurance Framework
I am providing a moderate opinion in respect of the Board Assurance Framework (BAF). The ICB rolled forward it's BAF from the predecessor CCGs. Whilst it is noted that the Board has reviewed and considered how to develop the BAF throughout 2022/23, including seeking external advice to support the development of the BAF and use of committees to assess progress, the strategic risks identified and managed within the BAF during the period under review have not been fully reflective of the totality of risk facing the ICB, when assessed against the strategic objectives. For 2023/24 the Board has updated its strategic objectives, and associated risks, in line with the national core purposes of an ICB which was discussed and agreed at the April 2023 Board meeting. This will be subject to ongoing review and refinement over the course of the coming year including further alignment with the 5 Year Forward Plan.

Individual assignment outturn
I am providing an opinion of significant assurance for the outturn of individual audit assignments. Of the six assurance reviews issued, all provided a significant assurance in the context of the ICB as a new organisation; four reviews were advisory where minimal recommendations were made.

Follow up of agreed actions
I am providing a moderate opinion for the follow up of agreed actions. There are no current year actions, and there were 10 historic actions brought forward from predecessor CCGs; of the 10 historic actions, seven have been implemented, all outside of the original due dates. In forming my opinion I have taken into account that the ICB has robust internal processes and reporting arrangements to monitor and manage agreed actions going forward.

The context of our opinion and the conclusions reached will be updated prior to publication in the Annual Governance Statement.

During the period, Internal Audit issued the following audit reports:

Area of Audit	**Level of Assurance Given**
Cyber governance	Significant assurance
Data Security Protection Toolkit	Substantial assurance
EPRR and business continuity planning	Significant assurance
Financial sustainability	N/A (advisory)
Financial ledger controls	Significant assurance
Governance – Phase 1	N/A (advisory)
Governance – Phase 2	Significant assurance
Head of Internal Audit Opinion – Stage 1	N/A (advisory)
Head of Internal Audit Opinion Final	Moderate
Quality governance framework – phase 1	N/A (advisory)
Risk Management – Phase 1	N/A (advisory)
Risk Management – Phase 2	Significant assurance

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 ICB. The ICB 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 ICB 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 ICB 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 ICB has suitable additional processes in place to mitigate any resultant risk.

Review of the effectiveness of governance, risk management and internal control

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 Board
- The Audit Committee.
- The Remuneration Committee
- The Executive Management Team
- The System Executive Committee
- The Strategic Commissioning Group
- The Finance Committee
- The Health Equity Committee
- The Quality and Safety Committee
- 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 quality review system assurance meetings with the NHS England. The specific role of the Board 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

The Remuneration Report and Staff Report set out the ICB'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 ICB. This means those who influence the decisions of the entity, rather than the decisions of individual directorates or departments. The ICB has interpreted this to mean the Chief Officers (i.e. the executives), the non-executive members (i.e. the non-executives), and other members of the Board (i.e. this includes representatives from partner organisations).

Remuneration Report

Remuneration Committee

The Remuneration Committee is made up of the following members:

Name	Position
Ms Simone Jordan	Non-Executive Member
Mrs Pauline Tagg, MBE	Non-Executive Member
Professor Azhar Farooqi	Non-Executive Member
Mr David Sissling	ICB Chair

Further details about the functions of the Remuneration Committee are available in the Governance Report.

Percentage change in remuneration of highest paid director

No comparator figures are provided as there is no prior year data with the Integrated Care Board being formed 1 July 2022.

Reporting bodies are required to disclose the relationship between the total 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 Leicester, Leicestershire and Rutland ICB in the financial year 2022-23 was £197.5k (being the mid-point of the £195 to £200k) The relationship to the remuneration of the organisation's workforce is disclosed in the below table.

2022-23	25th percentile	Median	75th percentile
Total remuneration (£)	36	49	62
Salary component of total remuneration (£)	36	49	62
Pay ratio information	5.50	4.03	3.15

In 2022-23, no employees received remuneration in excess of the highest-paid director / member. Annualised gross remuneration ranged from £163k to £21k based on annualised gross pay.

No comparator figures are provided as there is no prior year data with the Integrated Care Board being formed 1 July 2022. It is worth noting that the pay ratios, when compared to the Clinical Commissioning Group organisations that preceded the Integrated Care Board, all show a marked increase in ratios. This is due to the executive management team previously being split between the three organisations, and therefore showing in the comparators at a reduced value.

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.

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 ICBs.

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

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

Remuneration of the ICB Directors was determined by the Remuneration Committee in line with due process, with the exception of the remuneration of the Chief Medical Officer which, at the time of writing this report, is awaiting Treasury approval.

Remuneration and Allowances Report July 2022 to March 2023 (Subject to Audit)

Name & Title	(a) Salary (bands of £5,000) £'000	(b) Expense Payments (taxable to the nearest £100) £	(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
Andy Williams, Chief Executive	145 - 150	0	0	0	200 - 202.5	350 - 355
David Sissling, Independent Chair	45 - 45	0	0	0	0 - 0	45 - 45
Nicola Briggs, Exec Director Finance, Contracting & Corporate Governance	10 - 15	0	0	0	7.5 - 10	20 - 25
Dr Caroline Trevithick, Chief Nursing Officer and Deputy Chief Executive	105 - 110	0	0	0	210 - 212.5	320 - 325
Sarah Prema, Chief Strategy Officer	100 - 105	0	0	0	147.5 - 150	250 - 255
Caroline Gregory, Interim Chief Finance Officer	100 - 105	0	0	0	80 - 82.5	185 - 190
Dr Nil Sanganee, Chief Medical Officer	85 - 90	0	0	0	50 - 52.5	135 - 140
Alice McGee, Chief People Officer	90 - 95	0	0	0	22.5 - 25	115 - 120
Rachna Vyas, Chief Operating Officer	100 - 105	0	0	0	20 - 22.5	120 - 125
Professor Mayur Lakhani, Clinical Executive Lead	15 - 20	0	0	0	0 - 0	15 - 20
Professor Azhar Farooqi, Non-Executive Director	10 - 15	0	0	0	0 - 0	10 - 15
Darren Hickman, Non-Executive Director	10 - 15	0	0	0	0 - 0	10 - 15
Pauline Tagg, MBE, Non-Executive Director	10 - 15	0	0	0	0 - 0	10 - 15
Simone Jordan, Non-Executive Director	10 - 15	0	0	0	0 - 0	10 - 15
Dr Nainesh Chotai, Primary Care Partner 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.

*2: Alice McGee Worked for the ICB fulltime up until 31st Jan 2022, whereafter she split her time between LLR ICB and Northamptonshire ICB 3.5:1.5. While when remains on the LLR ICB Payroll, an adjustment has been made to her salary and pension value to reflect the split with Northamptonshire. Her full position is shown in the table below.

*3 Nicola Briggs left the organisation, 31st July 2022.

*4 Caroline Gregory was appointed (on secondment), 25th July 2022.

*5 Nil Sanganee was appointed, 1st September 2022

*6 The Integrated Care Board was formed 1st July 2022. Previously the senior managers were responsible for the three former Leicester, Leicestershire and Rutland Clinical Commissioning Group's.

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

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.

We have a number of partner organisations who are represented on our board. We do not incur a cost for these representatives, rather the cost is borne by their parent organisation. These members are:

Mike Sandys, Local authority sectoral representative
Martin Samuels, Local authority sectoral representative
Mark Andrews, Local authority sectoral representative
Angela Hillery, Community/Mental Health Sector Representative
Richard Mitchell, Acute Sector Representative
Richard Henderson, Representative from Ambulance Trust
Harsha Kotecha, Representative from Healthwatch Leicester and Leicestershire
Dr Janet Underwood, Representative from Healthwatch Rutland

Total Remuneration for members allocated over a number of ICBs	(a) Salary (bands of £5,000) £'000	(b) Expense Payments (taxable to the nearest £100) £	(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
Alice McGee, Executive Director of People and Innovation	100 - 105	0	0	0	22.5 - 25	125 - 130

Pension benefits as at 31 March 2023 (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 31 March 2023 (bands of £5,000) £'000	(d) Lump sum at pension age related to accrued pension at 31 March 2023 (bands of £5,000) £'000	(e) Cash Equivalent Transfer Value at 01 July 2022 £'000	(f) Real Increase in Cash Equivalent Transfer Value £'000	(g) Cash Equivalent Transfer Value at 31 March 2023 £'000	(h) Employers Contribution to stakeholder pension £'000
Andrew Williams, Chief Executive	10 - 12.5	20 - 22.5	95 - 97.5	235 - 237.5	1895	228	2143	0
Alice McGee, Executive Director of People and Innovation	0 - 2.5	0 - 0	5 - 7.5	0 - 0	41	4	59	0
Rachana Vyas, Executive Director of Integration & Transformation	0 - 2.5	0 - 0	10 - 12.5	0 - 0	93	3	114	0
Nilesh Sanganee, Chief Medical Officer	2.5 - 5	5 - 7.5	5 - 7.5	15 - 17.5	76	34	123	0
Sarah Prema, Executive Director of Strategy and Planning	5 - 7.5	15 - 17.5	67.5 - 70	150 - 152.5	1255	161	1430	0
Nicola Briggs, Exec Director Finance, Contracting & Corporate Governance	0 - 2.5	0 - 0	27.5 - 30	0 - 0	285	5	291	0
Caroline Gregory, Chief Finance Officer	2.5 - 5	7.5 - 10	55 - 57.5	107.5 - 110	999	86	1099	0
Caroline Trevithick, Executive Director of Nursing, Quality and Performance	10 - 12.5	22.5 - 25	60 - 62.5	165 - 167.5	1088	212	1316	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.

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

Fair Pay Disclosure (subject to audit)

Percentage change in remuneration of highest paid director

No comparator figures are provided as there is no prior year data with the Integrated Care Board being formed 1 July 2022.

