



Meeting: **Health and Wellbeing Board**

Date/Time: **Monday, 15 June 2026 at 2.00 pm**

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

Contact: **Euan Walters (Tel: 0116 305 6016)**

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

Membership

Mr. P. Harrison CC (Chairman)

Barney Thorne	Siobhan Peters
Edd de Coverly	Mr. M. Squires CC
Mike Sandys	Mr. C. Pugsley CC
Jon Wilson	Cllr. J. Kaufman
Jean Knight	Cllr Cheryl Cashmore
Simon Pizzey	Matt Gaunt
Kevin Allen-Khimani	Sharon Cooke
Fiona Barber	Yasmin Sidyot

AGENDA

Item

Report by

1. Appointment of Chairman.

To note that Mr. P. Harrison CC is the Leicestershire County Council Cabinet Lead Member for Health and Public Health and is therefore the new Chairman of the Health and Wellbeing Board.

2. Minutes of the meeting held on 26 February 2026. (Pages 3 - 10)
3. To advise of any other items which the Chairman has decided to take as urgent elsewhere on the agenda.
4. Declarations of interest in respect of items on the agenda.

Democratic Services ◦ Department of Public Health, Communities, Law and Governance

◦ Leicestershire County Council ◦ County Hall

Glenfield ◦ Leicestershire ◦ LE3 8RA ◦ Tel: 0116 232 3232 ◦ Email: democracy@leics.gov.uk



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| 5. | Position Statement by the Chairman. | | |
| 6. | Joint Health and Wellbeing Strategy progress update on Staying Healthy Safe and Well. | Staying Healthy Partnership Board | (Pages 11 - 40) |
| 7. | Physical Activity Framework (2022-2031). | | (Pages 41 - 48) |
| 8. | Better Care Fund 2025-26 Year End. | Director of Adults and Cultural Services | (Pages 49 - 66) |
| 9. | Better Care Fund 2026-27 Plan. | Director of Adults and Cultural Services | (Pages 67 - 124) |
| 10. | Voluntary Action Leicestershire offer. | | (Pages 125 - 134) |
| 11. | Healthwatch Leicestershire report - Improving Hospital Discharge. | Healthwatch | (Pages 135 - 140) |
| 12. | Carers' Strategy Consultation. | Director of Adults and Cultural Services | (Pages 141 - 170) |
| 13. | Health Protection Annual Report. | Director of Public Health, Communities, Law and Governance | (Pages 171 - 214) |

14. Date of next meeting.

The next meeting of the Health and Wellbeing Board will be held on Thursday 17 September 2026 at 2.00pm.

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



Minutes of a meeting of the Health and Wellbeing Board held at County Hall, Glenfield on Thursday, 26 February 2026.

PRESENT

Leicestershire County Council

Mr. M. Squires CC (in the Chair)
Mr. C. Pugsley CC
Mike Sandys
Tracy Ward
Nicci Collins

District Councils

Cllr. J. Kaufman
Edd de Coverly

Integrated Care Board

Matt Gaunt

University Hospitals of Leicester NHS Trust

Ashley Epps

Leicestershire Partnership NHS Trust

Jean Knight

Healthwatch Leicester and Leicestershire

Fiona Barber

Voluntary Action Leicestershire

Kevin Allen-Khimani

In attendance

Mala Razak (Leicestershire County Council)
Shaun McGill (Leicestershire County Council)
Lisa Carter (Leicestershire County Council)
Abbe Vaughan (Leicestershire County Council)
Kerryjit Kaur (Integrated Care Board)
Pete Burnett (Integrated Care Board)
Victoria Rice (Leicestershire County Council)
Amy Chamberlain (Leicestershire County Council)
Euan Walters (Leicestershire County Council)

Apologies

Harsha Kotecha, Jane Moore, Rachel Dewar, Siobhan Peters, Cllr Cheryl Cashmore, Toby Sanders and Mr. C. Abbott CC

45. Minutes of the previous meeting.

The minutes of the meeting held on 4 December 2025 were taken as read, confirmed and signed.

46. Urgent items.

There were no urgent items for consideration.

47. 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.

The Chairman himself declared an interest in all substantive agenda items due to his employment with a partner organisation.

Cllr. J. Kaufman declared a non-registerable interest in all substantive agenda items as he had a close relative that worked for NHS England.

48. Position Statement by the Chairman.

The Chairman presented a Position Statement on the following matters:

- (i) Adult Social Care;
- (ii) Chair's Engagement Activity;
- (iii) Key Messages;

A copy of the position statement is filed with these minutes.

49. Election of Vice Chairman.

RESOLVED:

That Matt Gaunt (Integrated Care Board) be elected Vice Chairman of the Health and Wellbeing Board for a period of two years.

50. Joint Local Health and Wellbeing Strategy update- Best Start for Life.

The Board considered a report of the Children & Families Partnership which provided an update in relation to the Best Start for Life priority of the Joint Health and Wellbeing Strategy (JHWS) 2022-32 and sought approval for proposed changes to the current relationship between the Children and Families Partnership, and the Health and Wellbeing Board. A copy of the report, marked 'Agenda Item 6', is filed with these minutes.

Arising from discussions the following points were noted:

- (i) The Children and Families Partnership (CFP) was the Operational Delivery Group that oversaw the Best Start for Life strategic priority of the JHWS, contributing also towards cross-cutting priorities. It was proposed that a new Operational Delivery Group of the Health and Wellbeing Board be created, provisionally named the "Children and Young People (CYP) Place Based Group", that would oversee the Best Start for Life commitments. The CFP meanwhile would become independent of the Health and Wellbeing Board and retain ownership of the wider CFP Plan, focusing on those priorities requiring partnership working that were not directly related to health.
- (ii) The wider determinants of health were more broad ranging than just the provision of healthcare. It was important that when tackling the wider determinants all partners were involved and kept sighted of the work that was taking place.
- (iii) There would be areas of overlap between the CFP and CYP and some crossover of membership between the two groups. Annual reports from one group would be taken to the other.
- (iv) Liaison was taking place with officers from the ICB to ensure there was no duplication of work.
- (v) In response to a comment that there was no reference in the Children and Families Partnership work to children being home schooled and the level of access to facilities and support they had, it was agreed to give consideration to this after the meeting.
- (vi) In response to a question about demonstrating outcomes from the CFP work it was explained that a dashboard of indicators that linked to the commitments in the JLHWS would be developed to show the direction of travel.
- (vii) There were opportunities for UHL to link in more with the CFP work particularly around maternity clubs.
- (viii) It was noted that the Voluntary, Community and Social Enterprise (VCSE) sector was not on the membership list of the CYP Place Based Group and agreed that they would be invited to meetings.

Jean Knight (Leicestershire Partnership NHS Trust) raised concerns about the proposed new governance arrangements particularly the possibility of a reduction in partnership collaboration and she suggested that the governance arrangements should be reviewed in one year's time to see how effective they were.

RESOLVED:

- (a) That the progress being made in relation to delivering against the Best Start for Life priority be noted;
- (b) That the progress being made in relation to delivering against the cross-cutting priorities be noted;
- (c) That the proposed changes to the Operational Delivery Group of the Health and Wellbeing Board overseeing the Best Start for Life strategic priority be approved,

and a review of these governance arrangements be requested to take place in one year's time.

51. Joint Local Health and Wellbeing Strategy amendment, Easy Read and Delivery Plans.

The Board considered a report of the Director of Public Health, Law and Governance which asked the Board to amend the wording of a commitment in the Joint Local Health and Wellbeing Strategy (JLHWS) (Reviewed and Revised 2022-2032), approve the easy read document of the JLHWS, and note the first iteration of the delivery plan. A copy of the report, marked 'Agenda Item 7', is filed with these minutes.

Arising from discussions the following points were noted:

- (i) There would be regular progress reports regarding all four areas of the JLHWS. The Operational Delivery Groups which sat under the Health and Wellbeing Board would have quarterly performance updates.
- (ii) It was important to be able to demonstrate value and positive outcomes from the JLHWS work, and each Action in the Delivery Plan had a success measure aligned to it and an indicator in the dashboard. However, it was not always easy to demonstrate the cause of improvements and effect of the work taking place. Obesity was one issue affected by lots of different factors which made it difficult to assess the impact of interventions. One of the success measures for the First 1001 Critical Days Delivery Plan was a 'sustained reduction in A&E attendances for 0-4 years'.
- (iii) The Better Care Fund outcomes would be aligned in the dashboard with the JSNA outcomes.
- (iv) With regards Dying Well there would be more reliance on qualitative data and case studies as less quantitative data was available.
- (v) One of the commitments in the JLHWS was Supporting Independent Living and it was suggested that housing should be linked to this commitment as well as the role played by the voluntary sector. In response, reassurance was given that the Integration Executive and Staying Healthy Partnership would have oversight of these issues, but consideration would be given to any gaps that were identified.
- (vi) Work was now commencing on the development of neighbourhood plans as an addendum to the delivery plan, setting out local priorities and supporting delivery at place level. Members emphasised the importance of this work. It was suggested that there needed to be a common understanding amongst partners regarding the definition of a neighbourhood.
- (vii) A member noted that care leavers were considered to have a protected characteristic and emphasised the importance of ensuring that care leavers were able to access services.

RESOLVED:

- (a) That the change of wording to the 'healthy homes' commitment in the Staying Healthy Safe & Well life course priority within the Joint Local Health & Wellbeing Strategy (JLHWS) be approved;

- (b) That the easy read document of the JLHWS be approved;
- (c) That the JLHWS Delivery Plan be noted.

52. Better Care Fund - Quarter 3 update.

The Board considered a report of the Director of Adults and Communities which provided the Quarter 3, 2025/26 template report of the Better Care Fund (BCF). A copy of the report, marked 'Agenda Item 8', is filed with these minutes.

Arising from discussions the following points were noted:

- (i) Money had been set aside for recruiting locum therapists but none were available locally so the funding would be repurposed.
- (ii) The average length of discharge delay for all acute adult patients was off target by 2.4% against planned performance. Work was taking place to improve the timeliness of decision making and make communication with families better. Consideration was also being given to pathways and early discharge planning. The Discharge Group was monitoring the situation.
- (iii) The UEC Ops Group involved multiple partners and would consider performance data and identify any gaps between health and social care. It was important that the appropriate level of data was available to the UEC Ops Group. This could then feed into the BCF return.

RESOLVED:

That the performance against the Better Care Fund outcome metrics, and the positive progress made in transforming health and care pathways up to Quarter 3, be noted.

53. Change to the Order of Business.

The Chairman sought and obtained the consent of the Board to vary the order of business from that set out on the agenda for the meeting.

54. Integrated Care Board 5 Year Commissioning Strategy.

The Board considered a report of the Integrated Care Board which presented the contents of the ICB 5 Year Strategic Commissioning Strategy. A copy of the report, marked 'Agenda Item 11', is filed with these minutes.

Arising from discussions the following points were noted:

- (i) The 5 Year Strategic Commissioning Strategy focused on a small number of priorities where it was felt the greatest difference could be made. Although mental health was not one of the priorities, it was still a core commissioning requirement for the ICB and work would continue to take place with providers to address mental health needs. It was felt that the most value could be gained from working with partners to prevent health needs arising in the first place. The preventative approach was crucial to ensuring the financial sustainability of the Integrated Care Board.

- (ii) In response to a question about value for money and the quality of services, it was explained that where it was clear that there was no value for money a service would no longer be commissioned, but with some services it was not clear whether there was value due to the various factors that lead to outcomes.
- (iii) The ICB had carried out a Health Needs Assessment to obtain data to base commissioning on. There was no Joint Strategic Needs Assessment for the whole ICB cluster area but JSNAs were fed into Health and Wellbeing Board strategies and therefore part of the commissioning process.
- (iv) Due to the short timescales within which the ICB had to produce their Commissioning Strategy not as much public engagement had taken place as was desirable. It was hoped that the public voice could be better incorporated into commissioning decisions going forward.
- (v) Conversations needed to take place about the expectations placed on the Voluntary, Community and Social Enterprise (VCSE) sector in helping delivering the ICB's Commissioning Strategy and what funding could be made available to VCSE organisations.

RESOLVED:

That the contents of the report and the 5 Year Strategic Commissioning Strategy be noted.

55. Joint Strategic Needs Assessment Programme of Work.

The Board considered a report of the Director of Public Health, Law and Governance which provide an update on the Joint Strategic Needs Assessment (JSNA) work completed during 2025 using the revised dashboard led approach, presented proposals for establishing a JSNA Steering group, and presented the updated demography dashboard. A copy of the report, marked 'Agenda Item 9', is filed with these minutes.

In presenting the report it was explained that it was proposed to establish a JSNA steering group to undertake the prioritisation and sequencing of JSNA topics which would guide the ongoing development of the JSNA programme of work. It was clarified that whilst the steering group would make decisions, the Health and Wellbeing Board would still have oversight and the steering group would report into the Board.

Members welcomed the appearance and functionality of the dashboard and noted that it would be a useful aid in making commissioning decisions. In response to a suggestion that the dashboard needed to be further publicised amongst partners, it was confirmed that there were no plans in place as yet but this would be discussed by the steering group.

In response to a suggestion that it would be useful to have the same level of data for Leicester as was in the dashboard for Leicestershire, it was explained that fortnightly data sharing meetings took place between the City and County Councils, however the City had different plans and priorities therefore they could not have exactly the same dashboard as Leicestershire.

RESOLVED:

- (a) That the establishment of a JSNA steering group to undertake the prioritisation and sequencing of JSNA topics which will guide the ongoing development of the JSNA programme of work, be approved;
- (b) That the new demography dashboard be welcomed.

56. University Hospitals of Leicester NHS Trust Clinical Strategy

The Board considered a report of University Hospitals of Leicester (UHL) regarding UHL's Group Clinical Strategy (2025-35). A copy of the report, marked 'Agenda Item 10', is filed with these minutes.

It was noted that parts of the Strategy were driven by UHL, and other parts were driven by partners such as the Integrated Care Board. A large amount of partnership working would have to take place to implement the Strategy. The frailty work was one example of this where Primary Care, Social Care and the voluntary sector all played a role.

The report set out that Focus area 3 of the Strategy was 'Delivering care in communities and neighbourhoods'. It was noted that delivering this part of the Strategy would require input from housing and community support teams and it would link in with the neighbourhood health work taking place. Concerns were raised that large changes were taking place with the structures of local authorities and partner organisations and therefore conversations needed to take place to ensure that any decisions on the community and neighbourhood work were made with the structure changes in mind. In response it was explained that conversations could take place at meetings of the proposed new County Place Based Team regarding the governance of neighbourhood health model development and Local Government Reorganisation. UHL would welcome being involved in the County Place Based Team.

RESOLVED:

- (a) That the Clinical Strategy, implementation progress to-date and key next steps be noted;
- (b) That the strategy's alignment with the Joint Health and Wellbeing Strategy, and the opportunities to support or enhance its delivery impact through partnership working be noted.

57. NHS Transformation and Transition.

The Board considered a report of the Integrated Care Board which provided an update and overview on the NHS transformation and transition for Integrated Care Boards. A copy of the report, marked 'Agenda Item 12', is filed with these minutes.

In presenting the report it was emphasised that the level of current health provision was not enough for future demand and therefore ways of working needed to change. There needed to be prioritisation towards the areas of work which would have the most impact.

In an update to the information provided in the report about the ICB staffing reduction, it was explained that the second round of voluntary redundancies had now taken place and the staff consultation was about to close. In response to concerns raised about the impact of the redundancies on partners and the possibility of the ICB being unable to carry out some of its duties, it was acknowledged that this was a risk but reassurance was given that any issues could be raised with the ICB Executive Team.

It was noted that a lot of changes were taking place regarding NHS England and regional health commissioning functions and the Board would benefit from a report providing an update on the new structures. It could also be useful to have another Health and Wellbeing Board Development Session regarding new developments in the health arena. It was confirmed that a Development Session was currently being planned.

RESOLVED:

That the contents of the report, and the position of the NHS transformation and change agenda, be noted.

58. Health and Wellbeing Board Terms of Reference Review.

The Board considered a report of the Director of Public Health, Law and Governance regarding a review of the Board's Terms of Reference which had taken place. A copy of the report, marked 'Agenda Item 13', is filed with these minutes.

It was noted that in addition to the amendments to the Terms of Reference proposed in the report, it was also proposed to remove the Chief Executive of Leicestershire County Council from the Board membership as the Chief Executive was satisfied that there was sufficient representation on the Board from the Council with the three Directors.

With regards to the County Place Based Team which was proposed to be set up, the membership was to consist of a broad range of partners. Edd de Coverly (Chief Executive of Melton Borough Council) requested that the membership include representatives from District Councils and in response it was agreed that this would be included in the Terms of Reference.

RESOLVED:

- (a) That the revised Terms of Reference for the Health and Wellbeing Board as set out in the appendix to the report be approved, subject to the removal of the Chief Executive of Leicestershire County Council from the membership list;
- (b) That the list of Operational Delivery Groups that sit under the Health and Wellbeing Board include the CYP Place Based Group instead of the Children and Families Partnership;
- (c) That an additional Operational Delivery Group known as the County Place Based Team be created.

59. Date of next meeting.

RESOLVED:

That the next meeting of the Board takes place on Wednesday 3 June 2026 at 2.00pm.

HEALTH AND WELLBEING BOARD: 15 JUNE 2026
REPORT OF THE STAYING HEALTHY PARTNERSHIP
JOINT LOCAL HEALTH & WELLBEING STRATEGY PROGRESS
UPDATE ON STAYING HEALTHY, SAFE & WELL

Purpose of report

1. The purpose of the report is to provide an update to the Health and Wellbeing Board (HWB) on progress in relation to the Staying Healthy, Safe & Well priority of the Joint Health and Wellbeing Strategy (JLHWS) 2022-32.
2. The Board is requested to:
 - a. Note the progress being made in relation to delivering against the Staying Healthy, Safe & Well priority.
 - b. Note the progress being made in relation to delivering against the cross-cutting priorities.

Background

3. One of the statutory requirements of the HWB is to produce and deliver a JLHWS. A Joint Strategic Needs assessment (JSNA) was carried out to provide the evidence base to identify the health and wellbeing needs of the local population. The JSNA along with contributions from key partners and stakeholders, helped to inform the JLHWS priorities.
4. The ten-year JLHWS was approved in February 2022, revised in 2025 and aims to improve the health, wellbeing and equity outcomes of Leicestershire residents. The strategy follows a life course approach:
 - a. Best Start for Life;
 - b. Staying Healthy, Safe and Well;
 - c. Living and Supported Well;
 - d. Dying Well.
5. Three HWB subgroups deliver the priorities within each specific life course. A fourth subgroup was established in January 2023 to specifically address the mental health needs across Leicestershire, recognising it cuts across all life courses and requires a greater focus.
6. Reducing health inequalities remains a cross-cutting priority and underpins the work of all four subgroups.

7. The COVID-19 Recovery cross-cutting priority has been removed and replaced by a broader commitment to health protection and emergency preparedness, which is now a new cross-cutting priority to be delivered across all four subgroups.
8. The Staying Healthy, Safe and Well strategic priority is split into two priority areas. Each priority area includes a set of commitments.
 - a. **Building Strong Foundations**
 - i. Health in and equity in all policies
 - ii. Healthy placemaking (**key area of focus 25-26**)
 - iii. Healthy workplaces and local economy
 - iv. Healthy homes
 - v. Healthy and safe communities
 - b. **Enabling Healthy Choices & Behaviours**
 - i. Healthy choices and behaviours
 - ii. Healthy weight, food and nutrition (**key area of focus 25-26**)
9. The Staying Healthy Partnership is responsible for overseeing the delivery of the Staying Healthy, Safe and Well strategic priority of the JLHWS and has a role to play in delivery of the cross-cutting priorities.
10. The latest report on progress was presented to HWB in May 2025. Since the last report, the JLHWS has been reviewed, and this report provides an update on the revised commitments and includes:
 - a. an update on progress since the last report.
 - b. challenges that would benefit from input from the HWB, and plans for the next 12 months in continuing to deliver against the Staying Healthy, Safe & Well strategic priority of the JLHWS.

Progress against the Staying Healthy, Safe & Well strategic priority of the JHWS

11. The table below details the progress being made against each of the priority areas and commitments and includes a data dashboard to measure associated outcomes that can be viewed in **appendix 1**:

JLHSW Priority 1: Building strong foundations

Health and equity in all Policies (HiAP)

Health in all Policies

The Health in All Policies pilot programme has continued at Leicestershire County Council (LCC) this year, comprising of online and face to face learning, and submission of health impact e-forms, summarising health considerations made on key pieces of work submitted to Scrutiny Committees and Cabinet at the County Council. To date, over 260 learners have completed the LCC 'Health in All Our Work' e-learning and or 'Health in All Our Decisions' training, with learners reporting significantly improved understanding of health inequalities and increased confidence applying learning to their work. A qualitative evaluation of the LCC Health in All Policies programme was conducted this year as part of a Public Health Masters Degree dissertation project. This reported positive impacts from the training and intersectional work and increased knowledge and understanding of the building blocks for health. There were also a number of recommendations around next steps for the programme.

