NHS
Leicester, Leicestershire and Rutland

Annual Report & Accounts

Leicester, Leicestershire & Rutland Integrated Care Board

1 April 2025 - 31 March 2026

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Chair's Introduction

Welcome to my first Annual Report for NHS Leicester, Leicestershire and Rutland Integrated Care Board (LLR ICB).

I am pleased to be presenting this report, which covers the period from 1 April 2025 to 31 March 2026. This report details the progress we have made in delivering the four aims of ICBs: improving health for all, reducing health inequalities, wisely spending public resources, and contributing to the economic and social development of the area we serve.

It sets out how we are working with partners across health and social care, including University Hospitals of Leicester NHS Trust (UHL), Leicestershire Partnership NHS Trust (LPT), Leicester City Council, Leicestershire County Council and Rutland County Council as well as the voluntary and charitable sector and other organisations.

In March 2025 the government made a series of announcements regarding the structures and funding levels of the NHS, which sees multiple ICBs working together in cluster arrangements with shared leadership and resources to improve efficiency and reduce costs, while remaining separate legal entities. From November 2025 a cluster arrangement with Leicester, Leicestershire and Rutland ICB was formalised although these arrangements had taken place much earlier with joint executive structures from September and the first NHS LLR ICB and NHS Northamptonshire ICB Board meetings held in common taking place in October 2025. I joined as Chair of the LLR ICB and Northamptonshire ICB cluster in October.

These arrangements set out a new chapter for ICBs and it is a real opportunity for us to take the amazing system and neighbourhood developments of the last few years and, together with our communities, make a lasting difference to health outcomes now and for generations to come. They have also presented their challenges as we continue to navigate these arrangements and understand what they mean for the future of our organisation.

The ICB receives an allocation of money annually to be spent on health services for the people registered with a GP practice across Leicester, Leicestershire and Rutland. This includes the cost of hospital outpatient appointments, inpatient stays and operations, prescribed medicines, investigations, GP practice appointments, GP out-of-hours services, services provided by urgent care / treatment centres, community and mental health facilities, dental services and many other services. Our Annual Report sets out how we have spent this allocation and it sets out our achievements against each of the NHS standards.

I would like to thank everyone across our health and care system who continues to work so hard to make a difference for our local population under what has been extremely challenging times. It has been a pleasure to meet and work with all of you.

Anu Singh
Chair
18 June 2026

Foreword

Welcome to my first Annual Report as Chief Executive for NHS Leicester, Leicestershire and Rutland Integrated Care Board (LLR ICB). This Report covers the period 1 April 2025 to 31 March 2026.

An Integrated Care System brings together hospital, community and mental health trusts, GPs and other primary care services with local authorities and other care providers to work together and apply their collective strength to addressing their residents' biggest health and care challenges.

This report aims to give you an overview of our organisation, our staff and how we work with partner organisations. It shows how we work through robust governance arrangements and how we assure ourselves and others that our services are delivered safely and to a high standard of quality - always working to ensure that the patient experience is positive. We will explain our mission, goals, achievements and challenges, highlighting the partnerships that we rely on to ensure the best possible outcomes for patients.

This year has been particularly challenging after reforms for ICBs were announced in March 2025, which has resulted in the organisation partnering with NHS Northamptonshire ICB in cluster arrangements that has seen a joint executive structure and committees in common. We have also completed two rounds of voluntary redundancies and a staff management of change process to enable us to make the required cost savings. I would like to pay tribute to our organisation's workforce which has shown continued professionalism and resilience in the most difficult of circumstances and a prolonged period of uncertainty.

Although there is a great deal to be proud of this year, I also need to acknowledge our NHS continues to face many challenges. This includes ambulance waiting times, emergency department waiting times and referral to treatment waiting times, which continue to be challenged. You can read more about our performance within the Performance Report section of our Annual Report.

Despite these challenges we have been working hard alongside our partners to provide the best care we can for the local population we serve.

We hope that you find this Annual Report informative, providing you with an overview of the period covered but please do contact us if you would like to know more about the ICB.

Toby Sanders
Chief Executive
18 June 2026

PERFORMANCE REPORT

The performance section provides information on NHS Leicester, Leicestershire and Rutland Integrated Care Board (LLR ICB), our main objectives and strategies and how we have discharged our duties and functions.

Within this chapter you will find information about who we are and what we do as well as the services we commission on behalf of our local population, and how we have performed against the NHS Standards.

Toby Sanders

Toby Sanders
Chief Executive (Accountable Officer)
18 June 2026

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.

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

- Identify and commission health and care needs of its population;
- 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 the local population for the public funds it spends and the outcomes and outputs of the services it commissions.

The statutory Board of LLR ICB is responsible for shaping and commissioning local healthcare for our registered population of approximately 1.2 million patients. The Board comprises the Chair, executive members, non-executive members, sectorial representation from acute, mental health, local authorities and primary medical services. For further information about the LLR ICB Board please see the Accountability Report Chapter within this Annual Report and visit our website https://leicesterleicestershireandrutland.icb.nhs.uk/ .

For 1 April 2025 – 31 March 2026, the LLR ICB was entrusted with an in-year allocation (our budget) of £2,997.6m (£2.998bn) with which to plan and buy the health services needed by people living in Leicester, Leicestershire and Rutland.

Why do we have an Integrated Care Board (ICB)?

Integrated Care Boards (ICBs) were established to ensure that the best possible care is available to people in our communities. An ICB constantly assesses what needs to change to meet the level and complexity of care. ICBs ensure that integrated care improves population health and reduces inequalities between different groups.

As an ICB, LLR ICB is responsible for planning and buying the following services:

- hospital treatment, including some specialised services
- rehabilitation services
- urgent and emergency care, this includes A&E, urgent treatment centres, NHS 111 and ambulance services
- community health services
- primary care services (i.e. primary medical services, pharmacy, ophthalmic and dental services)
- personalised services, this includes continuing healthcare for adults, continuing care for children, funded nursing care, and mental health aftercare
- mental health services, including a number of specialised services
- learning disability and autism services, including a number of specialised services.

We hold ourselves and provider organisations to account to improve the situation where the quality of care may have fallen below the standards we expect for our population. 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 Leicester, Leicestershire and Rutland (LLR) is served by various services provided by partner organisations across health and social care.

Services are also provided by some out of county NHS Trusts and a range of independent sector providers. During 2025/26, we awarded a number of grants to various voluntary and community sector organisations across Leicester, Leicestershire, and Rutland to support our patient population. The health and care services commissioned across Leicester, Leicestershire and Rutland can be found on the ICB's website www.leicesterleicestershireandrutland.icb.nhs.uk .

Performance Overview

Purpose

The Performance Overview is the section within the overarching Performance Report Chapter that provides an overview of our vision, values and strategic aims; and provides an insight into our population's health needs.

This section also provides a summary of our performance across key areas, and the challenges and financial pressures we have faced during the last year.

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 2025/26. This section should be read in conjunction with the Performance Analysis section which provides further information.

It is not possible to highlight all of our achievements and areas for improvement within this Annual Report, therefore please do review our website and also our Board papers as published on the ICB website at:
www.leicesterleicestershireandrutland.icb.nhs.uk .

Vision, values and strategic aims

Our vision

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.

Our values

Our ICB values, set out below, were developed in conjunction with our staff:

- We are kind, compassionate and respectful
- We are collaborative and supportive
- We are honest and accountable.

Our values underpin and drive the implementation of our strategy and the strategic aims of our organisational culture.

Our strategic aims and objectives

Our Five-Year Joint Forward Plan describes a shared vision and objectives that outlines how the ICB and our partner NHS trusts intend to work together to deliver services to improve the quality and health of our population over the next five years.

The “Five-Year Plan 2023/24 – 2027/28” (published in July 2023) was refreshed in 2025. This sets out the strategic aims, objectives and priorities for the ICB considering the increasing financial and operational challenges, and alignment to the three ‘shifts’ to be included in the 10-year plan.

Our key strategic priorities are to:

- Develop and deliver integrated **neighbourhood models of care**
- Deliver our **Urgent and Emergency Care** strategy to mitigate and respond to urgent and emergency care demand
- Focus on waiting times for autism spectrum disorder (ASD) and attention deficit hyperactivity disorder (ADHD), our Special Educational Needs and Disabilities (SEND) inspection actions, community Paediatrics and our **Children and Young People** transformation programme priorities
- Improve **access to services** across urgent and elective care in our hospitals, mental health and community services.

As we continue to transform our ICB in line with the national transformation programme, our focus will be on:

- Understanding the population’s health need – understanding the needs of our population to determine the NHS interventions that will impact on this
- Effective care and quality improvement – focus on evidence-based interventions and pathways that should be adopted for our highest service demands
- Efficient care (‘left shift’) – focus on driving care to be delivered in the most appropriate setting
- Setting and monitoring progress against a clear set of outcomes and metrics to measure the progress in delivering our ICS aims and the three ‘shifts’ in the 10-year plan.

In addition, to our Five-Year Joint Forward Plan, we also produce a Joint Capital Plan at the start of the financial year setting out our planned capital resource use, this Plan is published on our website https://leicesterleicestershireandrutland.icb.nhs.uk/ .

The Five-Year Joint Forward Plan is assessed against an outcomes framework that enables the measurement of the actions was tracked through partnership meetings and through the governance arrangements as outlined within the Accountability Report Chapter. The ICB governance structure is as at Appendix 1 and also available within the ICB’s Governance Handbook as published on the ICB website https://leicesterleicestershireandrutland.icb.nhs.uk/ .

The ICB, with local partners, work in collaboration across LLR to deliver the plans for improving the health and wellbeing of our population, addressing the needs of our

populations as identified in the Joint Strategic Needs Assessments, and focusing on prevention and reducing health inequalities.

The Leicester City, Leicestershire County and Rutland County Health and Wellbeing Boards have been involved in the development of the NHS Leicester, Leicestershire and Rutland ICB Five-Year Joint Forward Plan.

You can read more about how these fits into the wider partnership working arrangements to reduce health and inequalities and our work with the respective Health and Wellbeing Boards, details for which can be found later in this section of the report.

LLR Integrated Care System (LLR ICS)

Across the LLR Integrated Care System (ICS) we work with 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 our population.

The LLR ICS aims 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; and enhance productivity and value for money. Further details about the LLR ICS and 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 1.

Figure 1

The priorities we have agreed across the LLR system can be found in the LLR Integrated Care Strategy (see the LLR ICB website https://leicesterleicestershireandrutlandhwp.uk/wp-content/uploads/2024/09/Integrated-Care-Strategy_FINAL.pdf). The Integrated Care Strategy focuses on the four key priorities across the health and social care partners in LLR as described in Figure 2.

Figure 2: 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.

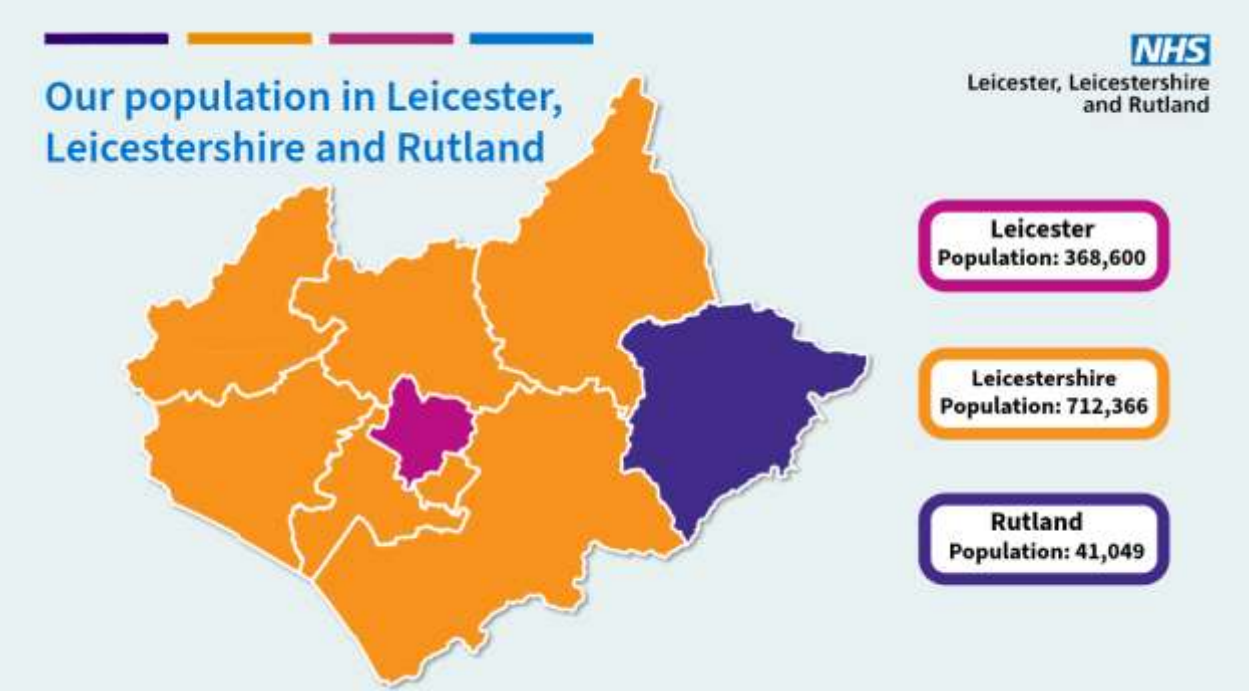
- **Dying well:** we will ensure you have a personalised, comfortable and supported end of life with personalised support for your carers and families. We will ensure people have a personalised, comfortable, and supported end of life with personalised support for carers and families.

Our population and their health needs

Our population

We serve approximately 1.2 million people across the rural, market towns and urban areas of Leicester, Leicestershire and Rutland (see Figure 3). Leicester is the tenth largest city in England and one of the most populous in the East Midlands. Leicestershire is a predominantly rural county and comprises of seven local authority districts, each with its own distinctive character. 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.

Figure 3: Our population in LLR



Source: *Census 2021 data, Office of National Statistics census www.ons.gov.uk*

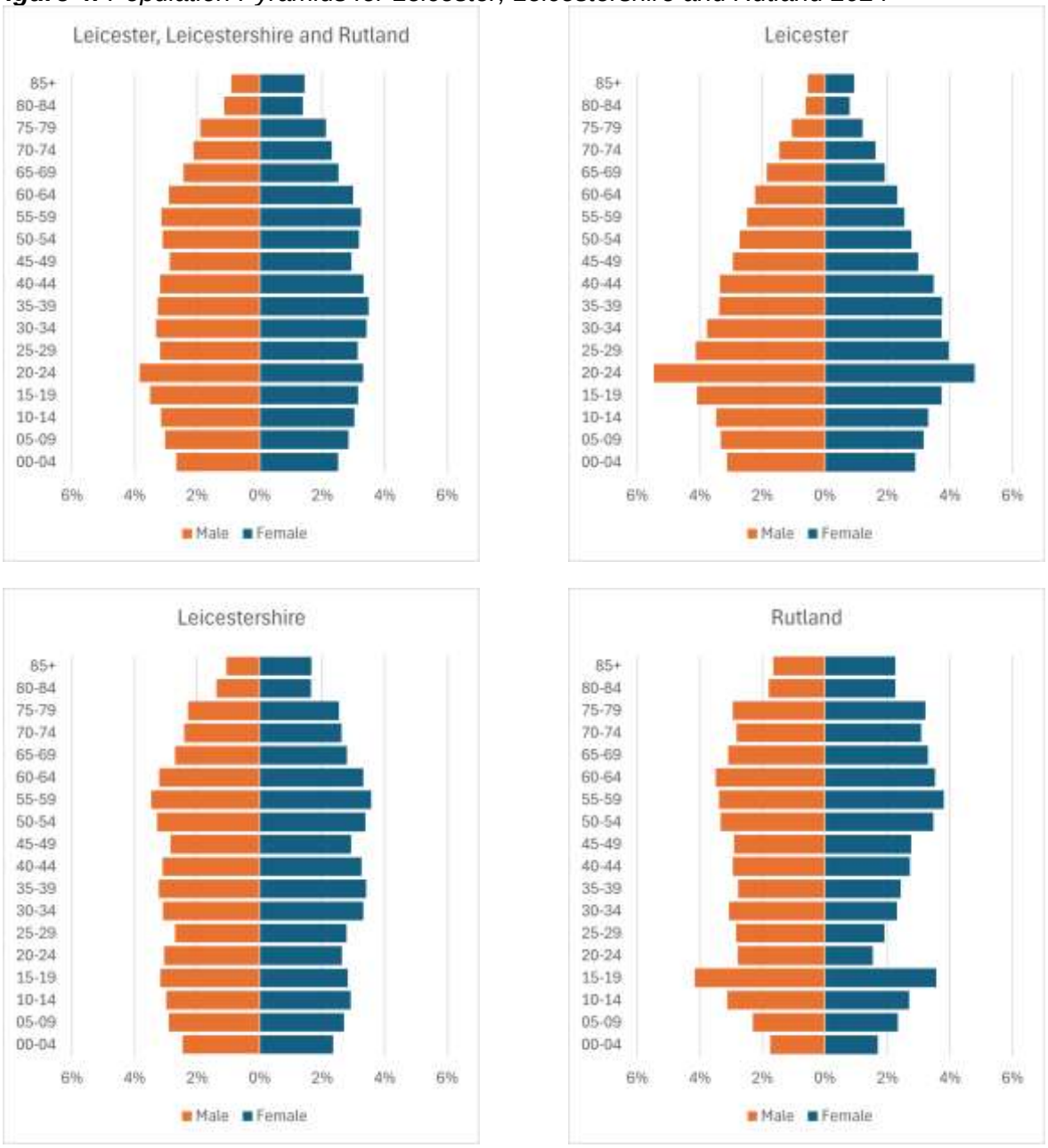
The population of LLR is diverse and health needs and life expectancy varies across each 'place'.

There are variations for mortality rates from differing causes across the LLR area, for instance, Leicester City has significantly worse mortality compared to Leicestershire and Rutland for the following causes: cardiovascular diseases, heart disease, stroke, cancer, and respiratory disease.

The age distribution of LLR is illustrated in Figure 4. The population of LLR has a similar age distribution to England, this masks variation in age distribution in each of the three local authorities:

- 18.2% of the LLR population are aged 65 years or over, compared with 18.7% in England
- In Rutland, 26.4% of the population and in Leicestershire 21.1% of the population are aged 65 years and over
- In Leicester City, 12.0% of the population are aged 65 years and over.

Figure 4: *Population Pyramids for Leicester, Leicestershire and Rutland 2024*



Source: 2024 Population Estimates, ONS Crown Copyright Reserved [from Nomis on 17 April 2026]

For further information please see LLR ICB's Health Inequalities Annual Report 2024-25 at the following: https://leicesterleicestershireandrutland.icb.nhs.uk/wp-content/uploads/2026/03/Health-Inequalities-Annual-Report-2024-25.pdf .

The 2025-26 Health Inequalities Annual Report will be published in due course.

Life expectancy

Life expectancy is an indicator of the overall health of the population.

Nationally and locally, there is variation across life expectancy for males and females. In 2024, life expectancy for LLR ICB was 79.9 years for males and 83.8 years for females, statistically similar to the England average of 79.8 years for males and 83.6 years for females (*Office for Health Improvement & Disparities. Public Health Profiles. Fingertips* https://fingertips.phe.org.uk):

- Life expectancy for females is consistently higher than life expectancy for males, representing an inequality linked to gender

- Life expectancy in Leicester is significantly lower than the England average at 77.3 years for males and 81.7 years for females

- Life expectancy in Leicestershire is significantly higher than the England average for males at 80.8 years and females at 84.5 years

- Life expectancy in Rutland is statistically higher than the England average for males, and is the highest ranking local authority in the country for life expectancy. For females, life expectancy is similar to England on annual rates but significantly higher when three-year rates are used. In 2024 life expectancy was 83.9 years for males and 84.9 years for females.

Legal Duties

We have embraced our legal duties in the delivery of our vision and strategic aims.

This includes, ensuring we continue to involve and listen to our population and communities, and act on their views to enable the ICB to deliver its 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 joint health and wellbeing strategies; and compliance with the Equality Act 2010.

Other sections of this Annual Report and also the ICB website provide information about how the ICB has complied with other legal duties such as the equality, diversity and inclusion https://leicesterleicestershireandrutland.icb.nhs.uk/about/publications/llr-equity-and-equality-action-plan-2022-2027/ . Please also see details on our website at the following: https://leicesterleicestershireandrutland.icb.nhs.uk/ .

Wider Partnership Working

Our experience from some of the most challenging times (e.g. cost of living crisis, financial challenges, management of incidents such as flooding) has shown us that when we act together, with health and care partners, we can achieve much more. Together we contribute to the wider health and wellbeing of the population of Leicester, Leicestershire and Rutland.

We have implemented 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. Local level Community Health and Wellbeing Plans continue to be developed in conjunction with District and Parish Councils. This work has continued to strengthen our joint commissioning and working arrangements to deliver integrated care at place and neighbourhood level in order to improve health and care outcomes, and to reduce health inequalities.

We have also been held to account through the local Health Overview and Scrutiny Committees to ensure that the health services we commission continue to meet the needs of our community and improve health outcomes.

We will continue to strengthen our existing partnerships and establish new partnerships across regional boundaries with other integrated care systems and ICBs. This will be pivotal going forward, enabling the ICB to effectively and efficiently deliver improved health care outcomes for our population and collectively address financial challenges.

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.

LLR ICB's strategic priorities and priorities are consistent with those of the Joint Health and Wellbeing Strategies across Leicester, Leicestershire and Rutland. The three Local Authorities, across each place, have worked with health and care partners, including district and parish councils, to develop the respective Joint Health and Wellbeing Strategies in response to the challenges identified in the Joint Strategic Needs Assessment (JSNA). The Strategies can be found on the respective Local Authority websites:

- Leicester City Council (unitary local authority) https://www.leicester.gov.uk/
- Leicestershire County Council (upper tier local authority) https://www.leicestershire.gov.uk/
- Rutland County Council (unitary local authority) 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.

Key areas for improvement are detailed within the Performance Analysis section of the Performance Report Chapter.

Public Health

We work closely with our public health colleagues from across each of the three Local Authorities 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 local authority 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 from Healthwatch Leicester and Leicestershire and from Healthwatch Rutland is invited to attend our ICB Board meetings as a participant. Healthwatch representatives are also involved in the review, development and implementation of programmes and projects, to support service changes. Representatives of the ICB attend Healthwatch meetings as requested to give presentations and provide updates on priorities.

We recognise that with the changing national landscape and proposal to abolish Healthwatch England and Local Healthwatch in their current form, ICBs will be responsible for collecting feedback from patients and users on the services they commission. We will need to give due consideration to ensure appropriate processes and functions are developed to effectively discharge these responsibilities.

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 and Tactical command groups. 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.

Overview of our performance

The last year has been a challenging one, particularly in relation to the national reset and transformation of ICBs, and our ability to identify efficient and effective ways to respond to the in-year financial and performance pressures.

Thank you to all of our NHS colleagues and local partners across Leicester, Leicestershire and Rutland (LLR), and our staff for their continued contributions, commitment, and support through these challenging circumstances.

Although we have not met all of the financial or national performance standards expected over the last year, the achievements we have made are a testament to the continued efforts and commitment of our staff and partners. Some of these achievements are highlighted in our Annual Report and other information is available within our Board papers and other sections of our website https://leicesterleicestershireandrutland.icb.nhs.uk/ .

Progress against the specific performance indicators are detailed within the Performance Analysis section of the Performance Report chapter.

Some of the key areas to highlight this year are set out below. The highlights include actions we have taken to enable regulatory compliance, but more importantly the commissioning decisions we have made to enable service improvements and development of new pathways all with a focus on improving the health outcomes and experience of our population.

Please do also visit the LLR ICB website https://leicesterleicestershireandrutland.icb.nhs.uk/ for a whole host of information about the work we have undertaken.

Transformation of ICBs and working with Northamptonshire ICB

In March 2025 the Government made a series of announcements regarding the structures and funding levels of the NHS. It announced the abolition of NHS England as well as a requirement for Integrated Care Boards (ICBs) to cut their costs by 50% at a national level and for significant financial savings also to be made by provider organisations.

The draft *Model ICB Blueprint* affirms that ICBs are essential to the future success of the NHS, delivering the Government's priorities.

The *Blueprint* makes clear that as strategic commissioners, ICBs will focus on providing system leadership for population health, setting evidence based and long-term population heath strategy and working as healthcare payers to deliver this, maximising the value that can be created from available resources.

ICB cluster arrangements were proposed and this involves multiple Integrated Care Boards (ICBs) working together with shared leadership and resources to improve efficiency and reduce costs, while remaining separate legal entities until potential formal

mergers are authorised, as part of a national move towards leaner operations and larger strategic footprints for commissioning.

These clusters share leadership, combined teams, and joint committees, aiming to achieve savings and streamline services, with specific groupings agreed by NHS England for various region. In October / November 2025, clustering arrangements were formally approved. This sees us officially working in a cluster arrangement with Northamptonshire ICB.

Action taken to date

During 2025/26, LLR ICB has partnered with NHS Northamptonshire ICB (NICB) to work collaboratively under 'cluster' arrangements, remaining a separate statutory body and through collaboration to meet the national NHS reform requirements to reduce running costs and focus our efforts on being strategic commissioners.

- We are required to make significant cost savings across the ICBs to meet our 2026/27 allocation of £19.40 per head of population, which will need to result in a reduction in overall headcount across the LLR ICB and NICB.

- We propose new directorate functions, structures, roles and ways of working to support the ICB cluster progress towards being a high performing strategic commissioning organisation.

- We are creating a new single organisation from 2026/27, noting that the ICBs are two statutory bodies at this time.

- We propose On-Call standardisation across the clustered ICBs from 1 May 2026, as the Category 1 Responder responsibility remains with ICBs after transfers have taken place.

Our aim to move towards the required running cost saving across both organisations, is to reduce headcount from around 650 members of staff to 500 members of staff – a reduction of 150 people. We have begun this process in a number of ways.

In October 2025, we ran a joint Mutually Agreed Resignation Scheme (MARS) and in November following approval by HM Treasury and NHS England that organisations could run voluntary redundancy schemes, our cluster ran a scheme from 1 December until 22 December. This resulted in 92 applications for the voluntary redundancy scheme. A second scheme ran from 20 January to 10 February 2026. This resulted in further applications for the voluntary redundancy scheme.

A Management of Change process was established, which created new directorate functions, structures, roles and ways of working to support the ICB cluster while recognising both ICBs are two statutory bodies at this time, or until new legislation states otherwise.

The Management of Change process ended on 5 March 2026. Following this, final structures were published in mid-March and processes have commenced to fill posts within the new staffing structure. Any members of staff without a role at the end of the process may be subject to compulsory redundancy. It is anticipated that this process will be completed by 30 June 2026.

We acknowledge how challenging this period has been not only for our organisation as a whole but also for individual members of staff. It has caused significant risks within our organisation due to recruitment freezes, prolonged uncertainty and working through the required Management of Change process at pace to meet the national requirements.

Throughout this period our staff have shown exemplary professionalism and continued commitment to our organisation, and we would like to thank them for that. It remains to be seen what risks losing such a significant number of our workforce will have, and what impact there will be on our capacity and capability to deliver over the next 12 months.

Health Inequalities Annual Report

Our *Health Inequalities in Leicester, Leicestershire and Rutland Annual Report in 2024* is available on the ICB website at the following https://leicesterleicestershireandrutland.icb.nhs.uk/annual-reports-and-accounts/ . The 2025-26 Health Inequalities Annual Report will be published in due course.

This report sets out inequalities that can be measured through routine NHS data sources, focusing on inequity in service access using deprivation and ethnicity. This does not negate the importance of other factors on health inequalities, for example, homelessness, being an asylum server or refugee, providing unpaid care for a family member, having a long-term mental health condition. These, and a whole range of other factors, will drive the inequalities that are experienced by the people of LLR and will be a feature of the work that the NHS and other partners are doing to reduce health inequity and improve outcomes for different populations.

The key findings within the report will help to inform commissioning decisions for the future.

Addressing health equity and health inequalities continues to be integral to all major strategies and work programmes of the ICB. The ICB's programme of work to improve health equity is guided by the principles set out in *LLR Health Inequalities Strategic Framework – Better Care for All* and the NHS inequalities improvement programme "CORE20Plus5". These principles are embedded in the LLR Integrated Care Strategy and the LLR Five Year Joint Forward Plan.

Mental Health services

In conjunction with Leicestershire Partnership NHS Trust (LPT) and our local communities, we have focused on improving the way adult mental health care is delivered across Leicester, Leicestershire and Rutland.

We have seen a sustained improvement in the performance of all Mental Health services, which has been recognised by NHS England. Again, this is something we are very proud of, but this does not stop us from striving for even better Mental Health services and support for the citizens of LLR.

Getting Help in Neighbourhoods

Through utilising our Getting Help in Neighbourhoods funding, we have been able to support a range of schemes run by voluntary community sector (VCS) organisations in local areas across LLR, this includes Neighbourhood Mental Health Cafes. We are pleased to report that we now have 16 Neighbourhood Mental Health Cafes across LLR, being run by voluntary and community sector (VCS) organisations. Between them, they offer a number of drop-in sessions per week for anyone who needs support with their mental health or emotional wellbeing. The cafes have been a lifeline for many people, who have found the support they need in their local area. These schemes delivered as follows:

- 10,638 Total Visits (9,147 visits 2024/25 - 16% increase)
- 4,703 City Visits (3,689 visits 2024/25 - 28% increase)
- 5,554 County Visits (4,732 visits 2024/25 - 17% increase)
- 109 Rutland Visits (97 visits 2024/25 - 12% increase)
- 15% New Visits (22% in 2024/25)

The support provided reduces pressure on NHS urgent and community service and better meets people's individual needs. We are extremely grateful and proud of the work undertaken by the VCS organisations.

Children and Young People (C&YP) Mental Health

Improving Access to mental health and emotional wellbeing support – VCSE and NHS providers across the system have delivered a variety of services for children and young people and performed above their planned target for C&YP's access. This has meant more C&YP have been able to access services and receive the support they need in a timely way.

Beacon Unit Day Service - Leicestershire Partnership NHS Trust chosen as one of two sites in the region to pilot a Day Service at the Beacon Unit for children & young people. It is designed to avoid inpatient admission and support the provision of care in the least restrictive environment. This means enabling children & young people to receive care and treatment closer to home and remain engaged in education, activities, and support networks locally. It will also play a key role in local eating disorder pathways, including provision for nasogastric feeding, to prevent avoidable admission and/or reduce the length of admissions.

Further information on performance across mental health is provided within the Performance Analysis section of the Performance Report chapter.

Learning disabilities services

Our learning disability services have continued to go from strength to strength. The establishment of the LLR Learning Disabilities (LD) Collaborative was one of the first of its kind nationally whereby all partners across health and care in LLR come together under the leadership of a single organisation to deliver transformative change across the system.

This collaborative has been led by LPT and in conjunction with partners has been working together to make a significant difference to the quality of care of our patients. We have seen an improving uptake of LD Annual Health checks with 85.7% of people, aged 14 and over, on the LD Register receiving an Annual Health check during 2025/26.

The Learning from lives and deaths – people with a learning disability and autistic people Programme (or the LeDeR programme) Annual Report is available on the ICS website https://leicesterleicestershireandrutlandhwp.uk/wp-content/uploads/2025/10/LLR-LeDeR-Annual-Report-October-2025.pdf .

Learning Disability and Autism (LDA)

The LLR LDA Collaborative, led by Leicestershire Partnership NHS Trust as the lead provider, continues to work with local partners to dramatically improve performance in all national performance indicators relating to learning disability and autism. There has been a key focus on discharge and getting people with LDA out of mental health inpatient settings and back into the community. The continued work of the dedicated LDA Case Managers, and closer joint working between health and local authorities as part of a discharge hub has seen a significant improvement. The LLR system has significantly reduced the number of people with a learning disability and autistic in mental health inpatient settings and is now below the per million inpatient rate set nationally by NHS England.

During 2025/26 the LLR LDA Collaborative was one of two national NHS England sites testing the feasibility of developing a combined health check for people with a learning disability, severe mental illness (SMI) and autistic people. This was in recognition of our consistently high performance in the delivery of LD Annual Health Checks, over a number of years. The pilot is in the final stages of being independently evaluated, and this report will be used by national NHSE colleagues to inform the future of health checks delivered in primary care. The LDA Collaborative is developing plans for piloting a targeted health check for autistic people during 2026/27 and identifying all opportunities for embedding the learning gained through participation in the pilot.

STOMP/STAMP

The system wide STOMP/STAMP (Stopping Over Medication of People with a Learning Disability, Autism or both with psychotropic medications) working group has continued its impactful work, with 3316 individuals with a learning disability and autistic people receiving a review of their psychotropic medication during 2025/26. This continues the year-on-year increase in the number of people receiving a STOMP review, with a total of 88 people having inappropriate medication stopped. As a result, the LLR system is able to demonstrate strong, safe and conservative psychotropic prescribing for people with a learning disability and autistic people.

GP Ambassador Network and LD Friendly GP Practices

Supporting the systems achievements in relation to Annual Health Checks is the establishment of the GP Ambassador Network, led by the Primary Care Liaison Nurses, and the development of the GP LD Friendly Practice Award to recognise and communicate good practice in improving access and reducing barriers for people with a learning disability.

SEND Alliance

The SEND Alliance has been established to ensure children, young people and young adults with special educational needs and disabilities and their families and carers can enjoy fulfilling lives and achieve their full potential, and to ensure that they can access impactful support from the right people at the right time.

The Alliance provides the opportunity for education, health, social care and voluntary and community sector organisations to come together to embrace difference, solve challenges such as unwarranted variation and inequality, as well as to improve resilience. It is expected that all parties will play a full part through commitment and the allocation of resources.
The Alliance, along with place-based partnerships, will be a key component of the Integrated Care Systems (ICS), enabling the local system to deliver better health, education, care and efficient use of resources.'

Services for Children and Young People

We are proud of our work with local partners to positively transform children and young people's experiences of emotional, mental health and wellbeing services through our Local Transformation Plan as published on the ICB website.

This has allowed us to reflect on the excellent quality of service we have delivered so far as we continue to build on our ambitions to transform children and young people's emotional, mental health and wellbeing

services within our integrated model of care. We continue to work on improving access to services by working collaboratively with our partner agencies from statutory organisations to voluntary, community and social enterprises and charities.

We have improved on our access to services across LLR through initiatives such as the online self-referral to triage and navigation, ensuring more children and young people are able to access support for their mental health and emotional wellbeing in a timely manner. The online self-referral is our single point of access to mental health and emotional wellbeing support. Previously the only route into services was via the GP. This now allows children and young people, parents and carers to complete a referral for mental health and emotional wellbeing support without the need to see their GP. See also the Performance Analysis section of the report.

Women's health and maternity

Our vison for women's and maternity services across LLR remains pivotal to our priorities. We continue to strive for an equitable service which is safe, personalised, kinder, professional and more family friendly. Where every woman has access to information to enable her to make decisions about her care; where she and her baby can access support that is centred around their individual needs and circumstances.

We want our staff to be supported to deliver care which is women-centred, working in high performing teams, in organisations which are well led and in cultures which promote innovation, continuous learning, and break down organisational and professional boundaries.

Over the last year our overarching key priorities remained:

- Listening to and collaborating with women and families with compassion.
- Reducing Health Inequalities
- Developing and sustaining a culture of safety, learning, and support.
- Improving access to care as close to home as possible.

Long-term conditions (LTCs)

a) An Enhanced Diabetes Service

An Enhanced Diabetes Service was rolled out to a further 78 GP practices, this means a total of 104 GP practices have signed up). Primary care staff have been trained and accredited to initiate insulin, provide continuous glucose monitoring and specialist medication. This is more convenient for patients, enables earlier specialist intervention, provides care closer to home and facilitates better condition

management. An external evaluation of the programme identified a significant improvement in HbA1c targets in Type 1 and Type 2 Diabetic patients.