Pay ratio information

Reporting bodies are required to disclose the relationship between the total 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 Leicester, Leicestershire and Rutland ICB in the financial year 2022-23 was £197.5k (being the mid point of the £195 to £200k) The relationship to the remuneration of the organisation's workforce is disclosed in the below table.

2022-23	25th percentile	Median	75th percentile
Total remuneration (£)	36	49	65
Salary component of total remuneration (£)	36	49	65
Pay ratio information	5.50	4.03	3.00

In 2022-23, no employees received remuneration in excess of the highest-paid director / member. Annualised gross Remuneration ranged from £196k to £21k based on annualised gross Pay.

No comparator figures are provided as there is no prior year data with the Integrated Care Board being formed 1 July 2022. It is worth noting that the pay ratios, when compared to the Clinical Commissioning Group organisations that preceded the Integrated Care Board, all show a marked increase in ratios. This is due to the executive management team previously being split between the three organisations, and therefore showing in the comparators at a reduced value.

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.

Staff Report

Number of senior managers

The number of 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
Dr	Caroline	Trevithick	VSM
Ms	Caroline	Gregory	VSM
Dr	Nil	Sanganee	VSM
Mrs	Alice	McGee	VSM
Ms	Sarah	Prema	VSM
Ms	Rachna	Vyas	VSM

Staff numbers and costs (subject to audit)

Employee benefits (1 July to 31 March 2023)

	Admin			Programme			Total		
	Permanent Employees £'000	Other £'000	Total £'000	Permanent Employees £'000	Other £'000	Total £'000	Permanent Employees £'000	Other £'000	Total £'000
Employee Benefits									
Salaries and wages	7,909	1,327	**9,236**	4,032	1,412	**5,444**	11,941	2,739	**14,680**
Social security costs	848	-	**848**	451	-	**451**	1,299	-	**1,299**
Employer contributions to the NHS Pension Schem	1,713	-	**1,713**	498	-	**498**	2,211	-	**2,211**
Apprenticeship Levy	45	-	**45**	-	-	**-**	45	-	**45**
Termination benefits	(96)	-	**(96)**	(115)	-	**(115)**	(211)	-	**(211)**
Gross employee benefits expenditure	**10,419**	**1,327**	**11,746**	**4,866**	**1,412**	**6,278**	**15,285**	**2,739**	**18,024**
Less recoveries in respect of employee benefits (note 4.1.2)	(310)	-	**(310)**	(192)	-	**(192)**	(502)	-	**(502)**
Net employee benefits excluding capitalised costs	**10,109**	**1,327**	**11,436**	**4,674**	**1,412**	**6,086**	**14,783**	**2,739**	**17,522**

Average number of people employed

	Permanently employed	Other	Total
	Number	Number	Number
Total	**278**	**30**	**308**

There were nil whole time equivalent people engaged on capital projects

Staff composition

As of the 31 March 2023, LLR ICB employed a total of 342 staff (excluding bank staff) (this cannot be comparable to previous years due to this being the first year in operation as an ICB). Of this breakdown 235 were female and 98 were male. Data based on staffing on 31 March 2023. The gender profile of these staff is detailed in the table below.

Staff Analysis by gender (based on staffing at 31 March 2023

	Headcount by Gender					**% by Gender**	
Staff Grouping	**Female**	**Male**	**Unknown***	**Totals**	**Female**	**Male**	**Unknown***
Board members	4	7	6	**17**	23.5%	41.2%	35.3%
Other Senior Management (Band 8C+)	40	22	0	**62**	64.5%	35.5%	0.0%
All Other Employees	191	69	0	**260**	73.5%	26.5%	0.0%
Grand Total	**235**	**98**	**6**	**339**	**69.32%**	**28.91%**	**1.77%**

** Board members (off-payroll) pertains to Board members without a pay record in the ICB Electronic Staff Record (ESR) system. Named individuals categorised as "unknown" are: Angela Hillery, Caroline Gregory, Mark Andrews, Martin Samuel, Mike Sandys, Richard Mitchell*

The following table shows an analysis of average staff numbers split by occupational code. The average number of employees is calculated as the whole-time equivalent number of employees under contract of service in each week in the financial year, divided by the number of weeks in the financial year. Data based on staffing on 31 March 2023.

Pay Band	**Headcount**
Apprentice	2
Band 1	0
Band 2	4
Band 3	4
Band 4	18
Band 5	30
Band 6	51
Band 7	45
Band 8 - Range A	70
Band 8 - Range B	36
Band 8 - Range C	28
Band 8 - Range D	6
Band 9	10
Medical	20
VSM*	7
Board members**	11
Grand Total	**342**

** VSM figure includes Caroline Gregory who is on secondment and off payroll.*

***Board members excludes executive Board members who are included within the VSM figure, also excludes Sir Mayur Lakhani who is included under "Medical" figure. The figure for Board members includes the Chair, the Non-Executive Members and also members who are off payroll (i.e. without a pay record in the ICB Electronic Staff Record (ESR) system) as follows: Angela Hillery, Richard Mitchell, Mark Andrews, Martin Samuels and Mike Sandys.*

Sickness absence data

The sickness absence data for the ICB in 2022 was whole time equivalent (WTE) days available of 64599.75 and WTE days lost to sickness absence of 1261.03 and average working days lost per employee was 4.39 which was managed through the absence management policy.

Staff sickness absence 2022	2022 Number
Total Days Lost	1261.03
Total Staff Years	287.11
Average Working Days Lost	4.39

Staff turnover percentages

Information on staff turnover can be viewed by visiting the NHS workforce statistics published by NHS Digital on their website at www.digital.nhs.uk

Staff engagement percentages

LLR ICB participated in the national NHS Staff Survey in November 2022 with 86% of the organisation taking the time to complete it which is higher than the national average.

The results have been published nationally on 9 March 2023 and a summary of the findings are below:

Top 5 scores vs Organisation Average	Org	Picker Avg
q15. Organisation acts fairly: career progression	61%	54%
q22d. Feel supported to develop my potential	64%	57%
q14a. Not experienced harassment, bullying or abuse from patients/service users, their relatives or members of the public	98%	92%
q7a. Team members have a set of shared objectives	73%	67%
q22a. Organisation offers me challenging work	82%	76%

Bottom 5 scores vs Organisation Average	Org	Picker Avg
q8c. Colleagues are polite and treat each other with respect	71%	81%
q10c. Don't work any additional unpaid hours per week for this organisation, over and above contracted hours	19%	28%
q8b. Colleagues are understanding and kind to one another	71%	79%
q7d. Team members understand each other's roles	53%	61%
q11a. Organisation takes positive action on health and well-being	59%	67%

Most improved scores	Org 2022	Org 2021
q14d. Last experience of harassment/bullying/abuse reported	48%	26%
q22d. Feel supported to develop my potential	64%	57%
q22c. Have opportunities to improve my knowledge and skills	71%	65%
q3a. Always know what work responsibilities are	70%	65%
q22b. There are opportunities for me to develop my career in this organisation	53%	48%

Most declined scores	Org 2022	Org 2021
q19b. Would feel confident that organisation would address concerns about unsafe clinical practice	64%	74%
q19a. Would feel secure raising concerns about unsafe clinical practice	70%	79%
q9i. Immediate manager helps me with problems I face	70%	78%
q9h. Immediate manager cares about my concerns	77%	84%
q4c. Satisfied with level of pay	53%	60%

p.5 | NHS LEICESTER, LEICESTERSHIRE AND RUTLAND INTEGRATED CARE BOARD | NHS Staff Survey 2022

Picker

The results were shared with all staff via our staff briefing and newsletter. Currently work is underway at a directorate level for senior leaders to engage their teams on the

department level results to understand what works well and how we can improve staff experience.

Previous staff survey results have led to 2 task and finish groups being formed to develop our Appraisal paperwork and promote the importance of supportive feedback and career conversations, alongside a second group supporting the formulation of ICB Values which are currently being rolled out across the organisation.

The ICB also takes part in the quarterly Pulse staff survey to help inform our understanding of staff experience and help inform us on the things the organisation is taking forward positively, as well as areas for improvement.

Staff policies

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

LLR ICB recognises the importance of the Equality Act 2010 and the provisions within this legislation are met within our policies.

As an organisation, we are dedicated to developing an organisational culture that promotes inclusion and embraces diversity, ensuring that the focus on EDI is maintained not only within the ICB but as part of the wider Integrated Care System.

Equality, Diversity and Inclusion strategy 2021 to 2025

LLR ICB remains committed to the long-term Equality, Diversity and Inclusion strategy 2021 to 2025 and further details can be found on our website: https://leicesterleicestershireandrutland.icb.nhs.uk/

Equality Diversity and Inclusion Annual Report

Our first EDI Annual Report as an ICB has been published on our website https://leicesterleicestershireandrutland.icb.nhs.uk/wp-content/uploads/2023/04/LLR-EDI-Annual-Report-2022-2023.pdf

It sets out how the organisation fulfils the responsibilities arising from the Equality Act and how the ICB meets the Public Sector Equality Duty 2010. The EDI Annual Report demonstrates improvements in a number of areas as described within the Performance Report. The Workforce profile is also analysed against the Census to inform workforce planning for the system.

Trade Union Facility Time Reporting Requirements

In accordance with the Trade Union (Facility Time Publication requirements) Regulations 2017 see below.

What was the total number of your employees who were relevant union officials during the relevant period?

