NHS England Midlands

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Anu Singh
ICB Chair, Leicester,
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Dear Anu

Annual assessment of Leicester, Leicestershire & Rutland Integrated Care Board's performance in 2025/26

I am writing under section 14Z59 of the NHS Act 2006, as amended by the Health and Care Act 2022, which requires NHS England to conduct an annual performance assessment of each Integrated Care Board (ICB).

This has been a particularly challenging year for ICBs, marked by significant system-wide pressures and continued organisational change. In parallel, ICBs have been required to adapt to an evolving operating model, while maintaining a clear focus on statutory duties, system leadership and delivery for local populations.

Against this backdrop, we recognise the complexity of the task facing your organisation and the sustained effort required to balance immediate operational pressures with longer-term strategic priorities. We also acknowledge the additional burden created by structural changes, and the need to maintain stability and continuity across systems during a period of transition.

In reaching this assessment, we have considered evidence from the ICB's annual report and accounts, available performance and assurance data, feedback from partners and stakeholders, and discussions held with ICB colleagues over the course of the year.

While this annual assessment is a statutory requirement, we have sought to ensure that it is balanced and proportionate, recognising both the need to assess performance against statutory responsibilities and the realities of the organisational change that has taken place during the year.

We remain committed to working constructively with you, building on learning from the year, and supporting ICBs as roles, responsibilities and arrangements continue to evolve.

We would like to thank you, your Board and your wider team for your leadership and continued commitment during a demanding period of change. We look forward to continuing to work with you in the year ahead.

Yours sincerely

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Cc. Dale Bywater, Regional Director Midlands, NHS England
Toby Sanders, Chief Executive Officer, Leicester, Leicestershire & Rutland ICB
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Section 1: ICB performance assessment

The ICB has a well-developed and continuing population health management (PHM) approach, supported by a person-level linked dataset, secure NHS data platform, and established information governance arrangements. A cross-system intelligence function and strong partnership working with public health colleagues are established strengths across the system, with national and regional recognition of the ICB's approach.

Outcomes show incremental improvement since 2023, including improvements in lipid-lowering therapy, hypertension treatment and a 5% increase in patients with severe mental illness (SMI) receiving all six health checks. SMI health check performance was reported at 70.8%; national datasets indicated 76% for quarter 4 (Q4), with both figures above regional and national benchmarks. However, some inequalities persist, alongside data quality challenges, including a 10% increase in unusable ethnicity data. Vaccination uptake also remains variable, with 46.2% of people over 65 unvaccinated for flu and 44.1% unvaccinated for COVID-19, while the deprivation gap in early cancer diagnosis remains at 8.43%. Taken together, this reflects a strengthening and established PHM approach, with improvement in selected outcomes but ongoing work needed to reduce variation and inequality.

ICB delivery against annual objectives for elective care showed some improvement during 2025/26, moving from below average in quarter 1 (Q1) to above average in the remaining quarters for waiting list growth, although this was not sustained at year-end, with a Q4 dip and core elective standards remaining unmet. In Q4, Leicester, Leicestershire & Rutland (LLR) ICB delivered 59.81% for 18-week waits, below the national average but improved on the previous year, with University Hospitals of Leicester (UHL) achieving 59.1% against a plan of 62.3%, while 52-week waits were 1.1% against a plan of 0.9%. A 65-week backlog remains, with no clear trajectory to elimination. Overall, the Access domain remains below average, reflecting a broadly unchanged position from last year, with some improvement but sustained recovery not yet demonstrated.

The ICB has established a recovery approach for cancer, supported by £505,600 of Cancer Alliance funding and engagement. However, this has not yet translated into improved performance. The ICB did not plan to meet the 62-day standard, aiming to achieve 70%, with performance remaining at 58.8% in Q4, below the 75% national target. Faster Diagnosis Standard performance was 11.7% below target and declined by 13.8% year-on-year. This represents a deterioration from the 2024/25 position, where Faster Diagnosis Standard performance was stronger and backlog reductions were achieved.

In urgent and emergency care delivery, the ICB has taken positive and sustained action to improve flow, discharge, same-day access and coordination, supported by national programmes and £2 million of capital at UHL. Performance improved to 77.7% in Q4, from 76.1%; however, the 78% standard was not met. Demand, operational

pressures and ambulance handover delays continued, mirroring 2024/25 fragility despite improvement. Overall, UHL shows year-on-year improvement.

The ICB has delivered strongly in primary care against most national requirements, including GP Connect, online consultation and online registration, with patient experience remaining positive and no national outlier position for access or continuity. Dentistry performance also improved, with 90.5% of urgent dental appointments delivered, although workforce challenges continue. This builds on a strong 2024/25 position, where the ICB was among the top performers regionally for primary care access and delivery metrics. Overall, the ICB demonstrates sustained strong delivery in primary care, with some workforce constraints impacting capacity.