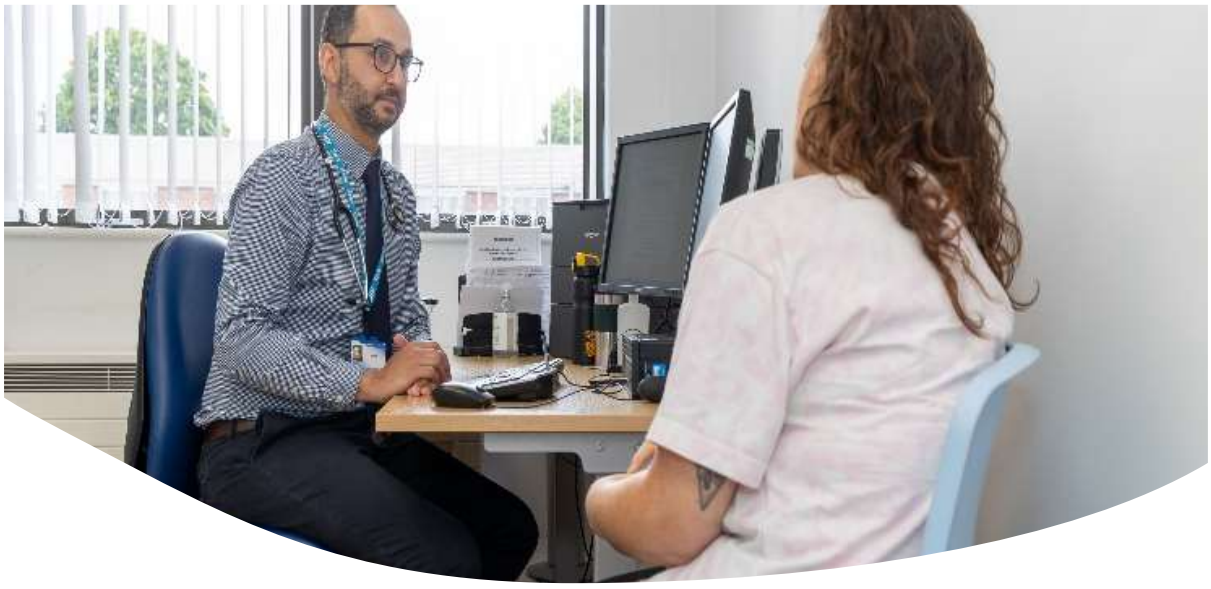
b) Type 2 Diabetes Remission Programme (T2DR)
Data from the first groups of patients completing the 12-month T2DR programme shows average weight loss of 12%. This makes a significant contribution to patient health and can result in the reversal of Type 2 diabetes. Both temporary or permanent weight loss can increase the number of years a person with a long-term condition spends in good health and reduces the risk of other diabetes complications and co-morbidities.

c) Outreach **respiratory case finding in homeless people –** this programme focused on finding and managing people not receiving treatment. It resulted in 595 people being invited and 68 attendances for screening. 15 of those received a new diagnosis of obstructive airway disease; 33 people received a clarified diagnosis of asthma/COPD and had treatment reviewed in a multidisciplinary team clinic; and 13 people with an existing diagnosis had their treatment changed.

d) **Long Covid assessments -** waiting times for rehabilitation have reduced from 9 months to only 6 weeks.

e) A **Rehabilitation in Multi-morbid Patients** (RAMP) research study is in process to identify the impact of inequalities on LLR patients' access to, and outcomes of, respiratory rehabilitation. The findings were discussed at a workshop and the resultant actions are being implemented to help increase rehabilitation attendance and completion.

f) **Lipid management** in LLR shows consistent incremental improvements month on month. We benchmark 2% higher than the national average and 3% higher than our 10 regional comparator ICBs. LLR has the highest levels of lipid treatment amongst people resident in the highest deprivation quintiles. Lipid management is for the primary and secondary prevention of cardiovascular disease (CVD).



Modern General Practice Model in LLR – achievements to date

Improved evening and weekend same-day NHS appointments for Leicestershire patients

During 2025/26 arrangements were agreed to enable patients registered with GP practices in Leicestershire to benefit from improved same-day GP appointments, available during evenings, weekends and bank holidays with effect from 1 April 2026. These appointments are part of a wider range of care options designed to make it easier for people to get help quickly for urgent but non-life-threatening health problems. The changes will increase the overall numbers of appointments and ensure patients are booked into the right appointment for their needs.

The new appointments will offer longer consultation times and will be delivered across a network of local GP practices and health centres, and at consistent opening times across Leicestershire.

Emergency Preparedness, Resilience and Response

The ICB works closely with EPRR teams and the Local Resilience Forum across LLR to ensure alignment of emergency plans. This partnership working has enabled the ICB to be part of a wider working group that shares a single purpose, improves productivity and supports managing the demands of emergency planning. The ICB represents health organisations at the Local Resilience Forum and in 2025/26 has supported, managed and co-ordinated the response to a number of incidents and events.

The NHS Core Standards for EPRR are the minimum standards which all NHS organisations and providers must meet to comply with the requirements of the Core Standards Framework, the NHS Contract, and the Civil Contingencies Act 2002. The ICB achieved an overall 'Substantial Compliance' rating for the 2025 Core Standards achieving 94% compliance up from 93% in 2024/25.

Over the past year the ICB has been involved in co-ordinating, managing or being part of a response to a number of incidents across the LLR footprint including, but not limited to, flooding, fires, IT outages and storms. Learning from these incidents has been used to further develop plans already in place and update training packages.

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 .

Delegation of commissioning functions – acute specialised commissioning services

On 1 April 2024, the LLR ICB had full delegated authority from NHS England for commissioning of 59 acute specialised services. The preparation for this delegation was undertaken in conjunction with the 11 ICBs across the Midlands regions.

Although NHS England remains accountable for the services, under this delegation the responsibility for all decisions relating to planning, design, quality, finance and delivery transferred to the ICB. LLR ICB continues to operate closely with other ICBs across the East and West Midlands to ensure effective commissioning and monitoring arrangements are in place.

There are numerous benefits to the delegation of these services to the ICB in terms of improving access to services for the populations that we serve hence improving health equity. There will also be opportunities for the ICB to influence and transform services to further meet local needs. The key benefits of this delegation include:

- **Equity of access for all patients:** there is good evidence that access varies across geographies with those further from specialised provision less likely to have access or may have delay in access.

- **Whole pathway approach:** joining up whole pathway is likely to encourage focus on upstream prevention improving overall patient outcomes and reducing need for specialised services. This ensures any proposed changes in specialised services are planned with interdependent local services; this could include diagnostic services, services that have a key pathway linkage or support services in health care or local authority provision.

- **Facilitation of whole pathway transformation across ICS footprints as new services are introduced:** allows implementation of clinical advances as close to home as possible for patients whilst maintaining speciality capacity for when needed most.

Leicester, Leicestershire and Rutland Green Plan

We have continued on 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, view the 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/

Implementation of the Provider Selection Regime (PSR) Regulations

During 2025-26 we continued to adhere to the legal framework for healthcare procurements. An annual summary of the number of contracts awarded through the PSR framework is detailed at Appendix 6.

Promoting research and development

Following the launch of our Research Strategy, during 2025/26 we have positively promoted research and development across LLR in conjunction with partners across healthcare and academic institutions to enable the use of research evidence to improve patient outcomes.

Further details are available in the Performance Analysis section of the Performance Report chapter.

Regular communication and engagement activities

We have continued to engage with our communities, including the voluntary, community and social enterprise sectors, with key information and updates.

a) We have produced and delivered impactful communication activities, developed to meet the needs of diverse communities, by actively involving them and supporting them to understand how to manage their health and how to access the local health services most suited to their needs.

b) With our **partnership approach** we use insights to ensure that our communication is timely, joined-up, that it resonates with the people we serve and is accessible. We regularly engage with our local communities, placing the patient voice at the forefront of how we shape and deliver our communication, to improve patient journeys.

c) The **population we serve is very diverse and our activities are co-ordinated to align with local needs** through awareness events and religious festivals celebrated by our communities, including marginalised groups, to ensure our communications is inclusive. The ICB is committed to actively contributing to positive workplace cultures and fostering community spirit. We will continue to celebrate diversity, ensuring our communication and engagement is sustainable and a catalyst for social and community cohesion.

d) Supporting people to access the right care when they need it**, increasing vaccination uptake, and helping communities manage seasonal illness and long-term conditions** have continued to be central themes of communications activity this year. Working with system partners and colleague networks, we provided adaptable toolkits for use across a wide range of channels, enabling consistent messaging and supporting behaviour change through local and national campaigns.

e) A key local initiative developed this year was the **'Need help fast?' campaign**, designed to help people get the right care, in the right place. To reduce confusion and avoid unnecessary use of walk-in services or the emergency department, the campaign promoted a simple two-step approach:

- Try self-care first using the NHS App, NHS 111 online or a local pharmacy.
- If symptoms are more serious, contact a GP practice or NHS 111, who will arrange the most appropriate care.

Launched in September 2025, the campaign has been positively received through our engagement programme, with 75 per cent of respondents saying they would follow the recommended steps the next time they needed same-day healthcare.

f) Throughout the year, we also continued to encourage **vaccination uptake** using a life-stage approach, helping people understand which vaccinations they were eligible for and when. This focused particularly on older and vulnerable adults, young children and people who are pregnant, and included promotion of Covid-19, flu, MMR, whooping cough and RSV vaccinations. Communications highlighted the benefits of vaccination, eligibility criteria, how to access appointments, and signposted to the online vaccination hub for tailored information. In addition, communications activity supported people to better manage long-term conditions, use inhalers correctly, stay well during seasonal illness, and take up screening offers.

g) Throughout the year, the ICB has **continued to produce a range of regular information** online and offline, to keep people informed of important health news. During 2025/26, our stakeholder e-bulletin Five for Friday has continued to go from strength to strength, achieving regular positive feedback and more subscriptions. Five for Friday is a weekly bulletin emailed to stakeholders and individuals in LLR, focusing on five timely health topics each week.

h) Since launching in September 2020, **Five for Friday** was sent to over 1000 people initially and is now sent to many more, including GP Practices, partner board members, local MPs, PPGs (Patient and Participation Groups), the voluntary sector and other interested individuals. It is shared wider by our partners and interest in the successful publication continues to grow. You can access Five for Friday and subscribe to receive it by clicking here.

i) The bulletin also includes e-toolkits that stakeholders are encouraged to use on their social media channels, to help spread the word on important health initiatives. Key stakeholders, including our local MPs have been helpful advocates in sharing and championing our health messages and we're grateful for the ongoing support.

j) During 2025/26 we **introduced quarterly NHS Briefings with our MPs' officers**, to discuss the health issues important to local MPs' constituents and to provide significant health updates. The briefings have been very popular and we will continue with this partnership, strengthening how we work together to deliver better services for our patients.

k) We have worked closely with our colleagues across the LLR health and care system, providing Communications support for the development and formal opening of a **Community Diagnostic Centre in Hinckley**. We also welcomed the national announcement that Hinckley Health Centre has been confirmed as one of the first 27 neighbourhood health centres to be rolled out across England, helping to bring more joined-up care closer to people's homes. The neighbourhood health centres will allow patients to access a greater range of health services from these centres – all under one roof and closer to their homes – including urgent treatment, GP and pharmacy services.

l) During the year, we secured **excellent media coverage on a range of positive news stories that will benefit local people**. Our news releases are available on our website and are also promoted on our social media channels. Our social media is a great way to keep people updated of healthcare news and advice instantly. We share valuable healthcare information several times a day and are active on X (former Twitter), Facebook, Instagram, LinkedIn and Youtube. People can visit our website homepage and click on the relevant social media icon to follow us and ensure they're not missing out on vital health news and updates: https://leicesterleicestershireandrutland.icb.nhs.uk/.

m) We are very proud of our achievements and we remain committed to strengthening our partnerships further as a ICB Cluster with Northamptonshire ICB. Our priority is to provide the modern, high-quality services that our local people expect and deserve, now and in the future, and with your support, we know we can achieve this together.

In celebrating all of our achievements over the year, we recognise there have also been a number of significant challenges during the last year. The main challenges being:

i. **Financial performance and risk** – ensuring financial sustainability and achieving financial balance has been extremely challenging over the last year as described in our regular reports presented to the ICB Board meetings. A collaborative approach to financial management and achieving value for money with our NHS partners across LLR and through our cluster arrangements with NICB has enabled actions to be taken collectively to manage our financial performance risks, although this continues to be significant risk for the ICB for the next year. Specific details on financial performance are detailed within the Performance Analysis section of the Performance Report chapter.

ii. **Performance against national targets and standards** - there is no doubt that this past year presented us with challenges in performance across the urgent and emergency care pathway as a result of increase in demand for services. This has impacted emergency response and impacted on elective services for our patients. 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 https://leicesterleicestershireandrutland.icb.nhs.uk/ . These reports provide further information about the standards and targets we have achieved and areas that require more work over the next year.

Toby Sanders

Toby Sanders
Chief Executive (Accountable Officer)
18 June 2026

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 to 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 2025/26.

The Accountability Report chapter provides further detail about how we identify and manage risks currently and Appendix 5 details the strategic risks as of 31 March 2025.

Our Performance

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. 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 the Performance Report chapter.

The national standards are outlined within the NHS Oversight Framework 2025/26 which informs the assessment of ICBs https://www.england.nhs.uk/nhs-oversight-framework/ .

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 Oversight Framework comprises a set of indicators and metrics aligned to priority areas in the NHS Long Term Plan. NHS England 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 is available on NHS England's website https://www.england.nhs.uk/nhs-oversight-framework/ . There are other performance metrics that are not within the NHS Oversight Framework, relating to cancer and mental health services waiting times, which are also reviewed to ensure the health outcomes of our patients continues to improve.

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 and delivery is through our performance framework that identifies standards that we have achieved and standards where further actions are required 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/ . The reports from the LLR Delivery Partnership for instance details the analysis of the performance 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.

Assurance on how well we are doing

Although during 2025/26 performance has improved significantly in some areas and in other areas performance has not been at the level that the ICB expected in the main due to increase in demand for urgent and emergency care services. 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 ambulance handover delays. However, this position positively improved through various interventions implemented throughout the year.

The quality and safety of the care the ICB commissions is pivotal to achieving our strategic objectives. 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. We have continued to challenge performance below expected standards through a number of routes; risks and challenges associated with non-compliance with specific standards is escalated through our governance arrangements as detailed in Appendix 1.

Performance against national metrics

The performance against national metrics is reported through the ICB's governance arrangements (Appendix 1) this included reports to the System Executive Committee, the Joint Quality, Performance and Outcomes Committee and then onwards to the ICB Board. These reports also provide overall progress against the ICB's Five-Year Joint Forward Plan and Operational Plan.

The report outlined key performance indicators and current areas of focus for Leicester, Leicestershire, and Rutland (LLR). The performance covers a selection of key performance indicators taken from local priorities such as ambulance handovers, as well as the NHS Oversight Framework (NOF) and national priorities to improve patient outcomes.

Performance against the national NHS system priorities and our ICB strategic objectives and pledges are highlighted below as reported in March 2026. The "Red, Amber and Green" (RAG) status in Table 1 below, the position demonstrates both positive areas of performance and areas for further development. Detailed trend analysis is provided within reports to the Board, Board papers can be found on the ICB website https://leicesterleicestershireandrutland.icb.nhs.uk/about/board-meetings/ .

Table 1: performance against NHS priorities 2025-26 as March 2026

UEC Measure	ICB Plan Mar-26	Current Month	ICB Plan	ICB Actual	UHL Plan	UHL Actual	12 month (ICB)
% of A&E attendances within 4 hours (all types)	78.2%	Mar-26	78.2%	79.5%	62.5%	66.4%	
% of Type 1 and 2 A&E attendances within 4 hours *UHL plan type 1	63.0%	Mar-26	63.0%	66.4%	59.6%	66.4%	
% of A&E attendances over 12 hours Type 1 and 2	-	Mar-26	-	8.1%	-	8.1%	
Ambulance handover monthly average time	00:15:00	Mar-26	00:15:00	00:23:51	00:15:00	00:24:31	
Ave bed occupancy (inc escalation)	93.0%	Mar-26	-	-	93.0%	89.3%	
Ave discharged on discharge ready date	88.3%	Mar-26	NA	NA	88.3%	86.9%	
Ave discharge delay	3.9%	Mar-26	NA	NA	3.9%	4.7%	

Elective RTT Measures	ICB Plan Mar-26	Current Month	ICB Plan	Current Month (29th March 2026)	UHL Plan (Feb)	UHL Actual (Feb)	12 month (ICB)
Total incomplete pathways	119,942	Mar-26	119,942	125,384	105,500	117,449	
65 week waits	NA	Mar-26	NA	82	0	103	
52 week waits	1,083	Mar-26	1,083	2,361	951	2,503	
52ww %	1.2%	Mar-26	1.2%	1.9%	0.9%	2.1%	-
18 week waits	74,746	Mar-26	74,746	72,148	65,726	57,544	
18ww %	-	Mar-26	-	57.50%	62.3%	55.7%	
First appointment 18ww %	69.8%	Mar-26	69.8%	60.00%	68.1%	61.6%	
Total <18 years	-	Mar-26	-	11,670	-	10,338	
52 ww <18 years	-	Mar-26	-	189	-	143	-
18 ww <18 years	6,582	Mar-26	6,582	7,607	-	6,755	
18ww % <18 years	-	Mar-26	-	65.20%	-	65.3%	-

Diagnostic Activity Measures	ICB Plan Mar-26	Current Month	ICB Plan	ICB Actual	UHL Plan	UHL Actual	12 month (ICB)
YTD Activity - MRI scans	7,283	Mar-26	7,283	7,842	6,535	6,885	
YTD Activity - CT scans	11,981	Mar-26	11,981	13,895	10,780	12,504	
YTD Activity - Non-obstetric Ultrasound	12,332	Mar-26	12,332	12,095	9,475	7,999	
YTD Activity - Colonoscopy	1,031	Mar-26	1,031	1,021	962	949	
YTD Activity - Flexi-sigmoidoscopy	394	Mar-26	394	328	357	296	
YTD Activity - Gastroscopy	837	Mar-26	837	1,105	765	1,003	
YTD Activity - Echocardiology	3,614	Mar-26	3,614	3,212	2,451	2,370	
YTD Activity - DEXA scans	1,128	Mar-26	1,128	1,202	1,020	1,068	
YTD Activity - Audiology assessments	1,658	Mar-26	1,658	1,705	1,041	1,225	
YTD Activity TOTAL	40,258	Mar-26	40,258	42,405	33,386	34,299	

Cancer Measures	ICB Plan Mar-26	Current Month	ICB Plan	ICB Actual	UHL Plan	UHL Actual	12 month (ICB)
% starting treatment within 62 days	70.3%	Mar-26	70%	64.8%	70%	63.8%	
% starting treatment within 31 days	90.0%	Mar-26	90%	89.2%	90%	88.2%	
% receiving diagnosis / confirmation within 28 days	80.0%	Mar-26	80%	68.3%	80%	67.6%	

Mental Health & Learning Disabilities Measures	ICB Plan Mar-26	Current Month	ICB Plan	ICB Actual	12 month (ICB)
Talking Therapies - Reliable Recovery	48.00%	Mar-26	48.00%	48.00%	
Talking Therapies - Reliable Improvement	67.00%	Mar-26	67.00%	69.00%	
Inappropriate Out of Area Placements	-	Mar-26	-		
Patients accessing Perinatal Mental Health services	1,259	Mar-26	1,259	1,255	
Children's & Young People's access to Mental Health services	17,745	Mar-26	17,745	18,525	
Individual Placement and Support	825	Mar-26	825	775	
Mental Health beds - ALOS	51.9	Mar-26	51.9	52.0	
Mental Health & Learning Disabilities Measures	**ICB Plan Mar-26**	**Current Month**	**ICB Plan**	**ICB Actual**	**12 month (ICB)**
Physical Health Checks - Learning Disabilities	4,009	Mar-26	4,009	4,585	
LD Inpatients - Adult	9	Mar-26	9	10	
Autistic Inpatients - Adult	13	Mar-26	13	14	
LD/A Inpatients - CYP	3	Mar-26	3	3	

Community Services Measures	ICB Plan Mar-26	Current Month	In Month	
			ICB Plan	ICB Actual
Community Care Contacts	1,126,352	Feb-26	86,096	100,965
Community Service waiting list over 52 weeks (CYP)	7,527	Feb-26	7,339	7,158
Community Service waiting list over 52 weeks (Adult	-	Feb-26	-	-

Primary Care Measures	ICB Plan Mar-26	Current Month	In Month	
			ICB Plan	ICB Actual
Appointments in General Practice	693,477	Mar-26	693,477	702,058
Units of dental activity delivered (rolling 12 months)	356,049	Q4	356,049	389,913
Unique patients seen - adult (rolling 12 months)	398,059	Q4	398,059	393,864
Unique patients seen - child (rolling 12 months)	164,777	Q4	164,777	166,846
Pharmacy First consultations	12,545	Mar-26	12,545	17,256

Maternity Care Measures	ICB Plan Mar-26	Current Month	In Month ICB Actual	
National safety ambition to reduce stillbirth (rate per 1000)	Reduction 2023 4	Dec-25	4	
Neonatal mortality (per 1,000 births)	Reduce 2021 2.4	2024	2.6	
Maternal mortality	Reduce 21/22 *	2023/24	0	

Area	NHS PRIORITIES 2025/26	Actual	Plan
CVDP002HYP: Percentage of patients aged 18 to 79 years with GP recorded hypertension, in whom the last blood pressure reading within the preceding 12 months is equal to 140/90 mmHg or less	Q3 25/26	66.46%	N/A
CVDP003HYP: Percentage of patients aged 80 years or over with GP recorded hypertension, in whom the last blood pressure reading within the preceding 12 months is 150/90 mmHg or less	Q3 25/26	80.86%	N/A
CVDP007HYP - Percentage of patients aged 18 and over, with GP recorded hypertension, in whom the last blood pressure reading (measured in the preceding 12 months) is below the age	Q3 25/26	69.34%	N/A
CVDP003CHOL - Increase the percentage of patients aged between 25 and 84 years with a CVD risk score greater than 20 percent on lipid lowering therapies to 60%	Q3 25/26	67.24%	N/A

Areas of performance improvement

Areas of improvement are indicated in the tables above.

Over the year, the system delivered measurable improvement in several priority areas, despite sustained demand and operational pressure:

- Improved 4-hour A&E performance (all types) exceeded the planned target and a significant stepped improvement in the delivery of type 1 4 hour performance.
- Significant improvement has been made in reducing handover delays.
- Increased diagnostic capacity, with activity delivered at or above plan across most modalities, providing a stronger platform to reduce waiting times.
- Earlier cancer diagnosis, with consistent achievement of the Faster Diagnosis Standard, supporting improved patient outcomes.
- Stronger mental health access and outcomes, including improved recovery and access rates for Talking Therapies, expanded access for children, young people and adults, and continued progress LDA annual health checks.

- Improved system resilience through primary care and community services, with high volumes of GP appointments, expansion of Pharmacy First, and growing community care activity helping to manage demand.

- Progress in elective recovery, including reductions in the longest waits, although further improvement is required to meet national standards consistently.

- Stabilisation of bed occupancy and flow, with targeted actions beginning to reduce long stays and support discharge, improving the system during periods of peak demand.

These improvements reflect significant collective effort across partners and provide a strong foundation for continued recovery and performance improvement in the year ahead.

Where performance deteriorates across specific standards and targets, the ICB is cognisant of the impact on health inequalities and application of corrective actions to improve performance is reported through the ICB's governance arrangements as outlined in Appendix 1.

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 partnership groups undertake further analysis of performance intelligence at place-level and neighbourhood level 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.

Performance against other metrics

Other requirements and metrics relating to our workforce and organisation systems and processes are also used as an indicator to understand and measure our performance.

- **Workforce policies** were in place across the organisation and continue to be reviewed to ensure they remain applicable and 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 to ensure we implement our workforce policies appropriately and are able to support our staff.

Mental Health expenditure

The ICB has demonstrated commitment to NHS England's mental health investment standard (MHIS) requirements, which require ICBs to increase their planned spending on mental health services by a greater proportion than their overall increase in budget allocation each year. This commitment is monitored through the ICB's governance arrangements as detailed in the Accountability Report.

Table 2 below details the amount and proportion of expenditure incurred by the ICB in relation to mental health over the last two years:

Table 2

Financial Years	2025/26	2024/25
Mental Health Spend	£230,646,000	£203,177,000
ICB Programme Allocation	£2,042,653,000	£1,904,559,000
Mental Health Spend as a proportion of ICB Programme Allocation	11.29%	10.67%

Children and Young People (CYP) safeguarding

The ICB continued to promote a positive culture of safeguarding through our partnership arrangements and through the safeguarding arrangements of services we commission to safeguard children and adults who are at risk of abuse.

The ICB successfully delivered against the benchmark requirements of the *NHS England Safeguarding and accountability assurance framework (SAAF): Safeguarding children, young people and adults at risk in the NHS* (2022) which set out the safeguarding roles and responsibilities of all individuals working in providers of NHS-funded care settings and NHS commissioning organisations.

The ICB continues to be responsible for the provision of effective clinical, professional and strategic leadership in child safeguarding, including the quality assurance of safeguarding through their contractual arrangements with all provider organisations and agencies, including from independent providers and has followed the necessary statutory assurance processes to support this.

Working in Partnership

Over the last year we have worked closely with Leicester City Council, Leicestershire County Council, Rutland County Council and the police to discharge our duties as members of the Safeguarding Children's Partnership Board. The ICB's designated professionals and Safeguarding Team have been both leading and engaging with partners to deliver against the agreed strategic priorities of the Board's Business Plans, and ensured that learning from all safeguarding reviews was disseminated across the health system to front line practitioners. Links to key documents are provided below:

- The Board's Business Plans can be accessed via the links below: https://www.lcitylscb.org/about-the-lscpb/lrscp-and-lscpb-joint-business-plan/

- The Leicestershire and Rutland Safeguarding Children Partnership Annual Report 2023/24 can be accessed at the following link https://democracy.leics.gov.uk/documents/s185069/Appendix%20-%20Leicestershire%20and%20Rutland%20Safeguarding%20Children%20Annual%20Report.pdf

- Leicester Safeguarding Children Partnership Yearly Report 2023/24 is available at the following link: https://cabinet.leicester.gov.uk/documents/s157647/Safeguarding%20-%20Scrutiny%20Commission%20-%20Cover%20Report.pdf

Working Together to Safeguard Children 2018 requires Local Safeguarding Children Partnerships to publish a threshold document, which sets out the local criteria for action in a way that is transparent, accessible and easily understood. For Leicester, Leicestershire and Rutland the Safeguarding Children Partnership has in collaboration published a procedures manual which is available at the following:

https://lrsb.org.uk/uploads/view-the-llr-scp-thresholds-for-access-to-services-for-children-and-families-in-leicester-leicestershire-rutland.pdf?v=1633694812

The joint business plan and annual reports can be found at the following https://lrsb.org.uk/scp-annual-reports-and-business .

Learning from safeguarding reviews and Domestic Homicide Reviews: The designated safeguarding professionals and Safeguarding Team have been instrumental in the design and delivery of safeguarding briefings, learning events and updating safeguarding procedures to support front line service delivery.

We set out below some of the examples of the positive actions and steps we have taken in discharging our duties:

a) Safeguarding Children

- In response to the Child Safeguarding Practice Review Panel*: National Review into Non-Accidental Injury in children under the age of 1. "The Myth of Invisible Men" Safeguarding children under 1 from nonaccidental injury caused by male carers* (2021): the ICB has supported the development and distribution to front line staff of Practice Principles – engaging fathers, and male carers in effective practice: this guidance is now embedded in the LLR Safeguarding Children Procedures.

- Leading the ICON programme (Infant Crying is normal: Comfort methods can help: it's okay to walk away: never, ever shake a baby) with messages being delivered by midwives, health visitors and general practitioners amongst others. https://lrsb.org.uk/icon.

- The dissemination of a multi-agency safer sleep assessment tool to reduce the incidence of baby death by overlay and unsafe sleeping arrangements.

- Questions have been developed to encourage disclosure of serious violence and child exploitation during assessment by the ICB commissioned Barnardo's Dynamic Support Pathway for children with learning difficulties or autism.

- Single organisation and joint organisations audits have been undertaken to provide assurance of delivery of national and local guidance including those aligned to the National Child Safeguarding Practice Review Panel and Children and Young People in Care Out of Area Midlands Mental Health Principles of Good Practice. Learning from the audits has been used to improve local systems and processes.

- The commissioning principles of the Special Allocation Scheme has been reviewed to include exploration of the provision of primary medical services for children and adults with care and support needs whose main carer is registered with the scheme.

- The self-harm and suicide procedure has been updated and reflects evidence of risks from the National NCMD research (2021) and local Child Death Overview Panel suicide reviews.

b) Looked After Children

The ICB Designated Nurse for Looked After Children has supported several initiatives for this cohort of children including:

- Working alongside the Leicestershire Police Missing Person's Referral Unit and the community health provider of Looked After Children's services supporting the delivery of the Philomena Protocol. This work involves assigning Looked After Children's nurses to geographical areas and aligning to independent and Local Authority run children's homes to build professional relationships and maintain a focus on the health and well-being of the children in care.

- Ensuring active participation at the Midlands Strategic Migration Partnership ensuring the specific health needs of Unaccompanied Asylum-Seeking Children is built into the work of Looked After Children's services and linked with refugee support in the ICB.

- Working with our community health provider of the Looked After Children teams to create a transition pathway that prepares where required Looked After Children to move to adult health services. This is via a staged process built into Review Health Assessments from Year 9 and transitions worker to support those Looked After Children aged 17.5 to 25 years to transfer into adult mental health service.

The ICB also continued its commitment to safeguarding adults, details for which are provided later in the Annual Report.

Environmental matters

Climate change remains one of the most significant threats to population health. As part of the NHS commitment to become the world's first net zero health service, Leicester, Leicestershire and Rutland ICB (LLR ICB) is strengthening its system leadership role to reduce emissions, improve environmental sustainability, and enhance health outcomes.

In 2025/26, the ICB has prioritised embedding sustainability within clinical transformation, medicines optimisation, infrastructure planning, and supply chain reform. Particular emphasis has been placed on aligning carbon reduction with population health improvement and health inequalities priorities, recognising the disproportionate impact of climate change on vulnerable communities.

Sustainability and procurement

We actively consider sustainability issues and risks. Social Value and the Carbon Reduction Plan requirements are part of the planning (pre-procurement) and procurement process. With the introduction of the NHS Provider Selection Regime (PSR) Regulations 2023 from 1 January 2024 Social Value (including Carbon Reduction Plans) remains one of the key requirements.

Reducing the overall environment impact in our buildings

We continue to work with our landlord and ICB staff to reduce power and water consumption, and we are working with our landlords to ensure sustainable practices are adopted such as recycling and good use of energy in our ICB headquarters at County Hall, Glenfield.

Due to our Agile Working Policy with staff working from home for part of the week, this has reduced our impact from commuting, and power and water consumption. Due to us leasing our ICB headquarters building and its shared occupancy, we are unable to provide figures for energy and water usage or waste and recycling.

Task Force on Climate-related Financial Disclosures (TFCD)

Taskforce on Climate-related Financial Disclosures (TCFD) recommended disclosures as interpreted and adapted for the public sector by the HM Treasury TCFD aligned disclosure application guidance, will be implemented in sustainability reporting requirements on a phased basis up to the 2025-26 financial year. Local NHS bodies are not required to disclose scope 1, 2 and 3 greenhouse gas emissions under TCFD requirements as these are computed nationally by NHS England.

The DHSC GAM has adopted a phased approach to incorporating the recommended TCFD, as part of sustainability annual reporting requirements for NHS bodies, stemming from HM Treasury's TCFD aligned disclosure guidance for public sector annual reports.

The phased approach incorporates the disclosure requirements of the governance, risk management and metrics and targets pillars. These disclosures have not been provided because our organisation has less than 500 employees, and we are not currently required to provide it.

Locally we have taken the following actions in relation to TCFD:

- The wider impact of climate-related risks on the ICB's broader responsibilities is integral to the ICB's Five Year Plan as it plays a pivotal role in commissioning high quality healthcare efficiently and effectively.
- As an NHS organisation, and as a spender of public funds, we have an obligation to continuing 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. We aim to make the most of social, environmental, and economic assets and consider social and environmental impacts for instance through our commissioning for value framework.
- We have embedded sustainability, environmental matters and consideration of social value through our business processes. For instance, through our procurement processes when assessing suppliers, and through our governance and risk management arrangements. The ICB has adopted the PESTLE (political, economical, social, technological, legal and environmental) model to identify and assess its strategic and operational risks. The ICB's risk management processes for identifying, assessing and managing risks, including climate-related risks, are outlined in the Governance Statement within the Accountability Report

The Green Plan

The ICB has in place the LLR ICS (Leicester, Leicestershire and Rutland Integrated Care System) Green Plan which covers a three-year period (July 2022 – July 2025) in line with the National Health Service (NHS) requirement to create a plan aligned to the goal of 'Delivering a Net Zero National Health Service'. The Green Plan is available on the ICB website at the following link https://leicesterleicestershireandrutland.icb.nhs.uk/our-work/green-plan/ .

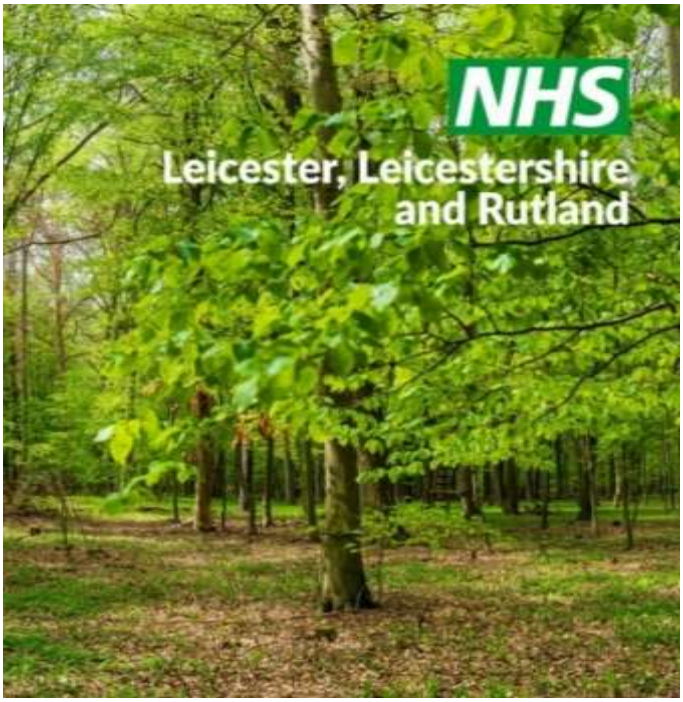
The Green Plan sets out a collective vision and the actions that the LLR system will take, to support national and regional NHS targets for carbon reduction; prioritising

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 across LLR partners to achieve desired outcomes in a cost-effective and efficient manner.

The Plan addresses wider sustainability priorities including carbon emissions, waste, elimination of single use plastic, travel and air pollution, site greening for patient and staff wellbeing, sustainable models of care across the region and collective efforts to reduce the impacts of medical processes (particularly anaesthetics) and the use of sustainable medicines, and sustainable procurement. It is built upon the foundations of the existing University Hospitals of Leicester NHS Trust (UHL) and Leicestershire Partnership NHS Trust (LPT) Green Plans.

The Green Plan follows a national NHS framework based on the following areas alongside a summary of key actions the system will take over the next three years:

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



The ICB Board has oversight of the performance against the metrics within the Plan through the Executive Officers, who review and assess risks and issues. The governance arrangements are detailed within the Accountability Report.

The LLR ICS Green Plan outlines the priorities and metrics that the LLR ICB is aiming to achieve working with partner organisations across the system. The Plan is available on the ICB website at the following link https://leicesterleicestershireandrutland.icb.nhs.uk/our-work/green-plan/. An overview of the key regional targets across the Midlands and achievements are detailed in Table 3.

Table 3

Achievement	Next Steps
Achieved a 24% reduction in the carbon footprint on the 2019/20 baseline year from all inhalers prescribed in primary care	Continue to promote safe and responsible disposal of inhalers through community pharmacy and by secondary care providers. Continue to optimise inhaler technique through training and education of both healthcare professionals and patients across the ICS. This will in turn reduce inhaler prescribing.
Identified causes of waste of nitrous oxide at all sites, decommissioned supply at Rutland Memorial hospital. and secured funding for decommissioning at Glenfield hospital.	Glenfield hospital Nitrous Oxide manifolds to be decommissioned
Complies with national requirements for sustainable procurement by the inclusion of a 10% weighting for social value in every tender, and by through the requirement for a Carbon Reduction Plan (CRP)/ Net Zero Commitment (NZC) for new procurements	The Trust partners and ICB are managing and shaping their supply chains through CRP Requirements for procurements of high value (£5m per annum) and through NZC for procurements of lower value (below £5m per annum.)
The Green Board has raised awareness of and supported the system to submit applications for external funding for sustainability measures – such as Nitrous oxide waste mitigation funding, Department for Energy Security and Net Zero (DESNZ), Great British Energy, EV Charging Infrastructure.	
Our provider trusts monitor and report progress on their journey to increase the proportion of their fleet vehicles to lower emission vehicles	(90% to be low emission, 11% to be ultra-low or zero emission)

As the current LLR Green Plan nears the end of its term, work is underway to refresh it with a new 3-year plan, building on the progress of the current plan and reaffirming the ICB's role in:

- providing system leadership on emissions reduction
- supporting partner trusts to deliver their green plan objectives and overseeing progress,
- supporting general practice to contribute to emissions reductions
- sharing best practice with our partners
- maximising opportunities to reduce emissions through the commissioning of NHS services
- ensuring that Plan priorities are aligned with and reflected in our key documents i.e. ICB Joint forward plan, LLR NHS Infrastructure Strategy and other relevant system-wide plans in line with the strategic priorities.