No. of employees who were TU officials during relevant period	Full time equivalent
1	1

Percentage of time spent on facility time

1 employee spent between 1-50% of their working hours on facility time. Percentage of pay bill spent on facility time is detailed in table below:

Provide the figure requested in the first column of the table below to determine the % of your total pay bill spent on paying employees who were relevant union officials for facility time during the relevant period	**Figures**
Total Cost of Facility Time	27.93ph X 7.5 hours of Trade Union Time (Sept – Oct 22) equals **£209.48**
Total Pay Bill	18,984,773
Provide % of total pay bill spent on facility time calculated as; (Total cost of facility time/total pay bill) x 100	0.00110341%

Paid TU activities

As a percentage of total paid facility time hours, how many activities were spent on paid union activities.

Total Hours spent on paid TU activities by relevant union officials during the relevant period/ total paid facility time hours x 100	100%

Other employee matters

Equality impact assessments are considered as part of any employment changes and policy reviews. As part of ICB board recruitment there have been diversity targets set and regular reviews undertaken. Since Covid – a review of hybrid working has been undertaken and staff are continuing to be supported in a flexible way to meet their work life balance and needs. A full office environment review has been underway to ensure a collaborative workspace is available, as well as work desk space. The ICB has undertaken a review of the new starter process to improve staff experience and a welcome guide for new starters and a move back to face to face corporate induction is underway.

Expenditure on consultancy

The expenditure on consultancy in 2022/23 for the Integrated Care Board was £110,583.

Off-payroll engagements

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

For all off-payroll engagements as of 31 March 2023 for more than £245* per day:

	Number
Number of existing engagements as of 31 March 2023	10
Of which, the number that have existed:	
for less than one year at the time of reporting	7
for between one and two years at the time of reporting	2
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 July 2022 and 31 March 2023, for more than £245 per day:

	Number
No. of temporary off-payroll workers engaged between 1 July 2022 and 31 March 2023	38
Of which:	
No. not subject to off-payroll legislation**	0
No. subject to off-payroll legislation and determined as in-scope of IR35**	0
No. subject to off-payroll legislation and determined as out of scope of IR35**	38
the number of engagements reassessed for compliance or assurance purposes during the year	0
Of which: no. 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 engagements / senior official engagements
For any off-payroll engagements of Board members and / or senior officials with significant financial responsibility, between 1 July 2022 and 31 March 2023:

Number of off-payroll engagements of board members, and/or senior officers with significant financial responsibility, during reporting period*	0
Total no. of individuals on payroll and off-payroll that have been deemed “board members, and/or, senior officials with significant financial responsibility”, during the reporting period. This figure should 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 (subject to audit)

There were no exit packages agreed and paid during the year.

Parliamentary Accountability and Audit Report

NHS LLR Integrated Care Board 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 of this report at note 18 of the accounts. An audit certificate and report is also included in this Annual Report at page 96.

Independent auditor's report to the members of the Board of NHS Leicester, Leicestershire and Rutland Integrated Care Board

Report on the audit of the financial statements

Opinion on financial statements

We have audited the financial statements of NHS Leicester, Leicestershire and Rutland ICB (the 'ICB') for the period ended 31 March 2023, 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 Schedule 1B of the National Health Service Act 2006, as amended by the Health and Care Act 2022 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 ICB as at 31 March 2023 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 Care Act 2022.

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 ICB 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.

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 ICB'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. However, future events or conditions may cause the ICB to cease to continue as a going concern.

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 ICB's financial statements shall be prepared on a going concern basis, we considered the inherent risks associated with the continuation of services currently provided by the ICB. 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 ICB and the ICB'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 ICB'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 ICB, or an officer of the ICB, 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 ICB 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 page 66, 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 ICB'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 ICB 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 ICB 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 ICB'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 ICB'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 recognition 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 which altered the financial performance of the ICB for the year
  - significant accounting estimates related to the prescribing accrual
  - the risk 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, and journals posted in March and post period-end that might relate to advancepayments;
  - challenging assumptions and judgements made by management in its significant accounting estimates in respect of the prescribing accrual;

- agreeing expenditure transactions, on a sample basis, to supporting evidence; and
- evaluating and challenging the estimates and the judgments made by management at yearend.

- 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.
- 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 ICB operates
  - understanding of the legal and regulatory requirements specific to the ICB 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 ICB'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 ICB's control environment, including the policies and procedures implemented by the ICB 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 ICB's arrangements for securing economy, efficiency and effectiveness in its use of resources

Matter on which we are required to report by exception – the ICB'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 ICB has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources for the period ended 31 March 2023.

Our work on the ICB's arrangements for securing economy, efficiency and effectiveness in its use of resources is not yet complete. The outcome of our work will be reported in our commentary on the ICB's arrangements in our Auditor's Annual Report. If we identify any significant weaknesses in these arrangements, they will be reported by exception in a further auditor's report. We are satisfied that this work does not have a material effect on our opinion on the financial statements for the period ended 31 March 2023.

Responsibilities of the Accountable Officer

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

Auditor's responsibilities for the review of the ICB'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 ICB 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 ICB's arrangements for securing economy, efficiency and effectiveness in its use of resources are operating effectively.

We undertake 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 ICB plans and manages its resources to ensure it can continue to deliver its services;
- Governance: how the ICB ensures that it makes informed decisions and properly manages its risks; and
- Improving economy, efficiency and effectiveness: how the ICB uses information about its costs and performance to improve the way it manages and delivers its services.

We document our understanding of the arrangements the ICB has 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 consider whether there is evidence to suggest that there are significant weaknesses in arrangements.

Report on other legal and regulatory requirements – Delay in certification of completion of the audit

We cannot formally conclude the audit and issue an audit certificate for NHS Leicester, Leicestershire and Rutland Integrated Care Board for the period ended 31 March 2023 in accordance with the requirements of the Local Audit and Accountability Act 2014 and the Code of Audit Practice until we have completed our work on the ICB's arrangements for securing economy, efficiency and effectiveness in its use of resources.

Use of our report

This report is made solely to the members of the Board of the ICB, as a body, 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 the ICB those matters we are required to state to them in an auditor's report and for no other purpose. To the fullest extent permitted by law, we do not accept or assume responsibility to anyone other than the ICB and the members of the Board of the ICB as a body, 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
28 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 period 1 July 2022 to 31 March 2023

	Note	2022-23 £'000
Income from sale of goods and services	2	(18,005)
Total operating income		**(18,005)**
Staff costs	4	18,024
Purchase of goods and services	5	1,546,331
Depreciation and impairment charges	5	87
Provision expense	5	(4)
Other Operating Expenditure	5	444
Total operating expenditure		**1,564,882**
Net Operating Expenditure		**1,546,877**
Finance expense		2
Total Net Expenditure for the period ending 31 March 2023		**1,546,879**
Comprehensive Expenditure for the period ending 31 March 2023		**1,546,879**

The notes on pages 107 to 126 form part of this statement.

Statement of Financial Position as at 31 March 2023

	Note	31 March 2023 £'000	1-July-2022 £'000
Non-current assets:			
Property, plant and equipment	9	67	101
Right-of-use assets	9a	201	254
Intangible assets	10	-	-
Total non-current assets		**268**	355
Current assets:			
Trade and other receivables	11.1	5,786	3,659
Cash and cash equivalents	12	325	550
Total current assets		**6,111**	4,209
Total assets		**6,379**	4,564
Current liabilities			
Trade and other payables	13	(79,330)	(96,068)
Lease liabilities	9a	(88)	(70)
Provisions	14	(833)	(977)
Total current liabilities		**(80,251)**	(97,115)
Non-Current Assets plus/less Net Current Assets/Liabilities		**(73,872)**	(92,551)
Non-current liabilities			
Lease liabilities	9a	(114)	(184)
Total non-current liabilities		**(114)**	(184)
Assets less Liabilities		**(73,986)**	(92,735)
Financed by Taxpayers' Equity			
General fund		(73,986)	(92,735)
Total taxpayers' equity:		**(73,986)**	(92,735)

The notes on pages 107 to 126 form part of this statement.

The financial statements on pages 103 to 126 were approved by the Audit Committee (as delegated by the Board of the ICB), on 20 June 2023 and signed on its behalf by:

A Williams

Chief Accountable Officer
Andrew Williams

Statement of Changes In Taxpayers Equity for the year ended 31 March 2023

	General fund £'000	Total reserves £'000
Changes in taxpayers' equity for 2022-23		
Balance at 01 July 2022	-	-
Transfer between reserves in respect of assets transferred from closed NHS bodies using modified absorption	(92,735)	(92,735)
Adjusted NHS Integrated Care Board balance at 01 July 2022	**(92,735)**	**(92,735)**
Changes in NHS Integrated Care Board taxpayers' equity for 2022-23		
Net operating expenditure for the financial year	(1,546,879)	(1,546,879)
Transfers by absorption to (from) other bodies	(598)	(598)
Net Recognised NHS Integrated Care Board Expenditure for the Financial year	**(1,547,477)**	**(1,547,477)**
Net funding	1,566,226	1,566,226
Balance at 31 March 2023	**(73,986)**	**(73,986)**

The notes on pages 107 to 126 form part of this statement.

Statement of Cash Flows for the year ended
31 March 2023

	Note	2022-23 £'000
Cash Flows from Operating Activities		
Net operating expenditure for the financial year		(1,546,879)
Depreciation and amortisation	5	87
Movement due to transfer by Modified Absorption		(92,410)
Interest paid		2
(Increase)/decrease in trade & other receivables	11.1	(5,786)
Increase/(decrease) in trade & other payables	13	79,330
Provisions utilised	14	(527)
Increase/(decrease) in provisions	14	(215)
Net Cash Inflow (Outflow) before Financing		**(1,566,398)**
Cash Flows from Financing Activities		
Grant in Aid Funding Received		1,566,226
Repayment of lease liabilities		(53)
Net Cash Inflow (Outflow) from Financing Activities		**1,566,173**
Net Increase (Decrease) in Cash & Cash Equivalents	12	**(225)**
Cash & Cash Equivalents at the Beginning of the Financial Year	12	**0**
Transfer (To) / From other Public Sector body on 1st July	12	**550**
Cash & Cash Equivalents (including bank overdrafts) at the End of the Financial Year		**325**

The notes on pages 107 to 126 form part of this statement.

