Leicestershire County Council

Meeting: **Health Overview and Scrutiny Committee**

Date/Time: **Wednesday, 5 November 2025 at 2.00 pm**

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

Contact: **Mr. E. Walters (0116 3052583)**

Email: **Euan.Walters@leics.gov.uk**

Membership

Dr. S. Hill CC (Chairman)

Mr. M. Bools CC	Mr. J. McDonald CC
Mr. N. Chapman CC	Mr. J. Miah CC
Mrs. L. Danks CC	Mr. B. Piper CC
Mr. M. Durrani CC	Mr J. Poland CC
Mr. P. King CC	Mr. K. Robinson CC
Mrs. K. Knight CC	

AGENDA

Item		Report by	
1.	Minutes of the meeting held on 3 September 2025.		(Pages 5 - 16)
2.	Question Time.		
3.	Questions asked by members under Standing Order 7(3) and 7(5).		
4.	To advise of any other items which the Chairman has decided to take as urgent elsewhere on the agenda.		
5.	Declarations of interest in respect of items on the agenda.		
6.	Declarations of the Party Whip in accordance with Overview and Scrutiny Procedure Rule 16.		

7. Presentation of Petitions under Standing Order 36.

A petition is to be presented by Mr. J. T. Orson CC signed by over 2,000 Leicestershire residents (over 3000 signatures in total) in the following terms:

> "We are a growing community in Melton Mowbray, and it is crucial to protect all our health-related services. However, the impending closure of St Mary's Birth Centre is more than just a Melton issue - it's a significant concern for the entire University of Leicester Hospitals Trust. St Mary's Birth Centre has been an invaluable facility for expectant mothers not only in Melton but also from across Leicestershire and Rutland. Many choose it for its outstanding maternity and postnatal care, characterised by a nurturing environment and exceptional professional support.
>
> Despite the invaluable services provided by St Mary's Birth Centre, it suffers from a lack of promotion and insufficient staffing. These issues affect its ability to operate to its full potential and serve the needs of our community. Closing this centre would not only limit choice for expectant mothers across the Trust, but also place additional strain on alternative maternity services within the region, potentially compromising the quality of care, particularly postnatally.
>
> "Better Births" a 2016 report from the National Health Service, reveals that having more birthing options leads to better health outcomes for both mothers and babies. The centralisation of maternity services often overlooks the unique benefits provided by community-focused and midwife-led centres like St Mary's.
>
> Our goal is to urge the University Hospitals of Leicester NHS Trust to not only re-open St Mary's Birth Centre but to revisit the decision to remove our only freestanding midwife-led unit in Leicestershire, and secure its future with adequate staffing and through promoting its services. We need to ensure that it receives the recognition and resources deserved to remain a viable option for expectant mothers now and for future generations.
>
> Stand with us in the fight to safeguard women's choices and local services. Sign this petition now to protect and promote the exceptional care provided by St Mary's Birth Centre, ensuring it remains the gem that it is."

8.	New LPT Strategy - Together We Thrive.	Leicestershire Partnership NHS Trust	(Pages 17 - 22)
9.	East Midlands Ambulance Service.	East Midlands Ambulance Service NHS Trust	(Pages 23 - 28)
10.	Leicestershire HIV Late Diagnosis.	Director of Public Health	(Pages 29 - 34)
11.	Healthwatch Leicestershire Annual Report 2024/25.	Healthwatch	(Pages 35 - 42)

12.	Issues arising from Health Performance report that merit more detailed scrutiny.	Chief Executive, Chief Executive and ICS Performance Service	(Pages 43 - 96)

This report will not be presented. Instead, members are asked to use it to identify any areas of health performance that require more detailed scrutiny at a future meeting.

13.	Noting the work programme of the Leicester, Leicestershire and Rutland Joint Health Scrutiny Committee.	(Pages 97 - 98)

14. Dates of future meetings.

Future meetings of the Committee are scheduled to take place on the following days all at 2.00pm:

Wednesday 14 January 2026;
Wednesday 4 March 2026;
Wednesday 3 June 2026;
Wednesday 9 September 2026;
Wednesday 4 November 2026.

15. Any other items which the Chairman has decided to take as urgent.

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Agenda Item 1

Leicestershire County Council

Minutes of a meeting of the Health Overview and Scrutiny Committee held at County Hall, Glenfield on Wednesday, 3 September 2025.

PRESENT

Dr. S. Hill CC (in the Chair)

Mr. M. Bools CC
Mr. N. Chapman CC
Mrs. L. Danks CC
Mr. M. Durrani CC
Mr. P. King CC
Mrs. K. Knight CC
Mr. J. Miah CC
Mr. B. Piper CC
Mr J. Poland CC

In attendance

Hardip Chohan, Voluntary Action Leicestershire (joined via Microsoft Teams).
Pete Burnett, Chief Strategy Officer, Leicester, Leicestershire and Rutland Integrated Care Board (minutes 20 and 21 refer).
Professor Nils Sanganee, Chief Medical Officer, Integrated Care Board (minute 22 refers).
Sarah Smith, Head of Emergency Care, Integrated Care Board (minute 22 refers).
Sarah Taylor, Deputy Chief Operating Officer, University Hospitals of Leicester NHS Trust (minute 22 refers).
Jean Knight, Managing Director, Leicestershire Partnership NHS Trust (minute 22 refers).
David Williams, Group Director Strategy & Partnerships, Leicestershire Partnership NHS Trust (minute 23 refers).
Alyson Taylor, Senior Mental Health and LD Transformation Lead, Integrated Care Board (minute 23 refers).
Chris Harbron, Chief Operating Officer, Vita Health (minute 23 refers).
Brendan Street, Clinical Lead, Vita Health (minute 23 refers).

13. Minutes of the previous meeting.

The Committee noted that minute no. 4. recorded the answer given to a member of the public Rachel Moore in response to her question about access to GP appointments. Point no. 2. in the answer stated “100% of practices now offer online booking, for appointments either on the same day or in the future.” However, since the meeting on 4 June 2025 discussions had been taking place between Rachel Moore and the Integrated Care Board regarding the answer given and the Integrated Care Board had now provided clarification saying that “All Practices in LLR have the *ability* to offer online appointments booking”. Therefore, whilst the minutes correctly recorded what happened on 4 June 2025 the Chairman proposed to add a note to the minute regarding the later clarification provided by the Integrated Care Board.

RESOLVED:

(a) That the minutes of the meeting held on 4 June 2024 be taken as read, confirmed and signed as an accurate record;

(b) That a note be added to the minutes of the meeting held on 4 June 2024 explaining the later clarification provided by the Integrated Care Board with regards to online appointment booking.

14. Question Time.

The Chief Executive reported that two questions had been received under Standing Order 35.

1. Question asked by Rachel Moore:

Is Leicestershire Partnership NHS Trust (LPT) planning to continue having a suicide prevention lead post within its workforce? I see from the LPT Board meeting papers of 27 May 2025 that the post is under review.

https://www.leicspart.nhs.uk/wp-content/uploads/2025/05/Paper-M_Public-Trust-Board-Patient-Safety-Report-May-2025.pdf

Reply by the Chairman:

Since the previous post holder retired an individual has been in post on a temporary basis. During this time LPT has progressed their STORM training (self-harm and suicide training) and their suicide prevention plan and contributed to the LLR suicide prevention strategy. The Trust is currently going through the approval process for a permanent recruitment.

2. Questions asked by Rachel Moore:

What suicide prevention training do LPT nurses/mental health practitioners get? In the LPT Board meeting papers of 28 January 2025 it states that there have been gaps in suicide prevention training.

https://www.leicspart.nhs.uk/wp-content/uploads/2025/01/Paper-L1_Public-Patient-Safety-Learning-Report-Jan-2025.pdf

Reply by the Chairman:

LPT has reviewed its training offer. The Trust has purchased STORM training for clinicians and 8 Practice Development Nurses (PDNs). The PDNs have further been able to offer STORM training to the clinical staff working through a priority list. This is in addition to existing training packages through LPT's on-line training, which has modules on suicide awareness training, clinical risk assessment & safety planning.

Supplementary question from Rachel Moore:

What gaps in training were LPT referring to?

Reply by the Chairman:

A further written answer would be obtained from Leicestershire Partnership NHS Trust and published after the meeting.

(Note: After the meeting Leicestershire Partnership NHS Trust provided the following answer: LPT provides several levels of training regarding suicide awareness and prevention including Suicide Awareness Training (level one), REACT Mental Health Conversations, Mental Health First Aid and Perinatal mental health training. In addition, we provide STORM which is specifically designed for frontline specialist mental health professionals, this is delivered via a train the trainer approach by our Practice Development Nurses. The January minutes from the LPT Trust Board identified that there was a gap in the STORM training which related to capacity of the PDNs which was resolved shortly after.)

15. Questions asked by members.

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

16. Urgent items.

There were no urgent items for consideration.

17. Declarations of interest.

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

Mr. B. Piper CC declared an Other Registerable interest in all agenda items as he was a member of the Mary Guppy Group which was campaigning regarding health services in Lutterworth.

Mr. J. Miah CC declared an Other Registerable interest in agenda item 10: Winter Plan 2025/26 as he had a close relative that worked at Leicester Royal Infirmary.

Mr. J. Poland CC declared an Non-Registerable interest in agenda item 11: Mental Health and Early Intervention as he was a trustee of the Loughborough Wellbeing Centre, a mental health charity.

18. Declarations of the Party Whip.

There were no declarations of the party whip in accordance with Overview and Scrutiny Procedure Rule 16.

19. Presentation of Petitions.

The Chief Executive reported that no petitions had been received under Standing Order 36.

20. NHS 10 Year Health Plan.

The Committee considered a report of the Integrated Care Board regarding the recently published NHS 10 Year Health Plan for England. A copy of the report, marked 'Agenda Item 8', is filed with these minutes.

The Committee welcomed to the meeting for this item Pete Burnett, Chief Strategy Officer, Leicester, Leicestershire and Rutland Integrated Care Board. Pete Burnett clarified that he was not attending as a government spokesperson, but was present to explain the contents of the Plan and how the Integrated Care Board intended to implement it.

Arising from discussions the following points were noted:

(i) A lot of what was set out in the NHS 10 Year Health Plan was not new and was taking place already. For example, the shift from hospital to community had been a key strategy for a while. A member raised concerns that if the content of the 10 Year Health Plan was not new then how would the Plan make a difference to the state of the NHS. It was queried how would the Plan solve the funding problems and could savings be made without staffing cuts being made. In response it was explained that treating patients in their own homes would be more cost-effective, and when those patients were admitted to hospital it would be carried out in a much more planned way than was done currently.

(ii) The 10 Year Plan set out an intention to have Neighbourhood Health Centres (NHCs) in every community which would act as local one-stop hubs, co-locating GPs, community services, diagnostics, and mental health support, open 12 hours a day, 6 days a week to improve access and ease hospital pressure. It was intended to have 250 to 300 new neighbourhood health centres nationally by the end of the plan and 40 to 50 over the course of this Parliament. In response to a query from a member, it was explained that there were enough NHS buildings in Leicestershire to house the neighbourhood health centres but not all of them were fit for purpose so renovations would have to take place.

(iii) Work on developing the Neighbourhood Health Programme was already underway in Leicestershire.

(iv) A key part of the 10 Year Health Plan was making greater use of technology and Artificial Intelligence (AI) to save time for clinicians and administrators. AI would be able to help patients stay in their own homes rather that at a hospital which would be more cost effective. AI was still developing and in the future it was likely to be possible for patients to receive AI powered advice without needing to engage with a clinician. The Rapid Health pilot was taking place in Leicestershire which was an online clinical triage system which used AI to ask patients about their problem and then allowed them to book appointments without needing to phone the practice. However, there were difficulties with AI powered advice that needed to be overcome such as governance and making it clear which organisation was accountable for the patient.

(v) In the past when the NHS had overspent in some areas, funding was often taken from the digital programme to make up the loss. There was a commitment in the 10 Year Health Plan that this would not happen going forward and the required funding for digital programmes would be ringfenced.

(vi) A member raised concerns that the NHS app had not developed and improved as quickly as had been promised and queried whether the technology proposals in the 10 Year Health Plan were too ambitious and whether there was a disconnect between the plans and reality. Members also raised concerns that not everyone would be able to access technology such as mobile phone apps. Some elderly people in particular would not have the ability to use a phone or computer due to eyesight or other physical problems. In response reassurance was given that it was not a 'one size fits all' approach and there would still be other avenues for patients to receive medical advice. Part of the role of the ICB and the Neighbourhood Teams was to know their cohort of patients well enough so that they could put measures in place to help their particular needs.

(vii) The NHS was developing Shared Care Records which were a safe and secure way of bringing a patient's separate records from different health and care organisations together digitally in one place. Members raised concerns that the NHS had attempted a similar project in previous years which had not been successful and been very costly.

(viii) The 10 Year Health Plan aimed to reduce the NHS's dependence on overseas staff, and instead NHS employers would recruit more from their communities rather than looking to international recruitment agencies. The 10 Year Health Plan would be accompanied by an NHS 10 Year Workforce Plan which would set out how the NHS would tackle the issues of retention, productivity, training and attrition. One of the reasons why overseas staff had to be recruited currently was because the courses at universities in the United Kingdom were oversubscribed. The lack of courses was partly due to a lack of funding and also because of insufficient staff available to teach the courses. Training was organised on a regional and national basis and was therefore not within the control of the ICB.

(ix) The 10 Year Health Plan set the NHS a target for the next 3 years to deliver a 2% year on year productivity gain. A member raised concerns that NHS productivity in Leicestershire had decreased. In response it was explained that further multi-year guidance was due to be published which could make this issue clearer.

(x) In response to concerns from a member that NHS services would not keep pace with the amount of housing development in Leicestershire, it was explained that the NHS did apply for developer contributions under Section 106 of the Town and Country Planning Act 1990. However, the process was not straightforward and the funding did not always arrive at the time it was needed.

RESOLVED:

That the update regarding the NHS 10 Year Health Plan be noted.

21. NHS Transformation.

The Committee considered a report of the Integrated Care Board (ICB) which provided an update on the national reform of the NHS operating model across England including the integration of the Department of Health and Social Care and NHS England, and a changed role for ICBs. A copy of the report, marked 'Agenda Item 9', is filed with these minutes.

The Committee welcomed to the meeting for this item Pete Burnett, Chief Strategy Officer, Leicester, Leicestershire and Rutland Integrated Care Board.

Arising from discussions the following points were noted:

(i) NHS England and government ministers had approved a new cluster for the region which covered Leicester, Leicestershire and Rutland (LLR) and Northamptonshire. However, LLR and Northamptonshire ICBs would remain separate statutory bodies. Part of the reason for taking the clustering approach rather than merging ICBs at this stage was because Local Government Reorganisation was taking place and the footprint on which councils would be working under was still unclear. It was advisable for ICBs to work on the same footprint as Councils.

(ii) Having a shared management team would reduce costs. Anu Singh would be the Chair of the new LLR and Northamptonshire cluster replacing Paula Clark who had been chair of LLR ICB since October 2024. Anu Singh had previously worked for the Black Country ICB. A member queried whether Anu Singh had sufficient knowledge of Leicestershire. It was noted that she had a lot of experience with the NHS and local authorities.

(iii) A member raised concerns that with a larger footprint the ability to tackle health inequalities across the area would be reduced. In response reassurance was given that the ICB had a legal duty to address health inequalities and improve the health of the whole population. Data would be analysed, and based on that data decisions would be made on where health interventions needed to be made. Directors of Public Health also had a role in tackling inequalities.

(iv) A member suggested that the general public were not particularly interested in the structure of health bodies; their focus was on treatment and waiting times. In response it was explained that as part of the plans ICBs were required to reduce running costs by 50% which would free up funding for frontline services. The staff redundancies had originally been planned to have taken place by the end of December 2025 but this had been delayed due to a lack of funding for the redundancy payments.

(v) Healthwatch Leicester and Leicestershire was expected to cease to exist in the coming years but the exact date of this happening was still unclear.

(vi) It was suggested that this NHS Transformation agenda item should have been considered at a meeting of the Leicester, Leicestershire and Rutland Joint Health Scrutiny Committee and questioned whether there were enough meetings of that Committee in the diary. The Chair Dr. S. Hill CC agreed to discuss this with the Chair of the Joint Committee Cllr. Karen Pickering.

RESOLVED:

That the update on the changes to the NHS Operating Model be noted.

22. Winter Plan 2025/26

The Committee considered a report of the Integrated Care Board regarding the plans in place to manage health system pressures across Leicester, Leicestershire and Rutland (LLR) over winter 2025/26. A copy of the report, marked 'Agenda Item 10', is filed with these minutes.

The Committee welcomed to the meeting for this item Professor Nils Sanganee, Chief Medical Officer, Integrated Care Board, Sarah Smith, Head of Emergency Care, Integrated Care Board, Sarah Taylor, Deputy Chief Operating Officer, University Hospitals of Leicester NHS Trust, and Jean Knight, Managing Director, Leicestershire Partnership NHS Trust.

Arising from discussions the following points were noted:

(i) Each year Integrated Care Board's were asked by NHS England to submit a Winter Plan to ensure the health and care system was fully prepared to manage the increased pressures that typically arose during the winter months (October to March). For Leicestershire plans were in place to deal with expected surges in demand and also 'supersurges' where the demand was higher than expected. This year NHS England had asked for more detail about the plans and modelling of different scenarios. NHS England also required health systems to test the plans they had in place for managing winter pressures. In LLR a local test event was taking place on 11 September 2025 and a regional stress testing event was taking place on 17 September 2025.

(ii) Monitoring was taking place of the winter in the southern hemisphere to see what lessons could be learnt and implemented for the UK winter.

(iii) In response to a question from the Chair as to whether the NHS still had spare wards which could be used in the winter it was explained that this was no longer the case due to financial challenges as beds were very expensive. There was no spare capacity at Leicester Royal Infirmary. However, as part of the acute community plan the first floor of the Preston Lodge community rehabilitation unit could be used during the winter.

(iv) In response to concerns raised by members about ambulance wait times outside the Leicester Royal Infirmary Emergency Department, it was acknowledged that this was still a problem but emphasised that significant improvements had been made. The 45 minute handover target was challenging to meet but was being met some of the time and needed to be met more consistently. Work was taking place to improve flow through the hospital. Ambulance response times had improved and EMAS staff were treating more patients at the scene rather than conveying them to hospital. Patients were also being given more treatment advice over the telephone. This all helped reduce demand at the Emergency Department.

(v) There was a comprehensive communications campaign in place to ensure patients went to the most appropriate place for treatment over the winter and did not attend the Emergency Department unnecessarily. However, the public did not always pay

attention to health messaging until they needed treatment therefore it could be difficult to get the message across.

(vi) In response to a question from a member, it was explained that opening another Emergency Department in Leicestershire was not a realistic option because the department would need a resus department and specialist children's facilities to accompany it which were only available at Leicester Royal Infirmary. There were, however, plans to build an additional Urgent Treatment Centre. Data indicated that this was the type of facility needed in LLR rather than an additional Emergency Department.

(vii) It was reported that a regular theme of feedback from patients that Healthwatch had engaged with was unsafe discharge from hospital. In response it was acknowledged that this was an area that could be improved and more work needed to be carried out to ensure that the transfer of information from hospital to community services was timely and accurate and that the medication the patient needed was available when they left hospital.

(viii) Loughborough Community Hospital had x-ray facilities so patients did not need to travel to the main hospitals if they just needed an x-ray. Members raised concerns about patients that did not reside near Loughborough particularly those in south Leicestershire. There was a lack of public transport from south Leicestershire into the city centre.

(ix) There was usually an increase in respiratory problems over the winter. The NHS was no longer focusing on Covid-19 and less testing for it was taking place. However, Covid-19 disproportionately affected frail and vulnerable people therefore these high-risk cohorts still needed to be vaccinated. If they were vaccinated for Covid-19 they were far less likely to require admitting to a hospital.

(x) A comprehensive vaccination strategy was in place for Leicestershire. Vaccine uptake was generally good in the county area of Leicestershire. Further work was needed to take place to improve vaccination uptake in some groups particularly children and social care staff. The flu vaccine was only available for pre-school children and children with particular health conditions such as asthma and diabetes. A vaccine would only be given to a child if parental consent had been received, though if the child was resisting the procedure the clinician may have to make a decision not to administer the vaccine, even if parental consent had been given.

(xi) The Management Team at Leicestershire County Council had held discussions regarding how to increase vaccine take-up amongst staff, and options had been considered to encourage more people to get vaccinated including holding clinics at County Council buildings and offering vouchers.

(xii) A member queried whether vaccine hesitancy due to safety concerns about previous vaccines, such as MMR, was an issue. In response it was explained that whilst there were now less concerns amongst the public about vaccine safety, vaccination rates had dropped since the Covid-19 pandemic had ended which was of concern. This was not necessarily thought to be due to safety concerns.

(xiii) In response to concerns raised that the vaccination clinics would have a negative impact on the day-to-day primary care work reassurance was given that the work streams were kept separate. Weekend working and enhanced access (GP

Practices open later in the evenings) meant that there was capacity for both. Efforts were also being made to encourage people to book their vaccinations in advance so the demand could be managed better.

(xiv) A member raised concerns about the supply of vaccines to south Leicestershire. In response it was explained that vaccine supplies were based on the previous year's levels plus expected growth. In the past there had been issues with supply from the manufacturers of the vaccine but this had improved significantly as planning had improved.

(xv) The slides appended to the report referred to a group of people known as "Healthcare – ESR" that were receiving vaccines. It was explained that this related to those NHS staff on the Electronic Staff Record which was used to manage the HR and payroll for NHS employees.

RESOLVED:

That the plans in place to manage winter pressures be noted.

23. Mental Health and Early Intervention.

The Committee considered a joint report of Leicester, Leicestershire and Rutland Integrated Care Board, Leicestershire Partnership NHS Trust, and Vita Health which provided an update on the overarching provision of mental health and early intervention services available locally. A copy of the report, marked 'Agenda Item 11', is filed with these minutes.

The Committee welcomed to the meeting for this item David Williams, Group Director Strategy & Partnerships, Leicestershire Partnership NHS Trust, Alyson Taylor, Senior Mental Health and LD Transformation Lead, Integrated Care Board, Chris Harbron, Chief Operating Officer, Vita Health, and Brendan Street, Clinical Lead, Vita Health.

Arising from discussions the following points were noted:

(i) Tackling mental health issues required a partnership approach involving different organisations. Step 1 initial support was provided by GPs and included use of self-help tools, lifestyle advice, or online resources. In addition to that, NHS Talking therapies supported people with common mental health problems such as stress, anxiety and depression. Locally Talking Therapies was provided by Vita Health Group. People could access Talking Therapies mainly at one of two levels. Most people could start Step 2 support in around 9 days. Step 3 provided more specialist therapy and this could take longer because of higher demand and the need for more trained staff. The wait time was usually over 3 months. Members welcomed that the number of people waiting for Talking Therapy was falling and that the therapy appeared to be having a positive effect but expressed concerns about the wait times for the more specialist therapy. Members were pleased to note that Talking Therapy sessions were available face to face and not just over the phone/video link. It was acknowledged that not everybody had access to digital technology. The initial assessments undertaken with patients would identify which method would best suit their needs.

(ii) The existing Talking Therapy service was not as beneficial for people with neurodiversity issues such as Attention Deficit Hyperactivity Disorder (ADHD) therefore a new version of the Talking Therapy service was being developed specifically for people with ADHD. It was acknowledged that demand for this service would increase as more people were being diagnosed with ADHD.

(iii) Members were invited to attend a Talking Therapies session and were advised to get in touch with Alyson Taylor to arrange a visit. Her contact details would be circulated after the meeting.

(iv) Healthwatch reported that they had received feedback from patients that there were inconsistencies regarding the referral process for therapy and wait times depending on where in Leicestershire they were being referred from. It was agreed that Healthwatch and the Integrated Care Board would discuss this further after the meeting.

(v) Isolation could be a contributing factor to mental health problems. Tackling the problem required input from not just the NHS but local authorities and community organisations as well. It was important that mental health problems were not just seen as a medical issue that could be solved with medication etc. A social and community-based approach could be just as beneficial. Medication helped tackle the symptoms of mental health issues but talking therapies and social interaction could help deal with the causes. The Joy mobile phone app was available for the public to use which offered social prescribing options amongst other things. The Committee had considered a report relating to tackling isolation and all the available services at its meeting on 5 March 2025 and as new Committee members may not have read the report it was agreed that it would be circulated to members after the meeting.

(vi) Concerns were raised that the use of text messaging meant that people did not talk to each other on the phone or face to face as much. In response, this issue was acknowledged but it was pointed out that text messaging could be a positive as some people were more comfortable with it than other forms of communication. Young people in particular could find texting easier and more discreet and confidential than speaking to a health professional face to face or over the phone. The Chat Health confidential text messaging service enabled young people to have a text conversation with a nurse, mental health professional or health visitor.

(vii) A lot of the mental health support in Leicestershire was provided by Voluntary, Community and Social Enterprise (VCSE) organisations. Concerns were raised that the VCSEs did not have enough funding for mental health. In response reassurance was given that the NHS was investing a significant amount of funding in the voluntary sector. It was recognised that a collective approach was needed and there was great value in VCSE organisations. Talking Therapies worked closely with VCSE organisations, invited them to sessions and offered them training.

(viii) Leicester, Leicestershire and Rutland was the third highest performing area across the midlands for getting people back into work after severe mental illness. It was agreed that further details about this work would be circulated to members after the meeting.