Following the successful LCC pilot and strong engagement at a district level, North West Leicestershire District Council is preparing to roll out the Leicestershire County Council Health in All Policies (HiAP) model in summer 2026, with Blaby District Council formally agreeing to adopt the LCC HiAP model at a Senior Leadership Team meeting in April 2026. This development from the initial LCC programme to system partner sign up aligns with the commitment from the Staying Healthy Partnership member organisations to HiAP adoption and roll out. It also recognises the critical role of district councils' statutory duties as some of the most powerful levers for shaping the wider determinants of health and reducing inequalities.

Nationally, Leicestershire's Health in All Policies approach and learning has informed and supported other local authorities through direct officer-to-officer engagement and national networks. We continue to support other authorities in creating and embedding their approaches, sharing Leicestershire's expertise and learning. We have held meetings with ten local authorities over the past 12 months, including Gloucestershire and Kent, alongside wider influence through the national HiAP Network. The Leicestershire approach has been recognised nationally as a gold-standard example of practice and will feature in forthcoming Local Government Association HiAP guidance as an exemplar model for other authorities.

The Local Transport Plan for Leicestershire Core Document 2025 – 2040 was formally adopted with ‘Enabling Health and Wellbeing’ as a core theme within the policy. This has then fed into the Enabling Travel Choice Strategy, with Public Health colleagues involved in the development of the strategy, which will be accompanied by a full, strategic Health Impact Assessment.

Over the past 12 months, the Leicestershire Public Health team has worked with planners in our District Councils where Local Plans were being renewed, to embed Health Impact Assessment requirements within policy.

The value of the HiAP programme lies in embedding health and equity considerations upstream in policy and investment decisions, reducing the risk of unintended harm, supporting more joined-up use of public resources, and helping to avoid avoidable pressure on services later on.

Next steps: We will continue to explore recommendations to strengthen our HiAP approach, including building internal capacity and advocacy through potential HiAP champions. We will improve visibility and shared learning further, through clear case studies demonstrating how HiAP has informed policy development and decision making to reduce potential risks to health and promote co-benefits for cross departmental outcomes. The programme roll outs with District Councils will be supported and early evaluation undertaken to share learning and explore additional potential organisations to adopt the programme going forward.

Health Impact Assessments (HIA) - District Update

- Continued working closely with districts to ensure health and wellbeing is enhanced through Local Plans, through assessing the impact of relevant policies within the local plan on health and wellbeing and recommendations for improvements.
- Regular proactive meetings to assist with the drafting and inclusion of a specific HIA policy within the forthcoming Local Plan, which will require developments that are of a particular type and over a certain threshold to undertake a HIA. This will encourage developments to consider the impact of proposals on health and wellbeing from the early stages of the process.

Healthy Placemaking

Healthy Placemaking

The Staying Healthy Partnership sponsored a Healthy Placemaking event in February 2026 to focus on this as a priority area. This brought together around 50 attendees from a range of organisations and departments across planning, public health, transport, housing,

the NHS, district councils and the voluntary sector to discuss opportunities and priorities for creating healthy places across Leicestershire. Delegates discussed how social and community factors, environmental conditions, access to amenities, enabling travel choices, enhancing access to nutritious food and supporting active lifestyles could impact our population and health inequalities, and how we could work together to address this. Attendees agreed to the re-establishment of the Healthy Placemaking Forum on a focused, topic-based basis, to reduce duplication and support the sharing of best practice, and more consistent and aligned policy approaches across the county. This has been presented to the Strategic Planning Group for agreement.

The Leicestershire Public Health team have conducted five strategic HIAs on emerging Local Plans within the county, working closely with Active Together to embed considerations on physical activity such as formal and informal spaces to live, work, travel and play. Pilot work with Planners in five District Councils has also taken place over the last 12 months to embed Health Impact Assessment requirements within Local Plan policy. These signpost to the Leicestershire Health Impact Assessment template which includes requirements to consider the impact of the proposal on social, economic and community factors, environmental conditions, access to amenities, connectivity, enhancing access to nutritious food and supporting active lifestyles.

The LCC Public Health team have been approached by three developers prior to the adoption of Local Plans to start pro-active conversations around HIA and place design on key strategic sites within the county. Conversations are in early stages and will include district health representatives and planners to ensure a collaborative approach. This also links to the action within the Air Quality and Health Partnership Action Plan to pilot work on healthy design in key strategic sites within the county.

To further strengthen routine health and wellbeing considerations in planning processes and use of health impact assessments, the Leicestershire Public Health team have worked with applicants on two National Significant Infrastructure Programmes within the county, to embed proportionate and accurate considerations of potential impacts and associated impact assessments within the application and examinations processes.

Evidence shows that good place design can improve physical and mental health, economic productivity, educational attainment, recruitment and retention of staff, community cohesion, social capital, civic pride, safety and crime rates, and sense of place. Our work this year on healthy placemaking has helped us start to gather a system wide agreement on what 'good' looks like for Leicestershire.

Next steps: Now that health related policy has been drafted for the Local Plans, extensive work will take place to support those leading on Local Plan examination processes to ensure the policies meet relevant requirements and are adopted. Alongside this, guidance will be created to support those drafting health impact assessments to ensure that the asks and procedures are proportionate and clear.

The relaunch of the Healthy Placemaking Forum will aim to positively contribute to communications and partnership working in an efficient way throughout the county.

Healthy Workplaces and Local Economy

Work Well Programme

WorkWell, as part of a broader government agenda linked to economic inactivity and recovery, is a key driver behind the ambition of 'Get Britain Working,' white paper. UK is the only G7 country to have not returned to pre-pandemic level of employment. For LLR, WorkWell fundamentally underpins our local health inequalities agenda, deepening social value and dignity, and supporting economic recovery. We also know good work is good for people, and WorkWell aims to support those with disability, and in LLR, specifically those struggling with MSK and mental health conditions, where these health-related conditions have become a barrier into work.

Key areas of progress:

- We have introduced and integrated 26 Work and Health Coaches into general practice, to work alongside the care navigation team (personalised care); Social Prescribers, Care Coordinators, Health and Wellbeing Coaches.
- LLR Training Hub have been commissioned by LLR ICB with WorkWell funding to provide the Work and Health Coaches a network and Community of Practice on a monthly basis, to provide local and national updates, training and CPD aligned to the NHSE Framework and competencies of Personalised care roles and outside of primary care and work in a complementary way.
- Since 1st April 2025 to 31st March, 1241 participants have started the WorkWell Programme, with a guided period of 12 weeks of low intensity personalised support with either a 'Thrive in Work Plan' if in work with barriers or a 'Return to Work Plan' in seeking employment with health barriers. The plan can be shared with a service provider of higher intense support i.e. Individual Placement and Support (IPS), Talking Therapies, Musculoskeletal services, and Adult Education Hubs.

Refer to the full report which includes next steps for the programme in **appendix 2**

Healthy Workplaces programme

The Healthy Workplaces Leicestershire programme helps organisations of all sizes across the county to become healthier places to work. The tailored accreditation programme has been designed in collaboration with, and for LLR business, helping to ensure steps are putting in place to embed a health and wellbeing which benefits both the employer and employee. Support can be provided with a

Workplace Health Need's Assessment, 3 step accreditation, MHFA & refresher training, Health MOT checks in house, healthy conversations support for managers and neurodiversity awareness training.

The data below indicates businesses that are currently engaged with the Healthy Workplaces Programme:

- 38 organisations across LLR are completing their Healthy Workplaces accreditation
- District progress towards accreditations:
 - Melton BC Empowered Feb 2026 (1st District to receive this result).
 - Charnwood to be awarded Empowered 6th March 2026.
 - NWLD committed – One step needed to complete committed and 2nd WHNA required
 - Harborough BC – Achieved Committed now working towards empowered
 - Hinckley & Bosworth, Blaby and Rutland – Working towards committed
- Over 50 businesses to date have completed their Workplace Health Needs Assessment identifying strengths and areas of opportunity to improve.
- Over 350 Health MOT checks completed to employees over the past 12 months.
- Over 50 Mental Health First Aiders (MHFA) trained up across LLR.

Healthy Homes

Warm Homes – Domestic energy efficiency retrofit

- The Public Health Warm Homes service has successfully completed Home Upgrade Grant phase 2 (HUG2) funding delivery in 2025. This funding is provided by the Department for Energy Security and Net Zero, supported by Midlands Net Zero Hub as part of a consortium and delivered a total of £1.2m capital works consisting of 145 energy efficiency measures across 108 low income off-gas grid homes against an anticipated delivery of approximately 160 energy efficiency measures across 120 households. This has achieved a significant average energy efficiency SAP score uplift of 21 points per home. This consortium project was led by LCC on behalf of 6 district authorities (excluding Oadby and Wigston, also delivering funding locally).
- Local Energy Advice Demonstrator funding was secured via the Department for Energy Security and Net Zero, supported by Midlands Net Zero Hub to support uptake of government grant initiatives and has delivered locally as the Home Energy Retrofit Offer (HERO). Outcomes include 288 home visits, 573 residents receiving face to face advice and confirmation of 43 households accessing 71 energy efficiency measure improvements through to April 2025.

- Warm Homes Local Grant funding has been secured by LCC as part of another Midlands Net Zero Hub led consortium project utilising the next round of funding provided by the Department for Energy Security and Net Zero and has commenced delivery to retrofit low income private sector homes with energy efficiency measures to reduce energy bills and improve thermal comfort. This represents ~ £4.5m of capital measures to be delivered between 2025 and March 2028 to an approximate 326 properties. This consortium project is led by LCC on behalf of 6 district authorities (excluding Oadby and Wigston, also delivering funding locally). Additional resources for the Warm Homes service to refer into is also being explored as part of the Social Value element of delivery contracts.

Reducing fuel and food poverty (cost of living crisis)

- Winter Wellness Packs have been developed to support residents experiencing heating or financial crisis at immediate risk of ill-health due to a cold home. Packs consist of practical items to keep the person warm such as low-cost electric blankets, thermal wear, thermos and hand warmers. The stock of 500 packs is anticipated to last several years. A small number of dehumidifiers have also been purchased to gift to low-income households experiencing significant issues with damp and mould.
- The Warm Homes services continue to maintain an all-encompassing self-help advice guide to managing energy costs at home and operates a periodic newsletter.

Housing and Respiratory Illness Project

- Between 1 April 2025 and 19 March 2026 102 cases were received from frontline health and social care professionals.
 - 69 have had repairs raised
 - 58 have been closed to the project following intervention and resolution
- Successful interventions can range from advisory visits to advise on best use of existing heating systems, checks on energy tariffs to ensure best value, benefit checks to ensure that people are receiving what they are entitled to assisting with cost of heating homes, mould clean and clears through to physical repairs to property such as roof repairs window repairs damp proofing etc.
- 23 teams/organisations have used us in the last year as the single point of contact for concerns around damp and mould. This alleviates pressure on their time as they do not need to distract from their work to make referrals themselves.
- This year the team have made onward referrals to 23 teams/organisations which demonstrates the difficulty that the frontline professionals would have had trying to work out who to reach out to with these different teams
- Every case is monitored until they are completed and support given to the customer by chasing up any delayed works on their behalf and/or giving advice on what can be done to resolve any additional issues. Some cases are referred to more than one organisation. For example when repairs are completed the customer may present with concerns about how to use their heating or costs which will result in a secondary referral to one of the support charities such as Groundworks or Age UK.

- Development of the new Damp and Mould reporting portal is nearing completion which should reduce administration of cases by automating some of the referral emails, while maintaining the human side of the phone calls to customers by our team.
- The Warm Homes service has established a two-way referral pathway with the Housing and Respiratory Illness project This will facilitate support for residents experiencing ill health due to cold inefficient homes to access grant funding for energy efficiency improvements.

Healthy Homes – other

- Lightbulb team continue to deliver the Housing MOT to support health and wellbeing in the home
- Delivery of tenancy management support to support retention of tenancies improving overall wellbeing.

Homelessness

- Homelessness pressures continue to rise across the County and Rutland, driven by affordability issues, private rented sector change, and cost-of-living pressures.
- Cases are becoming more complex, with non-housing issues increasingly driving demand and length of stay in services.
- Temporary accommodation demand and costs remain a significant and escalating challenge, particularly for families with children and single-person households.
- The lack of new affordable homes coming on to the market and the significant decrease in properties coming back available increases the time households have to spend in TA. Some families, with a larger bed need have been in TA for over 2 years.
- Latest data (July–September 2025) shows sustained pressure at both prevention and relief stages, with consistent patterns in the reasons households present as homeless.
- Strong multi-agency collaboration is already in place, including CHOG, the Homeless Delivery Group, and the LLR Homelessness Alliance, but needs continued leadership support.
- Targeted initiatives are underway, including acquisition of temporary accommodation, rough sleeping interventions, supported housing needs assessment, and work with public health and criminal justice partners.
- The Government’s National Homelessness Strategy (launched late 2025) sets an ambitious long-term direction, including strengthened duties to cooperate, which will require collective local leadership to implement effectively.

Compliance with Social Housing Regulation Act 2023

The Social Housing (Regulation) Act 2023 came into force in April 2024. All district council landlords and registered providers with 1,000 or more homes are subject to the regulatory regime and must comply with a strengthened set of Consumer Standards. Compliance is assessed through routine inspections, scheduled to take place at least once every four years. Oadby and Wigston Borough Council and

Hinckley and Bosworth Borough Council are yet to be inspected. All district and borough councils with retained housing stock continue to work towards embedding the requirements of the Social Housing (Regulation) Act 2023 and ensuring ongoing compliance with the Consumer Standards. The standards seek to ensure improved housing conditions for resident.

Healthy & Safe Communities

- The number of LCC Volunteers supporting Leicestershire Communities continues to grow, with over 1400 volunteers supporting activity in a variety of roles across Leicestershire.
- January 2026 saw the launch of the 'Mission Ready: Supporting Families on the Move' project. Funded through the Armed Forces Covenant Fund, this project aims to ensure Armed Forces Families moving to LLR will have improved access to information, advice and guidance from LCC and partner agencies.
- The number of Neighbourhood Plans created across Leicestershire continues to grow – currently there are over 70 made plans in Leicestershire. More and more plans are including 'Community Aspirations' within them, giving some insight into the 'asks' of communities outside the planning system.
- Risk Ready Communities launched in March 2026, supporting individuals, households and communities across LLR to prepare for emergency situations, including power outages and floods.

JLHWS Priority 2: Enabling healthy choices and behaviours

Healthy Choices & Behaviours

Sexual Health

L&R Sexual Health Steering Group:

- Formed in 2025 Our L&R SH Steering group has been developed to:
 - champion the work of the sexual health system
 - align pathways across the system to ensure no wrong doors
 - agree and monitor strategic priorities
 - form a SH plan for L&R in line with the national strategy
 - review local data to inform programmes of work to support the SH plan.
 - co-ordinate transformation and link in with wider opportunities through other collaboratives

In line with the above, a sexual health plan is being developed by the steering group currently and this will drive our collective work. The strategic plan will be finalised late summer, actions will report into the Staying Healthy Partnership.

Drug & Alcohol Use

- The Combating Drugs and Alcohol Partnership (CDAP) continues to meet regularly to review the delivery plan for substance use
- The integrated substance use treatment and recovery service continues to deliver and exceed targets for numbers of people in treatment
- Additional funding has been received for 2026/27 via the Public Health Grant which is designed to support additional numbers in treatment and those experiencing or at risk of experiencing rough sleeping
- Tracking of local data on need and take up continues via the substance use strategic lead, the Turning Point service and the CDAP

Gambling Harms

- The Leicestershire Gambling Harms Health Needs Assessment recommended a number of key priorities to prevent harmful gambling and progress is being made across partners
- First Contact + have introduced a screening process for harmful gambling and the Leicestershire and Rutland substance use treatment and support offer provided through Turning Point, now includes screening for harmful gambling
- Chapter One is working across Leicestershire and Rutland delivering a programme of training for professionals to raise awareness of harmful gambling and signposting for those in need of treatment and support along with affected others
- Engagement work with those impacted by harmful gambling will help to shape and influence next steps

Physical Activity (Active Together)

The Active Together Core Team and Partnership, have continued to deliver against the Physical Activity Framework, with a focus on targeting our inactive communities and addressing inequalities in access to physical activity. Our Annual Review, which outlines our key achievements against our Framework for 2025/26 will be published by end of June 2026 and will be able to be found at: [How do we deliver? | Active Together](#) . Some notable achievements:

- Funding secured from Public Health to work with localities to develop both a universal and targeted physical activity offer across Leicestershire, and provide capacity to advocacy for the role of physical activity across multiple agendas.
- Funding secured from the ICB to work with localities to deliver a Falls Prevention and MSK offer.
- Continue to work with our locality partners to provide a physical activity service which supports residents into appropriate activities such as Exercise Referral, Community Groups, Cardio-Pulmonary etc.

- Developed new relationships with Adult Social Care at LCC, working with the principle social worker to embed physical activity into existing workstreams.
- Sport England Place Universal funding provides a further platform to work with People and Communities to cement the importance of our Place based work across Leicestershire.
- Active Together continue to sit on facility strategy steering groups to ensure best outcomes for community usage e.g. Playing Pitch Strategies, Built Facilities, Local Football Facility Plans etc
- Work has continued around the Active Environments agenda, working closely with Public Health to ensure physical activity is considered in HIA's, S106, Local Plans etc
- The Funding Finder continues to successfully support organisations to access funding to continue delivery in local communities.
- Our Sports Welfare work has provided over 100 local clubs with both intensive and light touch support.
- Our Active Medicine offer has grown, with 58 GP practices are accredited or working towards Active Practice Accreditation.
- Continue to sit on the Leicestershire Community Health and Wellbeing Plan forums and associated Integrated Neighbourhood Team Meetings, embedding physical activity into the health care system.
- Over 20,000 users accessing the Active Together Website on a quarterly basis, with the job finder, activity tracker challenge and funding finder being some of the most visited pages.
- Local Government Reorganisation has provided the opportunity to engage our partners in a meaningful dialogue about the future of Physical Activity in the context of LGR and Devolution. Three advocacy papers developed to support the positioning of Physical Activity in the emerging Business Case. We have continued to reinforce with partners that AT is an LLR wide organisation and as such will treat all bids with both sensitivity and integrity.

Making Every Contact County (MECC) - Healthy Conversations

- UHL still delivering HCS training and have embedded this within the training for new health care support workers, with training for estates and facilitator workers completed as and when required.
- HCS training is still being delivered as part of Healthy Workplaces product and has been added to the Mental Health Friendly Places and Clubs programme.
- HCS training is a part of ASC in LCC CPD and wellbeing week and has been delivered for a 2nd year running. Re-visiting conversations to embed the training into wider service provision.
- Continued to deliver quarterly open learning and development sessions for LCC staff
- Conversations around delivering HCS training to support managers with the role out of new LCC ways of working policy

- Ad hoc delivery of HCS training continues where opportunities arise (and resource available) e.g. LCC connect to work employment officers, St Luke's hospital)
- Evaluation of the pre and post training surveys has been completed and will look to present at relevant staying health partnership meeting
- Still no financial investment in system delivery

Healthy Weight Strategy

Whole Systems Approach to Healthy Weight, Food & Nutrition

- The Whole Systems Approach continues to mature and gain momentum across partners. Following two successful partnership workshops in summer 2025, five shared priority areas have been agreed: **education, social influences, accessibility, advertising, and active lifestyles**. These provide a clear and consistent framework for collective action
- A streamlined governance structure is now in place, replacing previous arrangements and reducing duplication. This comprises a single Steering Group, supported by four sub-groups focused on food insecurity; food plan management (including Sustainable Food Places); Healthy Food Places and Access; and Skills and Active Living. This structure brings together relevant partners and organisations under a coherent system approach.
- Work is underway to develop a Strategic Plan for Food, which will sit beneath the Joint Health and Wellbeing Strategy. The Plan will provide a shared vision and set of commitments, bringing together partner activity across the agreed priority areas and offering a clear line of sight between strategy, governance and delivery.
- Resident engagement is a central element of this work. A programme of local Food Conversations has recently been launched to understand people's lived experiences of food and healthy eating. Insights from this engagement will directly inform priorities and future action.
- The programme is also supported by strong academic partnerships, including collaborative work with local universities. This includes funded doctoral research exploring perceptions of the National Child Measurement Programme and how its local impact could be strengthened, alongside research into public understanding of ultra-processed foods and effective approaches to reducing consumption.
- In parallel, a number of complementary workstreams are progressing, including improving uptake of Healthy Start, supporting healthy eating within Short Breaks services for people with learning disabilities, and working with schools to strengthen food procurement arrangements.
- Physical Activity partners have attended the Whole System Workshops and will support the identified work stream around moving more as part of this work.