Notes to the financial statements

1 Accounting Policies

NHS England has directed that the financial statements of Integrated Care Boards 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 2022-23 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 Integrated Care Boards, 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 Integrated Care Board for the purpose of giving a true and fair view has been selected. The particular policies adopted by the Integrated Care Board 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.

The Health and Social Care Act was introduced into the House of Commons on 6 July 2021. The Act allowed for the establishment of Integrated Care Boards across England and abolished Clinical Commissioning Groups. Integrated Care Boards took on the commissioning functions of Clinical Commissioning Groups.The functions, assets and liabilities of: NHS Leicester City Clinical Commissioning Group; NHS East Leicestershire and Rutland Clinical Commissioning Group; and NHS West Leicestershire Clinical Commissioning Groups, were transferred to NHS Leicester Leicestershire and Rutland Integrated Care Board on 1 July 2022.

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.

When Clinical Commissioning Groups ceased to exist on 1 July 2022, the services continued to be provided by Integrated Care Boards (using the same assets, by another public sector entity). The financial statements for Integrated Care Boards are prepared on a Going Concern basis as they will continue to provide the services in the future.

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 Group Accounting Manual 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 Integrated Care Board 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 Integrated Care Board 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 Integrated Care Board 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 Integrated Care Board receives no income from the pooled budgets.

1.6 Operating Segments

The Integrated Care Board has one operating segment, the commissioning of healthcare services.

1.7 Revenue

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

- As per paragraph 121 of the Standard the Integrated Care Board will not disclose information regarding performance obligations part of a contract that has an original expected duration of one year or less;
- The Integrated Care Board 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 Integrated Care Board to reflect the aggregate effect of all contracts modified before the date of initial application.

The main source of funding for the Integrated Care Board 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 obligation.

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

Payment terms are standard reflecting cross government principles.

The value of the benefit received when the Integrated Care Board 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.

Notes to the financial statements

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 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.

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 Integrated Care Board 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 Integrated Care Board;
- 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 Integrated Care Board'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 Integrated Care Board;
- 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.

Notes to the financial statements

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 Integrated Care Board expects to obtain economic benefits or service potential from the asset. This is specific to the Integrated Care Board 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 Integrated Care Board 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 use an asset for a period of time in exchange for consideration. The Integrated Care Board assesses whether a contract is or contains a lease, at inception of the contract.

1.13.1 The Integrated Care Board 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 3.51% is applied for leases commencing, transitioning or being remeasured in the 2023 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 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 Integrated Care Board's cash management.

Notes to the financial statements

1.15 Provisions

Provisions are recognised when the Integrated Care Board has a present legal or constructive obligation as a result of a past event, it is probable that the Integrated Care Board 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 cash flows 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 Integrated Care Board 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 Integrated Care Board 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 Integrated Care Board.

1.17 Non-clinical Risk Pooling

The Integrated Care Board participates in the Property Expenses Scheme and the Liabilities to Third Parties Scheme. Both are risk pooling schemes under which the Integrated Care Board pays an annual contribution to 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 Integrated Care Board, 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 Integrated Care Board. 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 Integrated Care Board 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 Integrated Care Board recognises a loss allowance representing the expected credit losses on the financial asset.

The Integrated Care Board 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).

Notes to the financial statements

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 Integrated Care Board 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 Integrated Care Board 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 impairment gain or loss.

1.20 Financial Liabilities

Financial liabilities are recognised on the statement of financial position when the Integrated Care Board 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 expired.

1.21 Value Added Tax

Most of the activities of the Integrated Care Board 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 Integrated Care Board not been bearing its own risks (with insurance premiums then being included as normal revenue expenditure).

1.23 Critical accounting judgements and key sources of estimation uncertainty

In the application of the Integrated Care Board's accounting policies, management is required to make various judgements, estimates and assumptions. These are regularly reviewed. It is considered that there is no source of material estimation uncertainty.

1.23.1 Critical accounting judgements in applying accounting policies

The following are the judgements, apart from those involving estimations, that management has made in the process of applying the Integrated Care Board's accounting policies and that have the most significant effect on the amounts recognised in the financial statements.

- None identified.

1.24 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.

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

The Department of Health and Social Care Group Accounting Manual does not require the following IFRS Standards and Interpretations to be applied in 2022-23. These Standards are still subject to HM Treasury FReM adoption.

- IFRS 14 Regulatory Deferral Accounts – Not UK-endorsed. Applies to first time adopters of IFRS after 1 January 2016. Therefore, not applicable to DHSC group bodies.
- 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 2025: early adoption is not therefore permitted.

2 Other Operating Revenue

	2022-23 Total £'000
Income from sale of goods and services (contracts)	
Non-patient care services to other bodies	**12,617**
Prescription fees and charges	**731**
Other Contract income	**4,155**
Recoveries in respect of employee benefits	**502**
Total Income from sale of goods and services	**18,005**
Total Operating Income	**18,005**

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

	2022-23			
	Non-patient care services to other bodies £'000	Prescription fees and charges £'000	Other Contract income £'000	Recoveries in respect of employee benefits £'000
Source of Revenue				
NHS	710	-	1,544	502
Non NHS	11,907	731	2,611	-
Total	**12,617**	**731**	**4,155**	**502**

	Non-patient care services to other bodies £'000	Prescription fees and charges £'000	Other Contract income £'000	Recoveries in respect of employee benefits £'000
Timing of Revenue				
Point in time	12,617	731	4,155	502
Total	**12,617**	**731**	**4,155**	**502**

3.2 Transaction price to remaining contract performance obligations

NHS Leicester Leicestershire and Rutland Integrated Care Board had no contract revenue expected 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

	2022-23		
	Permanent Employees £'000	Other £'000	Total £'000
Employee Benefits			
Salaries and wages	11,941	2,739	**14,680**
Social security costs	1,299	-	**1,299**
Employer Contributions to NHS Pension scheme	2,211	-	**2,211**
Apprenticeship Levy	45	-	**45**
Termination benefits	(211)	-	**(211)**
Gross employee benefits expenditure	**15,285**	**2,739**	**18,024**
Less recoveries in respect of employee benefits (note 4.1.2)	(502)	-	**(502)**
Total - Net admin employee benefits	**14,783**	**2,739**	**17,522**

4.1.2 Recoveries in respect of employee benefits

	2022-23		
	Permanent Employees £'000	Other £'000	Total £'000
Employee Benefits - Revenue			
Salaries and wages	(502)	-	(502)
Total recoveries in respect of employee benefits	**(502)**	**-**	**(502)**

4.2 Average number of people employed

	2022-23		
	Permanently employed Number	Other Number	Total Number
Total	**278**	**30**	**308**

(No staff were engaged on capital projects).

4.3 Exit packages agreed in the financial year

There were no exit packages or agreed departures during the period 1 July 2022 to 31 March 2023.

4.4 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:

4.4.1 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 2023, is based on valuation data as 31 March 2022, updated to 31 March 2023 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.

4.4.2 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 actuarial valuation as at 31 March 2020 is currently underway and will set the new employer contribution rate due to be implemented from April 2024.

5. Operating expenses

	2022-23 Total £'000
Purchase of goods and services	
Services from other ICBs, CCGs and NHS England	5,676
Services from foundation trusts	51,327
Services from other NHS trusts	933,208
Purchase of healthcare from non-NHS bodies	230,638
Purchase of social care	4,322
Prescribing costs	145,802
Pharmaceutical services	9
General Ophthalmic services	4
GPMS/APMS and PCTMS	158,988
Supplies and services – clinical	2,650
Supplies and services – general	1,660
Consultancy services	111
Establishment	1,295
Transport	6,087
Premises	3,006
Audit fees	233
Other non statutory audit expenditure	
· Other services	60
Other professional fees	165
Legal fees	411
Education, training and conferences	679
Total Purchase of goods and services	**1,546,331**
Depreciation and impairment charges	
Depreciation	87
Total Depreciation and impairment charges	**87**
Provision expense	
Provisions	(4)
Total Provision expense	**(4)**
Other Operating Expenditure	
Chair and Non Executive Members	136
Grants to Other bodies	190
Clinical negligence	12
Research and development (excluding staff costs)	58
Expected credit loss on receivables	18
Other expenditure	30
Total Other Operating Expenditure	**444**
Total operating expenditure	**1,546,858**

Internal audit services are provided by 360 Assurance (hosted by Leicestershire Partnership NHS Trust) and the associated expenditure is included within "Other professional fees".

The "audit fees" relate to the statutory external audit and "other non statutory audit expenditure" is in respect of the review of the Mental Health Investment Standard (MHIS). Both sets of fees include VAT.

The fee for the stautory external audit of the Integrated Care Board was £175k plus VAT and the audit of the MHIS was £45k plus VAT. The additional expenditure reported in the operating expenses, relates to the difference on the fees estimated for 2022-23 quarter 1 within the CCG accounts and the actual fees charged.

The auditor's liability for external audit work carried out for the nine months ending 31 March 2023, is limited to £2,000,000.

6.1 Better Payment Practice Code

Measure of compliance	2022-23 Number	2022-23 £'000
Non-NHS Payables		
Total Non-NHS Trade invoices paid in the Year	12,097	211,189
Total Non-NHS Trade Invoices paid within target	12,079	211,117
Percentage of Non-NHS Trade invoices paid within target	**99.85%**	**99.97%**
NHS Payables		
Total NHS Trade Invoices Paid in the Year	709	1,011,063
Total NHS Trade Invoices Paid within target	705	1,011,014
Percentage of NHS Trade Invoices paid within target	**99.44%**	**100.00%**

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

The Integrated Care Board incurred £nil charges relating to claims made under this legislation

7. Finance costs

	2022-23 £'000
Interest	
Interest on lease liabilities	2
Total finance costs	**2**

8. Net gain/(loss) on transfer by absorption

Transfers as part of a reorganisation fall to be accounted for by use of absorption accounting in line with the Government Financial Reporting Manual, issued by HM Treasury. The Government Financial Reporting Manual does not require retrospective adoption, so prior year transactions (which have been accounted for under merger accounting) have not been restated. 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.