(ix) Discussion took place about whether there had been an increase in mental health issues amongst the population generally or whether this was the perception

because there was more awareness and diagnosis and people were coming forward asking for help.

RESOLVED:

That the contents of the update regarding mental health and early intervention services available locally be welcomed.

24. Joint Local Health and Wellbeing Strategy Review.

The Committee considered a report of the Director of Public Health which sought the views of the Committee on recommended changes to the current Joint Local Health and Wellbeing Strategy (JLHWS) 2022-2032 as part of the current review. A copy of the report, marked 'Agenda Item 12', is filed with these minutes.

Arising from the report the following discussions took place:

(i) A member raised concerns that reference to some key health issues was proposed to be removed from the commitments in the JLHWS, such as vaccinating 1 and 2 year olds, and ensuring that there were opportunities for all 16-17 year olds to gain education, employment and training. The member questioned how progress in tackling those issues could be tracked if they were not part of the commitments. In response it was explained that rather than removing those issues from the strategy altogether, the approach was to refine the wording in the commitments and make it more concise. These issues would still be addressed in the Delivery Plans that accompany the Strategy. It was agreed that when the Health and Wellbeing Board Annual Report was presented to the Health Overview and Scrutiny Committee in future it could include the Delivery Plans. It was also noted that by simplifying the wording in the commitments it gave more flexibility to tackle emerging issues such as vaping. Some of the issues the member referred to relating to children sat better in the Children's Partnership strategy rather than the JLHWS.

(ii) A member emphasised the importance of ensuring that the final period of a person's life was as comfortable as possible and queried what was being done to help those people. The member submitted that there was a lack of focus on helping people adjust to life after retirement from work. In response reassurance was given that this was where the life course approach and the Dying Well section of the JLHWS played a role. The Staying Healthy Partnership Board sub-group covered all ages. Consideration was also being given to having more focus in Leicestershire on healthy ageing and the member welcomed this.

(iii) A member raised concerns about sedentary lifestyles and the need to get people to exercise more. In response it was acknowledged that this was an important issue that needed to be tackled. The amount of screen time people had was also a problem not just because they tended not to be exercising whilst watching a screen, but also because of the mental health impacts from some of the content on the screen. Therefore, it was hoped that the Strategy would help tackle this issue.

RESOLVED:

(a) That the contents of the revised Joint Local Health and Wellbeing Strategy be noted;

(b) That the comments now made by the Committee be reported to the Health and Wellbeing Board at its meeting on 25 September 2025.

25. Date of next meeting.

RESOLVED:

That the next meeting of the Committee take place on Wednesday 5 November 2025 at 2.00pm.

2.00 - 4.56 pm CHAIRMAN
03 September 2025

Agenda Item 8

Leicestershire Partnership NHS
NHS Trust

HEALTH OVERVIEW AND SCRUTINY COMMITTEE: 5 NOVEMBER 2025

REPORT OF THE DIRECTOR OF STRATEGY AND PARTNERSHIPS - LEICESTERSHIRE PARTNERSHIP NHS TRUST

NEW LPT STRATEGY – TOGETHER WE THRIVE

Purpose of report

1. The purpose of this report is to introduce the Committee to Leicestershire Partnership NHS Trust's (LPT) new strategy, **Together we thrive**.

Background

2. Launched in April 2025, **Together we thrive** is our first Group strategy with Northamptonshire Healthcare NHS Foundation Trust (NHFT). The strategy sets out how our organisations will:

   a. work together to improve health outcomes for our local communities;
   b. help the people we support to thrive, and;
   c. ensure our staff thrive.

Our Healthcare Group

3. LPT and NHFT have been working together as a Group to share best practice, increase productivity and use resources wisely since 2019. We have a very successful history of working in partnership:

   a. from our award-winning Together Against Racism programme;
   b. to developing a Group Health Inequalities Framework;
   c. publishing a Group Social Value Charter;
   d. our many continuous improvement programmes;
   e. and more recently realising our Associate University Healthcare Group status.

4. **Together we thrive** sets strong foundations for longer term commitments designed to ensure we can effectively:

   a. meet the challenges of new and emerging policy and legislative requirements;
   b. meet new financial envelopes;
   c. identify and respond to the changing demographic;
   d. maximise the benefits from working in partnerships.

Our new Healthcare Group mission and vision:

5. Our strategy was developed following a year-long engagement with our staff, our patients and service users, their families and carers, and our system stakeholders. We heard from over 3,000 people – including our staff and volunteers, our patients and service users, their carers and families, in addition to our stakeholders (including Local Authorities, our Integrated Care Boards (ICB), Public Health in addition to our Voluntary and Community Sector).

   a. our new mission is: '**making a difference, together'**. Our communities told us they wanted a strategy that prioritised the best outcomes for patients, service users and our wider communities each day.

   b. our new vision is: '**Together we thrive; building compassionate care and wellbeing for all'**. Our communities told us how important it was for us to be inclusive for all, that we work together in partnership, and we maintain our clear vision to provide compassionate, safe and caring services.

Our new strategic priorities:

6. Our new strategic themes are:

7. The context within each of our strategic themes (detailed within Appendix A) have been designed and framed around the views of our staff, our communities and support the wider strategic direction of our 'system partners'.

8. Importantly, they have also been developed to ensure we can meet both the strategic and legislative requirements of healthcare delivery over the coming years, as directed nationally by NHS England. These are significantly important as we develop services in line with the national NHS direction, enabling three key shifts in healthcare (as described within the NHS Long Term Plan), namely:

a. Hospital to community
b. Analogue to digital
c. Sickness to prevention

9. Our THRIVE priorities will help guide us ensuring we are proactive and responsive to local needs, co-producing care offers and maximising partnership opportunities to enhance access, experience and patient outcomes.

How 'Together we thrive' aligns partner strategies and strategic direction:

10. The framing of our strategic priorities provides the opportunity for continued and focused partnership opportunities with the intention to reduce duplication, becoming ever more effective and efficient – from how and where we work, how we develop integrated care offers, to supporting seamless pathways and interventions, ensuring we can facilitate and offer the right care at the right time and place.

11. The table below highlights how our priorities align to local system priorities and where we envisage opportunities to further support our communities' health and wellbeing across Leicestershire.

	Leicestershire County Council strategic priorities					Leicestershire Public Health strategic priorities							Leicestershire Health and Wellbeing Board priorities				UHL strategic priorities			Voluntary Action Leicestershire (VAL) strategic priorities					NHS Long Term Plan						LLR ICB Joint Forward Plan								
	Clean and green	Great communities	Improved opportunities	Strong economy	Safe and well	Reduce cause of ill health	Improve health and wellbeing across life course	Reduce health inequalities	Strengthen partnership working	Prevention and early intervention	Embedding health in everything / wider determinants	Quality of life and wellbeing	Best start to life	Staying healthy, safe and well	Living and supported well	Dying well	Transforming patient care	Strengthening our culture	Deliver our financial plan	Helping others change their lives	Strengthen VCS sector	Volunteer engagement and coordination	Current opportunities via partnerships and projects	Sustainability and organisational development	Transforming models of care	Harnessing digital, technology, AI and data	Workforce and organisational reform	Improving outcomes, tackling major disease burdens	Quality, safety and reducing inequality	Financial stability and efficiency	Improve health equity	Prevent illness and help people stay well	Best start to life	Living and supported well	Dying well	Championing integration	Mental Health	Access to services	Anchor organisation
T			■	■	■	■	■	■	■	■	■	■	■	■	■	■	■		■	■			■		■	■	■	■	■	■	■	■	■	■	■	■	■	
H	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■		■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■
R		■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■			■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■
I		■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■		■	■	■	■	■		■	■	■	■	■	■	■	■	■	■	■	■	■	■
V			■	■	■	■	■	■	■	■	■	■		■	■							■	■		■	■	■	■	■	■	■	■	■	■	■	■	■	
E	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	

What 'Together we thrive' means for Leicestershire:

12. With a strong focus on neighbourhood health **Together we thrive** is an important strategy for our system. Our partnership with Local Authority departments, Public Health and the third sector is important in supporting communities to engage early in care and support, be supported to improve self-care and prevent harm and illness where at all possible and involving our communities in the design of efficient and effective services.

13. Over the next five-years we will work collaboratively with system partners to:

a) Collaboratively develop our community-based model of care. Working with system partners we will mainstream digitally enabled care across Leicestershire. This will reduce the need for patient travel whilst improving access to health records and appointments, offering more virtual treatment pathways and connecting with more service users through remote technology.
b) Provide a model of care that ensures people get the right care at the right time; helping patients and service users avoid being admitted to hospital if they do not
c) need to be there and access to health and social care when they need it by working collaboratively.
d) Share our data and intelligence with system partners and co-produce health inequality solutions with our communities across Leicestershire.
e) Evaluate and adopt innovative technologies in the county, and participating in clinical trials and research for new treatments.
f) Provide a clear and joined up approach to the prevention of ill health, improving experiences and outcomes for our communities across the county.

Summary

a) Together is key to our organisation, we are committed to working with others; public open spaces, housing, employment, public safety – all of these make large contributions to good health and well-being.
b) We are both providers across Leicester, Leicestershire and Rutland working with our communities to improve self-care, health literacy, and healthy years of life.
c) Scrutiny and elected members can help our continued partnership working between children's services, education, social care, housing, Public Health, and our Voluntary and Community Sector and the NHS to improved services for our communities.

Proposals/Options

14. The Health Overview and Scrutiny Committee is invited to:

a) Note LPT's new strategy, **Together we thrive**;
b) Note the strategic direction of travel, from: Hospital to community; Analogue to digital; Sickness to prevention.
c) Note the partnership opportunities aligned to our new strategy strategic priorities.

Equality Implications

15. There are no equality implications arising from the recommendations in this report.

Human Rights Implications

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

Appendices

17. Appendix A: **Together we thrive**.

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Leicestershire County Council

HEALTH OVERVIEW AND SCRUTINY COMMITTEE: 05.11.2025

[INTRODUCTION AND OVERVIEW OF SERVICE - East Midlands Ambulance Service]

REPORT OF THE EMAS DIVISIONAL DIRECTOR FOR LLR

Purpose of report

1. The purpose of this report is to present an overview of East Midlands Ambulance Service (EMAS) and its provision within Leicester, Leicestershire and Rutland (LLR). This document will provide information in relation to how Ambulance Services, as a part of the NHS are commissioned, how it delivers care to patients, and how it is monitored and the performance expected to be delivered. It will also share the current challenges and expected future model of care. The purpose of this report is to ensure that the Committee understand the service to enable them to be able to be able to both support and ask questions

Background

2. There are ten NHS Ambulance Trusts within England, each covering a geographical region and they are individually commissioned by single Integrated Care Boards (ICB), on behalf of, and collaboratively with other ICBs within that region. Under the current ICB arrangements the commissioning ICB for EMAS is Joined Up Care Derbyshire (JUCD).

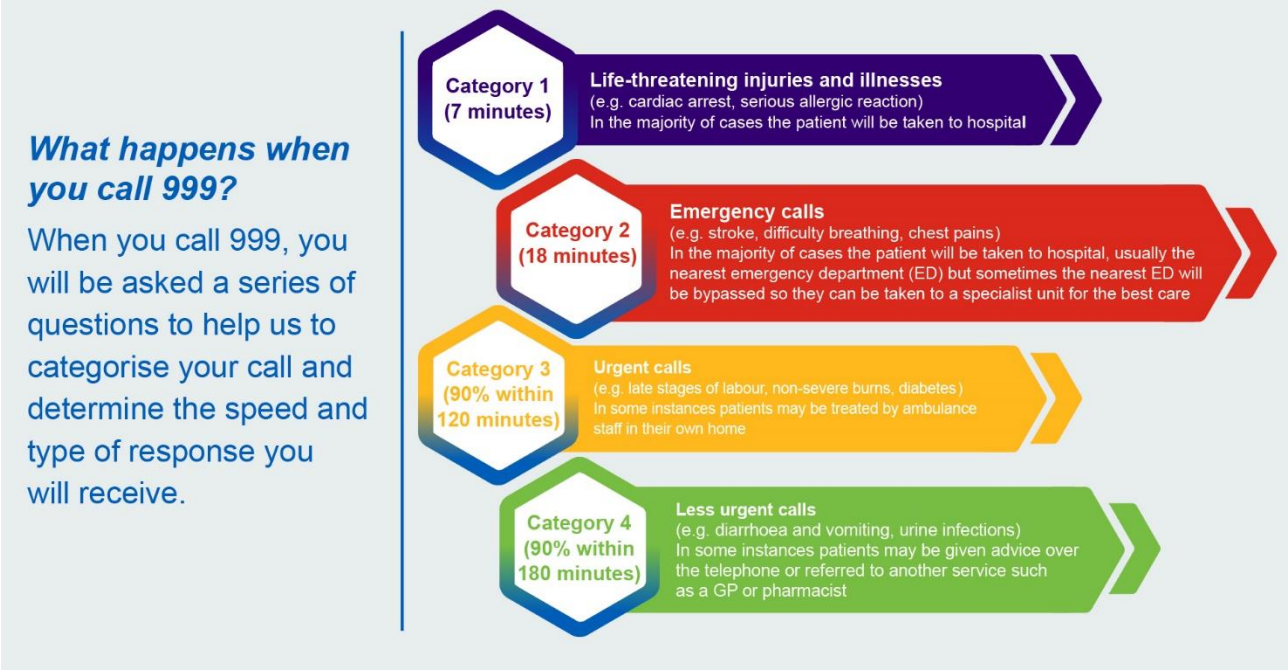
   East Midlands Ambulance Service from a response perspective operates as 5 localised Divisions; Derbyshire, LLR, Lincolnshire, Northamptonshire and Nottinghamshire. These Divisions each have their own operational leadership structure, working alongside centralised corporate teams, to ensure standardisation across core activities but enabling local variation, where necessary to support localised population needs and health system partners.

   Regionally EMAS has 2 Emergency Operation Centres (call taking and clinical assessment function) and these are based in Nottingham (EMAS Trust Headquarters) and Lincoln and support all 5 Divisions. EMAS operates Non-Emergency Patient Transport Services across Lincolnshire, Derbyshire and Northamptonshire. This provision is contracted by the ICB from a different provider in LLR and Nottinghamshire. Each ambulance service also hosts at least one HART base (Hazardous Area Response Team), this is classed as a National Asset and for EMAS is based in Mansfield. HART support the whole of the East Midlands and provide mutual aid across the Country as needed. They provide specialist skills, often in more challenging environments such as water rescue, emergencies at a height as examples. EMAS also utilises the support of 2 private ambulance providers who support in the

delivery of the service across the region, working alongside the substantive workforce following EMAS procedures and clinical guidelines.

Call answering and response times

Call response times are set nationally and are captured as a mean to assess performance.

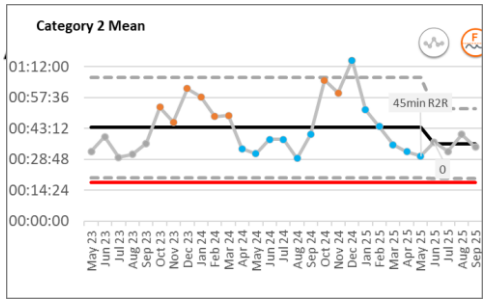


The NHS England Ambulance Quality Indicators Data is published monthly by NHS England and can be accessed via their website. The dataset includes the mean and 90th centile ambulance response times for a given month. The response times are reported in hours, minutes, and seconds by:

- Ambulance response category
- For England overall
- For the English regions
- For the separate NHS Ambulance services of England

The table below demonstrates the LLR performance since April 2025, for all incident categories, with Category 2 response being the key area of national focus and where the National drive for improvement is being directed. The graph demonstrates the LLR Category 2 mean performance since May 2023.

	Apr-25	May-25	June- 25	July-25	Aug-25	Sept-25
C1 mean	00:08:05	00:07:41	00:08:21	00:08:15	00:08:46	00:08:15
C2 mean	00:32:22	00:30:26	00:36:57	00:32:34	00:40:28	00:34:30
C1 90th	00:13:43	00:13:05	00:14:24	00:14:30	00:15:43	00:14:23
C2 90th	01:05:24	01:00:24	01:15:13	01:04:25	01:23:05	01:11:14
C3 90th	04:45:21	03:48:37	05:51:06	04:42:48	05:51:58	06:28:02
C4 90th	03:32:30	03:53:53	03:23:34	05:13:34	05:06:36	06:46:02



Within EMAS, and particularly within LLR, category 3,4 and 5 activity does not always require a double crewed ambulance to respond and convey a patient to hospital, particularly

the Emergency Department. Most of these patients can either be treated in their own home or referred to a significant number of local services that are able to address their needs.

Many of these patients receive an alternative pathway of care when they make their initial phone call. This might be an appointment at an Urgent Treatment, advice and guidance, a recommendation to attend a pharmacist or a referral to urgent community response teams that can support patients to remain at home. When ambulance crews attend a patient, they can also access many of these alternatives to the Emergency Department and thus leave the patient at home, only transferring to hospital those that require that response, because they need a specialist or are very unwell and need emergency interventions. If crews leave a patient at home, they will provide advice as to what the patient needs to do if their condition deteriorates.

As a Trust EMAS are taking several actions to support the improvement of C2 performance. These actions for 25/26 include:

- Increase in the number of call takers within the control centres
- Increase the number of clinicians including Paramedics and Nurses and Mental Health Nurses who form part of the Clinical Assessment Team, to support Hear and Treat decisions and call patients back who are experiencing prolonged waits for an ambulance crew to attend.
- Increase in both “Hear and Treat” and “See and Treat” (by the Clinical Assessment Team supporting non-conveyance).
- All category 3 and 4 calls are clinically validated prior to an ambulance being dispatched ensuring they receive a review by a clinician.
- Introduction of Advanced Practitioners and Critical Care Desk within Call Centre to support advanced clinical decision making.
- Reducing the amount of time crews spend on scene
- Reducing sickness absence to support increased resource available
- Increase the number of double crewed ambulance hours, through recruitment and internal efficiencies. This includes improving turnaround time between patients.

Pre-Handover

The National standard for ambulance services for handing over a patient to the hospital is 15 minutes. Once an ambulance arrives on site at the hospital the responsibility of the patient becomes that of the hospital. This is a current challenge across many hospitals across the country. Each year University Hospitals of Leicester are asked by the ICB and NHS England to set a trajectory of improvement that pre-handover time progresses towards the 15 minute standard. This trajectory was met in July and September 2025. UHL and EMAS are working collaboratively to put in place processes to support this area of required improvement. It is widely recognised that there is a correlation between prolonged pre-handover delays and Category 2 mean. An established process, with associated escalation actions, is in place that supports the clinical review and early identification of potential patient harm as a result of prolonged waits at UHL.

		Pre Handover Trajectories - 2025/26											
		Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26
Plan	Glenfield General Hospital	00:18:19	00:17:39	00:19:04	00:20:23	00:20:52	00:21:56	00:22:19	00:21:11	00:20:38	00:21:21	00:22:00	00:22:00
	Leicester Royal Infirmary	00:45:33	00:33:55	00:40:53	00:38:42	00:36:21	00:45:25	00:45:20	00:50:00	00:45:00	00:55:00	00:35:00	00:30:00
	ICB Level	**00:41:08**	**00:31:14**	**00:37:04**	**00:35:44**	**00:33:37**	**00:41:27**	**00:42:13**	**00:45:03**	**00:41:52**	**00:49:20**	**00:33:22**	**00:29:21**
Actual	Glenfield General Hospital	00:20:24	00:22:13	00:21:46	00:20:02	00:23:31	00:20:17						
	Leicester Royal Infirmary	00:46:18	00:35:39	00:40:18	00:33:49	00:56:26	00:34:09						
	ICB Level	**00:42:44**	**00:34:13**	**00:37:52**	**00:32:02**	**00:51:16**	**00:33:04**						
Variance	Glenfield General Hospital	00:02:05	00:04:34	00:02:42	-00:00:21	00:02:39	-00:01:39						
	Leicester Royal Infirmary	00:00:45	00:01:44	-00:00:35	-00:04:53	00:20:05	-00:11:16						
	ICB Level	**00:01:36**	**00:02:59**	**00:00:48**	**-00:03:42**	**00:17:39**	**-00:08:23**						

UHL and EMAS continue to work together to reduce these delays which ensures crews can respond to patients waiting in the community. This work utilises all system partners in the improvements required for this position, and a reduction in the hours lost by EMAS to prolonged handover delays to be sustained and this is a key priority for the Health Secretary, the ICB, EMAS and the wider system. Hospital handover delays are very closely monitored and scrutinised by the NHS England regional Team, through regular meetings that include sharing of initiatives that have shown improvement in other areas across the Midlands and Nationally.

LLR Operational and Resource Overview

Within LLR division of EMAS there are approximately 500 frontline staff, covering its emergency response 24/7. There are qualified Paramedics and Technicians, as well as unqualified clinical support roles and student Paramedics and Student Technicians on a variety of educational pathways including university programmes and apprenticeships. There are also Community First Responder programmes across the footprint, with committed volunteers also responding alongside frontline teams, as appropriate and providing education to local communities in relation to CPR, and other activities. Rotas are primarily based around service demand and skill mix and incorporate flexible working and development opportunities.

Across the LLR footprint are ambulance stations of varying sizes and functions with the Divisional Headquarters based within Leicestershire Fire and Rescue HQ in Birstall.

Ambulance Stations are currently located in:

- Coalville
- Gorse Hill (Includes fleet workshops and the daily Operational Cell with Clinical and Command Leadership)
- Goodwood
- Hinckley
- Loughborough
- Lutterworth
- Market Harborough
- Narborough (Includes an Education Centre and Remembrance Garden)
- Oakham

Our crews respond in a variety of vehicles, primarily double crewed ambulances (DCAs). EMAS also utilise fast response cars (FRV), these support clinicians getting to our rural areas more easily, and Paramedics with Specialist skills or medicines being able to support larger, more complex or challenging jobs. Many of the FRVs are now electric and LLR are working towards having the first electric powered ambulances in operation for EMAS in

2026. An internal fleet team provide maintenance, cleaning, re-stocking services where possible and many apprenticeships are available within this area of the service offering great job opportunities and qualifications for school leavers.

The Ambulance Service has a key part to play in responding to Major Incidents and committee members keen to understand more would find the recommendations from the Manchester Arena Inquiry useful to be aware of. Not all of these have been moved forward, as many of them carry a budgetary implication, which has not yet been identified. EMAS have made steps to address some of these, as a Trust, as a cost pressure.

Collaboration

The Ambulance Service has a unique position being both a core NHS Health System Partner and also a Blue Light Response Service. EMAS is a key partner in the Local Resilience Forum and is classed as a Category 1 Responder for Emergency Planning and Response.

EMAS work very closely with local Health and Social Care Partners daily, supporting patients to receive the most appropriate care in a timely way, close to home where possible and appropriate.

Conclusions

3. This report is primarily to inform the committee and provide a base level of knowledge to understand the ambulance service, its demands, challenges, responsiveness and the factors that impact these within LLR. This is intended to ensure that appropriate and informed scrutiny can be applied to the service and the wider health system to improve the experience and outcomes for those who require a response. It is not intended to be exhaustive, and the author would welcome the opportunity to speak further with any members of the committee who would like to understand more. There are no specific proposals or approvals being sought at this time.

Background information

Further information in relation to ambulance services from a National perspective can be found using the public websites and links below:

- AACE: Association of Ambulance Chief Executives
- NHS England » Ambulance Response Programme
- Delayed Hospital Handovers: Impact Assessment of Patient Harm - AACE, Nov 2021 - aace.org.uk
- AACE TAKING STOCK 09.2023. 1.0
- Manchester Arena Inquiry Volume 2: Emergency Response - GOV.UK

Circulation under the Local Issues Alert Procedure

4. None.

Equality Implications

5. All internal EMAS policies and procedures are subject to an Equality Impact Assessment (EIA).

Human Rights Implications

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

Officer(s) to Contact

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Leicestershire County Council

HEALTH OVERVIEW AND SCRUTINY COMMITTEE: 05 NOVEMBER 2025

LEICESTERSHIRE HIV LATE DIAGNOSIS UPDATE

REPORT OF THE DIRECTOR OF PUBLIC HEALTH

Purpose of report

1. The purpose of this report is to update the Committee on the latest HIV late diagnosis position, and actions underway to improve diagnosis across Leicestershire.

Policy Framework and Previous Decisions

2. Nationally, work on HIV is directed through 'Towards Zero – An action plan towards ending HIV transmission, AIDS and HIV related deaths in England'. The plan sets four objectives to achieving this goal:

    - ensuring equitable access and update of HIV prevention;
    - scaling up of HIV testing;
    - optimising rapid access to treatment and retention in care;
    - improving the quality of life for people living with HIV and addressing stigma.

3. At its meeting on 4 June, this Committee received an update on public health and health system performance in Leicestershire based on available data at the time. The Committee requested further information on the metric 'HIV late diagnosis in people first diagnosed with HIV in the UK' which was rag rated red for the period 2021-23. Leicestershire was ranked 15th out of 16 when benchmarked against comparable authorities on this metric.

Background

4. The commissioning of sexual health, reproductive health and HIV is shared between NHS England, Integrated Care Boards (ICBs) and Local Authorities. HIV prevention and Pre-Exposure Prophylaxis (PrEP) delivery is the responsibility of Local Authorities (funded through the Public Health Grant) whilst testing and contraception are shared responsibilities between NHS England, ICBs and Local Authorities.