The refresh of the plan will be considered across the ICB cluster, in collaboration with Northamptonshire ICB.

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.

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 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 continued to be underpinned by our Quality and Performance Improvement Strategy and implementation is monitored via the System Quality Group which reports into the LLR ICB's Quality and Safety Committee.

Key areas of focus during 2025/26

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

Urgent and emergency care pathways and winter preparedness

During 2025/26 the assessment of risk to quality and patient safety was at the forefront of strategic decision-making in preparing for the surge of demand for urgent and emergency care throughout the winter period.

Patient safety

From a patient safety perspective, we have continued to support:

- Sharing of learning from incidents identified through the Patient Safety Incident Review Framework (PSIRF)
- Learning from transferring care safely concerns raised within the system, resulting in changes to care pathways.
- Education for General Practice regarding the Learning from Patient Safety Events service (LFPSE) and support with registration. LFPSE offers a single national system

for recording safety events, ensuring GP practices can report incidents, near-misses, and good practice consistently, which supports stronger learning and improved care.

Infection Prevention and Control

We have continued to work collaboratively with our healthcare providers, bringing oversight, leadership, support, and guidance to ensure effective management in the prevention and control (IPC) of infections. This included working with colleagues across our medicines management and immunisation and vaccination teams, systemwide meetings with IPC leads across acute, mental health, community and primary care settings to learn from incidents, outbreaks management and good practice as well as working with our Local Authority partners and the UK Health Protection Agency.

Risk focused visits have been undertaken during 2025/26 and IPC data is systematically reviewed and shared locally to ensure maximum impact on improvements and support best clinical practice.

It has been a challenging year with infection outbreaks (Mpox, RSV, Flu and Norovirus have been very visible within the healthcare system) and the emergence of measles which became prevalent, however, as a system we have responded quickly and effectively for our service users. System IPC response action cards have been developed with system partners to build on learning from infection threats where a dynamic system co-ordination and collaboration is required to respond. This partnership collaboration in developing local standards, and development of pathways for our more vulnerable cohorts of our population helps retain our focus on preventable infections.

Serious Violence duty

The Serious Violence Duty (SVD) came into effect in January 2023 and introduced a new statutory duty for specified authorities in a locality to collaborate to prevent and reduce serious violence. Leicester Leicestershire and Rutland ICB is the specified authority for health. We continue to work as a member of the LLR Strategic Partnership Board (SPB) with the Leicestershire police force, local authorities, the justice system, Leicestershire fire and rescue service and other partners to share information and collaborate on interventions to prevent and reduce serious violence and crimes.

We have supported the Violence Reduction Unit Home | Violence Reduction Network which is an alliance of groups, organisations, and communities determined to prevent and reduce serious violence locally, in undertaking a strategic needs' assessment and producing a plan to tackle serious violence in LLR. We are active members of Community Safety Partnerships (CSPs) which provide a multi-agency approach to tackling local issues with the aim of making communities safer.

Youth Justice Service

The two Youth Justice services across LLR promote a child first approach that diverts children away from the criminal justice system through early intervention and rehabilitation aiming to support at risk young people to lead crime free lives. The ICB supports this work and fulfils its duties by actively participating and contributing to the service, the aims of the national Youth justice Board and local ambitions by supporting the two local youth justice management boards delivered by the respective Local

Authorities. All youth justice management board members have undergone child first training.

Looked After Children

We are fully committed to ensuring parity for Looked After Children and Care Leavers. We work together with our providers and Local Authorities to commission effective services including initial and review heath assessments. We do meet our requirements with these assessments. Our Designated Nurse and Designated Dr for Looked After Children provide expertise and support to ensure the voices, feelings and wishes of children and young people are heard, and that they remain central to service development and commissioning intentions. One of the greatest achievements is the NHS Universal Family programme to support introduction to employment ,2 cohorts have now graduated.

Safeguarding

The ICB continued to work collaboratively with our statutory partners the three Local Authorities and Police, and with wider ICS partner agencies, such as healthcare providers, education, and justice system to safeguard children, young people and adults at risk.

The ICB is a statutory safeguarding partner alongside three Local Authorities and the police as a member of the Safeguarding Children's Partnership Board and the Safeguarding Adults Board. Over the last 12 months a key focus of the work of the ICB designated professionals and Safeguarding Team has been both leading and engaging with partners to deliver against the agreed strategic priorities of the Boards Business Plans, and to ensure that learning from all safeguarding reviews and Domestic Homicide Reviews has been disseminated across the health system to front line practitioners.

The Boards' Business Plans can be accessed via the links below:

- https://www.lcitylscb.org/about-the-lscpb/lrscp-and-lscpb-joint-business-plan/
- https://lrsb.org.uk/uploads/leicester-leicestershire-rutland-safeguarding-adults-boards-strategic-plan-2020-25.pdf?v=1634744914

- **Safeguarding Children and Adults -** throughout 2025/26 Leicester Leicestershire and Rutland ICB has continued to discharge its statutory safeguarding duties in relation to safeguarding children, young people and adults at risk. The Chief Executive Officer holds overall accountability for safeguarding. This accountability is supported by the Executive Chief Nurse and enacted at place through the directorate senior management team and Designated Professional teams and functions. We continue to discharge safeguarding duties and functions in line with relevant current statutory legislation.

  The System Quality Group provided safeguarding system oversight to give assurance that we are meeting our statutory duties and against the Safeguarding Children, Young People and Adults at Risk NHS: Safeguarding Accountability and Assurance Framework 2022 (SAAF).

  During this period safeguarding assurance of NHS commissioned services continue via quality schedules, safeguarding key performance indicators, NHS

England commissioning standards, Section 11 audits, action plans and self-evaluation frameworks. NHS England requires the ICB to submit a response to the requirements of the SAAF. The ICB has submitted its Safeguarding Self-Assessment to provide assurance of its arrangements and evidence in how the framework is met. We were able to maintain compliance with all measures except for compliance with the safeguarding workforce capacity.

As an organisation, we have supported and contributed towards statutory safeguarding reviews and disseminated learning from national and local reviews across the ICB and wider partnership

- **Partnership Working:** The ICB worked seamlessly across the Integrated Care System (ICS) to safeguard children, young people, and adults at risk, working with statutory and responsible partners and agencies to effectively safeguard our population. We are a statutory safeguarding partner and member of the Safeguarding Children's Partnership Board and the Safeguarding Adults Board. As an active member of the board and its subgroups we support delivery of the agreed strategic priorities of the Boards Business Plans, and to ensure that learning from all safeguarding reviews and domestic abuse related deaths has been disseminated across the health system. Links to board business plans can be found below.

  During this period the ICB worked across our Children's Safeguarding Partnerships to meet the published requirements of the Working Together to Safeguard Children Guidance.

- **Child Death Overview panels (CDOP):** The ICB commissions our local provider Leicestershire Partnership Trust to continue its leadership of the Child Death CDOP process. A separate annual report is undertaken each year.

- **Domestic Abuse:** We recognise this as an area of focus. We are members of the Domestic Abuse Boards working with our system colleagues supporting work at a strategic and operational level to safeguarding vulnerable individuals.

- **Prevent:** Designated professionals have supported the local Prevent partnership and ensured ICB staff and staff in commissioned services can access appropriate training.

- **Families First Partnership (FFP):** A key area of focus this year has been with the planning around the Families First Partnership (FFP) programme where our safeguarding children designate has taken a lead role. The ICB will continue supporting the delivery expectations within this programme throughout the coming year. Families First Partnership programme - GOV.UK

  The ICB via the Safeguarding team will continue to support delivery against statutory functions and safeguarding responsibilities. Key safeguarding priorities will be agreed so that we can remain responsive, flexible to demands and work positively across the system to ensure safeguarding process and practice are effective and robust.

The following links provide information on the safeguarding arrangements and annual reports for the Safeguarding Children Partnership Boards and Safeguarding Adult Boards.

	Children's Safeguarding	Adult Safeguarding
Annual Report	lscp-yearly-report-2024-25-final.pdf Leicestershire and Rutland Safeguarding Children Partnership - Leicestershire and Rutland Safeguarding Partnerships Business Office	Leicestershire and Rutland Safeguarding Adults Annual Report Safeguarding adults board | Leicester City Council
Strategic Plans	SCP Annual Reports and Business Plan - Leicestershire and Rutland Safeguarding Partnerships Business Office	Leicester, Leicestershire and Rutland safeguarding adults boards strategic plan 2025-2031.pdf

Children and Young People (CYP) Services

The focus of CYP activities are sub-divided into the following core areas: 1) Transformation, 2) Mental Health, 3) Personalisation and 4) Special Educational Needs and Disability (SEND).

The ICB has taken a lead in relevant groups and partnerships (both Clinical and Managerial) and is working in conjunction with Leicestershire Partnership NHS Trust, University Hospitals of Leicester NHS Trust and all three Local Authorities to focus on supporting Children and Families with their physical, mental and education requirements by working collaboratively.

Special Educational Needs and Disabilities (SEND)

Special educational needs and disabilities (SEND), The Children and Families Act 2014 and corresponding SEND regulations and SEND code of practice sets out statutory duties and guidance to local authorities, education, health and social care to ensure that children and young people with SEND are supported to meet their potential and achieve good outcomes.

We continue to work with our system partners to jointly commission and deliver SEND services and to ensure quality Education, Health and Care Plans (EHCPs).

Working in partnership with our three Local Authorities, community health providers and parent carer forums, we

have continued with the following programmes of work: East Midlands Regional Partnership Change Programme, Early Language Skills for Every Child (ELSEC) Programme and Partnership for Inclusion of Neurodiversity in Schools (PINS) project.

There were a number of areas of focus during 2025/26 that we have progressed to improve patient care and support families as follows:

- Children's Mental Health – improvements in access to diagnosis and treatment to children with ADHD and Autism as there were significant waits which we will continue to address.
- SEND and Personalisation – these services are provided by dedicated teams across all organisations who are collaborating to ensure consistency and continuity of support.
- Transformation – improvements in access to Urgent Care and Elective Services for children and to continue to focus on improving the provision of services to children with epilepsy, diabetes, continence issues, respiratory conditions and end of life support. We have worked in partnership to develop plans to support children with Downs syndrome and cerebral palsy
- Prevention – we have continued to work with our partners to maintain a focus on prevention across the system focusing on both physical and mental health.

The key priorities for SEND during 2025/26 included:

- Help shape whole school SEND provision.
- Provide early interventions at a school level.
- Upskill school staff.
- Support strengthening of partnerships between schools and parent carers.

PINS projects have provided two parallel and complementary strands of work for each participating school. These have consisted of delivery of a package of tailored support (which could include training, resources, audits and reviews of provision) by specialist education and health workforces to the school; and a programme of parent carer engagement activity, which have included the formation or development of a parent carer engagement group in each school, and the facilitation of regular meetings between representatives of this group and the school's senior management team.

The key achievements during 2025/26 included:

- September 2025 was the launch of year 2 of the PINS programme of work across LLR.
- Completed a series of Training Courses either in person or remotely.
- Supportive Tool/training Kits delivered to all schools involved in the project, these included books, sensory aids and equipment to support children with neurodiverse needs.
- 3 Embed Community of Practice Sessions completed
    1. 17 November 2025 – Introduction to the Embed Offer, areas of Good Practice, challenges, access to resources and future sessions.
    2. 12 February 2026 – shared good practice from training sessions, included feedback form parent career forums and individuals with lived experiences of children and young people with Autism.
    3. 28 March 2026 – Hypersensitivity and experience of seeing the Autism Outreach Bus.

Women's health programme

A key priority area for 2025/26 was to better understand and tackle disparities in experience and outcomes through women's lives. To begin this undertaking, we need to understand the position and overview of women's health across Leicester, Leicestershire and Rutland, identify key areas where information is lacking, describe current services in relation to need, and to make recommendations on addressing gaps.

We successfully developed a Women's Health Needs Assessment in collaboration with Public Health and Integrated System Leads. This Health Needs Assessment mirrors the National Women's Health Strategy (2022) scope. Due to be published Summer 2026

To support the transformation and improvements of women's health pathways:

- Termination of Pregnancy (abortion) – Ensuring women have access to suitable contraception and the right to choose termination of pregnancy.

- Local network in place and undertaking scoping exercises in improving pathways between sexual health and abortion services, prioritising embedding national commissioning guidance (2025) and National Improving Abortion Care bundle, through embedding new quality and performance indicators, and ensuring contractual requirements meet national standards

- Fertility – Ensure consistency across regional as well as increase equity and access for same-sex

- Supporting the development of the new East Midlands Fertility Policy which increases access and consistency for the LLR population in receiving NHS-funded fertility treatment

- Women's Health Hubs (including menopause) - Increase proportion of care in high volume low complexity pathways provided in the community

- Women's Health Hubs have continued to show their impact, with 10,000 appointments attended.

- Understanding menopause needs across LLR, taking the North-West Leicestershire HSJ finalist (2025) to system boards for scaling across LLR.

Another key priority was to radically improve the way in which the health and care system engages and listens to all girls and women.

- LLR ICB have collaborated with Public Health and Health Watch to undertake a 6-month programme of engagement across Leicester, Leicestershire and Rutland to answer 1 key question:

  "Do women have the right information at the right time in their lives to make autonomous and informed choice about their health and wellbeing?"

- Methods of engagement have included a full survey, press-releases, focus groups and outreach events and VCSE promotion.

This seeks to:

- Produce a report summarising key findings, identifying and addressing key service gaps, outcomes an any barriers to accessing specialist care.
- Make targeted recommendations to NHS providers, Local Authorities and policy makers to enhance women's healthcare experiences.
- Host a stakeholder dissemination event to ensure local findings lead to action.
- Ensure follow-up with LLR ICB and local providers to track how services respond to recommendations.

Key areas for improvement include ensuring that the Women's Health Needs Assessment is utilised in the way it is intended working with system partners to implement areas for improvement.

Our priority areas for 2026/27 include the following:

- Drawing together the two sources of Health Needs Assessment and Engagement information, plus the addition of any further important intelligence in order to inform the continuing approach to women's health across the system.
- Prioritisation process and embedding recommendations from the WHNA, Engagement programme – including national women's health equity framework
- Embedding new policy for fertility.

Maternity, neonatal and perinatal services

2025/06 has been a challenging year for maternity and neonatal services across the UK with increased scrutiny and public attention with the announcement form the Secretary of State for health and Social Care that there would be a National Rapid Review of Maternity Services.

The investigation included 12 Trusts including University Hospitals of Leicester NHS Trust.

We worked in close partnership with the maternity Neonatal Voices Partnership (MNVP) and local communities groups to ensure the voices of families in LLR were heard in that process. We also worked closely with providers organisations to ensure that the interim recommendations from Baroness Amos were being embedded while we await the full report and recommendations.

The NHS England three-year maternity and neonatal three-year Single Delivery Plan for Maternity (published in March 2023 available at the following link https://www.england.nhs.uk/wp-content/uploads/2023/03/B1915-three-year-delivery-plan-for-maternity-and-neonatal-services-march-2023.pdf has now been completed.

The ICB has worked across the system and supported key workstreams that has led to improvement to experience and outcomes for families in Leicester, Leicestershire and Rutland. Being an organisation committed to excellence we continue to focus on continual improvement. We currently awaited the publication of the National Maternity and Neonatal Investigation due in June which will provide a focus our next steps.

We have already started to see improvements in our local maternity services which can be seen in the recent results in our maternity survey and regional HEAT map. However, we still have great deal of work to do to continue to embed the cultural shifts.

We have worked hard as an ICB/LMNS to ensure we have an open and honest culture, encourage open conversations and a culture of no blame but one of learning and listening. Leadership and governance structures have been strengthened to take on the additional roles from NHSE. Clinical leadership has and been strengthened at all levels across our providers. We are now starting to see the benefits of this with a more stable workforce However, workforce continues to be a key challenge specifically in neonatal services and it will continue to be a key area of focused throughout 2026/27.

Maternity and Neonates Voices Partnership (MNVP) - throughout 2025/26 we have worked closely with the maternity team to support and develop the MNVP to improve maternity and neonatal services by engaging women and families. The MNVP have a clear vision ensuring women, their partners and their families are at the heart of our plan and future development work with the aims of:

- Increasing the awareness of the MNVP for Leicester, Leicestershire and Rutland particularly around seldom heard populations
- Increasing the membership of the MNVP ensuring representation from all socio-demographics
- Increasing the number of people involved in the work of the MNVP ensuring representation from all socio-demographics
- Empowering staff, VCSE and key stakeholders to increase awareness, membership and involvement of the MNVP
- Enhancing the digital presence of the MNVP across a range of online platforms
- Providing mechanism for receiving insights and data relating to maternity services
- Engagement undertaken from January to February 2026 gathered feedback from patients, families, carers, staff and students on the impact of the July 2025 pause of births at St Mary's Birth Centre
- Gathering feedback on the current and potential future service improvements and change.

Following the release of the 10-year plan, the national *model ICB blueprint*, the Strategic Commissioning Framework, and other essential documents, along with the ICB's decision to cluster with Northampton ICB, our Local Maternity and Neonatal System (LMNS) is currently in a period of transition

Consequently, existing governance structures will remain in place, but as the picture evolves, they will change to meet new requirements, including having a more cluster focus.

Other Key Achievements during 2025/26 include:

- Full implementation of Perinatal Pelvic Health Service. The service is available from pregnancy to 12 months postnatally and is led by a specialist team, following the national specification. The service is available in both acute and family hub setting to ensure equity of access for women and birthing people.

- The Perinatal Mental Health Team has exceeded its target of 10% of women accessing the service, to 10.8%, with waiting times for appointments improving.

- We are fully compliant this year with the maternity Incentive Scheme, meeting all 10 safety actions and are 97% compliant with the Saving Babies Lives Care Bundle.

- Introduction of electronic patient record system, Badgernet that has already resulted in improvements to access to data. There have been significant teething problems but maternity and digital teams are working closely with system partners to rectify this.

- Progress in strengthening Midwifery Continuity of Carer with new team recruited to offer antenatal and postnatal continuity to families in Bowling Green Lane area. The vision is to offer intrapartum care once established and the dedicated team are keen to be able to offer this gold standard of safe care as soon as they can.

- Key progress in implementing the LLR Equity and Equality Plan 2022-2027 including improvement to early booking rates with targeted focus on black women, who were disproportionately represented as late bookers, Vitamin D given to all pregnant women and implementation and embedding of Janam app that offers culturally appropriate information specifically for South Asian women.

- Since its launch in 2023 4136 have received STORK training (Supportive Training Offering Reassurance and Knowledge to new parents) and 3737 have received Basic life Support for a baby training.

- Key areas of Improvements for services for women with gestational diabetes include improvement in referral letters, safer alert systems so all health professionals are aware of gestational diabetes diagnosis and improvement to education and awareness to both professionals and families.

Areas for improvement include the following:

- University Hospitals Leicester has been included in the National Maternity Rapid review. Though the Maternity and Neonatal Voice Partnership the ICB has supported ensuring that voices of families in LLR are heard and are included in the investigation. The ICB will be working closely with partners to implement the recommendations from the final report when published.

- Though national EMMBRACE data from 2024 demonstrates there has been a reduction in neonatal deaths in the last year but that Leicester City continue to have infant mortality rates more than 5% higher than comparable trusts. Initial data from 2025 shows the rates of neonatal deaths are continuing to fall. With support from NHSE, the ICB and local authority have worked in partnership to undertake a deep dive into infant mortality with key stakeholders from across the system..

The next steps are to turn these insights into a robust action plan with key measurable outcomes.

Key priorities for 2026/27 will be:

- Being proactive and responsive to the upcoming publication and recommendations from the National Review of Maternity Services, Ockenden report into Nottingham University Hospitals and the Thirwill inquiry, all due for publication this year.

- In partnership with Local Authority, lead a system wide approach to reducing infant mortality in Leicester with high impact, measurable outcomes that positively impact our most vulnerable families

- Development of a strategic outcomes-based commissioning framework for maternity services

- Ensure we have a culture of listening and engagement with staff and women. we will engage service users, and community groups in the planning, implementation and review of services utilising our MNVP in the first instance

- Improve preconception/antenatal and postnatal offer as part of prevention by brining care closer to home via neighbourhood footprint

- To commission full implementation of Maternal Care Bundle via the EMMMN supported by robust commissioning arrangements in place with the other ICB clusters within EM to sustain service.

- To commission enhanced antenatal care to all women by offering Engagement

- Commission Transitional Care and ensure service achieves British Association of Perinatal Medicine (BAPM) standards and reduces separation of mothers and babies.

Research

The ICB has complied with its statutory duty to facilitate or otherwise promote (a) research on matters relevant to the health service, and (b) the use in the health service of evidence obtained from research.

The Research Strategy Group and Operational Working group meet regularly to provide oversight and leadership in this area, including activities to facilitate and promote research, such as:

- The development of a revised Research Strategy 2024 – 2029.
- The establishment of ICS Research Champions has been effective in promoting and supporting research and will continue in 2025/26.
- Provision of a local Research Conference
- Supporting the LLR Research Engagement Network (REN) project to increase engagement from underserved communities in research

Primary care research activity has increased, both in relation to the number of practices active in recruitment and the number of patients recruited. LLR is:

- second highest recruiting in the East Midlands
- Has the highest percentage of research active GP practices in the region
- Has the second highest recruitment in NHS trusts in the region
- Has the second highest number of ICS open studies in the region.

The ICB has complied with its statutory duty, as required by the Health and Care Act 2022, to facilitate or otherwise promote research on matters relevant to the health service, and the use in the health service of evidence obtained from research.

We are working Northamptonshire ICB to consider the research capability across the two ICBs, bringing partners together to design a more resilient and scalable regional function. Although national guidance on the future operating model continues to evolve, the ICB is proactively shaping this transition to protect local strengths, maintain visibility of research priorities, and ensure system partners continue to benefit from established academic collaborations and research infrastructure.

Through 2025/26 the ICB has strengthened its leadership, governance, and system-wide support for research. The ICS Research Strategy (2024–2029) is now being implemented across the system, supported by a refreshed Research Strategy Group with expanded membership to ensure broad engagement from partners across Leicester, Leicestershire and Rutland.

The ICB has continued to promote and support research through:

- **Strategic support to more than 40 research projects**, including funding applications, training, and project development.
- **Ongoing investment in Research Champions**, including strengthened focus on pharmacy and commercial research, contributing to increased primary care engagement.
- **Support for the Research Engagement Network (REN)** and wider public involvement initiatives, including multilingual ambassadors, community roadshows, and co-produced resources to increase participation from underserved groups.
- **Strong academic and system partnerships**, including with UHL, LPT, EMAS, the University of Leicester, DMU, ARC East Midlands, and the Leicester & Northamptonshire Academic Health Partners.
- **Support for innovation programmes**, including work on obesity pathways, health inequalities, and research capability building across primary and community care.

Research recruitment across LLR continues to lead the region. Leicestershire achieved the highest total recruitment, the highest GP practice recruitment, and the highest proportion of research-active GP practices in the East Midlands. This reflects strong engagement across primary care, NHS Trusts, and community settings.

The ICB also continues to promote the use of research evidence in commissioning and service improvement. Examples include the Falls Management Exercise programme, now rolled out and funded by the ICB, and the Egg Donation Study, led by DeMontfort University, whose outputs have been adopted nationally by the Human Fertilisation and Embryology Authority.

Overall, the ICB continues to demonstrate strong system leadership in research, supporting high levels of activity, collaboration, and public involvement, and remains fully compliant with its statutory research duties.

Medicine Optimisation and Safety

During 2026/27 we continued to improve quality and reduce harm from medicines. The following illustrates some of the ways in which we achieved this over the last year:

a) Corticosteroid eyedrops

Following a serious incident resulting in patient harm, we reviewed the prescribing of corticosteroid eyedrops across primary and secondary care to minimise inappropriate prolonged use by improving communication and introduction of a referral pathway back into secondary care. In January 2026, 586 patients were referred via the pathway for review and to date 564 have been clinically triaged. 138 did not require an appointment and 271 have been given an appointment or seen.

b) Anticoagulants

Following a series of incidents involving anticoagulants, and feedback from primary care clinicians, the ICB Medicines Optimisation Team (MOT) convened an anticoagulation task-and-finish group. From February 2025 – January 2026, the group undertook a strategic review of anticoagulant prescribing across LLR GP practices, using 143 alerts generated by the Eclipse risk-stratification tool which flagged co-prescribing of anticoagulants.

Follow up demonstrated that most practice responses to the alerts detailed a plan to manage the anticoagulant agents, which in most cases related to bridging between two agents. One practice required some support with management of the review process for patients prescribed DOACs and how this relates to their use of repeat dispensing. Overall, the T&F group were assured that there was a consistent approach to the prescribing of anticoagulants in primary care alongside strong awareness and use of local guidelines related to these medicines.

c) Ongoing improvement of READ coding of sodium valproate Pregnancy Prevention Plans (PPPs) and ARRs (Annual Risk Assessments)

Monitoring of the National Patient Safety Alert (NPSA) through the Medicines Optimisation Partnership Quality and Safety Subgroup highlighted ongoing gaps following the implementation of the referral pathway (March 2024) for the completion of Pregnancy Prevention Plans (PPP) and Annual Risk Acknowledgement Forms (ARAF) for patients prescribed valproate.

Additionally, a recent Car Quality Commission (CQC) inspection identified a requirement for the establishment of a sodium valproate register to record patients with a PPP/ARAF in place and ensure ongoing monitoring.

In response, the ICB convened a Task and Finish Group with representation from local NHS Trusts. This group coordinated a communication to primary care outlining three key actions:

1. Code all patients who have a completed PPP and/or ARAF.
2. Refer any outstanding neurology patients without a PPP/ARAF to UHL.
3. Refer all outstanding mental health patients to LPT.

These actions were reinforced via a dedicated primary care webinar.

Indications show positive improvement, with a doubling of the number of patients with a PPP/ARR in place. Continued oversight and progress tracking will be maintained by the Medicines Optimisation Partnership Quality and Safety Subgroup and a plan to address coding directly with outstanding practices.

d) Prevention of hospital admissions due to medication related events

For several years, General Practices across LLR have reviewed Eclipse safety alerts. A report commissioned by the ICB in Jan 2025 showed that LLR ICB ranks as a top performer in alert review rates and has a significantly lower proportion of patients with an active alert at the time of analysis compared to the system-wide average of other ICBs who use the Eclipse platform. This indicates a proactive and thorough approach to patient safety and clinical governance.

The findings of the report reinforce confidence in the alerting system's ability to accurately identify high-acuity patients who are most in need of clinical attention. Through an analysis of likely avoided scenarios because of timely alert reviews, LLR ICB's efforts in engaging with the Eclipse alerts has been associated with significant savings in 2985 bed days and the associated healthcare costs (£1,194,158).

e) LLR Appliance Prescription Service

In 2025 we implemented an LLR Appliance Prescription Service for continence appliances to issue prescriptions instead of GPs for these items. The Service is run by specialist nurses and trained operators. As part of the care package, patients receive a clinical review to ensure that they are prescribed the best appliance to meet their needs. Alongside this, we implemented an LLR Appliance Formulary led by specialists to select which are the best appliances to offer our patients.

f) Food First in Care Homes

We worked with Dietitians to implement a "food first" approach in care homes. Patients are now offered a choice of freshly made drinks to increase their calorie or protein intake which residents much prefer to the ready-made oral nutritional supplements (ONS) supplied on prescription.

Feedback from care homes and nursing homes has been positive. Staff report improved confidence in nutritional assessment and food fortification, as well as stronger collaboration with GP practices and dietetic teams. Importantly, care home residents are more likely to enjoy and accept food-based alternatives, which are described as tastier and more acceptable than prescribed ONS, supporting improved compliance and a more person-centred approach to care.

g) Reduce health inequalities through improving access and optimisation of medicines.

Completion of an Atrial Fibrillation (AF) Detect Pilot with a focus on deprived areas which has found 325 cases of AF across LLR, allowing appropriate treatment to be initiated to prevent stroke.

Ongoing development of risk stratification tools to enable prioritisation and review of patients with chronic kidney disease by the LUCID clinic and cardio-renal-metabolic syndrome(CRM) multi-disciplinary teams to make high impact interventions to ensure more patients have access to the right medicines and stop the use of medicines which are of no longer of benefit to the patient.

h) Tackle antimicrobial resistance

Robust antimicrobial stewardship is essential to reduce resistance developing to antimicrobials and enable patients to recover well from infections. Reducing resistance involves reducing inappropriate use by ensuring that the right antimicrobials are used to treat infections only when needed. In LLR, we are already one of the best areas in the Midlands Region for using shorter courses of antimicrobials and reducing use of intravenous injections. However, during 2025 we have also achieved the national target (27%) set out in the NHS Oversight Framework 2025/26 to reduce prescribing of at least one antibiotic in the last 12 months to children aged 0–9 years.

To tackle this, a system-wide strategy was agreed along with support from the Children and Young Person (CYP) Collaborative to drive improvement at pace. This included focused support for high-prescribing practices, enhanced clinical education through targeted webinars, and wider use of evidence-based tools such as prescribing alerts and self-care resources. A public facing 'Superbodies' communications campaign, supported by schools, pharmacies and local authorities, reinforced key messages around appropriate antibiotic use. Prescribing data from January 2026 showed the ICB met the threshold (26.1%).

i) **Tackle overprescribing and reduce the prescribing of drugs of dependence** - the NHS England Reviews for Overprescribing (2021) and Medicines associated with dependence or withdrawal symptoms (April 2022) highlighted the issues and drivers of overprescribing and the difficulties in withdrawing treatment

In 2025 we focussed on upskilling primary care clinicians to review prescribing of hypnotics and anxiolytics which are associated with addiction and withdrawal problems. Although more work needs to be done, these supportive measures have helped to sustain the downward trend in the number of patients in LLR prescribed these medicines and the amount prescribed on each prescription.

j) Reduce the environmental impact of medicines and dispensing:

Medicines account for approximately 5% of the NHS carbon footprint of which 3% is attributable to the propellant in respiratory inhalers and 2% to anaesthetic gases. Our aim is to reduce the carbon footprint of medicines to Net Zero by 2040. To date we have made considerable progress with reducing the LLR carbon footprint of inhalers by approximately 15% compared to the year before (37.2% in Jan 26) vs 24.3% in February 2025).

To achieve this, we have undertaken a focussed quality improvement project with General Practice incentivised through the Medicines Optimisation Framework 25-26 alongside provision of training and resources and a public facing Green Medicines Campaign

k) Transform community pharmacy to support acute and elective care pathways.

Community Pharmacy in LLR plays a vital role in primary care. Led by our community pharmacy clinical lead, the ICB has worked continually through 2025-2026 with the community pharmacy network to drive engagement and performance in several key services:

To support the ICB's prevention agenda, community pharmacies in LLR delivered over **93,000** blood pressure measurements

To improve patient's access to healthcare, community pharmacies across LLR completed over **146,000 Pharmacy First** consultations which saved over **24,000 hours** of GP and other health care professional's time, which is the equivalent of **25 full-time clinicians.** In addition, the Community Pharmacy Contraception Service plays an important role in preventing unintended pregnancies and supporting women's health, with over **26,000 consultations** performed. The ICB supported local pharmacies with the addition of emergency contraception to the service in October 2025, with over 4,000 emergency contraception consultations performed to reduce the risk of unwanted pregnancy.

Working in partnership with Leicestershire Partnership Trust and University Hospitals of Leicester, the ICB has supported community pharmacy teams to deliver over **9,500** Discharge Medicines Service (DMS) episodes in the 10 months until January 2026. For every 10 DMS consultations, 1 admission is prevented, and it is therefore estimated that **950 admissions were prevented** by community pharmacy, delivering a system **saving in excess of £2m.**

As all pharmacists start to become independent prescribers, the ICB has participated in trialling models of care to utilise prescribing in delivering clinical services from 5 local community pharmacies. This trial programme continued throughout 2025-26 and has allowed community pharmacists to see more complex unwell patients to support GP practices and urgent care centres, as well as performing asthma reviews and supporting patients when medication that was prescribed elsewhere was unavailable. The programme concluded at the end of March 2026 and the learning will be used to inform future use of independent prescribing in community pharmacy.

The ICB progressed our relationship with the East Midlands Primary Care Team (EMPCT) who commission community pharmacy services on our behalf to monitor and enhance the quality of services performed by community pharmacies.

l) Financial Management of Prescribing Budgets

Ensuring prescribing delivers value within the allocated budget is fundamental to ensuring we can afford preventative health strategies that will improve population health. The Medicines Optimisation Partnership has established medicines value work programs to release prescribing efficiencies in primary care and in secondary care high-cost drug spend.

In 2025-26 we delivered an efficiency plan of £17.95 million through prescribing of more cost-effective treatments or reducing prescribing of drugs of low clinical value and overordering/ prescribing which meant that we had the resources to treat more people with the right medicines. Some of the transformational changes that we have made to reduce costs included:

- Ending prescribing of Gluten Free Foods on prescription.
- Introducing Food First in Care Homes and reducing prescribing of oral nutritional supplements.
- Implementation of the LLR Appliance Prescription Service to reduce overprescribing and increase use of Formulary recommendations.
- Reducing medicines wastage in care homes through auditing and revision of medicines management processes.

For secondary care high-cost drugs efficiency involving switching to more cost-effective biosimilars, LLR realised £4.1 million of savings. This was predominantly driven by switch to ustekinumab biosimilar and early adoption (compared to midlands peers) for aflibercept biosimilar in ophthalmology.

Personalisation (Continuing Health Care and NHS funded Nursing 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 (CHC) or NHS-funded Nursing Care.

Numbers of people eligible for CHC has increased during 2025-26. This is due to more people with complex health needs being able to be supported to live well in the community. Within LLR Personal Health Budgets (PHBs) are the default option for all adults and children eligible for Continuing Healthcare and Continuing Care. PHBs give people the opportunity to manage their own care and choose their own support providers. The ICB is also supporting the delivery of Personal Wheelchair Budgets for those requiring specialist wheelchair provision.

Learning Disability and Autism (LDA)

The LLR LDA Collaborative, led by Leicestershire Partnership NHS Trust as the lead provider, continues to work with local partners to dramatically improve performance in all national performance indicators relating to learning disability and autism. There has been a key focus on discharge and getting people with LDA out of mental health inpatient settings and back into the community. The introduction of dedicated LDA Case Managers and closer joint working between health and local authorities as part of a discharge hub has seen a significant improvement and the LLR system is now on trajectory for both adult and children's inpatient numbers.

LLR has coproduced a Dynamic Support Pathway with engagement from people with lived experience and parent/carers. The DSP provides support for individuals (all age) with a learning disability, autism or both who are deteriorating in their health and well-being whilst living in the community. It identifies concerns early and is able to take steps to provide additional support to prevent further deterioration and avoid hospital admissions.

Alternative Hospital Placements (AHPs)

Hospital placements continue to be commissioned where individuals require more specialist hospital treatment/environments that are not available through the local NHS provider trust. The ICB maintains oversight of the Independent Placement Team through the LPT contract.

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 (subsequently the Joint Quality, Performance and Outcomes 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. For example:

- A Quality and Performance Improvement Strategy is in place that describes how the LLR ICB discharges its responsibility through the system and its leadership.
- The ICB's Quality Self-Assessment (QSA) was developed into six quality domains to fully assess and support the quality function of each Collaborative, including a scoring system with supportive criteria and rationale to demonstrate progress.

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 Care Act 2022, and in line with the NHS Constitution, we remain committed to involving the public in the development of our commissioning plans and the decisions we make as an Integrated Care Board. Our ambition is to ensure that local people, patients and partners are among the most engaged, well-informed and empowered communities when it comes to shaping local health and care.

We continue to recognise the essential role that meaningful communication and engagement plays in ensuring that our commissioning decisions reflect the needs, priorities and lived experiences of our population.

Principles for working with people and communities

Our approach is guided by the ten national principles (Figure 5) for how ICSs work with people and communities. Building on these principles, we will continue to:

- Strengthen engagement skills and capacity across our workforce, enabling our 21,000 colleagues—alongside service users, patients, carers and community members—to contribute to positive social change.
- Integrate intelligence, insight and feedback from people and communities at the core of our ICS, ensuring their voices are valued and influence decision-making at every level.

- Use Equality Impact Assessments proactively to tackle health inequalities and ensure that equality considerations are embedded in all decision-making, supported by the six-step LLR Inclusive Decision-Making Framework.
- Develop and maintain strong relationships with children, young people, families and the organisations that advocate for them.
- Deepen partnerships with family carers and the groups that represent them, making sure their insights and experiences help drive continuous improvement across health and care services.