- The scale and complexity of improving healthy weight and food access across the county should not be underestimated. These are long-term, system-wide challenges that require sustained commitment, trust and resource from all partners. Public Health has played a convening and enabling role, investing time in stakeholder and community engagement to build shared understanding and alignment. The Strategic Plan for Food will be a key mechanism for maintaining collective focus, commitment and buy-in over time.

Sustainable Food Places (Gold Award)

- We are progressing work towards becoming a Gold Sustainable Food Place (SFP). We are aiming to submit our application during Q4 of 2026/27.
- As part of the submission, we need to demonstrate strong progress in several key areas. Current projects contributing to this include:
 - The development of a Grassroots Food Plan and the delivery of Food Conversations with local residents, VCSE organisations, and wider food system partners. These conversations aim to deepen our understanding of what people want and need from their local food system, helping us identify the most meaningful actions we can take to support its development.
 - Working in partnership with The Allerton Project, we have brokered £109,000 over three years from the Samworth Foundation for The Allerton Project to develop a sustainable farming cluster across Leicestershire. This initiative aims to engage farmers meaningfully, helping us understand their priorities, the challenges they face, and what they hope to achieve collectively as a cluster, as well as identifying where support, training, and capacity-building are needed.
 - Alongside the Food Conversations and the development of the Grassroots Food Plan, the Farmer-Led Project represents one of the standout areas within our Gold SFP award submission. It will make a significant contribution to strengthening our understanding of local communities and their connection to, and influence within, the local food system.
 - We are also progressing our work on rural food insecurity. This includes undertaking a detailed analysis of food provision and food access across the county to better understand gaps, challenges, and opportunities for strengthening support.
- We officially launched our bid for Gold during an event in Summer 2026, which was attended by over 80 local partners from a broad range of sectors including public bodies, private organisations, VCSE, educational establishments and local food producers.
- Partners are fully on board with this piece of work, as evidenced with our 'Going for Gold' video, which can be found here - ([Leicestershire County Council Going for Gold](#)).
- We are also in the early stages of working with local partners and farmers to support food provision, local supply chains and farmers mental and physical health ensuring this work connects with existing initiatives across the county, particularly of that seen in Melton.

- The Food Conversations will inevitably highlight a range of challenges within the food system, some of which may be beyond our direct influence. However, they will also provide a valuable opportunity to identify local issues that we can address, working collaboratively with partners to develop meaningful and achievable solutions.
- Throughout summer and autumn, we will continue to work with partners on the projects highlighted above. This will culminate in a visit from Sustainable Food Places where we can showcase local food activities in action. This is an exciting and excellent opportunity for us to showcase the great work happening across the County.

Progress against cross-cutting priorities of the JLHWS

JLHWS cross-cutting priorities (reducing health inequalities and health protection & emergency preparedness)

Health Inequalities

Learning Disability Health Checks

- National performance data from NHSE confirms that LLR has consistently exceeded the Q1 -3 targets within our Operational Plan - with more Annual Health Checks (AHCs) continuing to be completed earlier in the financial year
- Local performance data indicates that 84.2% of people aged 14+ on the LD Register received an AHC during 25/26, against a local target of 80%.
- The LLR LD Register has been a 3% year on year growth - annual validation of individual practice registers carried out by the Primary Care Liaison Nurses
- The local target for 26/27 has been agreed at 80%, with the revised national NHSE metric now requiring a AHC and a completed Health Action Plan; LLR has consistently performed strongly in completion of Health Action Plans following the AHC
- System wide LD AHC Project Group continues and is led by the ICB LD Clinical Lead
- During 25/26 the LDA Collaborative participated in a national NHSE pilot to examine the feasibility of combining existing health checks for people with a LD, Severe Mental Illness (SMI) and autistic people. A total of 531 checks were completed, and the independent evaluation is to be published at the end of April 26. The Collaborative is working with NHS England to develop a hosted webpage supporting other systems in England who are looking to implement a combined annual health check. Local plans are being developed to embed learning from the pilot, including development of a targeted health check for autistic people.
- During 26/27 our plans include:
 - Embedding a new Health Action Plan across primary care - roll out via the LD Ambassador Network
 - Further improving AHC access for people aged 14-19, including LD coding accuracy checks in CAMHS and Community Paediatrics and launch of the LD Screening Tool

Women's Health

- A comprehensive Women’s Health Needs Assessment has been undertaken, alongside extensive resident engagement led by Healthwatch with over 2,000 responses. Final analysis is underway, and together these will provide a robust evidence base to shape system-wide actions across prevention, primary care and secondary care, ensuring a more coordinated and equitable approach to improving women’s health outcomes.

Health Protection & Emergency Preparedness

Vaccination & Screening Programmes

- Screening coverage performance in Leicestershire is significantly better than the national average, except for the Newborn and infant physical examination (NIPE) screening indicator. There has been a significant increasing and improving trend over the most recent five years for breast cancer screening coverage as well as bowel cancer and abdominal aortic aneurysm (AAA) screening coverage. Cervical screening coverage has shown a significant decreasing and worsening trend over the most recent five time periods for both age groups, but there has been an improvement in the 25-to-49-year age group in the most recent period. Work continues to reduce health inequalities and improve screening uptake.
- Leicestershire’s vaccination uptake remains above national averages overall, with recent data showing infant vaccines and MMR 1 meeting the 95% target, but completion at pre-school still below target (including MMR2 at 91.0%). Work continues to improve timely uptake, tackle inequalities and sustain strong flu and RSV vaccine delivery for eligible cohorts.
- Delivery is being strengthened through VCSE/ community approaches designed to address access barriers and improve uptake in priority areas and underserved groups through the Public Health Investment Fund for vaccination and screening, focusing on low uptake communities and inequality groups.

Emergency Preparedness

- EPRR arrangements continue to support preparedness, response and recovery for threats to human welfare (including communicable disease and environmental hazards), with the local authority maintaining its Category 1 responder duties and working through the LRF and LHRP to coordinate health-related emergency planning at system level.
- LLR partners continue to test and strengthen emergency preparedness through a structured LRF/ LHRP training and exercising programme. Recent activity has included a multi-agency major incident exercise (Exercise Mercury) with post-exercise reporting

and learning actions, alongside pandemic preparedness exercising (Pegasus and related activity) with formal debriefing through LHRP governance.

Key Challenges

12. The challenges identified within each initiative will be addressed through the appropriate governance channels and, where necessary, through the Staying Healthy Partnership (SHP). Should any of these issues require escalation to the Health and Wellbeing Board (HWB), they will be brought forward in a subsequent report.

Next Steps

13. The following section describes where further focus will be placed over the next 12 months:
 - a. Keep the momentum going on the great work currently taking place across the partnership as outlined in the tables above.
 - b. Place greater focus over the next 12 months on the areas where Leicestershire faces ongoing challenges.
 - c. Build on the work that has commenced in relation to healthy placemaking and Healthy weight, food and nutrition priorities.
 - d. Work closely with neighbourhood models of care programme and develop a neighbourhood plan as an addendum to the delivery plan.

Background Papers

Report to Health and Wellbeing Board 29 May 2025:

<https://democracy.leics.gov.uk/documents/s189913/0.14%20HWB%20Report%20Staying%20Healthy%20Safe%20and%20Well%20LATEST%2011%20Apr.pdf>

Appendices

Appendix A – Staying Healthy, Safe & Well Dashboard

Appendix B – Work well Report

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Risk Assessment

14. Risk log managed as part of Staying Healthy Partnership governance

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Leicestershire Joint Health and Wellbeing Strategy - Staying Healthy, Safe and Well (1)

Rank is compared to the nearest neighbours only. Rank: 1 is calculated as the best (or lowest when no polarity is applied).

Indicator	Sex	Age	Time Period	Value	Rank	England	DoT	RAG
Access to Healthy Assets & Hazards Index (%)	P	All ages	2024	16.6	13/16	20.9		
Air pollution: fine particulate matter (new method - concentrations of total PM2.5) (µg/m3)	N/A	Not applicable	2024	7.1	8/16	7.1		
D01 - Estimated fraction of mortality attributable to particulate air pollution (%)	P	30+ yrs	2024	5.3	8/16	5.3		
Gap in the employment rate between those with a physical or mental long term health condition (aged 16 to 64) and the overall employment rate (percentage po..	P	16-64 yrs	2022/23	8.0	6/16	10.4		
	P	18-64 yrs	2022/23	70.9	4/16	70.9		
		F	18-64 yrs	2022/23	70.9	7/16	68.1	
Gap in the employment rate between those who are in receipt of long term support for a learning disability (aged 18 to 64) and the overall employment rate (percentage points)	M	18-64 yrs	2022/23	71.6	3/16	74.1		
	P	18-69 yrs	2020/21	70.9	13/15	66.1		
		F	18-69 yrs	2020/21	69.2	15/15	61.8	
Gap in the employment rate for those who are in contact with secondary mental health services (aged 18 to 69) and on the Care Plan Approach, and the overall employment rate (percentage points)	M	18-69 yrs	2020/21	73.5	10/15	71.5		
	P	16+ yrs	2021 - 23	1.4	1/16	2.2		
B09a - Sickness absence: the percentage of employees who had at least one day off in the previous week	P	16+ yrs	2021 - 23	0.9	3/16	1.2		
B09b - Sickness absence: the percentage of working days lost due to sickness absence	P	16+ yrs	2021 - 23	0.9	3/16	1.2		
B16 - Utilisation of outdoor space for exercise or health reasons (%)	P	16+ yrs	Mar 2015 - Feb 2016	20.8	4/15	17.9		
B17 - Fuel poverty (low income, low energy efficiency methodology) (%)	N/A	Not applicable	2023	9.6	7/16	11.4		
Density of fast food outlets per 100,000 population	P	All ages	2024	88.8	7/16	115.9		
Food Insecurity (INDIRECT measure) – percentage of local authority population living in areas at highest risk of food insecurity	P	All ages	2022	4.2	4/16	Null		
Number of premises licensed to sell alcohol per square kilometre	N/A	Not applicable	2023/24	1.0	9/16	1.3		
Percentage of adults walking for travel at least three days per week	P	16+ yrs	2022/23	14.9	10/16	18.6		

Statistical Significance compared to England or Benchmark:

- Better
- Similar
- Worse
- Not compared
- Higher
- Lower

Direction of Travel:

- Decreasing
- Decreasing and getting better
- Decreasing and getting worse
- Increasing
- Increasing and getting better
- Increasing and getting worse
- No significant change
- Cannot be calculated

Leicestershire Joint Health and Wellbeing Strategy - Staying Healthy, Safe and Well (2)

Rank is compared to the nearest neighbours only. Rank: 1 is calculated as the best (or lowest when no polarity is applied).

Indicator	Sex	Age	Time Period	Value	Rank	England	DoT	RAG
All new STI diagnoses rate per 100,000 population	P	All ages	2024	377.2	8/16	632.3	▲	●
D02b - New STI diagnoses (excluding chlamydia aged 24 years and under) per 100,000 population	P	All ages	2024	236.5	4/16	482.3	▲	●
D02a - Chlamydia detection rate per 100,000 aged 15 to 24 years	P	15-24 yrs	2024	1,184.8	16/16	1,249.8	▬	●
	F	15-24 yrs	2024	1,564.0	15/16	1,589.4	▬	●
	M	15-24 yrs	2024	840.5	16/16	837.2	▬	●
C01 - Total prescribed LARC excluding injections rate / 1,000	F	All ages	2024	39.0	5/16	40.0	▲	●
C02a - Under 18s conception rate	F	<18 yrs	2022	13.5	10/16	13.9	▶	●
Over 25s abortion rate / 1000	F	25+ yrs	2023	18.7	7/16	21.6	▲	●
Total abortion rate / 1000	F	All ages	2023	20.5	7/16	23.4	▲	●
C06 - Smoking status at time of delivery (%)	F	All ages	2024/25	6.4	10/16	6.1	▼	●
Smoking attributable mortality (new method) (per 100,000)	P	35+ yrs	2017 - 19	172.3	9/15	202.2	▬	●
C18 - Smoking Prevalence in adults (aged 18 and over) - current smokers (APS) (%)	P	18+ yrs	2024	7.4	2/16	10.4	▬	●
	F	18+ yrs	2024	7.5	8/16	8.7	▬	●
	M	18+ yrs	2024	7.2	2/16	12.2	▬	●
Smoking prevalence in adults in routine and manual occupations (aged 18 to 64) - current smokers (APS) (%)	P	18-64 yrs	2023	20.4	9/16	19.5	▬	●
C15 - Percentage of adults meeting the '5-a-day' fruit and vegetable consumption recommendation	P	16+ yrs	2023/24	32.1	10/16	31.3	▬	●
C16 - Overweight (including obesity) prevalence in adults, (using adjusted self-reported BMI)	P	18+ yrs	2023/24	65.8	8/16	64.5	▬	●
C17a - Percentage of physically active adults	P	19+ yrs	2023/24	68.6	9/16	67.4	▬	●
C17b - Percentage of physically inactive adults	P	19+ yrs	2023/24	20.8	11/16	22.0	▬	●
Admission episodes for alcohol-related conditions (Narrow) (per 100,000 population)	P	All ages	2023/24	503.4	10/16	504.1	▲	●
	F	All ages	2023/24	375.7	10/16	339.5	▶	●
	M	All ages	2023/24	644.8	10/16	686.5	▲	●
Alcohol-specific mortality (per 100,000 population)	P	All ages	2024	13.0	12/16	13.8	▶	●
C19a - Successful completion of drug treatment: opiate users (%)	P	18+ yrs	2024/25	7.9	3/16	5.3	▶	●
C19b - Successful completion of drug treatment: non opiate users (%)	P	18+ yrs	2024/25	30.1	9/16	29.1	▼	●
C19c - Successful completion of alcohol treatment (%)	P	18+ yrs	2024/25	33.1	9/16	34.6	▼	●
Hospital admissions due to substance misuse (15 to 24 years) (per 100,000)	P	15-24 yrs	2021/22 - 23/24	42.7	5/14	47.4	▬	●
	F	15-24 yrs	2021/22 - 23/24	41.7	8/14	48.9	▬	●
	M	15-24 yrs	2021/22 - 23/24	43.7	5/14	46.1	▬	●
HIV testing rate per 100,000 population	P	All ages	2024	2,138.0	5/16	2,842.7	▲	●

Statistical Significance compared to England or other regions

■ Better
■ Worse
■ Higher
■ Similar
■ Not compared
■ Lower

Direction of Travel:

▼ Decreasing
▼ Decreasing and getting better
▼ Decreasing and getting worse
▲ Increasing
▲ Increasing and getting better
▲ Increasing and getting worse
▶ No significant change
▬ Cannot be calculated

Leicestershire Joint Health and Wellbeing Strategy - Staying Healthy, Safe and Well (3)

Rank is compared to the nearest neighbours only. Rank: 1 is calculated as the best (or lowest when no polarity is applied).

Indicator	Sex	Age	Time Period	Value	Rank	England	DoT	RAG
C24a - Cancer screening coverage: breast cancer (%)	F	53-70 yrs	2025	73.0	11/16	71.7		
C24b - Cancer screening coverage: cervical cancer (aged 25 to 49 years old) (%)	F	25-49 yrs	2024	72.6	5/16	66.1		
C24c - Cancer screening coverage: cervical cancer (aged 50 to 64 years old) (%)	F	50-64 yrs	2024	77.9	4/16	74.3		
C24d - Cancer screening coverage: bowel cancer (%)	P	60-74 yrs	2025	76.7	4/16	72.9		
C24e - Abdominal Aortic Aneurysm Screening Coverage (%)	M	65	2024/25	87.7	2/16	82.2		
C26b - Cumulative percentage of the eligible population aged 40 to 74 offered an NHS Health Check who received an NHS Health Check	P	40-74 yrs	2020/21 - 24/25	35.8	11/16	38.9		
C26c - Cumulative percentage of the eligible population aged 40 to 74 who received an NHS Health check	P	40-74 yrs	2020/21 - 24/25	31.3	5/16	29.6		
Proportion of eligible adults with a learning disability having a GP health check (%)	P	14+ yrs	2018/19	49.4	9/15	52.3		
D03l - Population vaccination coverage: Flu (2 to 3 years old) (%)	P	2-3 yrs	2024/25	48.1	9/16	42.6		
D04d - Population vaccination coverage: Flu (primary school aged children) (%)	P	4-11 yrs	2024	57.6	6/16	54.5		
D05 - Population vaccination coverage: Flu (at risk individuals) (%)	P	6 months-64 yrs	2024/25	42.0	6/16	40.0		
D06a - Population vaccination coverage: Flu (aged 65 and over) (%)	P	65+ yrs	2024/25	78.6	7/16	74.9		
D06c - Population vaccination coverage: Shingles vaccination coverage (71 years) (%)	P	71	2022/23	55.6	2/16	48.3		

Statistical Significance compared to England or Benchmark:

Better
 Worse
 Higher
 Similar
 Not compared
 Lower

Direction of Travel:

Decreasing
 Increasing
 No significant change
 Decreasing and getting better
 Increasing and getting better
 Cannot be calculated
 Decreasing and getting worse
 Increasing and getting worse

Note: For the most recent time period, values for D03l, D04d, D05 and D06a present information for Leicestershire and Rutland combined. For combination details for previous time periods please see source.

Data Source: Office for Health Improvement & Disparities <https://fingertips.phe.org.uk/>.

Produced by Business Intelligence Service, Updated April 2026

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Appendix B



**Leicester, Leicestershire
and Rutland**

STAYING HEALTHY PARTNERSHIP BOARD (30th June 2026)

REPORT OF LLR INTEGRATED CARE BOARD

LLR WORKWELL UPDATE

Purpose of report

1. What is the purpose of this report:
 - Provide information

The purpose of this report is to inform the Staying Healthy Partnership Board of the progress for Leicestershire, Leicester City and Rutland (LLR) WorkWell Vanguard, and contribution of the programme to the ICB 4th purpose - social and economic development.

WorkWell, as part of a broader government agenda linked to economic inactivity and recovery, is a key driver behind the ambition of 'Get Britain Working,' white paper. UK is the only G7 country to have not returned to pre-pandemic level of employment. For LLR, WorkWell fundamentally underpins our local health inequalities agenda, deepening social value and dignity, and supporting economic recovery. We also know good work is good for people, and WorkWell aims to support those with disability, and in LLR, specifically those struggling with MSK and mental health conditions, where these health-related conditions have become a barrier into work.

There is a significant opportunity to align current and new programmes of work under the framework of 'Get Britain Working' plans. In particular, the roll-out of WorkWell programme with 'Connect to Work,' supports joint working around referrals and employer engagement offers, in recognition of the alignment, synergy and potential for overlap.

The WorkWell model is unique in its partnership approach across the country, delivering largely through a multiagency partnership model, and with primary care and neighbourhood teams driving delivery. It also is extending links beyond job centre plus, into higher education to support skills development, and business sector, developing links to commerce, particularly SMEs where parts of LLR we are rich in. WorkWell is being delivered through Neighbourhood teams in its broadest sense, with additionality of work and health coaches.

Progress in delivery of the Programme

Data Sharing Agreements, and Data Sharing and Processing Agreements between DWP and LLR General Practice are in place. An area of significant delay to the original timeframe was the challenge of having a data sharing agreement in place across primary care and with DWP. As we move forward with ever complex areas of work across the ICS, data sharing is a key area to address.

Following delay to the mobilisation period, the WorkWell service for LLR mobilised in March 2025, and is has actively been recruiting workforce since October 2024 and consenting participants. Currently, we are testing out new models for engagement and in-reach into communities and, developing our Employer Engagement Strategy, to maximise access to the service and support individuals back to work. (See appendix 1. Leicester, Leicestershire and Rutland Work, Health, and Skills Small & Medium Enterprises (SME) Employer Engagement Strategy (2025/26).

Primary Care Network (PCN) Engagement

Onboarded to the Programme; 7 PCNs City - 15 PCNs in County - 1 PCN in Rutland

A total 23 of 26 Primary Care Networks (PCNs) across LLR have joined the programme. onboarded to the WorkWell programme and patients being supported by the LLR roving 'Community WorkWell' model which has been initiated, originally to support the mitigation of shortfall of City PCNs' not onboarded to the WorkWell Programme. The LLR roving 'Community WorkWell' model, has also given the scope to embed the testing in the model, to support a withdrawal of a PCN in County due British Medical Association 'Collective Action,' by providing opportunity for those patients in the PCNs member practices, in accessing the WorkWell services.

An additional PCN in City and one member practice from County, wish to join the programme and is going the PCN Board approval, following the same data sharing agreement, and data sharing and processing agreements in place.

The LLR roving 'Community WorkWell' model is also being tested in Rutland, as this model is able to in-reach to the challenges faced by the residents in the geographical spread and isolation, transport challenges and access to the Job Centre Plus in Lincolnshire. The model is also being stood up in County, to widen the access to residents that may not access general practice regularly.