5. A late HIV diagnosis is defined as having a CD4 count below 350 cells per mm^3 of blood (indicating a presence of HIV) within 91 days of diagnosis and no evidence of a recent infection.

6. Late HIV diagnosis has several negative impacts: it increases the risk of early death, causes significant ill health, impacts quality of life and can increase onward transmission.

7. A 2024 United Kingdom Health Security Agency (UKHSA) report states that people first diagnosed in England in 2022 at a late stage were 10 times more likely to die (deaths due to all causes among people with HIV) within a year of their diagnosis, compared to people who were diagnosed promptly (33 versus 4 deaths, respectively).

8. Late diagnosis trends are changing nationally; the highest proportions of late diagnoses were among people aged 50 years and over. Since 2022, the increase in the number of late diagnoses is largely among people of black ethnicity, and increases are also evident in heterosexual men and women. However, late diagnosis (both number and proportion) decreased for men exposed through sex with men, and those exposed through injecting drug use.

9. 2023 Research indicates that insufficient testing is the primary driver of late HIV diagnosis. A range of societal, systemic, and individual factors contribute to this issue, including:

    - Misconceptions about personal risk of HIV infection;
    - Stigma and fear of discrimination associated with HIV;
    - Lack of awareness regarding the availability of free testing services;
    - Clinician-related barriers, such as:
        - Misjudgement of a patient's HIV risk based on personal characteristics.
        - Concerns about causing offence when offering a test.

10. These factors collectively hinder timely testing and diagnosis, highlighting the need for targeted interventions to improve awareness, reduce stigma, and support clinicians in offering HIV tests confidently and appropriately.

Performance metrics - HIV Late diagnosis

11. Reporting on this measure is benchmarked by the percentage value using the goals presented below. Of our 15 comparator neighbours, only 1 is achieving the benchmark of <25%, 5 fall into the amber values which corresponds with the national position, and the remaining 9 are benchmarked red alongside Leicestershire. Nationally, only 9 local authorities are achieving the benchmark of <25%. It is therefore important that this metric is considered alongside other HIV indicators to provide a more comprehensive understanding of the local picture.

HIV late diagnosis in people first diagnosed with HIV in the UK 2021 - 23

Proportion - %

Area	Recent Trend	Neighbour Rank	Count	Value	95% Lower CI	95% Upper CI
England	–	-	2,587	43.5	41.8	45.2
Neighbours average	–	-	-	-	-	-
Worcestershire	–	9	4	12.5	3.4	32.0
South Gloucestershire	–	6	4	40.0	10.9	100
Nottinghamshire	–	2	21	42.0	26.0	64.2
Central Bedfordshire	–	14	7	43.8	17.6	90.1
Staffordshire	–	8	16	44.4	25.4	72.2
Lancashire	–	5	29	49.2	32.9	70.6
Kent	–	11	61	50.4	38.6	64.8
Warwickshire	–	1	23	51.1	32.4	76.7
Essex	–	15	65	52.4	40.5	66.8
Surrey	–	3	52	52.5	39.2	68.9
Cambridgeshire	–	13	23	53.5	33.9	80.3
Oxfordshire	–	10	15	53.6	30.0	88.4
Buckinghamshire UA	–	7	19	54.3	32.7	84.8
West Northamptonshire	–	12	18	58.1	34.4	91.8
Leicestershire	–	-	14	60.9	33.3	100
Gloucestershire	–	4	22	61.1	38.3	92.5

12. The HIV late diagnosis indicator is based on the proportion of all those diagnosed with HIV who are diagnosed late. For Leicestershire this equates to 23 individuals diagnosed with HIV, of which 14 were diagnosed late. With such small numbers, we expect performance to fluctuate year on year.

Performance metrics - HIV diagnosis

13. The 'new HIV diagnosis' indicator which is measured as a rate per 100,000 is used as a marker for how well local areas are doing in preventing HIV infection and in preventing onward transmission.

14. Leicestershire's rate is significantly better than the national average (6.8/100,000 compared with England's rate of 10.4/100,000) and ranks 5th out of 16 when benchmarked against comparable authorities.

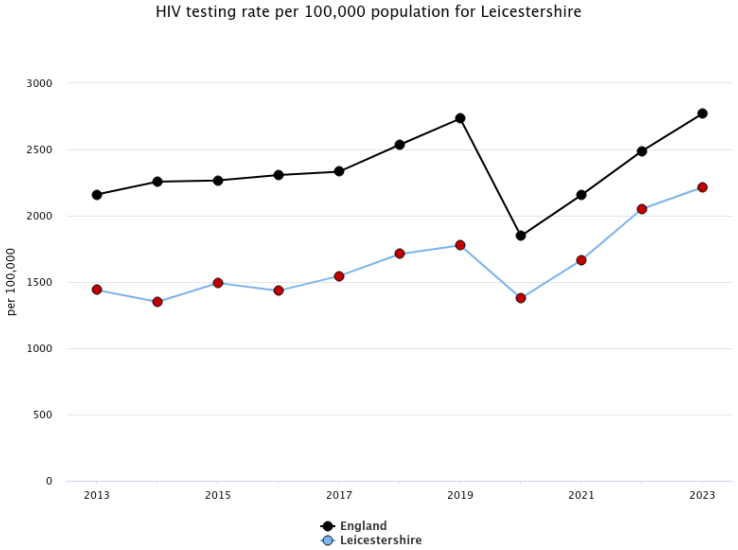
New HIV diagnosis rate per 100,000 2023

Crude rate - per 100,000

Area	Recent Trend	Neighbour Rank	Count	Value	95% Lower CI	95% Upper CI
England	↑	-	6,008	10.4	10.2	10.7
Neighbours average	↑	-	-	-	-	-
Lancashire	→	5	51	4.0	3.0	5.3
Staffordshire	→	8	42	4.7	3.4	6.3
Worcestershire	→	9	34	5.5	3.8	7.7
Warwickshire	→	1	41	6.6	4.8	9.0
Leicestershire	→	-	50	6.8	5.1	9.0
Essex	↑	15	109	7.1	5.8	8.6
Kent	↑	11	117	7.3	6.0	8.7
Central Bedfordshire	→	14	24	7.8	5.0	11.6
Nottinghamshire	↑	2	66	7.8	6.0	9.9
South Gloucestershire	→	6	25	8.3	5.4	12.3
Oxfordshire	→	10	64	8.5	6.6	10.9
Surrey	↑	3	107	8.7	7.1	10.5
Cambridgeshire	→	13	61	8.7	6.7	11.2
Buckinghamshire UA	→	7	50	8.8	6.5	11.6
Gloucestershire	↑	4	75	11.4	8.9	14.3
West Northamptonshire	↑	12	71	16.3	12.8	20.6

Performance metrics - HIV testing

15. While Leicestershire's HIV testing rate (number of tests carried out per 100,000 population) is significantly worse than England (2,214/100,000 vs 2,771/100,000), the rate is improving, and the gap is narrowing.



16. It is also worth noting that Leicestershire's testing rate is significantly better than the average of its comparable authorities, ranking 3rd out of 16.

HIV testing rate per 100,000 population 2023 — Crude rate - per 100,000

Area	Recent Trend	Neighbour Rank	Count	Value	95% Lower CI	95% Upper CI
England	→	-	1,582,243	2,770.7	2,766.4	2,775.0
Neighbours average	→	-	243,367	1,885.7*	1,878.2	1,893.2
Kent	↑	11	39,317	2,467.8	2,443.5	2,492.3
Buckinghamshire UA	↑	7	13,585	2,424.1	2,383.5	2,465.2
Leicestershire	↑	-	15,989	2,214.1	2,179.9	2,248.7
Surrey	→	3	26,479	2,180.2	2,154.0	2,206.6
Essex	↑	15	32,850	2,161.9	2,138.6	2,185.4
Central Bedfordshire	↑	14	6,025	1,998.3	1,948.2	2,049.4
Nottinghamshire	↑	2	15,893	1,903.8	1,874.3	1,933.6
Gloucestershire	↑	4	12,417	1,903.3	1,869.9	1,937.0
Warwickshire	↑	1	11,389	1,874.4	1,840.1	1,909.2
Staffordshire	→	8	15,791	1,781.7	1,754.0	1,809.7
Lancashire	→	5	21,112	1,684.7	1,662.1	1,707.6
Cambridgeshire	→	13	11,091	1,609.5	1,579.7	1,639.7
Oxfordshire	→	10	11,711	1,586.3	1,557.7	1,615.3
Worcestershire	→	9	5,133	842.6	819.7	865.9
West Northamptonshire	→	12	3,176	740.3	714.8	766.5
South Gloucestershire	↓	6	1,409	478.0*	453.4	503.6

The Local Response

17. Late diagnosis is a serious public health concern and although Leicestershire sees low numbers, a Leicester, Leicestershire and Rutland (LLR) HIV action plan has been developed to work towards both reducing the number of late diagnoses made and a continued reduction in HIV diagnosis overall.

18. The aim of the LLR HIV action plan is to replicate the national policy and action plan locally and achieve zero new HIV infections and zero AIDS and HIV-related deaths in Leicester, Leicestershire and Rutland by 2030.

19. Aligned to the national policy, Leicester, Leicestershire and Rutland have 4 key objectives within the plan:

    1. Ensure equitable access and uptake of HIV prevention programme.
        - Focus on prevention campaigns and access to Pre-Exposure Prophylaxis (PrEP) which can help to prevent transmission.
    2. Scale up HIV testing in line with national guidelines.
        - Equitable access to HIV testing, promotion of testing, understanding and breaking down barriers to testing, focus on high risk groups.
    3. Optimise rapid access to treatment and retention in care.
        - Ensure equitable access to treatment and care, retention, barriers to treatment
    4. Improving quality of life for people living with HIV and addressing stigma.
        - Improve information around HIV transmission, U=U (someone living with HIV but with a fully supressed viral load), destigmatisation of living with HIV, operating a peer support service

20. In recognition that Leicester City has distinct differences with regard to HIV both geographically and demographically, a separate delivery plan for Leicestershire and Rutland has been developed. This is aligned to the LLR HIV action plan but contains specific actions and monitoring related to local activities.

21. The expansion of HIV testing, particularly through the implementation of blood-borne virus opt-out testing in emergency departments introduced locally in 2024, is expected to lead to an increase in diagnoses. Over time, this proactive approach should result in a reduction in late HIV diagnoses, ensuring that individuals living with HIV gain timely access to treatment and care.

Areas for further work and development

22. The majority of late HIV diagnosis in Leicestershire are in heterosexual men and heterosexual and bisexual women. This indicates a need for a level of education around testing and prevention within these groups.

23. Pre-Exposure Prophylaxis (PrEP) is used to reduce the risk of getting HIV. There are significant differences in PrEP need and uptake by population group - for example, heterosexual women are much less likely to have their need identified at a clinical consultation at a specialist sexual health service and to start and continue using HIV PrEP than gay, bisexual and other men who have sex with men. An ongoing focus on prevention via the LLR action plan should see an increase in use of barrier methods and/or PrEP to reduce HIV transmission.

24. Work with primary care to increase knowledge of PrEP and HIV testing.

Conclusion

25. Leicestershire's position with regard to HIV must be viewed through a multifaceted lens. The low HIV diagnosis rate reflects effective local efforts in both preventing new infections and reducing onward transmission. In addition, improvements in HIV testing have been made, with acknowledgement that further work is required in this area.

26. Insufficient testing is the primary driver of late HIV diagnosis. A range of societal, systemic, and individual factors contribute to this issue.

27. HIV treatment is very effective, and adherence allows patients to achieve an undetectable viral load. People living with HIV who are on treatment and have a fully supressed viral load have zero risk of transmitting the virus to their sexual partners. Enabling those living with HIV to achieve this is fundamental to ending new transmissions.

Background papers

4 June 2025 HOSC PAPER

Circulation under the Local Issues Alert Procedure

28. None

Equality Implications

29. There are no equality implications arising from the recommendations in this report.

Human Rights Implications

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

Appendices

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healthwatch Leicester and Leicestershire

HEALTH OVERVIEW AND SCRUTINY COMMITTEE:

5th NOVEMBER 2025

REPORT OF HEALTHWATCH LEICESTER AND LEICESTERSHIRE

ANNUAL REPORT AND FORWARD PLAN 2024-25

Purpose of report

1. The purpose of the report is to present the Committee with Healthwatch Leicester and Leicestershire's (HWLL) Annual Report for 2024-25; summarising the activities and impact of HWLL over the past year as a joint Leicester and Leicestershire commissioned Contract. The report also provides a summary of the HWLL Business/forward plan for 2025-26.

Policy Framework and Previous Decision

2. The Health and Social Care Act 2012 introduced statutory duties on local authorities to deliver effective local Healthwatch services.

3. The main statutory functions of HWLL are set out below:
    a. Gather and share the views of members of the public who use health and social care services.
    b. Influence the planning, commissioning, delivery, re-design and scrutiny of health and social care services.
    c. Assess the standard of local health and care provision and make recommendations for improvement based on the views of service users.
    d. Help people access and make choices about health and care services.
    e. Is representative of local people, representing the diversity of the community it serves and different users of services in the way in which it exercises its functions.
    f. Has powers to request information from commissioners and providers of health and social care and to enter health and social care premises, known as "Enter & View" visits.
    g. Has a seat on Leicester City and Leicestershire County Health & Wellbeing Boards (HWBB).
    h. Signposts people to information about local health and care services and how to access them.
    i. Is able to alert Healthwatch England (HWE), or the Care Quality Commission (CQC) where appropriate, to specific care providers, health or social care matters.

j. Has a duty to produce an annual report on their activities and finance and send a copy of their annual reports to NHS England, relevant Clinical Commissioning Groups/Integrated Care Systems (ICS) and HWE, among others specified in previous legislation.

Background

4. The HWLL Contract is held by Leicester City Council and Leicestershire County Council under a formal joint working agreement.

5. A three year contract was awarded to Voluntary Action LeicesterShire (VAL) in April 2023.

6. HWLL promotes improvements in health and social care services improving outcomes for local people in Leicester and Leicestershire by ensuring services are designed around the needs and experiences of local people.

Annual Report and Annual Business Plan

7. The annual report outlines HWLL statutory activities undertaken and the impact on service commissioning and delivery.

8. The report gives examples of the work undertaken with statutory partners and illustrates how HWLL has worked to support the public in accessing information on health and social care services.

9. HWLL Annual Business Plan sets out HWLL focus and strategic direction for 2025-26. The plan outlines the steps HWLL will take over the next 12 months to support delivery of our statutory duties and contract.

10. The full Annual Report 2024-2025 can be found here: Front and Centre: Unlocking the power of people-driven care

11. HWLL Business Plan 2025-26 is reviewed quarterly alongside Key Performance Indicators and Outcome Indicators at pre-arranged contractual meetings with VAL and HWLL Chair and Vice-Chair.

Consultation/ Patient and Public Involvement

12. Key engagement activities in 2024-25 included:

a. 10434 people engaged sharing their experiences of health and social care services over the past year helping to highlight what still needs to improve.
b. 9259 people came to us for advice, information and signposting on local services on a range of topics. This included support with GP appointments, dental care, social care and support for long-term conditions. 464 of those individuals were directly supported through the signposting helpline.

c. 24 reports were published about the improvements people would like to see to health and social care services.
d. 20 Enter and View visits were conducted with recommendations for providers to respond including Care Homes, CAMHS, Gynaecology services, Children's ED Department and GP Practices.
e. 18 #SpeakUp events were hosted to gather topic based public feedback across the City and County, 11 of these were in the County.
f. To better understand rural issues, in addition to ensuring all seven district/ boroughs had presence throughout the year we held targeted events in: Oadby and Wigston, Hinckley and Bosworth, Ashby (NWL), Syston, Sileby, Coalville, Shepshed, Stoney Stanton (Blaby), Measham, Melton and Market Harborough.

Impact

13. To deliver our statutory obligations HWLL maintains links with key stakeholders, including departmental links within the local authorities, Public Health, Adult Social Care and representation at the Leicester, Leicestershire and Rutland Integrated Care Board and attending relevant meetings. Ensuring we contribute to plans and decisions around health and social care services.

14. HWLL Collaborates with other Healthwatch's to ensure the experiences of people in Leicester and Leicestershire influence decisions made about services at the Leicester, Leicestershire and Rutland (LLR) Integrated Care System (ICS) level.

15. Our work with the Adult Emergency Department (ED) last year led to improvements for patients. Building on this success we visited the Children's Emergency Department. The visit shared positive experiences as well as highlighting opportunities to further enhance the experiences for families and children. This feedback has led to a detailed action plan produced by University Hospitals of Leicester NHS Trust (UHL). Improvements already implemented include clearer communication on waiting times via updated screens, better signage, restocking of PPE and water stations and plans for a dedicated private space for sensitive conversations. Broken toys are being repaired, and staff are being supported to enhance the patient experience during busy periods.

16. We know from experience that emergency departments are often used because people cannot access care in the community. We have been working closely with the Integrated Care Board to help shape the new pre-hospital model of care aiming to improve access and reduce pressure on hospitals. Our insights on patient experience and local need have helped to shape a more responsive service proposal.

17. Our visit to the Child and Adolescent Mental Health Service (CAMHS) has enabled HWLL to work in partnership with Leicestershire Partnership NHS

Trust (LPT) on implementing improvements for young people at The Beacon Unit. Including improvements to food provision, staff input and recruitment and better use of facilities. More broadly we are working closely with LPT around access and appropriate communication for families and how to better support men's mental health.

18. To support the improvement of hospital experiences of people with learning disabilities we visited wards within Leicester Royal Infirmary engaging with people with learning disabilities and their carers. In addition to this we conducted targeted outreach through the Voluntary Community and Social Enterprise sector and day services tailoring events to gather information. Recommendations were presented to UHL and have been included in the Learning Disability Action Plan, including staff training, reviewing how care bags are used and supporting carers.

19. We conducted a survey to understand the impact of changes to local bus routes, due to the feedback from some Ibstock and Heather residents struggling to reach essential health services. Over half of respondents reported reduced access to GP and pharmacy care, with older and less mobile people most affected.

Forward Plan 2025-26

20. HWLL priorities for 2025-26 are shaped by extensive public engagement, including online surveys and consultation, targeted outreach and our successful 'Have your Say' conference and Speak Up events. Of the 1738 responses we collated, 67% was from the County.

21. The key three themes identified were:

    a. GP Access: GP appointments remain a number one issue across the County and City. We will work closely with the Integrated Care Board (ICB) to share intelligence and to deliver a GP Access Survey. We will conduct Enter and View visits at practices to identify best practice and areas of improvement and share this with the ICB for quality improvement.
    b. Mental Health: mental health remains a key concern for both adults and young people. We have plans to work with LPT to review referral pathways and Neighbourhood Mental Health Cafes. To identify gaps/ barriers and better understand need.
    c. Adult Social Care: we will listen to people's experiences of care pathways and service quality to understand need and build trust between the public and providers. We will work in partnership with care providers and local authorities to ensure a collaborative approach.

22. All priorities will have a spilt between County and City planned activities to enable a distinction between urban and rural issues.

23. Current planned activities include:

a. Every Woman's Health Matters Survey. This engagement programme will gather real stories and ideas from women, girls and local communities. This work is part of a wider effort to combine data and personal experiences, helping us improve how women experience care.
b. 20 Enter and View visits planned to include care homes and GP practices.
c. 5 follow up visits to assess progress and improvements.
d. 3 Surveys on:
    i. Experiences of Hospital Discharge
    ii. Deaf Community – experience of health and care services
    iii. Stakeholder Survey – targeting stakeholders on our relations and evidence.

Resource Implications

24. We are funded by Leicestershire County Council and Leicester City Council.

25. We employ 7 staff and 29 volunteers.

a. 1 FTE Manager;
b. 1 FTE Information, Advice and Data officer;
c. 1 FTE Enter and View officer (volunteering management);
d. 1 0.6 FTE Media and communications officer;
e. 1 FTE Outreach Officer City;
f. 1 0.7 FTE Outreach Officer County (covers 4 areas);
g. 1 0.63 FTE Outreach Officer County (covers 3 areas);
h. 1443 volunteer hours per year.

Future of Healthwatch

26. The Department of Health and Social Care in England commissioned an independent review of patient safety across health and social care. The review was carried out by Dr Penny Dash and looked at 6 bodies and how they worked within the wider health and care landscape. One of these bodies was Healthwatch. The outcome of the review was published in July 2025 and the report can be found here: Review of patient safety across the health and care landscape - GOV.UK Dr Dash made 9 recommendations.

27. The government announced its response to the Dash review:

a. It accepts all of Dr Dash's recommendations, including proposals for Healthwatch functions related to healthcare to be combined with the

involvement and engagement functions of Integrated Care Boards and for functions related to social care to transfer to local authorities.

b. It will enact primary legislation to make these changes, but in the meantime, local authorities should continue to make contractual arrangements to ensure that an effective Local Healthwatch organisation operates in each local authority area and delivers the activities set out in the legislation.
c. The Government will provide funding for Local Healthwatch services in 2025-26 during the Autumn via the Local Reform and Community Voices grant, and funding for 2026-27 will be confirmed in due course.
d. Department of Health and Social Care will work with us, Ministry of Housing, Communities and Local Government and stakeholders to develop the details and legislation required to deliver the recommendations in the Dash review.

Relevant Impact Assessments

Equality Implications

28. VAL is committed to promoting equality and welcomes diversity in all aspects of its service delivery. We operate in a diverse community and our aim is to harness the talent within the community to help improve our service provision further. We understand that our services have to be delivered in a different way to meet the legitimate needs of different communities.

29. We are committed to preventing and eliminating discrimination, harassment and victimisation of any form, fostering good relations between all our people, advancing equality of opportunity for all and welcoming diversity.

30. We operate an Equality and Diversity Policy in service delivery and employment. VAL aims to provide appropriate service delivery to very diverse communities. VAL aims to recruit a staff and volunteer(s) team that reflects and is understanding of that diversity. This means that services have to be delivered in a different way to meet the legitimate needs of different communities. VAL will ensure it will recruit to each project/post staff with the appropriate understanding and specific skills needed.

31. In pursuit of this diversity VAL will ensure that no job applicant, volunteer, employee, user of services or member is discriminated against directly, indirectly, by association or perception because of disability, gender (including gender reassignment), race, colour, nationality, ethnic or national origin, marital status or civil partnerships, responsibility for dependents, sexuality, pregnancy or maternity, age, trade union activity, political or religious, agnostic or atheist beliefs and (unrelated to the post) criminal convictions.

32. We will not tolerate any form of harassment or victimisation.

Human Rights Implications

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

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Agenda Item 12

Leicestershire County Council

HEALTH OVERVIEW AND SCRUTINY COMMITTEE: 5 NOVEMBER 2025

REPORT OF THE CHIEF EXECUTIVE AND ICS PERFORMANCE SERVICE

HEALTH PERFORMANCE UPDATE

Purpose of Report

1. The purpose of the report is to provide the Committee with an update on public health and health system performance in Leicestershire and Rutland based on the available data in October 2025.

2. The report contains the latest available data for Leicestershire and Rutland and LLR on a number of key performance metrics (as available in October 2025) and provides the Committee with local actions in place.

Background

3. The Committee has, as of recent years, received a joint report on health performance from the County Council's Chief Executive's Department and the ICS Commissioning Support Unit Performance Service. The report aims to provide an overview of performance issues on which the Committee might wish to seek further reports and information, inform discussions and check against other reports coming forward.

Future Changes to Performance Reporting Framework

4. In March 2025 NHS England (NHSE) published its new NHS Performance Assessment Framework for 2025/26 setting out a revised approach to assessing how success and areas for health performance improvement will be identified and how organisations will be rated. The new framework replaces the NHS System Oversight Framework 2021/22. NHSE are testing new ICS operational plan submissions against the new framework. The framework data was published on 26 June 2025 in an interactive web-based public accountability tool.

5. The approach is based on assessing performance metrics across four domains of an integrated care system for ICBs and acute care, mental health, community and ambulance providers. The extensive set of metrics cover a wide range of areas including national operating objectives in the NHS planning guidance, finance and productivity metrics, public health and patient outcome metrics, quality and inequalities metrics, and priority system metrics.

6. A number of national and local priorities have been set for the health system for 2025/26 including: -

- Improving referral to treatment to 65% nationally by March 2026, with every trust expected to deliver a minimum 5% improvement. Improving performance against the cancer 62-day and 28-day Faster Diagnosis Standard to 75% and 80% respectively by March 2026.
- Improving Accident and Emergency waiting times with a minimum of 78% of patients seen within 4 hours in March 2026. Category 2 ambulance response times should average no more than 30 minutes across 2025/26.
- Improving patients access to general practice, improving patient experience, and improving access to urgent dental care, providing 700,000 additional dental appointments.
- Improving patient flow through mental health crisis and acute pathways, reducing average length of stay in adult acute beds, and improving access to children and young people's mental health services, to achieve the national ambition for 345,000 additional children and young people aged 0 to 25 compared to 2019.

7. Delivery of the national priorities will aim to be achieved by focusing on -
    - Reducing demand through developing Neighbourhood Service models;
    - Making full use of Digital Tools;
    - Addressing inequalities and shifting towards secondary prevention;
    - Living within budget, reducing waste and improving productivity; Providers will need to reduce their cost base by at least 1% and achieve 4% overall improvement in productivity.
    - Maintaining focus on the overall quality and safety of services.

8. The following 3 areas form the main basis of current reporting to this Committee, and they will continue to be revised as the new performance assessment approach takes shape:

    a. ICB/ICS NHS System Priorities Performance Report – Appendix 1
    b. Leicestershire Public Health Strategy outcome metrics and performance – Appendix 2.
    c. Performance against metrics/targets set out in the Better Care Fund plan.