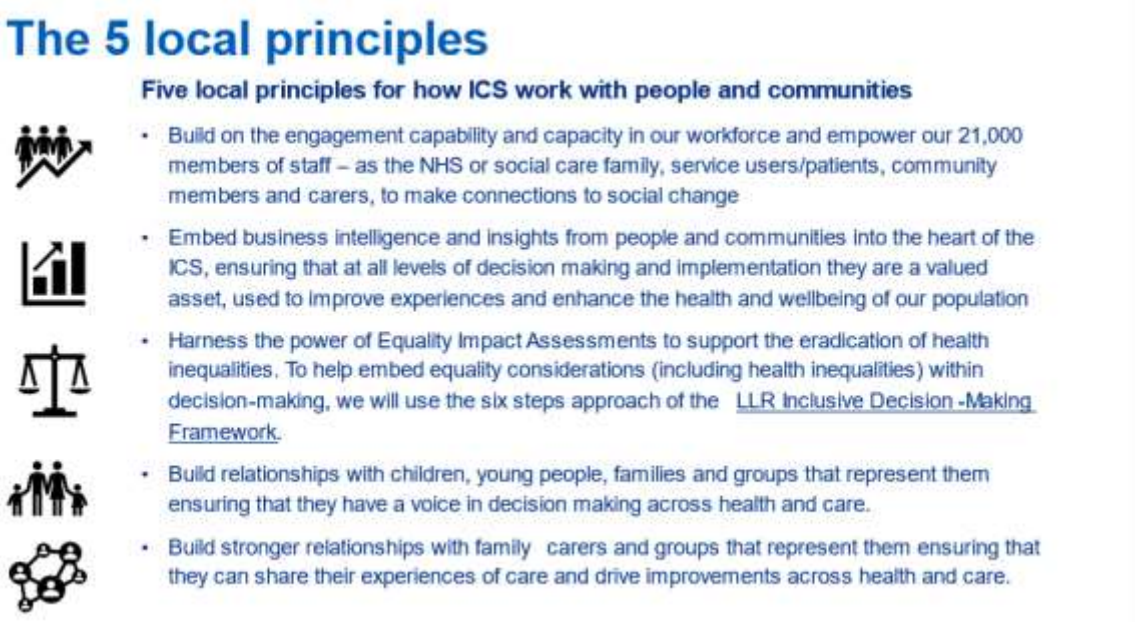
Figure 5: Ten national ICS principles for engagement

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

1. Put the voices of people and communities at the centre of decision-making and governance, at every level of the ICS.	6. Provide clear and accessible public information about vision, plans and progress, to build understanding and trust.
2. Start engagement early when developing plans and feed back to people and communities how their engagement has influenced activities and decisions.	7. Use community development approaches that empower people and communities, making connections to social action.
3. Understand your community's needs, experience and aspirations for health and care, using engagement to find out if change is having the desired effect.	8. Use co-production, insight and engagement to achieve accountable health and care services.
4. Build relationships with excluded groups, especially those affected by inequalities.	9. Co-produce and redesign services and tackle system priorities in partnership with people and communities.
5. Work with Healthwatch and the voluntary, community and social enterprise (VCSE) sector as key partners.	10. Learn from what works and build on the assets of all ICS partners - networks, relationships, activity in local places.

In addition to the 10 national principles, we added five local principles (Figure 6) for how the ICS works with people and communities ensuring that they have a voice in decision making across health and care.

Figure 6



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

- 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 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.

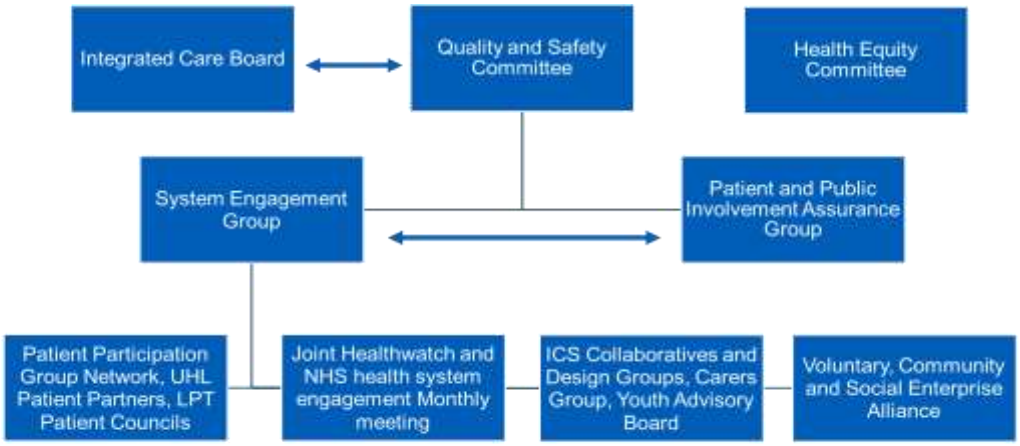
We use The Engagement Cycle as part of our commissioning and engagement planning. The Engagement Cycle is a strategic tool that helps to identify who needs to do what, to engage communities, patients, and the public at each stage of commissioning.

Structures and process that support collaborating with people and communities

We have embedded the voices and experiences of people and communities across LLR at the centre of the ICB's work, ensuring they run as a golden thread throughout our governance structures (see Figure 7). This approach enables the system and its partners to clearly understand what matters to local people, what is working well, where improvements are needed, and how we can collaborate to deliver better outcomes.

Evidence-based insights and business intelligence, drawn from people's lived experiences, are integral to delivering safe, high-quality and compassionate care. These insights are reported to the ICB Board through the Quality and Safety Committee, which provides assurance that this feedback is being acted upon and is influencing ongoing improvements.

Figure 7



Public and Patient Involvement Assurance Group (PPIAG)

The PPIAG brings creative, fresh, objective and independent perspectives on our decision-making and is a critical friend of the NHS in relation to engagement and involvement. The group exists to gain assurance that (a) all proposals to change and improve healthcare services are developed with appropriate and sufficient public and patient involvement, and (b) that insights and business intelligence from patients, staff, carers and public that tell us what matters to them are regarded and have influenced the decisions that are made.

The PPIAG continued with an extensive programme of work in 2025/26, and through this forum we have reviewed and received assurance on the following communication and engagement plans for:

- Pre-hospital Model of Care
- GP survey approach
- CYP 3 year communication and engagement plan
- Leicester City and County Same Day Access engagement
- Changes to oral Nutritional Supplements in care homes
- Same day access in Rutland engagement
- End of Life and Palliative Care strategy engagement
- St Mary's Birth Centre engagement

We also held development sessions with the Group to share information on the following topics:

- The 10-year plan
- Maternity and Neonatal Voices Partnership (MNVP) procurement
- Supporting colleagues with equality, diversity and inclusion
- Neighbourhood plans
- The transition of the ICB

As the ICB evolves into its new role as a strategic commissioner, the PPIAG continues to be a significant asset to the organisation. The Group's constructive challenge, independent insight and consistent commitment to meaningful involvement strengthens the quality and legitimacy of our decision-making. Their ongoing support ensures that the voices of patients, carers, staff and the wider public remain central to how we design, prioritise and improve services across Leicester, Leicestershire and Rutland.

Maximising partnerships

System partners meet regularly comprising of engagement professionals from health organisations (commissioners and providers), Healthwatch Leicester and Leicestershire and Healthwatch Rutland, to discuss strategy and operational issues.

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.

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/

The ICB engagement team also works closely with the LLR local authorities on shared priorities, such as Neighbourhood plans and cross cutting services. For example, the ICB has supported the engagement in the city with five neighbourhood planning workshops and coordinated attendees through its VCSE Alliance.

Our work and achievements in 2025/26

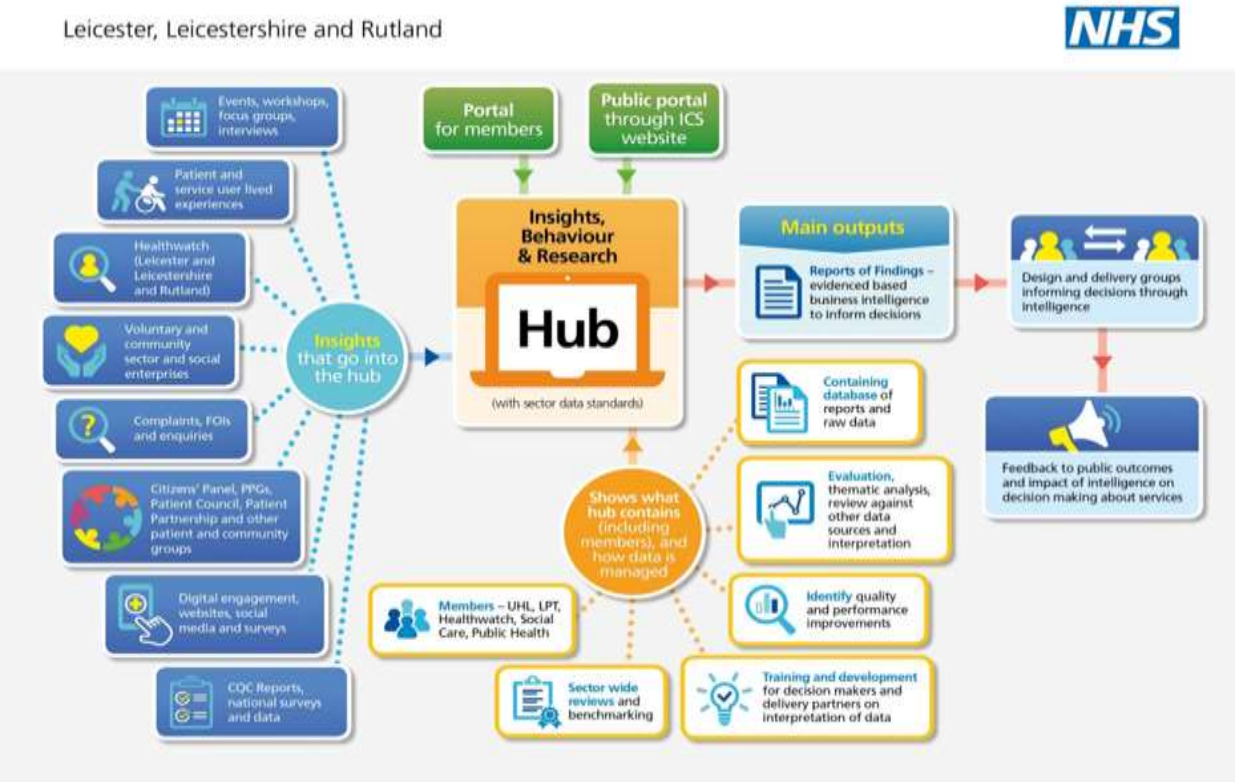
In the last 12 months we have extended our ICB People and Communities Strategy 2022-2024 and continued to deliver against its priorities.

The strategy was developed on the firm foundations of participation, involvement and engagement over many years with LLR organisations, commissioners, providers and partners.

During 2025/26 we have further developed:

a) **Insights, Behaviour and Research Hub** (**Figure 8**)- a valuable tool for enhancing services and improving the health and wellbeing of people locally, the hub is a central point for research and inequality data. Through this online database we store and retrieve data and insights from local NHS bodies and other local organisations including Healthwatch Leicester and Leicestershire and Healthwatch Rutland.

Figure 8



b) Over the past year, we have expanded access to the site, allowing VCSE organisations to obtain data directly from the hub. We also encourage them to share their own insights, helping to strengthen our collective understanding of our communities. To support a consistent approach, we have developed a range of supporting resources.

c) We work with collaboratives and neighbourhood-led plan groups to ensure that the business intelligence and data informs plans and decision-making.

d) **Voluntary, Community and Social Enterprise Alliance (VCSE)** - the VCSE Alliance is a genuine partnership between the voluntary and community sector, social enterprises and individual communities, initially with NHS and overtime, across all partners. Figure 10, the co-designed Alliance model, launched in November 2022, provides a structured and effective way to embed this diverse and creative sector into system decision-making, while strengthening resilience and ensuring the VCSE remains an integral part of the health and care system.

e) During 2025/26, we continued to share a monthly VCSE newsletter featuring local updates, with a particular focus on funding activity and opportunities. The Alliance also maintains an active forum on the NHS Futures platform, where organisations share best practice, information, and events.

This year, the ICB delivered two major funding programmes to support VCSE involvement:

1. Outreach in Leicester City – 'Getting NHS Help Fast' Engagement

- Small grants of up to £2,000 (from a £45,000 total budget) were awarded to support VCSE organisations to deliver educational sessions within communities on how to access NHS care appropriately and effectively.

2. Maternity and Neonatal Voices Partnership (MNVP) Contract

- A public procurement opportunity valued at £83,000 was launched, inviting VCSE organisations to bid to deliver the MNVP service.
- The Engagement Team supported the development of the MNVP offer in preparation for the new contract commencing April 2026.
- An online briefing webinar was held for VCSE organisations prior to the tender release, helping ensure fair access and informed applications.

In addition, we promoted multiple partner-led funding opportunities and supported outreach to potential VCSE bidders, ensuring representation from organisations serving a wide range of protected characteristics.

VCSE Funding for Screening and Vaccination Across LLR

The Public Health Investment Fund aims to reduce health inequalities and improve uptake of key screening and vaccination programmes across Leicester, Leicestershire and Rutland (LLR). VCSE organisations were invited to collaborate with NHS and Public Health teams to help address barriers faced by priority communities.

The funding focused on two key project areas:

1. Reducing inequalities in immunisation uptake
2. Reducing inequalities in screening uptake

The Engagement Team supported this initiative by identifying suitable VCSE partners across LLR and by delivering screening education sessions to strengthen their capability to engage communities effectively.

Impact of the VCSE Alliance

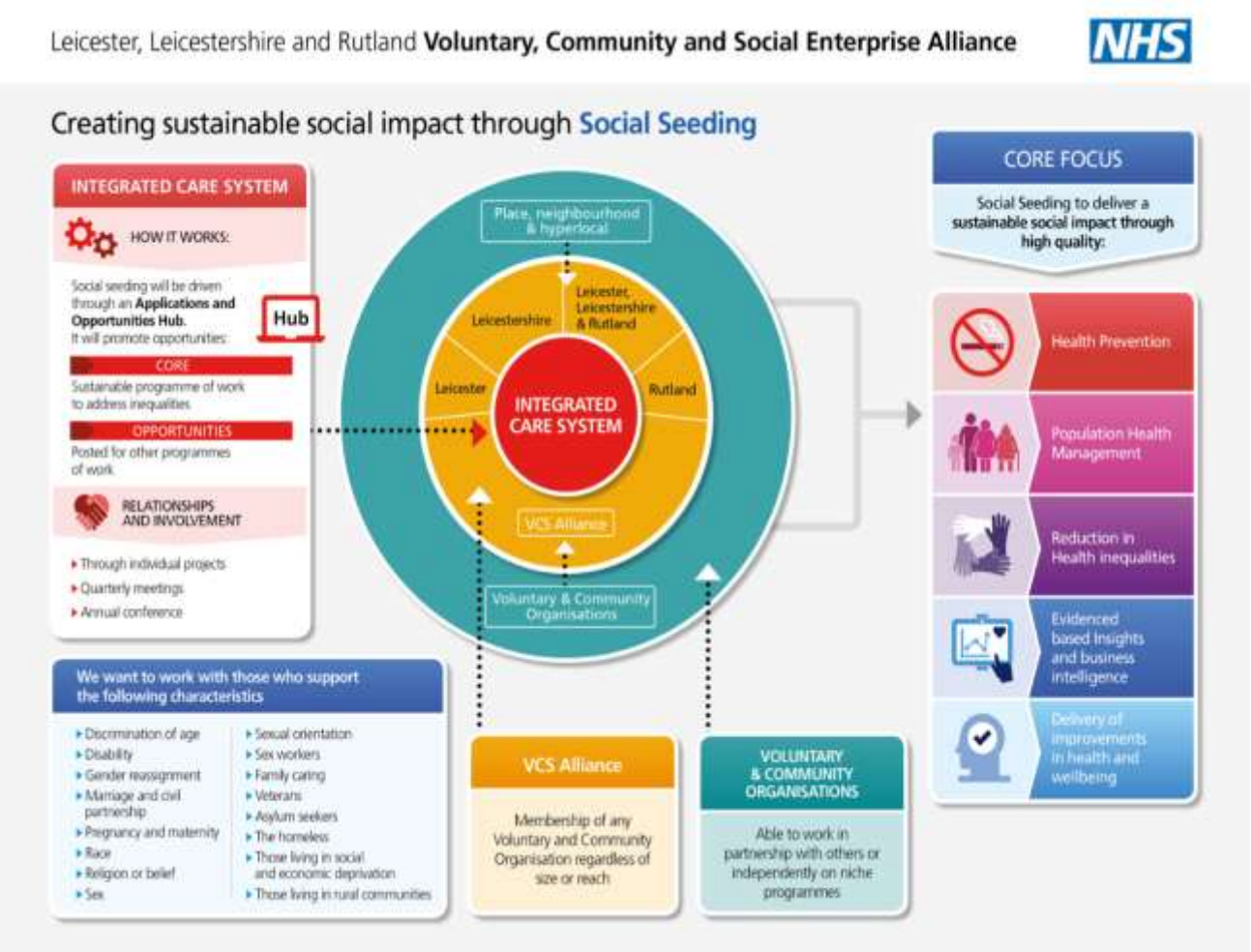
The VCSE Alliance (Figure 9) continues to serve as a vital vehicle for reaching communities across all protected characteristics and localities. Its deep-rooted connections, cultural insight and established trust within communities enable us to engage with groups that statutory services often find difficult to reach. This approach not only broadens our engagement footprint but also ensures that voices from diverse and underserved populations shape our programmes and decision-making. A clear example of this impact is the LLR Prostate Cancer Campaign:

LLR Prostate Cancer Campaign

This campaign focused on Black, African, and African Caribbean men across Leicester, Leicestershire and Rutland, who face a significantly higher risk of prostate cancer. Evidence shows that men from these communities are 2.5 times more likely to be diagnosed with prostate cancer than white men.

The initiative delivered culturally tailored education and outreach to reduce health inequalities, raise awareness, improve early detection and increase access to care. The Engagement Team played a key role in ensuring strong representation from Black, African, and African Caribbean men across LLR, enabling the campaign to be shaped directly by their lived experiences and community priorities.

Figure 9



Maternity and Neonates Voices Partnership (MNVP) - throughout 2025/26 we have worked closely with the maternity team to support and develop the MNVP to improve maternity and neonatal services by engaging women and families. The MNVP have a clear vision ensuring women, their partners and their families are at the heart of our plan and future development work with the aims of:

- increasing the awareness of the MNVP for Leicester, Leicestershire and Rutland particularly around seldom heard populations
- increasing the membership of the MNVP ensuring representation from all socio-demographics
- increasing the number of people involved in the work of the MNVP ensuring representation from all socio-demographics
- empowering staff, VCSE and key stakeholders to increase awareness, membership and involvement of the MNVP
- enhancing the digital presence of the MNVP across a range of online platforms
- providing mechanism for receiving insights and data relating to maternity services
- gathering feedback on the current and potential future service improvements and change.

We continue to benefit from:

- The online **LLR Citizens' Panel**, which provides a systematic approach to gathering insights 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, now comprising of 1,395 members, who we endeavour to ensure are demographically and attitudinally representative of our population provide views on a range of services and have supported all our engagement activities.

- **The PPG network** - a network of Patient Participation Groups (PPGs) from across LLR (meeting virtually every other month) to provide key information and engage with their communities. This network has traditionally had the ability to network on behalf of the NHS, amplifying messages to their local communities and provided insights. The ways in which we work with PPGs include:

    - Bi-monthly network online meetings with PPGs across LLR (with occasional face to face sessions)
    - Building relationships with GP Practices
    - Knowledge sharing
    - Regular communication
    - Engagement advice and support for PPGs and GP Practices
    - Raising issues and concerns
    - Encouraging ideas and suggestions
    - Supporting with ICB engagement opportunities as requested.

  As requested by PPG members, a number of extra sessions were held online to educate members on the use of social media and the NHS APP. This included additional face to face sessions with two PCNs.

  We continue to run an online PPG Knowledge hub; a place where PPG members can share and discuss ideas and examples of best practice.

We will continue to work closely with our local PPG members to utilise their local knowledge, networks and skills throughout developments in primary care as well as the wider NHS.

Engagement and consultation

This year we have undertaken a number of large-scale public engagement programmes and many more involvement activities across a wide range of communities.

i. **Engagement on Getting NHS Help Fast across Leicester, Leicestershire and Rutland**

The *Getting NHS Help Fast* engagement gathered 6,188 responses across Leicester, Leicestershire and Rutland, exploring public understanding and experiences of same-day healthcare. Two additional improvement questions were added to the questionnaire about GP practices, building on previous years' GP surveys to provide deeper insight into recent patient experience.

The engagement used extensive online, community and voluntary-sector outreach, successfully reaching over 20,000 people through 299 VCSE-led events, ensuring strong representation across protected characteristic groups and rural communities. Insights from the engagement have directly informed future improvements in same-day healthcare access, communication, and service design across LLR.

ii. Engagement on same day access for Leicester City services

As part of the Getting NHS Help Fast engagement, the ICB added additional questions to understand Leicester City residents' views on the changes made to same day access appointments.

The engagement gathered a wide range of views from online surveys, printed questionnaires, digital communications (social media, partner newsletters, mass emails), and face-to-face outreach at community events, universities, shopping centres and local meetings, Partners were supported by a toolkit such as leaflets, posters, Easy Read materials and translation options.

Additionally, 22 VCSE organisations were funded to run targeted, hyper-local engagement with seldom-heard groups, and a series of train-the-trainer sessions equipped staff, the local authority and community leaders to educate and share consistent information for accessing care across Leicester, ultimately reaching over 20,833 people through over 250 activities.

Below shows examples of the educational sessions held directly by the ICB:

- St John the Baptist Primary School, Leicester City – NHS awareness assembly engaging approximately 700 pupils and staff, followed by a classroom self-care activity shared with parents.
- Bangladesh Youth and Cultural Shomiti – In-person NHS training with around 50 participants.
- South Asian Health Action – Men's Health Event – Right Care, Right Place presentation and facilitated discussion.

- Leicester City Adult Education – NHS-focused ESOL CPD training delivered to all staff.
- E2 Community Hub, Beaumont Leys – Engagement session with young people aged 9–16.
- Leicester City Council – Adult Social Care – Training delivered to Enablement, First Contact and Early Support Teams.
- Education Sector Engagement – ESOL, digital skills, and basic first aid/self-care training for education staff across the city.
- Leicestershire County Local Area Coordinators (LACs) – Right Care, Right Place training workshop for all LACs.
- Ready4Winter, Coalville Library – Public engagement and resource distribution alongside local councillors.
- Northwest Leicestershire GP Federation – PPG Meeting – Training, presentations, and distribution of materials.
- LLR PPGs – Right Care, Right Place workshop for Patient Participation Groups across LLR.
- 'Better Mental Health for All' Conference (NSPCC) – Presentation to VCSE organisations and distribution of resource packs.
- Loughborough University – Training sessions for wardens and university staff.

As a result of this engagement, we identified an opportunity to pilot work with local pharmacies and VCSE organisations in deprived areas. The aim is to support pharmacies in educating local communities on how to use their community pharmacy effectively. This project is currently underway, with plans to explore wider rollout across LLR.

iii. Engagement on the impact of the pause of services at St Mary's Birth Centre, Melton

Engagement undertaken from January to February 2026 gathered feedback from patients, families, carers, staff and students on the impact of the July 2025 pause of births at St Mary's Birth Centre. Respondents highlighted significant disruption, including reduced choice of birthplace, increased travel, and concerns about continuity of care. Overall themes included the emotional impact on families, the importance of safe staffing, and a desire for clearer communication about future plans. The findings informed decisions on implementing the 2021 consultation outcome, which proposed relocating births to the midwifery-led unit at Leicester General Hospital while maintaining community maternity services in Melton. They are also be used to develop the existing maternity services at The Leicester Royal Infirmary and The General Hospital.

iv. LLR ICB and Leicester City Council – Bowel Cancer Awareness

In partnership with the Leicester City Public Health team, we have launched a bowel cancer awareness campaign focused on increasing screening uptake among residents aged 50–74. The campaign specifically targets areas of the city with historically lower participation including Beaumont Leys, Belgrave, Highfields, New Parks, St Matthew's and Spinney Hill.

Our engagement team has delivered educational sessions on bowel cancer to Community Wellbeing Champions, Core20Plus Cancer Champions and VCSE organisations involved in screening and vaccination programmes. These sessions aim to

improve understanding of the screening process and support community-led conversations in centres, places of worship, and other local venues that work closely with harder to reach populations. This approach helps address common barriers such as fear of results, embarrassment, and misconceptions about the purpose of the test.

As part of this initiative, we have also engaged local employers, such as Next, to deliver targeted workplace interventions. Following this work, several large employers across Leicester have invited us to provide similar bowel cancer awareness sessions for their staff.

v. Supporting practice engagement and consultation

In 2025/26 we supported one GP practice to undertake consultation and engagement activities supporting proposals to merge contracts and relocate to new premises. In the past year, this role has been strengthened, with practices now requiring formal authorisation from the ICB of materials before publishing information.

The engagement team continues to support patient engagement on practice-level improvements, efficiencies, procurements, and mergers. The team also works closely with the quality and contracting teams to identify and assist practices that require additional support.

Reducing health inequalities

What are health inequalities?

The King's Fund describes health inequalities as 'unfair and avoidable differences in health across populations and between different groups within society'.

The unequal distribution of the social factors which affect our health – such as education, housing and employment – drives inequalities in physical and mental health, reduces people's ability to prevent sickness, or to get treatment when ill health occurs.

These inequalities are complex and rooted in society, but they can also be prevented. The dimensions of health inequalities are overlapping.
They include:

- Socioeconomic groups and deprivation (e.g. unemployed; low income; deprived areas)
- Inclusion health and vulnerable groups (e.g. homeless people; Gypsy, Roma and Travellers; sex workers; vulnerable migrants; people who leave prison)
- Protected characteristics in the Equality Duty (e.g. age; sex; religion; sexual orientation; disability; pregnancy and maternity)
- Geography (e.g. urban; rural)

Addressing inequalities in health and care

It is vital to act and drive forward work programmes that reduce inequalities, prevent poor health and improve opportunities for better health. It is vital too that the structural inequalities in our society – unemployment, overcrowded housing, and a lack of green space, as a few examples – are tackled because it is changes at the root cause that will reduce health inequalities in the long term. Integrated Care System partners are committed to taking action at all levels to reduce health inequality.

Our work in the ICB is guided by the Core20PLUS5 framework to ensure a systematic and targeted approach to improving equity and tackling inequalities across our population. Our programmes focus on the Core20PLUS5 clinical priorities for adults and children and young people, supporting earlier diagnosis, improved access to services, and better outcomes in areas where inequalities are greatest.

In line with national planning requirements, the ICB prioritises:

- Reducing unwarranted variation in access, experience, and outcomes
- Improving prevention and early diagnosis in the most deprived communities
- Targeted action for populations at greatest risk of poor outcomes

Good robust data enables the NHS to understand more about the populations we serve. It enables NHS bodies to identify groups that are at risk of inequitable access to healthcare, poor experiences of healthcare services, and deliver targeted action to reduce healthcare inequalities and improve outcomes.

Addressing health equity and health inequalities is central to all major strategies and work programmes for the ICB. The ICBs programme of work to improve health equity is guided by the principles set out in LLR Health Inequalities Strategic Framework - Better Care For All and embedded in the systems Integrated Care Strategy and LLR ICB Five-Year Plan.

In February 2026, the ICB developed its 5 Year Strategic Commissioning Plan, based on the Cluster Integrated Needs Assessment, setting out three key transformational themes – frailty, premature mortality and children and young people - which will ensure action to target and reduce inequalities are embedded in all of our work. These strategic documents have been developed to ensure our residents have exceptional quality healthcare by ensuring equitable access, excellent experiences and optimal outcomes. The ICBs strategic direction is built on the NHS inequalities improvement programme, “CORE20PLUS5”.

Health inequalities are not a problem we can tackle in isolation. Our approach has been to work in partnership with public health teams, local authorities, GP member practices,

the voluntary and community sector and patients to co-produce relevant plans and initiatives.

The ICB is an active member of Leicester City Council Health and Wellbeing Board, Leicestershire Health and Wellbeing Board and Rutland County Council Health and Wellbeing Board, which both consist of senior leaders and stakeholders from across LLR who provide a strategic lead for the health, care and wellbeing system

The overall purpose of each Board is to secure:

- Better health and wellbeing outcomes for the local population
- Better quality of care for all patients and care users
- Better value for the taxpayer
- A reduction in the health and wellbeing outcomes gap (inequalities) between different groups

The Boards work with local people to identify health and wellbeing needs of the population, agree priorities, and ensure that the NHS, local government and partners work together in a more joined-up way.

Each Board has prepared Joint Local Health and Wellbeing Strategy (JHWS). This provides a jointly agreed and locally determined set of priorities for Leicester City, Leicestershire County and Rutland County. The JHWS is based on a detailed analysis of local demographic and health data demonstrating the extent of inequality published in local Joint Strategic Needs Assessment. These are available on the local authority websites.

Health Inequalities work in LLR

The ICB publishes an annual report on health inequalities, responding to NHS England's Statement on Health Inequalities.

The report is used to drive actions across the system to ensure that the ICB is delivering sustainable improvements in health our Core20 populations.
In 2025/26, the ICB cluster established a Quality, Performance and Outcomes (QPO) Committee. Our work on health inequalities is reported to the QPO and inequalities are a core component of the system's outcomes frameworks in 2026/27.

Some key achievements in 2025/26 include;

- Securing additional funding from the East Midlands Cancer Alliance to sustain the Core20Plus Connectors for another year. Thirty Connectors, all with lived experience of cancer have been recruited and trained by VCSE sector partners to engage with people in their community. This has reduced the stigma associated with talking about cancer and removed barriers in access to screening, especially bowel screening and improved peoples experience of engaging with screening services.

- Sixteen Core20Plus Ambassadors have completed the training and have graduated from the national programme. Ambassadors include clinicians, managers and VCSE leaders. This ensures that leaders across the LLR system

are championing approaches to improving health care inequalities and that decisions are made by people who have experience of health equity and how to improve it.

- The Alcohol Care team in UHL addresses the disproportionate effect of harmful drinking on those from the least advantaged, and most excluded cohorts of the population. In 2025/26 they saw over 2500 patients – many of whom were enrolled in recovery programmes or supported to better habits in relation to alcohol.

- 2024/25 saw a reduction in the percentage of mothers smoking at the time of delivery to 6.3% partly through the work of our hospital-based tobacco dependency services. More patients are successfully quitting tobacco. This is a central plank in our prevention and health inequalities reduction strategy as rates of smoking are most prevalent in the least affluent cohorts of the population.

- Leicester has the highest case-rate of TB in the country. In 2025/26 the ICB continued to supplement national funding allocations to enable additional community testing and to commission additional staff to assess and treat patients. There was a small reduction in cases in 2025/26 This is a hopeful sign, but we cannot be satisfied. Our work in this area is seen as exemplary by the UKHSA and NHSE.

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.

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 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. Some examples of our work in this area in 2025/26 are listed below.

- The West Leicestershire National Neighbourhood Health Implementation Programme is an example of a population health management programme that has been implemented in 2025/26. Population health data has been used to identify a cohort of patients who are clinically vulnerable and who could benefit from a neighbourhood approach to manage their care in a more integrated way. The cohort of patients is patients with Chronic Obstructive Pulmonary Disease who are housebound. The patients are selected using a data driven approach and a multidisciplinary team from primary care, community services and adult social care review these patients and identify where they can support these patients differently to achieve better outcomes and experience.

- Our population health management data is used to support additional investment of more than £2.8M in 2025/26 to selected general practices. This is allocated using our health equity payment programme which uses our PHM data to identify practices who are underfunded relative to the needs of their population under the national funding formula. This programme is unique to LLR and was favourably reviewed in an external evaluation by the Health Foundation. We were invited to present our work to the NHSE team undertaking a review of the national payment formula

- Data has been used across LLR to improve access and outcomes linked to prevention programmes. For example, local work to improve uptake in childhood vaccinations, particularly targeting children in Lecester City and the Core20 areas. Between June 2023 and June 2025, coverage of children aged 5 years for the 6 in 1 vaccination has increased from 91.5% to 94.5% and Leicester City is now achieving higher uptake rates than the England average.

Annual Report on Health Inequalities

To meet the necessary reporting requirements, the ICB has published the 2024/25 Annual Report on Health Inequalities and response to NHS England's Statement on Health Inequalities on the ICB website at the following https://leicesterleicestershireandrutland.icb.nhs.uk/wp-content/uploads/2025/04/LLR-Health-Inequalities-Report-2024.pdf . This report sets a baseline for the LLR system with respect to inequalities in health outcomes and equity of access to services. It reviews the available quantitative evidence, alongside the ICBs plans and case studies of good practice. A further report will be published in due course.

The Statement sets out 24 indicators across the following 11 'domains':

- Elective recovery
- Urgent and emergency care
- Respiratory
- Mental health
- Cancer
- Cardiovascular disease
- Diabetes
- Smoking cessation

- Oral health
- Learning disability and autistic people
- Maternity and neonatal

This report will is used to drive actions across the system to ensure that the actions that the ICB is taking are delivering sustainable improvements in health.

In addition to the annual report on Health Inequalities, the ICB has developed a new dashboard presenting data on the Core20 clinical priorities (published in Q1 2025/26). 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.

Equality Delivery System

LLR ICB currently produces a separate Equality, Diversity and Inclusion (EDI) Annual report which demonstrates how the ICB is complying with the Equality Act 2010, the Public Sector Equality Duty (PSED) 2011 and NHS Mandated Standards. The report additionally includes initiatives that the ICB has undertaken both organisationally and with LLR system partners over the past 12 months. It demonstrates how we embed equalities to reduce inequalities in everyday work with our communities, staff and stakeholders. Other relevant information such as Equality Impact Assessments and the Gender Pay Gap can be found on our website together with a copy of the EDI Annual Report 2025/26.

https://leicesterleicestershireandrutland.icb.nhs.uk/equality-statement/

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 (BCF) continues to be a critical enabler to take forward the integration of health and care services. In April 2025 to March 2026 our contribution to the BCFs were as follows:

- Leicester City Better Care Fund £40.839m
- Leicestershire Better Care Fund £57.071m
- Rutland Better Care Fund £3.058m.

This investment enabled health and care to be jointly commissioned locally to drive better integration of health services and improve outcomes for patients, service users and carers. Performance against the Better Care Fund metrics is reviewed through the place-based governance arrangements with partner organisations.

In this respect 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://www.leicestershire.gov.uk/sites/default/files/2024-04/Joint-Health-and-Wellbeing-Strategy-2022-2032.pdf

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

The key areas for across each of the local authority areas aligns with the LLR Health and Wellbeing Partnership's Integrated Care Strategy as referenced earlier in the Report.

Through each of the respective Health and Wellbeing Boards 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 Groups have agreed to become the place-based planning groups for the system and have recently agreed to come together to deliver the 1001 critical days agenda which looks at improving outcomes from conception to age 2 years.

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 2024/25 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

The total funding for ICB from April 2025 to March 2026 was £2,997.6m (£2.998bn). This allocation is received in five parts:

- Programme: £2,297.0m
- Primary Care Co-Commissioning: £244.6m
- Running Costs: £22.5m
- Delegated Dental, Ophthalmic and Pharmacy Services: £118.1m
- Delegated Specialised Services: £315.3m

The Programme allocation funds the direct provision of core services to our population including secondary healthcare, mental health services, community services and some primary care services. The Primary Care Co-Commissioning allocation is delegated from NHS England to support primary care general practice. Primary care services provide the first point of contact in the healthcare system, acting as the 'front door' of the NHS. The Running Costs allocation funds the administration of the ICB. The Dental, Ophthalmic and Pharmacy Services and Specialised Services allocation fund the commissioning and contracting of those services for which the ICB was awarded delegated authority from NHS England from 1 April 2023 and 1 April 2024 respectively.

Financial planning for 2025/26 confirmed the LLR system was facing significant financial challenges. A £0.3m deficit 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 ICB has been monitored on a monthly basis by the Joint Executive Team (JET) with regular reports to the Finance Committee (subsequently the Joint Finance and Contracting Committee) and the ICB Board, in line with the governance arrangement outlined within the Accountability Report.

The key strategic financial risk during 2025/26 is outlined within the ICB's Board Assurance Framework as referenced within the Accountability Report. The JET were responsible for regular review of the risk to ensure mitigations were in place with oversight provided through the Finance Committee (subsequently the Joint Finance and

Contracting Committee) and the ICB Board. This included the identification of further in-year efficiencies and review of planned investments.