		2022-23					
		NHS Leicester City CCG	NHS East Leicester & Leicestershire CCG	NHS West Leicestershire CCG	Sub total CCGs	NHS England	Total
		£'000	£'000	£'000	£'000	£'000	£'000
	Note	(1)	(1)	(1)	(1)	(2)	
Transfer of property plant and equipment		1	81	19	**101**		101
Transfer of Right of Use assets		-	254	-	**254**		254
Transfer of cash and cash equivalents		144	121	285	**550**		550
Transfer of receivables		607	949	2,103	**3,659**		3,659
Transfer of payables		(42,557)	(22,813)	(30,698)	**(96,068)**		(96,068)
Transfer of provisions		(539)	(251)	(187)	**(977)**		(977)
Transfer of Right Of Use liabilities		-	(254)	-	**(254)**		(254)
Transfer of PUPOC provision						**(598)**	(598)
Net loss on transfers by absorption		(42,344)	(21,913)	(28,478)	**(92,735)**	**(598)**	(93,333)

The transfer of assets and liabilities reported in note 8 relate to that from:
(1) The demised clinical commissioning groups: NHS Leicester City Clinical Commissioning Group; NHS East Leicester, Leicestershire and Rutland Clinical Commissioning Group; and NHS West Leicestershire Clinical Commissioning Group. The consolidated figures in the table are after eliminating the inter-trading between the three Clinical Commissioning Groups and so represent the net trading balances.
(2) NHS England for provisions relating to the continuing healthcare previously unassessed periods of care (PUPoC). This was done through transfer by absorption.

The transfers from the demised Clinical Commissioning Groups (1), were completed using modified absorption accounting. Modified absorption accounting requires that entities account for their transactions in the period in which they took place, with no restatement of performance required. Where assets and liabilities transfer, the gain or loss resulting is recognised directly in the general fund.

9. Property, plant and equipment

2022-23	Buildings excluding dwellings	Plant & machinery	Information technology	Furniture & fittings	Total
	£'000	£'000	£'000	£'000	£'000
Cost or valuation at 01 July 2022	111	86	463	26	686
Cost/Valuation at 31 March 2023	**111**	**86**	**463**	**26**	**686**
Depreciation 01 July 2022	69	86	408	21	584
Charged during the year	9	-	24	2	35
Depreciation at 31 March 2023	**78**	**86**	**432**	**23**	**619**
Net Book Value at 31 March 2023	**33**	**-**	**31**	**3**	**67**
Purchased	33	-	31	3	67
Total at 31 March 2023	**33**	**-**	**31**	**3**	**67**
Asset financing:					
Owned	33	-	31	3	67
Total at 31 March 2023	**33**	**-**	**31**	**3**	**67**
Net Book Value at 01 July 2022	42	-	55	5	102

The property, plant and equipment of the demised Leicester, Leicestershire and Rutland Clinical Commissioning Groups were consolidated and transferred to the Integrated Care Board by modified absorption and are reported in the balance at 1 July 2022.

9.1 Cost or valuation of fully depreciated assets

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

	2022-23 £'000
Plant & machinery	86
Information technology	369
Furniture & fittings	19
Total	**474**

9.2 Economic lives

	Minimum Life (years)	Maximum Life (Years)
Buildings excluding dwellings	3	3
Information technology	0	4
Furniture & fittings	0	4

9a Leases

9a.1 Right-of-use assets

	Buildings excluding dwellings £'000
Cost or valuation at 01 July 2022	272
Cost/Valuation at 31 March 2023	**272**
Depreciation 01 July 2022	18
Charged during the year	52
Depreciation at 31 March 2023	**70**
Net Book Value at 31 March 2023	**202**
Net Book Value at 01 July 2022	254

The right-of-use assets of the demised Leicester, Leicestershire and Rutland Clinical Commissioning Groups were consolidated and transferred to the Integrated Care Board by modified absorption and are reported in the balance at 1 July 2022.
The above asset relates entirely to office space at County Hall, Leicester and is leased from Leicestershire County Council, a DHSC group body.

9a.2 Lease liabilities

	2022-23 £'000
Lease liabilities at 01 July 2022	(254)
Interest expense relating to lease liabilities	(2)
Repayment of lease liabilities (including interest)	53
Lease liabilities at 31 March 2023	**(202)**

9a.3 Lease liabilities - Maturity analysis of undiscounted future lease payments

	31 March 2023 £'000	1-July-2022 £'000
Within one year	(72)	
Between one and five years	(132)	
Balance at 31 March 2023	**(204)**	
Effect of discounting	2	
Current lease liabilities	(88)	(70)
Non-current lease liablities	(114)	(184)
Total	**(202)**	(254)

The lease liabilities of the demised Leicester, Leicestershire and Rutland Clinical Commissioning Groups were consolidated and transferred to the Integrated Care Board by modified absorption and are reported in the balance at 1 July 2022.
The lease of the above asset relates to office space at County Hall, Leicester and is leased entirely from Leicestershire County Council, a DHSC group body.

9a.4 Amounts recognised in Statement of Comprehensive Net Expenditure

	2022-23 £'000
Depreciation expense on right-of-use assets	52
Interest expense on lease liabilities	2

9a.5 Amounts recognised in Statement of Cash Flows

	2022-23 £'000
Total cash outflow on leases under IFRS 16	53

10. Intangible non-current assets

2022-23	Computer Software: Purchased £'000
Cost or valuation at 01 July 2022	114
Cost / Valuation At 31 March 2023	**114**
Amortisation 01 July 2022	114
Amortisation At 31 March 2023	**114**
Net Book Value at 31 March 2023	**-**
Net Book Value at 01 July 2022	-

The intangible non-current assets of the demised Leicester, Leicestershire and Rutland Clinical Commissioning Groups were consolidated and transferred to the Integrated Care Board by modified absorption and are reported in the balance at 1 July 2022.

10.1 Cost or valuation of fully amortised assets

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

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

11.1 Trade and other receivables

	Current 31 March 2023 £'000	Current 1-July-2022 £'000
NHS receivables: Revenue	64	1,534
NHS prepayments	14	6
NHS accrued income	3,292	154
Non-NHS and Other WGA receivables: Revenue	140	205
Non-NHS and Other WGA prepayments	822	907
Non-NHS and Other WGA accrued income	987	711
Expected credit loss allowance-receivables	(84)	(123)
VAT	551	265
Total Trade & other receivables	**5,786**	**3,659**
Total current and non current	**5,786**	**3,659**

The receivables balances of the demised Leicester, Leicestershire and Rutland Clinical Commissioning Groups were consolidated and transferred to the Integrated Care Board by modified absorption and are reported in the balance at 1 July 2022.
There are no prepaid pension contributions included.

11.2 Receivables past their due date but not impaired

	31 March 2023	
	DHSC Group Bodies	Non DHSC Group Bodies
	£'000	£'000
By up to three months	41	111
By three to six months	4	58
By more than six months		58
Total	**45**	**227**

11.3 Loss allowance on asset classes

	Trade and other receivables - Non DHSC Group Bodies £'000
Balance at 01 July 2022	**(123)**
Lifetime expected credit losses on trade and other receivables-Stage 2	**(17)**
Amounts written off	**56**
Total	**(84)**

The loss allowance balances of the demised Leicester, Leicestershire and Rutland Clinical Commissioning Groups were consolidated and transferred to the Integrated Care Board by modified absorption and are reported in the balance at 1 July 2022.

12. Cash and cash equivalents

	2022-23 £'000
Balance at 01 July 2022	550
Net change in year	(225)
Balance at 31 March 2023	**325**
Made up of:	
Cash with the Government Banking Service	325
Cash and cash equivalents as in statement of financial position at 31 March 2023	**325**

The cash balances held by the demised Leicester, Leicestershire and Rutland Clinical Commissioning Groups were consolidated and transferred to the Integrated Care Board by modified absorption and are reported in the balance at 1 July 2022.
The Integrated Care Board does not hold patients monies.

13. Trade and other payables

	Current 31 March 2023 £'000	Current 1-July-2022 £'000
NHS payables: Revenue	924	459
NHS payables: Capital	-	3
NHS accruals	3,303	19,367
NHS deferred income	95	202
Non-NHS and Other WGA payables: Revenue	11,527	3,269
Non-NHS and Other WGA accruals	59,366	68,804
Non-NHS and Other WGA deferred income	25	120
Social security costs	232	279
Tax	174	216
Other payables and accruals	3,684	3,349
Total Trade & Other Payables	**79,330**	**96,068**
Total current and non-current	**79,330**	**96,068**

The payables balances of the demised Leicester, Leicestershire and Rutland Clinical Commissioning Groups were consolidated and transferred to the Integrated Care Board by modified absorption and are reported in the balance at 1 July 2022.
The Integrated Care Board does not have any liabilities included above for arrangements to buy out the liability for early retirement

Other payables include £1,234,282 outstanding pension contributions at 31 March 2023.