9. Performance reporting is also a key element of the LLR ICB Collaboratives, and many of these groups have Quality and Performance subgroups, which receive performance reports throughout the year.

NHS System Oversight Framework

10. The new NHS Oversight Framework 2025/26 describes a consistent and transparent approach to assessing integrated care boards (ICBs) and NHS trusts and foundation trusts, ensuring public accountability for performance and providing a foundation for how NHS England works with systems and providers to support improvement. This is a 1-year framework and has been developed with the engagement and contributions from the NHS leadership and staff, representative bodies and think tanks, including through two public consultations.

11. NHSE will report ICB performance against the full suite of oversight metrics, but will not issue a comparative rating. ICBs will still be assessed through a statutory annual assessment, which reviews how well each ICB is performing its statutory duties. NHSE will introduce the segmentation approach for ICBs in 2026/27.

Summary of ICB/ICS Performance

12. The performance report attached as Appendix 1 aims to provide a high-level overview of the Leicester, Leicestershire and Rutland (LLR) achievement of the 2025/26 National NHS System Priorities. Slides 5-7 set out NHS priorities for 2025/26 together with planned/targeted performance, actual performance and supporting rag ratings for 26 areas. Of those currently reported, 8 are green/achieving, 4 amber/within 5% and 8 red/under. A range of supporting slides set out further detail on progress/performance in service areas.

13. Red areas include - reducing the % of people waiting over 52 weeks for treatment to less than 0.9% of the total waiting list; improving category 2 ambulance response times to an average of 30 minutes across 2025/26; the number of people on waiting lists for CYP services who are waiting over 52 weeks; reducing average length of stay in adult acute mental health beds; reducing reliance on mental health inpatient care for people with a learning disability and people with autism; reducing reliance on mental health inpatient care for adults with autism; delivery of planned system financial deficit; increasing patients aged 18 and over with GP recorded hypertension below the treatment threshold.

14. A summary of some of the recent performance progress includes: -

Elective Care

- The UHL long waiter position 65+ weeks is monitored daily by the Deputy COO for elective care (UHL).
- Utilising super-clinics to increase outpatient capacity.
- Advice and guidance funding allocated with an additional c.20,000 requests expected.
- Continued roll-out and focus on Patient Initiated Follow Ups to increase capacity for new patients.
- Validating patients who have been waiting over 12 weeks.
- Assessment of demand for elective treatment by specialty.
- Elective Care Referral To Treatment (RTT) training incorporated as pre-requisite for UHL's new patient administration system.
- Theatre productivity and outpatient transformation workstreams to improve productivity and increase capacity.
- Hinckley Community Diagnostic Centre opened – expect up to 70,000 tests this year supporting faster time to reach a treatment decision.
- Working closely with University Hospitals of Northampton and the Northants Integrated Care Board (ICB) to review benefits to working together to improve waits.

Cancer

- Clinical prioritisation of patients and review of next steps for >104-day patients.
- Additional weekly Patient Tracking List for challenged tumour sites in place.
- Recovery and Performance (RAP) meetings in place.
- East Midlands Cancer Alliance funding fully utilised.
- Additional Tier 1 funding being used to support challenged tumour sites.
- Oncology regional review of mutual aid and workforce opportunities (East Midlands Acute Providers) with East Midlands Cancer Alliance supporting.
- Working with University Hospitals of Northampton (UHN) to support Oncology fragile services.
- Pre-diagnosis nursing team supporting patient engagement.
- Radiotherapy 5th Linac operational, on track to clear backlog by January 2026.
- Radiotherapy mutual aid being provided from UHN, Nottingham University Hospitals (NUH) and University Hospitals of Coventry and Warwickshire (UHCW).
- Changes to prostate fractions in place (methods and schedules used to deliver radiation therapy).
- Implementation of paperless processes planned to support further capacity release in radiotherapy and review of scheduling to maximise capacity.
- Services working to increase cancer 1st appointment capacity for Head and Neck (H&N), Breast and Skin to support.
- H&N reviewing referral criteria and pathway improvement opportunities.

Urgent and Emergency Care

- Fortnightly meetings with NHSE Midlands to share best practice whilst UHL has been moved into Tier 2 monitoring owing to;

  - ED 4hr performance.
  - ED 12hr performance.
  - Ambulance handover delays >45 mins.
- Work continues to improve ambulance conveyances directly to SDECs and avoiding the Emergency Department where clinically appropriate.
- Continuing with the establishment of NHS Pathways Directory of Service headline profiles for all UHL Same Day Emergency Care (SDEC) services to maximise patient navigation directly to those services and reduce ED pressure.
- Establishment of Ambulance Handover Working group to improve all handovers with the aim of reducing average handover time (which will impact on ambulance release and therefore Cat 2 time).
- Community beds audit in progress to also support the identification of appropriate beds for 'step up' from community referrals.
- UHL SDECs directory of care pathways in development to support digital access to information in primary care / community care.

Community Services

- Attention deficit hyperactivity disorder (ADHD) nurses see stable cases, releasing consultant capacity for new referrals. 1200 children remain on consultant caseload with c1900 transferred to Nurse Medical Prescriber.
- Advanced Nurse Practitioner (ANP) to support nursing capacity and oversight – 2 clinics set up with an additional 240 children allocated to ANP.
- Resources identified to support timely and appropriate response to complaints and concerns.
- ADHD nurse input to diagnostic pathway pilot maximises consultant capacity and will increase capacity to assess and diagnose ADHD, moving to a majority being undertaken by specialist nurses. Advanced Nurse Practitioner will facilitate roll out, with project management support. Remaining actions include specific demand and capacity work to maximise nurse caseload and development of a training and supervision structure.
- ADHD Annual Review Primary Care pilot increases follow up slots, exploring roll out options.
- Funding of one external educational psychology provider sustained for 2025/26 academic year to support continued capacity. Options for increased capacity under consideration (within existing resources)
- Clinical leaders review long waits for core service to pro-actively manage and deliver zero 52+ week waits.
- Patient tracking supports robust oversight at service, directorate and Trust level.
- Robust Did Not Attend/Was Not Brought measures minimise lost capacity.
- Health Innovation East Midlands applications to further enhance digital waiting well offer. Outcome awaited.

- Working with ICB to support alternative options for Voluntary, Community and Social Enterprise (VCSE) support following closure of ADHD Solutions.
- Robust waiting list management processes give early warning of changes to referral patterns which may risk lengthening waits.

Mental Health

- Now a standing agenda item on NHSE monthly assurance meeting.
- Improving Access to Children & Young People's (CYP) Mental Health and bringing services closer to the Children & Young People in neighbourhoods.
- Triage and Navigation - Run by Derbyshire Health United (DHU). Online Self-referral for C&YP and their parents and/or carers to improve access to MH services for C&YP.
- Eating Disorders - First Steps ED is an online service for eating disorders. They work closely with Child and Adolescent Mental Health Services (CAMHS) providing support for those discharged by CAMHS.
- Monthly meetings with providers to progress work on the CYP Waiting Time Metric.

Learning Disability and/or Autism

- An Options Appraisal has been developed by the LDA Collaborative in response to the increasing number of autistic adults being admitted; this was presented to the Collaborative Board meeting with positive assurance on the options presented. Progress being monitored through LDA Collaborative Board.
- A ‘Time to Think’ session held with Directorate Mental Health (DMH) colleagues in July 25 – LDA Collaborative supporting development of DMH plans. National NHSE funding provided for development of peer advocacy support.
- A Group Risk Summit is being arranged focusing on Autistic Adults in Escalation.
- Working Group to be established to develop a clinical model across both LDA and MH directorates in Leicester Partnership Trust (LPT) – initial work ongoing to review existing service specifications to ensure all available options are utilised.
- CYP requiring admissions to inpatient beds are continuing to be supported by the CAMHS Intensive Community Support Team (ICST), therefore reducing the length of stay of individuals.
- Number of CYP inpatients continues to remain at one – LLR met inpatient CYP trajectory from June 2024 onwards.
- Project meetings established to ensure young people at risk of admission are continuing to receive support from Keyworkers. Dynamic Support Pathway (DSP) Referral criteria and supporting processes are under review. The first DSP Project Group meeting took place in August 2025, where the project plan was shared and formally agreed. The DSP Hub team is now piloting the use of a clinical prioritisation tool developed by Cheshire and Wirral.

Use of Resources/Finance

- The ICB is forecasted to exceed its running cost allocation due to under delivery against the corporate staff costs target.
- Staff 'Bank' spend is above the system cap YTD and forecast to continue to be at year end, however this was planned at the start of the year.

Maternity

- As a level 3 neonatal intensive care unit (NICU) we accept very sick babies across the region. We are keen to understand what additional factors other than medical complexities may be contributing to this. In response several steps are in place including working with other hospital trusts and Public Health colleagues both regional and local to build a deeper understanding of our population health needs and demographics to support us improve outcomes for mothers and babies.
- Our local picture mirrors the national data. We are doing work with our maternity services and public health colleagues around access to care and understanding demographic issues.
- Service hoping to have recruited into all vacancies by the end of this calendar year including a pipeline to cover expected attrition rates with the midwives who are due to complete their course later this year.
- Continued working with the universities and to implement the Safer Learning Environmental Charter (SLEC) principles to improve retention.

Hypertension and Lipids (fats)

- Place-based targeted work to support practices below target to identify patients and optimise their treatment, linked to neighbourhood plans.
- Understanding gaps and ensuring a more targeted approach to address this, by focusing more effort on those 18 to 79 years old.
- Hypertension Task and Finish group at their last meeting considered a focus on effective approaches for different population groups, combined with practice-based interventions and community engagement.
- Gaps in detection highlighted via the PCN Direct Enhanced Services assurance group.
- Community pharmacy data being used to identify where opportunistic measures are not being taken.
- Monthly review of practice delivery against trajectory and placed based performance shared with relevant place-based leads for information and action to support practices below target to identify patients and optimise their treatment, linked to neighbourhood plans.
- Review of the LLR lipid pathway to make accessible to more practice staff.
- Communications plan to support medication adherence, linked to national campaigns.

- Use of business intelligence to understand gaps and ensure a more targeted approach.

Public Health Outcomes Performance – Appendix 2

15. Appendix 2 sets out current performance against a range of outcomes set in the performance framework for public health. The Framework contains 36 indicators related to public health priorities and delivery. The dashboard sets out, in relation to each indicator, the statistical significance compared to the overall England position or relevant service benchmark where appropriate. A rag rating of 'green' shows those that Leicestershire is performing better than the England value or benchmark and 'red' worse than the England value or benchmark.

16. Analysis shows that of the comparable indicators, 13 are green, 18 amber and 2 red. There are 3 indicators that are not suitable for comparison or have no national data.

17. Of the thirteen green indicators: cancer screening coverage-bowel cancer, has shown significant improvement over the last five years. Cervical cancer screening coverage (25-49 years old) and cervical cancer screening coverage (50-64 years old) have both shown a significant declining (worsening) performance over the last five years, whilst new STI diagnoses (excluding chlamydia aged 24 years and under) has shown a significant increasing (worsening) performance.

18. Of the eighteen indicators that are amber: smoking status at time of delivery has shown significant improvement over the last 5 time periods. Successful completion of drug treatment: non opiate users and admission episodes for alcohol-related conditions have both shown a significant worsening performance over the last five years.

19. Of the two red indicators: HIV late diagnosis in 2022-24, Leicestershire ranked 15th out of 16 when compared to its nearest statistical neighbours. For the cumulative percentage of the eligible population aged 40 to 74 offered an NHS Health Check who received an NHS Health Check in 2020/21-2024/25, Leicestershire ranked 11th out of 16. Further work is underway to progress improvement across the range of indicator areas. Further consideration will be given to actions to tackle these areas as part of the Health and Wellbeing Strategy implementation and the public health service plan development process.

20. Inequality in life expectancy at birth for males in Leicestershire falls within the best quintile of the country, whilst females fall within the 2nd best quintile.

Leicestershire and Rutland have combined values for the following two indicators - successful completion of drug treatment (opiate users) and successful completion of drug treatment (non-opiate users).

Better Care Fund and Adult Care Health/Integration Performance

21. Nationally, the Better Care Fund (BCF) plan guidance for 2025/26 was published by NHS England (NHSE) in January 2025. Full Health and Wellbeing Board BCF Submissions were made by end of March 2025, with outcome letters in May 2025.

22. The BCF performance framework for 2025/26 is set out in the table below: -

Emergency Admissions	
Indicator	Emergency admissions to hospital for people aged 65+ per 100,000 pop.
Supporting Metric	Unplanned hospital admissions for chronic ambulatory care sensitive conditions per 100,000 pop.
Supporting Metric	Emergency hospital admissions due to falls in people aged 65 and over directly age standardised rate per 100,000.
Discharge Delays	
Indicator	Average length of discharge delay for all acute adult patients
Indicator	Proportion of adult patients discharged from acute hospitals on their discharge ready date
Indicator	For those adult patients discharged on Discharge Ready Date (DRD), average number of days DRD to discharge
Supporting Metric	Patients not discharged on their DRD, and discharged within 1 day, 2-3 days, 4-6 days, 7-13 days, 14-20 days and 21 days or more.
Supporting Metric	Local data on average length of delay by discharge pathway.
Residential Admissions	
Indicator	Long-term support needs of older people (age 65 and over) met by admissions to residential and nursing care homes, per 100,000 population.
Supporting Metric	Percentage of people, resident in the HWB, who are discharged from acute hospital to their normal place of residence.

Supporting Metric	The proportion of people who received reablement during the year, where no further request was made for ongoing support.

23. The table below shows the latest BCF metrics for the 2025/26 financial year, the targets and outturns for Q1 where available:

Metric	Target Q1	Actual Q4 (24/25)	Commentary
Indirectly standardised rate (ISR) of emergency hospital admissions per 100,000 population	1599	11691	The monthly targets for January and February 2026 have been amended slightly against the agreed plan based on the 2025 actuals. Actual data for Q1 has not been published however Q4 was on target (variance of 0.057)
Average length of discharge delay for all acute adult patients, derived from a combination of: proportion of adult patients discharged from acute hospitals on their discharge ready date (DRD) for those adult patients not discharged on DRD, average number of days from DRD to discharge.	 85.4% 3 days	 84.9% 4.4 days	The target has not been revised and remains the same as published for this metric. As at Q4 for 24/25 we were performing 0.5% off target against the projected Q1 performance. And we were taking 1.4 days longer to discharge delayed patients than the projection for Q1.
Long-term support needs of older people (age 65 and over) met by admission to residential and nursing care homes, per 100,000 population	217	208	The plan for 2025/26 is to reduce admissions to 867 across the full year; down from 925 the previous year. This equates to around 217 admissions per quarter and therefore the figure of 208 in Q1 is on target.

List of Appendices

Appendix 1 – LLR NHS System Priorities Performance Report
Appendix 2 – Public Health Outcomes – Key Metrics

Background papers

University Hospitals Leicester Trust Board meetings can be found at the following link:
http://www.leicestershospitals.nhs.uk/aboutus/our-structure-and-people/board-of-directors/board-meeting-dates/

LLR Integrated Care Board meetings can be found at the link below
https://leicesterleicestershireandrutland.icb.nhs.uk/about/board-meetings/

NHS Performance Assessment Framework for 2025/26.

Officers to Contact

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APPENDIX 1

Leicester, Leicestershire and Rutland

Working in partnership with
Northamptonshire Integrated Care Board

NHS Priorities Performance Report 25/26 September 2025

Prepared by:
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A proud partner in the:

Leicester, Leicestershire and Rutland
Health and Wellbeing Partnership

Executive Summary

Elective Care	RTT waiting list % less than 18 weeks	Waiters over 52 weeks	Waiters over 65 weeks	Confidence levels year end achievement	Assurance
June 25	57.6% against of 57.8% plan (amber). The total number of incomplete RTT pathways at the end of the month achieved in June with 122,699 patients waiting against a target of 127,387.	2.4% against 1.4%, therefore not achieving target.	141 in June compared to May 136 patients.	**GREEN**	Specialities with high discharge rates at 1st outpatient appointment are helping to reduce follow-up demand, though some areas continue to face long waits. Conversation rate to admitted care are being closely monitored to ensure patients are accommodated appropriately and elective pathways remain efficient. Independent sector (IS) capacity is being utilised to support specialities and maintain patient flow. Oversight arrangements are in place with weekly tracking of key metrics to monitor progress and bi-weekly Tier 2 calls.

Cancer	62-day cancer	28-Day Faster Diagnosis Standard (FDS)	Confidence levels year end achievement	Assurance
June 25	61.3% against 60.2% plan, achieving target.	77.5% against 77% plan, achieving target.	FDS – **GREEN** 62 day - **RED**	**FDS –** Pathways are in place, with additional clinics running. However, bookings are extending beyond 4 weeks. Two locums have been appointed; one for skin and one for head and neck. **62 day –** Cancer performance remains a priority, with continued focus on the 62-day standard. Pathway reviews are driving improvement, including gynaecology mapping, and targeted enhancements in the breast pathway through MDT vetting, double reporting, and shared learning. Peer comparison across head, neck, and breast tumour sites will further support benchmarking. **31 day –**Mutual aid contracts are in place with UHCW and NGH, with additional support being provided by NUH to help manage the 31-day cancer waits. Improvements have been made for SACT patient scheduling, with further from enhancements planned later in the year. Surgical to Focus on Breast and Colorectal pathways, with encouraging improvement already seen in the breast pathway in June's data.

Executive Summary

Urgent Care	A&E four hour waits	CAT 2 EMAS ambulance response time	Percentage of patients waiting in ED over 12 hours (All Types)	Confidence levels year end achievement	Assurance
July 25	79.3% against plan of 76%, achieving target.	32.34 minutes against a plan of 30 mins, an improvement in performance from last month.	as per operational plan 9% against 11% plan, showing an achievement against plan.	ED 4hr - **AMBER** System 4hr – **GREEN** Ambulance handovers <45 mins – **AMBER** Ambulance C2 Mean <30 mins - **AMBER**	• ED 4 hour performance – Achievement of delivery of 4 hour performance as system for Q1 of 25/26. Continue with re-direction plans to support directing appropriate activity away from ED front door. • Improvement of Ambulance Handover delays <45mins – establishment of ambulance handover working group to improve all handovers with aim of reducing average handover time. • Improve CAT 2 Mean response – work continues to improve ambulance conveyance directly to SDEC to avoid ED where clinically appropriate. • UHL in tier 2 monitoring with NHSE – fortnightly meetings now in place with NHSE.

Community Services	Waiting lists for CYP services	Confidence levels year end achievement	Assurance
June 25	Over 52 weeks 5,858 against 5,835 over plan.	**RED**	We continue to work towards achieving the planned position however the continuing high levels of referrals for community paediatrics, especially for children presenting with neurodevelopmental disorders, does place this at risk.

Executive Summary

Mental Health	Children and Young people (CYP) access	NHS talking therapies- Completing a Course of Treatment	Reduce Average length of stay (LOS)	Confidence levels year end achievement	Assurance
June 25 July 25	July, 18,815 against 17,745 plan, achieving target.	June- 865 against 826 plan, achieving target. Regionally have seen -5% in the numbers completing treatment, locally we are at +5.5%.	June – 65 against 55.9	**Reduce LoS - AMBER** **CYP Access & Talking Therapies - GREEN**	LIMBIC care now in place. Limbic Care is an innovative app offering round-the-clock access to a chat-based feature that delivers tailored psychoeducation and self-help materials. It's designed to complement therapy sessions by helping people better understand their mental health difficulties, access resources in their own time and complete therapeutic exercises between appointments. We are co-developing a talking therapies offer for neurodiverse individuals.

Learning Disability	Reduce reliance on inpatient care for adults-	Confidence levels year end achievement	Assurance
August 25	Number of adult inpatients exceed Quarter 2 plan.	**AMBER:** Reduced reliance on mental health inpatient care for people with a learning disability and people with a learning disability and autism **AMBER:** Reduced reliance on mental health inpatient care for adult with autism **GREEN:** Reduced reliance on mental health inpatient care for children with a learning disability and/or autism.	CYP requiring admissions to inpatient beds are continuing to be supported by the Children adolescent mental health services (CAMHS) Intensive Community Support Team (ICST), therefore reducing the length of stay of individuals. Leicester Leicestershire and Rutland (LLR) met inpatient CYP trajectory from June 2024 onwards. We have seen a reduction in the number of mental health inpatients with a learning disability and/or autism. The amber position recognises the need to prevent any further admissions.

Maternity Services	National safety ambition to reduce stillbirth	Confidence levels year end achievement	Assurance
May 25	Numbers are very small; however, this is being monitored closely	**AMBER**	LLR infant/ perinatal mortality working group set up working in partnership with ICB/Public Health/UHL to help address our perinatal mortality rates. Any intervention/workstreams in place will take time to translate and will continue to require a system response.

Performance Priorities Summary

Area	NHS PRIORITIES 2025/26	Month	Plan	Actual	RAG
Reduce the time people wait for elective care	Improve the percentage of patients waiting no longer than 18 weeks for treatment by March 2026 (Every trust expected to deliver a minimum 5%-point improvement) (Trajectories set as part of Ops Plan 25/26)	Jul-25	57.3%	55.1%	
	Improve the percentage of patients waiting no longer than 18 weeks for a first appointment by March 2026. (Trajectories set as part of Ops Plan 25/26)	Jul-25	63.7%	66.2%	
	Reduce the proportion of people waiting over 52 weeks for treatment to less than 0.9% of the total waiting list by March 2026	Jul-25	1.3%	2.7%	
	Improve performance against the headline 62-day cancer standard to 70.3% by March 2026	Jun-25	61.3%	60.2%	
	Improve performance against the 28-day Faster Diagnosis Standard to 80% by March 2026 (ICS)	Jun-25	78%	75.9%	
Improve A&E waiting times and ambulance response times	Improve A&E waiting times of patients seen within 4 hours in Mar 26 (All Types System Wide, Trajectories set as part of Ops Plan 25/26)	Jul-25	76.0%	79.3%	
	Percentage of patients waiting in ED over 12 hours (All Types) As per operational plan	Jul-25	11%	9%	
	Improve Category 2 ambulance response times to an average of 30 minutes across 2025/26	Jul-25	00:30:00	00:32:34	
Community Services	Number of people on waiting lists for CYP services who are waiting over 52 weeks	Jun-25	5835	5858	
	Number of people on waiting lists for adult services who are waiting over 52 weeks	Jun-25	0	0	

	Under achieved target
	5% Threshold
	Achieved target
*	Supressed numbers <5

Performance Priorities Summary

Area	NHS PRIORITIES 2025/26	Month	Plan	Actual	RAG
Improve mental health and learning disability care	Reduce average length of stay in adult acute mental health beds	Jun-25	55.9	65	
	Increase the number of CYP accessing services (Trajectories set as part of Ops Plan 25/26)	Jul-25	17,745	18,815	
	NHS talking therapies- Completing a Course of Treatment (having had at least two treatment sessions)	Jun-25	826	865	
Improve mental health and learning disability care	Reduce reliance on mental health inpatient care for people with a learning disability and people with autism	Aug 25 Q2 Plan	10	11	
	Reduce reliance on mental health inpatient care for adults with autism	Aug 25 Q2 Plan	14	15	
	Reduce reliance on mental health inpatient care for children with a LDA	Aug 25 Q2 Plan	3	*	
Live within the budget allocated, reducing waste and improving productivity	2025/26- System Delivery of planned deficit (gross of deficit support funding)	M4	(41.91)	(45.99)	
	Close the activity/WTE gap against pre-Covid levels (adjusted for case mix)	TBC			

Performance Priorities Summary

Area	NHS PRIORITIES 2025/26	Month	Plan	Actual	RAG
Maintain our collective focus on the overall quality and safety of our services	Continue to implement the Three-year delivery plan for maternity and neonatal services:				
	National safety ambition to reduce stillbirth	May-25	Reduction 2023 4	4	
	Neonatal mortality (per 1,000 births)	2023	Reduce 2021 2.4	2.8	
	Maternal mortality	2023/24	Reduce 21/22 *	0	
Address inequalities and shift towards prevention	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	Q4 24/25	67.1%		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	Q4 24/25	82.2%		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-appropriate treatment threshold	Q4 24/25	80.0%	70.1%	
	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%	Q4 24/25	60.0%	66.1%	

Elective Care

NHS PRIORITIES 2025/26	Month	Plan	Actual	RAG
Improve the percentage of patients waiting no longer than 18 weeks for treatment by March 2026 (Every trust expected to deliver a minimum 5% point improvement) (Trajectories set as part of Ops Plan 25/26)	Jul-25	57.3%	55.1%	
Improve the percentage of patients waiting no longer than 18 weeks for a first appointment by March 2026. (Trajectories set as part of Ops Plan 25/26)	Jul-25	63.7%	66.2%	
Reduce the proportion of people waiting over 52 weeks for treatment to less than 0.9% of the total waiting list by March 2026	Jul-25	1.3%	2.7%	

Metric	Risk	Mitigation
Improve the percentage of patients waiting no longer than 18 weeks for treatment by March 2026. Improve the percentage of patients waiting no longer than 18 weeks for a first appointment by March 2026. Reduce the proportion of people waiting over 52 weeks for treatment to less than 0.9% of the total waiting list by March 2026.	• Operational pressures due to the emergency demand impacting upon elective activity. • Pediatrics remains challenged. • Recovery of cancer position and urgent priority patients requiring treatment. • Workforce challenges across a range of posts, particularly administration for booking waiting list teams. • Rollout of new PAS has reduced activity and will impact on productivity in the short term and the total size of the waiting list in the longer term this year.	• The UHL long waiter position 65+ weeks is monitored daily by the Deputy COO for elective care (UHL). • Utilizing super-clinics to increase outpatient capacity. • Advice and guidance funding allocated with an additional c.20,000 requests expected. • Continued roll-out and focus on Patient Initiated Follow Ups to increase capacity for new patients. • Validating patients who have been waiting over 12 weeks. • Assessment of demand for elective treatment by specialty. • Elective Care RTT training incorporated as pre-requisite for UHL's new patient administration system. • Theatre productivity and outpatient transformation workstreams to improve productivity and increase capacity. • Hinckley Community Diagnostic Centre is open – expect up to 70,000 tests this year supporting faster time to reach a treatment decision. • Working closely with University Hospitals of Northampton and the Northants ICB to review benefits to working together to improve waits.