Integrating Work & Health Coaches into General Practice and the Care Navigation Team

We have introduced and integrated 26 Work and Health Coaches into general practice, to work alongside the care navigation team (personalised care); Social Prescribers, Care Coordinators, Health and Wellbeing Coaches. This has enabled shared learning on case management of the patient lists, and work as part of the wider multi-disciplinary team (MDT) and feed into clinical governance of complex care.

The Work and Health Coaches are supported by 4 Senior Work and Health Coaches, to lead the development and standardisation the personalised care and

coaching approaches, with a Designated Data Lead to manage the data collection of the Management Information required to provide measurable input and outcomes, to the Department of Work and Pensions (DWP) Policy Team on a monthly basis.

Work and Health Coaches are working outside of the boundaries and guidance of the NHSE Network Contract for Additional Roles Reimbursement Scheme (ARRS), however, must be able to access supervision to reflect on their experiences, challenges and celebrations, with access to professional development in the same way that all care navigation teams are offered and building the multi-disciplinary team approach.

LLR Training Hub have been commissioned by LLR ICB with WorkWell funding to provide the Work and Health Coaches a network and Community of Practice on a monthly basis, to provide local and national updates, training and CPD aligned to the NHSE Framework and competencies of Personalised care roles and outside of primary care and work in a complementary way.

Utilising the WorkWell funding for Training and Education, the Work and Health Coaches are all accessing a Personalised Care Institute accredited programme for 'Health Coaching Practitioner' and the Seniors are accessing the 'Health Coaching Supervisor Practitioner' programme.

WorkWell Programme Participants

Following eligibility criteria; over 16, a resident of LLR, registered with a GP and have the right to work in the UK with a health barrier to work, followed by consenting through triage of direct referrals and self-referrals.

Since 1st April 2025 to 31st March, 1241 participants have started the WorkWell Programme, with a guided period of 12 weeks of low intensity personalised support with either a 'Thrive in Work Plan' if in work with barriers or a 'Return to Work Plan' in seeking employment with health barriers. The plan can be shared with a service provider of higher intense support i.e. Individual Placement and Support (IPS), Talking Therapies, Musculoskeletal services, and Adult Education Hubs.

Next Steps for the programme and support from the Staying Healthy Board

Government announced on 20th January 2026, WorkWell will to be expanded to 2028/29 with a national rollout of WorkWell by November 2026, following the successes of the 15 Vanguard Pilot sites.

Within WorkWell LLR, our approach remains within the general practice delivery model, alongside the roving community model. There are currently 23 Primary Care Networks (PCNs) delivering WorkWell, and the roving community model catering for the patient cohort population of three City PCNs. The geography is set out in three 'Places'; City, County and Rutland and with the success of the roving community model, is also operational in County and Rutland to focus on community and employer engagement.

The LLR model will remain focused on the key drivers of local health need - specifically mental health and musculoskeletal conditions - and will continue to evolve its approach to meet emerging priorities. This includes targeted support for

16–17-year-olds who are not in education, employment or training (NEET), and for 18–24-year-olds who are claiming Universal Credit, ensuring that WorkWell interventions reach those with the highest risk of long-term health and employment challenges with the prevalence of mental health and musculoskeletal conditions.

The Department of Health and Social Care and NHS England have published Neighbourhood Health framework (17 March 2026) – (see appendix 1) which outlines the approach to collaborative working of the NHS, Local Authorities and wider partnerships to deliver local get Britain working plans – ‘Get LLR Working Plans’ with local initiatives to tackle health related employment barriers and provides an example of WorkWell as an enabler and lever to improve employment healthy lifecycles.

As part of the Get LLR Working Plan (see appendix 2), LLR ICB have commissioned a ‘Digital Single Point of Referral and Triage for the health and employment support programmes within the LLR footprint; WorkWell, Connect to Work, Talking Therapies Employment Advisors, Mental Health IPS - Employment Services and Adult Education. This will form the trajectory to the Work, Health and Skills agenda digitally and support the governments ambition to reach 80% employment rate.

Staying Healthy Board

We are asking for sponsorship of the board, with the links between the Neighbour Health Framework March 2026, LLR WorkWell Programme expansion 2026-2029 (Return-to-work/thrive-in-work) and the Healthy Workplaces Programme (Healthier Places to Work), in respect of joint ambition to support small and medium enterprises (SMEs) across LLR;

Commitment D3. Healthy workplaces and local economy: We will work with employers and local organisations to create fair, inclusive and healthy workplaces, helping more people to get into work and thrive in their jobs.

Action D3.1 We will strengthen system-wide understanding and coordination of employment and healthy workplace programmes, support the sharing of information/insights, help unlock delivery challenges and link to wider support services to help people stay in or return to work.

Appendices -

1. GOV.UK - Neighbourhood Health Framework - 17th March 2026;

<https://www.gov.uk/government/publications/neighbourhood-health-framework/neighbourhood-health-framework>

2. Get LLR Working Plan - 11th December 2025;

<https://www.leicestershire.gov.uk/news/authorities-launch-joint-plan-to-get-more-people-working>

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HEALTH AND WELLBEING BOARD: 15TH JUNE 2026

REPORT OF ACTIVE TOGETHER

PHYSICAL ACTIVITY FRAMEWORK (2022-2031)

Purpose of report

1. To provide the Health and Wellbeing Board with information on the Active Together Partnership Physical Activity Framework (2022-2031).
2. To update the Health and Wellbeing Board on Active Together's approach to reviewing and refreshing the Framework to ensure it is still fit for purpose for its remaining duration.

Recommendation

3. It is recommended that the Board:
 - a) Notes the approach to reviewing and refreshing the Physical Activity Framework.
 - b) Supports the Physical Activity Framework and the collaborative systems approach to delivery of its priorities.
 - c) Champions physical activity within the respective organisations and partnerships, thus supporting a coordinated place-based and preventative approach which uses physical activity to support residents' wellbeing.
 - d) Promote and encourage engagement with the Physical Activity and Wellbeing Residents Survey.

Policy Framework and Previous Decision

4. Physical activity is a key determinant of health and wellbeing and plays an important role in preventing long-term conditions and reducing health inequalities.
5. Active Together is the Active Partnership for Leicestershire, Leicester and Rutland. It is aimed at supporting organisations and individuals to help more people be active and move more.
6. Active Together forms part of a network of 42 Active Partnerships, which are locally led, not for profit, strategic organisations covering the whole of England. Active Partnerships work collaboratively to increase physical activity levels and develop an effective and inclusive physical activity system.

7. The Active Together Partnership Physical Activity Framework for 2022-2031 was developed through consultation with a range of partners and residents and aligned to national and local physical activity, health and wellbeing strategies.
8. The Framework sets out a shared vision and co-ordinated approach to increasing physical activity levels across Leicestershire, Leicester and Rutland. The framework:
 - Sets out a collective message about the importance of physical activity.
 - Explores how the partnership will work collaboratively to use physical activity as a tool to improve wider societal outcomes.
 - Has clear ambition to reach those who find it most difficult to be physically active.
 - Is explicit about reducing inequality of access to physical activity and tackling physical inactivity.
 - Indicates that the partnership needs to target resources where they are most needed.
 - Acts as a call to action for partners.
9. Partners locally endorsed the Physical Activity Framework (in 2022), and they have joined the Active Together Core Team to think differently and work collaboratively (in using policy and practice) to deliver the strategic priorities and support the vision of Leicestershire, Leicester and Rutland; A place where physical activity is part of daily life leading to people living healthier and happier lives.

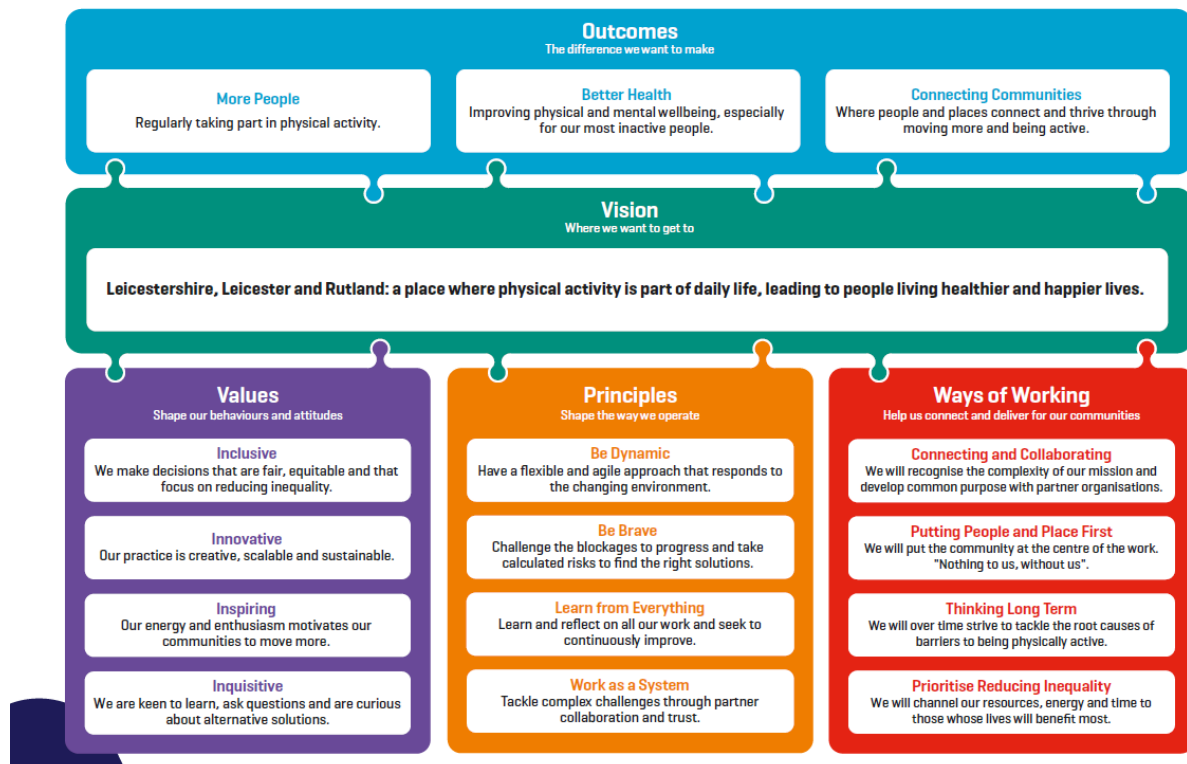
Background

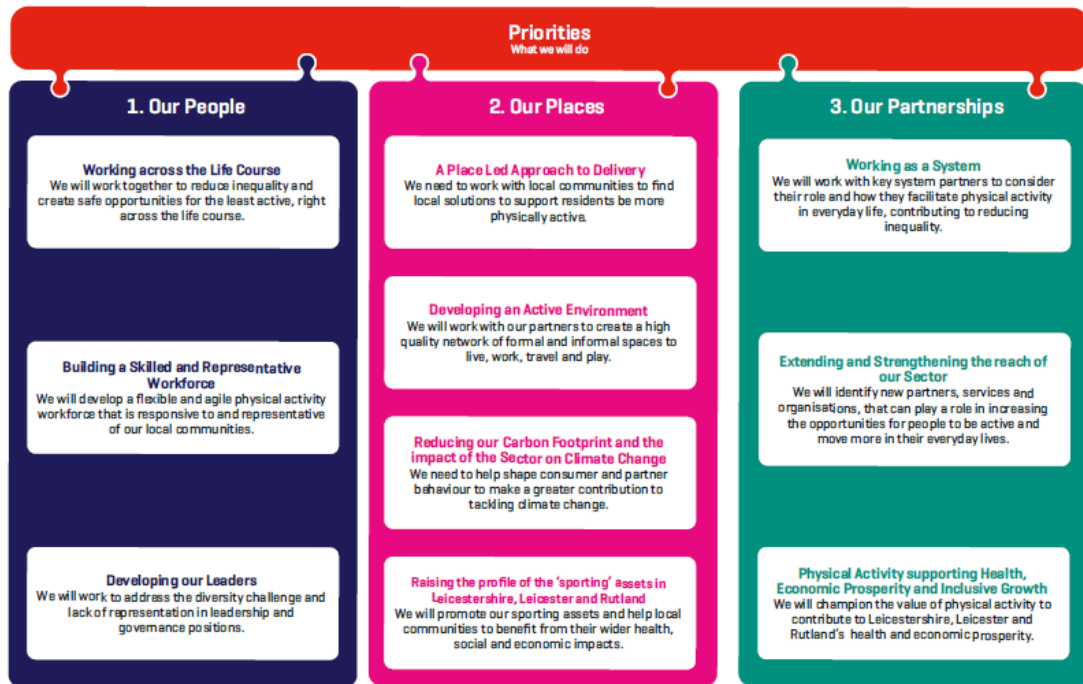
10. The Active Together Partnership consists of a Core Team of staff (hosted by Leicestershire County Council and directed by its Board) and they work with a range of sectors and partners across Leicestershire, Leicester and Rutland with a shared ambition to reduce inequality of access to physical activity and help our communities realise the many health and social benefits of living an active life.
11. Let's Get Moving is the collective strapline (of the Active Together Partnership), used by individuals, communities and organisations (alongside their existing branding) to bring about a movement of positive physical activity change.
12. Active Together is also one of over 130 "System Partners" part funded by Sport England, to level up access to physical activity and sport and play its part to deliver the national 10-year strategy 'Uniting the Movement'. Similarly, Active Together is part funded by local partners to lead the strategic direction and delivery of physical activity, ensuring alignment and contribution to local priorities.

13. Physical Activity isn't a 'nice to have', it is essential to support people to live healthier and happier lives. Physical inactivity contributes to 1 in 6 deaths and conversely being active can support up to a 50% reduction in the prevention of numerous long-term health conditions. Physical Activity can also contribute to wider outcomes linked to prevention, economic growth, skills and employment, planning and climate change.
14. Sport England Active Lives Data tells us that 34.8% of Leicestershire's adult population do not meet the Chief Medical Officers Guidelines for physical activity (achieving at least 150 minutes of physical activity a week), and 23.1% of these are classed as inactive (do less than 30 minutes of physical activity a week).
15. Similarly for Children & Young People, the survey outlines that 49.8% do not meet the guidelines (achieving an average of 60 minutes of physical activity a day) and 28.4% are classed as inactive (do less than an average of 30 minutes of physical activity a day).
16. There are important disparities within the above data, outlining growing inequalities in physical activity levels within our communities. For example, the data outlines that residents are more likely to be inactive if they are from a lower socio-economic group / live within the most deprived communities, have a long-term health condition / disability or are from a diverse ethnic community.
17. Getting people to move more is not just the responsibility of the physical activity sector, physical activity can contribute to positive outcomes linked to prevention, health and wellbeing, climate change, skills and employment, planning and economic growth:
 - a) Physical activity can support up to a 50% reduction in preventing numerous long-term health conditions.
 - b) The annual social value of community sport and physical activity (the value to individuals improved wellbeing and the wider value to society) is more than £120 billion, with a return of investment of £4.38 for every £1 spent.
 - c) There is a direct relationship between physical activity, reduced sick days and reduced economic inactivity.
18. However, reducing levels of inactivity is a complex challenge and it is the collective power of collaboration across multiple partners that will enable the partnership to make a difference. A collective and shared commitment is needed to raise the profile and the tangible benefits of moving more. Non-physical activity partners need to be supported to understand how physical activity can contribute to their outcomes - to see physical activity as a solution for their complex challenges

19. The Active Partnership Physical Activity Framework (which is designed as partnership framework and not just an Active Together Board and Core Team document) outlines the long-term priorities to tackling inactivity levels through working in collaboration with our local communities and a wide range of partners.
20. Working through three key themes of People, Place and Partnerships, the Framework identifies 10 key priorities (what we will do). These in turn support the collective vision (where we want to get to) and identified outcomes (the difference we want to make).

2022 to 2031 – Framework Summary





Approach

21. The framework is now at a midpoint in its delivery period (2022-2031), providing an opportunity to review progress and ensure it remains relevant and impactful.
22. The duration of the Physical Activity Framework is longer than any previous physical activity strategies that have been in place. It was recognised that to achieve the vision, the partnership needed time to embed system change but also time was needed to change resident's behaviour and have an impact on the inactivity inequality measures.
23. Whilst it is recognised that this is still applicable, there have been significant changes within the landscape the Active Together Partnership is working in since the Framework was developed. For example, the physical activity sector has changed post pandemic and there have also been significant changes to both national and local priorities as well as to funding levels and capacity levels within the partnership. Further changes are anticipated to priorities from national and local partners from April 2027 onwards.
24. In addition, the Framework contains milestones to success, with the most recent milestones ending in 2025. Consultation with partners at the Active Together Partnership annual stakeholder event, indicated that progress against some priorities was further ahead than others, and that not all priorities were relevant to all partners.

25. Active Together Board have therefore agreed that the Active Together Core Team will undertake a review of the Physical Activity Framework, to ensure the priorities are still relevant to our partners, funders and residents. It is, however, important to note that this will be a refresh of the Framework and not a rewrite, due to the initial commitment of a longer-term Framework.
26. It is intended that consultation on the Physical Activity Framework will be undertaken in 2026 and a refreshed Framework will be in place by April 2027 and will last for the remainder of the initial time frame. (2027-2031).

Consultation/Patient and Public Involvement

27. Consultation with both residents and partners took place in 2021 as part of the Framework development. At the time, residents stated that activity levels had been hit hard by the pandemic and barriers to being active were time restraints, access to opportunities and their health. Partners stated that priorities should include connecting physical activity to wider agendas, developing physical activity messaging, supporting place led opportunities, working as a system and supporting children, young people and older people.
28. As part of our process to refresh the Physical Activity Framework, there is a need to re-consult with both partners and residents, to ensure that the document is still fit for purpose and meets the needs and priorities of the partnership.
29. Partners will be engaged in the planned refresh to understand how they have utilised the current document, if the priorities remain relevant and to further explore how the Framework can be endorsed and adopted by a wide range of stakeholders. Key funders of the Active Together Partnership will also be engaged to ensure there is further alignment with both national and local strategies.
30. A Physical Activity and Wellbeing Residents Survey is planned from 26th May – 10th July 2026. The survey will help produce a picture of residents' current physical activity levels, the challenges they face to be active and their future intentions. This in turn will help the Active Together Partnership shape the offer for the least active communities to support them to move more.

Conclusion

31. The refresh of the Physical Activity Framework presents an opportunity for the Health & Wellbeing Board to demonstrate collective leadership in improving health and wellbeing outcomes.

32. Active support and commitment from Board members will be essential to ensure physical activity is embedded within system-wide approaches to prevention, reducing inequalities and supporting healthier communities

Background papers

For further information on the Active Together Partnership: Physical Activity Framework 2022-2031 and Active Together Partnership: Annual Review, please visit: <https://www.active-together.org/framework>

For further information on the support provided to local partners, please visit: [Partners | Active Together](#)

For further information on the support provided to local residents, please visit: [Let's Get Moving | Active Together](#)

For further information on the Physical Activity and Wellbeing Residents' Survey 2026, please visit: www.active-together.org/toolsandresources-residentssurvey and www.active-together.org/pasurvey

Officer to contact

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Relevant Impact Assessments

Equality Implications

33. An Equality and Human Rights Impact Assessment Screening was undertaken on the Physical Activity Framework as part of its development.
34. It is proposed that a new EIHRA screening will be undertaken as part of the refresh of the Framework.

Human Rights Implications

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

Partnership Working and associated issues

36. The Physical Activity Framework should be seen as a Partnership Framework and not just an Active Together Board and Core Team document. It is only through collaboration that priorities within this Framework will be delivered.
37. Reducing levels of inactivity is a complex challenge and there is no one single organisation or service that can provide the solution on their own. It is the collective power of collaboration that will make the difference. Active Together will encourage wider system partners to consider their role and how they facilitate physical activity in everyday life.
38. Connecting with partners in the system such as health, education, housing, workplaces, private and voluntary sector organisations as well as supporting collaboration at a local level will contribute to reducing inequalities. Active Together will encourage the physical activity sector to look outward to develop new relationships, become system leaders and advocate the power of physical activity to our wider system partners.
39. Support of the Framework by partners shows the commitment of the partnership to work within one framework. Active Together will look to increase the number of partners who endorse the Physical Activity Framework.



HEALTH AND WELLBEING BOARD: 15th JUNE 2026

REPORT OF DIRECTOR OF ADULTS AND CULTURAL SERVICES

BETTER CARE FUND YEAR END 2025-26 PERFORMANCE

Purpose of report

1. The purpose of this report is to provide the Health and Wellbeing Board (HWBB) with the year-end performance reporting of the Better Care Fund (BCF) programme for 2025-26.

Recommendation

2. It is recommended that:
 - a) The performance against the Better Care Fund (BCF) outcome metrics, and the positive progress made in transforming health and care pathways in 2025-26 be noted;
 - b) The Board notes that the year-end BCF 2025-26 template, attached as the appendix to the report, has been approved and was submitted to NHS England for the 5th June, 2026 submission deadline; This was completed under the delegated powers of the Chief Executive as the submission date was prior to the HWBB meeting 15th June 2026.