14. Provisions

	Current 31 March 2023 £'000	Current 1-July-2022 £'000
Redundancy	-	211
Continuing care	833	492
Other	-	274
Total	**833**	**977**
Total current and non-current	**833**	**977**

	Redundancy £'000	Continuing Care £'000	Other £'000	Total £'000
Balance at 01 July 2022	**211**	**492**	**274**	**977**
Arising during the year	-	605	-	**605**
Utilised during the year	-	(264)	(263)	**(527)**
Reversed unused	(211)	(598)	(11)	**(820)**
Transfer (to) from other public sector body under absorption	-	598	-	**598**
Balance at 31 March 2023	**-**	**833**	**-**	**833**
Expected timing of cash flows:				
Within one year	-	833	-	**833**
Balance at 31 March 2023	**-**	**833**	**-**	**833**

The provisions held by the demised Leicester, Leicestershire and Rutland Clinical Commissioning Groups were consolidated and transferred to the Integrated Care Board by modified absorption and are reported in the balance at 1 July 2022.

As a result of a prior re-organisation of the three Leicester, Leicestershire and Rutland Clinical Commissioning Groups, provisions were set aside for expected redundancies. These were transferred to the newly formed Integrated Care Board under the heading of "Redundancy" provision. Staff previously placed at risk have subsequently found other suitable alternative employment and so the associated redundancy provisions have therefore been reversed, as unused. This has resulted in a one-off economic benefit to the staff costs and is reported as such under "termination costs" in note 4.1.

A provision for the dilapidation costs associated with previous clinical commissioning group accommodation at St Johns House, Leicester, had been transferred to the newly formed Integrated Care Board and is reported under the "Other" provisions heading. This was utilised and a small balance remaining was reversed, as unused. The Integrated Care Board now has nil provisions under this heading.

The Integrated Care Board received £1,090k transferred as continuing care provisions (this included £598k transferred from NHS England for liabilities relating to legacy previously unassessed periods of care (PUPoC) and the balance related to continuing healthcare retrospective cases and disputes from the demised Leicester, Leicestershire and Rutland clinical commissioning groups). Following review of the PUPoC cases, the full provision was reversed as unused. Continuing healthcare retrospective claims and disputes have been reviewed with £264k utilised in year and an additional £605k arising in year.

Legal claims are calculated from the number of claims currently lodged with the NHS Resolution and the probabilities provided by them. As at 31 March 2023, NHS Resolution was providing £11,543 under the Clinical Negligence scheme, on behalf of the Integrated Care Board.

15. Financial instruments

15.1 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 Integrated Care Board 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 Integrated Care Board 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 Integrated Care Board in undertaking its activities.

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

15.1.1 Currency risk

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

15.1.2 Interest rate risk

The Integrated Care Board 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 Integrated Care Board therefore has low exposure to interest rate fluctuations.

15.1.3 Credit risk

Because the majority of the Integrated Care Board and revenue comes parliamentary funding, Integrated Care Board 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.

15.1.4 Liquidity risk

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

15.1.5 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.

15.2 Financial assets

	Financial Assets measured at amortised cost 2022-23 £'000
Trade and other receivables with NHSE bodies	3,016
Trade and other receivables with other DHSC group bodies	1,311
Trade and other receivables with external bodies	156
Cash and cash equivalents	325
Total at 31 March 2023	**4,809**

15.3 Financial liabilities

	Financial Liabilities measured at 2022-23 £'000
Trade and other payables with NHSE bodies	233
Trade and other payables with other DHSC group bodies	4,052
Trade and other payables with external bodies	74,721
Total at 31 March 2023	**79,005**

All financial liabilties are due within one year.

16. Joint arrangements - interests in joint operations

This table summarises the Integrated Care Board share of expenditure incurred for each of the pooled budgets of which it is a partner. Details of the pooled budget arrangements follow.

Scheme	Area	Category	Accounting Treatment	Total 22/23 (£000)
Better Care Fund	Adult Social Care	BCF (s.75 agreement)	Resources transferred to Leicestershire County Council who act as host	20,737
Better Care Fund	Adult Social Care	BCF (s.75 agreement)	Resources transferred to Rutland County Council who act as host	1,355
Better Care Fund	Adult Social Care	BCF (s.75 agreement)	Resources transferred to Leicester City Council who act as host	14,023
Community Equipment (ICES)	Social Care	Support to live at home	Leicester City Council who act as host	4,062
Learning Disabilities Pool	Social Care	LD	Leicestershire County Council who act as host	5,845
Total Council act as host				**46,022**
Better Care Fund	Learning Disabilities	Leics County BCF	Resources controlled and expended by the ICB	692
Better Care Fund	Community Health	Leics County BCF	Resources controlled and expended by the ICB	8,787
Better Care Fund	Step Down Beds	Leics County BCF	Resources controlled and expended by the ICB	401
Better Care Fund	Urgent Care/Out of Hours	Leics County BCF	Resources controlled and expended by the ICB	3,738
Better Care Fund	Community Health	Rutland County BCF	Resources controlled and expended by the ICB	643
Better Care Fund	Early Discharge Planning	Leicester City BCF	Resources controlled and expended by the ICB	1,405
Better Care Fund	Community Based Schemes	Leicester City BCF	Resources controlled and expended by the ICB	1,155
Better Care Fund	Intermediate Care Services	Leicester City BCF	Resources controlled and expended by the ICB	2,544
Better Care Fund	Prevention / Early Intervention	Leicester City BCF	Resources controlled and expended by the ICB	1,026
Better Care Fund	Community Based Schemes	Leicester City BCF	Resources controlled and expended by the ICB	317
Better Care Fund	Integrated Care Planning and Navigation	Leicester City BCF	Resources controlled and expended by the ICB	538
Better Care Fund	Other	Leicester City BCF	Resources controlled and expended by the ICB	307
Total Resources controlled and expended by the Integrated Care Board				**21,553**
Total				**67,575**

16.1.1 Interests in joint operations - Better Care Fund Pooled Budget (Leicestershire County)

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 LLR ICB for the Better Care Fund, which provides the financial support to local authorities and the NHS to jointly plan and deliver local services. There has been no change to the arrangements of this pooled budget from previous financial years.

16.1.2 Interests in joint operations - Better Care Fund Pooled Budget (Rutland County)

Rutland County Council has entered into a pooled budget arrangement under s75 of the NHS Act 2006 with the Integrated Care Board for the Better Care Fund. The Better Care Fund provides the financial support to local authorities and the NHS to jointly plan and deliver local services, Rutland County Council is the host authority.

16.1.3 Interests in joint operations - Better Care Fund Pooled Budget (Leicester City)

The Integrated Care Board had entered into a pooled budget with Leicester City Council. The pool is hosted by the Integrated Care Board under a Section 75 pooled budget arrangement.
Under the arrangement funds are pooled under Section 75 of the NHS Act 2006 for Better Care Fund. As a commissioner of healthcare services, the Integrated Care Board makes contributions to the pool, which are then used to purchase healthcare services.

16.1.4 Interests in joint operations - Integrated Community Equipment Services (ICES) Pooled Budget

The Integrated Care Board had entered into a pooled budget with Leicester City Council, Leicestershire County Council and Rutland County Council. The pool is hosted by Leicester City Council, who act as Lead Commissioner to a Section 75 pooled budget arrangement.
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 Integrated Care Board makes contributions to the pool, which are then used to purchase healthcare services.

16.1.5 Interests in joint operations - Learning Disabilities Pooled Budget

The Integrated Care Board has a pooled budget arrangement with Leicestershire County Council, for Learning Disabilities (LD) Services. Leicestershire County Council (Adult Social Care Service) is the host organisation.

17. Related party transactions

During the nine months to the 31 March 2023, none of the Governing Body Members or parties related to them have undertaken any material transactions with the Integrated Care Board, other than those set out below (the following transactions identified were not with the member but between the Integrated Care Board and the related party):

Related Party	Relationship with Related Party	Payments to Related Party	Receipts from Related Party	Amounts owed to Related Party	Amounts due from Related Party
		£'000	£'000	£'000	£'000
Castle Medical Group (Dr Nilesh Sanganee)	GP Partner - Principal at Castle Medical Group	9,695	-	-	-
East Midlands Anbulance Service (Pauline Tagg)	Chair of East Midlands Ambulance Service NHS Trust (ended 31 July 2022).	35,941	-	-	(102)
Vista (Pauline Tagg)	Chair of VISTA (sight loss charity and care home provider).	154	-	-	-
Rutland County Council (Mark Andrews, Mike Sandys)	Chief Executive; and Director of Public Health (respectively) of Rutland County Council	2,522	-	(930)	3
Leicester City Council (Martin Samuels)	Strategic Director, Social Care & Education, Leicester City Council	33,314	-	644	6
Leicestershire County Council (Mike Sandys)	Director of Public Health for Leicestershire County Council	42,983	-	(6,739)	46
University Hospitals of Leicester (Richard Mitchell)	Chief Executive, University Hospitals of Leicester NHS Trust.	624,000	(56)	2,354	(26)
Leicestershire Partnership Trust (Angela Hillery)	Chief Executive, Leicestershire Partnership NHS Trust	232,187	(39)	886	(17)
Glenfield Surgery (Dr Nainesh Chotai)	GP Partner at Glenfield Surgery.	7,953	-	(5)	-
Groby Surgery (Dr Nainesh Chotai)	GP Partner at Groby Surgery.	1,114	-	(1)	-
G3 Primary Care Network (Dr Nainesh Chotai)	Clinical Director of G3 Primary Care Network.	1,031	-	-	-
Leiecstershire and Rutland Local Medical Committee Ltd (Dr Nainesh Chotai)	Director of Leicester, Leiecstershire and Rutland Local Medical Committee Ltd (resigned on 25 August 2022).	797	-	-	-
Highgate Medical Centre (Prof Mayur Lakhani)	GP Principal Highgate Medical Centre GMS Contract	2,161	-	(1)	-
Charnwood GP Network Ltd (Prof Mayur Lakhani)	Charnwood Medical Group is part of Charnwood GP Network Ltd	1,934	-	-	-

All transactions have been at arm's length as part of the Integrated Care Board's healthcare commissioning.