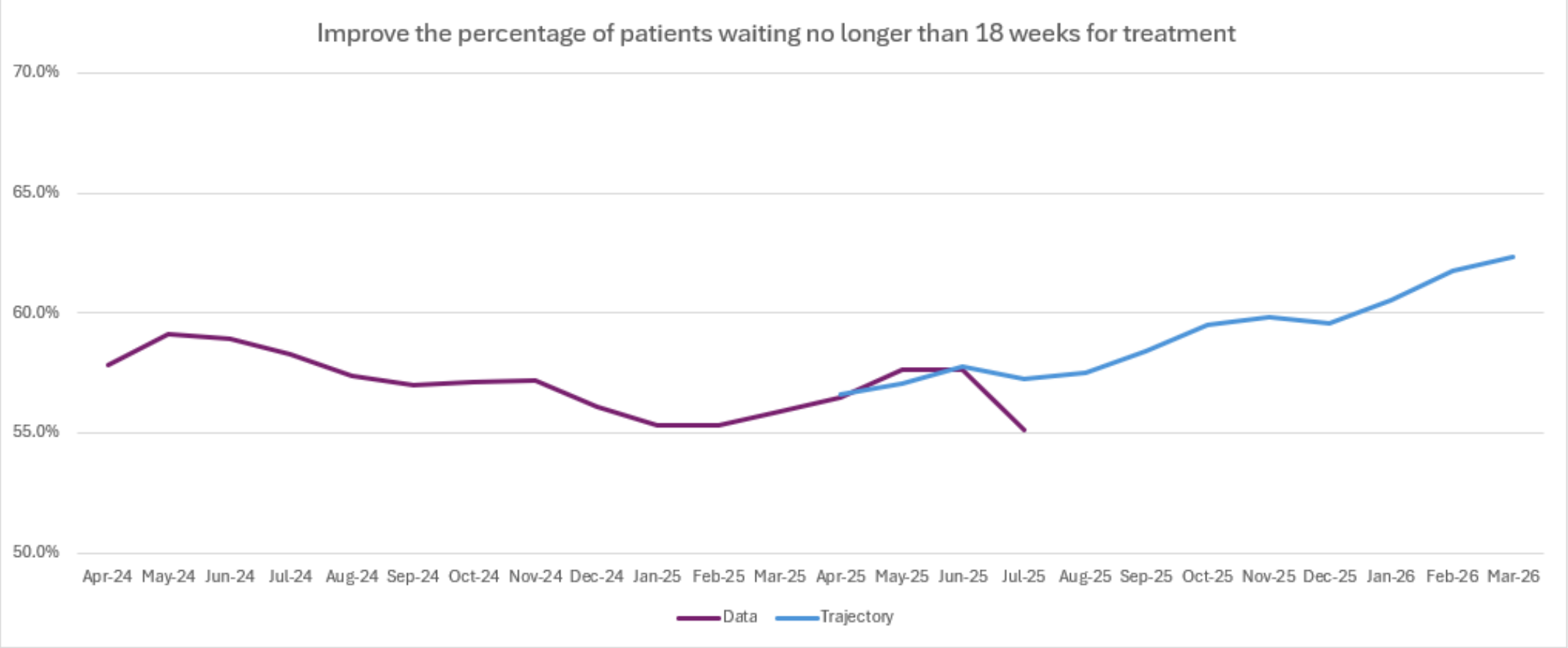
Good news: N/A

Patient Outcome: The time to wait for treatment or a decision that no treatment is required continues to reduce.

Link to summary table

Elective Care

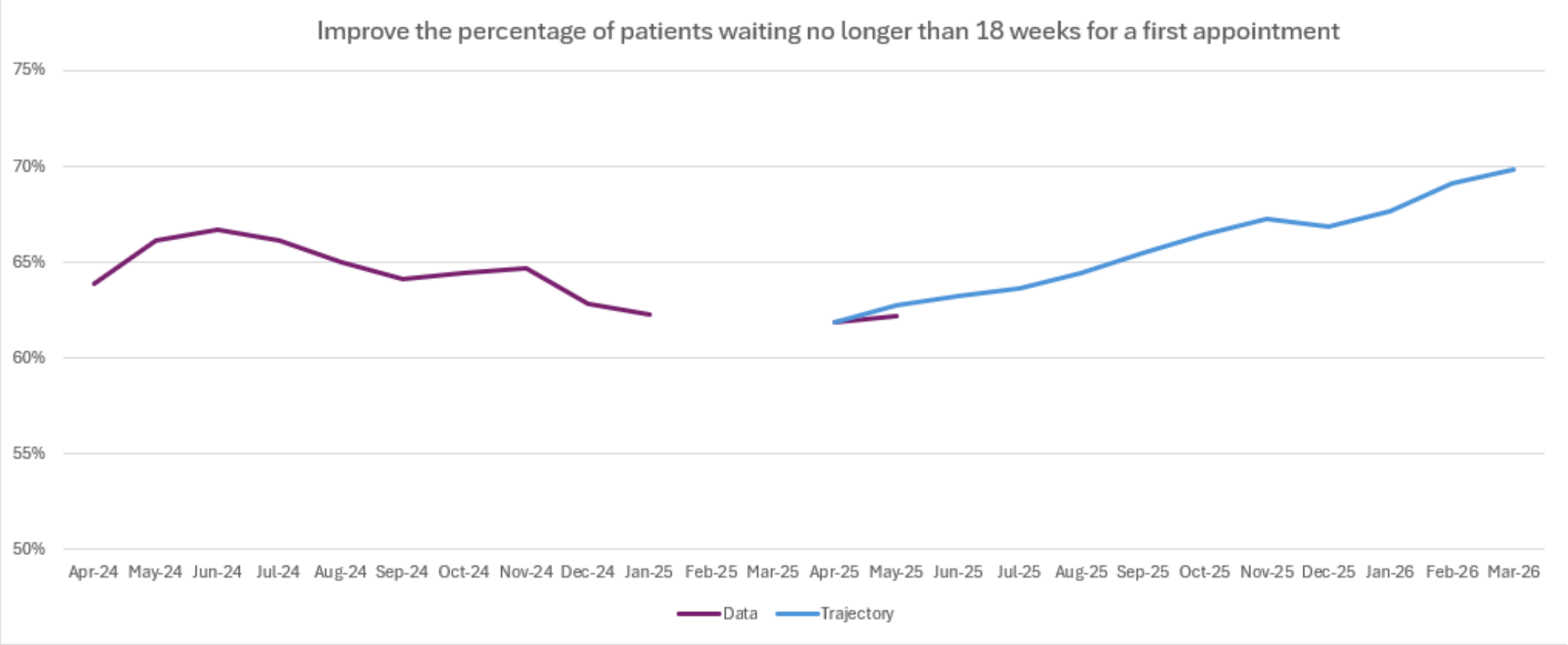
Measure	Month	Value	25/26 Ops Plan Target	Desired Direction
Percentage of patients waiting no longer than 18 weeks for treatment	Jul-25	55.1%	57.3%	Higher is better



Link to summary table

Elective Care

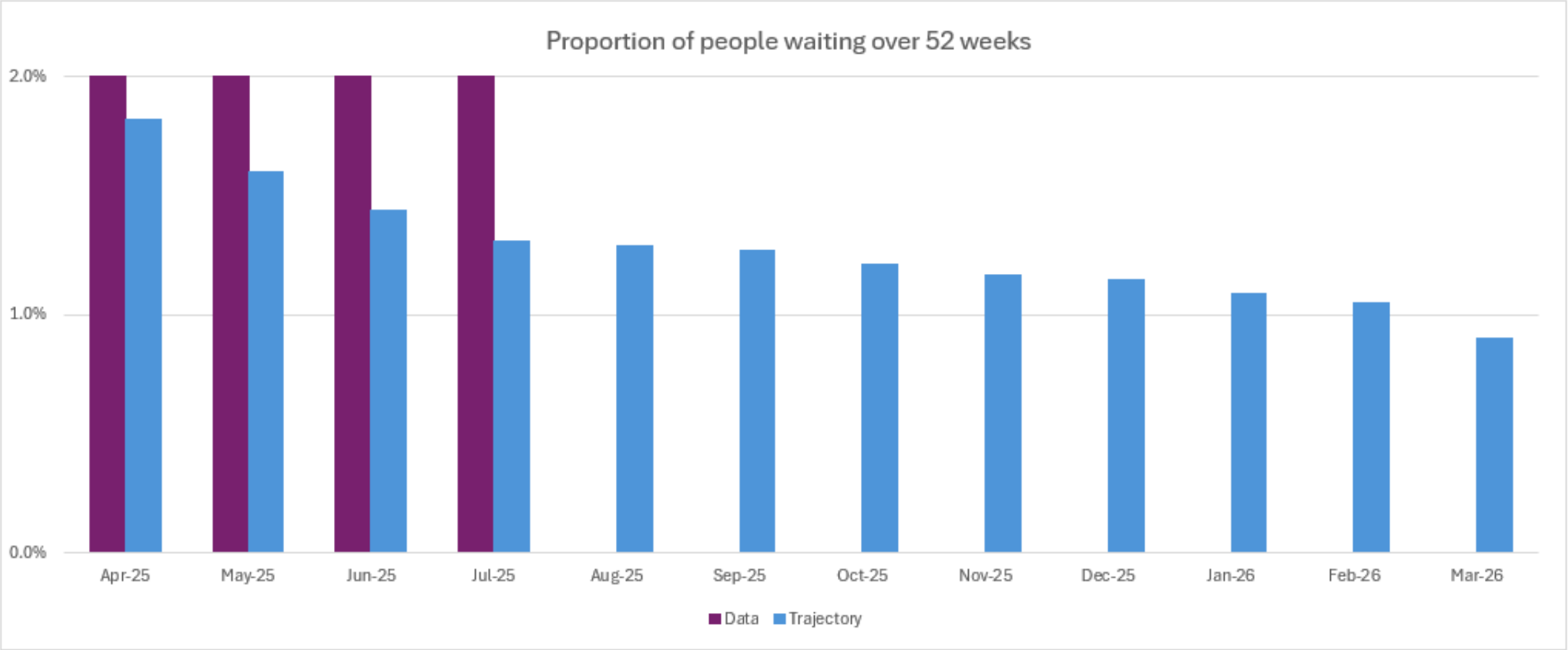
Measure	Month	Value	25/26 Ops Plan Target	Desired Direction
Improve the percentage of patients waiting no longer than 18 weeks for a first appointment	Jul-25	66%	64%	Higher is better



Link to summary table

Elective Care

Measure	Month	Value	25/26 Ops Plan Target	Desired Direction
Reduce 52 week waits	Jul-25	2.7%	1.3%	Lower is better



Link to summary table

Cancer

NHS PRIORITIES 2025/26	Month	Plan	Actual	RAG
Improve performance against the headline 62-day cancer standard to 70.3% by March 2026	Jun-25	61.3%	60.2%	
Improve performance against the 28 day Faster Diagnosis Standard to 80% by March 2026 (ICS)	Jun-25	78%	75.9%	

Metric	Risk	Mitigation
Reduce the number of patients waiting over 62 days (70.3% by Mar 2026) Improve cancer faster diagnosis standard by March 2024 to 80% by March 2026	• Capacity constraints across various points of the pathways including workforce challenges. • Focus on treating patients in order of clinical priority and longest waits impact performance. • Increase in diagnostic tests required and patient factors impacting. • Oncology OPD capacity. • Radiotherapy capacity. • 1st appointment time emerging risk due to demand and loss of workforce/capacity in H&N, Breast and Skin, affecting FDS performance and 62day.	• Clinical prioritisation of patients and review of next steps for >104-day patients. • Additional weekly Patient tracking list (PTL) for challenged tumour sites in place. • Recovery & Performance (RAP) meetings in place. • East Midlands Cancer Alliance funding fully utilised. • Additional Tier 1 funding for Q1 and Q2 being used to support challenged tumour sites. • Oncology regional review of mutual aid and workforce opportunities (East Midlands Acute Providers) with East Midlands Cancer Alliance (EMCA) supporting. • Working with University Hospitals of Northampton (UHN) to support Oncology fragile services, next meeting September. • Pre-diagnosis nursing team supporting with patient engagement. • Radiotherapy 5th Linac operational, on track to clear backlog by Jan 26. • Radiotherapy mutual aid being provided from UHN, Nottingham University Hospitals (NUH) and University Hospitals of Coventry and Warwickshire (UHCW). • Changes to prostate fractions in place. • Implementation of paperless processes planned to support further capacity release in radiotherapy in Q3 and review of scheduling to maximise capacity. • Services working to increase cancer 1st appointment capacity for H&N, Breast and Skin to support. • H&N reviewing referral criteria and pathway improvement opportunities.

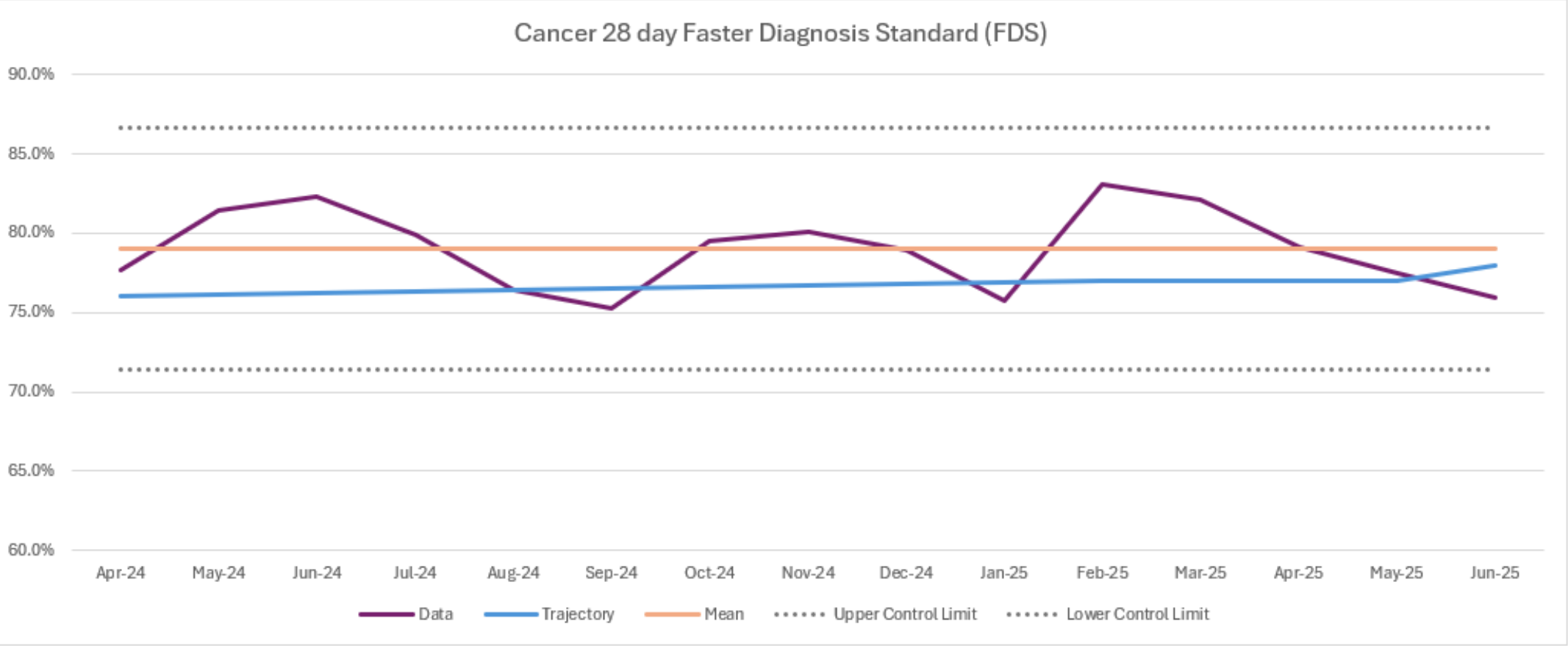
Good news: N/A

Patient Outcome: Faster diagnosis or ruling out of cancer and improved waiting times for treatment.

Link to summary table

Cancer

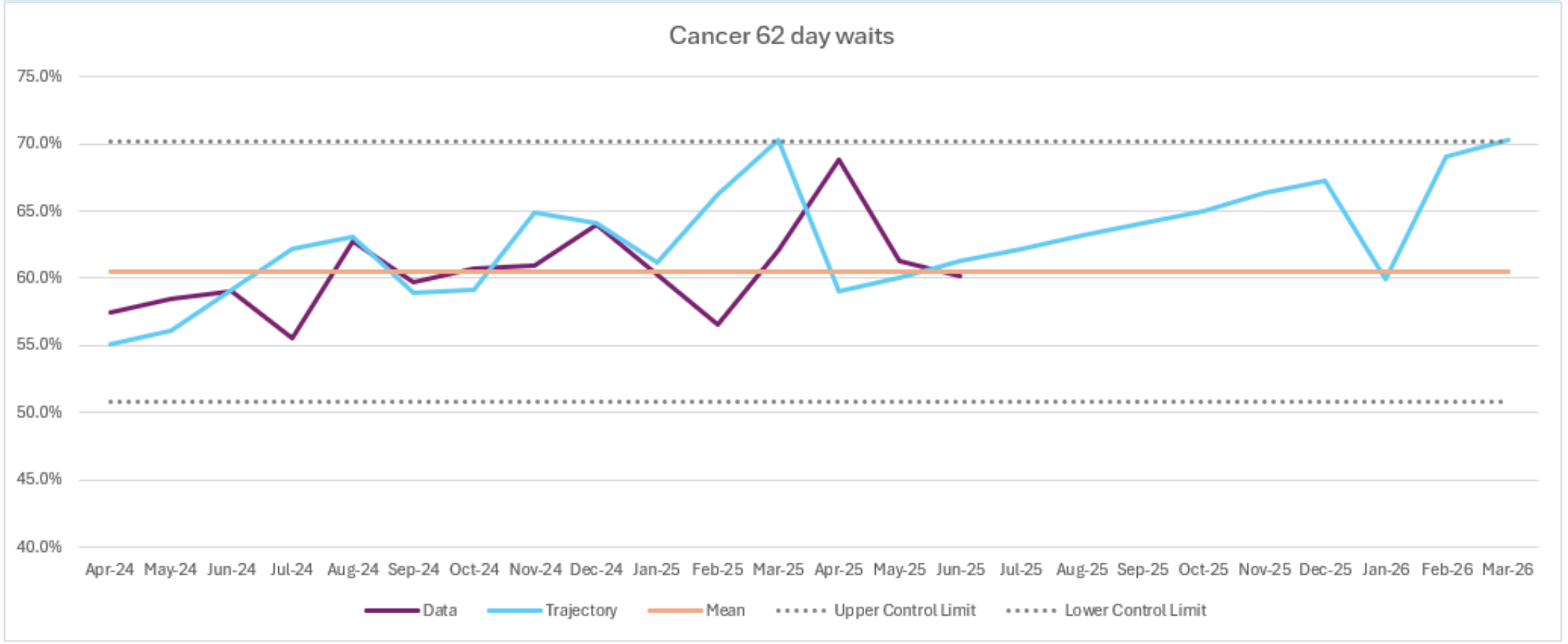
Measure	Month	Value	25/26 Ops Plan Target	Desired Direction
Cancer 28 day Faster Diagnosis Standard (FDS)	Jun-25	75.9%	78.0%	Higher is better



Link to summary table

Cancer

Measure	Month	Value	25/26 Ops Plan Target	Desired Direction
Improve performance against the headline 62-day standard to 70% by March 2025	Jun-25	60.2%	61.3%	Higher is better



Link to summary table

Urgent and Emergency Care

NHS PRIORITIES 2025/26	Month	Plan	Actual	RAG
Improve A&E waiting times of patients seen within 4 hours in Mar 26 (All Types System Wide, Trajectories set as part of Ops Plan 25/26)	Jul-25	76.0%	79.3%	
Percentage of patients waiting in ED over 12 hours (All Types) As per operational plan	Jul-25	11%	9%	
Improve Category 2 ambulance response times to an average of 30 minutes across 2025/26	Jul-25	00:30:00	00:32:34	

Metric	Risk	Mitigation

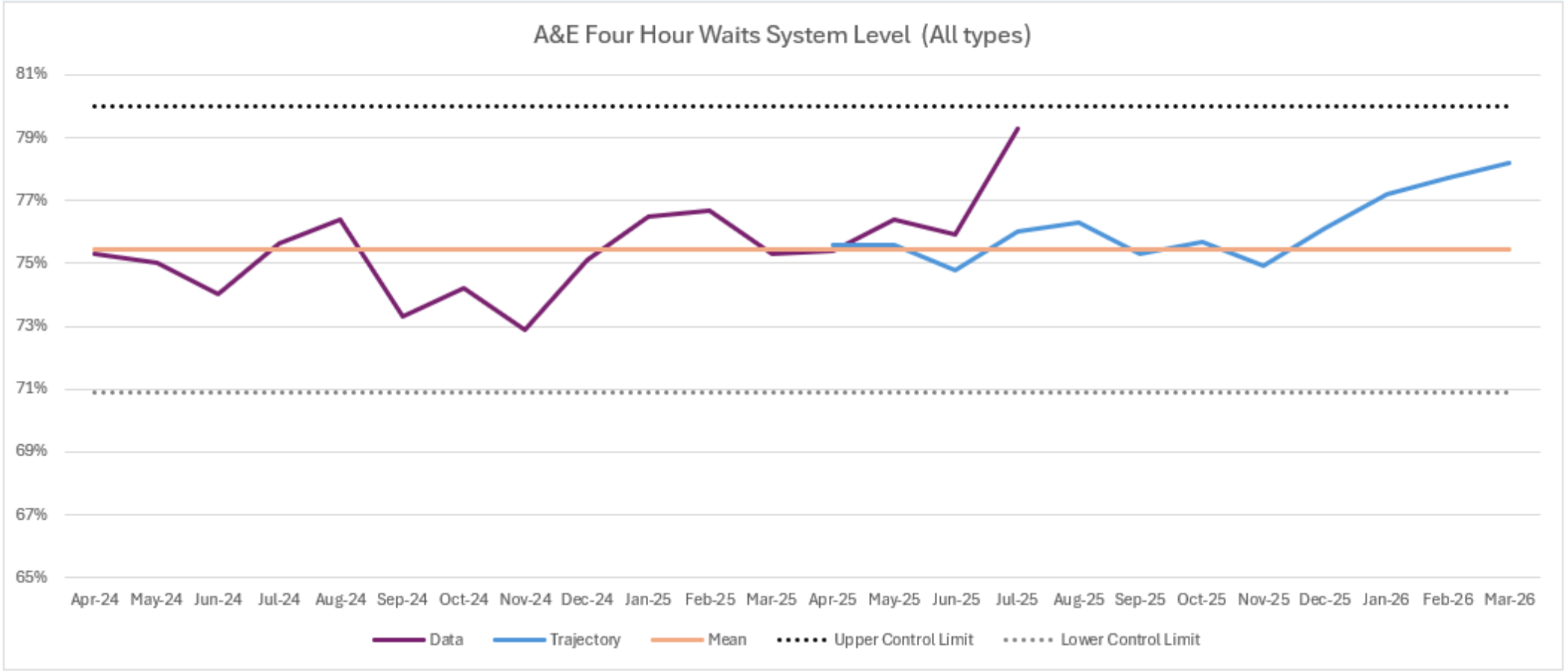
Improvement of A&E waiting times	• UHL gross Type 1 and 2 attendances in July 2025 and August 2025 were 3% below plan net of re-direction and on plan respectively.	• Increased capacity for Emergency Department (ED) re-direction to community Urgent Care (UEC) services at Merlyn Vaz UTC and Belgrave Hub live from 30/06/2025 to 30/09/2025 when City Same Day Access commences.
		• Fortnightly meetings with NHS E Midlands to share best practice whilst UHL has been moved into Tier 2 monitoring owing to
		  • ED 4hr performance.
		  • ED 12hr performance.
		  • Ambulance handover delays >45 mins.