In 2025/26, the ICB had a planned target value of £70.201m to achieve for its financial efficiencies. The actual achieved value was £66.757m which equates to a shortfall of £3.444m.

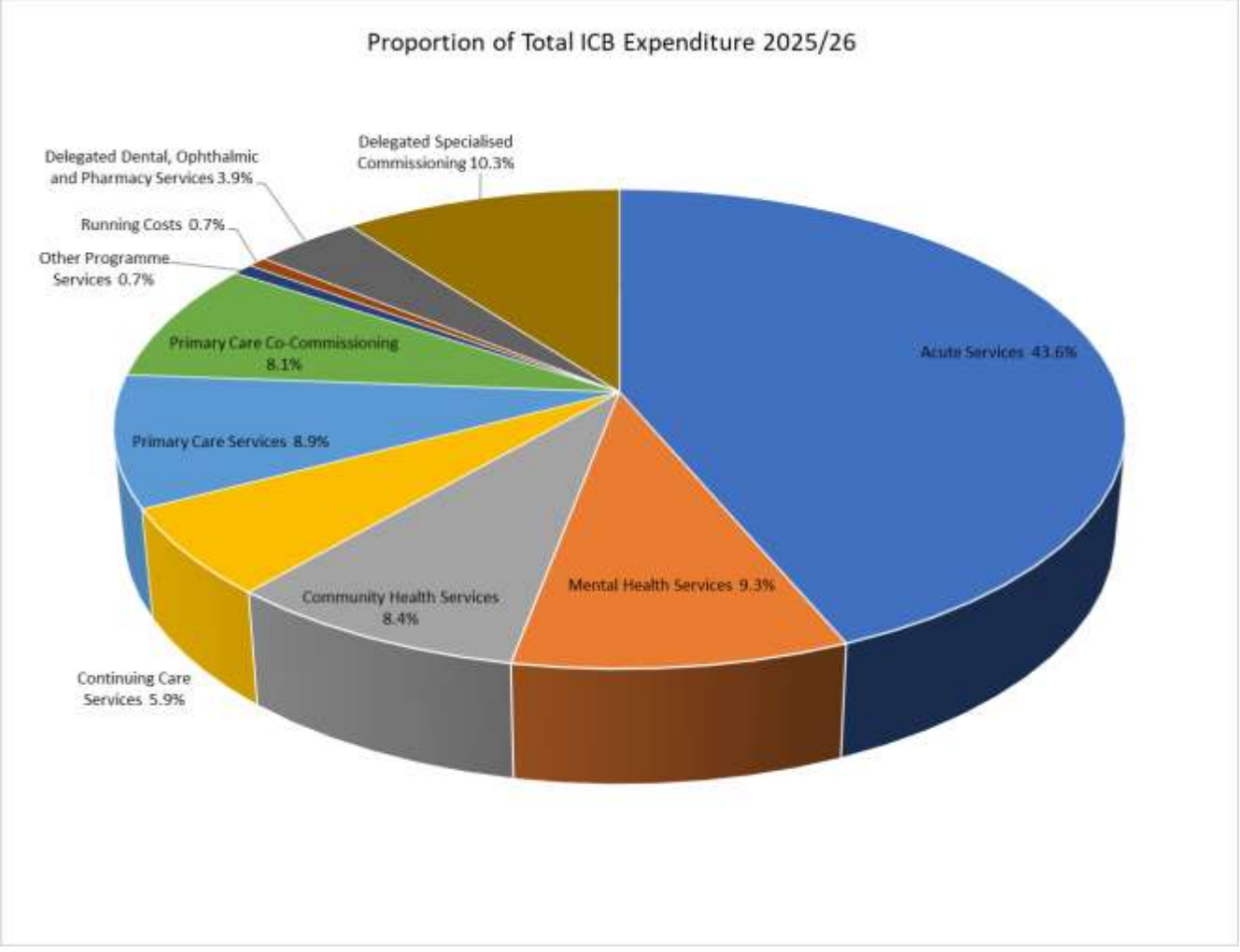
The final expenditure position for the ICB was a deficit of £23.3m against funding available of £2,997.6m.

How we spend our money

Expenditure Profile

In April 2025 to March 2026 the ICB spent £3,020.8m (£3.021bn) on healthcare and running costs for the local population. This was allocated as is shown in Figure 10 (including running costs and primary care co-commissioning expenditure).

Figure 10



Running Cost Allowance

The ICB had an allocation for April 2025 to March 2026 of £22.5m (0.7% of total ICB allocation) to spend on administrative staff costs and non-pay. Administrative costs incurred by the ICB must not exceed this allocation and were £21.2m for the period. This underspend of £1.3m arose from maintaining several staff vacancies throughout the year 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 £21.2m.
- Weighted population (number) 1,169,531.
- Running costs per head of weighted population £18.08.

Capital Expenditure

The ICB did not receive any capital allocation from NHS England for its own use during the period April 2025 to March 2026. Capital allocations for primary care are held by NHS England on behalf of the ICB.

Cash Balance

NHS England guidance specified that the ICB's bank balances as at 31 March 2026 should be less than £2.9m. The actual bank balance was £0.11m and therefore the target has been achieved.

Priorities for 2026/27

Our commissioning priorities for 2026/27 include delivery of our operational plan and Five-Year Joint Forward Plan and delivery of our collective priorities for LLR ICB and as an ICB Cluster with Northamptonshire ICB.

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.

For 2026/27 national priorities have been identified and captured within the ICB's Five-Year Joint Forward Plan as referenced earlier, these are to:

- Develop and deliver integrated **neighbourhood models of care**
- Deliver our **Urgent and Emergency Care** strategy to mitigate and respond to urgent and emergency care demand
- Focus on waiting times for ASD/ADHD, our SEND inspection actions, community Paediatrics and our **children and young people** transformation programme priorities
- Improve **access to services** across urgent and elective care in our hospitals, mental health and community services.

It is expected that these priorities will be delivered in collaboration with Northamptonshire ICB and our partners.

In addition, the ICB will be targeting its efforts on further reviewing continuing healthcare services and prescribing across primary medical services to enable further improvements in outcomes for patients and financial efficiencies to be made.

Further details on these and all of our priorities including prevention, learning disabilities and autism, women's health and maternity, children and young people, cancer and diagnostics and end of life will be available in our 2026/27 Operational Plan.

We will also continue to work hard to reduce health inequalities, improve health outcomes for our population, and improve patient experience.

This will be against a background of transition and transformation as we continue to implement the future model for ICBs during 2026/27.

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 and financial challenges 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.

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 2025 to 31 March 2026 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.

Toby Sanders

Toby Sanders
Chief Executive (Accountable Officer)
18 June 2026

Corporate Governance Report

Members Report

During 2025-26, the Board of LLR ICB comprised the members detailed in Table 4.

Table 4

Member	ICB Board role
Ms Anu Singh	**Joint ICB Chair** *(joint position across LLR ICB and NHS Northamptonshire ICB from 1 October 2025)*
Ms Paula Clark	**ICB Chair** *(until 30 September 2025)*
Mr Toby Sanders	**Joint Chief Executive Officer** *(joint position across LLR ICB and NHS Northamptonshire ICB from 1 October 2025)* *(interim from 1 July 2025 and substantive from 1 October 2025)*
Dr Caroline Trevithick	**Chief Executive Officer** *(until 30 June 2025)*
Ms Simone Jordan	**Joint Non-Executive Member – Remuneration** *(joint position across LLR ICB and NHS Northamptonshire ICB from 16 October 2025)* Deputy Chair / Non-Executive Member – Remuneration and People / Senior Independent Non-Executive Member *(LLR ICB until 15 October 2025)*
Mr Afzal Ismail	**Joint Non-Executive Member – Audit** *(joint position across LLR ICB and NHS Northamptonshire ICB from 16 October 2025)*
Mr Darren Hickman	**Non-Executive Member – Audit and Conflicts of Interest** *(until 15 October 2025)*
Ms Liz Gaulton	**Joint Non-Executive Member – Quality** *(joint position across LLR ICB and NHS Northamptonshire ICB from 16 October 2025)*
Mrs Pauline Tagg, MBE	**Non-Executive Member – Quality, Safety and Transformation** (until 30 November 2025)
Mr Andrew Hammond	**Joint Non-Executive Member – Finance** *(joint position across LLR ICB and NHS Northamptonshire ICB from 16 October 2025)*
Mr Anil Majithia	**Non-Executive Member – Health Inequalities, Public Engagement, Third Sector and Carers** *(until 30 November 2025)*

Member	ICB Board role
Ms Eileen Doyle	**Joint Chief Delivery Officer** *(joint position across LLR ICB and NHS Northamptonshire ICB from 1 October 2025)*
Ms Rachna Vyas	**Deputy Chief Executive / Chief Operating Officer** *(until 30 September 2025)*
Mr Matt Gaunt	**Joint Chief Finance Officer** *(joint position across LLR ICB and NHS Northamptonshire ICB. Interim from 1 October 2025 and substantive from December 2025)*
Mr Robert Toole	**Chief Finance Officer** *(until 30 September 2025)*
Ms Maria Laffan	**Joint Chief Nursing Officer** *(joint position across LLR ICB and NHS Northamptonshire ICB from 1 October 2025)*
Ms Kay Darby	**Chief Nursing Officer** *(until 30 September 2025)*
Professor Nilesh Sanganee	**Joint Chief Medical Officer** *(joint position across LLR ICB and NHS Northamptonshire ICB from 1 October 2025)* *(previously Chief Medical Officer, LLR ICB)*
Mr Peter Burnett	**Joint Chief Strategy Officer** *(joint position across LLR ICB and NHS Northamptonshire ICB from 1 October 2025)* *(previously Chief Strategy Officer, LLR ICB from 2 June 2025 – 30 September 2025)*
Ms Alice McGee	**Chief People Officer** *(until 30 September 2025)*
Mr Richard Mitchell	**Partner Member - Acute sector representative** (Chief Executive Officer, University Hospitals of Leicester NHS Trust)
Ms Angela Hillery	**Partner Member - Community / Mental Health sector representative** (Chief Executive Officer, Leicestershire Partnership NHS Trust) *(until March 2026)*
Mr Laurence Jones	**Partner Member - Local authority sectoral representative** (Strategic Director, Social Care and Education, Leicester City Council) *(until March 2026)*
Mr Mike Sandys	**Partner Member - Local authority sectoral representative** (Director of Public Health, Leicestershire County Council)
Mr Mark Andrews	**Partner Member - Local authority sectoral representative** (Chief Executive, Rutland County Council) *(until March 2026)*
Dr James Ogle	**Partner Member** - Primary Medical Services sector representative

Board member profiles

Anu Singh, Joint ICB Chair (from October 2025)

Anu jointed the Leicester, Leicestershire and Rutland ICB and Northamptonshire ICB as Chair in October 2025.

She had previously been Chair of Black Country ICB and has also Chaired an integrated NHS Trust, brining a wealth of experience to the role as a Board-level local governance and health leader.

Anu has also held the roles of statutory Local Authority Director of Adult Social Care and Director of Patient and Public Participation and Insight for NHS England, taking the lead for the NHS in ensuring the voice of patients, service users, carers and the public is at its heart.

Paula Clark, Chair (until September 2025)

Paula was the Chair of the Integrated Care Board until September 2025. Paula has NHS Hospital Trust Chief Executive with over 30 years' experience in the NHS including 20 years at chief executive level at University Hospitals of the North Midlands, Dudley Group Foundation Trust and Burton Hospitals Foundation Trust. She has also worked at board level roles across a number of NHS networks and two universities.

Since retiring from full time work in 2019, Paula was appointed as a Non-Executive Director for Benenden Health and continues to support them as an Independent Trustee for their Hospital Trust in Kent. Closer to home, Paula chaired a Community Interest Company, LLR Patient Care Locally, which supports the local NHS system in LLR in delivering a range of out of hospital services.

Her pre-NHS career was in sales, marketing, public relations and further education. A business school graduate, with a master's degree in business administration, Paula also holds post graduate qualifications in marketing and coaching. Paula is also a charity Trustee for the RSPCA Woodside Animal Centre and Branch.

Toby Sanders, Joint Chief Executive Officer (from October 2025)

Toby is the Joint Chief Executive Officer of Leicester, Leicestershire and Rutland ICB and Northamptonshire ICB since October 2025. Previously, Toby was the Chief Executive of Northamptonshire CCG. With over 20 years' experience in the NHS, Toby was previously the Managing Director of West Leicestershire CCG. Toby is passionate about working with health and care professionals across public services to achieve the best value and outcomes.

Caroline Trevithick, Chief Executive Officer (until June 2025)

Caroline was the Chief Executive Officer of the Integrated Care Board until June 2025. She 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 brought 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. 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 and Rutland and retained responsibility for all aspects of high quality, safe patient care.

Simone Jordan, Joint Non-Executive Member – Remuneration

Simone is an experienced Executive working at Board, system and national levels for almost 30 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.

Afzal Ismail, Joint Non-Executive Member – Audit (from October 2025)

Afzal is currently a Non-Executive Director at University Hospitals Coventry & Warwickshire and recently served as a trustee of a large multi schools academy trust board. He is also a Group Executive Director at Orbit Housing Group. He is also the Conflicts of Interest Guardian.

Darren Hickman, Non-Executive Member - Audit and Governance (until October 2025)

Darren was Audit Committee Chair of the Integrated Care Board until October 2025. Darren was the Finance and Relationship Director for the Insurance Company of Santander Bank. 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 he was responsible for audit, governance and conflicts of interest as a Non-Executive Members for the LLR ICB.

Liz Gaulton, Joint Non-Executive Member – Quality (from October 2025)

Liz started her career as a general and mental health nurse, working in primary and secondary care before pursuing a career in public health. She has a wealth of experience in senior roles in both local government and the NHS and has previously held the position of Director of Public Health in St Helens and Coventry. Her key interests and expertise include social inclusion and health inequalities.

Pauline Tagg, MBE - Non-Executive Member – Quality, Safety and Transformation (until October 2025)

Pauline was a Non-Executive Member of the Integrated Care Board until October 2025 with responsibility for quality, safety and transformation. 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. 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.

Andrew Hammond, Joint Non-Executive Member – Finance (from October 2025)

Andrew is an experienced Executive and Non-executive Director working in Charity, Commercial and Public sectors. He spent his early career establishing a National Awareness Charity, and is now Chief Executive of Instructus, an education charity working in skills development, personal development, and apprenticeships.

Anil Majithia, Non-Executive Member – Health Inequalities, Public Engagement, Third Sector and Carers (until October 2025)

Anil was a Non-Executive Member of the Integrated Care Board until October 2025. Anil has held numerous roles as Chair, Vice Chair and Chair of Committees and has experience of working with board members from all walks of life. He has participated at board level since 2011 and has significant experience of governance and oversight, holding executive officers accountable. Anil was also a Non-Executive Director and lead Finance Non-Executive Director at George Eliot Hospital NHS Trust and chairs the George Eliot Hospital Charity. Additionally, he holds current Board roles as Member of the Corporation Board, Vice Chair and Chair of the Audit and Risk Committee at North Warwickshire and South Leicestershire College and is a Trustee/Director and Chair of the Pay and People Committee for LiFE Multi Academy Trust. Anil has also been working at Board level within the Not-For-Profit sector for the past 15 years.

Eileen Doyle, Joint Chief Delivery Officer (from October 2025)

Eileen previously worked as the county's Integrated Care System (ICS) Transition Director and has almost 30 years of NHS experience. She has held several executive positions including as Hospital CEO at Northampton General Hospital and Hospital Chief Executive at Kettering General Hospital.

Rachna Vyas, Deputy Chief Executive / Chief Operating Officer (until September 2025)

Rachna was the Deputy Chief Executive and Chief Operating Officer of the Integrated Care Board until September 2025. She began her NHS career in Leicester in 2005, working with our local communities to transform services within and across health and care across Leicester, Leicestershire and Rutland. Since 2022, Rachna has held the position of Chief Operating Officer for the LLR ICB and has added responsibilities as Deputy Chief Executive since January 2024. In this role, Rachna holds the strategic lead for the successful operational running of the LLR health and care system. She is responsible for the design and delivery of transformed models of care at system level for urgent care, elective care, children's services, maternity services, all age mental health and learning disability services as well as integration of services at place and neighbourhood level and is the Accountable Emergency Officer for the ICB.

Rachna holds an honorary lecturer position with the University of Leicester, with a focus on health equity, in recognition of her work within the communities of Leicester during the pandemic.

Matt Gaunt, Joint Chief Finance Officer (from December 2025)

Matt has over 40 years' experience of commercial and financial management in a succession of senior roles in the private and public sectors. He joined the NHS in 2009 and has worked in the Midlands and Northwest of England in senior finance roles including over 10 years as CFO. Matt is executive lead for finance, contracting, procurement and corporate governance.

Robert Toole, Chief Finance Officer (until September 2025)

Robert was the Chief Finance Officer for the Integrated Care Board until September 2025. He has over 20 years of experience as a Board Director with extensive experience in both the public and private sectors. This includes 20 years of experience within the NHS covering all major areas including multi-site acute, mental health and community, ambulance, NHS 111 and primary care. He has also been a System Improvement Director and Managing Director of an NHS subsidiary company providing estates and facilities, and procurement/supply chain services. In October 2023, Robert was appointed as the Chief Finance Officer for the LLR ICB and he is also the senior information risk officer.

He is a keen advocate of team development and training and ensuring the benefits realisation of service improvements. He previously worked at Rolls-Royce PLC and Carnaud Metal Box PLC. His role at Rolls-Royce included being a Commercial and Finance Director holding a global role based in the United States and previously in Europe with a multi-national French based company. He is a Fellow Chartered Management Accountant and enjoys cycling and skiing.

Maria Laffan, Joint Chief Nursing Officer (from October 2025)

Maria is a registered general nurse and has spent most of her career working across Bedfordshire & Hertfordshire in nursing, operational and director roles. Her interest is in supporting quality health care provision and oversight, working collaboratively and across systems and places to reduce health inequalities to support providing the highest quality clinical care for the population she serves.

Kay Darby, Chief Nursing Officer (until September 2025)

Kay was the Chief Nursing Officer for the Integrated Care Board until September 2025. She is a registered general nurse and registered mental health nurse and has a MMedSci in Clinical Nursing and an MSc in Health Services Management. She has worked at Executive Director and senior leadership level in multiple healthcare sectors including mental health, community services, acute services and GP led out of hours and NHS111. Kay's experience spans nursing, quality, governance, operations and strategy. Kay was also the Caldicott Guardian.

Prof. Nil Sanganee, Joint Chief Medical Officer

Nil has been a GP since 2004 and previously was 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 was a Board Member and deputy Chair of West Leicestershire CCG and since 2020, leading on a wide range of clinical pathways and driving improvements in the quality of care. Nil was previously the Chief Medical Officer for LLR ICB. In his role as Joint Chief Medical Officer for LLR ICB and Northamptonshire ICB, he 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. Nil is the Caldicott Guardian.

Peter Burnett, Joint Chief Strategy Officer

Pete joined the NHS in 2008 and has worked in a range of roles across service delivery, strategy, planning and leading transformation programmes. During his career he has worked for various NHS organisations including East Midlands Ambulance Service, Nottingham University Hospitals, Nottingham City Clinical Commissioning Group and Lincolnshire ICB.

Alice McGee, Chief People Officer (until September 2025)

Alice was the Chief People Officer for the Integrated Care Board until September 2025. 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 focussing 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 and subsequently she was appointed to the position of Chief People Officer in LLR ICB focussing on transformation for our people, our population and the technology we use to deliver care.

Richard Mitchell, Partner Member - Acute sector representative

Richard was appointed as the Chief Executive of University Hospitals of Leicester NHS Trust (UHL) in October 2021. In November 2023, he was also appointed as Chief Executive of University Hospitals of Northamptonshire NHS Group. He was previously the chief executive of Sherwood Forest Hospitals NHS Foundation Trust for four years. 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 the Chair of the East Midlands Cancer Alliance and Midlands Regional.

Angela Hillery, Partner Member - Community / Mental Health sector representative (until March 2026)

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 a clinical background as a Speech and Language Therapist. 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 2023 she was named No1 CEO by HSJ and received a CBE for services to the NHS. In July 2019 Angela was awarded an Honorary Doctorate from the University of Northampton for her leadership contribution. 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.

Laurence Jones, Partner Member - Local Authority sectoral representative (until March 2026)

Laurence was a Partner Member on the Board of the Integrated Care Board until March 2026. Laurence has responsibility for the full range of adult social care, children's social care and education services. He re-joined Leicester City Council in February 2024 having worked in Nottinghamshire for the last 15 years as a director of children's social care leading on residential care, strategic safeguarding, early years and commissions amongst other areas. Laurence has led a number of regional collaborations to improve services and is an experienced Caldicott Guardian dealing with complex and sensitive information sharing.

Mike Sandys, Partner Member - Local Authority sectoral representative

Mike was appointed Director of Public Health for Leicestershire County Council and Rutland County Council in February 2014. He has worked in public health since the early 1990s 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.

Mark Andrews, Partner Member - Local Authority sectoral representative (until March 2026)

Mark has been Rutland County Council Chief Executive since August 2020. He was a Partner Member on the Board of the Integrated Care Board until March 2026. He has worked in local government for nearly 25 years, with over 18 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, for Nottingham City Council and Rutland County Council. He is currently a LLR ICB Board Member and Senior Responsible Officer for the LLR Workwell programme.

Mark is also the East Midlands lead on the National Health and Care Sounding Board, the East Midlands SOLACE branch Health and Care lead and was the Department for Levelling Up, Housing and Communities Hospital Discharge Champion between Jul 2023-2024. Beyond health and care he is also the Senior Responsible Officer for Melton and Rutland Levelling Up Fund.

Dr James Ogle, Partner Member – Primary Medical Services

Dr Ogle has been a GP Partner at Ratby Surgery since 2015 and led a project for the development of Ratby Medical Centre which opened in 2023. He has been engaged with Hinckley and Bosworth Medical Alliance, a GP Federation in Hinckley and Bosworth District. During 2017-2019 he was involved in Medicines Prescribing and Urgent Care for the former West Leicestershire CCG between. Since 2019, Dr Ogle has been the Clinical Director for both Bosworth Primary Care Network and Hinckley and Bosworth Medical Alliance, before being elected as a Primary Care Lead for Leicestershire Place in 2022, which he combines with both his clinical director roles. He is committed to championing patient care closer to home through improving the development and improvement of Primary Care Services, with a focus on Primary Care Access and Community Based Services such as Phlebotomy and Wound Care.

Board participants

- 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, including through the Fit and Proper Persons Test checks. The current Register of Interests 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 2026.

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 2026 is published on our website at www.leicesterleicestershireandrutland.icb.nhs.uk .

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 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 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 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.

To the best of my knowledge and belief, and subject to the disclosures set out below, I have properly discharged the responsibilities set out under the National Health Service Act 2006 (as amended), Managing Public Money and in my ICB Accountable Officer Appointment Letter.

Disclosures:

- s30 letter issued by external auditors due to the year-end deficit position.

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 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.

Toby Sanders

Toby Sanders
Chief Executive (Accountable Officer)
18 June 2026

Governance Statement

Introduction and context

NHS Leicester, Leicestershire and Rutland Integrated Care Board (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 April 2024 and 31 March 2025 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). A s30 letter was issued by external auditors due to the year-end deficit position

Scope of responsibility

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

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

The main function of the LLR ICB's Board is to ensure that the ICB 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. Further detail on the membership of the Board can be found in the section on Board member profiles.

LLR ICB Constitution

The LLR 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 ICB Board ensures that robust systems of internal control and management are in place. This responsibility is supported through an effective committee structure, which includes joint committees established with the local authorities and partner organisations.

The LLR ICB Constitution and Governance Handbook set out the corporate governance framework, as agreed by the Board. The 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 (SoRD) clearly details matters reserved to the membership and authority delegated to the Board, its committees and officers. The Scheme of Reservation and Delegation are underpinned by Operational Scheme of Delegation (OSoD). The SoRD and the OSoD were aligned across LLR ICB and NICB to enable a consistent framework to be in place across the clustered ICBs.

The Constitution has been updated to reflect the changes to the membership of the ICB Board resulting through the ICB Clustering arrangements during 2025/26. NHS England approved the updated Constitution in January 2026.

Committees of the Board

The committee structure underpinning the ICB Board supports the identification and management of internal controls and risks.

During 2025/26, LLR ICB began working under a clustered arrangement with Northamptonshire ICB (NICB).

From October 2025 the ICBs established a Joint Executive Management Team (JET) to provide executive leadership across the two ICBs. The JET enables health population strategy/planning developments, transformational delivery of the plans, increasing performance, efficiency and quality through contracting for outcomes, focusing on integration of primary and community services to support delivery of care in the community/closer to home and enables us to monitor and drive quality, safety and equity of services throughout the organisation.

The different iterations of the governance arrangements during 2025/26, including the clustered ICB arrangements, are set out in Appendix 1. Further detail on the remit of the Board and committees can be found later in the Governance Statement.

From 1 April 2025 to 30 September 2025 the LLR ICB Committees met under the established Committees of the Board at that time. From 1 October 2025 the remit and functions of the committees were undertaken by the interim governance arrangements under which the clustered ICBs operated.

The committee structure is provided at **Appendix 1** and the following provides an overview of the role of each Committee:

a) **Audit Committee** – the Audit Committee is a statutory committee and is accountable to the Board. It is chaired by a non-executive member. The terms of reference have been reviewed and approved. 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. This includes providing assurance to the Board that the organisation has appropriate and adequate systems in place to ensure links between financial, corporate and clinical governance risk.

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

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

From October 2025 the Committee met under an in common arrangement with NICB. The membership of the Audit Committee as at 31 March 2026:

- Non-Executive Member for Audit (Chair)
- Non-Executive Member for Remuneration

The Committee will continue to meet under an in common arrangement in 2026/27.

The Committee convened four meetings during 2025/26. All meetings were quorate, well attended and supported by the Chief Finance Officer and the Head of Corporate Governance. The Committee Chair presents an assurance report to the Board following Committee meetings.

b) **Remuneration Committee** – the Remuneration Committee is a statutory committee, and it is accountable to the Board. It 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.

From October 2025 the Committee met under an in common arrangement with LLR ICB. The Committee will continue to meet under an in common arrangement with LLR ICB in 2026/27.

The membership of the Remuneration and People Committee as at 31 March 2026:

- Non-Executive Member – Remuneration (Chair)
- Non-Executive Member – Finance (Vice Chair)
- Non-Executive Member - Commissioning
- Non-Executive Member – Quality, Performance and Outcomes
- Chair of the clustered ICBs

In addition, the following are also invited as regular attendees:

- Chief Executive Officer
- Chief Strategy Officer
- Senior HR Advisor
- Corporate Governance Lead

The Committee convened as required during the year with all meetings being quorate with good attendance from members. From June 2025 the Committee met under an in common arrangement with NICB a further seven times up to March 2026. The chair of the committee draws the Board's attention to any issues that require disclosure or executive action as required.

c) **System Executive Committee** – is a Committee of the Board and was established to provide the Board with assurance on the day to day running of the NHS across LLR. This included:

- Developing the yearly LLR System Operational Plan for approval by the ICB Board.
- Developing and monitoring the yearly activity, financial, revenue and capital plans, commissioning intentions and the long-term financial plans and regimes for the NHS system for approval by the ICB Board.
- Assurance on operational resilience and dealing with any escalations, i.e. risks and barriers to delivery of the plan relating to activity, finance, performance and quality, including wider aspects such as partnership working, Green Plan etc.
- Overseeing the programme and project assurance arrangements to deliver the yearly financial plan transformation priorities and strategic programmes.
- Commissioning and overseeing the development of the Collaboratives and Partnerships within LLR.
- Approving Business Cases within delegated limits.
- Approving contracts within delegated limits.

The System Executive Committee was chaired by the ICB Chief Executive. The Committee convened as required during the year with all meetings being quorate and it continues to operate within its approved set of terms of reference. This Committee was disestablished in March 2026.

e) Quality and Safety Committee was established to provide the ICB Board with assurance that the ICB 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. The Committee is chaired by a Non-Executive Member. The Committee scrutinises internal controls that support it to effectively deliver the ICB's strategic objectives and provide sustainable, high-quality care. The Committee held meetings at agreed intervals during the year, meetings were quorate, and ensured regular assurance updates are presented to the Board in relation to activities and items within its remit. This Committee was disestablished in March 2026.

f) Finance Committee – the purpose of the Committee is to provide the ICB with assurance that it is delivering its statutory functions in relation to financial planning and management. The Committee scrutinises the robustness of internal controls relating to financial planning and management in order to effectively deliver the ICB's strategic objectives. The Committee is chaired by a Non-Executive Member. Meetings were held at agreed intervals during the year, providing regular assurance updates to the ICB in relation to activities and items within its remit. This Committee as disestablished in March 2026.

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 was chaired by a Non-Executive Member and met at agreed intervals during the year. The Committee provides regular assurance updates to the ICB in relation to activities and items within its remit. This Committee was disestablished in March 2026.

h) Joint Transition Committee was established during 2025 to oversee and scrutinise arrangements for transition across the LLR ICB and NICB.

i) LLR Health and Wellbeing Partnership (LLR HWP) – referred to as the Integrated Care Partnership (ICP) within the Health and Social Care Act 2022, was co-chaired by one of the three Chairs of the Health and Wellbeing Boards (in rotation) and the LLR ICB Chair. The 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 approving an integrated care strategy on how to meet the health and wellbeing needs of the population across LLR.

j) East Midlands ICBs Joint Committee was disestablished from March 2026, to reflect the establishment of the Midlands Joint and Collaborative Committee in shadow form from April 2026. This committee supported collaborative working and joint commissioning of delegated functions and associated activities. Responsible for arranging, assuring and where delegated to do so make decisions on specified services across the East Midlands footprint.

ICBs' cluster governance arrangements and change in committee structure

Interim committee arrangements were in place for the clustered ICBs from October 2025 to enact the statutory duties, required business, remit and function of the nationally mandated and locally determined Committees across the two ICBs. In March 2026, the interim arrangements transitioned into the new governance framework across the

clustered ICBs ensuring that there was a focus on the core statutory duties and functions, reducing duplication and promote efficiency/effectiveness.

The respective ICB Boards and the statutory committees (i.e. Audit Committees and Remuneration Committees) met in common. The locally determined committees from each of the respective ICBs met under the following arrangements until March 2026:

- Committees meeting in Common for Commissioning Strategy
- Committees meeting in Common for Finance and Contracting
- Committees meeting in Common for Quality, Performance and Outcomes

From March 2026, a new governance framework has been approved by the LLR ICB and NICB Boards to reflect the clustered ICBs' governance arrangements. The respective ICBs remain as two separate statutory organisations and as such the ICB mandated Committees (Audit and Remuneration) remained under an "in common" arrangement in line with the national requirements.

The ICB has established Joint Committees with NICB for the locally determined Committees (Commissioning Strategy; Finance and Contracting; Quality, Performance and Outcomes) to undertake the remit and function as set out within the Terms of Reference for each of these Committees. Following the establishment of the ICBs' cluster governance framework, the previous ICB specific locally determined committees were disestablished. The remit of the Joint Transition Committee was extended to include transformation and therefore renamed to Jont Transition and Transformation Committee. Furthermore, the Joint Transition and Transformation Committee is time limited whilst the programme of work continues through the transition period to a single organisation expected to be from April 2027.

In summary, the established Committees of the ICB Board as at 31 March 2026 were:

- LLR ICB Audit Committee (meeting in common with NICB Audit Committee)
- LLR ICB Remuneration and People Committee (meeting in common with NICB Remuneration and People Committee)
- LLR ICB and N ICB Joint Commissioning Strategy Committee
- LLR ICB and N ICB Joint Finance and Contracting Committee
- LLR ICB and N ICB Joint Quality, Performance and Outcomes Committee
- LLR ICB and N ICB Joint Transition and Transformation Committee

An overview of the function and remit of the new joint committees are provided below:

i. Joint Commissioning Strategy Committee

The Joint Commissioning Strategy Committee primary focus is on oversight and assurance of the following areas:

- Strategic and operational planning (overarching and component parts).
- Delivery of operational planning commitments (excluding finance).
- Delivery of planning commitments (excluding finance) outside of the approved long term/ annual plan.
- Population Health Management, data and analytics – informing planning and commissioning decisions.
- Reducing health inequality though planning and commissioning of health services

- Population involvement, engagement and consultation.
- Supporting place / neighbourhoods / collaboratives to development.
- Collaborative commissioning / new models of care.
- Capital Estates Planning and Green Agenda.

The membership of the Joint Commissioning Strategy Committee as at 31 March 2026:

- Non-Executive Member for Commissioning Strategy (Chair)
- Non-Executive Member for Finance
- Chief Strategy Officer
- Chief Delivery Officer
- Chief Finance Officer
- Chief Nursing Officer or Chief Medical Officer
- Cluster Representative Director of Public Health
- Cluster Representative Healthwatch

In addition the following are also invited as regular attendees:

- Senior Lead Strategy
- Senior Lead Public/Patient Engagement
- Senior Lead Digital/Data

The chair of the committee draws the Board's attention to any issues that require disclosure or executive action as required.

ii. **Joint Finance and Contracting Committee**

The Joint Finance and Contracting Committee has a primary focus on the oversight and assurance of the following areas:

- Financial Strategy and Planning.
- Resource allocation.
- Financial delivery, in year and multi year
- Financial Recovery.
- Capital expenditure
- Procurement and Contracting Strategy and Planning
- Contracting / Collaboration / Delegation Model Agreements
- Contractual delivery / value for money.

The membership of the Joint Finance and Contracting Committee as at 31 March 2026:

- Non-Executive Member for Finance (Chair)
- Non-Executive Member for Audit (Vice Chair)
- Chief Finance Officer
- Chief Delivery Officer
- Chief Nursing Officer
- Chief Medical Officer
- Deputy Chief Strategy Officer (Senior Lead for Strategy)

The chair of the committee draws the Board's attention to any issues that require disclosure or executive action as required.

iii. Joint Quality, Performance and Outcomes Committee

The Joint Quality, Performance and Outcomes Committee primary focus is on the oversight and assurance of the following areas:

- Quality
- Safeguarding
- Infection, Prevention and Control
- Consider the quality and equality impact of commissioned services
- Assurance of delivery against performance standards and
- Constitutional standards
- Delivery of planned outcomes for patients / service users.

The membership of the Joint Quality, Performance and Outcomes Committee as at 31 March 2026:

- Non-Executive Member Quality (Chair)
- Non-Executive Member Remuneration (Vice Chair)
- Chief Nursing Officer
- Chief Medical Officer
- Chief Strategy Officer
- Chief Delivery Officer
- Cluster representative Director of Public Health
- Cluster representative Healthwatch

The chair of the committee draws the Board's attention to any issues that require disclosure or executive action as required.

iv. Joint Transition and Transformation Committee

The Joint Transition and Transformation Committee primary focus is to oversee and scrutinise arrangements for the transition and transformation of the ICBs into their future operating model, in line with national guidance, which may include consideration of a potential merger of the ICBs.

The membership of the Joint Transition and Transformation Committee as at 31 March 2026:

- Non- Executive Member – Remuneration (Chair of meeting)
- Non-Executive Member – Quality (vice Chair)
- Chief Executive
- Chief Strategy Officer
- Transition Director
- Senior HR Lead

In addition, individuals may be asked to attend on a regular basis, however they do not form part of the membership and therefore do not have voting rights.

The chair of the committee draws the Board's attention to any issues that require disclosure or executive action as required.

Other Joint committees with partners

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 respective Health and Wellbeing Boards 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.

Board performance and development

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.

The Board receives regular information and briefings enabling members to gain greater clarity on national guidance / change in legislation and the impact on the ICB's business; to develop further insight into performance issues with key providers; and enhance their knowledge on specific topics.

Board members' attendance record is positive for both the Board development sessions and board meetings. All Board meetings held in public throughout the year, including meetings held in common with NICB, 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.

For the financial year ended 31 March 2026, and up to the date of signing this statement, the ICB has applied best practice and the principles of the Code that have been considered relevant to the ICB. Some examples of how the ICB has applied best practice are provided below:

- A clear division of responsibilities between the Board and the executive responsibilities for running the organisation. The Chair 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 executive officer. Directorates have confirmed that their structures provide the necessary capability to undertake all of the ICB's statutory duties and capacity to deliver is regularly assessed.

Risk management arrangements and effectiveness

The proactive and continuous management of risk is essential to the efficient and effective delivery of an organisation's strategic objectives. The LLR ICB's Risk Management Strategy and Policy sets the strategic and operational frameworks of successful management and evaluation of risk across the organisation. The chosen method of risk management is aligned with the *ISO 31000:2009 – Risk Management Principles and Guidelines* and *The Orange Book: Management of Risk*, which are widely adopted set of principles and guidelines.