The Department of Health is regarded as a related party. During the year the Integrated Care Board has had a significant number of material transactions with entities for which the Department is regarded as the parent Department. The most significant ones are with:

- University Hospitals of Leicester NHS Trust
- Leicestershire Partnership NHS Trust
- East Midlands Ambulance Service NHS Trust
- Nottinghamshire Healthcare NHS Trust
- NHS Midlands and Lancashire Commissioning Support Unit
- NHS England and NHS Improvement

The Integrated Care Board also has material transactions with all the GP Practices within its locality and membership.

In addition, the Integrated Care Board has had a number of material transactions with other Government departments and other central and local government bodies. The most significant transactions have been in respect of joint arrangements with:

- Leicester City Council
- Leicestershire County Council
- Rutland County Council

18. Events after the reporting period

The NHS England Board formally approved the delegation of commissioning responsibilities for pharmaceutical, general ophthalmic and dental services to the Integrated Care Board, effective 1 April 2023. The expected net impact on the statement of comprehensive net expenditure is £93.1m and the Integrated Care Board is expected to receive this level of revenue resource funding to commission these services.

19. Losses and Special Payments

	Total Number of Cases 2022-23 Number	Total Value of Cases 2022-23 £'000
Administrative write-offs	2	56
Total	**2**	**56**

Following the administration of Central Nottinghamshire Clinical Services (CNCS - a provider of GP out of hours services) and allocation of final dividends by the administrator, CNCS was liquidated. As a result, two remaining debts had to be written-off. These were legacy debts of £10,185.12 (East Leicester, Leicestershire and Rutland Clinical Commissioning Group) and £46,275 (West Leicestershire Clinical Commissioning Group).

There were no special payments in year.

20. Financial performance targets

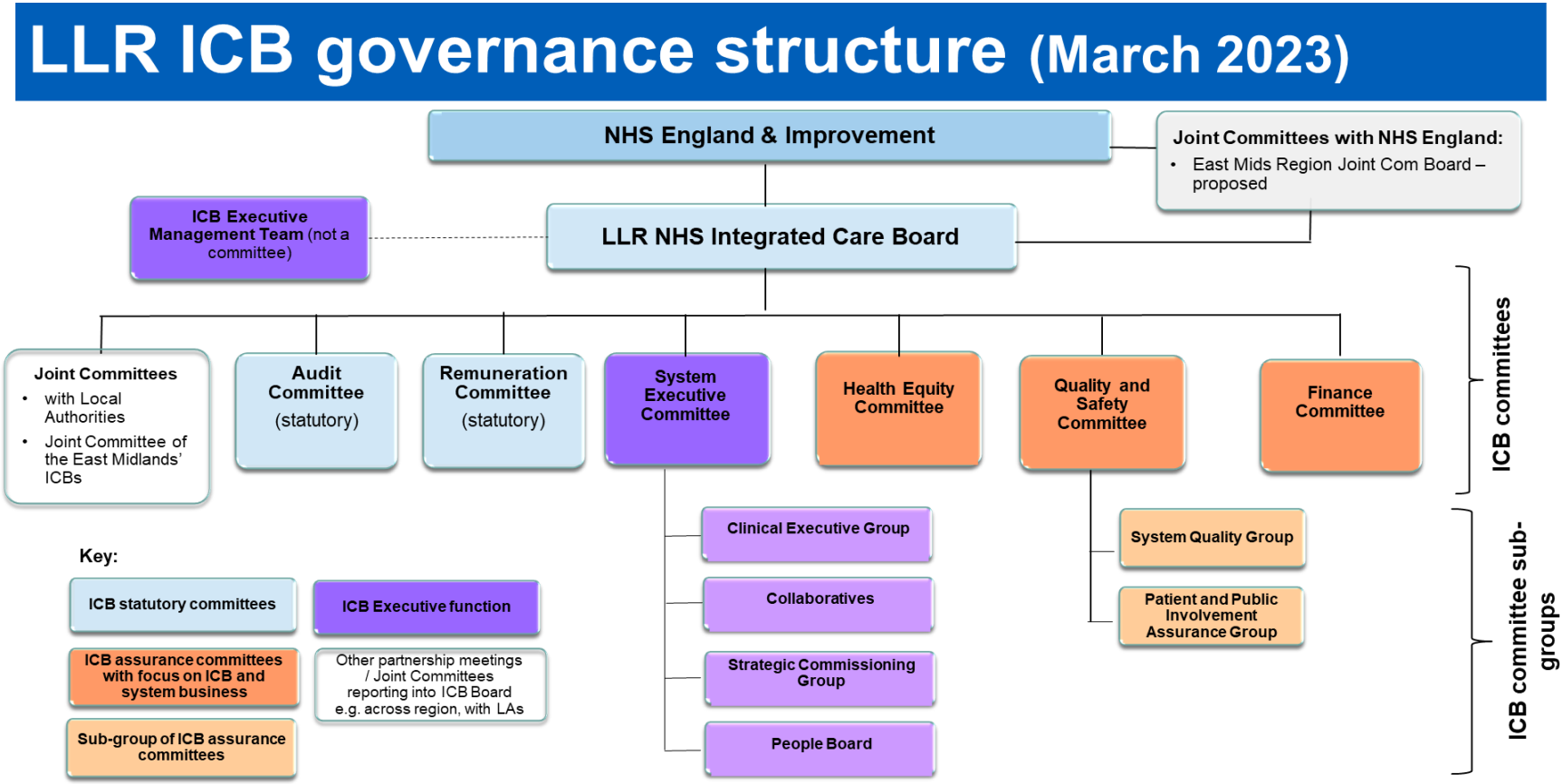
NHS Integrated Care Boards have a number of financial duties under the NHS Act 2006 (as amended).
NHS Leicester Leicestershire and Rutland Integrated Care Board performance against those duties was as follows:

	Target £'000	2022-23 Performance £'000	Duty achieved? Yes / No
Expenditure not to exceed income	1,565,500	1,564,884	Yes
Revenue resource use does not exceed the amount specified in Directions	1,547,495	1,546,879	Yes
Revenue administration resource use does not exceed the amount specified in Directions	16,987	14,731	Yes

APPENDICES

- Appendix 1 – LLR ICB Governance Arrangements
- Appendix 2 – LLR ICB Board Members' Register of Interests
- Appendix 3 – Members of ICB Committees
- Appendix 4 – Attendance at Board meetings
- Appendix 5 – Key corporate risks: LLR ICB Board Assurance Framework
- Appendix 6 – contact details

Appendix 1 – LLR ICB Governance Arrangements



Appendix 2 – LLR ICB Board Members' Register of Interests

NHS LEICESTER, LEICESTERSHIRE AND RUTLAND INTEGRATED CARE BOARD

Declarations of Interest - 2022 - 2023 (v6, March 2023)

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)
Mr David Sissling	Chairman	Wife is a manger at University Hospitals of Leicester NHS Trust (current).	Work for NHS England / Improvement (Midlands Region) as a Senior Leadership Advisor 1 day 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).	N/A	N/A	Appropriate actions to be taken as necessary during system-wide meetings and during conduct of business, particularly in relation to matters concerning UHL. Action will be taken dependent on the nature of the conflict.
Mr Andy Williams	Chief Executive	N/A	Chair and Trustee of Brap - charity working in the rights and equality field. Director of Jupiter Phase 3 Management Company (not remunerated) - residents property management. .	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.	Appropriate action would be taken during procurement processes. Interests are non-financial in the main. 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	Chief Nurse	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	Chief Finance Officer (until 31 July 2022)	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
Ms Caroline Gregory	Interim Chief Finance Officer (from 1 August 2022)		Member of the Chartered Institute of Public Finance & Accountancy (CIPFA).	Parish Councillor on Hook Norton Parish Council (from May 2020 - May 2024)		Appropriate will be taken if necessary, although limited action required as the Council is outside of the geographical area of LLR.
Mrs Alice McGee	Chief People Officer	N/A	N/A	N/A	N/A	N/A

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)
Mrs Rachna Vyas	Chief Operating Officer	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 LLR. 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 Executive Management Team 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	Chief Strategy Officer	Local Public Sector Director at Leicester LIFT Co.	N/A	N/A	Registered as a patient at Birstall Medical Practice which is a Practice in LLR. Son is employed by Boots in Leicester working as a trainee Pharmacist Assistant.	Appropriate actions to be taken as necessary and dependent on the nature of the conflict.
Dr Nilesh Sanganee	Chief Medical Officer	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. (With effect from 4 October 2022 Sanganee Medical Ltd was dissolved). Practice is a member of the LLR Provider Company Castle Medical Group is a member of the North West Leicestershire GP Ltd. Examiner for the MRCGP with the RCGP. Director of Sangco Ltd, a residential property letting company (from 25 June 2022). Practice has a contractual relationship with Derbyshire Health CIC, note also that DHU CIC and the LLR Provider Company have an affiliation.	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. Senior Fellow of the Faculty of Medical Leadership and Management.	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.