Improve category 2 ambulance response times	• The LLR EMAS Category 2 Mean exceeded the national standard of 00:30:00:00 at 00:40:28 in August 2025, yielding year to date performance of 00:34:32. • Work continues to improve ambulance conveyances directly to SDECs and avoiding the Emergency Department where clinically appropriate. • Continuing with the establishment of NHS Pathways DoS headline profiles for all UHL SDEC services (without an existing full profile) to maximise patient navigation and reduce ED pressure. • Establishment of Ambulance Handover Working group to improve all handovers with aim of reducing average handover time (which will impact on ambulance release and therefore Cat 2 time)	
Reduce adult general and acute (G&A) bed occupancy	• Outcomes of the Virtual Wards review will be presented in September 2025. • Community beds audit in progress to also support the identification of appropriate beds for 'step up' from community referrals. • UHL SDECs directory of care pathways in development to support digital access to information in primary care / community care.	
Good news	• The LLR (Health and Care) Winter Plan has received positive feedback from NHS England Midlands. • 1,340 patients registered in LE4 and LE5 attended the Merlyn Vaz additional UEC pathway in July and August 2025.	
Patient Outcomes:	• 1,340 patients registered in LE4 and LE5 attended the Merlyn Vaz additional UEC pathway in July and August 2025. • NHS111 call reviews being reinstated to assess the breadth of discussions at the initial point of contact and whether the most appropriate clinical pathway was accepted.	

Link to summary table

Urgent Emergency Care

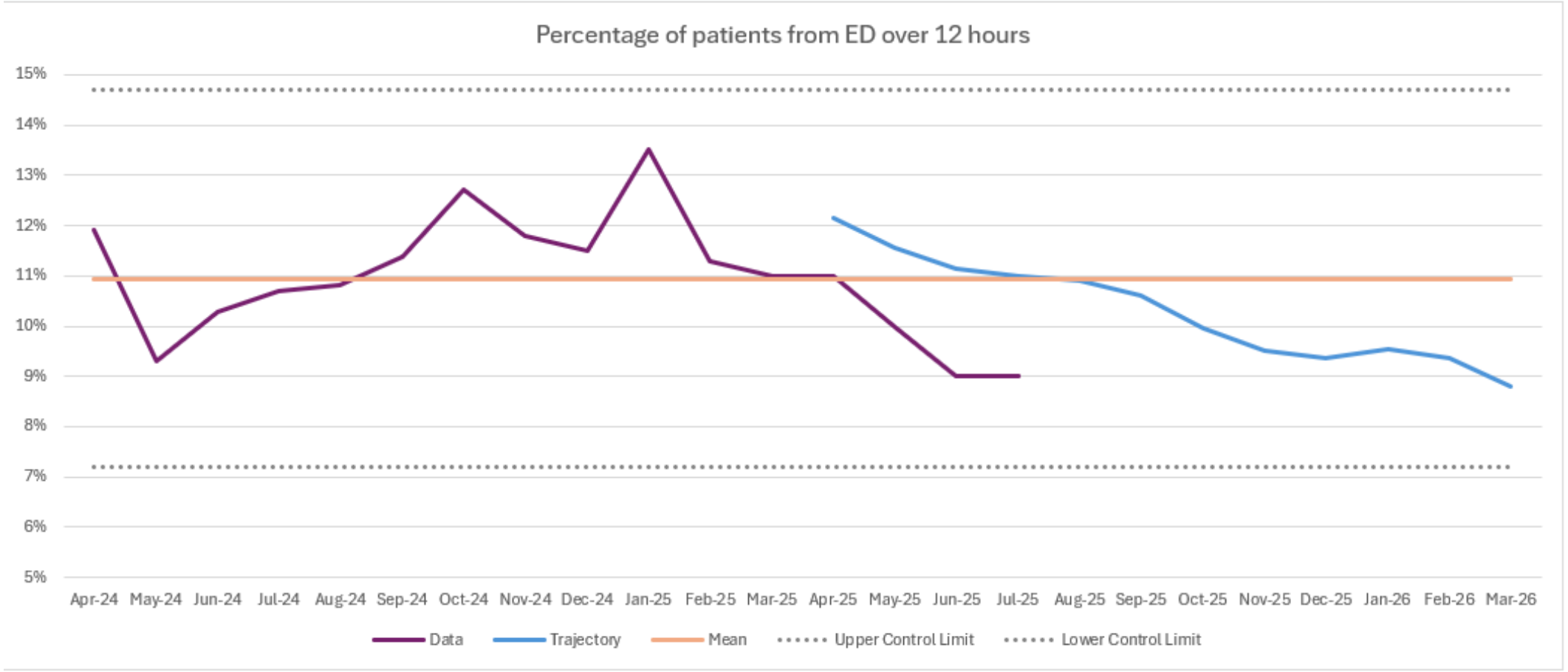
Measure	Month	Value	Ops plan 25/26 Target	Desired Direction
Improve A&E four hour waits, compared to 2023/24, of patients seen within 4 hours	Jul-25	79.3%	76.0%	Higher is better



Link to summary table

Urgent Emergency Care

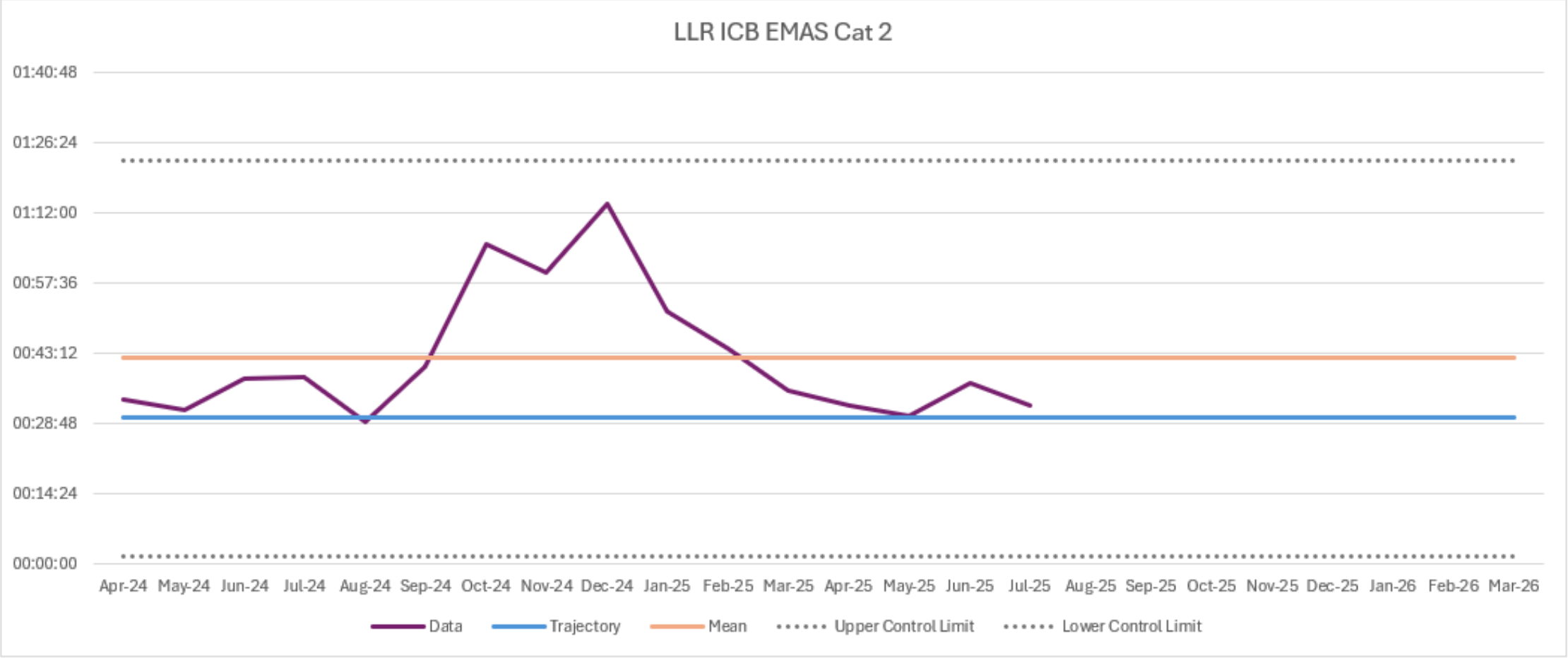
Measure	Month	Value	Ops plan 25/26 Target	Desired Direction
Percentage of patients from ED over 12 hours	Jul-25	9.0%	11.0%	Lower is better



Link to summary table

Urgent Emergency Care

Measure	Month	Value	Target	Desired Direction
LLR ICB EMAS Cat 2	Jul-25	00:32:34	00:30:00	Lower is better



Link to summary table

Community Services - Over 52 Week Waits

NHS PRIORITIES 2025/26	Month	Plan	Actual	RAG
Number of people on waiting lists for CYP services who are waiting over 52 weeks	Jun-25	5835	5858	
Number of people on waiting lists for adult services who are waiting over 52 weeks	Jun-25	0	0	

Metric	Risks	Mitigations
Improve CYP community services waiting times, with a focus on reducing long waits. All children waiting over 52 weeks are referrals to our community paediatrics service for neurodevelopmental disorders.	• Diagnostic delays affect long term outcomes. • Increase in complaints and concerns due to delays. • Exclusions increase in education settings. • Negative impact on families as a result of greater prevalence of mental health and behaviour management issues. • Trust reputation. • Substantive recruitment to Educational Psychology posts unsuccessful. • Numbers waiting increase with continuing high volumes referrals. • Negative impact of reduced local voluntary, community and sector (VCS) capacity to support CYP / families whilst waiting.	• Attention deficit hyperactivity disorder (ADHD) nurses see stable cases, releasing consultant capacity for new referrals. 1200 children remain on consultant caseload with c1900 transferred to Nurse Medical Prescriber. • Advanced Nurse Practitioner to support nursing capacity and oversight – 2 clinics set up with an additional 240 children allocated to ANP. • Resources identified to support timely and appropriate response to complaints and concerns. • ADHD nurse input to diagnostic pathway pilot maximises consultant capacity and will increase capacity to assess and diagnose ADHD, moving to a majority being undertaken by specialist nurses. Advanced Nurse Practitioner will facilitate roll out, with project management support. Remaining actions include specific demand and capacity work to maximise nurse caseload and development of a training and supervision structure. • ADHD Annual Review Primary Care pilot increases follow up slots, exploring roll out options. • Funding of one external educational psychology provider sustained for 2025/26 academic year to support continued capacity. Options for increased capacity under consideration (within existing resources) • Clinical leaders review long waits for core service to pro-actively manage and deliver zero 52+ week waits. • Patient tracking supports robust oversight at service, directorate and Trust level. • Robust Did Not Attend / Was Not Brought measures minimise lost capacity. • Health Innovation East Midlands applications to further enhance digital waiting well offer. Outcome awaited. • Working with ICB on to support alternative options for VCSE Support following closure of ADHD Solutions.
Improve adult community services waiting times, with a focus on reducing long waits	• Growing demand leads to over 52 week waits in adult community services (risk low).	• Robust waiting list management processes give early warning of changes to referral patterns which may risk lengthening waits. • Data quality measures in place to reduce risk of incorrect reporting.

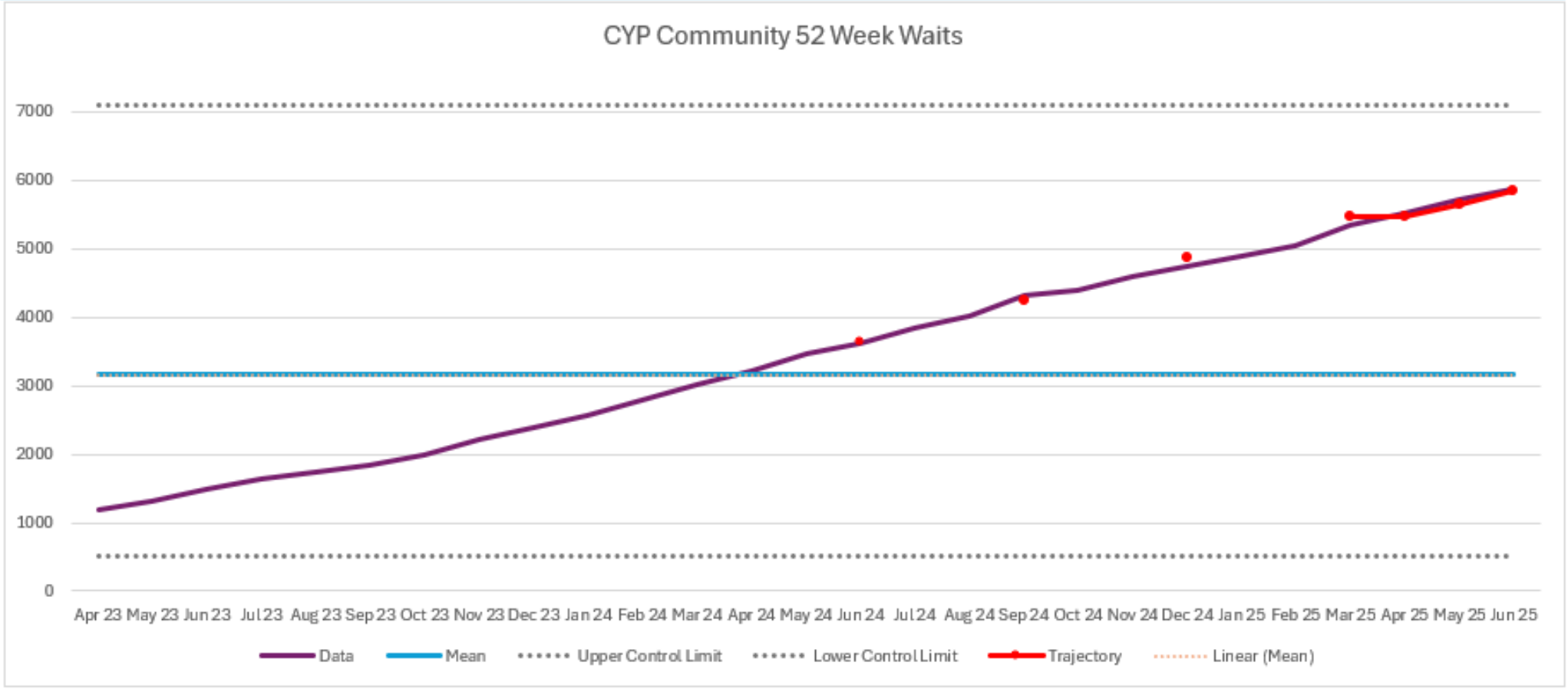
Good news/ positive patient outcome

- Advanced Nurse Practitioner recruited to Child and Adolescent Mental Health/ Community Paeds to support Neurodevelopmental Pathway (ND) pathway now clinically active.
- Recruitment of Allied Health Professionals is supporting capacity for Autism Spectrum Condition assessment and ADHD medication initiation and titration.
- Priority children seen within 18 weeks of referral with measures supporting early intervention for urgent cases.
- PTLs support 'live' review and action where clinical condition changes.
- Stable children with ADHD seen by nurses enabling timely titration, two additional titration clinics now in place.
- Good user/carer feedback with satisfaction scores consistently above 90%.

Link to summary table

Community Services - Over 52 Week Waits

Measure	Month	Value	Target	Desired Direction
No. of people on waiting lists for CYP services who are waiting over 52 wks	Jun-25	5858	5835	Lower is better



Link to summary table

Mental Health

NHS PRIORITIES 2025/26	Month	Plan	Actual	RAG
Reduce average length of stay in adult acute mental health beds	Jun-25	55.9	65	
Increase the number of CYP accessing services (Trajectories set as part of Ops Plan 25/26)	Jul-25	17,745	18,815	

Metric	Risk	Mitigation
Reduce average length of stay in adult acute mental health beds	Court of protection or delays due to MoJ impact on the timelines and they are out of LPTs control but adversely affect the target	This is now a standing agenda item for discussion on the NHSE monthly assurance meeting.
Improve access to MH support for Children and Young People (CYP)	CYP mental health inpatients much higher than expected trajectory. Numbers of children with Autism Spectrum Disorder (ASD) and eating disorders in crisis has increased and there is a lack of appropriate community provision causing delayed discharges.	Improving Access to C&YP's Mental Health and bringing services closer to the C&YP's in neighbourhood. Triage and Navigation - Run by Derbyshire Health United (DHU). Online Self-referral for C&YP and their parents and/or carers to improve access to MH services for C&YP. Eating Disorders - First Steps ED is an online service for Eating Disorders. They work closely with Child and Adolescent Mental Health Services (CAMHS) providing support for those discharged by CAMHS. Monthly meetings with Providers to progress work on the CYP Waiting Time Metric.

Good news:

Two community focus groups were delivered in August focused on generating insights from individuals in the black community on mental health services. The sessions were organised by the African Heritage Alliance with 15 people taking part. People suggested they want services that are holistic, culturally relevant, informative, and therapeutic, grounded in respect and connection, ensuring that support is accessible AND meaningful to those it is intended to serve.

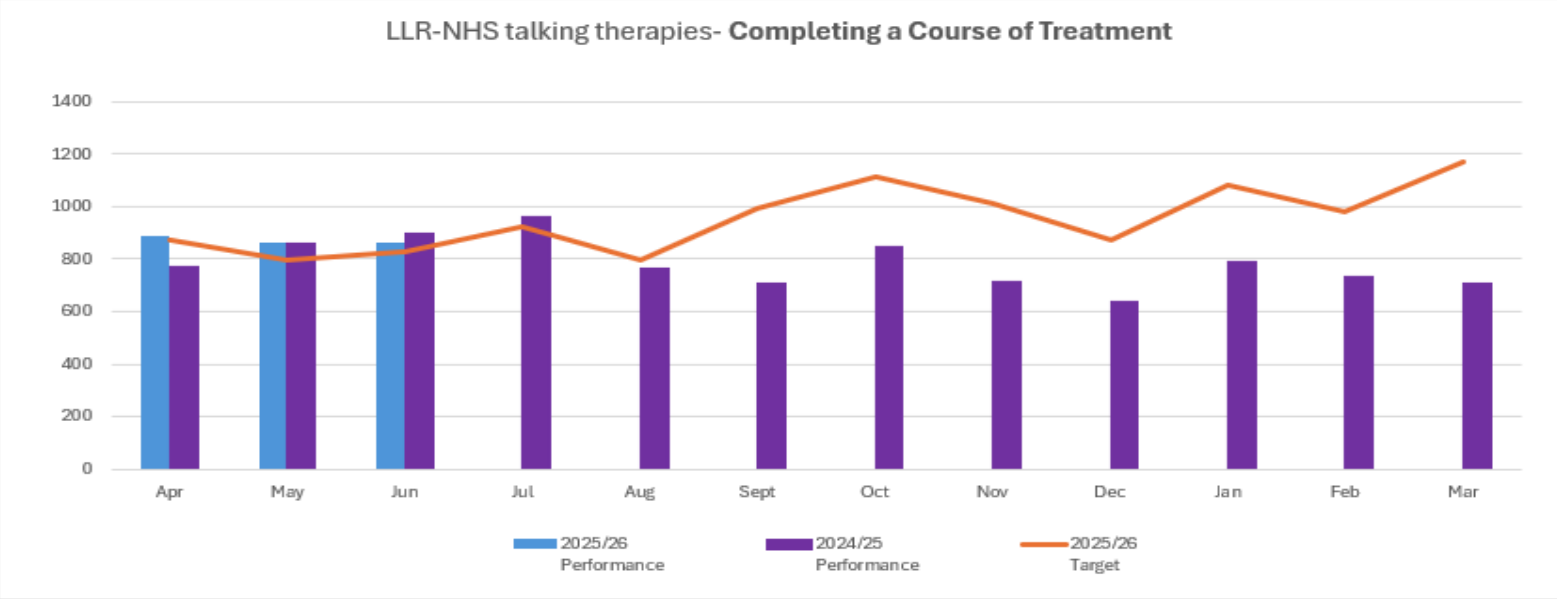
A Mental Health Workshop took place on 30th August in partnership with the Bangladeshi Friendship Club. Approximately 50 people attended and heard a presentation by Dr Khokar, Consultant Psychiatrist who supported the event from City East Neighbourhood Mental Health Team, as well as members of the community who have experience in working in mental health. Jamila's Legacy attended to increase awareness about the Mental Health Cafe's.

A new monthly drop-in session is being launched to support collaborative and holistic case discussions between Adult Social Care & Neighbourhood MH team in Hinckley & Bosworth. This informal networking session will be a place for remit discussions, case consultations, and to build integrated team working across statutory services. The sessions also aim to further develop links between Adult Social Care and secondary mental health services in Hinckley and Bosworth

Link to summary table

Mental Health – Talking Therapies-Completing a Course of Treatment (additional measure)

Measure	Month	Value	Target	Desired Direction
NHS talking therapies- Completing a Course of Treatment (having had at least two treatment sessions)	Jun-25	865	826	Higher is better

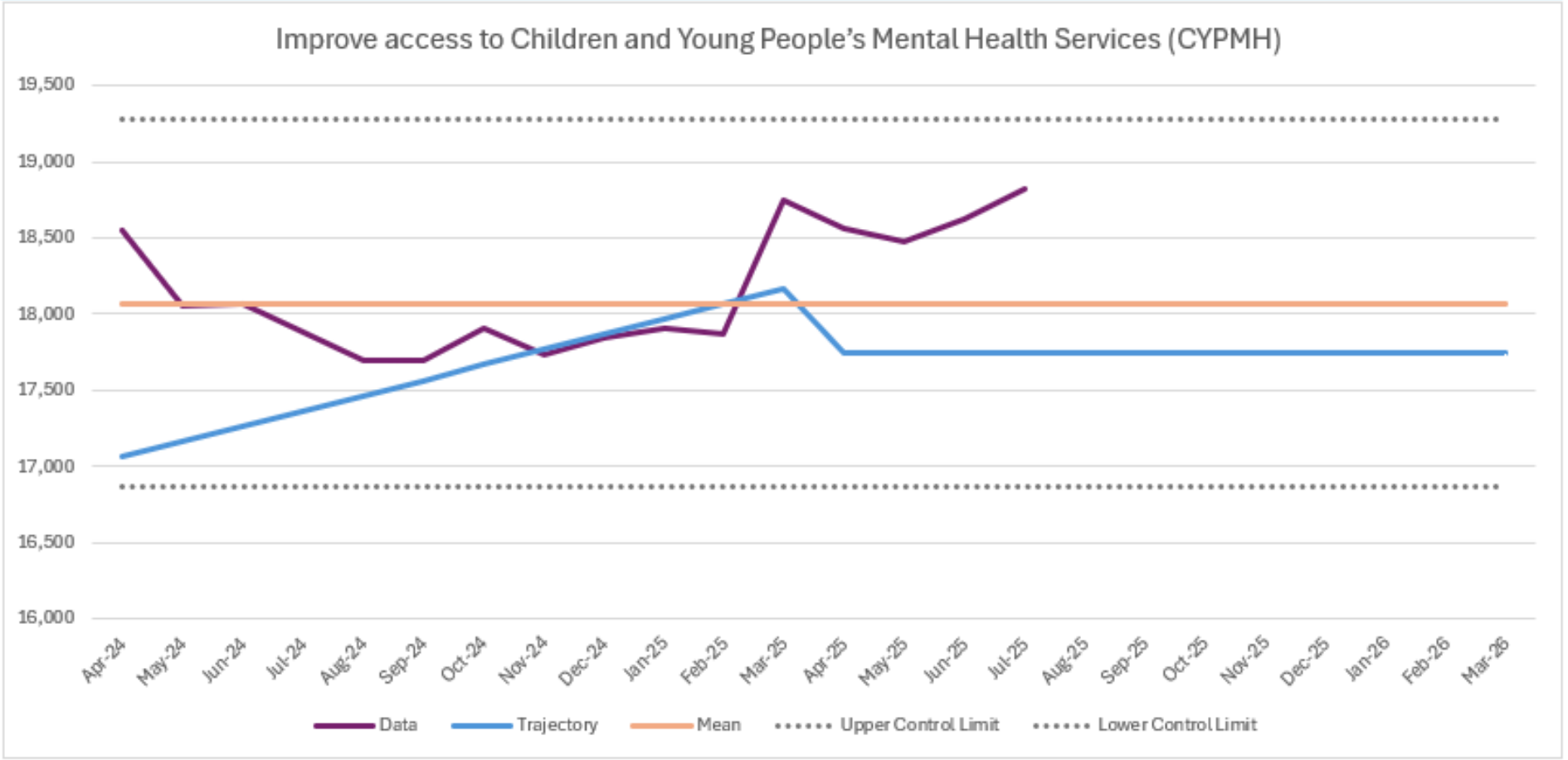


NHS PRIORITIES 2025/26	Month	Plan	Actual	RAG
NHS talking therapies- Completing a Course of Treatment (having had at least two treatment sessions)	Jun-25	826	865	

Metric	Risk	Mitigation
Talking Therapies- Completing a Course of Treatment- Count of referrals with a discharge date in the period that had at least two treatment sessions (excluding follow up).	• Increased waits for assessment. • Reduction in reliable recovery rate. • Reduction in reliable improvement. • Negative impact on patient experience. • Higher probability of relapse.	• Improving conversion rates through digitalisation. Digital front door now live. • New reasonable growth target agreed for 25/26. • Deep dive into high number of re-referrals. • Focus on DNAs (Did not attend) at next steering group meeting in August. • 7 Cognitive behavioural therapist (CBT) trainees have completed the training and will now increase their caseloads. • +2 Contract agreed, new focus areas being agreed. • Closer work with Voluntary Community and Social Enterprise (VCSE) partners • Focus on older adults

Mental Health

Measure	Month	Value	25/26 Ops Plan Target	Desired Direction
Improve access to Children and Young People's Mental Health Services (CYPMH)	Jul-25	18815	17745	Higher is better



Link to summary table

People with Learning Disabilities and/or Autism

NHS PRIORITIES 2025/26	Month	Plan	Actual	RAG
Reduce reliance on mental health inpatient care for people with a learning disability and people with autism	Aug 25 Q2 Plan	10	11	
Reduce reliance on mental health inpatient care for adults with autism	Aug 25 Q2 Plan	14	15	
Reduce reliance on mental health inpatient care for children with a LDA	Aug 25 Q2 Plan	3	*	

Metric	Risk	Mitigation
Reduce reliance on inpatient care for adults	• The LLR inpatient trajectories for autistic adults and people with a learning disability and autism do not meet the requirements of the 25/26 planning guidance (20% reduction from March 24 baseline) • Due to an increasing number of autistic adults being admitted, the current inpatient trajectories are being exceeded	• An Options Appraisal has been developed by the LDA Collaborative in response to the increasing number of autistic adults being admitted; this was presented to the Collaborative Board meeting on 14 July 25 with positive assurance on the options presented. Progress being monitored through LDA Collaborative Board. • A 'Time to Think' sessions held with Directorate Mental Health (DMH) colleagues on 2 July 25 – LDA Collaborative supporting development of DMH plans. National NHSE funding provided for development of peer advocacy support. • A Group Risk Summit is in the process of being arranged focusing on Autistic Adults in Escalation – date to be confirmed. • Working Group to be established to develop a clinical model across both LDA and MH directorates in Leicester Partnership Trust (LPT) – initial work ongoing to review existing service specifications to ensure all available options are utilised.
Reduce reliance on inpatient care for under 18's	• Late referral to the Dynamic Support Pathway means that individuals are referred for crisis management, rather than crisis avoidance; there is a risk that the low CYP trajectory could be exceeded • Key working contract for 25/26 has been recommissioned and provides reduced Keyworker capacity across LLR	• CYP requiring admissions to inpatient beds are continuing to be supported by the CAMHS Intensive Community Support Team (ICST), therefore reducing the length of stay of individuals. • Number of CYP inpatients is continues to remain at one – LLR met inpatient CYP trajectory from June 2024 onwards. • Ongoing system wide monitoring of CYP on the red cohort of the Dynamic Support Pathway (DSP) to ensure any further admissions can be avoided. • Project meetings established to ensure young people at risk of admission are continuing to receive support from Keyworkers. DSP processes being reviewed and streamlined where possible. DSP Referral criteria and supporting processes currently being reviewed. The first DSP Project Group meeting took place on 21 August 2025, where the project plan was shared and formally agreed. This outlined key project steps, assigned actions, and identified initial risks. The DSP Hub team is now piloting the use of a clinical prioritisation tool developed by Cheshire and Wirral.