Mental health outcomes have been variable, with strong delivery in children and young people (CYP) access at 104%, length of stay at 52 days, Talking Therapies outcomes at 103% reliable improvement and 100% recovery, alongside zero out-of-area placements. Improvement activity includes suicide prevention, CYP crisis pathways and more culturally responsive care models. However, challenges remain in Talking Therapies and Individual Placement and Support (IPS), with delivery falling short in IPS at 94%, perinatal access at 99.6% and completed treatments at 89%. There is strong underlying performance in Physical Health Checks for people with Severe Mental Illness and Core20Plus5. Overall, this reflects an unchanged but variable position since 2024/25, with continued strong delivery in selected areas alongside some ongoing performance challenges.

Performance has been strong across several metrics in learning disabilities and autism, including adult inpatient rate of 27 per million (5th out of 42) and health checks exceeding plan by 14%. However, the inpatient plan was narrowly missed and risks remain around capacity, local government reorganisation, housing and capital planning. Strong headline performance is offset by sustainability risks.

In relation to Special Educational Needs and Disabilities statutory duties, the ICB remains actively engaged in system collaboration and strengthened governance. Delivery is variable, with Leicestershire subject to statutory intervention, ongoing concerns in Rutland, and Leicester City awaiting inspection. Regional improvement support is in place across local area partnerships. Capacity pressures and system reorganisation increase delivery risk.

The ICB has built stronger foundations in the shift to community-based care through expanded primary care, community and Voluntary, Community and Social Enterprise provision and redesigned pathways, with visible progress in moving care closer to home. This builds on 2024/25 progress in neighbourhood working and pathway redesign, though reductions in hospital demand have not yet been fully realised.

The ICB has made progress in digital transformation, with full cloud-based telephony rollout and improved NHS App integration, although it is not yet fully compliant, particularly on prospective record access.

Governance is in place for effectiveness and safety through the Quality and Performance Improvement Strategy. However, the disestablishment of the Quality and Safety Committee, alongside gaps in Continuing Healthcare (CHC) reporting and limited triangulation, reduces clarity in elements of assurance.

There is a strong commitment to service experience and patient engagement through Citizens' Panels, Patient Participation Groups, self-referral, and expanded access, with complaints embedded in oversight. This builds on 2024/25 evidence of strong stakeholder engagement and public involvement, though system pressures continue to impact performance and outcomes across some services.

Safeguarding duties and arrangements remain stable, with effective partnership working and statutory compliance, reflecting a consistent and secure position.

Wider system performance shows a mixed picture. LLR ranked highly for Experience and Workforce, while Safety and Population Health were below average, and Access and Finance were in the lowest quartile. Strengths include CHC referrals completed within 28 days at 88%, access to a preferred GP at 86.1% and learning disability annual health checks at 82.34%, alongside low out-of-area bed days at 1.0% and reduced antibiotic prescribing for children aged 0–9 at 26.5%. Access and Finance performance in Q4 remained in the lowest quartile, reflecting continued challenges. Accident and Emergency (A&E) four-hour performance at 77.7%, 18-week Referral to Treatment at 59.81% and 62-day cancer performance at 58.8% remain below target, with A&E and cancer deteriorating year-on-year. Performance is further constrained by elective waiting list growth at 6.5%, reduced GP booking satisfaction at 66.4% and waning diabetes care processes at 42.5%.

Review of key ICB metrics showed that LLR ICB's performance in the Finance domain within the NOF was assessed as below average nationally in Q4 of 2025/26, and its Finance System Performance Indicator was in the lowest-performing quartile nationally in Q4. Underlying finance metrics reflected a challenging position, with the combined finance score deteriorating from 2 to 3 in Q4 despite productivity growth of 4.7%. The ICB reported a £30.8 million deficit against a planned £15.5 million deficit. There was a system-wide deficit of £115.8 million, £35.8 million above plan, alongside an in-year system deficit of £23.3 million against a planned deficit of £0.3 million. Performance was further impacted by under-delivery of efficiency targets, with £66.8 million delivered against a £70.2 million plan, and a £22.9 million system shortfall. The ICB did not meet its financial duties, and providers also did not deliver financial or efficiency plans. Productivity initiatives, including the use of population health management to target investment and actions to reduce avoidable admissions and shift care closer to home, were in place; however, there was limited quantified evidence linking these initiatives to financial savings or demonstrating monetised productivity gains. Productivity improved by 4.7%, exceeding the regional average of 2.4%, and initiatives including population health management, reducing avoidable admissions and shifting care closer to home were reported. However, limited quantified evidence was provided to demonstrate the financial impact of these

initiatives, monetised productivity gains, clear deficit drivers or quantified future efficiency trajectories.