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)
Darren Hickman	Non-Executive Member - Audit	Non-Executive Director - Leicestershire Partnership NHS Trust (January 2014 - June 2022) Non-Executive Director & Risk Chair, Earl Shilton Building Society (Nov 20 to present) Non-Executive Director of Northampton Children's Trust (Sept 2020 to present) Director of D&JH Services Ltd a consulatncy and property managemnet company (Jul 2021 to Present)	N/A	N/A	N/A	Note that individual held a position previousy as a NED within the provider Trust however has stood down from that position prior to commencing the role in the ICB. Therefore no longer conflicted.
Simone Jordan	Non-Executive Member - People and Remuneration	Managing Director - Simone Jordan & Associates Ltd (from 2015 to date) Vice Chair - Royal Orthopaedic Hospital NHS Foundation Trust: Associate NED from 2017-2020, and Vice-Chair from 2021 to present. Non-Executive Director - George Eliot Hospital NHS Trust (from 2018 to present)	Visiting Fellow - Nottingham Business School (from 2015 to December 2022) Member of Chartered Institute of Personnel and Development	N/A	N/A	In relation to financial interests, to ensure individual does not participate in the decision-making process (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.
Pauline Tagg	Non-Executive Member - Quality, Performance and Transformation	Co-owner of Approved Fire Protection Ltd. Chair of East Midlands Ambulance Service NHS Trust (ended 31 July 2022).	Chair of VISTA (sight loss charity and care home provider).	N/A	N/A	In relation to financial interests, to ensure individual does not participate in the decision-making process (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)
Prof Azhar Farooqi	Non-Executive Member - Health Inequalities, Public Engagement, Third Sector and Carers	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 (e.g to absent themselves from meetings at the relevant point on the agenda); if involved in procurement processes then individual to seek advice to clarify if they can / cannot be involved and at what stage. 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.
Mark Andrews	Partner Member - Local Authority Sectoral representative	Chief Executive of Rutland County Council.	N/A	N/A	Spouse is a Director for Worldwide Clinical Trials, a Contract Research Organisation (from July 2022).	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)
Martin Samuels	Partner Member - Local Authority Sectoral representative	Strategic Director, Social Care & Education, Leicester City Council	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.
Mike Sandys	Partner Member - Local Authority Sectoral representative	Director of Public Health for Leicestershire County Council and Rutland County Council.	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.
Richard Mitchell	Partner Member - Acute Sector representative	Chief Executive, University Hospitals of Leicester NHS Trust. Occasional consultancy work (less than £500 per year).	Chair East Midlands Cancer Alliance (work with NHS England / Improvement). Chair Midlands Leadership Board (work with NHS England / Improvement). Chair Midlands East pathology Network.	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.
Angela Hillery	Partner Member - Community and Mental Health Sector representative	Joint Chief Executive for Northamptonshire Healthcare NHS Foundation Trust (NHFT) and Leicestershire Partnership NHS Trust (LPT). Transition to role within LPT commenced on 8 July 2019 and accountability for LPT role from 15 July 2019. Director of 3Sixty Care Partnership on behalf of NHFT.	National NHS Providers Board member. Executive Reviewer for Care Quality Commission. Member of the Royal College of Speech and Language Therapists. Member of the Board of NHS Northamptonshire Integrated Care Board. Midlands region CEO representative for National Mental Health working group. Member of East Midlands Alliance - Mental Health. Chair of Buddy meeting with St Andrews Healthcare. Member of National Mental Health Programme Board. Member of NHS Employers workforce policy board.	N/A	Sister is employed by William Blake House charity which operates several residential homes for people with learning disabilities. Husband is a property surveyor.	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 Nainesh Chotai	Partner Member - primary care sector representative (from September 2022)	GP Partner at Glenfield Surgery and Groby Surgery. Director of G&G Surgery Ltd, company providing general medical practice activities (since May 2017). Clinical Director of G3 Primary Care Network. Director and shareholder in Glenfield Pharmacy Ltd. GP Practice is a member of the LLR GP Provider Company. Director of Southmeads Properties Ltd. Director of Southmeads Professional Services & Investments Ltd. (since March 2013). Providing management consultancy activities other than financial management. Director of Leicester, Leiecstershire and Rutland Local Medical Committee Ltd (resigned on 25 August 2022).	N/A	N/A	Wife is a franchise holder in Wigston, Oadby and Blaby Specsavers Opticians.	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.
Prof Mayur Lakhani	Clinical Executive Lead	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. Honoraria to be received from LuminaDx and Pulse Magazine (CRP/D-Dimer Testing, point of care (undertaken as a GP and not in ICB capacity). Chair, Session on Lipid Management and secondary prevention, Sanofi (undertaken as a GP and not in ICB capacity). Panel Member of a (national) GP Consultancy (GPCA) – ad hoc work. Undertaken as a GP not in ICB capacity. Clinical Advisor, Arden and GEM CSU. (undertaken as a GP and not in ICB capacity).	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 Clinical Lead, UHL, non-site specific cancer pathway, and Cancer Board.	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.

Appendix 3 – Members of ICB Committees

ICB Board and Executive Member name	LLR ICB Board meetings	Executive Management Team	Audit Committee	Remuneration Committee	System Executive Committee	Quality and Safety Committee	Finance Committee	Health Equity Committee
Mr David Sissling	Chair			✓				
Mr Andy Williams	✓	Chair			Chair			
Dr Caroline Trevithick	✓	✓			✓		✓	
Ms Sarah Prema					✓			✓
Ms Nicci Briggs *(until 31 July 2022)*	✓	✓			✓		✓	
Ms Caroline Gregory *(from 1 August 2022)*	✓	✓			✓		✓	✓
Dr Nil Sanganee	✓	✓			✓	✓	✓	
Ms Rachna Vyas		✓			✓			
Ms Alice McGee		✓			✓			✓
Sir Mayur Lakhani CBE	✓							
Professor Azhar Farooqi	✓		✓	✓		✓		Chair
Mr Darren Hickman	✓		Chair				✓	
Mrs Pauline Tagg, MBE	✓		✓	✓		Chair		✓
Ms Simone Jordan	✓		✓	Chair				
Mr Richard Mitchell	✓				✓			
Ms Angela Hillery	✓				✓			
Mr Mike Sandys	✓							✓
Mr Martin Samuels	✓							
Mr Mark Andrews	✓							
Dr Nainesh Chotai *(from September 2022)*	✓							
Cathy Ellis*							Chair	

** Chair of the Finance Committee is not a member of the NHS LLR ICB Board*

Appendix 4 – Attendance at Board meetings

NHS LLR ICB Board - Attendance Record for meetings in public

1 July 2022 – 31 March 2023

Board member	Role	1 July 2022	14 July 2022	11 August 2022	13 October 2022	8 December 2022	9 February 2023	Percentage Attendance
Mr David Sissling	Independent Chair	✓	✓	✓	✓	✓	✓	**100%**
Mr Andy Williams	Chief Executive	✓	X	✓	✓	✓	✓	**83%**
Dr Caroline Trevithick	Chief Nursing Officer	Deputy	✓	✓	X	✓	✓	**67%**
Ms Sarah Prema	Chief Strategy Officer	✓	✓	✓	X	✓	✓	**83%**
Ms Nicci Briggs *(until 31 July 2022)*	Chief Finance Officer	✓	Deputy	N/A	N/A	N/A	N/A	**-**
Ms Caroline Gregory *(from 1 August 2022)*	Interim Chief Finance Officer	N/A	N/A	✓	✓	✓	✓	**100%**
Dr Nil Sanganee	Chief Medical Officer	✓	Deputy	✓	✓	✓	✓	**83%**
Sir Mayur Lakhani CBE	Clinical Executive Lead	✓	✓	✓	✓	✓	✓	**100%**
Professor Azhar Farooqi	Non-Executive Member	✓	X	✓	✓	✓	✓	**83%**
Mr Darren Hickman	Non-Executive Member	X	✓	✓	✓	✓	✓	**83%**
Mrs Pauline Tagg, MBE	Non-Executive Member	✓	✓	✓	✓	✓	X	**83%**
Ms Simone Jordan	Non-Executive Member	✓	✓	✓	X	✓	✓	**83%**
Mr Richard Mitchell	Partner Member - Acute Trust Sector Representative	✓	✓	Deputy	✓	✓	✓	**83%**
Ms Angela Hillery	Partner Member - Trust sector - community / mental health representative	✓	✓	✓	✓	✓	✓	**100%**
Mr Mike Sandys	Partner Member - Local authority sectoral representative (with children's and adult's social care and / or public health)	Deputy	✓	✓	✓	✓	✓	**83%**
Mr Martin Samuels	Partner Member - Local authority sectoral representative (with children's and adult's social care and / or public health)	✓	✓	✓	✓	X	X	**67%**

x

Board member	Role	1 July 2022	14 July 2022	11 August 2022	13 October 2022	8 December 2022	9 February 2023	Percentage Attendance
Mr Mark Andrews	Partner Member - Local authority sectoral representative (with children's and adult's social care and / or public health)	✓	✓	✓	✓	✓	X	**83%**
Dr Nainesh Chotai *(from September 2022)*	Partner Member - Primary Care sector representative	N/A	N/A	N/A	✓	✓	✓	**100%**
Was the meeting quorate? (Yes or no)		Yes	Yes	Yes	Yes	Yes	Yes	-

Appendix 5 – Key corporate risks: LLR ICB Board Assurance Framework 2022/23

Risk Ref as at 31 March 2023 (strategic objectives)	Risk theme
ICB BAF 1 ***(previously LLR BAF 07)*** (A,B,C,F)	Emergency Preparedness, Resilience and Response (EPRR) arrangements
ICB BAF 3 ***(previously LLR BAF 13)*** (D,E)	Failure to assure local health economy financial viability over the next 5 years
ICB BAF 4 ***(previously LLR BAF 17)*** (A,B,C,D,E,F,G)	Cyber Security risk - the impact from new and previously unknown cyber threats is potentially significant across all LLR organisations.
ICB BAF 7 **(previously LLR BAF 20)** (A,B,C,E)	There is high demand for GP appointments which continues to exceed availability of appointments due to variety of factors. This could result in the risk of patients being unable to access appointments and seeking alternatives placing pressure on other services.
Risks archived / de-escalated in November 2022	LLR ICB will fail to meet core standards in relation to the delivery of the cancer targets.
	Ambulance Handover delays **-** concerning ambulance handover delays and cancellation of elective activity.
	The 104 week wait standard not being met primarily due to Covid-19, increased pressures in the system relating to workforce capacity, sickness absence and theatre capacity across providers resulting in poor patient experience and a potential deterioration in health of patients.

Appendix 6 – contact details

NHS Leicester, Leicestershire and Rutland Integrated Care Board 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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