Patient Outcome: Addressing the increasing number of autistic adults being admitted to a mental health hospital would provide the following benefits:
- Reduced admission and readmission rates, therefore improving quality of life and patient outcomes.
- Reduced Length of Stay/Bed Days.
- Improved compliance with the new Mental Health Act requirements regarding autism.
- Improved staff wellbeing and development.
- Improved ICS performance against NHSE autism inpatient trajectories.

Use Of Resources (Finance M4)

System KPI Dashboard	YTD £m			M1-12 £m		
	Target	Actual	Rating	Target	FOT	Rating
System Delivery of planned deficit (gross of deficit support funding)	41.91	45.99		80.00	80.00	
System Revenue expenditure not to exceed income (net of deficit support funding)	1,196.40	1,210.23		3,554.76	3,554.76	
System Capital expenditure not to exceed allocations	21.34	12.11		96.59	96.16	
System Operates within Cash Reserves	23.06	55.33		38.96	38.96	
System CIP delivery	35.18	35.87		190.47	190.47	
CIP delivery as a % of FOT	18.47%	18.83%				
System Better Payment Practice code % NHS invoices paid within target (£)	95.00%	98.56%		95.00%	98.56%	
System Better Payment Practice code % NHS invoices paid within target (number)	95.00%	96.37%		95.00%	96.37%	
System Agency spend within ceiling	7.79	5.66		23.37	17.54	
System Bank spend within ceiling	19.79	29.88		59.37	66.63	
Provider total pay costs	500.00	496.59		1,460.79	1,460.93	

Metric	Mitigation
2025/26- System Delivery of planned deficit (gross of deficit support funding)	• The ICB is forecasting to exceed its running cost allocation due to under delivery against the corporate staff costs target • Bank spend is above the system cap YTD and forecast to continue to be at year end, however this was planned at the start of the year.

Link to summary table

Maternity

Area	NHS PRIORITIES 2025/26	Month	Plan	Actual	RAG
Maintain our collective focus on the overall quality and safety of our services	National safety ambition to reduce stillbirth	May-25	Reduction 2023 4	4	
	Neonatal mortality (per 1,000 births)	2023	Reduce 2021 2.4	2.8	
	Maternal mortality	2023/24	Reduce 21/22 *	0	

Metric	Risk	Mitigation
Make progress towards the national safety ambition to reduce stillbirth	Currently on track.	Slight variation in figures at start of year but due to very small numbers, it does not change overall picture however this is being monitoring closely.
Neonatal mortality	We remain an outlier for neonatal deaths with our extended mortality being more than 5% greater than expected; This is consistent with some trusts providing neonatal surgery and congenital heart surgery.	As a level 3 neonatal intensive care unit (NICU) we accept very sick babies across the region. We are keen to understand what additional factors other than medical complexities may be contributing to this. In response several steps are in place including working with other hospital trusts and Public Health colleagues both regional and local to build a deeper understanding of our population health needs and demographics to support us improve outcomes for mothers and babies.
Maternal mortality	In line with national data.	Our local picture mirrors the national data; however, one death is too many. We are doing work with our maternity services and public health colleagues around access to care and understanding demographic issues.
Increase maternity fill rates	Requirement to work with revised Birth rate plus trajectories (when refreshed) may mean our system shows a lag in achieving required midwifery numbers dependent on the version used.	Service hoping to have recruited into all vacancies by the end of this calendar year once the Midwives including a pipeline to cover expected attrition rates with the midwives who are due to complete their course later this year. Continue working with the universities and implement the Safer Learning Environmental Charter (SLEC) principles to improve retention.

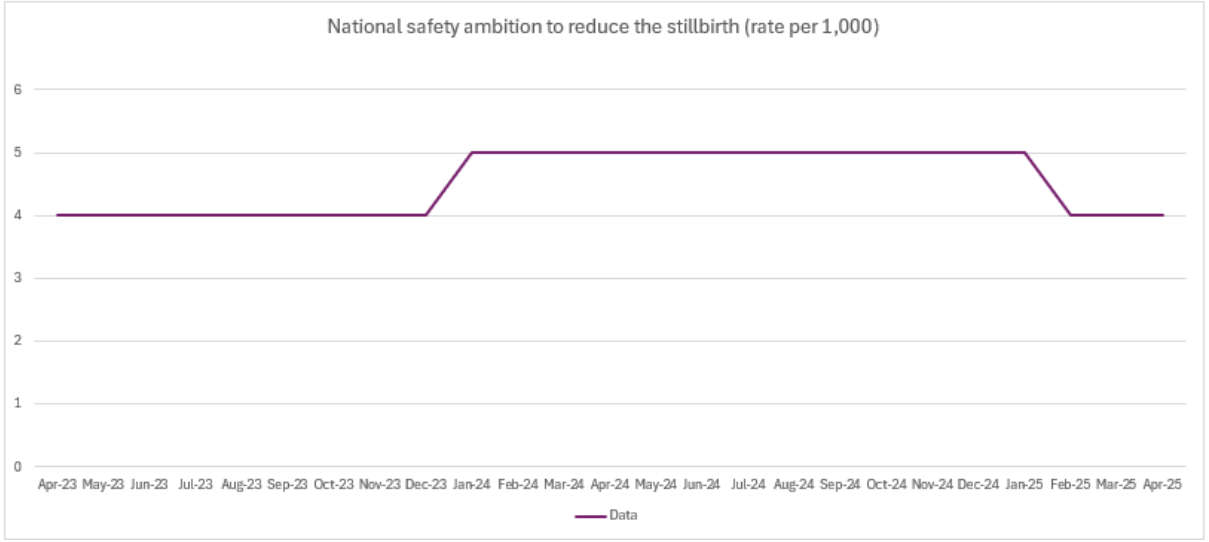
Good News: An LLR infant/ perinatal mortality working group set up working in partnership with ICB/Public Health/UHL to help address our perinatal mortality rates.

Patient Outcome: Following review of our Maternity & Neonatal Voice Partnership (MNVP)* we have secured an interim arrangement to support delivery of MNVP whilst we work to secure a permanent arrangement. *The MNVP supports women to have their voices heard and support improvements in services.

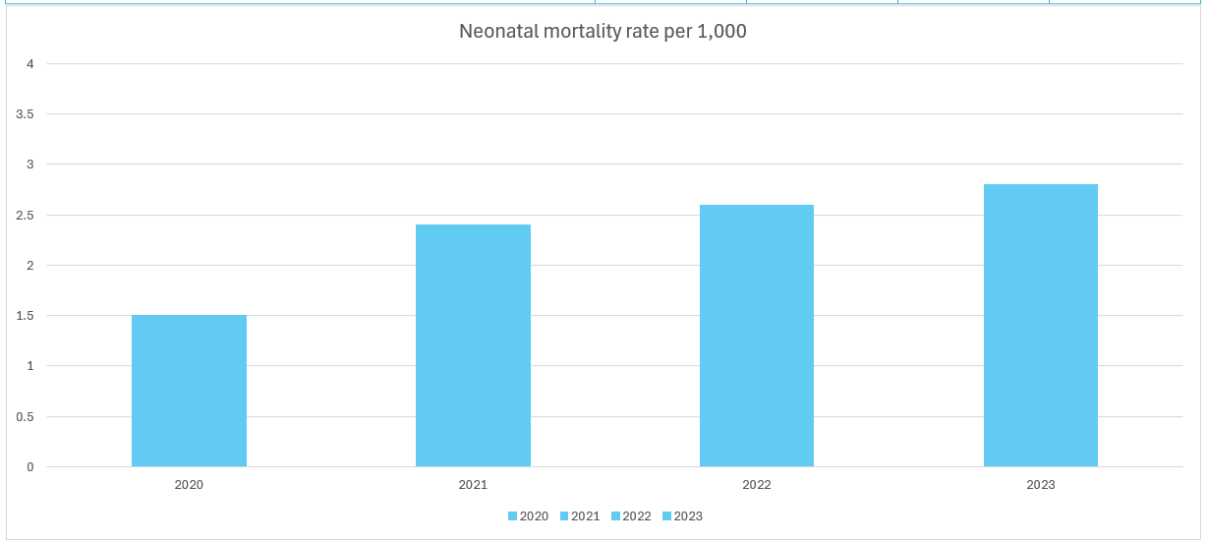
Link to summary table

Maternity

Measure	Month	Value	Target	Desired Direction
National safety ambition to reduce the stillbirth (rate per 1,000)	May-25	4	Reduction	Lower is better



Measure	Year	Value	Target	Desired Direction
Neonatal mortality rate per 1,000	2023	2.8 per 1,000	Reduction	Lower is better



Link to summary table

Hypertension & Lipids

NHS PRIORITIES 2025/26	Month	Plan	Actual	RAG
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	Q4 24/25	67.1%		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	Q4 24/25	82.2%		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 appropriate treatment threshold	Q4 24/25	80.0%	70.1%	
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%	Q4 24/25	60.0%	66.1%	

Metric	Risk	Mitigation
Increase 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-appropriate treatment threshold to 80% by March 2025 **CVDP007 HYP**	• Capacity of general practice to identify and optimise 'at risk' groups throughout the year with increased numbers on registers. • Activated patients to attend and adhere to medication once prescribed.	• Placed based targeted work to support practices below target to identify patients and optimise their treatment, linked to neighbourhood plans. This was introduced in the City last year. • Use of business intelligence to understand gaps and ensure a more targeted approach to address this, by focusing more effort on the 18 to 79 years old. • Hypertension Task & Finish group at their last meeting considered focus on effective approaches for different population groups, combined with practice based interventions and community engagement. • Gaps in detection highlighted via the PCN DES assurance group. • Community pharmacy data to March 25 will be used to identify where opportunistic measures are mot being taken.
Increase percentage of patients aged between 25 - 84 years with a CVD risk score greater than 20 percent on lipid lowering therapies to 60% by March 2025 **CVDP003Chol**	• Capacity of general practice to identify and optimise 'at risk' groups throughout the year with increased numbers on registers. • Activated patients to attend and adhere to medication once prescribed.	• Monthly review of practice delivery against trajectory and placed based performance shared with relevant place-based leads for information and action to support practices below target to identify patients and optimise their treatment, linked to neighbourhood plans. • Review of the LLR lipid pathway to make accessible to more practice staff. • Communications plan to support medication adherence, linked to national campaigns. • Use of business intelligence to understand gaps and ensure a more targeted approach.

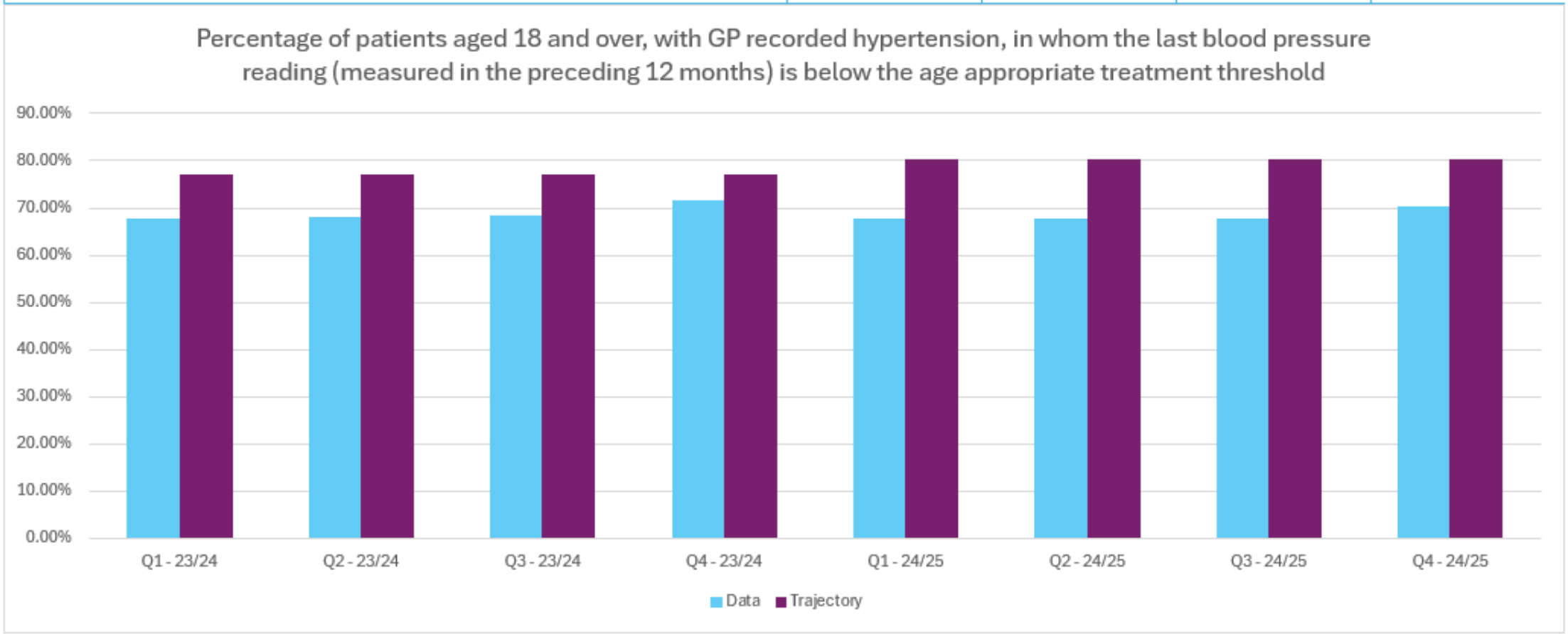
Good news:
Hypertension national target NHSE have retired the 80% target for treatment thresholds and alternates are being discussed.
NHSE report a drop , nationally in lipid treatments LLRs data doesn't reflect this and LLR remains in the top 3 of 10 comparator ICBs.
The number of Patients on lipid lowering therapy national target (65% by March 25) has been achieved in Dec 24 (65.3%), and LLR performance above national position (61.6%).
CVD QI data has been shard and discussed at the PCN DES assurance group and with PCN and Federation managers meetings. 4 PCNs have requested specific data on achievements across inequalities marks to identify if they can be sued to target gaps in diagnostics and optimisation.
One PCNs shared an innovative use of the community pharmacy hypertension service , reporting 20% detection rates and identification of NDH. Other PCNs may take this on. LTC team engaged with the PCN to explore the model further.

Patient Outcome:
On-going/ annual patient reviews will help reduce the risk of number of serious and potentially life-threatening health conditions such as heart disease, heart attacks and strokes.

Link to summary table

Prevention

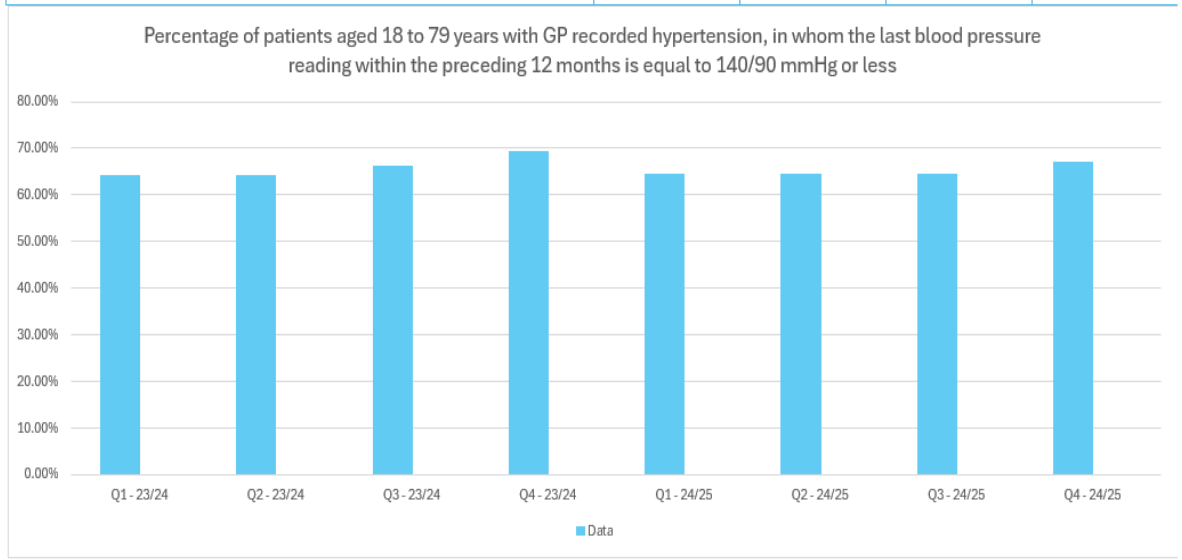
Measure	Month	Value	Mar-25	Desired Direction
CVDP007HYP - % of patients aged 18 and over, with GP recorded hypertension	24/25 Q4	70.10%	80%	Higher is better



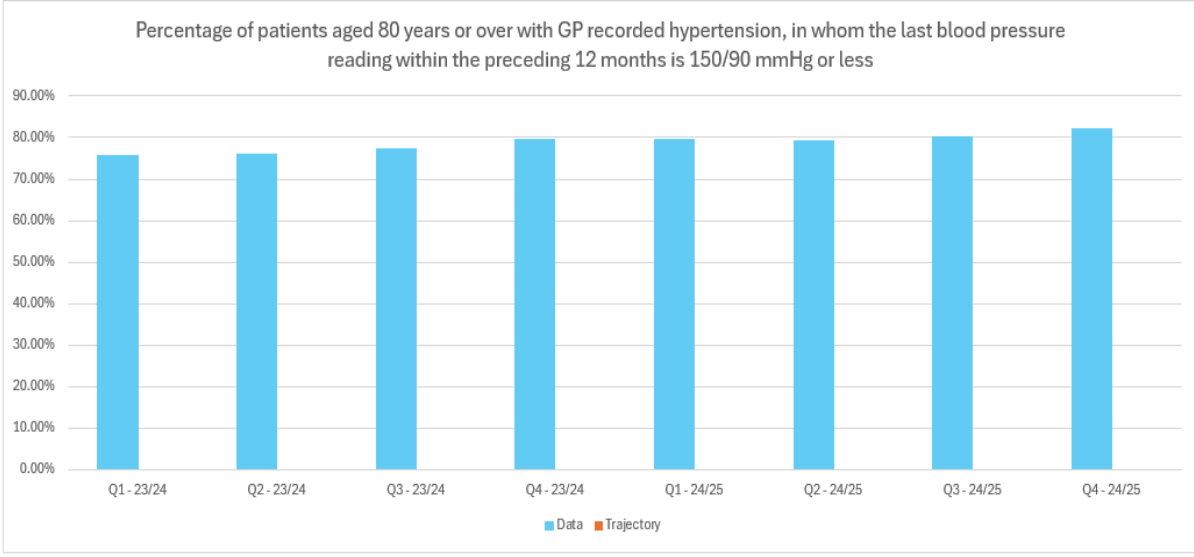
Link to summary table

Prevention

Measure	Month	Value	No National Target	Desired Direction
CVDP002HYP: % of patients aged 18 to 79 years with GP recorded hypertension	24/25 Q4	67.10%	N/A	Higher is better



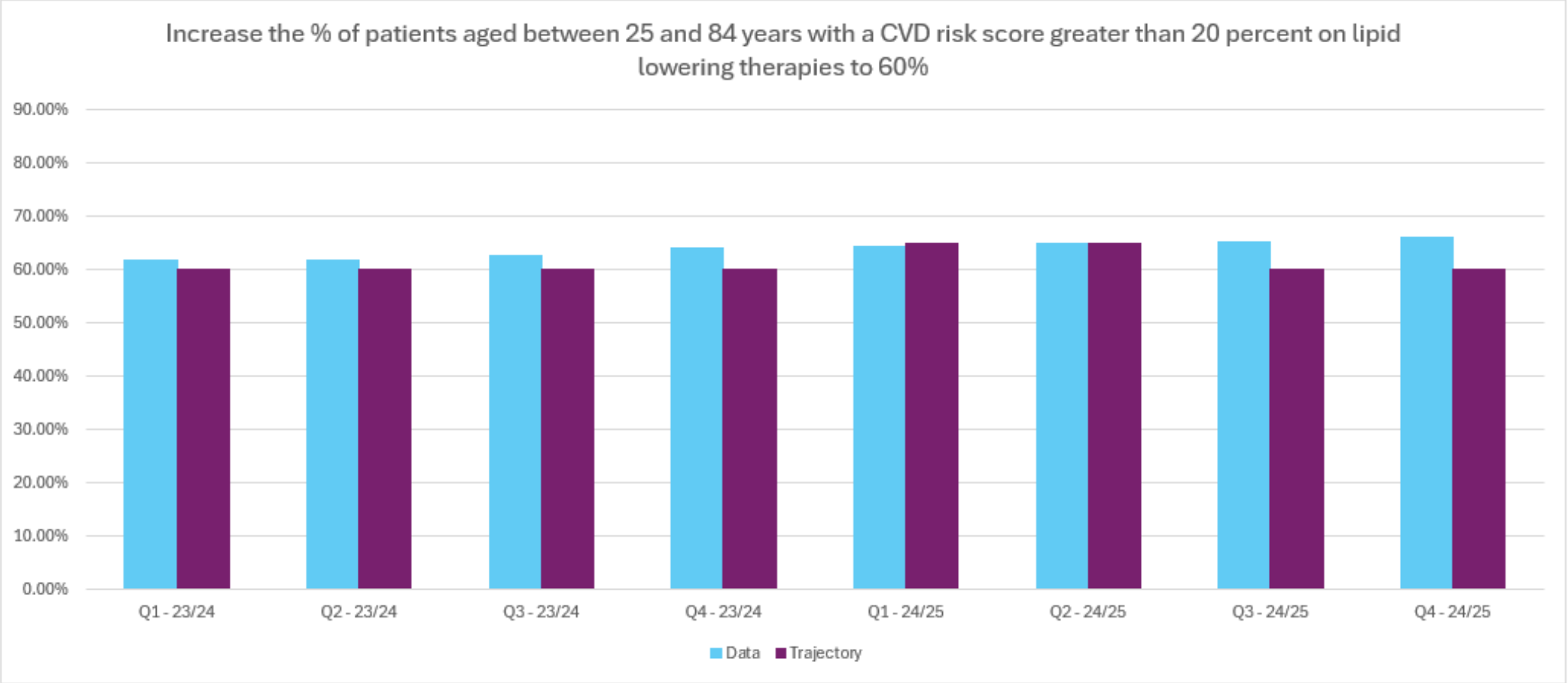
Measure	Month	Value	No National Target	Desired Direction
CVDP003HYP: % of patients aged 80 years or over with GP recorded hypertension	24/25 Q4	82.20%	N/A	Higher is better



Link to summary table

Prevention

Measure	Month	Value	Mar-25	Desired Direction
CVDP003CHOL - Increase the % of patients aged between 25 and 84 years with a CVD risk score greater than 20 percent on lipid lowering therapies to 60%	24/25 Q4	66.10%	60.00%	Higher is better