Policy Framework and Previous Decisions

3. The BCF policy framework was introduced by the Government in 2015, with the first year of BCF plan delivery being 2015/16. The Cabinet in February 2014 authorised the Health and Wellbeing Board to approve the BCF Plan and plans arising from its use.
4. The Better Care Fund Year End 2025-26 was approved by the Chief Executive of Leicestershire County Council on 28th May using delegated powers.
5. The Better Care Fund Year End 2025-26 was submitted to NHS England before the submission date of 5th June 2026.

Background.

6. On 12th March 2026 the national BCF team published the year end template for reporting the position for the 2025-26 financial year which requires approval by the HWBB.
7. The aim of the report and template is to inform the HWBB of progress against integration priorities and BCF delivery. BCF quarterly reporting can be used by local areas, alongside any other information to help inform HWBs on progress with integration and the BCF. It is also intended to inform BCF national partners as well as those responsible for delivering the BCF plans at a local level (including integrated care boards, local authorities and service providers).
8. The year end template is attached as Appendix A to this report. The NHS England submission deadline was the 5th June 2026.
9. The template consists of tabs that update progress against the following:
 - Whether the four national conditions detailed in the Better Care Fund planning requirements for 2025-26 continue to be met through the delivery of the plan.
 - A confidence assessment on achieving the metric targets for each of the BCF metrics which includes a brief commentary outlining the challenges faced in achieving the target along with any support needs and successes that have been achieved.
 - Confirms the level of income received within the HWBB area against actual expenditure and spend and activity against each of the schemes where known activity can be reported.
 - Year-end feedback.

BCF Income

10. The approved BCF Plan for Leicestershire for 2025-26 totalled £84.4million. This included the initial allocation of Disabled Facilities Grant funding of £5.5 million. Later in the year the Government announced a further £0.4m of DFG for Leicestershire.
11. The table below has the planned income for 2025-26 taking the additional DFG into account:

ICB minimum NHS contribution	£57,070,979
LA Better Care Grant	£21,824,275
Disabled Facilities Grant	£5,906,353
Total	£84,801,607

12. Discharge grant funding elements seen in previous years have been rolled into main funding elements for 2025-26. The Local Authority discharge grant has been incorporated into the previous Improved Better Care Grant (iBCF) and is renamed the LA Better Care Grant.
13. The overall uplift to the NHS minimum contribution was 1.7%. However, the ICB discharge grant element has been incorporated into the NHS minimum contribution and forms part of the 3.9% uplift to ASC BCF schemes that are paid for from the NHS minimum contribution. As in previous years, the uplift will contribute to the costs of the pay award, provider fee uplifts and other cost pressures.
14. It should be noted that NHS England/Improvement expectation is that all allocations are spent fully in year. Identification of underspends and overspends are for internal decision-making purposes and not external reporting.

BCF Metrics

15. The below table shows the BCF metrics for this financial year, the targets and actuals where available:

Metric	Target	Actual	Commentary
Emergency admissions to hospital for people aged 65+ per 100,000 population	1661	1469	On Track
DISCHARGE DELAY Average length of discharge delay for all acute adult patients (this calculates the % of patients discharged after their DRD, multiplied by the average number of days)"	89%	86.2%	NOT ON TARGET YTD data shows that we are currently off target against planned performance. Throughout 25-26, Leicestershire performance has been off target for the 'Proportion of adult patients discharged from acute hospitals on their discharge ready date' indicator requirements. The target was to achieve 89% by the end of the financial year. This has not been achieved, with the best individual monthly performance in June of 86.2%. In 25-26, Leicestershire consistently

			performed better than the East Midlands average.
RESIDENTIAL Admissions Long-term support needs of older people (age 65 and over) met by admission to residential and nursing care homes, per 100,000 population	867	858	NOT ON TARGET Residential admissions have increased during 2025/26, and the current figure for total admissions during the twelve-month period is 972 (note this is based on the old SALT logic, and not the newer CLD method). More detailed analysis is in progress to try to better understand the reasons for this recent increase.

Update against national conditions for the 2025-26 Plan

16. For 2025-26 year end reporting all national conditions have been reported as being met. For reference, these are listed below.
17. **National Condition 1** - Plans jointly agreed. Local authorities and Integrated Care Boards (ICBs) must agree a joint plan, signed off by the Health and Wellbeing Board (HWB), to support the policy objectives of the BCF for 2025 to 2026. The development of these plans must involve joint working with local NHS trusts, social care providers, voluntary and community service partners and local housing authorities. These plans must be submitted to BCF national and regional teams and must include locally agreed goals against these 3 headline metrics (see below) and an intermediate care capacity and demand plan.
18. **National Condition 2** – Implementing the objectives of the Better Care Fund
Local authorities and ICBs must, in their joint HWB plans, show how health and social care services will support improved outcomes against the fund's 2 principal policy objectives:
 - To support the shift from sickness to prevention – including timely, proactive and joined-up support for people with more complex health and care needs; use of home adaptations and technology; and support for unpaid carers.
 - To support people living independently and the shift from hospital to home – including help prevent avoidable hospital admissions; achieve more timely and effective discharge from acute, community and mental health hospital settings; support people to recover in their own homes (or other usual place of

residence); and reduce the proportion of people who need long-term residential or nursing home care.

19. **National Condition 3** – Complying with grant and funding conditions, including maintaining the NHS minimum contribution to adult social care. The NHS minimum contribution to adult social care must be met and maintained by the ICB and will be required to increase by at least 3.9% in each HWB area. Local authorities must comply with the grant conditions of the Local Authority Better Care Grant and of the Disabled Facilities Grant. HWB plans will also be subject to a minimum expectation of spending on adult social care, which are published alongside the BCF planning requirements. HWBs should review spending on social care, funded by the NHS minimum contribution to the BCF, to ensure the minimum expectations are met, in line with the national conditions.

20. **National Condition 4** – Complying with oversight and support processes

Local areas and HWBs are required to engage with BCF oversight and support processes, which include:

- a regionally led oversight process;
- enhanced oversight where there are performance concerns.

Circulation under the Local Issues Alert Procedure

21. None

Background papers

Better Care Fund Planning Requirements 2025-26:

<https://www.england.nhs.uk/long-read/better-care-fund-planning-requirements-2025-26/#planning-expectations-meeting-national-conditions>

Better Care Fund Policy Framework 2025-26:

<https://www.gov.uk/government/publications/better-care-fund-policy-framework-2025-to-2026/better-care-fund-policy-framework-2025-to-2026#bcf-objectives>

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List of Appendices

Appendix A – Year End Template 2025-26

Relevant Impact Assessments

Equality and Human Rights Implications

22. The BCF aims to improve outcomes and wellbeing for the people of Leicestershire, with effective protection of social care and integrated activity to reduce emergency and urgent health demand.
23. An equalities and human rights impact assessment has been undertaken which is provided at <http://www.leicestershire.gov.uk/sites/default/files/field/pdf/2017/1/11/better-care-fund-overview-ehria.pdf>.

This concluded that the BCF will have a neutral impact on equalities and human rights.
24. A review of the assessment was undertaken as part of the BCF submission for 2021.

Partnership Working and associated issues

25. The delivery of the BCF plan and the governance of the associated pooled budget is managed in partnership through the collaboration of commissioners and providers in Leicestershire.
26. Day to day oversight of delivery is via the Integration Executive through the scheme of delegation agreed via the Integration Executive's terms of reference which have been approved by the Health and Wellbeing Board.
27. The delivery of the Leicestershire BCF ensures that several key integrated services are in place and contributing to the system wide changes being implemented through the five-year plan to transform health and care in Leicestershire, known as the Sustainability and Transformation Partnerships <http://www.bettercareleicester.nhs.uk/>

Better Care Fund 2025-26 EOY Reporting Template

0

1. Guidance

Overview

The Better Care Fund (BCF) reporting requirements are set out in the BCF Planning Requirements for 2025-26 (refer to link below), which supports the aims of the BCF Policy Framework and the BCF programme; jointly led and developed by the national partners Department of Health and Social Care (DHSC), Ministry for Housing, Communities and Local Government (MHCLG), NHS England (NHSE).

<https://www.england.nhs.uk/long-read/better-care-fund-planning-requirements-2025-26/#introduction>

<https://www.gov.uk/government/publications/better-care-fund-policy-framework-2025-to-2026/better-care-fund-policy-framework-2025-to-2026>

As outlined within the planning requirements, quarterly BCF reporting will continue in 2025-26, with areas required to set out progress on delivering their plans by reviewing metrics performance against goals, spend to date as well as any significant changes to planned spend.

The primary purpose of BCF reporting is to ensure a clear and accurate account of continued compliance with the key requirements and conditions of the fund. The secondary purpose is to inform policy making, the national support offer and local practice sharing by providing a fuller insight from narrative feedback on local progress, challenges and highlights on the implementation of BCF plans and progress on wider integration.

BCF reporting is likely to be used by local areas, alongside any other information to help inform HWBs on progress on integration and the BCF. It is also intended to inform BCF national partners as well as those responsible for delivering the BCF plans at a local level (including ICBS, local authorities and service providers) for the purposes noted above.

In addition to reporting, BCMs and the wider BCF team will monitor continued compliance against the national conditions and metric ambitions through their wider interactions with local areas.

BCF reports submitted by local areas are required to be signed off HWB chairs ahead of submission. Aggregated data reporting information will be available on the DHSC BCF Metrics Dashboard and published on the NHS England website.

Note on entering information into this template

Please do not copy and paste into the template

Throughout the template, cells which are open for input have a yellow background and those that are pre-populated have a blue background, as below:

Data needs inputting in the cell

Pre-populated cells/Not required

Note on viewing the sheets optimally

To more optimally view each of the sheets and in particular the drop down lists clearly on screen, please change the zoom level between 90% - 100%. Most drop downs are also available to view as lists within the relevant sheet or in the guidance tab for readability if required.

The row heights and column widths can be adjusted to fit and view text more comfortably for the cells that require narrative information.

Please DO NOT directly copy/cut and paste to populate the fields when completing the template as this can cause issues during the aggregation process. If you must 'copy and paste', please use the 'Paste Special' operation and paste Values only.

The details of each sheet within the template are outlined below.

Checklist (2. Cover)

1. This section helps identify the sheets that have not been completed. All fields that appear as incomplete should be complete before sending to the BCF Team.
2. The checker column, which can be found on the individual sheets, updates automatically as questions are completed. It will appear 'Red' and contain the word 'No' if the information has not been completed. Once completed the checker column will change to 'Green' and contain the word 'Yes'
3. The 'sheet completed' cell will update when all 'checker' values for the sheet are green containing the word 'Yes'.
4. Once the checker column contains all cells marked 'Yes' the 'Incomplete Template' cell (below the title) will change to 'Template Complete'.
5. Please ensure that all boxes on the checklist are green before submission.

2. Cover

1. The cover sheet provides essential information on the area for which the template is being completed, contacts and sign off. Once you select your HWB from the drop down list, relevant data on metric goals from your BCF plans for 2025-26 will pre-populate in the relevant worksheets.
2. HWB Chair sign off will be subject to your own governance arrangements which may include a delegated authority.
3. Question completion tracks the number of questions that have been completed; when all the questions in each section of the template have been completed the cell will turn green. Only when all cells are green should the template be sent to:
england.bettercarefundteam@nhs.net

(please also copy in your respective Better Care Manager)

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4. Please note that in line with fair processing of personal data we request email addresses for individuals completing the reporting template in order to communicate with and resolve any issues arising during the reporting cycle. We remove these addresses from the supplied templates when they are collated and delete them when they are no longer needed.

3. National Conditions

This section requires the Health & Wellbeing Board to confirm whether the four national conditions detailed in the Better Care Fund planning requirements for 2025-26 (link below) continue to be met through the delivery of your plan. Please confirm as at the time of completion.

<https://www.england.nhs.uk/long-read/better-care-fund-planning-requirements-2025-26/>

This sheet sets out the four conditions and requires the Health & Wellbeing Board to confirm 'Yes' or 'No' that these continue to be met. Should 'No' be selected, please provide an explanation as to why the condition was not met for the year and how this is being addressed. Please note that where a National Condition is not being met, an outline of the challenge and mitigating actions to support recovery should be outlined. It is recommended that the HWB also discussed this with their Regional Better Care Manager.

In summary, the four National conditions are as below:

National condition 1: Plans to be jointly agreed

National condition 2: Implementing the objectives of the BCF

National condition 3: Complying with grant and funding conditions, including maintaining the NHS minimum contribution to adult social care (ASC) (and section 75 in place)

National condition 4: Complying with oversight and support processes

4. Metrics

The BCF plan includes the following metrics (these are not cumulate/YTD):

1. Emergency admissions to hospital for people aged 65+ per 100,000 population. (monthly)

2. Average number of days from Discharge Ready Date to discharge (all adult acute patients). (monthly)

3. Admissions to long term residential and nursing care for people aged 65+ per 100,000 population. (quarterly)

Plans for these metrics were agreed as part of the BCF planning process outlined within 25/26 planning submissions.

Populations are based on 2024 mid year estimates, please note this has been updated from the Q2 template to match the DHSC metrics dashboard.

Within each section, you should set out how the ambition has been reached, including analysis of historic data, impact of planned efforts and how the target aligns for locally agreed plans such as Acute trusts and social care.

■

The bottom section for each metric also captures a confidence assessment on achieving the locally set ambitions for each of the BCF metrics.

The metrics worksheet seeks a short explanation if a goal has not been met - in which case please provide a short explanation, including noting any key mitigating actions. You can also use this section to provide a very brief explanation of overall progress if you wish.

In making the confidence assessment on progress, please utilise the available metric data via the published sources or the DHSC metric dashboard along with any available proxy data.

https://dhexchange.kahootz.com/Discharge_Dashboard/groupHome

5. Income & Expenditure

This section requires confirmation of an update to actual income received in 2025-26 across each fund, as well as spend to date at Q3. If expenditure by activity has changed since the original plan, please confirm that this has been agreed by local partners. If that change in activity expenditure is greater than 5% of total BCF expenditure, please use this box to provide a brief summary of the change.

On the 'DFG' row in the 'Source of Funding' table, 'Updated Total Income for 25-26' this should include the total funding from DFG allocations that is available for you to spend on DFG in this financial year 2025-26. 'EOY Actual Expenditure' should include total amount that has been spent at year-end, even if the application or approval for the DFG started in a previous quarter or there has been slippage.

The template will automatically pre-populate the planned income in 2025-26 from BCF plans, including additional contributions. Please enter the update amount of income even if it is the same as in the submitted plan. Note that the extra £50m DFG top-up that had been introduced at the start of the year is now included in the total DFG amount therefore please include this in your total actuals expenditure.

Please also use this section to provide the aggregate End of Year Spend. This tab will also display what percentage of planned income this constitutes.

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Better Care Fund 2025-26 EOY Reporting Template

2. Cover

Version 1.0

Please Note:

- The BCF quarterly reports are categorised as 'Management Information' and data from them will be published in an aggregated form on the NHSE website. This will include any narrative section. Also a reminder that as is usually the case with public body information, all BCF information collected here is subject to Freedom of Information requests.

- At a local level it is for the HWB to decide what information it needs to publish as part of wider local government reporting and transparency requirements. Until BCF information is published, recipients of BCF reporting information (including recipients who access any information placed on the BCE) are prohibited from making this information available on any public domain or providing this information for the purposes of journalism or research without prior consent from the HWB (where it concerns a single HWB) or the BCF national partners for the aggregated information.

- All information will be supplied to BCF partners to inform policy development.

- This template is password protected to ensure data integrity and accurate aggregation of collected information. A resubmission may be required if this is breached.

Health and Wellbeing Board:	Leicestershire
Completed by:	Lisa Carter
E-mail:	Lisa.Carter@leics.gov.uk
Contact number:	1163050786
Has this report been signed off by (or on behalf of) the HWB Chair at the time of submission?	Yes
If no, please indicate when the report is expected to be signed off:	

Checklist
Complete:
Yes
Yes
Yes
Yes
Yes
Yes

Question Completion - when all questions have been answered and the validation boxes below have turned green you should send the template to england.bettercarefundteam@nhs.net saving the file as 'Name HWB' for example 'County Durham HWB'.

Complete

	Complete:
2. Cover	Yes
3. National Conditions	Yes
4. Metrics	Yes
5. Income & Expenditure	Yes

For further guidance on requirements please refer back to guidance sheet - tab 1.

[<< Link to the Guidance sheet](#)

[^^ Link back to top](#)

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Better Care Fund 2025-26 EOY Reporting Template

3. National Conditions

Selected Health and Wellbeing Board:

Leicestershire

Confirmation of Nation Conditions		
National Condition	Confirmation	If the answer is "No" please provide an explanation as to why the condition was not met in the quarter and mitigating actions underway to support compliance with the condition:
1) Plans to be jointly agreed	Yes	
2) Implementing the objectives of the BCF	Yes	
3) Complying with grant and funding conditions, including maintaining the NHS minimum contribution to adult social care (ASC) and Section 75 in place	Yes	
4) Complying with oversight and support processes	Yes	

Checklist
Complete:
Yes
Yes
Yes
Yes

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Better Care Fund 2025-26 EOY Reporting Template

4. Metrics for 2025-26

Selected Health and Wellbeing Board:

Leicestershire

For metrics time series and more details:

[BCF dashboard link](#)

For metrics handbook and reporting schedule:

[BCF 25/26 Metrics Handbook](#)

4.1 Emergency admissions

Plan		Apr 25 Plan	May 25 Plan	Jun 25 Plan	Jul 25 Plan	Aug 25 Plan	Sep 25 Plan	Oct 25 Plan	Nov 25 Plan	Dec 25 Plan	Jan 26 Plan	Feb 26 Plan	Mar 26 Plan
Emergency admissions to hospital for people aged 65+ per 100,000 population	Rate	1,484.0	1,576.1	1,633.3	1,649.2	1,677.8	1,525.3	1,592.0	1,553.9	1,598.4	1,595.2	1,506.2	1,655.6
	Number of Admissions 65+	2,335	2,480	2,570	2,595	2,640	2,400	2,505	2,445	2,515	2,510	2,370	2,605
	Population of 65+	157,349.0	157,349.0	157,349.0	157,349.0	157,349.0	157,349.0	157,349.0	157,349.0	157,349.0	157,349.0	157,349.0	157,349.0

Assessment of whether goal has been met in Q4:	On track to meet goal
You may use this box to provide a very brief explanation of overall progress if you wish.	When comparing actuals with planned performance, the data for the year so far shows that we are currently on target.