Although governance arrangements were in place, these did not prevent deterioration, and the ICB did not meet its statutory financial duties or wider system financial responsibilities. Overall, the position reflects significant financial pressure and reduced delivery against plan.

The ICB has a structured approach to tackling inequalities, aligned with national frameworks, with targeted interventions including outreach, Core20 Connectors and £2.8m of primary care investment. This builds on a strong 2024/25 focus on health inequalities and PHM-led planning, although assurance is constrained by gaps in some datasets and the completeness of reporting.

Section 2: ICB Capability assessment

The ICB has discharged its specialised commissioning responsibilities through proactive engagement in formal joint committee arrangements and supporting sub-groups with NHS England. These forums enable consistent, system-wide decision-making across delegated services, supported by a single integrated NHS England ICB commissioning team. This model ensures alignment and transactional effectiveness; however, strategic commissioning capability remains in development, with further maturation planned through 2026/27.

The ICB has established a comprehensive and clearly defined governance framework, including its Constitution, Standing Orders and Schemes of Delegation, which set out accountability across Board, committees and officers. These are reinforced through an established committee structure and System Executive Committee oversight, supporting effective escalation, assurance and timely decision-making. Board effectiveness is evidenced through consistent quoracy, strong attendance and ongoing development. Partnership working with local authorities and system partners is well embedded, including place-based arrangements that support joint planning and delivery. These arrangements provide a clear and well-established framework for governance, decision-making and access to appropriate expertise, supporting consistent oversight and assurance across the system.

The ICB has worked constructively with system and government partners, with evidence of positive engagement and productive relationships. However, feedback suggests further work is required to strengthen and reset some partnerships, including developing a shared understanding of the ICB's revised role and ensuring collective priorities are consistently translated into delivery. Continued focus on engagement and relationship-building will support more effective partnership working across the system.

The ICB's delivery across innovation, research and sustainability demonstrates a structured contribution to social and economic value, with strong examples of service innovation, established research collaboration and clinical leadership shaping

pathways. Sustainability maturity is incomplete, including the absence of a published Green Plan, with emissions reductions positioned mid-range nationally. Consequently, while the breadth of delivery is clear, scale and consistency remain limited.

The ICB has primarily contributed to the government's 'health and work' policy by securing funding for and launching the 'WorkWell' service, driving this policy forward through several local strategies and operational plans. In addition, the ICB is a core partner in the 'Get Leicester, Leicestershire & Rutland Working' Plan, a joint 10-year strategy launched alongside local authorities and the Department for Work and Pensions.

Finally, the ICB has embedded the Triple Aim within its strategic and planning frameworks, including the Integrated Care Strategy, Joint Forward Plan and Five-Year Plan, supported by a population health management approach. Governance and assurance processes ensure decisions are routinely tested for their impact on population health, service quality, value and inequalities. This provides a robust and structured basis for balanced, evidence-informed decision-making across population health, service quality, value and inequalities.

Section 3: Support and intervention

The ICB did not operate under any formal legal enforcement or statutory intervention during 2025/26, and no system-level financial or recovery interventions were applied during the reporting period. Oversight was provided through established regional and national arrangements rather than formal escalation processes. However, this should be viewed alongside evidence of significant financial challenges during the year, including deficits above plan, under-delivery of efficiency targets and failure to meet financial duties.

The ICB has maintained active engagement with national and regional oversight processes, including provider tiering arrangements for acute services. These have supported focused scrutiny and constructive challenge across elective, cancer and diagnostic pathways. Provider-level discussions demonstrate increasing operational grip, with targeted actions in place to address long waits, pathway bottlenecks, and workforce constraints, alongside the use of mutual aid, insourcing and productivity initiatives. There is also evidence of effective commissioner–provider collaboration in managing pressures and supporting recovery trajectories.

Conclusion

In forming this assessment, we have sought to take a balanced and proportionate view of your performance, recognising both what has been delivered and the complexity of the operating environment in which ICBs continue to function. We are encouraged by progress towards a more mature system of integrated care, with decision-making increasingly informed by, and responsive to, the needs of local people and communities.

We recognise that, for some systems, this assessment relates to an ICB that has since merged or transitioned into a new organisational form. This letter therefore reflects performance for the statutory body in place during the period assessed. NHS England acknowledges the pace of change across systems and is committed to working with you in your current configuration, supporting continuity, learning from predecessor organisations, and continued improvement as the new ICB develops and embeds its responsibilities.

I ask that you share this assessment with your board and senior leadership team and consider publishing it alongside your annual report at a public meeting. In line with our statutory responsibilities, NHS England will also publish a summary of the outcomes of all ICB annual performance assessments.