Link to summary table

Measures

RTT - 18 weeks wait		
Time Period	Data	Trajectory
Apr-24	57.8%	
May-24	59.1%	
Jun-24	58.9%	
Jul-24	58.3%	
Aug-24	57.4%	
Sep-24	57.0%	
Oct-24	57.1%	
Nov-24	57.2%	
Dec-24	56.1%	
Jan-25	55.3%	
Feb-25	55.3%	
Mar-25	55.9%	
Apr-25	56.5%	56.6%
May-25	57.6%	57.1%
Jun-25	57.6%	57.8%
Jul-25	55.10%	57.3%

18 week waits for first appointment		
Time Period	Data	Trajectory
Apr-24	64%	
May-24	66%	
Jun-24	67%	
Jul-24	66%	
Aug-24	65%	
Sep-24	64%	
Oct-24	64%	
Nov-24	65%	
Dec-24	63%	
Jan-25	62%	
Feb-25		
Mar-25		
Apr-25	61.9%	62%
May-25	62.2%	63%
Jun-25		63%
Jul-25	66.20%	64%

52 weeks wait		
Time Period	Data	Trajectory
Apr-24		
May-24		
Jun-24		
Jul-24		
Aug-24		
Sep-24		
Oct-24		
Nov-24		
Dec-24		
Jan-25		
Feb-25		
Mar-25		
Apr-25	2.0%	1.8%
May-25	2.1%	1.6%
Jun-25	2.4%	1.4%
Jul-25	2.7%	1.3%

Caner 62 day waits		
Time Period	Data	Trajectory
Apr-24	57.5%	55.1%
May-24	58.5%	56.1%
Jun-24	59.0%	59.1%
Jul-24	55.5%	62.2%
Aug-24	62.8%	63.1%
Sep-24	59.7%	58.9%
Oct-24	60.7%	59.1%
Nov-24	61.0%	64.9%
Dec-24	64.0%	64.1%
Jan-25	60.3%	61.2%
Feb-25	56.6%	66.2%
Mar-25	62.1%	70.3%
Apr-25	68.8%	59.0%
May-25	61.3%	60.0%
Jun-25	60.2%	61.3%

Cancer 28 day Faster Diagnosis Standard (FDS)		
Time Period	Data	Trajectory
Apr-24	77.7%	76.0%
May-24	81.4%	76.1%
Jun-24	82.3%	76.2%
Jul-24	79.9%	76.3%
Aug-24	76.4%	76.4%
Sep-24	75.3%	76.5%
Oct-24	79.5%	76.6%
Nov-24	80.1%	76.7%
Dec-24	78.9%	76.8%
Jan-25	75.7%	76.9%
Feb-25	83.1%	77.0%
Mar-25	82.1%	77.0%
Apr-25	79.1%	77.0%
May-25	77.5%	77.0%
Jun-25	75.9%	78.0%

Link to summary table

Measures

A&E Four Hour Waits (All Types)		
Time Period	Data	Trajectory
Apr-24	75%	
May-24	75%	
Jun-24	74%	
Jul-24	76%	
Aug-24	76%	
Sep-24	73%	
Oct-24	74%	
Nov-24	73%	
Dec-24	75%	
Jan-25	76%	
Feb-25	77%	
Mar-25	75%	
Apr-25	75.4%	75.6%
May-25	76.4%	75.6%
Jun-25	75.9%	74.8%
Jul-25	79.3%	76.0%

Percentage over 12 hours (All)		
Time Period	Data	Trajectory
Apr-24	12%	
May-24	9%	
Jun-24	10%	
Jul-24	11%	
Aug-24	11%	
Sep-24	11%	
Oct-24	13%	
Nov-24	12%	
Dec-24	12%	
Jan-25	14%	
Feb-25	11%	
Mar-25	11%	
Apr-25	11.0%	12%
May-25	10.0%	12%
Jun-25	9.0%	11%
Jul-25	9.0%	11%

LLR ICB EMAS Cat 2		
Time Period	Data	Trajectory
Apr-24	00:33:47	00:30:00
May-24	00:31:30	00:30:00
Jun-24	00:38:05	00:30:00
Jul-24	00:38:11	00:30:00
Aug-24	00:29:11	00:30:00
Sep-24	00:40:23	00:30:00
Oct-24	01:05:37	00:30:00
Nov-24	00:59:50	00:30:00
Dec-24	01:14:02	00:30:00
Jan-25	00:51:55	00:30:00
Feb-25	00:44:14	00:30:00
Mar-25	00:35:38	00:30:00
Apr-25	00:32:22	00:30:00
May-25	00:30:26	00:30:00
Jun-25	00:36:57	00:30:00
Jul-25	00:32:34	00:30:00

Length of stay in adult acute mental health beds		
Time Period	Data	Trajectory
Apr-24		
May-24		
Jun-24		
Jul-24		
Aug-24		
Sep-24		
Oct-24		
Nov-24		
Dec-24		
Jan-25	55	
Feb-25	61	
Mar-25	61	
Apr-25	64	56.3
May-25	62	56.1
Jun-25	65	55.9

Improve access to Children and Young People's Mental Health Services (CYPMH)		
Time Period	Data	Trajectory
Apr-24	18,550	17,065
May-24	18,060	17,165
Jun-24	18,065	17,265
Jul-24	17,880	17,365
Aug-24	17,700	17,465
Sep-24	17,690	17,565
Oct-24	17,910	17,665
Nov-24	17,730	17,765
Dec-24	17,850	17,865
Jan-25	17,905	17,965
Feb-25	17,870	18,065
Mar-25	18,745	18,165
Apr-25	18,565	17,745
May-25	18,475	17,745
Jun-25	18,620	17,745
Jul-25	18,815	17,745

Link to summary table

Measures

NHS talking therapies- Completing a Course of Treatment (having had at		
	Actual	Trajectory
Apr-24	770	820
May-24	860	860
Jun-24	895	934
Jul-24	960	929
Aug-24	765	834
Sep-24	705	1094
Oct-24	850	1256
Nov-24	715	1120
Dec-24	635	908
Jan-25	790	1320
Feb-25	730	1255
Mar-25	705	1392
Apr-25	890	871
May-25	860	793
Jun-25	865	826

Reliance on mental health inpatient care for adults with a learning disability and autism		
Time Period	Data	Trajectory
Apr-24	11	
May-24	13	
Jun-24	14	10
Jul-24	13	
Aug-24	12	
Sep-24	12	10
Oct-24	12	
Nov-24	13	
Dec-24	13	9
Jan-25	11	
Feb-25		
Mar-25		9
Apr-25	14	
May-25	14	
Jun-25	13	10
Jul-25	13	
Aug-25	11	
Sep-25		10

Reliance on mental health inpatient care for autistic adults		
Time Period	Data	Trajectory
Apr-24	11	
May-24	10	
Jun-24	12	14
Jul-24	14	
Aug-24	13	
Sep-24	12	14
Oct-24	16	
Nov-24	15	
Dec-24	15	13
Jan-25	14	
Feb-25		
Mar-25		13
Apr-25	17	
May-25	16	
Jun-25	16	14
Jul-25	16	
Aug-25	15	

No. of people on waiting lists for CYP services who are waiting over 52 weeks		
Time Period	Data	Trajectory
Apr-23	1186	
May-23	1319	
Jun-23	1498	
Jul-23	1642	
Aug-23	1731	
Sep-23	1835	
Oct-23	1987	
Nov-23	2208	
Dec-23	2397	
Jan-24	2573	
Feb-24	2784	
Mar-24	3012	
Apr-24	3214	
May-24	3463	
Jun-24	3618	3627
Jul-24	3846	
Aug-24	4020	
Sep-24	4303	4242
Oct-24	4394	
Nov-24	4588	
Dec-24	4742	4857
Jan-25	4895	
Feb-25	5044	
Mar-25	5335	5472
Apr-25	5526	5459
May-25	5723	5647
Jun-25	5858	5835

Link to summary table

Measures

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 appropriate treatment threshold		
Time Period	Data	Trajectory
Q1 - 23/24	67.43%	77.00%
Q2 - 23/24	67.76%	77.00%
Q3 - 23/24	68.29%	77.00%
Q4 - 23/24	71.43%	77.00%
Q1 - 24/25	67.48%	80%
Q2 - 24/25	67.49%	80%
Q3 - 24/25	67.50%	80%
Q4 - 24/25	70.10%	80%

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	
Time Period	Data
Q1 - 23/24	64.15%
Q2 - 23/24	64.25%
Q3 - 23/24	66.24%
Q4 - 23/24	69.40%
Q1 - 24/25	64.46%
Q2 - 24/25	64.51%
Q3 - 24/25	64.40%
Q4 - 24/25	67.10%

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		
Time Period	Data	Trajectory
Q1 - 23/24	75.73%	
Q2 - 23/24	75.80%	
Q3 - 23/24	77.22%	
Q4 - 23/24	79.50%	
Q1 - 24/25	79.51%	
Q2 - 24/25	79.29%	
Q3 - 24/25	80%	
Q4 - 24/25	82.20%	

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%		
Time Period	Data	Trajectory
Q1 - 23/24	61.67%	60%
Q2 - 23/24	61.77%	60%
Q3 - 23/24	62.49%	60%
Q4 - 23/24	64.00%	60%
Q1 - 24/25	64.34%	65%
Q2 - 24/25	64.75%	65%
Q3 - 24/25	65.30%	60%
Q4 - 24/25	66.10%	60%

Link to summary table

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APPENDIX 2

Public Health and Prevention Indicators in Leicestershire

Leicestershire County Council

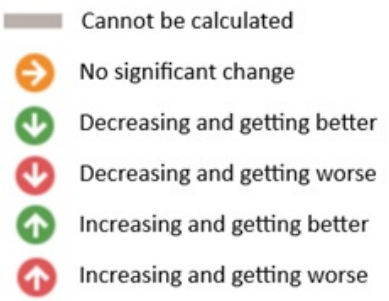
This dashboard presents performance data for Leicestershire on a range of Public Health and prevention indicators. The indicators included cover life expectancy, health improvement, health protection and healthcare and mortality.

Nearest Neighbour Rank (NN Rank): 1 is calculated as the best (or lowest when no polarity is applied).
Direction of Travel (DoT): Trend based on most recent five time periods.
RAG: Statistical significance compared to England or Benchmark.
Trendline: The scale and range of the vertical axis of each line graph changes in line with the values presented, where charts have a small axis range this can result in small differences between values appearing more considerable.

Notes:
-Indicators 'Successful completion of drug treatment: opiate users' and 'Successful completion of drug treatment: non opiate users' present figures for Leicestershire and Rutland combined.

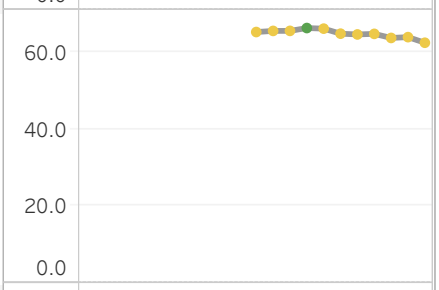
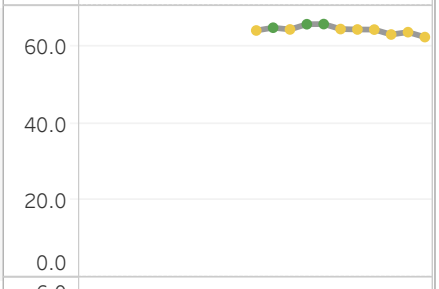
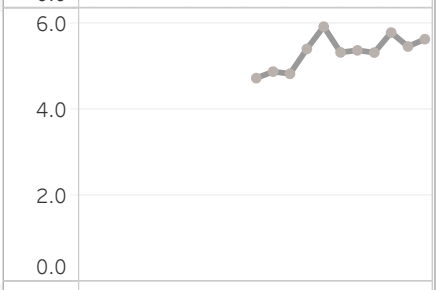
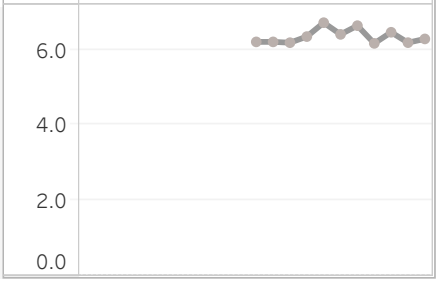
Statistical significance compared to England or Benchmark:

Direction of travel:

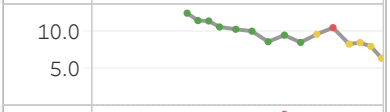
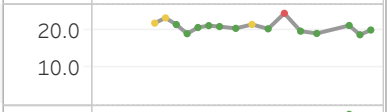
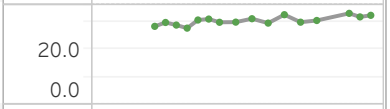
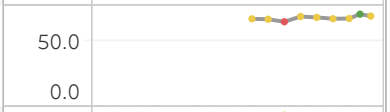
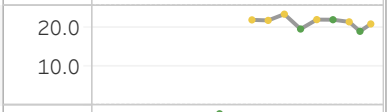
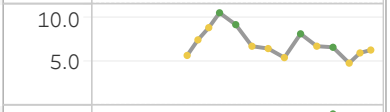
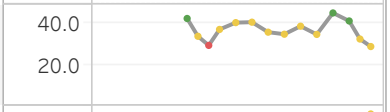
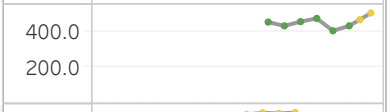
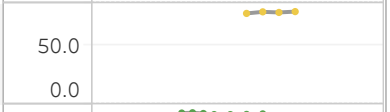
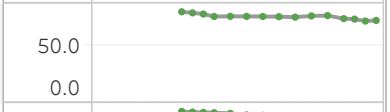
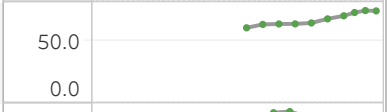
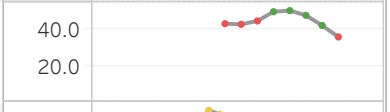


Source: OHID, https://fingertips.phe.org.uk/ - October 2025

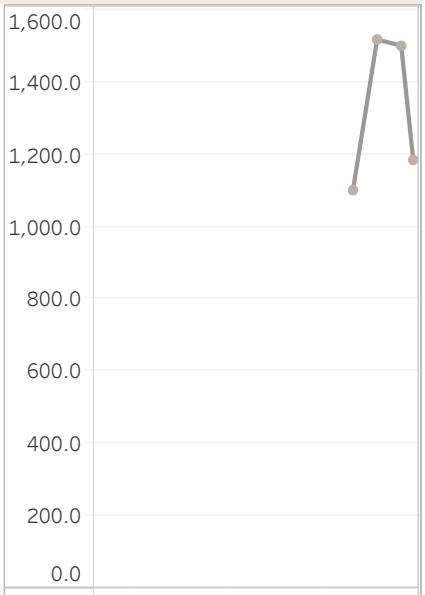
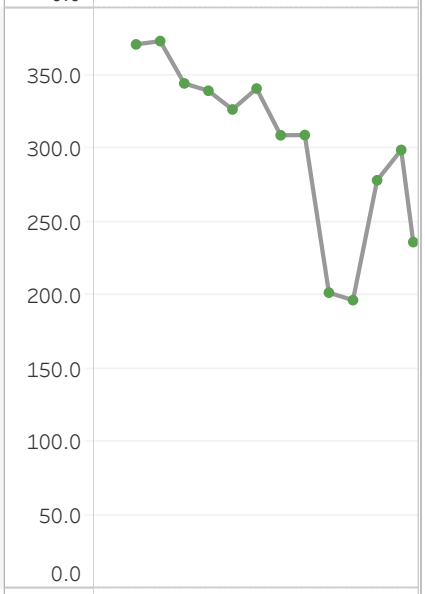
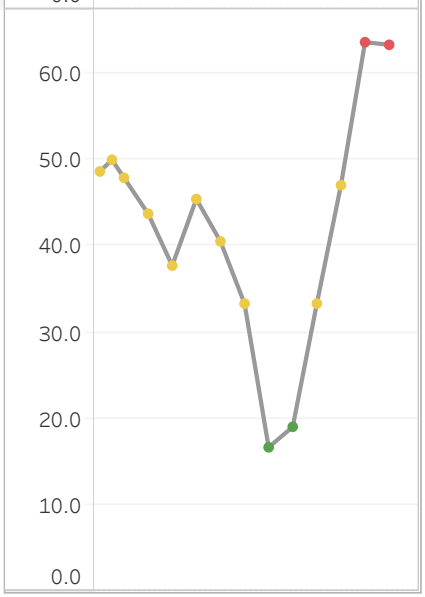
Public Health and Prevention Indicators in Leicestershire - Life Expectancy

Indicator	Latest Value	Latest Period	Prev. Value	DoT	Polarity	RAG	NN Rank	England Value	Trendline
Life expectancy at birth, years - Females	**83.7**	2021 - 23	83.6		High		8/16	83.1	
Life expectancy at birth, years - Males	**80.2**	2021 - 23	80.0		High		7/16	79.1	
Healthy life expectancy at birth, years - Females	**62.6**	2021 - 23	64.1		High		12/16	61.9	
Healthy life expectancy at birth, years - Males	**62.7**	2021 - 23	64.0		High		10/16	61.5	
Inequality in life expectancy at birth, years - Females	**5.6**	2021 - 23	5.5		Low		3/16	8.3	
Inequality in life expectancy at birth, years - Males	**6.3**	2021 - 23	6.2		Low		3/16	10.5	

Public Health and Prevention Indicators in Leicestershire - Health Improvement

Indicator	Latest Value	Latest Period	Prev. Value	DoT	Polarity	RAG	NN Rank	England Value	Trendline
Under 18s conception rate, per 1,000 - Females	**13.5**	2022	10.7	→	Low		10/16	13.9	
Breastfeeding prevalence at 6 to 8 weeks, % - Persons	**51.9**	2023/24	50.0	–	High		6/12	52.7	
Smoking status at time of delivery, % - Females	**6.4**	2024/25	8.0	↓	Low		10/16	6.1	
Reception prevalence of overweight (including obesity), % - Persons	**19.9**	2023/24	18.7	–	Low		7/16	22.1	
Year 6 prevalence of overweight (including obesity), % - Persons	**32.5**	2023/24	31.9	–	Low		7/16	35.8	
Overweight (including obesity) prevalence in adults - Persons	**65.8**	2023/24	65.9	–	Low		8/16	64.5	
Percentage of physically active adults, % - Persons	**68.6**	2023/24	70.1	–	High		9/16	67.4	
Percentage of physically inactive adults, % - Persons	**20.8**	2023/24	18.9	–	Low		11/16	22.0	
Successful completion of drug treatment: opiate users, % - Persons	**6.4**	2023/24	6.0	→	High		3/16	5.1	
Successful completion of drug treatment: non opiate users, % - Persons	**28.7**	2023/24	32.4	↓	High		10/16	29.5	
Admission episodes for alcohol-related conditions (Narrow), per 100,000 - Pers..	**503.4**	2023/24	466.8	↑	Low		10/16	504.1	
Estimated diabetes diagnosis rate, % - Persons	**79.4**	2018	78.6	–	High		6/14	78.0	
Cancer screening coverage: breast cancer, % - Females	**72.9**	2024	70.4	→	High		9/16	69.9	
Cancer screening coverage: cervical cancer (aged 25 to 49 years old), % - Females	**72.6**	2024	72.1	↓	High		5/16	66.1	
Cancer screening coverage: cervical cancer (aged 50 to 64 years old), % - Females	**77.9**	2024	78.0	↓	High		4/16	74.3	
Cancer screening coverage: bowel cancer, % - Persons	**75.0**	2024	75.3	↑	High		5/16	71.8	
Cumulative percentage of the eligible population aged 40 to 74 offered an NHS Health Ch..	**35.8**	2020/21 - 24/25	42.2	–	High		11/16	38.9	
Self reported wellbeing: people with a low worthwhile score, % - Persons	**3.3**	2022/23	2.2	–	Low		4/16	4.4	

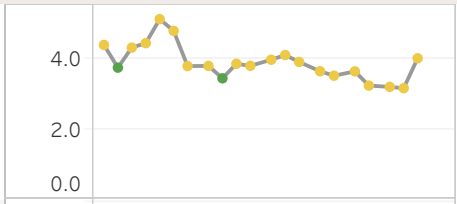
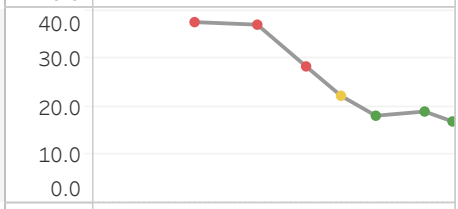
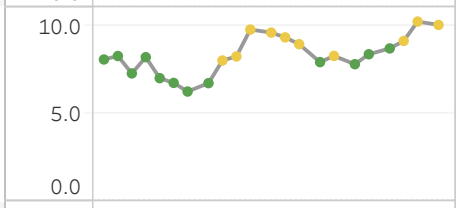
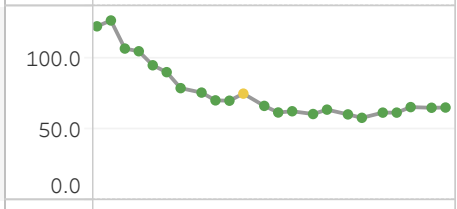
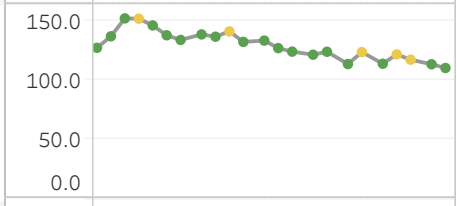
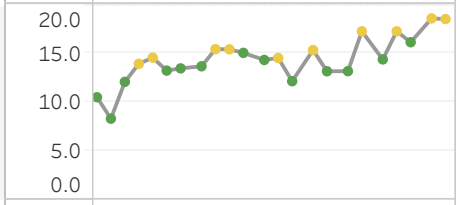
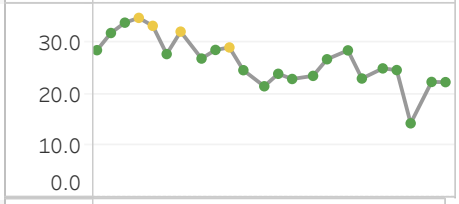
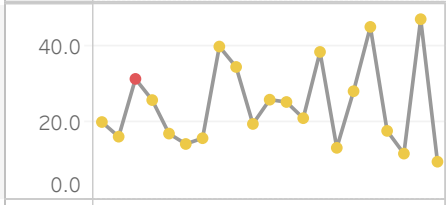
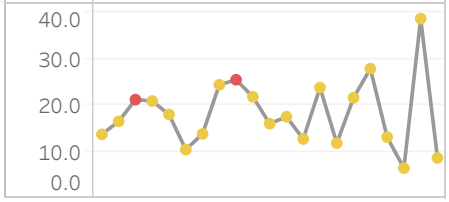
Public Health and Prevention Indicators in Leicestershire - Health Protection

Indicator	Latest Value	Latest Period	Prev. Value	DoT	Polarity	RAG	NN Rank	England Value	Trendline
Chlamydia detection rate per 100,000 aged 15 to 24 years - Persons	**1,184.8**	2024	1,500.5		N/a		16/16	1,249.8	
New STI diagnoses (excluding chlamydia aged 24 years and under) per 100,000 - Persons	**236.5**	2024	299.4	↑	Low		4/16	482.3	
HIV late diagnosis, % - Persons	**63.3**	2022 - 24	63.6		Low		15/16	43.3	

Note: On the trendline for 'HIV late diagnosis', the statistical significance compared to the benchmark in 2010 - 12 should be red/worse.

Public Health and Prevention Indicators in Leicestershire

- Healthcare & Premature Mortality

Indicator	Latest Value	Latest Period	Prev. Value	DoT	Polarity	RAG	NN Rank	England Value	Trendline
Infant mortality rate, per 1,000 - Persons	**4.0**	2021 - 23	3.2		Low		12/16	4.1	
Percentage of 5 year olds with experience of visually obvious dental decay, % - Persons	**17.0**	2023/24	19.1		Low		7/13	22.4	
Suicide rate, per 100,000 - Persons	**10.1**	2022 - 24	10.3		Low		8/16	10.9	
Under 75 mortality rate from cardiovascular disease - Persons	**65.6**	2023	65.5		Low		5/16	77.4	
Under 75 mortality rate from cancer, per 100,000 - Persons	**110.4**	2023	113.6		Low		7/16	120.8	
Under 75 mortality rate from liver disease, per 100,000 - Persons	**18.6**	2023	18.6		Low		6/16	21.9	
Under 75 mortality rate from respiratory disease, per 100,000 - Persons	**22.4**	2023	22.5		Low		3/16	33.7	
Winter mortality index (age 85 plus), % - Persons	**9.9**	Aug 2021 - Jul 2022	46.9		Low		7/16	11.3	
Winter mortality index, % - Persons	**8.6**	Aug 2021 - Jul 2022	38.7		Low		7/16	8.1	

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Leicester, Leicestershire and Rutland Joint Health Scrutiny

Work Programme 2025-26

Date of Meeting	Agenda Items	Organisation Responsible	Notes
Thursday 27 November 2025	System Health Equity Committee request to conduct a 'deep dive' into longer waits at both the Emergency department and patients waiting for ambulances to assess the impact against protected characteristics.	**EMAS / UHL/ ICB**	
	Digital Focus (Presentation)	**UHL/ ICB**	
	24/25 year-end review – info circulated	**ICB/LPT**	
	Dentistry	**ICB**	
Monday 23 February 2026	In depth session on GP specifics across LLR broken down by each area (Possible informal briefing)		
	CAMHS and SALTS		