4.2 Discharge Delays

Original Plan	Apr 25 Plan	May 25 Plan	Jun 25 Plan	Jul 25 Plan	Aug 25 Plan	Sep 25 Plan	Oct 25 Plan	Nov 25 Plan	Dec 25 Plan	Jan 26 Plan	Feb 26 Plan	Mar 26 Plan
Average length of discharge delay for all acute adult patients (this calculates the % of patients discharged after their DRD, multiplied by the average number of days)	0.45	0.44	0.43	0.42	0.41	0.40	0.38	0.38	0.36	0.35	0.34	0.33
Proportion of adult patients discharged from acute hospitals on their discharge ready date	85.0%	85.4%	85.7%	86.1%	86.5%	86.8%	87.2%	87.5%	87.9%	88.3%	88.6%	89.0%

For those adult patients not discharged on DRD, average number of days from DRD to discharge	3.00	3.00	3.00	3.00	3.00	3.00	3.00	3.00	3.00	3.00	3.00	3.00
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Assessment of whether goal has been met in Q4:	Not on track to meet goal
You may use this box to provide a very brief explanation of overall progress if you wish.	YTD data shows that we are currently off target against planned performance. Throughout 25-26, Leicestershire performance has been off target for the 'Proportion of adult patients discharged from acute hospitals on their discharge ready date' indicator requirements. The target was to achieve 89% by the end of the financial year. This has not been achieved, with the best individual monthly performance in June of 86.2%

4.3 Residential Admissions

Actuals + Original Plan		2023-24 Full Year Actual	2024-25 Full Year CLD Actual	2025-26 Plan Q1 (April 25-June 25)	2025-26 Plan Q2 (July 25-Sept 25)	2025-26 Plan Q3 (Oct 25-Dec 25)	2025-26 Plan Q4 (Jan 26-Mar 26)
Long-term support needs of older people (age 65 and over) met by admission to residential and nursing care homes, per 100,000 population	Rate	509.8	523.7	132.2	137.9	137.9	137.3
	Number of admissions	785.0	824.0	208.0	217.0	217.0	216.0
	Population of 65+*	157349.0	157349.0	157349.0	157349.0	157349.0	157349.0

Better Care Fund 2025-26 EOY Reporting Template

5. Income & Expenditure

Selected Health and Wellbeing Board:

Leicestershire

Source of Funding	2025-26		DFG EOY Actual Expenditure
	Planned Income	Updated Total Income for 25-26	
DFG (including top-up)	£5,906,353	£5,906,353	£4,512,965
Minimum NHS Contribution	£57,070,979	£57,070,979	
Local Authority Better Care Grant	£21,824,275	£21,824,275	
Additional LA Contribution	£0	£0	
Additional NHS Contribution	£0	£0	
Total	£84,801,607	£84,801,607	

End of Year Actual Expenditure		% of Planned Income
	£83,408,219	98%

If expenditure by activity has changed since the original plan, please confirm that this has been agreed by local partners. If that change in activity expenditure is greater than 5% of total BCF expenditure, please use this box to provide a brief summary of the change.	Partners have confirmed that the DFG underspend is due to a number of reasons, including length of time taken for building works and staff shortages.
---	---

Checklist

Complete:

- Yes
- Yes
- Yes
- Yes
- Yes

Yes

Yes

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Better Care Fund 2024-25 EOY Reporting Template

6. Year End Impact Summary

Selected Health and Wellbeing Board:

Leicestershire

Confirmation of Statements		
Question statements	Confirmation	If the answer is "No" please provide an explanation:
Overall delivery of BCF has improved joint working between health and social care	Yes	
Our BCF schemes were implemented as planned in 2025-26	Yes	
The delivery of our BCF plan 2025-26 has had a positive impact on the integration of health and social care in our locality.	Yes	

Checklist
Complete:

Yes
Yes
Yes

Highlight success and challenges within reference to the most relevant enablers from SCIE logic model:	
Logic model for integrated care - SCIE	
Success and Challenges	Narrative
2 key successes observed towards driving the enablers for integration	Neighbourhood Model of care - West Leicestershire has been part of the national implementer site programme for neighbourhood Health. The focus has been on the delivery of MDT's for people who have COPD and are housebound. BCF funded Care Co-ordinators have worked with other professionals to attend MDT's and to work with people in their own homes to offer a range of preventative and supportive services. The MDT's have worked with approximately a quarter of the cohort, defined using population health management data, linking 120 people out of 450 so far, with social care, carers support services, voluntary sector and housing. This has also allowed us to focus on person-centred outcomes in (PROMS and PREMS) and the collation of case-studies to show the difference this is making to people in their communities
2 key challenges observed towards driving the enablers for integration	Recruitment to meet demand for certain services remained a challenge across the system. This is despite investment. To mitigate investment in other teams has helped to bridge any gaps in capacity to ensure services are as equitable as possible. D2A bedded capacity away from spot-purchasing still remains a challenge for the system that will continue to be mitigated in 26-27. We will be investing in Project Management resource to produce and take forward options for reducing the use of spot purchase beds and overall system bed utilisation. However, funding to manage the remainder of the demand is going to prove challenging to provide a RRR model for 4 weeks for all who are assessed as needing this type of support.

Yes
Yes

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HEALTH AND WELLBEING BOARD:15 JUNE 2026

REPORT OF THE DIRECTOR OF ADULTS AND CULTURAL SERVICES

LEICESTERSHIRE BETTER CARE FUND PLAN 2026-27

Purpose of report

1. The purpose of this report is to provide the Health and Wellbeing Board with an overview of the progress to date on the submission of the Leicestershire Better Care Fund (BCF) Plan 2026-27.

Recommendation

2. It is recommended that the HWB:
 - a. Note the content of the report
 - b. Note the Better Care Fund (BCF) Plan 26-27 numerical template attached as Appendix A and the narrative document, attached as Appendix B, that details the contents of the BCF Plan return;
 - c. Note the action taken by the Chief Executive of Leicestershire County Council, to use powers of delegation to approve the BCF Plan for submission prior to the deadline of 19th May 2026.

Policy Framework and Previous Decisions

3. The BCF policy framework was introduced by the Government in 2015, with the first year of BCF Plan delivery being 2015-16. The Cabinet in February 2014 authorised the HWBB to approve the BCF Plan and plans arising from its use.
4. Links to the policy framework and planning requirements for the 2026-27 BCF plans are also listed in the Background Papers section below.
5. The Integration Executive, a subgroup of the Health and Wellbeing Board with responsibility for the day-to-day delivery of the BCF, considered the draft BCF Plan 2026-27 at its meeting on the 5th May. The Executive supported its contents

Timetable for Decisions

6. The submission documentation was published on the 18th February, 2026 with a deadline of submission to NHS England of the 19th May, 2026.
7. The Better Care Fund plan 2026-27 was approved by the Chief Executive of Leicestershire County Council on 18th May, 2026 using delegated powers.
8. The Better Care Fund Plan 2026-27 was submitted to NHSE on 19th May 2026.

Background

9. The BCF programme supports local systems to successfully deliver the integration of health and social care in a way that supports person-centred care, sustainability and better outcomes for people and carers. It represents a unique collaboration between:
 - The Department of Health and Social Care;
 - Department for Levelling Up, Housing and Communities;
 - NHS England and Improvement;
 - The Local Government Association.
10. The four partners work closely together to help local areas plan and implement integrated health and social care services across England, in line with the vision outlined in the [NHS Long Term Plan](#). Locally, the programme spans both the NHS and local government to join up health and care services, so that people can manage their own health and wellbeing and live independently in their communities for as long as possible.
11. Launched in 2015, the programme established pooled budgets between the NHS and local authorities, aiming to reduce the barriers often created by separate funding streams. The pooled budget is a combination of contributions from the following areas:
 - minimum allocation from NHS Integrated Care Boards (ICB's);
 - disabled facilities grant – local authority grant;
 - social care funding (improved BCF) – local authority grant;
 - winter pressures grant funding £240 million – local authority grant.

BCF Plan for 2026-27

12. The primary purpose of BCF reporting is to ensure a clear and accurate account of continued compliance of spending in line with the national conditions of the Fund. The secondary purpose is to inform policy making, the national support offer and local practice sharing by providing a fuller insight from narrative feedback on local progress, challenges and highlights on the implementation of BCF Plans and progress on wider integration.
13. The BCF Plan differs from previous years in that there is no formal demand and capacity modelling template, however, HWB areas are expected to still undertake this to inform commissioning and spend. The submission still consists of the expenditure plan, narrative and outcome metrics.
14. An excel template is made available for areas to use to record and agree spending in local BCF Plans, named the BCF Numerical Template. This is intended to support local planning and reporting at year end. It includes targets and current data against the national metrics included in the requirements. The template is attached as Appendix A to this report.
15. To give assurance to the Board on the initial developments on completing the plan, Appendix B narrative highlights how the HWB area and overall system will aim to meet the national conditions required to gain national approval of the plans. This mirrors the planning requirements tab on the excel template.

16. The planning principles document is attached as Appendix C to this report.

BCF National Conditions

17. The three national conditions set by the Government in the policy framework for 2026-27 are:

18. **National condition 1: effectively support the delivery of integrated and preventative care.** ICBs and local authorities must develop joint plans, agreed by health and wellbeing boards, outlining how ICBs and local authorities intend to use BCF funding to deliver more integrated and preventative care, linked to the relevant areas of neighbourhood health and social care services.

The planning requirements are as follows.

ICBs and local authorities must:

- have considered how to use the BCF most effectively to support the delivery of more integrated and preventative services, particularly supporting those with more complex health and social care needs. This must include setting out how the funding will be used to develop the quality, efficiency and outcomes from intermediate care
- set out plans that:
 - show reasonable progress in the metrics of non-elective admissions (for people aged 65 and over) and delayed discharges
 - show how they will monitor and drive progress in preventing avoidable long-term care home admissions and improving outcomes from reablement
 - include the specific contribution of BCF-funded services
 - demonstrate that their plans for the use of the BCF represent value for money and improve overall productivity

To demonstrate these requirements:

- named ICB and local authority chief executives and a named health and wellbeing board chair must confirm that BCF expenditure is agreed and aligned with wider strategic objectives for neighbourhood health and social care
- the BCF assurance return must include a short statement setting out how BCF funding will support wider strategic objectives, including those referenced in the ICB 5-year strategic commissioning plan. This statement must include:
 - a short explanation for any substantial changes in allocations compared with the 2025 to 2026 BCF funding and, if doing so, set out how ICBs and local authorities are ensuring continuity of critical services
 - a summary of assessments in the demand and capacity needed for intermediate care
- the assurance return must also:
 - set out local goals for non-elective hospital admissions for people aged 65 and over and discharge delays and the rationale for these goals, including alignment with local NHS provider medium-term planning assumptions. It should also set out plans to drive progress in preventing avoidable long-

term care home admissions and improving outcomes from reablement and, if agreed locally, the rationale for local goals for long-term admissions to care homes

- include an explanation of how BCF-funded services will contribute to meeting these goals
- set out how ICBs and local authorities have confidence that the services funded through the BCF represent value for money, and how they will seek to raise the productivity of services. The value for money section of the return must reference how the joint governance set out under national condition 3 will review value for money and productivity
- must be submitted to the national BCF team and regional better care managers by email, using the provided template on the BCF Exchange (NHS Futures login required) by 19 May 2026

19. **National condition 2: comply with expenditure and grant conditions**

ICBs and local authorities must comply with all national grant and funding conditions and deliver in accordance with their approved return. ICBs must maintain the NHS minimum contribution to adult social care and pool NHS BCF contributions into a section 75 (of the NHS Act 2006) pooled fund.

The planning requirements are:

- ICBs and local authorities must pool their designated minimum contribution (in the case of ICB partners) and the Local Authority Better Care Grant and DFG (in the case of local authority partners). ICBs and local authorities may voluntarily pool additional funding through the BCF where they consider this is likely to lead to an improvement in the services being funded
- the NHS minimum contribution to adult social care must be met and maintained by the ICB in line with the published BCF allocations. This represents an increase of 4.4% in each health and wellbeing board area
- local authorities must comply with the grant conditions of the Local Authority Better Care Grant and the DFG, including the pooling of funding

To demonstrate the requirements:

- the BCF assurance return must set out:
 - planned expenditure against core categories
 - the sources of this expenditure from different components of the BCF, including the NHS minimum contribution to social care
- assurance statements in the return will ask ICBs and local authorities to confirm that funding conditions have been met
- ICBs and local authorities must confirm that they will place the funding into one or more pooled funds under section 75 of the NHS Act 2006 once the BCF 2026 to 2027 assurance return is approved. They must do this no later than 30 September 2026

20. **National condition 3: effective governance, reporting and engagement**

ICBs and local authorities must comply and engage with BCF planning, governance and reporting requirements, including adherence to any assurance and oversight processes.

The planning requirements are:

- ICBs and local authorities must have effective joint governance in place to ensure local accountability for delivery of outcomes, including reviewing

performance against plan objectives and local goals, and taking action if necessary to bring delivery back on track

- ICBs, local authorities and health and wellbeing boards are required to engage with BCF reporting, oversight and support processes

To demonstrate these requirements:

- the BCF assurance return must set out robust joint governance for managing the expenditure of BCF funding, including assessing impact of funding, value for money and continuous improvement
- ICBs and local authorities will need to confirm through assurance statements that they will engage with BCF oversight and support processes if necessary

Strategic Narrative

- 19 The narrative template, attached as Appendix B, sets out Leicestershire's initial approach to the integration of health and social care under the 5 questions set out within it.
- 20 Detail within the narrative has been based on a series of partner discussions to determine priorities for delivery in the next financial year. At its meeting of the 27th January, 2026, members of the Health and Wellbeing Board and the Integration Executive took part in a workshop to discuss the priorities for the plan, any changes in investment required and key lines of enquiry documents produced for each line of the Better Care Fund schemes. This determined priority areas for inclusion in the plan.
- 21 Priority areas were determined as opportunities for further integration, areas where finances could be better aligned across partners and improvements needed to align to national priorities e.g. development of neighbourhood models of care and to demonstrate increased productivity and value for money.

BCF Income

- 22 The BCF Plan for Leicestershire for 2026-27 will total £86.5million. This includes Disabled Facilities Grant funding of £5.7 million which is passported to District Councils. Contributions are summarised in the table below:

ICB minimum NHS contribution	£59,017,028
LA Better Care Grant	£21,824,275
Disabled Facilities Grant	£5,716,379
Total	£86,557,682

BCF Metrics

- 23 In addition to the national conditions, the BCF Policy Framework sets national metrics that must be included in BCF Plans in 2026-27. The local authority and ICB are required to establish ambitions associated with each metric and set out how they will be achieved. This process should then be approved by the HWBB. The framework has three headline metrics:

- Emergency admissions to hospital for people aged 65+ per 100,000 population.
- 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.
- Long-term admissions to residential care homes and nursing homes for people aged 65+ per 100,000 population

24 In addition to the headline metrics there is an additional metric for reablement outcomes

- Proportion of people aged 65 and over discharged from hospital with reablement provided partly or solely by LAs, and who remained in the community within 12 weeks of discharge

25 Ambitions reflect underlying changes in demand over the coming year. For example, the goals for maximum levels of emergency admissions to hospital should take into account any expected underlying growth in demand for admissions due to population demographics. This has been aligned to Urgent and Emergency Care (UEC) planning which will be based on the same increases.

Background papers

Better Care Fund Policy Framework 2026-27:

<https://www.gov.uk/government/publications/better-care-fund-framework-2026-to-2027/better-care-fund-framework-2026-to-2027#bcf-national-funding-conditions>

Circulation under the Local Issues Alert Procedure

26. None

Officer to Contact

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Email: jon.wilson@leics.gov.uk

Lisa Carter Health and Social Care Integration Service Manager

Telephone: 0116 3050786

Email: lisa.carter@leics.gov.uk

List of Appendices

Appendix A – BCF Numerical Template 26-27

Appendix B – BCF Narrative Template 26-27

Appendix C – BCF Planning Principles

Relevant Impact Assessments

Equality and Human Rights Implications

27. The BCF aims to improve outcomes and wellbeing for the people of Leicestershire, with effective protection of social care and integrated activity to reduce emergency and urgent health demand.

28. An equalities and human rights impact assessment has been undertaken when the BCF was established and is provided at <http://www.leicestershire.gov.uk/sites/default/files/field/pdf/2017/1/11/better-care-fund-overview-ehria.pdf>. This identified that the BCF will have a neutral impact on equalities and human rights.

29. A review of the assessment was undertaken in March 2017.

Partnership Working and associated issues

30. The delivery of the BCF Plan and the governance of the associated pooled budget is managed in partnership through the collaboration of commissioners and providers in Leicestershire.

31. Day to day oversight of delivery is via the Integration Executive, a subgroup of the Health and Wellbeing Board.

Partnership Working and associated issues

32. The delivery of the Leicestershire BCF ensures that a number of key integrated services are in place and contributing to the system wide changes being implemented through the NHS Long-term plan.

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Better Care Fund 2026-27 Numerical Template

Data Sharing Statement

Data Sharing Statement

Please see below important information regarding data sharing and how the data provided during this collection will be used. This statement covers how NHS England will use the information provided.

Purpose of data collection

NHS England is collecting data on behalf of Better Care Fund (BCF) partners to fulfil statutory duties, including improving healthcare quality, efficiency, and transparency. The data supports operational and strategic planning, financial management, workforce planning, and system feedback, as mandated by the NHS Act 2006 and relevant regulations.

Type and scope of data

Patient-level data, including identifiable information like NHS numbers, is not required.

Data includes finance, activity, workforce, and planning information as specified in the national guidance documents.

The BCF numerical template is categorised as "Management Information," and aggregated data, including narrative sections, will be published on the NHS England website and gov.uk.

Access, sharing, and publication

The BCF numerical template is categorised as 'Management Information' and data submitted will be published in an aggregated form on the NHS England website and gov.uk. This will include a narrative section. Please also note that all BCF information collected here is subject to Freedom of Information requests.

Internal Access: Data will be accessed by NHS England national and regional teams on a "need-to-know" basis and may be shared internally to support statutory responsibilities.

External Sharing: Data and information from this numerical template and associated narrative return may be shared with partner organisations and Arm's Length Bodies (ALBs) including BCF partners (i.e. Ministry of Housing, Communities and Local Government (MHCLG), Department of Health and Social Care (DHSC) and NHS England) for joint working and policy development.

Publication: Local Health and Wellbeing Boards (HWBs) are encouraged to publish local plans. Until publication, recipients of BCF reporting data (including those accessing the Better Care Exchange) cannot share it publicly or use it for journalism or research without prior consent from the HWB (for single HWB data) or BCF national partners (for aggregated data).

Storage and security

Data will be securely stored on NHS England servers. Shared data will be minimised and handled per confidentiality and security requirements.

The BCF template is password-protected to ensure data integrity and accurate aggregation. Breaches may require resubmission.

Data analysis and use

NHS England will analyse data submissions for feedback, reporting, benchmarking, and system improvement.

Triangulation with other data may be conducted to support deeper analysis and insights and inform decision-making.

Concerns

For any questions about data sharing, please contact your regional Better Care Managers or the national Better Care Fund team england.bettercarefundteam@nhs.net

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Better Care Fund (BCF) 2026-27 Numerical Template

1. Guidance

Overview
 The numerical return is designed to capture planned BCF spend, goals and assurance statements. Together with the narrative return these will enable local areas to demonstrate how they meet the national funding conditions, in line with the published BCF 2026-27: <https://www.gov.uk/government/publications/better-care-fund-framework-2026-to-2027/better-care-fund-framework-2026-to-2027>.

Completed numerical returns are due by Tuesday 19 May 2026 (noon)

Submissions should be sent to the national BCF team at england.bettercarefundteam@nhs.net, as well as to regional Better Care Managers.

This guidance provides an overview of how to complete this numerical return. Further guidance is provided in the BCF Planning Principles guidance and supporting documents which can be found on the Better Care Exchange - <https://future.nhs.uk/bettercareexchange/view?objectID=70716560>

Functional use of the template
 We are using the latest version of Excel in Office 365, an older version may cause an issue. Throughout the template, cells which are open for input have a yellow background and those that are pre-populated have a blue background, as below:

Data needs inputting in the cell
Pre-populated cells

This template is password protected to ensure data integrity and accurate aggregation of collected information. A resubmission may be required if this is breached.

2. Cover
 The cover sheet provides essential information on the area for which the template is being completed, contacts and sign off. To view pre-populated data for your area and begin completing your template, you should select your HWB from the top of the sheet.

Governance and sign-off
 National condition one (refer to tab 6) outlines the expectation for the local sign off of plans. Plans must be jointly agreed and be signed off in accordance with organisational governance processes across the relevant ICB and local authorities. Plans must be accompanied by signed confirmation from local authority and ICB chief executives that they have agreed to their BCF plans, including the goals for performance against headline metrics. Please enter date of expected sign off if not yet signed off. **This accountability must not be delegated.**

Data completeness and data quality:

- Question completion tracks the number of questions that have been completed; when all the questions in each section of the template have been completed the cell will turn green. Only when all cells in this table are green should the template be sent to the BCF team: england.bettercarefundteam@nhs.net (please also copy in your better care manager).
- The checker column, which can be found on each individual sheet, updates automatically as questions are completed. It will appear red and contain the word 'No' if the information has not been completed. Once completed the checker column will change to green and contain the word 'Yes'.
- The 'sheet completed' cell will update when all 'checker' values for the sheet are green containing the word 'Yes'.
- Once the checker column contains all cells marked 'Yes' the 'Incomplete Template' cell (below the title) will change to 'Template Complete'. Please ensure that all boxes on the checklist are green before submission. Please contact your regional BCF team if you have any issues.

3. Income
 This sheet should be used to specify all funding contributions to the HWBs BCF plan and pooled budget for 2026-27. This section will be pre-populated with the NHS minimum contributions, Disabled Facilities Grant (DFG) and Local Authority Better Care Grant (LABCG). For any questions regarding the BCF funding allocations, please contact england.bettercarefundteam@nhs.net (please also copy in your better care manager).

Additional Contributions
 This sheet also allows local areas to add in additional contributions from both the NHS and local authority. You will be able to update the value of any additional contributions (local authority and NHS) income types locally. If you need to make an update to any of the funding streams, select 'Yes' in the boxes where this is asked and cells for the income stream below will turn yellow and become editable. Please use the comments boxes to outline reasons for any changes and any other relevant information as this will ensure section is marked as complete.

Unallocated funds
 Plans should account for full allocations meaning no unallocated funds should remain once the template is complete.

4. Expenditure

Please see tab '4a. Expenditure guidance' for further information.

5. Metrics

For 2026-27, local authorities, integrated care boards (ICBs) and HWBs will be expected to monitor performance and improvement for the four metrics listed in the Metrics Handbook <https://future.nhs.uk/bettercareexchange/view/objectID=277641413>, available on the Better Care Exchange:

It is a national requirement for partners to set local goals in relation to the following two metrics:

- Non elective admissions to hospital for people aged 65 and over per 100,000 population
- Average length of discharge delay for all acute adult patients

HWBs are also encouraged to set goals for the metric on long-term admissions to residential and nursing homes for people aged 65 and over per 100,000 population.