The PESTLE (political, economic, social, technological, legal and environmental) model is used by the ICB for risk identification. The ICB has adopted a common framework for the assessment and analysis of all risk categories including clinical, financial, information governance / security and organisational risks. Risks are also identified through quality and equality impact assessments, data protection impact assessments, and through complaints and incidents. The actions required to manage the risks are documented on the risk registers, and monitored and assessed at regular intervals.

A two-tier process involving local directorate-based registers and the 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 is aligned to the ICB's strategic aims and objectives, provides 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 strategi risks identified are detailed in Appendix 5.

During 2025/26 the clustered ICBs have considered and are developing an aligned cluster risk management approach. As at 31 March 2026, the BAF risks have been aligned where possible with further development and alignment to take place during

2026/27. The strategic risks detailed within the LLR ICB BAF as at 31 March 2026 are set out in the Appendix 5. Further detail on the mitigations and actions in place to manage the impact of and management of key risks can be found in the reports presented to the Board during meetings held in public – please see our website for further information.

Oversight of risks

All committees of the ICB have been critical in the review of the risk profile of the ICB through the review and oversight of strategic risks and associated mitigations. The Executive Management Team has been and continues to be responsible for ensuring strategic risks facing the ICB are current; have been captured and evaluated appropriately; and actions undertaken in a timely manner.

At directorate level, a directorate / function level (operational) risk register is maintained to monitored local risks. Risks are linked to strategic 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 have been considered by the Executive Management Team / Joint Executive 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.

During 2025/26, updates and reports on the status of key risks have been considered by the Committees and the executive team as required with the Board receiving assurance at least twice a year. 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 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 / Joint Executive Team. The Board, and through oversight provided by Board Committees, 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 and Cyber lead (external); information Governance support (internal), 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), the availability 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.

From 1 April 2025 to 31 March 2026 the ICB has continued to maintain the management of risk as detailed above. The Board continues to recognise risk management as an important development area to improve internal controls and its own effectiveness.

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 included the review of risk and the impact on strategic decision making through for instance an equality and quality impact assessment, data protection impact assessment and review of incidents and complaints.

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 and quality 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 Leicester, Leicestershire and Rutland 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 2026 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 (Committees in common for Quality, Performance and Outcomes) 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 (Committees in common for Finance and Contracting), received assurance, reports in respect of finance and activity for the ICB and the impact across the NHS system partners.

The System Executive Committee (Committees in common for Commissioning Strategy) 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 the aforementioned 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 aim 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 and Scheme of Reservation and Delegation) 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 / Joint Executive 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.

While the Health and Care Act 2022 places responsibility on ICBs to manage conflicts of interest and publish their own conflicts of interest policy, which should be included in ICB's governance handbook, NHS England's engagement with local stakeholders suggests nationally-commissioned basic training would be of value to avoid unnecessary duplication across systems. NHS England will provide updated national e-learning modules on managing conflicts of interest in the context of the new ICB arrangements and also explore developing additional guidance on conflicts of interest in consultation with ICB Chairs.

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 auditors have 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 an information governance toolkit and the annual submission process provides assurances to the Leicester, Leicestershire and Rutland ICB, other organisations and to individuals that personal information is dealt with legally, securely, efficiently and effectively.

LLR ICB submitted an interim baseline against the Cyber Assessment Framework aligned Data Security Protection Toolkit (CAF DSPT) in December 2025 and will be making a final submission by 30 June 2026 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 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 continue to develop our information risk assessment and management procedures and a programme to fully embed an information risk culture throughout the ICB.

Information risks are clearly defined within the Risk Management Strategy and Policy including the role of the Senior Information Risk Officer (SIRO) and the Information Asset Owners, which supports the requirements for identifying and managing information risk. The ICB can report that there have been no information governance incidents reported in 2025/26 that required onward escalation to the Information Commissioner's Officer (ICO).

In 2025/26 we ensured that the NHS data mapping exercise was undertaken in line with UKGDPR and Data Protection regulations. It 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 Assurance

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. 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 1 April 2025 – 31 March 2026 the ICB has reported control issues in relation to financial sustainability.

The financial environment continues to prove challenging for the ICB and many other ICBs across the country. Work is continuing to create recurrent efficiency savings for 2026-27.

The Head of Internal Audit Opinion from the internal auditors is detailed later in this report.

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

The effectiveness of the use of resources and financial performance of the ICB was monitored on a monthly basis by the Board and the Executive Management Team / Joint Executive 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 (Committees in common for Finance and Contracting), System Executive Committee (Committees in common for Finance and Contracting, and Committees in common for Commissioning Strategy) and the Quality and Safety Committee (Committees in common for Quality, Performance and Outcomes).

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 2025/26 an audit to review accounts receivable and pay expenditure financial systems. These two audits were 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.

Commissioning of delegated services (primary care services and specialised services)

Leicester, Leicestershire and Rutland ICB has signed delegation agreements with NHS England for the commissioning of delegated primary care services and specialised services and held full commissioning responsibilities for delegated services during the 2025/26 reporting period.

To the best of the ICB leadership's knowledge, all delegated services were commissioned in accordance with 2025/26 delegation agreements and national service specifications. The ICB leadership is able to provide the necessary evidence of compliance with the delegation agreements, any associated developmental requirements and national service specifications, and to show how effectively the delegated function is operating (either directly or via multi-ICB working arrangements) should NHS England or a third party (e.g. external auditors) ask for such evidence.

Delegation of ICB functions

The ICB Board has delegated specific functions to committees, sub-groups and officers of the organisation in line with the ICB's Scheme of Reservation and Delegation (the Scheme of Reservation and Delegation is available within the LLR ICB's Governance Handbook on the LLR ICB website). Assurance reports from each of the Committees of the Board are presented to the Board to demonstrate how the Committees discharge the responsibilities delegated to them, and they escalate risks and issues for the Board's attention. Appendix 1 details the corporate governance and accountability framework.

Functions associated with commissioning pharmacy, optometry and dental primary care services have been delegated to the joint committees created in conjunction with other ICBs across the East Midlands. The joint committee created in conjunction with the ICBs across the East Midlands and the West Midlands enable a collaborative approach to be adopted in the commissioning and management of NHS England delegated acute specialised commissioning functions across a larger footprint. The ICB Board receives summary reports from the joint committees providing assurance in respect of performance and key risks and issues.

The ICB Board in conjunction with each of the three Local Authorities across LLR has established pooled fund arrangements under a Section 75 of the NHS Act 2006, such as for Better Care Funds. Section 75 agreements give power to local authorities and integrated care boards to contribute to and maintain pooled funds out of which payment may be made towards expenditure incurred in the exercise of prescribed health-related functions and / or prescribed NHS functions. Oversight of performance and delivery against the schemes governed via Section 75 arrangements and assessment of risks and issues are reviewed through joint governance arrangements established in conjunction with local authority partners.

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 April 2025 to 31 March 2026 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 significant assurance that there is a generally sound framework of governance, risk management and control designed to meet the organisation's objectives, and controls are generally being applied consistently.*
>
> *The outcome of individual audits undertaken was mixed, highlighting some areas for improvement. As the ICB reviews and updates its arrangements through clustering, there is an opportunity to address these issues.*
>
> *The ICB implemented all its high and medium risk actions in accordance with the timescales agreed.*
>
> *This opinion should be taken in its entirety for the Annual Governance Statement and any other purpose for which it is repeated.*

During the period, Internal Audit issued the audit reports as detailed in Table 5.

Table 5

Area of Audit	Level of Assurance Given
Patient, Care and resident engagement (2024/25 review)	Significant assurance
Delegated commissioning	Significant assurance
Financial reporting – focus on ICB Finance Committee	Significant assurance
Board Assurance Framework and strategic risk management	Significant assurance
Data quality framework	Moderate assurance
Digital strategy delivery	Moderate assurance
IT disaster recovery	Moderate assurance
Additional Roles Reimbursement Scheme	Limited assurance
Data Security Protection Toolkit	Very low risk / high confidence (NHS England opinion level)
Cyber security and artificial intelligence	Advisory review

I am not aware of any risks that have materialised resulting in deficiencies in internal control systems, with the exception of the financial risk which has been referenced earlier. 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. 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

My review of the effectiveness of the system of internal control is informed by the work of the internal auditors, executive managers and clinical leads within the ICB who have responsibility for the development and maintenance of the internal control framework. I have drawn on performance information available to me. My review is also informed by comments made by the external auditors in their annual audit letter and other reports.

Our assurance framework provides me with evidence that the effectiveness of controls that manage risks to the ICB achieving its principles objectives have been reviewed.

I have been advised on the implications of the result of this review by:

- The LLR ICB Board
- The LLR ICB Audit Committee.
- The LLR ICB Remuneration Committee
- The LLR ICB System Executive Committee
- The LLR ICB Finance Committee
- The LLR ICB Health Equity Committee
- The LLR ICB Quality and Safety Committee
- The LLR ICB and NICB Joint Commissioning Strategy Committee
- The LLR ICB and NICB Joint Finance and Contracting Committee
- The LLR ICB and NICB Joint Quality, Performance and Outcomes Committee
- The LLR ICB and NICB Joint Transition and Transformation Committee
- The LLR ICB and NICB Joint Executive Team
- and internal audit.

A plan to address weaknesses and ensure continuous improvement of the system is in place. The processes and committees that have been integral to maintaining and reviewing the effectiveness of the system of internal control, and in addition to the reviews undertaken by internal audit; and quarterly 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

As alluded to earlier the significant internal control issues that has been identified relates to financial sustainability.

The financial environment continues to prove challenging for the ICB and many other ICBs across the country. Work is continuing to create recurrent efficiency savings for 2026/27 as outlined in our Operational and Financial Plan 2026/27.

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 and other Members of the Board (i.e. this includes representatives from partner organisations).

Remuneration Report

Remuneration Committee

Table 6a details the Remuneration Committee members up to 15 October 2025. From 16 October the Remuneration Committee was made up of the members as detailed in Table 6b.

Table 6a: LLR ICB Remuneration Committee members (until 30 September 2025)

Name	Position
Ms Simone Jordan	Non-Executive Member (Chair of the Committee)
Mrs Pauline Tagg, MBE	Non-Executive Member
Mr Anil Majithia	Non-Executive Member
Ms Paula Clark	ICB Chair

Table 6b: Remuneration Committees meeting in common members

Name	Position
Ms Simone Jordan	Non-Executive Member – Remuneration (Chair of the Committee)
Mr Andrew Hammond	Non-Executive Member - Finance
Ms Liz Gaulton	Non-Executive Member – Quality, Performance and Outcomes
To be confirmed	Non-Executive Member – commissioning strategy
Ms Anu Singh	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 (subject to audit)

Table 7	Salary and allowances (2025/26)	Performance pay and bonuses 2025/26)	Salary and allowances (2024/25)	Performance pay and bonuses 2024/25)
The percentage change from the previous financial year in respect of the highest paid director	-32.91%	0.00%	-2.47%	0.00%
The average percentage change from the previous financial year in respect of employees of the entity, taken as a whole	0.00%	0.00%	8.00%	0.00%

These figures are based on total remuneration paid to the highest paid director versus the total gross remuneration paid to all remaining employees in M12. From 1 October 2025, Leicester, Leicestershire and Rutland ICB has been clustered with Northamptonshire ICB, under which arrangement a single shared management board operates across both organisations. As such, the salary of the highest paid director has decreased by 32.91% since 2024-25 as 50% of directors' salaries were shared with Northamptonshire ICB in 2025-26.

The average percentage change in respect of employees taken as a whole has reduced from 8% in 2024-25 to 0% in 2025-26 for the same reason.

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 2025/26 was £132.5k (being the mid point of £130 to £135k) The relationship to the remuneration of the organisation's workforce is disclosed in the below table.

The relationship to the remuneration of the organisation's workforce is disclosed in the below table (Table 8).

Table 8

2025-26	25th percentile	Median	75th percentile
Total remuneration (£'000)	47	58	75
Salary component of total remuneration (£'000)	47	58	75
Pay ratio information	2.84	2.27	1.77
2024-25			
Total remuneration (£'000)	45	56	75
Salary component of total remuneration (£'000)	45	56	75
Pay ratio information	4.39	3.50	2.65

From 1 October 2025, Leicester, Leicestershire and Rutland ICB has been clustered with Northamptonshire ICB, under which arrangement a single shared management board operates across both organisations. As a consequence of this arrangement, remuneration costs for the directors are shared equally, with Northamptonshire ICB recognising 50% of the related expenditure. This has resulted in a reduced pay ratio of the highest paid director's salary to each percentile compared to 2024-25.

During the reporting period 2025-26, 24 employees received remuneration in excess of the highest-paid director / member. This is because of directors' salaries are being shared evenly between Leicester, Leicestershire and Rutland ICB and Northamptonshire ICB. Annualised gross remuneration ranged from £186k to £24k. (2024/25, £197.5k to £22k) based on annualised gross pay for March 2026.

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 and agreed.

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 Executive Directors was determined by the Remuneration Committee in line with due process.

Senior manager remuneration (including salary and pension entitlements)

Remuneration and Allowances Report April 2025 to March 2026 (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
Toby Sanders, Chief Executive	85 - 90	900	0	0	60 - 62.5	150 - 155
Caroline Trevithick, Chief Executive	45 - 50	0	0	0	0 - 0	45 - 50
Alice McGee, Chief People Officer	70 - 75	0	0	0	22.5 - 25	95 - 100
Eileen Doyle, Chief Operating Officer	45 - 50	0	0	0	0 - 0	45 - 50
Rachna Vyas, Chief Operating Officer	75 - 80	0	0	0	20 - 22.5	95 - 100
Nilesh Sanganee, Chief Medical Officer	130 - 135	0	0	0	37.5 - 40	165 - 170
Peter Burnett, Chief Strategy Officer	85 - 90	0	0	0	107.5 - 110	195 - 200
Matt Gaunt, Chief Finance Officer	45 - 50	0	0	0	15 - 17.5	60 - 65
Robert Toole, Chief Finance Officer	85 - 90	0	0	0	25 - 27.5	110 - 115
Maria Laffan, Chief Nursing Officer	35 - 40	0	0	0	37.5 - 40	75 - 80
Kay Darby, Chief Nursing Officer	70 - 75	0	0	0	17.5 - 20	90 - 95
James Ogle, Partner Member - Primary Medical Services	10 - 15	0	0	0	0 - 0	10 - 15
Simone Jordan, Non-Executive Member: People and Remuneration	15 - 20	0	0	0	0 - 0	15 - 20
Anu Singh, Independent Chair of LLR ICS	15 - 20	0	0	0	0 - 0	15 - 20
Paula Clark, Independent Chair of LLR ICS	35 - 40	0	0	0	0 - 0	35 - 40
Darren Hickman, Non-Executive Member: Audit	10 - 15	0	0	0	0 - 0	10 - 15
Anil Majithia, NEM: Health Inequalities Public Engagement 3rd Sector Carers	10 - 15	0	0	0	0 - 0	10 - 15
Pauline Tagg, Non-Executive Member: Quality, Safety and Transformation	10 - 15	0	0	0	0 - 0	10 - 15
Elizabeth Gaulton-Hurst, Non-Executive Member	0 - 5	200	0	0	0 - 0	0 - 5
Andrew Hammond, Non-Executive Member	0 - 5	200	0	0	0 - 0	0 - 5
Afzal Ismail, Non-Executive 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 Employer Pension Notices and replicated in the HM Treasury Financial Reporting Manual Cabinet Officer.
*2: Toby Sanders commenced in the role of Chief Executive on 1st July 2025. He split his time between LLR ICB and Northamptonshire ICB 50:50 between 1st July and 31st March. An adjustment has been made to his salary and pension value to reflect the split with Northamptonshire ICB. His full position is shown in the table below.
*3: Eileen Doyle commenced in the role of Chief Operating Officer on 1st October 2025. She split her time between LLR ICB and Northamptonshire ICB 50:50 between 1st October and 31st March. An adjustment has been made to her salary and pension value to reflect the split with Northamptonshire ICB. Her full position is shown in the table below.

*4: Nilesh Sanganee split his time between LLR ICB and Northamptonshire ICB 50:50 between 1st October and 31st March. An adjustment has been made to his salary and pension value to reflect the split with Northamptonshire ICB. His full position is shown in the table below.
*5: Peter Burnett commenced in the role of Chief Strategy Officer on 2nd June 2025. He split his time between LLR ICB and Northamptonshire ICB 50:50 between 1st October and 31st March. An adjustment has been made to his salary and pension value to reflect the split with Northamptonshire ICB. His full position is shown in the table below.
*6: Matt Gaunt commenced in the role of Chief Finance Officer on 1st October 2025. He split his time between LLR ICB and Northamptonshire ICB 50:50 between 1st October and 31st March. An adjustment has been made to his salary and pension value to reflect the split with Northamptonshire ICB. His full position is shown in the table below.
*7: Maria Laffan commenced in the role of Chief Nursing Officer on at October 2025. She split her time between LLR ICB and Northamptonshire ICB 50:50 between 1st October and 31st March. An adjustment has been made to her salary and pension value to reflect the split with Northamptonshire ICB. Her full position is shown in the table below.
*8: Caroline Trevithick left the organisation on the 30th June 2025.
*9: Robert Toole was Chief Finance Officer between 1st April 2025 - 30th September 2025
*10: Alice McGee was Chief People Officer between 1st April 2025 - 30th September 2025
*11: Rachna Vyas was Chief Operating Officer between 1st April 2025 - 30th September 2025
*12: Kay Darby was interim Chief Nursing Officer between 1st April 2025 - 30th September 2025
*13: James Ogle commenced his role as Partner Member for Primary Medical Services on 1st July 2025.
*14: Simone Jordan split her time between LLR ICB and Northamptonshire ICB 50:50 between 16th October 2025 and 31st March 2026.
*15: Anu Singh commenced her role as Independent Chair on 1st October 2025. She split her time between LLR ICB and Northamptonshire ICB 50:50 between 1st October 2025 and 31st March 2026
*16: Paula Clark left the organisation on the 30th September 2025.
*17: Darren Hickman left the organisation on the 30th November 2025.
*18: Anil Majithia left the organisation on the 30th November 2025.
*19: Pauline Tagg left the organisation on the 30th November 2025.
*20: Elizabeth Gaulton-Hurst commenced in post on 16th October 2025. She split her time between LLR ICB and Northamptonshire ICB 50:50 between 16th October and 31st March.
*21: Andrew Hammond commenced in post on 16th October 2025. He split his time between LLR ICB and Northamptonshire ICB 50:50 between 16th October and 31st March.
*22: Afzal Ismail commenced in Post on 16th October 2025. He split his time between LLR ICB and Northamptonshire ICB 50:50 between 16th October and 31st March.

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
Laurence Jones, Local authority sectoral representative
Mark Andrews, Local authority sectoral representative
Angela Hillery, Community/Mental Health Sector Representative
Richard Mitchell, Acute Sector Representative

Total Remuneration for members allocated over a number of ICB's	(a) Salary (bands of £5,000) £'000	(b) Expense Payments (taxable to the nearest £100) £'000	(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
Toby Sanders, Chief Executive	175 - 180	1,800	0	0	122.5 - 125	300 - 305
Eileen Doyle, Chief Operating Officer	90 - 95	0	0	0	0 - 0	90 – 95
Nilesh Sanganee, Chief Medical Officer	175 - 180	0	0	0	50 - 52.5	225 - 230
Peter Burnett, Chief Strategy Officer	125 - 130	0	0	0	155 - 157.5	280 – 285
Matt Gaunt, Chief Finance Officer	90 - 95	0	0	0	30 - 32.5	120 – 125
Maria Laffan, Chief Nursing Officer	75 - 80	0	0	0	72.5 - 75	150 – 155
Simone Jordan, Non-Executive Member: People and Remuneration	15 - 20	0	0	0	0 - 0	15 – 20
Anu Singh, Independent Chair of LLR ICS	30 - 35	0	0	0	0 - 0	30 - 35
Elizabeth Gaulton-Hurst, Non-Executive Member	5 - 10	400	0	0	0 - 0	5 - 10
Andrew Hammond, Non-Executive Member	5 - 10	300	0	0	0 - 0	5 – 10
Afzal Ismail, Non-Executive Member	5 - 10	100	0	0	0 - 0	5 - 10

Pension benefits as at 31 March 2026 (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 2026 (bands of £5,000) £'000	(d) Lump sum at pension age related to accrued pension at 31 March 2026 (bands of £5,000) £'000	(e) Cash Equivalent Transfer Value at 01 April 2025 £'000	(f) Real Increase in Cash Equivalent Transfer Value £'000	(g) Cash Equivalent Transfer Value at 31 March 2026 £'000	(h) Employers Contribution to stakeholder pension £'000
Toby Sanders, Chief Executive	2.5 - 5	5 - 7.5	65 - 67.5	147.5 - 150	1,296	60	1,367	-
Caroline Trevithick, Chief Executive	0 - 0	0 - 0	55 - 57.5	167.5 - 170	159	1,269	1,436	-
Alice McGee, Chief People Officer	0 - 2.5	0 - 0	15 - 17.5	0 - 0	159	12	181	-
Eileen Doyle, Chief Operating Officer	0 - 0	0 - 0	25 - 27.5	12.5 - 15	440	-	430	-
Rachna Vyas, Chief Operating Officer	0 - 2.5	0 - 0	20 - 22.5	0 - 0	244	12	270	-
Nilesh Sanganee, Chief Medical Officer	2.5 - 5	0 - 2.5	17.5 - 20	25 - 27.5	303	27	351	-
Peter Burnett, Chief Strategy Officer	5 - 7.5	0 - 0	52.5 - 55	0 - 0	719	85	814	-
Matt Gaunt, Chief Finance Officer	0 - 2.5	0 - 0	50 - 52.5	0 - 0	913	16	935	-
Robert Toole, Chief Finance Officer	0 - 2.5	0 - 0	25 - 27.5	0 - 0	399	28	443	-
Maria Laffan, Chief Nursing Officer	0 - 2.5	2.5 - 5	55 - 57.5	142.5 - 145	1,254	39	1,298	-
Kay Darby, Chief Nursing Officer	0 - 2.5	0 - 0	42.5 - 45	92.5 - 95	976	21	1,022	-

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.

Remuneration and Allowances Report April 2024 to March 2025 (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
Dr Caroline Trevithick, Chief Executive	195 - 200	0	0	0	160 – 162.5	360 - 365
Paula Clark, Independent Chair	20 - 25	0	0	0	0 - 0	20 - 25
Robert Toole, Chief Finance Officer	175 - 180	0	0	0	50 – 52.5	225 - 230
Sarah Prema, Chief Strategy Officer	140 - 145	0	0	0	0 - 0	140 - 145
Dr Nil Sanganee, Chief Medical Officer	150 - 155	0	0	0	37.5 - 40	190 - 195
Alice McGee, Chief People Officer	145 - 150	0	0	0	40 – 42.5	185 - 190
Rachna Vyas, Chief Operating Officer	150 - 155	0	0	0	40 - 42.5	190 - 195
Kay Darby, Chief Nursing Officer	140 - 145	0	0	0	37.5 - 40	175 - 180
Professor Mayur Lakhani, Clinical Executive Lead	5 - 10	0	0	0	0 - 0	5 - 10
Professor Azhar Farooqi, Non-Executive Director	0 - 5	0	0	0	0 - 0	0 - 5
Darren Hickman, Non-Executive Director	15 - 20	0	0	0	0 - 0	15 - 20
Pauline Tagg, MBE, Non-Executive Director	30 - 35	0	0	0	0 - 0	30 - 35
Dr Nainesh Chotai, Primary Care Partner Member	0 - 5	0	0	0	0 - 0	0 - 5
Anil Majithia, Non-Executive Director	10 - 15	0	0	0	0 - 0	10 - 15
Simone Jordan, Non-Executive Director	15 - 20	0	0	0	0 - 0	15 - 20

*1: Paula Clark commenced in the role of Independent Chair on 28th October 2024.
*2: Sarah Prema claimed her 1995 Scheme pension on 29th October 2024.
*3: Nilesh Sanganee split his time between LLR ICB and Northamptonshire ICB 60:40 between 3rd June and 31st August. An adjustment has been made to his salary and pension value to reflect the split with Northamptonshire. His full position is shown in the table below.
*4: Professor Mayur Lakhani left the organisation on 30th August 2024.
*5: Professor Azhar Farooqi left the organisation on the 30th June 2024.
*6: Pauline Tagg was acting Independent Chair from 3rd June 2024 to 27th October 2024. she returned to her position of Non-Executive Director on 28th October 2024.
*7: Dr Nainesh Chotai left the organisation on the 30th August 2024.

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
Laurence Jones, Local authority sectoral representative
Mark Andrews, Local authority sectoral representative
Angela Hillery, Community/Mental Health Sector Representative
Richard Mitchell, Acute Sector Representative
James Ogle, Partner Member – Primary Medical Services
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 ICB's	(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
Dr Nil Sanganee, Chief Medical Officer	165 - 170	0	0	0	42.5 - 45	210 - 215

Pension benefits as at 31 March 2025 (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 2025 (bands of £5,000) £'000	(d) Lump sum at pension age related to accrued pension at 31 March 2025 (bands of £5,000) £'000	(e) Cash Equivalent Transfer Value at 01 April 2024 £'000	(f) Real Increase in Cash Equivalent Transfer Value £'000	(g) Cash Equivalent Transfer Value at 31 March 2025 £'000	(h) Employers Contribution to stakeholder pension £'000
Dr Caroline Trevithick, Chief Executive	7.5 - 10	15 - 17.5	85 - 87.5	225 - 227.5	1,728	0	159	0
Alice McGee, Chief People Officer	2.5 - 5	0 - 0	12.5 - 15	0 - 0	116	19	159	0
Rachna Vyas, Chief Operating Officer	2.5 - 5	0 - 0	17.5 - 20	0 - 0	191	24	244	0
Nilesh Sanganee, Chief Medical Officer	2.5 - 5	0 - 0	15 – 17.5	25 – 27.5	240	27	303	0
Sarah Prema, Chief Strategy Officer	0 - 0	0 - 0	75 – 77.5	200 – 202.5	1,759	0	138	0
Robert Toole, Chief Finance Officer	2.5 - 5	0 - 0	22.5 - 25	0 - 0	310	47	399	0
Kay Darby, Chief Nursing Officer	2.5 - 5	0 - 2.5	40 – 42.5	90 – 92.5	859	43	976	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.

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 directors (subject to audit)

No such payments have been proposed or paid during the year.

Staff Report

Number of senior managers

The number of senior managers (i.e. executives) are detailed in the table below including their salary band. Further details are available in the Remuneration and Allowance table within the Remuneration Report section of the report.

Table 9

Title	First Name	Last Name	Band
Mr	Toby	Sanders	VSM
Mr	Matt	Gaunt	VSM
Prof	Nilesh	Sanganee	VSM
Ms	Maria	Laffan	VSM
Mr	Peter	Burnett	VSM
Ms	Eileen	Doyle	VSM

Staff numbers and costs (subject to audit)

Employee benefits (1 April 2025 to 31 March 2026) (subject to audit)

4.1.1 Employee benefits	Admin			Programme					
	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	9,100	368	**9,469**	8,668	335	**9,003**	17,768	703	**18,472**
Social security costs	1,240	-	**1,240**	1,183	-	**1,183**	2,423	-	**2,423**
Employer contributions to the NHS Pension Scheme	2,718	-	**2,718**	1,056	-	**1,056**	3,774	-	**3,774**
Apprenticeship Levy	72	-	**72**	-	-	**-**	72	-	**72**
Gross employee benefits expenditure	**13,130**	**368**	**13,499**	**10,907**	**335**	**11,242**	**24,037**	**703**	**24,740**
Less recoveries in respect of employee benefits (note 4.1.2)	(415)	-	**(415)**	(103)	-	**(103)**	(519)	-	**(519)**
Total - Net admin employee benefits including capitalised costs	**12,715**	**368**	**13,083**	**10,804**	**335**	**11,139**	**23,518**	**703**	**24,222**
Less: Employee costs capitalised	-	-	**-**	-	-	**-**	-	-	**-**
Net employee benefits excluding capitalised costs	**12,715**	**368**	**13,083**	**10,804**	**335**	**11,139**	**23,518**	**703**	**24,222**

Average number of people employed

	Permanently employed	Other	Total
	Number	Number	Number
Total	**269**	**7**	**276**

There were nil whole time equivalent people engaged on capital projects

Staff numbers and costs (subject to audit)

Employee benefits (1 April 2024 to 31 March 2025)

	Admin			Programme			Total		
	Permanent Employees	Other	Total	Permanent Employees	Other	Total	Permanent Employees	Other	Total
	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000
Employee Benefits									
Salaries and wages	10,278	69	**10,347**	7,486	487	**7,973**	17,764	556	**18,320**
Social security costs	1,192	-	**1,192**	814	-	**814**	2,006	-	**2,006**
Employer contributions to the NHS Pension Scheme	2,841	-	**2,841**	876	-	**876**	3,717	-	**3,717**
Apprenticeship Levy	71	-	**71**	-	-	**-**	71	-	**71**
Termination benefits	-	-	**-**	-	-	**-**	-	-	**-**
Gross employee benefits expenditure	**14,381**	**69**	**14,451**	**9,176**	**487**	**9,663**	**23,557**	**556**	**24,114**
Less recoveries in respect of employee benefits (note 4.1.2)	(229)	-	**(229)**	(118)	-	**(118)**	(347)	-	**(347)**
Net employee benefits excluding capitalised costs	**14,152**	**69**	**14,222**	**9,058**	**487**	**9,545**	**23,211**	**556**	**23,767**

Average number of people employed

	Permanently employed	Other	Total
	Number	Number	Number
Total	**271**	**5**	**276**

There were nil whole time equivalent people engaged on capital projects

Staff composition

As of the 31 March 2026, LLR ICB employed a total of 320 staff (excluding bank staff) (at 31 March 2025 there were a total of 341 staff) of this breakdown 227 were female and 81 were male. The gender profile of these staff is detailed in the table below.

Table 10: Staff analysis by gender (based on staffing at 31st March 2026)

	Headcount by Gender			
Staff Grouping	**Female**	**Male**	**Unknown***	**Totals**
Board Member	2	3	12	**17**
Other Senior Management (Band 8C+)	40	26	0	**66**
All Other Employees	185	52	0	**237**
Grand Total	**227**	**81**	**12**	**320**

**Unknown pertains to Board Members without a pay record in the ICB Electronic Staff Record (ESR) system.*

% by Gender		
Female	**Male**	**Unknown***
11.8%	17.6%	70.6%
60.6%	39.4%	0.0%
78.1%	21.9%	0.0%
70.94%	**25.31%**	**3.75%**

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 2026.

Table 11 - Senior staff analysis by band (based on staffing at 31st March 2026

Pay Band	Headcount
Ad Hoc / Local	3
Apprentice	0
Band 1	0
Band 2	2
Band 3	3
Band 4	15
Band 5	20
Band 6	43
Band 7	48
Band 8 - Range A	68
Band 8 - Range B	35
Band 8 - Range C	25
Band 8 - Range D	7
Band 9	10
Medical	23
VSM	6
Board (off payroll)	12
Grand Total	**320**

**Board (off payroll) pertains to Board Members without a pay record in the ICB Electronic Staff Record (ESR) system. Named individuals categorised as "unknown" are: Toby Sanders, Afzal Ismail, Liz Gaulton, Andrew Hammond, Eileen Doyle, Matt Gaunt, Maria Laffan, Angela Hillery, Richard Mitchell, Mark Andrews, Mike Sandys and Laurence Jones.*

Sickness absence data

The sickness absence data for the ICB in 2025 was whole time equivalent (WTE) days available of 63321.73 and WTE days lost to sickness absence of 1080.71 and average working days lost per employee was 3.84 which was managed through the absence management policy.

Table 12

Staff sickness absence 2025	2025 Number
Total Days Lost	1080.71
Total Staff Years	281.43
Average Working Days Lost	3.84

Staff turnover percentages

The ICB Staff Turnover Rate for 2025-26 has been calculated by dividing the total FTE Leavers in-year by the average FTE Staff in Post during the year. The ICB's Total FTE Leavers in year was 29.53. The ICB's Average FTE Staff in Post during the year was 277.83. The ICB Staff Turnover Rate for the year was 10.63%.

Table 13

ICB Staff Turnover 2025-26	2025-26 Number
Average FTE Employed 2025-26	277.83
Total FTE Leavers 2025-26	29.53
Turnover Rate	10.63%

Staff engagement percentages

LLR ICB participated in the national NHS Staff Survey between October and November 2025. The results are available at the following https://cms.nhsstaffsurveys.com/app/reports/2025/QK1-breakdown-2025.pdf .

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.

Trade Union Facility Time Reporting Requirements

The Trade Union (Facility Time Publication Requirements) regulations 2017, requires public sector organisations who employ over 49 full time equivalent staff to report and publish information relating to trade union facility time in their organisations. The Trade Union Facility Time Publication Service's deadline for public sector organisations to centrally submit data is 31 July. Facility time is paid time off for union representatives to carry out trade union activities.

During the period 1 April 2025 to 31 March 2026, three members of ICB staff was an accredited workplace representative. The total cost associated with any facility time undertaken would have been less than one per cent of the overall pay bill, and full detail will be submitted in in accordance with the above regulation requirements.

Other employee matters

Expenditure on consultancy

The expenditure on consultancy in 2025/26 for the LLR ICB was £1,500.

Off-payroll engagements

Table 14: Length of all highly paid off-payroll engagements

For all off-payroll engagements as at 31 March 2026, for more than £245* per day:

	Number
Number of existing engagements as of 31 March 2026	0
Of which, the number that have existed:	
for less than one year at the time of reporting	0
for between one and two years at the time of reporting	0
for between 2 and 3 years at the time of reporting	0
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 15: Off-payroll workers engaged at any point during the financial year

For all off-payroll engagements between 1 April 2025 to 31 March 2026, for more than £245[1] per day:

	Number
No. of temporary off-payroll workers engaged between 1 April 2025 to 31 March 2026	0
Of which:	
No. not subject to off-payroll legislation[2]	0
No. subject to off-payroll legislation and determined as in-scope of IR35[2]	0
No. subject to off-payroll legislation and determined as out of scope of IR35[2]	0
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

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

[2] 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 16: Off-payroll engagements / senior official engagements

For any off-payroll engagements of Board members and / or senior officials with significant financial responsibility, between 1 April 2025 to 31 March 2026:

Number of off-payroll engagements of board members, and/or senior officers with significant financial responsibility, during reporting period[1]	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.[2]	21

[1] 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 six months

[2] As both on payroll and off-payroll engagements are included in the total figure, no entries here should be blank or zero.

Exit packages, including special (non-contractual) payments (subject to audit)

Table 17: Exit Packages

Exit package cost band (inc. any special payment element)	Number of compulsory redundancies	Cost of compulsory redundancies	Number of other departures agreed	Cost of other departures agreed	Total number of exit packages	Total cost of exit packages	Number of departures where special payments have been made	Cost of special payment element included in exit packages
	WHOLE NUMBERS ONLY	£s	WHOLE NUMBERS ONLY	£s	WHOLE NUMBERS ONLY	£s	WHOLE NUMBERS ONLY	£s
Less than £10,000			3	14,163	3	14,163		
£10,000 - £25,000			13	228,128	13	228,128		
£25,001 - £50,000	1	49,167	18	708,605	19	757,772		
£50,001 - £100,000			20	1,439,770	20	1,439,770		
£100,001 - £150,000	2	282,333	7	848,615	9	1,130,948		
£150,001 – £200,000			6	1,031,786	6	1,031,786		
>£200,000								
TOTALS	3	331,500	67	4,271,067	70	4,602,567		

Redundancy and other departure cost have been paid in accordance with the provisions of NHS Scheme. Exit costs in this note are accounted for in full in the year of departure. Where the Leicester, Leicestershire and Rutland ICB has agreed early retirements, the additional costs are met by the Leicester, Leicestershire and Rutland ICB and not by the NHS Pensions Scheme. Ill-health retirement costs are met by the NHS Pensions Scheme and are not included in the table.

Table 18: Analysis of Other Departures

	Agreements	Total Value of agreements
	Number	£000s
Voluntary redundancies including early retirement contractual costs	67	4,271
Mutually agreed resignations (MARS) contractual costs		
Early retirements in the efficiency of the service contractual costs		
Contractual payments in lieu of notice*		
Exit payments following Employment Tribunals or court orders		
Non-contractual payments requiring HMT approval**		
TOTAL	67	4,271

As a single exit package can be made up of several components each of which will be counted separately in this Note, the total number above will not necessarily match the total numbers in Note 3.3 which will be the number of individuals.
*any non-contractual payments in lieu of notice are disclosed under “non-contracted payments requiring HMT approval” below.
**includes any non-contractual severance payment made following judicial mediation, and amounts relating to non-contractual payments in lieu of notice.
No non-contractual payments were made to individuals where the payment value was more than 12 months’ of their annual salary.

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

Parliamentary Accountability and Audit Report

NHS Leicester, Leicestershire and Rutland ICB 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 page 145. An audit certificate and report are also included in this Annual Report at page 140.