We also expect HWBs to monitor and drive improvements for the metric on the proportion of people aged 65 and over discharged from hospital with reablement provided partly or solely by local authorities who remained in the community within 12 weeks of discharge.

Further details on the metrics, can be found below:

1. Non-elective admissions to hospital for people aged 65 and over per 100,000 population. (monthly)

- This is a count of non-elective inpatient spells at English hospitals with a length of stay of at least 1 day, for specific acute treatment functions and patients aged 65+
- This requires inputting of both the planned count of emergency admissions. The population figure is pre-populated using the latest available mid-year estimates.
- This will then auto populate the rate per 100,000 population for each month

Source statistics: <https://digital.nhs.uk/supplementary-information/2026/non-elective-inpatient-spells-at-english-hospitals-occurring-between-1-april-2020-and-30-november-2025-for-patients-aged-18-and-65>

2. Average number of days from Discharge Ready Date to discharge (all adult acute patients). (monthly)

- This is calculated as the sum of all bed days between the Discharge Ready Date and discharge (bed days lost) for patients discharged in a given month, divided by the total number of patients discharged in that month.

In completing the table for 2026-27 we ask areas to set out these two components and sheet automatically calculates the average figure:

- In a given month, the total number of patients discharged on the same day as their Discharge Ready Date, divided by the total number of patients discharged in that month.
- The sum of all bed days between the Discharge Ready Date and discharge (bed days lost) for patients discharged in a given month, divided by the total number of patients delayed by at least 1 day and discharged in that month.

Source statistics: <https://www.england.nhs.uk/statistics/statistical-work-areas/discharge-delays/discharge-ready-date/>

3. Long-term admissions to residential and nursing care homes for people aged 65 and over per 100,000 population

- Admissions data is taken from the Client Level Data (CLD) source published on a quarterly basis and presents admissions as a rolling 12-month total, calculated to the end of each quarter and reported as a rate per 100,000 population.
- Population are based on a calendar year using the latest available mid-year estimates.

Any improvement planned in reablement can be noted in the narrative template but does not need to be included in this numerical template.

For missing pre-populated actuals data from November 2025 to date, please check the BCF dashboard on the DHeXchange which will have more recent data as it becomes available.

6. National conditions

This section requires local authorities, ICBs and HWBs to confirm whether the three BCF national conditions and planning requirements detailed in the published BCF 2026-27 guidance will be met. The assurance statements in this section refer to specific planning requirements, supplementing the information provided in the narrative template and this numerical template.

This sheet requires the local authorities, ICBs and HWBs to confirm 'Yes' or 'No' to the assurance statements. Should 'No' be selected, please note the actions in place towards meeting the requirement and outline the timeframe for resolution.

In summary, the national conditions are as below:

- **National condition 1:** ICBs and local authorities must develop joint plans, agreed by health and wellbeing boards, outlining how ICBs and local authorities intend to use BCF funding, to deliver more integrated and preventative care, linked to the wider development of neighbourhood health and social care services.
- **National condition 2:** ICBs and local authorities must comply with all national grant and funding conditions and deliver in accordance with their approved return. ICBs must maintain the NHS minimum contribution to adult social care and pool NHS BCF contributions into a section 75 (of the NHS Act 2006) pooled fund.
- **National condition 3:** ICBs and local authorities must comply and engage with BCF planning, governance and reporting requirements including adherence to any assurance and oversight processes.

Better Care Fund 2026-27 Numerical Template

Social Care

Local Government

11-11-2025

2. Cover

Version 1.0

Please Note:

- The BCF numerical template is categorised as 'Management Information' and data from them will be published in an aggregated form on the NHS England website and gov.uk. This will include any narrative section. Some data may also be published in non-aggregated form on gov.uk. Also a reminder that as is usually the case with public body information, all BCF information collected here is subject to Freedom of Information requests.
- At a local level it is for the HWB to decide what information it needs to publish as part of wider local government reporting and transparency requirements. Until BCF information is published, recipients of BCF reporting information (including recipients who access any information placed on the Better Care Exchange) are prohibited from making this information available on any public domain or providing this information for the purposes of journalism or research without prior consent from the HWB (where it concerns a single HWB) or the BCF national partners for the aggregated information.
- All information will be supplied to BCF partners (MHCLG, DHSC, NHS England) to inform policy development.
- This template is password protected to ensure data integrity and accurate aggregation of collected information. A resubmission may be required if this is breached.

Governance and Sign off

Health and Wellbeing Board:	Leicestershire
Confirmation that the plan has been signed off by Health and Wellbeing Board ahead of submission - Plans should be signed off ahead of submission.	Yes
If no indicate the reasons for the delay.	
If no please indicate when the HWB is expected to sign off the plan:	

Submitted by:	Lisa Carter
Role and organisation:	Integration Service Manager
E-mail:	Lisa.Carter@leics.gov.uk
Contact number:	1163050786
Documents submitted (please select from drop down) In addition to this template the HWB are submitting the following:	Narrative

	Role:	Professional title (e.g. Dr, Cllr, Prof)	First-name:	Surname:	E-mail:	Organisation
Health and wellbeing board chair(s) sign off	Health and wellbeing board chair	Cllr	Michael	Squires	Michael.squires@leics.gov.uk	Local Authority
	Health and wellbeing board chair	Mr	Matt	Gaunt	m.gaunt@nhs.net	ICB
Named accountable person	Local authority chief executive	Mrs	Jane	Moore	Jane.Moore@leics.gov.uk	Local Authority
	ICB chief executive 1	Mr	Toby	Sanders	toby.sanders1@nhs.net	ICB
	ICB chief executive 2 (where required)					
	ICB chief executive 3 (where required)					

Finance sign off	LA section 151 officer	Mr	Declan	Keegan	Declan.Keegan@leics.gov.uk	Local Authority
	ICB finance director 1	Mr	Matt	Gaunt	m.gaunt@nhs.net	ICB
	ICB finance director 2 (where required)	Ms	Kitty	Tsui	Kitty.Tsui@nhs.net	ICB
	ICB finance director 3 (where required)					

Area assurance contacts <i>Please add any additional key contacts who have been responsible for completing the plan</i>	Local authority director of adult social services	Mr	Jon	Wilson	Jon.Wilson@leics.gov.uk	Local Authority
	DFG lead	Ms	Julia	Smith	julia.smith@blaby.gov.uk	Local Authority
	ICB place lead 1	Ms	Kerryjit	Kaur	kerryjit.kaur2@nhs.net	ICB
	ICB place lead 2 (where required)					
	ICB place lead 3 (where required)					

Question Completion - When all questions have been answered and the validation boxes below have turned green, please send the template to the Better Care Fund Team england.bettercarefundteam@nhs.net saving the file as 'Name HWB' for example 'County Durham HWB'. Please also copy in your better care manager(s).

	Complete:
2. Cover	Yes
3. Income	Yes
4. Expenditure	Yes
5. Metrics	Yes
6. National Conditions	Yes

[^^ Link back to top](#)

Better Care Fund 2026-27 Numerical Template

3. Income

Selected HWB:

Leicestershire

Local authority contribution	
Disabled Facilities Grant (DFG)	Gross Contribution
Leicestershire	£5,716,379
DFG breakdown for two-tier areas only (where applicable)	
Blaby	£853,241
Charnwood	£1,448,118
Harborough	£658,584
Hinckley and Bosworth	£744,152
Melton	£443,083
North West Leicestershire	£977,627
Oadby and Wigston	£591,574
Total Minimum local authority contribution (exc local authority BCF grant)	£5,716,379

Local authority better care grant (LABCG)	Contribution
Leicestershire	£21,824,275
Total Local authority better care grant	£21,824,275

Are any additional local authority contributions being made in 2026-27? If yes, please detail below	No
---	----

Local authority additional contribution	Contribution	Comments - Please use this box to clarify any specific uses or sources of funding
Total additional local authority contribution	£0	

NHS minimum contribution	Contribution
NHS Leicester, Leicestershire and Rutland ICB	£59,017,028

Total NHS minimum contribution	£59,017,028

Are any additional NHS contributions being made in 2026-27? If yes, please detail below	No
---	----

Additional NHS contribution	Contribution	Comments - Please use this box clarify any specific uses or sources of funding
Total additional NHS contribution	£0	
Total NHS contribution	£59,017,028	

Total BCF pooled budget	2026-27 £86,557,682
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Funding contributions comments
For any useful details please use the text box below (for no additional comments, insert 'NA')

N/A

Better Care Fund 2026-27 Numerical Template

4. Expenditure

Selected Health and Wellbeing Board:

Running Balances	2026-27		
	Income	Expenditure	Balance
DFG	£5,716,379	£5,716,379	£0
NHS Minimum Contribution	£59,017,028	£59,017,028	£0
Local Authority Better Care Grant	£21,824,275	£21,824,275	£0
Additional LA Contribution	£0	£0	£0
Additional NHS Contribution	£0	£0	£0
Total	£86,557,682	£86,557,682	£0

Required spend on adult social care from NHS minimum allocations

Adult Social Care services spend from the NHS minimum allocations	2026-27	
	Minimum required spend	Planned Spend
	£33,404,355	£34,228,078

Checklist

Column complete:

	Yes	Yes	Yes	Yes	Yes
Number	Category of scheme	Description of scheme	Source of funding	Adult Social Care Spend	Expenditure for 2026-27 (£)
1	Support to carers, including unpaid carers	Provision for enhanced carer support	Local Authority Better Care Grant	Yes	£250,700
2	Evaluation and enabling integration	Case Managers Case Assessment	Local Authority Better Care Grant	Yes	£420,900
3	Home-based intermediate care (short-term home-based rehabilitation, reablement and	HART Reablement & Community Response	NHS Minimum Contribution	Yes	£1,972,054
4	Wider local support to promote prevention and independence	Care Coordination	NHS Minimum Contribution	Yes	£845,327
5	Wider local support to promote prevention and independence	Care Coordination - OT	NHS Minimum Contribution	Yes	£56,826
6	Wider local support to promote prevention and independence	Home Enteral Nutrition Service (HENS)	NHS Minimum Contribution	No	£38,906
7	Long-term home-based community health services	Integrated Community Nursing	NHS Minimum Contribution	No	£7,301,446
8	Wider local support to promote prevention and independence	Post Diagnostic Community & In-Reach Service for people affected by Dementia	NHS Minimum Contribution	No	£59,211
9	Long-term home-based social care services	Multi-disciplinary review team for top 100 high cost placements	Local Authority Better Care Grant	Yes	£250,600
10	Long-term home-based social care services	Stabilising the social care provider market	Local Authority Better Care Grant	Yes	£14,189,870
11	Assistive technologies and equipment	Technology Enabled Care	Local Authority Better Care Grant	Yes	£1,284,300
12	Long-term home-based social care services	Single Handed Care Team	Local Authority Better Care Grant	Yes	£377,200
13	Wider local support to promote prevention and independence	First Contact Plus	NHS Minimum Contribution	Yes	£207,718
14	Long-term home-based social care services	Integrated Personal Care Framework Training	NHS Minimum Contribution	No	£81,400
15	Short-term home-based social care (excluding rehabilitation, reablement or recovery	Low Level Health Tasks	NHS Minimum Contribution	Yes	£150,282
16	Assistive technologies and equipment	Whzan Boxes	NHS Minimum Contribution	No	£67,364
17	Other	Armed Forces	NHS Minimum Contribution	No	£40,000
18	Disabled Facilities Grant related schemes	Blaby District Council	DFG	Yes	£727,024
19	Disabled Facilities Grant related schemes	Charnwood Borough Council	DFG	Yes	£1,321,903
20	Disabled Facilities Grant related schemes	Harborough Borough Council	DFG	Yes	£532,369
21	Disabled Facilities Grant related schemes	Hinckley and Bosworth Borough Council	DFG	Yes	£617,937
22	Disabled Facilities Grant related schemes	Melton Borough Council	DFG	Yes	£316,868
23	Disabled Facilities Grant related schemes	North West Leicestershire District Council	DFG	Yes	£851,414
24	Disabled Facilities Grant related schemes	Oadby and Wigston Borough Council	DFG	Yes	£465,359
25	Disabled Facilities Grant related schemes	Integrated Hoarding Planning- safe places	DFG	Yes	£315,000
26	Disabled Facilities Grant related schemes	Integrated Respiratory Illness - Housing and Respiratory Illness Project	DFG	Yes	£147,000
27	Disabled Facilities Grant related schemes	Assistive Technologies and Dementia PILOT - Home Gadgets	DFG	Yes	£149,100
28	Disabled Facilities Grant related schemes	Case worker Pilot	DFG	Yes	£149,450

29	Disabled Facilities Grant related schemes	DFG Delivery Project lead	DFG	Yes	£54,600
30	Disabled Facilities Grant related schemes	Housing Occupational Project	DFG	Yes	£68,355
31	Home-based intermediate care (short-term home-based)	Intake Model	Local Authority Better Care Grant	Yes	£2,134,000
32	Long-term home-based social care services	Home First Case Management	NHS Minimum Contribution	Yes	£638,819
33	Long-term home-based social care services	Home First management	NHS Minimum Contribution	Yes	£120,000
34	Urgent community response	Home Visiting Service	NHS Minimum Contribution	No	£2,525,208
35	Urgent community response	Night Nursing Service	NHS Minimum Contribution	No	£221,513
36	Evaluation and enabling integration	Primary Care Funding to support D2A placements in care homes	NHS Minimum Contribution	No	£131,840
37	Bed-based intermediate care (short-term bed-based)	P2 Hospital Discharge	NHS Minimum Contribution	Yes	£574,185
38	Discharge support and infrastructure	Case management of HD cohort & THC via MLCSU	NHS Minimum Contribution	No	£140,271
39	Discharge support and infrastructure	D2A High Dependency (HD) x15 beds, Plus MH clinical oversight	NHS Minimum Contribution	No	£579,076
40	Discharge support and infrastructure	D2A HD GP funding to support additional interventions	NHS Minimum Contribution	No	£44,238
41	Discharge support and infrastructure	HD 1-1s for blocked booked beds	NHS Minimum Contribution	No	£235,894
42	Discharge support and infrastructure	Case managers for TCP to support inpatient reductions	Local Authority Better Care Grant	Yes	£131,600
43	Wider local support to promote prevention and independence	Positive Behaviour Support Team	NHS Minimum Contribution	Yes	£117,842
44	Wider local support to promote prevention and independence	Enhanced TCP Training Wraparound Service Offer	NHS Minimum Contribution	Yes	£73,324
45	Wider local support to promote prevention and independence	Transforming Care Programme - Implementing Actions from the TCP Recovery Plan	NHS Minimum Contribution	Yes	£80,376
46	Housing related schemes	MH relationship Enabler	Local Authority Better Care Grant	Yes	£48,660
47	Support to carers, including unpaid carers	LD Short Breaks	NHS Minimum Contribution	No	£947,541
48	Long-term home-based social care services	Assessment and Review (ASC protected)	NHS Minimum Contribution	Yes	£2,340,015
49	Support to carers, including unpaid carers	Residential Respite Service (ASC protected)	NHS Minimum Contribution	Yes	£1,059,635
50	Home-based intermediate care (short-term home-based)	LLR Community Integrated Neurology & Stroke Rehabilitation Service (CINSS)	NHS Minimum Contribution	No	£342,271
51	Urgent community response	Loughborough Urgent Treatment Centre	NHS Minimum Contribution	No	£1,448,556
52	Urgent community response	Urgent Care Centres (ELRCCG)	NHS Minimum Contribution	No	£1,297,794
53	Discharge support and infrastructure	Care Homes Support / Trusted Assessor	Local Authority Better Care Grant	Yes	£185,700
54	Discharge support and infrastructure	CHC Commissioning Capacity	Local Authority Better Care Grant	Yes	£196,400
55	Discharge support and infrastructure	Flow Improvement Team	Local Authority Better Care Grant	Yes	£626,530
56	Wider local support to promote prevention and independence	DHU Falls Bus	NHS Minimum Contribution	No	£550,000
57	Discharge support and infrastructure	Home First Case Management (Hosp Link Workers)	NHS Minimum Contribution	Yes	£568,172
58	Discharge support and infrastructure	Home First Integrated Reablement	NHS Minimum Contribution	Yes	£470,910
59	Housing related schemes	Lightbulb - Housing (Discharge) Enablement Team	Local Authority Better Care Grant	No	£165,760
60	Housing related schemes	Lightbulb - Housing (Discharge) Enablement Team	NHS Minimum Contribution	Yes	£154,000
61	Discharge support and infrastructure	Discharge Hub	NHS Minimum Contribution	No	£252,877
62	Discharge support and infrastructure	RVS Discharge Support	NHS Minimum Contribution	No	£140,356
63	Discharge support and infrastructure	Hospital Staff Training on Home First Process	NHS Minimum Contribution	Yes	£5,387
64	Discharge support and infrastructure	Assertive In Reach MH	Local Authority Better Care Grant	Yes	£178,300
65	Discharge support and infrastructure	Agency Social Workers (MH teams)	Local Authority Better Care Grant	Yes	£164,000
66	Discharge support and infrastructure	Community Support Workers in Hospital Team (MH)	Local Authority Better Care Grant	Yes	£93,000
67	Discharge support and infrastructure	Improving Mental Health Discharge	NHS Minimum Contribution	Yes	£377,353
68	Discharge support and infrastructure	LD Discharges	NHS Minimum Contribution	Yes	£17,500
69	Short-term home-based social care (excluding rehabilitation)	HF Team Support Worker	Local Authority Better Care Grant	Yes	£65,000
70	Discharge support and infrastructure	Discharge Project	NHS Minimum Contribution	Yes	£35,000
71	End of life care	Discharge pathway 3 contract	NHS Minimum Contribution	No	£2,164,852
72	End of life care	Nursing Care Packages (ASC protected)	NHS Minimum Contribution	Yes	£5,135,932
73	Personalised budgeting and commissioning	Brokerage	Local Authority Better Care Grant	Yes	£198,000
74	Personalised budgeting and commissioning	HC4L Back Office Support	NHS Minimum Contribution	Yes	£137,564
75	Long-term home-based community health services	Home First, Nursing & Therapies	NHS Minimum Contribution	No	£6,026,218
76	Evaluation and enabling integration	Care Coordinator (Falls & Pro-Active Care Coordinator)	NHS Minimum Contribution	Yes	£256,000
77	Home-based intermediate care (short-term home-based)	Home Care Packages due to HART no capacity	Local Authority Better Care Grant	Yes	£270,255
78	Housing related schemes	Extra Care short term packages	NHS Minimum Contribution	Yes	£52,000
79	Personalised budgeting and commissioning	LD Lead Commissioning Arrangements	NHS Minimum Contribution	Yes	£180,692
80	Other	Development of External Workforce	Local Authority Better Care Grant	Yes	£246,500
81	Support to carers, including unpaid carers	Care Act Enablers	NHS Minimum Contribution	Yes	£101,548

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4a. Expenditure Guidance

Guidance for completing expenditure sheet

1. Please enter spend information in the bottom table starting cell B30 including the category of spend which is a dropdown containing the categories listed in the table below. You must also enter scheme-level detail for the line of spend in 'Description of Scheme' with the appropriate level of information keeping this relatively succinct, for example 'Community Health Rehabilitation' or 'MSK services' or 'Integrated Crisis and Rapid Response' would be sufficient. Please also enter source of funding which determines the total spend appearing in the source of funding table at the top. Ensure a 'Number' is entered in the 'Expenditure for 2026-27 (£)' so that the validation boxes can be marked as complete.

2. Please ensure 'Adult Social Care Spend' is marked 'Yes' when the money is spent on Adult Social Care across any funding source.

Scheme Types

Number	Category of scheme	Description
1	Assistive technologies and equipment	Using technology in care processes to support self-management, maintenance of independence and more efficient and effective delivery of care. (eg. Telecare, Wellness services, Community based equipment, Digital participation services).
2	Housing related schemes	This covers expenditure on housing and housing-related services other than adaptations; eg: supported housing units.
3	DFG related schemes	The DFG is a means-tested capital grant to help meet the costs of adapting a property; supporting people to stay independent in their own homes. The grant can also be used to fund discretionary, capital spend to support people to remain independent in their own homes under a Regulatory Reform Order, if a published policy on doing so is in place.
4	Wider support to promote prevention and independence	Services or schemes where the population or identified high-risk groups are empowered and activated to live well in the holistic sense thereby helping prevent people from entering the care system in the first place. These are essentially upstream prevention initiatives to promote independence and wellbeing.
5	Short-term home-based intermediate care (rehabilitation, reablement and recovery services)	Short-term (up to 6 weeks), therapy-led services in the person's usual residence (home or care home), following the 'Home First' principle. For adults 18+ to regain independence post-illness/injury/discharge (step-down) or prevent admissions/long-term care (step-up). Person-centred, with initial assessment and regular reviews; led by registered therapists (physiotherapists, occupational therapists, speech/language therapists) plus support from unregistered workers and other professionals (nurses, doctors, social workers). Outcomes: better function, confidence, wellbeing; less carer reliance and long-term care demand. Domiciliary social care (personal care, domestic help) included only within a rehab/reablement-focused package.
6	Short-term home-based social care (excluding rehabilitation, reablement and recovery services)	Short-term domiciliary social care (e.g. personal care, help with domestic tasks, voluntary sector support), except where it is provided as part of a package that also includes rehabilitation, reablement and/or recovery services.
7	Long-term home-based social care services	Ongoing social care services (e.g. personal care, help with domestic tasks), helping people continue to live at home and maintain independence.
8	Long-term home-based community health services	Ongoing health services provided in people's own homes or in other non-residential community-based settings.