Independent auditor's report to the members of the Governing Body 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 Integrated Care Board (the 'ICB') for the year ended 31 March 2026, 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 material accounting policy information. 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 2025-26.

In our opinion, the financial statements:

- give a true and fair view of the financial position of the ICB as at 31 March 2026 and of its expenditure and income for the year 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 2025-26; 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 (2024) ("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 2025-26 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 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 2024) 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 November 2024 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 requirements of the Department of Health and Social Care Group Accounting Manual 2025-26 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 2025-26; 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 period for which the financial statements are prepared is consistent with the financial statements.

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

In our opinion, except for the effects of the matter described in the basis for qualified opinion on regularity section report, 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.

Basis for qualified opinion on regularity

The ICB reported expenditure of £3,068.303 million against income of £3,045.035 million in its financial statements for the year ended 31 March 2026. The ICB thereby breached its duty under section 223GC (1) of the National Health Service Act 2006, as amended, to ensure that expenditure it incurred in a financial year does not exceed the sums received by it in that year.
Under sections 223GB and 272(7) and (8) of the National Health Service Act 2006, as amended, NHS England directed that revenue resource use for the ICB in 2025/26 should not exceed £2,997.572 million. The ICB's revenue resource use for 2025/26 was £3,020.840 million, thereby breaching the direction given to it by NHS England.

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 except on 19 May 2026 we referred a matter to the Secretary of State under section 30 of the Local Audit and Accountability Act 2014 in relation to the ICB's breach of its breakeven duty and revenue resource limit for the year ending 31 March 2026.

Responsibilities of the Accountable Officer

As explained more fully in the Statement of Accountable Officer's responsibilities, 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 Care Act 2022 and interpreted and adapted by the Department of Health and Social Care Group Accounting Manual 2025-26).
- 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 management override of control. 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; and
  - significant accounting estimates, including that of the prescribing accrual.
- 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 journals posted by senior finance officers, journals posted in February, March and post-period end, and journals that alter the financial performance of the ICB for the year;
  - challenging assumptions and judgements made by management in its significant accounting estimates in respect of the prescribing and continuing healthcare accruals;
  - assessing the extent of compliance with the relevant laws and regulations as part of our procedures on the related financial statement item.

- 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.
- We communicated relevant laws and regulations and potential fraud risks to all engagement team members, including the potential for fraud in revenue and/or expenditure recognition, and the significant accounting estimates related to expenditure accruals, in particular the prescribing accrual. We remained alert to any indications of non-compliance with laws and regulations, including fraud, throughout the audit.

- The engagement partner's 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 year ended 31 March 2026.

We have nothing to report in respect of the above matter except on on 17 June 2025 we identified a significant weakness in the ICB's arrangements for financial sustainability for the year ended 31 March 2025. We recommended that the ICB bring forward its financial planning to allow more time to identify appropriate schemes, and ensure that they are more developed and lower risk to reduce the risk of non-delivery of efficiencies on a recurrent basis.

We have reviewed the progress made by the ICB, but consider that the significant weakness in relation to financial sustainability remains in place as at 31 March 2026. We have updated our recommendation to reflect that the ICB must strengthen financial governance arrangements to provide assurance over delivery of the breakeven position in the medium- term and mitigate risk including through improved oversight of key financial risks, a continued focus on high-risk planning assumptions, and embedding robust arrangements for delivering savings.

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 have undertaken our review in accordance with the Code of Audit Practice, having regard to the guidance issued by the Comptroller and Auditor General in March 2026. 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 have documented 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 have considered 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 year ended 31 March 2026 in accordance with the requirements of the Local Audit and Accountability Act 2014 and the Code of Audit Practice until we have completed the work necessary in relation to the ICB's consolidation schedules and we have received confirmation from the National Audit Office that the audit of the NHS group consolidation is complete for the year ended 31 March 2026. We are satisfied that this work does not have a material effect on the financial statements for the year ended 31 March 2026.

Use of our report

This report is made solely to the members of the Governing Body 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 Governing Body 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 Governing Body of the ICB as a body, for our audit work, for this report, or for the opinions we have formed.

Laurelin Griffiths, Key Audit Partner
for and on behalf of Grant Thornton UK LLP, Local Auditor

Birmingham
18 June 2026

ANNUAL ACCOUNTS

Toby Sanders

Toby Sanders
Chief Executive (Accountable Officer)
18 June 2026

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The Primary Statements:

Notes to the Accounts

Statement of Comprehensive Net Expenditure for the year ended 31 March 2026

	Note	2025-26 £'000	2024-25 £'000
Income from sale of goods and services	2	(47,453)	(42,442)
Other operating income	2	(9)	-
Total operating income		**(47,462)**	**(42,442)**
Staff costs	3	31,247	24,114
Purchase of goods and services	4	3,035,326	2,856,783
Depreciation and impairment charges	4	105	126
Provision expense	4	-	43
Other operating expenditure	4	1,624	415
Total operating expenditure		**3,068,302**	**2,881,481**
Net Operating Expenditure		**3,020,840**	**2,839,039**
Finance expense	6	0	1
Net expenditure for the Year		**3,020,840**	**2,839,039**
Comprehensive Expenditure for the year		**3,020,840**	**2,839,039**

The notes on pages 151 to 173 form part of this statement.

Statement of Financial Position as at 31 March 2026

	Note	2025-26 £'000	2024-25 £'000
Non-current assets:			
Property, plant and equipment	7	38	64
Right-of-use assets	7a	-	59
Intangible assets	8	60	80
Total non-current assets		**98**	203
Current assets:			
Trade and other receivables	9.1	9,759	11,706
Cash and cash equivalents	10	26	98
Total current assets		**9,785**	**11,805**
Total assets		**9,883**	12,007
Current liabilities			
Trade and other payables	11	(105,267)	(81,148)
Lease liabilities	7a	-	(6)
Provisions	12	(88)	(283)
Total current liabilities		**(105,355)**	(81,436)
Non-Current Assets plus/less Net Current Assets/Liabilities		**(95,472)**	(69,429)
Non-current liabilities			
Lease liabilities	7a	-	(54)
Total non-current liabilities		**-**	**(54)**
Assets less Liabilities		**(95,472)**	(69,483)
Financed by Taxpayers' Equity			
General fund		(95,472)	(69,483)
Total taxpayers' equity:		**(95,472)**	(69,483)

The notes on pages 151 to 173 form part of this statement

The financial statements on pages 147 to 173 were approved by the LLR ICB Board on 18 June 2026 and signed on its behalf by:

Toby Sanders

Chief Accountable Officer
Toby Sanders

Statement of Changes In Taxpayers' Equity for the year ended 31 March 2026

	General fund £'000	Total reserves £'000
Changes in taxpayers' equity for 2025-26		
Balance at 01 April 2025	(69,483)	(69,483)
Changes in NHS Integrated Care Board taxpayers' equity for 2025-26		
Net operating expenditure for the financial year	(3,020,840)	**(3,020,840)**
Net Recognised NHS Integrated Care Board Expenditure for the Financial year	**(3,020,840)**	**(3,020,840)**
Net funding	2,994,851	**2,994,851**
Balance at 31 March 2026	**(95,472)**	**(95,472)**

	General fund £'000	Total reserves £'000
Changes in taxpayers' equity for 2024-25		
Balance at 01 April 2024	(80,154)	**(80,154)**
Adjusted NHS Integrated Care Board balance at 31 March 2025	**(80,154)**	**(80,154)**
Changes in NHS Integrated Care Board taxpayers' equity for 2024-25		
Net operating costs for the financial year	(2,839,039)	(2,839,039)
Net Recognised NHS Integrated Care Board Expenditure for the Financial Year	**(2,839,039)**	**(2,839,039)**
Net funding	2,849,711	2,849,711
Balance at 31 March 2025	**(69,483)**	**(69,483)**

The notes on pages 151 to 173 form part of this statement

Statement of Cash Flows for the year ended 31 March 2026

	Note	**2025-26 £'000**	2024-25 £'000
Cash Flows from Operating Activities			
Net operating expenditure for the financial year		(3,020,840)	(2,839,039)
Depreciation and amortisation	4	105	126
Interest paid / received		0	1
(Increase)/decrease in trade & other receivables	9.1	1,947	109
Increase/(decrease) in trade & other payables	11	24,120	(10,040)
Provisions utilised	12	(195)	(635)
Increase/(decrease) in provisions	12	-	43
Net Cash Inflow (Outflow) from Operating Activities		**(2,994,863)**	(2,849,436)
Cash Flows from Investing Activities			
(Payments) for property, plant and equipment		-	(131)
Net Cash Inflow (Outflow) from Investing Activities		**-**	(131)
Net Cash Inflow (Outflow) before Financing		**(2,994,863)**	(2,849,567)
Cash Flows from Financing Activities			
Grant in Aid Funding Received		2,994,851	2,849,711
Repayment of lease liabilities		(60)	(72)
Net Cash Inflow (Outflow) from Financing Activities		**2,994,791**	2,849,639
Net Increase (Decrease) in Cash & Cash Equivalents	10	**(72)**	71
Cash & Cash Equivalents at the Beginning of the Financial Year		**98**	27
Cash & Cash Equivalents (including bank overdrafts) at the End of the Financial Year		**26**	98

The notes on pages 151 to 173 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 (ICBS) 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 2025-26 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 ICB for the purpose of giving a true and fair view has been selected. The particular policies adopted by the ICB are described below. They have been applied consistently in dealing with items considered material in relation to the accounts.

1.1 Going Concern

These accounts have been prepared on a going concern basis despite the issue of a report to the Secretary of State for Health and Social Care under Section 30 of the Local Audit and Accountability Act 2014 with regards to the Integrated Care Board's breach of its statutory duty to break even.

On 13 March 2025 the government announced NHS England and the Department for Health and Social Care will increasingly merge functions, ultimately leading to NHS England being fully integrated into the Department. The legal status of ICBs is currently unchanged. Public sector bodies are assumed to be going concerns where the continuation of the provision of a service in the future is anticipated. If services will continue to be provided in the public sector the financial statements should be prepared on the going concern basis. The statement of financial position has therefore been drawn up at 31 March 2026, on a going concern basis.

1.2 Accounting Convention

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

1.3 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.

1.4 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.

1.5 Operating Segments

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

1.6 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

1.7 **Employee Benefits**

1.7.1 **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.

1.7.2 **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.

1.8 **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.

1.9 **Property, Plant & Equipment**

1.9.1 **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.

1.9.2 **Measurement**

All property, plant and equipment are 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 and, where capitalised in accordance with IAS 23, borrowings costs. 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.

1.9.3 **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.

Notes to the financial statements

1.10 **Intangible Assets**

1.10.1 **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.

1.10.2 **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. Expenditure on development is capitalised when it meets the requirements set out in IAS 38.

From 1 April 2025, intangible assets are carried at cost. Where intangible assets have been carried historically under a revaluation approach following initial recognition, the carrying net amount as 31 March 2025 will be considered to be the deemed historic cost. In accordance with the GAM this change in valuation is being applied prospectively.

1.10.3 **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.

1.11 **Leases**

A lease is a contract or part of a contract that conveys the right to control the 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.

1.11.1 **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 4.81% is applied for leases commencing, transitioning or being remeasured in the 2025 calendar year; and 5.32% to new leases commencing in 2026 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.

Notes to the financial statements

The subsequent measurement of the right-of-use asset is consistent with the principles for subsequent measurement of property, plant and equipment. Accordingly, right-of-use assets that are held for their service potential and are in use are subsequently measured at their current value in existing use. Right-of-use assets for leases that are low value or short term and for which current value in use is not expected to fluctuate significantly due to changes in market prices and conditions are valued at depreciated historical cost as a proxy for current value in existing use.

Other than leases for assets under construction and investment property, the right-of-use asset is subsequently depreciated on a straight-line basis over the shorter of the lease term or the useful life of the underlying asset. The right-of-use asset is tested for impairment if there are any indicators of impairment and impairment losses are accounted for as described in the 'Depreciation, amortisation and impairments' policy.

Peppercorn leases are defined as leases for which the consideration paid is nil or nominal (that is, significantly below market value). Peppercorn leases are in the scope of IFRS 16 if they meet the definition of a lease in all aspects apart from containing consideration.

For peppercorn leases a right-of-use asset is recognised and initially measured at current value in existing use. The lease liability is measured in accordance with the above policy. Any difference between the carrying amount of the right-of-use asset and the lease liability is recognised as income as required by IAS 20 as interpreted by the FReM.

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

1.12 **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.

1.13 **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 3.64% (2024-25: 4.03%) for inflation adjusted expected cash flows up to and including 5 years from Statement of Financial Position date.

• A nominal medium-term rate of 4.22% (2024-25: 4.07%) 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 5.32% (2024-25: 4.81%) 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 5.07% (2024-25: 4.55%) 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.

1.14 **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.

1.15 **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.

1.16 **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.

Notes to the financial statements

1.17 **Insurance contracts**

IFRS 17 Insurance contracts has replaced IFRS 4 Insurance contracts and is effective for periods beginning on or after 1 April 2025.

An insurance contract is a contract under which the issuer accepts significant insurance risk from the policyholder by agreeing to compensate the policyholder if a specified uncertain future event adversely affects the policyholder.

The ICB has not identified any insurance under IFRS17.

1.18 **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.

1.18.1 **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.

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

A financial asset is measured at fair value through other comprehensive income where business model objectives are met by both collecting contractual cash flows and selling financial assets and where the cash flows are solely payments of principal and interest. Movements in the fair value of financial assets in this category are recognised as gains or losses in other comprehensive income except for impairment losses. On derecognition, cumulative gains and losses previously recognised in other comprehensive income are reclassified from equity to income and expenditure, except where the Integrated Care Board elected to measure an equity instrument in this category on initial recognition.

1.18.3 **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 at fair value through other comprehensive income. This category also includes financial assets and liabilities acquired principally for the purpose of selling in the short term (held for trading) and derivatives. Derivatives which are embedded in other contracts, but which are separable from the host contract are measured within this category. Movements in the fair value of financial assets and liabilities in this category are recognised as gains or losses in the Statement of Comprehensive income.

1.18.4 **Impairment of financial assets**

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, or assets measured at fair value through other comprehensive income, 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).

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.

1.19 **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.

1.20 **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.

1.21 **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).

Notes to the financial statements

1.22 **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.

• None identified.

1.22.1 **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.

1.23 **Gifts**

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

1.24 **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 2025-26. These Standards are still subject to HM Treasury FReM adoption.

• IFRS 18 Presentation and Disclosure in Financial Statements - The Standard is effective for accounting periods beginning on or after 1 January 2027. The Standard is not yet UK endorsed and not yet adopted by the FReM. Early adoption is not permitted.

• IFRS 19 Subsidiaries without Public Accountability: Disclosures - The Standard is effective for accounting periods beginning on or after 1 January 2027. The Standard is not yet UK endorsed and not yet adopted by the FReM. Early adoption is not permitted.

2 Other Operating Revenue

	2025-26 Total £'000	2024-25 Total £'000
Income from sale of goods and services (contracts)		
Non-patient care services to other bodies	**4,409**	2,192
Prescription fees and charges	**17,050**	17,088
Dental fees and charges	**17,613**	15,994
Other Contract income	**7,862**	6,821
Recoveries in respect of employee benefits	**519**	347
Total Income from sale of goods and services	**47,453**	**42,442**
Other non contract revenue	**9**	-
Total Operating Income	**47,462**	**42,442**

Cost allocation and setting of charges

NHS Leicester, Leicestershire and Rutland ICB certifies that it has complied with the HM Treasury guidance on cost allocation and the setting of charges. The following table provides details of income generation activities whose full cost exceeded £1 million or was otherwise material:

2025-26	Income	Full Cost	Surplus/ (Deficit)
Total delegated dental services	15,994	(79,631)	(63,637)
Total delegated pharmacy services	14,005	(41,854)	(27,849)
Total Fees and Charges	**29,999**	**(121,485)**	**(91,486)**

2024-25	Income	Full Cost	Surplus/ (Deficit)
Total delegated dental services	17,613	(82,183)	(64,570)
Total delegated pharmacy services	14,197	(49,179)	(34,982)
Total Fees and Charges	**31,810**	**(131,362)**	**(99,552)**

The fees and charges information in this note is provided in accordance with section 6.7.1 of the Government Financial Reporting Manual. It is provided for fees and charges purposes and not for International Financial Reporting Standards (IFRS) 8 purposes.

The financial objective is to collect charges from those patients that do not meet the eligibility criteria for free prescriptions and dental treatments.

Prescription charges are a contribution to the cost of pharmaceutical services including the supply of drugs. In 2025/26, the NHS prescription charge for each medicine or appliance dispensed was £9.90 (previously £9.90). However, around 89% of prescription items are dispensed free each year where patients are exempt from charges. In addition, patients who were eligible to pay charges could purchase pre-payment certificates at £32.05 for 3 months or £114.50 for a year. A number of other charges were payable for wigs and fabric supports.

NHS dental charges fall into 3 bands dependent on the level and complexity of care provided. Those who meet the eligibility criteria for exemption are not required to pay such charges. In 2025/26, the charge for Band 1 treatments was £27.90, for Band 2 was £76.60 and for Band 3 was £332.10.

3. Employee benefits and staff numbers

3.1.1 Employee benefits	**Total 2025-26**		
	Permanent Employees £'000	**Other £'000**	**Total £'000**
Employee Benefits			
Salaries and wages	17,768	703	**18,472**
Social security costs	2,423	-	**2,423**
Employer Contributions to NHS Pension scheme	3,774	-	**3,774**
Apprenticeship Levy	72	-	**72**
Termination benefits	6,507	-	**6,507**
Employee benefits expenditure	**30,544**	**703**	**31,247**

	Total 2024-25		
	Permanent Employees £'000	**Other £'000**	**Total £'000**
Employee Benefits			
Salaries and wages	17,764	556	**18,320**
Social security costs	2,006	-	**2,006**
Employer Contributions to NHS Pension scheme	3,717	-	**3,717**
Apprenticeship Levy	71	-	**71**
Employee benefits expenditure	23,557	556	**24,114**

3.2 Average number of people employed

	2025-26		
	Permanently employed Number	**Other Number**	**Total Number**
Total	**269**	**7**	**276**

	2024-25		
	Permanently employed Number	Other Number	Total Number
Total	**271**	**5**	**276**

(No staff were engaged on capital projects)

3.3 Exit packages agreed in the financial year

	2025-26 Compulsory redundancies		2025-26 Other agreed departures		2025-26 Total	
	Number	**£**	**Number**	**£**	**Number**	**£**
Less than £10,000	-	-	3	14,163	3	14,163
£10,001 to £25,000	-	-	13	228,128	13	228,128
£25,001 to £50,000	1	49,167	18	708,605	19	757,772
£50,001 to £100,000	-	-	20	1,439,770	20	1,439,770
£100,001 to £150,000	2	282,333	7	848,615	9	1,130,948
£150,001 to £200,000	-	-	6	1,031,786	6	1,031,786
Over £200,001	-	-	-	-	-	-
Total	**3**	**331,500**	**67**	**4,271,067**	**70**	**4,602,567**

	2024-25 Compulsory redundancies		2024-25 Other agreed departures		2024-25 Total	
	Number	£	Number	£	Number	£
Less than £10,000	-	-	1	8,355	1	8,355
£10,001 to £25,000	-	-	1	17,729	1	17,729
Total	**-**	**-**	**2**	**26,084**	**2**	**26,084**

In 2024-25 both departures were contractual payments in lieu of notice

Analysis of Other Agreed Departures

	2025-26 Other agreed departures		2025-26 Other agreed departures	
	Number	**£**	Number	£
Voluntary redundancies including early retirement contractual costs	67	4,271,067	-	-
Contractual payments in lieu of notice	-	-	2	26,084
Total	**67**	**4,271,067**	**2**	**26,084**

The termination benefits of £6,507k include £1,246k of redundancy costs to which the ICB is formally committed but for which exit packages have not yet been agreed with individual staff members. It also includes £658k relating to former Midlands and Lancashire Commissioning Support Unit staff who directly support the ICB but who are employed by Northamptonshire ICB.

3.4 Pension costs

Past and present employees are covered by the provisions of the 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 the 1995/2008 and 2015 schemes are accounted for, and the scheme liability valued, as a single combined scheme. 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:

3.4.1 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 2026, is based on valuation data as at 31 March 2024, updated to 31 March 2026 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 Statement by the Actuary, which forms part of the annual NHS Pension Scheme Annual Report and Accounts. These accounts can be viewed on the NHS Pensions website and are published annually. Copies can also be obtained from The Stationery Office.

3.4.2 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 (considering recent demographic experience), and to recommend the contribution rate payable by employers.

The latest actuarial valuation undertaken for the NHS Pension Scheme was completed as at 31 March 2020. The results of this valuation set the employer contribution rate payable from 1 April 2024 to 23.7% of pensionable pay. The core cost cap cost of the scheme was calculated to be outside of the 3% cost cap corridor as at 31 March 2020. However, when the wider economic situation was taken into account through the economic cost cap cost of the scheme, the cost cap corridor was not similarly breached. As a result, there was no impact on the member benefit structure or contribution rates.

The 2024 actuarial valuation is currently being prepared and will be published before new contribution rates are implemented from April 2027.

The ICB also offers an additional defined contribution workplace pension scheme called National Employment Savings Scheme (NEST). NEST is a workplace pension scheme established by an Act of Parliament (Pensions Act 2008). This is an employee benefit in line with IAS 19. During 25/26 there have been 2 members. The ICB has recognised the cost in the accounts as an expense of £8,490.18.

4. Operating expenses

	2025-26 Total £'000	2024-25 Total £'000
Purchase of goods and services		
Services from other ICBs and NHS England	8,462	8,314
Services from foundation trusts	136,046	101,063
Services from other NHS trusts	1,782,244	1,719,481
Services from Other WGA bodies	2	-
Purchase of healthcare from non-NHS bodies	441,515	410,394
Purchase of social care	5,256	4,874
General Dental services and personal dental services	70,297	66,122
Prescribing costs	227,520	218,342
Pharmaceutical services	48,658	41,646
General Ophthalmic services	19,585	18,871
GPMS/APMS and PCTMS	260,042	242,169
Supplies and services – clinical	5,481	4,098
Supplies and services – general	7,857	1,971
Consultancy services	2	15
Establishment	4,238	3,393
Transport	10,131	8,311
Premises	5,215	4,083
Audit fees	237	229
Other non statutory audit expenditure		
· Other services	1	52
Other professional fees	348	807
Legal fees	1,461	1,512
Education, training and conferences	730	1,034
Total Purchase of goods and services	**3,035,326**	**2,856,783**
Depreciation and impairment charges		
Depreciation	85	106
Amortisation	20	20
Total Depreciation and impairment charges	**105**	**126**
Provision expense		
Provisions	-	43
Total Provision expense	**-**	**43**
Other Operating Expenditure		
Chair and Non Executive Members	148	138
Grants to Other bodies	925	-
Clinical negligence	7	8
Research and development (excluding staff costs)	156	207
Expected credit loss on receivables	341	-
Other expenditure	46	62
Total Other Operating Expenditure	**1,624**	**415**
Total operating expenditure	**3,037,055**	**2,857,367**

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 and National Fraud Initiative conducted by the Cabinet Office. Both sets of fees include VAT.

The fee for the statutory external audit of the Integrated Care Board was £237k including VAT.

The auditor's liability for external audit work carried out for the period ending 31 March 2026, is limited to £2,000,000.

4.1 Mental Health expenditure

	2025-26 £'000	**2024-25 £'000**
Minimum expenditure in mental health services to meet the Mental Health Investment Stan	230,493	203,167
Eligible mental health expenditure	230,646	203,177
Mental health expenditure above/(below) minimum investment required	153	10
Mental health expenditure as a proprortion of total expenditure	11%	11%

The Integrated Care Board exceeded the minimum required investment in mental health expenditure by £153k in 2025/26 (£10k in 2024/25). Mental Health accounts for 11% of the total Integrated Care Board programme expenditure in 2025/26 (11% in 2024/25).

5 Payment Compliance Reporting

5.1 Better Payment Practice Code

Measure of compliance	**2025-26 Number**	**2025-26 £'000**	2024-25 Number	2024-25 £'000
Non-NHS Payables				
Total Non-NHS Trade invoices paid in the Year	21,244	372,033	20,479	375,296
Total Non-NHS Trade Invoices paid within target	21,108	368,929	20,403	368,739
Percentage of Non-NHS Trade invoices paid within target	**99.36%**	**99.17%**	**99.63%**	**98.25%**
NHS Payables				
Total NHS Trade Invoices Paid in the Year	1,450	1,941,816	1,549	1,836,703
Total NHS Trade Invoices Paid within target	1,447	1,941,703	1,545	1,836,661
Percentage of NHS Trade Invoices paid within target	**99.79%**	**99.99%**	**99.74%**	**100.00%**

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

The Integrated Care Board incurred £nil charges relating to claims made under this legislation. The Integrated Care Board also incurred £nil charges relating to claims made under this legislation in the period 1 April 2024 to 31 March 2025.

6 Finance costs

	2025-26 £'000	2024-25 £'000
Interest		
Interest on lease liabilities	0	1
Total finance costs	**0**	**1**

7 Property, plant and equipment

2025-26	Buildings excluding dwellings £'000	Plant & machinery £'000	Information technology £'000	Furniture & fittings £'000	Total £'000
Cost or valuation at 01 April 2025	111	86	498	49	744
Disposals other than by sale	-	(86)	(393)	-	(479)
Cost/Valuation at 31 March 2026	**111**	**-**	**104**	**49**	**265**
Depreciation 01 April 2025	100	86	465	29	680
Disposals other than by sale	-	(86)	(393)	-	(479)
Charged during the year	11	-	10	5	26
Depreciation at 31 March 2026	**111**	**-**	**81**	**35**	**227**
Net Book Value at 31 March 2026	**0**	**-**	**23**	**15**	**38**
Purchased	0	-	23	15	38
Total at 31 March 2026	**0**	**-**	**23**	**15**	**38**
Net Book Value at 01 April 2025	11	-	33	20	64
Asset financing:					
Owned	0	-	23	15	38
Total at 31 March 2026	**0**	**-**	**23**	**15**	**38**

2024-25	Buildings excluding dwellings £'000	Plant & machinery £'000	Information technology £'000	Furniture & fittings £'000	Total £'000
Cost or valuation at 01 April 2024	111	86	500	49	746
Additions purchased	-	-	(2)	-	(2)
Cost/Valuation at 31 March 2026	**111**	**86**	**498**	**49**	**744**
Depreciation 01 April 2025	89	86	446	24	645
Charged during the year	11	-	19	5	35
Depreciation at 31 March 2025	**100**	**86**	**465**	**29**	**680**
Net Book Value at 31 March 2025	**11**	**-**	**33**	**20**	**64**
Purchased	11	-	33	20	64
Total at 31 March 2025	**11**	**-**	**33**	**20**	**64**
Net Book Value at 01 April 2024	22		54	25	101
Asset financing:					
Owned	11	-	33	20	64
Total at 31 March 2025	**11**	**-**	**33**	**20**	**64**

7.1 Cost or valuation of fully depreciated assets

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

	2025-26 £'000	2024-25 £'000
Plant & machinery	-	86
Information technology	56	450
Furniture & fittings	19	19
Total	**75**	**554**

7.2 Economic lives

	Minimum Life	Maximum Life
Buildings excluding dwellings	5	5
Information technology	5	5
Furniture & fittings	5	5

7a Leases

7a.1 Right-of-use assets

2025-26	**Buildings excluding dwellings £'000**
Cost or valuation at 01 April 2025	271
Cost/Valuation at 31 March 2026	**271**
Depreciation 01 April 2025	212
Charged during the year	59
Depreciation at 31 March 2026	**271**
Net Book Value at 31 March 2026	**-**
Net Book Value at 01 April 2025	59

The lease of the above assets relates to office space at County Hall, Leicester and is leased entirely from Leicestershire County Council, a DHSC group body.

7a.2 Lease liabilities

2025-26	**2025-26 £'000**	2024-25 £'000
Lease liabilities at 01 April 2025	(60)	(131)
Interest expense relating to lease liabilities	(0)	(1)
Repayment of lease liabilities (including interest)	60	72
Lease liabilities at 31 March 2026	**(0)**	**(60)**

7a.3 Lease liabilities - Maturity analysis of undiscounted future lease payments

	2025-26 £'000	2024-25 £'000
Within one year	-	(60)
Balance at 31 March 2026	**-**	**(60)**
Effect of discounting	0	0
Current lease liabilities	-	(6)
Non-current lease liabilities	-	(54)
Total	**-**	**(60)**

The lease of the above assets relates to office space at County Hall, Leicester and is leased entirely from Leicestershire County Council, a DHSC group body.

7a.4 Amounts recognised in Statement of Comprehensive Net Expenditure

2025-26	**2025-26 £'000**	2024-25 £'000
Depreciation expense on right-of-use assets	59	71
Interest expense on lease liabilities	0	1

7a.5 Amounts recognised in Statement of Cash Flows

	2025-26 £'000	2024-25 £'000
Total cash outflow on leases under IFRS 16	60	72

8 Intangible non-current assets

2025-26	Computer Software: Purchased £'000
Cost or valuation at 01 April 2025	**213**
Disposals other than by sale	(103)
Cost / Valuation At 31 March 2026	**110**
Amortisation 01 April 2025	**134**
Disposals other than by sale	(103)
Charged during the year	20
Amortisation At 31 March 2026	**50**
Net Book Value at 31 March 2026	**60**

2024-25	Computer Software: Purchased £'000
Cost or valuation at 01 April 2024	**213**
Cost / Valuation At 31 March 2025	**213**
Amortisation 01 April 2024	**114**
Charged during the year	20
Amortisation At 31 March 2025	**134**
Net Book Value at 31 March 2025	**80**
Net Book Value at 31 March 2024	100

8.1 Cost or valuation of fully amortised assets

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

	2025-26 £'000	2024-25 £'000
Computer software: purchased	11	134
Total	**11**	**134**

8.2 Economic lives

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

9.1 Trade and other receivables

	Current 2025-26 £'000	Current 2024-25 £'000
NHS receivables: Revenue	79	853
NHS accrued income	5,519	1,760
Non-NHS and Other WGA receivables: Revenue	644	878
Non-NHS and Other WGA prepayments	1,200	1,282
Non-NHS and Other WGA accrued income	942	3,075
Non-NHS and Other WGA Contract Receivable not yet invoiced/non-invoice	1,070	3,557
Expected credit loss allowance-receivables	(341)	-
VAT	646	302
Other receivables and accruals	-	1
Total Trade & other receivables	**9,759**	**11,706**
Total current and non current	**9,759**	**11,706**

There are no prepaid pension contributions included.

9.2 Receivables past their due date but not impaired

	2025-26 DHSC Group Bodies £'000	**2025-26 Non DHSC Group Bodies £'000**	2024-25 DHSC Group Bodies £'000	00-Jan-00 Non DHSC Group Bodies £'000
By up to three months	-	(2)	685	367
By three to six months	19	3	-	-
By more than six months	-	336	-	0
Total	**19**	**336**	**685**	**367**

9.3 Loss allowance on asset classes

	Trade and other receivables - Non DHSC Group Bodies £'000
Balance at 01 April 2025	**(0)**
Lifetime expected credit losses on trade and other receivables-Stage 2	**(341)**
Total	**(341)**

10 Cash and cash equivalents

	2025-26 £'000	2024-25 £'000
Balance at 01 April 2025	98	27
Net change in year	(72)	71
Balance at 31 March 2026	**26**	**98**
Made up of:		
Cash with the Government Banking Service	26	98
Cash and cash equivalents as in statement of financial position	**26**	**98**

The Integrated Care Board does not hold patients' monies.

11 Trade and other payables	**Current 2025-26 £'000**	Current 2024-25 £'000
NHS payables: Revenue	1,021	1,877
NHS accruals	2,383	5,921
Non-NHS and Other WGA payables: Revenue	5,506	6,109
Non-NHS and Other WGA accruals	79,943	62,102
Social security costs	258	233
Tax	198	207
Other payables and accruals	15,959	4,699
Total Trade & Other Payables	**105,267**	**81,148**
Total current and non-current	**105,267**	**81,148**

The Integrated Care Board does not have any liabilities included above for arrangements to buy out the liability for early retirement.

Other payables and accruals include £1,587,208 outstanding pension contributions at 31 March 2026 (£1,758,938 at 31 March 2025) and a £6,507,000 redundancy accrual (£0 at 31st March 2025).

12. Provisions

	Current 2025-26 £'000	Current 2024-25 £'000
Continuing care	88	283
Total	**88**	**283**
Total current and non-current	**88**	**283**

	Continuing Care £'000	**Total £'000**
Balance at 01 April 2025	**283**	**283**
Utilised during the year	(195)	**(195)**
Balance at 31 March 2026	**88**	**88**
Expected timing of cash flows:		
Within one year	88	**88**
Balance at 31 March 2026	**88**	**88**

Continuing healthcare retrospective claims and disputes have been reviewed with £195k utilised in year.

13 Financial instruments

13.1 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 the 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.

13.1.1 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 and therefore has low exposure to currency rate fluctuations.

13.1.2 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.

13.1.3 Credit risk

Because the majority of the Integrated Care Board's 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.

13.1.4 Liquidity risk

The 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.

13.1.5 Financial Instruments

As the cash requirements of Integrated Care Board 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 the Integrated Care Board's expected purchase and usage requirements and the Integrated Care Board is therefore exposed to little credit, liquidity or market risk.

13.2 Financial assets

	Financial Assets measured at amortised cost 2025-26 £'000	Financial Assets measured at amortised cost 2024-25 £'000
Trade and other receivables with NHSE bodies	2,500	2,454
Trade and other receivables with other DHSC group bodies	3,099	159
Trade and other receivables with external bodies	2,656	7,510
Cash and cash equivalents	26	98
Total at 31 March 2026	**8,281**	**10,221**

13.3 Financial liabilities

	Financial Liabilities measured at amortised cost 2025-26 £'000	Financial Liabilities measured at amortised cost 2024-25 £'000
Trade and other payables with NHSE bodies	1,535	280
Trade and other payables with other DHSC group bodies	1,869	7,509
Trade and other payables with external bodies	101,407	72,919
Private Finance Initiative and finance lease obligations	-	60
Total at 31 March 2026	**104,811**	**80,767**

13.4 Maturity of financial liabilities

	Payable to DHSC Group £'000	Payable to Other bodies £'000	Total £'000
In one year or less	3,404	101,407	104,811
Total at 31 March 2026	**3,404**	**101,407**	**104,811**

	Payable to DHSC Group £'000	Payable to Other bodies £'000	Total £'000
In one year or less	7,789	72,979	80,767
Total at 31 March 2025	**7,789**	**72,979**	**80,767**

14. 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 25/26 (£000)	Total 24/25 (£000)
Better Care Fund	Adult Social Care	BCF (s.75 agreement)	Resources transferred to Leicestershire County Council who act as host.	33,573	30,966
Better Care Fund	Adult Social Care	BCF (s.75 agreement)	Resources transferred to Rutland County Council who act as host.	2,373	1,994
Better Care Fund	Adult Social Care	BCF (s.75 agreement)	Resources transferred to Leicester City Council who act as host.	22,584	20,749
Learning Disabilities Pool	Social Care	LD	Leicester City Council who act as host.	10,638	9,401
Community Equipment (ICES)	Social Care	Support to live at home	Leicestershire County Council who act as host.	4,730	4,371
Total council act as host				**73,898**	**67,482**
Better Care Fund	Learning Disabilities	Leics County BCF	Resources controlled and expended by the ICB	928	985
Better Care Fund	Community Health	Leics County BCF	Resources controlled and expended by the ICB	13,448	13,031
Better Care Fund	Community Health	Rutland County BCF	Resources controlled and expended by the ICB	932	946
Better Care Fund	Step Down Beds	Leics County BCF	Resources controlled and expended by the ICB	1,842	726
Better Care Fund	Urgent Care/Out of Hours	Leics County BCF	Resources controlled and expended by the ICB	5,381	5,800
Better Care Fund	Other	Leics County BCF	Resources controlled and expended by the ICB	1,899	0
Better Care Fund	Early Discharge Planning	Leicester City BCF	Resources controlled and expended by the ICB	1,980	1,980
Better Care Fund	Enablers for Integration	Leicester City BCF	Resources controlled and expended by the ICB	99	86
Better Care Fund	Community Based Schemes	Leicester City BCF	Resources controlled and expended by the ICB	4,648	3,717
Better Care Fund	Intermediate Care Services	Leicester City BCF	Resources controlled and expended by the ICB	2,474	3,514
Better Care Fund	Prevention / Early Intervention	Leicester City BCF	Resources controlled and expended by the ICB	110	106
Better Care Fund	Home Care or Domiciliary Care	Leicester City BCF	Resources controlled and expended by the ICB	169	169
Better Care Fund	Integrated Care Planning and Navigation	Leicester City BCF	Resources controlled and expended by the ICB	730	730
Better Care Fund	Other	Leicester City BCF	Resources controlled and expended by the ICB	3,722	359
Total Resources controlled and expended by the ICB				**38,362**	**32,149**
Total				**112,260**	**99,631**

Both the ICB and local authority collaborate to agree on schemes funded via the BCF, ensuring they meet the required criteria and yield mutual benefits for both social care and healthcare services.

14.1.1 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.

14.1.2 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.

14.1.3 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.

14.1.4 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.

14.1.5 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.

15 Related party transactions

During period to the 31 March 2026, 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 £'000	Receipts from Related Partv £'000	Amounts owed to Related Partv £'000	Amounts due from Related Partv £'000
NHS Northamptonshire ICB (Joint Board)	Joint Board	88	(89)	321	(31)
LLR Patient Care Locally (Ms Paula Clark)	Chair	17,824	-	(8)	-
Castle Medical Group (Dr Nilesh Sanganee)	GP Partner - Principal at Castle Medical Group	3,269	-	17	(81)
University of Leicester (Dr Nilesh Sanganee)	Honorary Professor, College of Life Sciences	50	-	3	-
University Hospitals Coventry & Warwickshire (Mr Afzal Ismail)	Non-Executive Director	25,556	-	412	-
Royal Orthopaedic Hospital NHS Foundation Trust (Ms Simone Jordan)	Vice Chair and Senior Independent Director. Preivously Associate NED from 2017-2020	590	-	-	-
George Eliot Hospital NHS Trust (Ms Simone Jordan)	Non-Executive Director and Chair of Audit Committee (from 2018 to December 2025)	27,715	-	-	(18)
Derbyshire Healthcare NHS Foundation Trust (Ms Simone Jordan)	Non-Executive Director (from December 2025)	1,966	-	15	-
George Eliot Hospitals NHS Trust (Anil Majithia)	Non Executive Director (from April 2018 to 31 August 2025)	27,715	-	-	(18)
Rutland County Council. (Mr Mark Andrews)	Chief Executive	3,975	(300)	481	(21)
Leicestershire County Council (Mr Mike Sandys)	Director of Public Health	60,910	(58)	17,435	(32)
Rutland County Council (Mr Mike Sandys)	Director of Public Health	3,975	(300)	481	(21)
Leicester City Council (Mr Laurence Jones)	Strategic Director, Social Care & Education	41,415	(1,393)	2,535	(92)
University Hospitals of Leicester NHS Trust. (Mr Richard Mitchell)	Chief Executive	1,253,691	(34)	1	(2,916)
Northamptonshire Healthcare NHS Foundation Trust (Ms Angela Hillery)	Joint Chief Executive	6,898	-	-	-
Leicestershire Partnership NHS Trust (Ms Angela Hillery)	Joint Chief Executive	368,108	(7)	165	(2)
Ratby Medical Centre (Dr James Ogle)	GP Partner at Ratby Medical Centre	1,072	-	1	-
Hinckley and Bosworth Medical Alliance (HBMA) (Dr James Ogle)	Ratby Medical Centre is a shareholder of Hinckley and Bosworth Medical Alliance (HBMA)	1,382	-	36	-
Bosworth Primary Care Network (Dr James Ogle)	Clinical Director - Bosworth Primary Care Network	1,608	-	58	-

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

16 Events after the end of the reporting period

There were no events after the reporting period.

17 Losses and special payments

The total number of NHS Integrated Care Board losses and special payment cases, and their total value, was as follows:

	Total Number of Cases 2025-26 Number	**Total Value of Cases 2025-26 £'000**
Administrative write-offs	-	-
	-	**-**

	Total Number of Cases 2024-25 Number	Total Value of Cases 2024-25 £'000
Administrative write-offs	2	9
	2	**9**

18 Financial performance targets

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

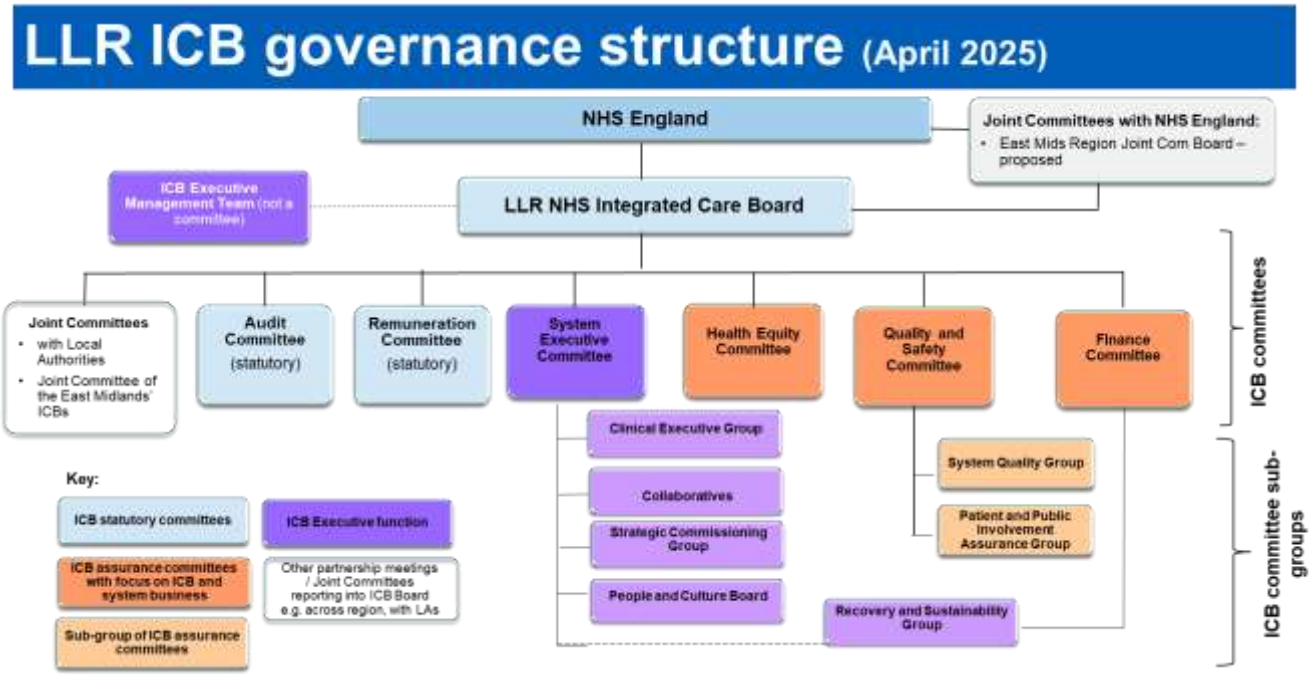
	2025-26 Target £'000	**2025-26 Performance £'000**	**Duty achieved? Yes/No**
Expenditure not to exceed income	3,045,035	3,068,302	No
Revenue resource use does not exceed the amount specified in Directions	2,997,572	3,020,840	No
Revenue administration resource use does not exceed the amount specified in Directions	22,478	21,150	Yes

	2024-25 Target	2024-25 Performance	Duty achieved? Yes/No
Expenditure not to exceed income	2,881,504	2,881,481	Yes
Revenue resource use does not exceed the amount specified in Directions	2,839,062	2,839,039	Yes
Revenue administration resource use does not exceed the amount specified in Directions	19,754	18,580	Yes

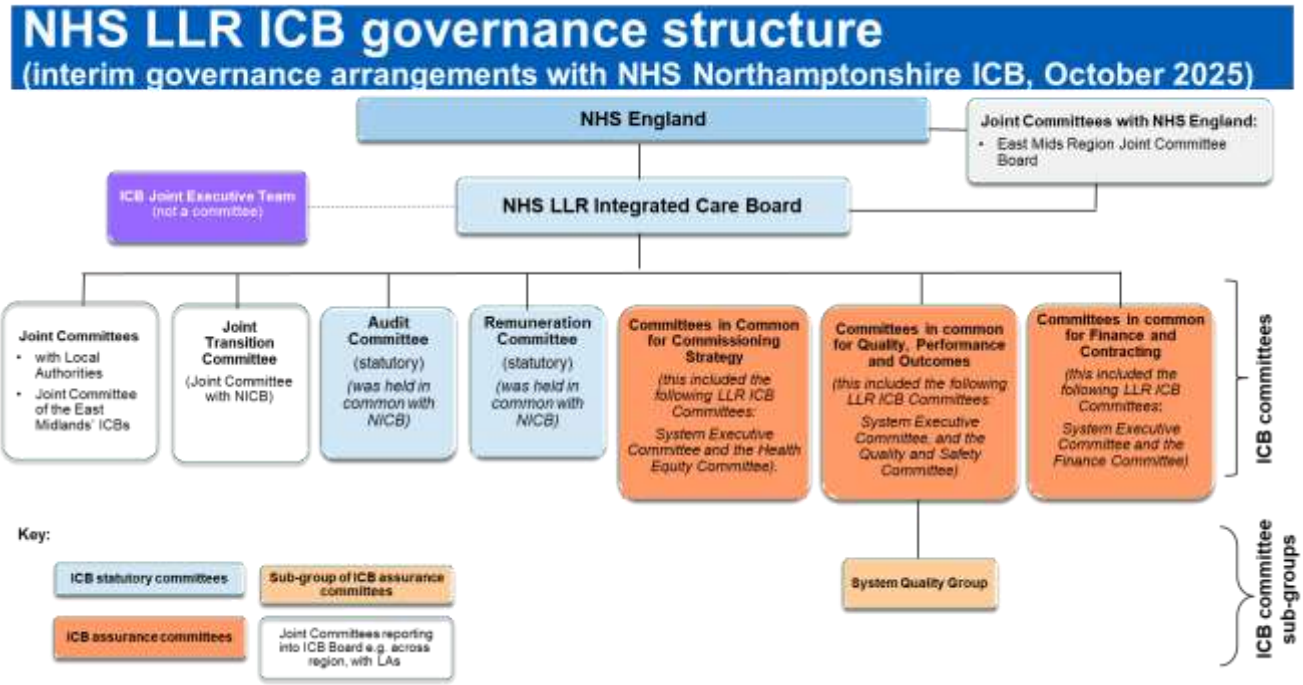
APPENDICES

APPENDIX 1 – LLR ICB Governance arrangements during 2025-26

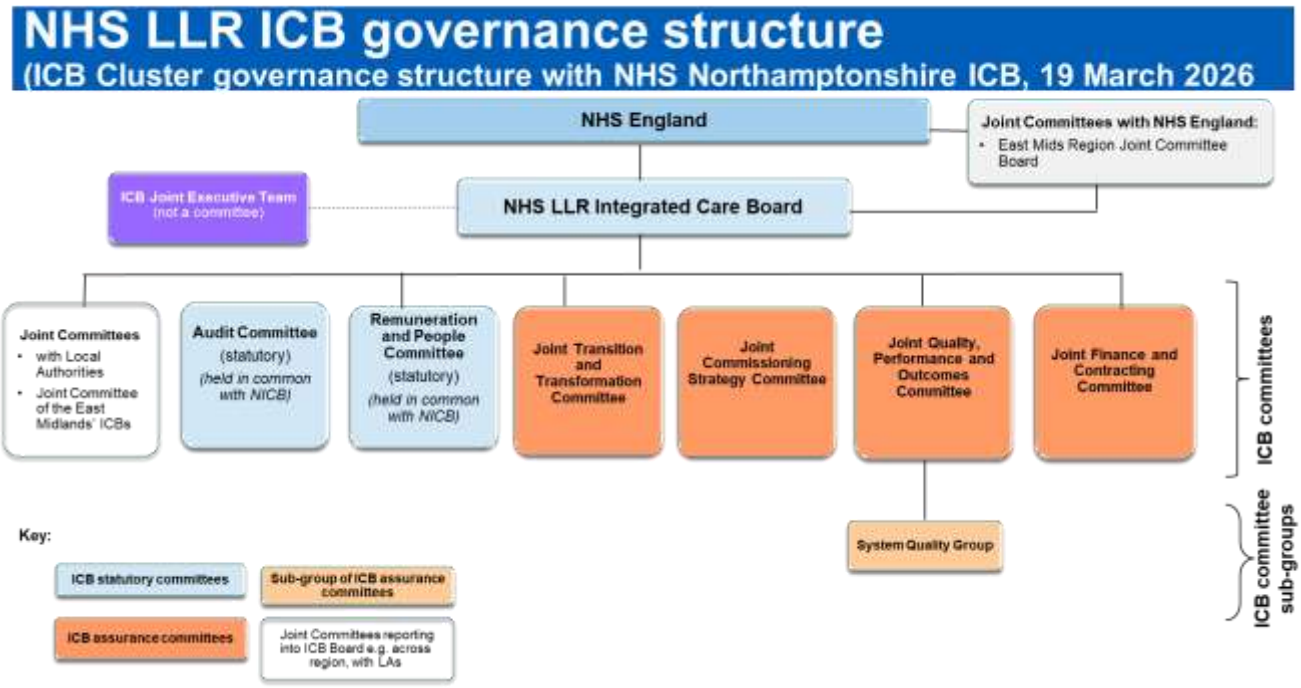
Governance structure 1 April 2025 – 15 October 2025:



Governance structure 16 October 2025 – 19 March 2026:



Governance structure from 19 March 2026:



APPENDIX 2

NHS LEICESTER, LEICESTERSHIRE AND RUTLAND INTEGRATED CARE BOARD

Declarations of Interest - 2025 - 2026 (v9, March 2026)
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)
Ms Anu Singh	Chair (Chair from 1 October 2025)	Jointly appointed Chair with Northamptonshire ICB. Non-Executive Director, Parliamentary and Health Service Ombudsman (from April 2020 to present). Member of the Advisory Committee for Fuel Poverty (from April 2019 to present). Independent Chair of Lambeth Adult Safeguarding Board (from February 2021 to present). Non-Executive Director, ICB Board of Birmingham and Solihull Integrated Care System. Non-Executive Director, ICB Board of South East London Integrated Care System.	N/A	N/A	N/A	Appropriate actions to be taken as necessary in line with the Policy and dependent on the nature of the conflict.
Ms Paula Clark	Chair (Interim Chair from 28 October 2024 until 30 September 2025)	Chair, LLR Patient Care Locally (PCL) CIC Ltd, Community Interest Company operates under ICB NHS contract (until 27 October 2024). Director, Mawbrook Management Ltd (management consultancy) (from June 2019 to present). Director of RSPCA Woodside Trading Ltd (from 29 April 2025 to present). Board of Governors Member, The Benenden Hospital Trust (from July 2019 to present).	N/A	N/A	N/A	Appropriate actions to be taken as necessary in line with the Policy and dependent on the nature of the conflict.
Mr Toby Sanders	Chief Executive (from 1 October 2025) (previously Interim CEO from 1 July 2025 - 30 September 2025)	Jointly appointed Chief Executive Officer with Northamptonshire ICB.	N/A	N/A	N/A	N/A
Dr Caroline Trevithick	Chief Executive (interim) (from 27 November 2023 to 30 June 2025) (previously Chief Nursing Officer until 26 November 2023)	N/A	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 in line with the Policy and dependent on the nature of the conflict.
Ms Maria Laffan	Chief Nursing Officer (from 1 October 2025)	Jointly appointed Chief Nursing Officer with Northamptonshire ICB.	Member of Royal college of Nursing & NMC.	N/A	Husband is Managing Director of AHP Toolkit. Husband is Managing director of Exercise Prescriber Limited.	Appropriate actions to be taken as necessary in line with the Policy and dependent on the nature of the conflict.
Ms Kay Darby	Chief Nursing Officer (interim) (from 11 December 2023 until 30 September 2025)	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)
Mr Matt Gaunt	Chief Finance Officer (from 1 October 2025)	Jointly appointed Interim Chief Finance Officer with Northamptonshire ICB.	N/A	Board member of Heads Up Leicester a mental health charity (Oct 2025 to present).	Registered as a patient at The Ratby Surgery, a GP Practice in LLR. No financial interest in the 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.
Mr Robert Toole	Chief Finance Officer (until 30 September 2025)	N/A	N/A	N/A	N/A	N/A
Mrs Alice McGee	Chief People Officer (until 30 September 2025)	N/A	N/A	N/A	N/A	N/A
Ms Eileen Doyle	Chief Delivery Officer (from 1 October 2025)	Jointly appointed Chief Delivery Officer with Northamptonshire ICB.	N/A	N/A	N/A	N/A
Mrs Rachna Vyas	Chief Operating Officer and Deputy Chief Executive (until 30 September 2025)	N/A	Board Trustee, Healthcare Quality Improvement Partnership (HQIP). Volunatary, non-remunerated position (from 14 July 2025 for 2 years).	N/A	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.
Mr Peter Burnett	Chief Strategy Officer (from 2 June 2025)	Jointly appointed Chief Strategy Officer with Northamptonshire ICB.	N/A	N/A	Wife is Director of Midwifery and Deputy Chief Nurse at University Hospitals of Leicester NHS Trust (from January 2023 to present). Mother-in-law is a Primary Care Commissioning Manager for NHS Nottingham and Notthinghamshire ICB (from February 2020 to present). Sister-in-law is employed in a Project Management role for Health Innovation East Midlands. Brother-in-law's partner is a technician for East Midlands Ambulance Service (from July 2022 to present).	Note that interest in UHL 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 provider. However, if a direct potential or actual conflict of interest arises then appropriate action to be taken in line with the Policy.

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)
Dr Nilesh Sanganee	Chief Medical Officer	Jointly appointed Chief Medical Officer with Northamptonshire ICB. GP Partner - Principal at Castle Medical Group (until 31 December 2025). Salaried GP at this Practice from 1 January 2026 to present. Trustee of Friends for Castle Medical Group - Registered Charity. Practice is a member of the LLR Provider Company Castle Medical Group is a member of the North West Leicestershire GP Ltd. Director of Sangco Ltd, a residential property letting company (from 25 June 2022 to current). 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. Honorary Professor, College of Life Sciences, University of Leicester (from 18 June 2025 to 17 June 2030). National NHSE CVD MSF Task and Finish Group (from 1 October 2025 to present).	N/A	Indirect interest in respect of discussions and decisions made relating to GP Practice property relating to Practice premises, which is under a lease from a third party.	In relation to financial interests, to ensure individual does not participate in the decision-making process in committee meetings (e.g to absent themselves from meetings at the relevant point on the agenda); during procurement processes individual to seek advice if and up to which part of the process individual can be involved in, or not involved with at all etc. For other declarations, appropriate actions to be taken as necessary in line with the Policy, dependent on the nature of the interest declared and whether a conflict arises.
Mr Afzal Ismail	Joint Non-Executive Member - Audit (from 16 October 2025)	Jointly appointed Non-Executive Member with Northamptonshire ICB. Executive Director at Orbit Group Ltd (October 2000 to present). Non-Executive Director at University Hospitals Coventry & Warwickshire (April 2020 to present). Director, First Campbell Park Property Management Company Limited - residents property management (from 31 December 2023 to present, directorship expected to end on 23 July 2026). Director, Second Campbell Park Property Management Company Limited - residents property management (from 31 december 2023 to present, directorship expected to end on 23 July 2026). Non-Executive Director and Chair of Audit Committee at Red Kite Devco Limited -- development of buildings projects (from 15 October 2025 to present, directorship expected to end on 23 July 2026). Director, Edenmead LTD - development of buildings projects (from 15 October 2025 to present, directorship expected to end on 23 July 2026).	N/A	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.
Mr Darren Hickman	Non-Executive Member - Audit and Conflicts of Interest (until 30 November 2025)	Non-Executive Director & Risk Chair, Earl Shilton Building Society (November 2020 to present) Non-Executive Director and Audit Chair of BHSF Ltd (an insurer based in Birmingham). From 1 April 2024 to present. Appledown Services Ltd - buildings consultancy (from 6 October 2025).	N/A	N/A	N/A	Appropriate actions to be taken as necessary in line with the Policy, dependent on the nature of the interest declared and whether a conflict arises.
Ms Simone Jordan	Joint Non-Executive Member - Remuneration (from 16 October to present). Previously Non-Executive Member - People and Remuneration (Deputy Chair and Senior Independent Non-Executive Member) (until 15 October 2025)	Jointly appointed Non-Executive Member with Northamptonshire ICB. Managing Director - Simone Jordan & Associates Ltd (from 2015 to December 2025) Vice Chair and Senior Independent Director - Royal Orthopaedic Hospital NHS Foundation Trust: Associate NED from 2017-2020, and Vice-Chair from 2021 to present, SID from September 2022 to present. Non-Executive Director and Chair of Audit Committee - George Eliot Hospital NHS Trust (from 2018 to Deceember 2025). Non-Executive Director Derbyshire Healthcare NHS Foundation Trust (from December 2025 to present).	N/A	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)
Ms Liz Gaulton	Joint Non-Executive Member - Quality (from 16 October 2025)	Jointly appointed Non-Executive Member with Northamptonshire ICB.	N/A	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.
Mrs Pauline Tagg	Non-Executive Member - Quality and Transformation (until 30 November 2025) (Previously Acting Chair from 3 June 2024 - 27 October 2024)	Co-owner of Approved Fire Protection Ltd (current).	N/A	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.
Mr Andrew Hammond	Joint Non-Executive Member - Finance (from 16 October 2025)	Jointly appointed Non-Executive Member with Northamptonshire ICB. CEO of Instructus - The Springboard Consultancy is one of our sub brands, providing Personal Development Training. We have some NHS Clients outside of Northamptonshire (2016 to present). Director of CQM Training and Consultancy Ltd. Provider of Training and Apprenticeships. No current NHS work (2017 to present).			Wife is state registered podiatrist undertaking private work in Northamptonshire (current).	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.
Mr Anil Majithia	Non-Executive Member - Health Inequalities and Communities (from 8 July 2024 - 30 November 2025)	Non Executive Director – George Eliot Hospital NHS Trust (from April 2018 to 31 August 2025). Chair – George Eliot Hospital Charity (from July 2019 to 31 August 2025) - not remunerated for this role. Director of AKM-SAM Ltd involving real estate (from 3 March 2025 to present).	Trustee/Director LiFE Multi Academy Trust a registered charity, role is not remunerated (from March 2024 to 15 May 2025). Chair of LiFE Multi Academy Trust a registered charity, role is not remunerated (from January 2025 to 15 May 2025). Vice Chair, Chair of Audit and corporation Member for NWSLC (from July 2017 to present).	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.
Mr 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 to present).	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)
Mr Mike Sandys	Partner Member - Local Authority Sectoral representative	Director of Public Health for Leicestershire County Council and Rutland County Council.	N/A	Chair and Board Member - Active Together. Board member - Active Partnerships.	N/A	In relation to financial interests, to ensure individual does not participate in the decision-making process in committee meetings (e.g to absent themselves from meetings at the relevant point on the agenda); during procurement processes individual to seek advice if and up to which part of the process individual can be involved in, or not involved with at all etc. For other declarations, appropriate actions to be taken as necessary in line with the Policy, dependent on the nature of the interest declared and whether a conflict arises.
Mr Laurence Jones	Partner Member - Local Authority Sectoral representative (from 1 March 2024)	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.
Mr Richard Mitchell	Partner Member - Acute Sector representative	Chief Executive, University Hospitals of Leicester NHS Trust. Chief Executive, University Hospitals of Northamptonshire NHS Group (from November 2023 to present).	Chair East Midlands Cancer Alliance (work with NHS England). Board Member NHS IMPACT - NHS Improvement Board. Chair of Midlands Leadership Board (work with NHS England). Chair of Midlands East Pathology Network. Deputy Chair Cancer Alliance Leadership Forum. Board member NHS Providers 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. For other declarations, appropriate actions to be taken as necessary in line with the Policy, dependent on the nature of the interest declared and whether a conflict arises.
Ms 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.	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. Member of other ICB fora and LLR partnership forums. Midlands region CEO representative for National Mental Health working group. Member of East Midlands Alliance - Mental Health. 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. Daughter is a teacher in Northants. Son and nephew are in the Northants Police Force.	In relation to financial interests, to ensure individual does not participate in the decision-making process in committee meetings (e.g to absent themselves from meetings at the relevant point on the agenda); during procurement processes individual to seek advice if and up to which part of the process individual can be involved in, or not involved with at all etc. For other declarations, appropriate actions to be taken as necessary in line with the Policy, dependent on the nature of the interest declared and whether a conflict arises.

Name	Job Title	Financial Interests	Non-financial professional interests	Non-financial personal interest	Indirect Interests	Actions to be taken to mitigate the risks (see Conflicts of Interest Policy for details)
Dr James Ogle	Partner Member - primary medical services sector representative (from September 2024)	GP Partner at Ratby Medical Centre. Shareholder in Parwaiz and Family (PFC) Ltd, GP Premises holding company. Hinckley and Bosworth Medical Alliance (HBMA), GP Federation - Ratby Medical Centre is a shareholder of HBMA.	Clinical Lead HBMA (from 1 September 2024 to present). Clinical Director - Bosworth Primary Care Network (from 1 September 2024 to present). 4FED Board Members and Chair (collaboration of HBMA, Charnwood and North West Leicestershire GP Federations) (from 1 September 2024 to present). Board Member Derbyshire Health United (DHU) and 4FED urgent care (joint venture between DHU and 4FED) (from 1 September 2024 to present).		Registered as patient with Desford Medical Centre, a GP Practice within LLR. Haematochromatosis sufferer, under long term care of University Hospitals of Leicester NHS Trust. Dr Reema Parwaiz (wife) is GP Partner at Ratby Medical Centre, PFC Ltd Shareholder. Practice shareholder HBMA, Board Member of HBMA. Dr Zan Parwaiz (brother-in-law) is GP Partner at Ratby Medical Centre, PFC Ltd shareholder. Dr Paul Parwaiz is GP Partner at Ratby Medical Centre, PFC Ltd shareholder. Dr Asim Parwaiz (brother-in-law) is GP locum within LLR.	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.

APPENDIX 3 - Committees and members of each committee

Table below shows Committee membership from 1 April 2025 – 15 October 2025

Board member	Role	Audit Committee	Remuneration Committee	System Executive Committee	Health Equity Committee	Finance Committee	Quality and Safety Committee
Anu Singh	Joint ICB Chair		✓				
Ms Paula Clark	Chair		✓				
Toby Sanders	Interim Chief Executive			✓			
Dr Caroline Trevithick	Chief Executive			✓			
Ms Kay Darby	Chief Nursing Officer			✓			✓
Mr Robert Toole	Chief Finance Officer			✓	✓	✓	
Dr Nil Sanganee	Chief Medical Officer			✓			✓
Mr Peter Burnett	Chief Strategy Officer			✓	✓		
Ms Rachna Vyas	Chief Operating Officer			✓			✓
Ms Alice McGee	Chief People Officer			✓	✓		
Mr Anil Majithia	Non-Executive Member	✓	✓		Chair	Chair	✓
Mr Darren Hickman	Non-Executive Member	Chair					
Ms Pauline Tagg	Non-Executive Member	✓	✓		✓		Chair
Ms Simone Jordan	Deputy Chair / Non-Executive Member	✓	Chair			✓	
Mr Richard Mitchell	Acute Trust Sector Representative			✓			
Ms Angela Hillery	Community / mental health sector representative			✓			
Mr Mike Sandys	Local authority sectoral representative				✓		

Table below shows Committee membership from 16 October 2025 – 31 March 2026

(this encompasses interim governance arrangements until 19 March 2026 and Joint Committee arrangements from 19 March 2026 until 31 March 2026)

Board member	Role	Audit Committee	Remuneration Committee	Joint Transition and Transformation Committee	Committees in common for Commissioning Strategy / Joint Commissioning Strategy Committee	Committees in common for Finance and Contracting / Joint Finance and Contracting Committee	Committees in common for Quality, Performance and Outcomes / Joint Quality, Performance and Outcomes Committee
Anu Singh	Joint ICB Chair		✓		✓		
Toby Sanders	Joint Chief Executive			✓			
Ms Maria Laffan	Joint Chief Nursing Officer				✓	✓	✓
Mr Matt Gaunt	Joint Chief Finance Officer				✓	✓	
Prof Nil Sanganee	Joint Chief Medical Officer				✓	✓	✓
Mr Peter Burnett	Joint Chief Strategy Officer			✓	✓		✓
Ms Eileen Doyle	Joint Chief Delivery Officer				✓	✓	✓
Mr Afzal Ismail	Joint Non-Executive Member	Chair				✓	
Ms Liz Gaulton	Joint Non-Executive Member		✓	✓			Chair
Ms Simone Jordan	Joint Non-Executive Member	✓	Chair	Chair			✓
Mr Andrew Hammond	Joint Non-Executive Member		✓		✓	Chair	
Mr Mike Sandys	Local authority sectoral representative				✓		✓

APPENDIX 4 - NHS LLR ICB Board - Attendance Record for meetings held in public

NHS Leicester Leicestershire & Rutland ICB
Board meetings held in Public - Attendance Record (1 April 2025 – 31 March 2026)
(including meetings held in common with Northamptonshire ICB from October 2025 onwards)

	10 April 2025	12 June 2025	14 August 2025	16 October 2025	18 December 2025	19 February 2026	19 March 2026	% Attendance by member
Anu Singh *Joint ICB Chair*				✓	✓	✓	✓	100%
Paula Clark *Chair (until 30 September 2025)*	✓	✓	✓					100%
Toby Sanders *Joint Chief Executive Officer*			✓	✓	✓	✓	✓	100%
Caroline Trevithick *Chief Executive Officer (until 30 June 2025)*	✓	✓						100%
Simone Jordan *Non-Executive Member (until 15 October 2025) / Joint Non-Executive Member*	X	X	✓	X	✓	✓	✓	57%
Afzal Ismail *Joint Non-Executive Member*				✓	✓	✓	X	75%
Darren Hickman *Non-Executive Member (until 15 October 2025)*	✓	✓	✓					100%
Liz Gaulton *Joint Non-Executive Member*				✓	✓	✓	✓	100%
Pauline Tagg *Non-Executive Member (until 15 October 2025)*	✓	✓	✓					100%
Andrew Hammond *Joint Non-Executive Member*				✓	✓	✓	✓	100%
Anil Majithia *Non-Executive Member (until 15 October 2025)*	✓	✓	✓					100%
Eileen Doyle *Joint Chief Delivery Officer*				✓	Deputy	✓	✓	75%
Rachna Vyas *Chief Operating Officer (until 30 September 2025)*	✓	✓	✓					100%
Matt Gaunt *Joint Chief Finance Officer*				✓	✓	✓	✓	100%
Robert Toole *Chief Finance Officer (until 30 September 2025)*	✓	✓	✓					100%
Maria Laffan *Joint Chief Nursing Officer*				✓	✓	✓	✓	100%
Kay Darby *Chief Nursing Officer (until 30 September 2025)*	✓	Deputy	✓					66%

	10 April 2025	12 June 2025	14 August 2025	16 October 2025	18 December 2025	19 February 2026	19 March 2026	% Attendance by member
Nil Sanganee *Chief Medical Officer / Joint Chief Medical Officer*	✓	✓	Deputy	✓	✓	✓	✓	86%
Pete Burnett *Chief Strategy Officer/ Joint Chief Strategy Officer*	Deputy	✓	✓	✓	✓	✓	✓	100%
Alice McGee *Chief People Officer*	✓	✓	Deputy					66%
Partner Members – NHS Leicester, Leicestershire and Rutland ICB								
Richard Mitchell *Acute Sector Representative* *Group Chief Executive UHL and UHN*	Deputy	Deputy	✓	✓	Deputy	Deputy	✓	43%
Angela Hillery *Community and Mental Health Sector Representative* *Chief Executive Officer LPT and NHFT*	✓	✓	✓	Deputy	✓	✓		83%
Laurence Jones *Local Authority Sector Representative* *Strategic Director, Social Care and Education* *Leicester City Council*	X	X	Deputy	X	X	X		0%
Mike Sandys *Local Authority Sector Representative* *Director of Public Health Leicestershire County Council and Rutland County Council*	✓	✓	✓	✓	X	X	✓	71%
Mark Andrews *Local Authority Sector Representative* *Chief Executive Rutland County Council*	✓	✓	✓	X	✓	✓		83%
Dr James Ogle *Primary Medical Services Sector Representative*	✓	X	✓	✓	✓	✓	✓	83%
Quoracy								
Was the meeting quorate? (Yes or no)	Yes	Yes	Yes	Yes	Yes	Yes	Yes	

APPENDIX 5 – Strategic risks across the LLR ICB as detailed within the Board Assurance Framework 2025/26

Strategic risk	Executive Lead	Committee oversight
BAF 1 – Partnership The ICB is unable to develop and sustain a culture of collaboration / partnership working and thus unable to improve outcomes in population health and healthcare.	Chief Executive	Joint Executive Team
BAF 2 – Health Inequalities Failure to adequately address health inequalities due to a lack of investment and / or lack of partnership working, therefore unable to improve health equity and outcomes for the population of LLR.	Chief Strategy Officer	Health Equity Committee
BAF 3 – Demand and Capacity Demand could exceed capacity in commissioned services due to a variety of factors. This could result in patients not accessing services in the right place, at the right time, at the right level of care.	Chief Delivery Officer	System Executive Committee
BAF 4 – Finance The financial viability of the local health economy (over the short, medium and long term) cannot be assured due to a lack of robust transformation processes and tested schemes, this could impact organisational reputation, incur possible financial penalties and result in closer regulatory scrutiny.	Chief Finance Officer	Finance Committee
BAF 5 – Quality and Safety Failure to maintain and improve the quality of services and meet the core standards could result in poor patient experience and potential harm and poor quality outcomes for patients.	Chief Nursing / Chief Medical Officer	Quality and Safety Committee
BAF 6 – Emergency Preparedness, Resilience and Response Failure to have robust emergency preparedness, resilience and response (EPRR) processes in place due to lack of capacity and / or lack of partnership could result in inadequate response to major and / or business continuity incidents.	Chief Delivery Officer	System Executive Committee / Joint Executive Team
BAF 7 – Cyber A significant rise in new and unknown cyber-attacks (locally or nationally) could make access to IT services unavailable for extended periods of time. This may result in risks to the confidentiality of corporate or patient confidential data, disruption to organisational business continuity and to operational services.	Chief Strategy Officer	Joint Executive Team
BAF 8 – relating to workforce risk was previously archived.		
BAF 9 – ICB Workforce Increased turnover and lack of leadership succession planning if the ICB does not adequately utilise workforce strategies aligned to the People Promise will result in an inability to deliver the ICB objectives. ***– risk archived October 2025***		Remuneration Committee
BAF 10 – NHS Reforms and lack of financial resources The ICB is unable to enact and deliver the required NHS Reforms due to a lack of additional financial resources to support implementation.	Chief Executive	Joint Transition Committee
BAF 11 – Delivery of strategic objectives The ICB is unable to deliver against its strategic objectives due to the pace of change, impact on workforce, and distraction caused by the NHS reform requirements resulting in non-compliance with statutory duties.	Chief Executive	Joint Executive Team

APPENDIX 6

LLR ICB Provider Selection Annual Summary
1 April 2025 – 31 March 2026

Provider Selection Regime Record 2025/26	NHS Leicester, Leicestershire and Rutland ICB
The number of contracts awarded where Direct Award Process A, Direct Award Process B or Direct Award Process C was followed in the year to which this summary relates:	39
The number of contracts awarded where the Most Suitable Provider Process was followed in the year to which this summary relates:	5
The number of contracts awarded where the Competitive Process was followed in the year to which this summary relates:	0
The number of Framework Agreements concluded in the year to which this summary relates:	0
The number of contracts awarded based on a framework agreement in the year to which this summary relates:	1
The number of contracts awarded, and modifications made in reliance on Regulation 14 (urgent award or modification) in the year to which this summary relates:	2
The number of new providers to whom a contract was awarded in the year to which this summary relates:	1
The number of providers who held a contract in the previous year but no longer hold any contracts in the year to which this summary relates:	1
The number of written representations made in accordance with Regulation 12(3) and received during standstill periods which ended in the year to which this summary relates and a summary of the nature and impact of those representations:	1
The total number of providers the relevant authority is currently contracted with in the year to which this summary relates:	216
The number of requests for consideration received by the Independent Patient Choice and Procurement Panel	1
The number of requests accepted and rejected by the Independent Patient Choice and Procurement Panel for consideration	0 Accepted 1 Rejected
The number of times the Independent Patient Choice and Procurement Panel advised the relevant authority to re-run, go back to an earlier step in a provider selection process under PSR, and the number of times the advice was followed	0

Pharmacy, Optometry and Dental Services Summary
[2025/26 PSR summary not yet available]

NHS
Leicester, Leicestershire and Rutland

NHS Leicester, Leicestershire and Rutland ICB
Room G30, Pen Lloyd Building,
County Hall, Glenfield,
Leicester, LE3 8TB

www.leicesterleicestershireandrutland.icb.nhs.uk

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