9	Bed-based intermediate care (short-term bed-based rehabilitation, reablement or recovery)	Short-term (up to 6 weeks), therapy-led services in a community bed-based setting (e.g. community hospital, care home bed or designated facility). For adults 18+ to regain independence post-hospital stay (step-down) or prevent avoidable admission/long-term residential care (step-up from community). Person-centred, with initial assessment and regular reviews; led by registered therapists (physiotherapists, occupational therapists, speech/language therapists) plus multi-disciplinary support (unregistered workers, nurses, doctors, others as needed). Where safe and appropriate, transition to home-based intermediate care is required to continue recovery at usual residence. Outcomes: improved function, confidence, wellbeing; reduced acute admissions, readmissions and long-term social care demand. May include mixed health and social care interventions.
10	Long-term residential or nursing home care	Ongoing care provided in a residential care home or nursing home for people who need more intensive or specialised support than can be provided at home.
11	Discharge support and infrastructure	Services and activity to enable discharge. Examples include multi-disciplinary/multi-agency discharge functions or Home First/ Discharge to Assess process support/ core costs.
12	End of life care	Schemes specifically designed to provide care and support for people nearing the end of life.
13	Support to carers, including unpaid carers	Supporting people to sustain their role as carers and reduce the likelihood of crisis. This might include respite care/carers breaks, information, assessment, emotional and physical support, training, access to services to support wellbeing and improve independence.
14	Evaluation and enabling integration	Schemes that monitor or evaluate the impact of integrated care schemes. Schemes or services that enable integrated care, such as (but not necessarily limited to): - Joint commissioning arrangements - Integrated care planning - Helping people navigate services - Workforce development or recruitment and retention
15	Urgent Community Response	Urgent community response teams provide urgent care to people in their homes which helps to avoid hospital admissions and enable people to live independently for longer. Through these teams, older people and adults with complex health needs who urgently need care, can get fast access to a range of health and social care professionals within two hours.
16	Personalised budgeting and commissioning	Various person centred approaches to commissioning and budgeting, including direct payments.
17	Other	This should only be selected where the scheme is not adequately represented by the above scheme types.

Better Care Fund 2026-27 Numerical Template

5. Metrics for 2026-27

Selected Health and Wellbeing Board:

5.1 Non-Elective admissions

		Apr 25 Actual	May 25 Actual	Jun 25 Actual	Jul 25 Actual	Aug 25 Actual	Sep 25 Actual	Oct 25 Actual	Nov 25 Actual	Dec 25 Actual	Jan 26 Actual	Feb 26 Actual	Mar 26 Actual
Non elective admissions to hospital for people aged 65 and over per 100,000 population	Rate	1,173	1,532	1,449	1,509	1,452	1,478	1,481					
	Number of admissions 65+	1845	2,410	2,280	2,375	2,285	2,325	2,330					
	Population of 65+*	157,349	157,349	157,349	157,349	157,349	157,349	157,349					
	Apr 26 Plan	1,641	1,613	1,619	1,654	1,682	1,520	1,663	1,567	1,691	1,731	1,482	1,654
	Rate	2582	2538	2548	2602	2646	2391	2617	2465	2661	2724	2332	2602
	Number of admissions 65+	157,349	157,349	157,349	157,349	157,349	157,349	157,349	157,349	157,349	157,349	157,349	157,349
	Population of 65+												

Source: <https://digital.nhs.uk/supplementary-information/2025/non-elective-inpatient-spells-at-english-hospitals-occurring-between-01-04-2020-and-30-11-2024-for-patients-aged-18-and-65>

5.2 Discharge delays

		Apr 25 Actual	May 25 Actual	Jun 25 Actual	Jul 25 Actual	Aug 25 Actual	Sep 25 Actual	Oct 25 Actual	Nov 25 Actual	Dec 25 Actual	Jan 26 Actual	Feb 26 Actual	Mar 26 Actual
*Dec Actual onwards are not available at time of publication													
Average length of discharge delay for all acute adult patients (this calculates the % of patients discharged after their DRD, multiplied by the average number of days)		0.71	0.61	0.54	0.73	0.58	0.65	0.64	0.73				
Proportion of adult patients discharged from acute hospitals on their discharge ready date		85.0%	85.6%	86.2%	81.2%	85.9%	85.4%	86.0%	84.2%				

For those adult patients not discharged on DRD, average number of days from DRD to discharge	4.7	4.3	3.9	3.9	4.1	4.4	4.6	4.6				
	Apr 26 Plan	May 26 Plan	Jun 26 Plan	Jul 26 Plan	Aug 26 Plan	Sep 26 Plan	Oct 26 Plan	Nov 26 Plan	Dec 26 Plan	Jan 27 Plan	Feb 27 Plan	Mar 27 Plan
Average length of discharge delay for all acute adult patients	0.48	0.48	0.48	0.48	0.48	0.48	0.48	0.48	0.48	0.48	0.48	0.48
Proportion of adult patients discharged from acute hospitals on their discharge ready date	87.7%	87.7%	87.7%	87.7%	87.7%	87.7%	87.7%	87.7%	87.7%	87.7%	87.7%	87.7%
For those adult patients not discharged on DRD, average number of days from DRD to discharge	3.90	3.90	3.90	3.90	3.90	3.90	3.90	3.90	3.90	3.90	3.90	3.90

Source: <https://www.england.nhs.uk/statistics/statistical-work-areas/discharge-delays/discharge-ready-date/>

5.3 Admissions to residential and nursing care homes

		Rolling 12 month total until end of quarter date indicated							
		Actual Ending 31-12-2024	Actual Ending 31-03-2025	Actual Ending 30-06-2025	Actual Ending 30-09-2025	2026-27 Plan Ending 30-06-2026	2026-27 Plan Ending 30-09-2026	2026-27 Plan Ending 31-12-2026	2026-27 Plan Ending 31-03-2027
Long-term admissions to residential and nursing care homes for people aged 65 and over per 100,000 population	Rate	521.1	526.9	509.1	521.8	551.6	551.6	552.3	552.3
	Number of admissions	820	829	801	821	868	868	869	869
	Population of 65+*	157,349	157,349	157,349	157,349	157,349	157,349	157,349	157,349

*Population of people aged 65 and above are based on the latest available mid-year estimates from the ONS

6.4 Reablement

Better Care Fund 2026-27 Numerical Template
6: National Condition Planning Requirements

Health and wellbeing board

National Condition	Planning requirement	Assurance statement	Yes/No to assurance statement	Where the planning requirement or assurance statement is not met, please note the actions in place towards meeting the requirement	Timeframe for resolution
<p>National Condition 1: effectively support the delivery of integrated and preventative care</p> <p>ICBs and local authorities must develop joint plans, agreed by health and wellbeing boards, outlining how ICBs and local authorities intend to use BCF funding to deliver more integrated and preventative care, linked to the relevant areas of neighbourhood health and social care services.</p>	<p>ICBs and local authorities must have considered how to use the BCF most effectively to support the delivery of more integrated and preventative services, particularly supporting those with more complex health and social care needs. This must include setting out how the funding will be used to develop the quality, efficiency and outcomes from intermediate care.</p>	<p>Named ICB and local authority chief executives and named HWB chair must confirm that BCF expenditure is agreed and aligned with wider strategic objectives for neighbourhood health and social care.</p>	Yes		
	<p>ICBs and local authorities must set out plans that:</p> <ul style="list-style-type: none"> - show reasonable progress in the metrics of non-elective admissions (for people aged 65 and over) and delayed discharges - show how they will monitor and drive progress in preventing avoidable long-term care home admissions and improving outcomes from reablement - include the specific contribution of BCF-funded services. 				
	<p>ICBs and local authorities must demonstrate that their plans for the use of the BCF represent value for money and improve overall productivity</p>				
<p>National Condition 2: comply with expenditure and grant conditions</p> <p>ICBs and local authorities must comply with all national grant and funding conditions and deliver in accordance with their approved return. ICBs must maintain the NHS minimum contribution to adult social care and pool NHS BCF contributions into a section 75 (of the NHS Act 2006) pooled fund.</p>	<p>ICBs and local authorities must pool their designated minimum contribution (in the case of ICB partners) and the Local Authority Better Care Grant and DFG (in the case of local authority partners). ICBs and local authorities are able to voluntarily pool additional funding through the BCF where they consider this is likely to lead to an improvement in the services being funded.</p>				
	<p>The NHS minimum contribution to adult social care must be met and maintained by the ICB in line with the published BCF allocations. This represents an increase of 4.4% in each health and wellbeing board area.</p>	<p>ICBs and local authorities confirm compliance with BCF national grant and funding conditions, and that they will deliver in accordance with approved spend and BCF numerical return, including maintaining the NHS minimum contribution to adult social care.</p>	Yes		
	<p>Local authorities must comply with the grant conditions of the Local Authority Better Care Grant and the DFG, including the pooling of funding.</p>	<p>ICBs and local authorities confirm they will pool funds through Section 75 agreements by 30th September 2026.</p>	Yes		
<p>National Condition 3: - effective governance, reporting and engagement</p> <p>ICBs and local authorities must comply and engage with BCF planning, governance and reporting requirements including adherence to any assurance and oversight processes.</p>	<p>ICBs and local authorities must have effective joint governance is in place to ensure local accountability for delivery of outcomes, including reviewing performance against plan objectives and local goals, and taking action if necessary to bring delivery back on track.</p>				
	<p>ICBs, local authorities and health and wellbeing boards are required to engage with BCF reporting, oversight and support processes</p>	<p>ICBs and local authorities confirm full compliance with BCF planning and reporting requirements and will adhere to the BCF oversight and support processes.</p>	Yes		

Complete:

Yes

Yes

Yes

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Choose an item.



Department
of Health &
Social Care



Ministry of Housing,
Communities &
Local Government



MAY 1, 2026

BCF NARRATIVE 26/27 PLANNING
DRAFT V.2
INTEGRATION TEAM

Choose an item.



Better Care Fund 2026-27 Narrative return

[Introduction and guidance](#)

This return has been designed to enable ICBs and local authorities, working with Health and Wellbeing Boards (HWBs), to submit information which demonstrates how their plans for the Better Care Fund (BCF) meet the national conditions and planning requirements for 2026-27. Completing and submitting the BCF narrative return is a required part of the overall BCF submission process. Planning leads should ensure that all questions within this narrative return are fully addressed.

This year, the length of the narrative return has been reduced. This reflects feedback on the benefits of a more focused BCF assurance process. In completing the return, HWBs, ICBs and local authorities may wish to develop more detailed joint plans for BCF expenditure for their own use and/or draw on other joint plans.

Each question in the return has a suggested length of around a page (around 500 words) and we would generally expect the overall submission to be around 2500 words. These act as a guide to support a more focused assurance process rather than strict limits.

The narrative provided in this return should align with the expenditure plans and the ambitions for the national metrics set out in your BCF excel numerical return.

When completing the narrative return, please use the following documents for guidance and support, these can be found on the [BCF Exchange](#):

- **Planning Principles:** outlines what good practice looks like in relation to each narrative question and aligns with the relevant national conditions.
- **Metrics Handbook:** provides the formal technical specifications for the national metrics within the framework, including the rationale, methodology, required data inputs and worked examples.

Submission Requirements:

- Each HWB area must have its own BCF excel numerical return, but a single narrative BCF return covering multiple HWBs may be submitted where this reflects local integrated working arrangements.
- Each HWB area included in a combined narrative return should provide clarity and state any specific details relevant to the separate HWBs within the narrative questions (and more words may be required for this than a single HWB return). Local authorities, ICBs and HWBs for each area should formally sign off the shared narrative return and their individual numerical excel BCF return.
- The deadline for completing this narrative return is **19 May 2026**.
- Please submit this return to both: england.bettercarefundteam@nhs.net and your regional better care manager(s).

Submission details

Mandatory to complete, please do not submit a return without completing the details below:

Adapt as necessary	HWB area 1	HWB area 2
HWB	Leicestershire	
ICB	Leicestershire, Northamptonshire & Rutland (LNR) ICB	
ICB		
ICB		

1. Please provide a short statement setting out the rationale for using BCF funding to maximise delivery of integrated and preventative care linked to the relevant areas of neighbourhood health and social care services.

Please provide a concise statement of around one page (e.g. around 500 words). Please provide your response below:

Our 2026–27 Better Care Fund (BCF) plan directs investment towards strengthening integrated and preventative services across neighbourhood health and social care, ensuring resources are aligned to shared system priorities and the needs of our local population. The focus of BCF funding continues to be enabling people—particularly those with more complex health and social care needs—to remain independent for longer, receive timely intermediate care, and experience more coordinated support across organisational boundaries.

Approximately 66% of BCF spend in Leicestershire is aligned to prevention services that improve and maintain independence in the community. A further circa 18% is aligned to community crisis response and intermediate care (step-up and step-down). This approach supports the strategic transformation priorities set out in the ICB's 5-year strategic commissioning plan around frailty and preventable mortality, ensuring that local and system-wide strategies remain connected.

The Health and Wellbeing Board's (HWB) assessment of demand and capacity for intermediate care and community care has directly informed the 2026–27 plan, highlighting areas where additional investment is required to meet rising levels of frailty, support timely discharge and the home first ethos and maintain flow through community services. Table 1 below, shows the change in demand for services and the investment opportunities to either increase capacity, reduce demand or provide more effective and efficient services.

Table 1:

Area	24-25 Activity	25-26 Activity	26-27 Planned Activity	Comments
HART Reablement (community)	2840	2188	2888	Increase in staffing see section 4 to reverse decline in capacity and increase starts
Community Dom Care	5702	6470	5702	Increased reablement capacity will reduce the number of domiciliary care starts to 24-25 numbers approx
HART capacity rejections (community)	229	166	120	Reduced by 30% in 25-26 and aiming for a further 30% reduction in 26-27
Community therapy / rehab (step up and down)	6617	6746	6881	Capacity in community therapy and rehab has increased by 2% in 25-26 and this increase has been reflected in further capacity for 26-27.
Community short stay beds (step up)	1656	1793	1656	We want to reduce the 8% rise seen in 25-26 to the usage for 24-25 by

				ensuring earlier intervention and increased reablement capacity
Intermediate care HART reablement step down (hospitals)	3062	3235	3655	Increased capacity in reablement ensures the increase in step-down reablement is maintained
Intermediate Care HART Urgents step up and down	550	424	424	We want urgent response service activity to remain stable
Intermediate care dom care step down	778	998	778	We want to further increase step-down activity into reablement prior to dom care so expect levels to return to 24-25 figures
HART capacity rejections (hospitals)	1527	1117	782	Increased reablement capacity is aiming to further reduce the amount of capacity rejections into dom care
Intermediate care bedded step down	840	934	840	We will be working in year to reduce the amount of P2 bed usage back to 24-25 levels
Total activity	26644	27258	28508	Overall activity is projected to increase by 4.5%

Overall, the intermediate care services that form part of the demand and capacity modelling have seen a 2% increase in activity during 25-26. For 26-27 this is projected to increase further by 4.5% representing a further 2.5% capacity on the predicted growth. This supports left-shift of demand and capacity into community and intermediate care from acute care services in line with national requirements for increased productivity in acute services. Additional BCF investment is aligned with increasing capacity in these areas. This is outlined in table 3 below.

Each year the Health and Wellbeing Board hold a BCF development session. This is attended by all partners and elected members. We discussed in each of the spend areas (table 2) how we could make improvements utilising changes in BCF funding. This focused particularly on preventing the need for statutory services, increasing reablement, reducing the utilisation of step-down short-stay residential care beds and reducing domiciliary care where reablement has not been considered first.

- We will be investing in Project Management resource to produce and take forward options for reducing the use of spot purchase beds and overall system bed utilisation. How this is expected to impact is covered in more detail in question 3.
- West Leicestershire has been part of the national implementer site programme for neighbourhood Health. The focus has been on the delivery of MDT's for people who have COPD and are housebound. BCF funded Care Co-ordinators have worked with other professionals to attend MDT's and to work with people in their own homes to offer a range of preventative and supportive services. The MDT's have worked with approximately a quarter of the cohort, defined using population health management data, linking 100 people out of 450 so far, with social care, carers support services, voluntary sector and housing. This has also allowed us to focus on person-centred outcomes in (PROMS and PREMS) and the collation of case-studies to show the difference this is making to people in their communities. As part of the 26/27 plan, the BCF is going to support the expansion of neighbourhood models of care through additional investment which has been scaled up based on the lessons learned in the implementer site pilot. Initially, this will be aligned to support the 24,439 people

in Leicestershire who are in Patient Need Groups (PNG's) 10 and 11 (Multi-morbid high complexity and frail populations – the populations with highest health care needs). Initiatives will also include support to those at end of life care including targeted conversations at neighbourhood level around end of life care including RESPECT planning and support to carers. This will support the urgent end of life medication service which provides earlier treatment to avoid escalation of acute needs. This is funded through capacity funding.

- To support delivery, investment to commission the VCSE sector in a hub and spoke model has been included in the BCF plan for 26-27. This will utilise a centrally contracted/funded hub to engage and commission services with VCSE sector organisations locally who can provide health and wellbeing support to residents referred via Integrated Neighbourhood Teams. This has the potential to target local resources to support identified local needs in a more time-responsive manner. Part of this will be to support INT's to develop in order to deliver preventative MDT's.
- We will be extending our VCSE 'Hospital to Home' contract with the Royal Voluntary Service (RVS) to March 2027. This will allow us sufficient time to conduct an effective procurement exercise as per contract and procurement rules and gives us an opportunity to ensure we are receiving value for money within the current market provision. This service supports safe discharges of people who are leaving hospital with either no formal support (pathway 0) or support provided in their own home (pathway 1). During 2025-2026, 604 patients were supported with assisted discharges which is an 18% increase from the previous year. This service also provides hospital to home provision providing 6-12 weeks of support once back at home. For example, helping people with a weekly shop, transport to any medical appointments and more. Demand for this service has increased over the last year with a 0.5% or below readmittance rate after 28 days being at home.
- We are continuing to work with one of our community health partners DHU Health care who provide a clinical falls response for low level fallers within the community. Between 2024/25 and 2025/26, referrals increased by 33.8%, with a corresponding 31.5% increase in the number of individuals supported to remain at home. Even with the increased demand, over 93% of referrals in 2025/26 remained at home. Based on current trends and with no planned service expansion, we anticipate a more moderate referrals increase of approximately 8–12% in the next year.

Governance arrangements for Health and Wellbeing Board (HWB) delivery against national Neighbourhood Health priorities have been put in place. A new sub-group will shape and deliver the models across Leicestershire and develop the place based strategy. This will form an addendum to the Leicestershire Joint Health and Wellbeing Strategy which has a life course approach and was refreshed in 25-26.

- 2. Please provide a brief explanation of the rationale for how you have set out goals for the metrics of non-elective admissions (for those 65 years old and over) and delayed discharges. Please also set out how you will monitor and drive progress in preventing avoidable long-term care home admissions and improving outcomes from reablement, including through any locally agreed goals for long term admissions to residential care and nursing homes.**

Please provide a concise statement of around one page (e.g. around 500 words). Please provide your response below:

Our goals for reducing non-elective admissions for people aged 65+ and delayed discharges have been developed using a combination of recent performance trends, benchmarking against comparable systems, and assessment of planned service changes. We have based goals on previous-year experience, peer comparison, and anticipated impact of operational changes.

To establish our targets and goals for next year we have utilised our own published performance via SUS data and the England average and East Midlands peer comparator data on the DHSC website.

It is important for Leicestershire to compare to East Midlands peers as 30% of residents utilise acute services out of area in neighbouring east midlands authorities including Derbyshire, Nottinghamshire and Northamptonshire. Main utilisation outside of UHL is George Elliot, Burton Hospital, Queens Med, Kettering and Derby Hospital. We also share usage of many services including the ambulance trust, 111 and Derbyshire Health United. It also shows us ICB cluster partner performance across Leicestershire, Northamptonshire and Rutland (LNR).

Health and Wellbeing Board (HWB) goals for non-elective admissions and discharge delays have also been aligned with NHS provider and ICB medium-term planning trajectories, with any variances highlighted where local expectations depart from NHS planning assumptions.

For non-elective admissions (over 65) in 25-26, the data so far (until Dec 25) shows a rate of 1469 admissions on average per month against an average target rate of 1,661 per month (20,810 actual admissions year to date against a target of 23,520). Using this data we have proposed a target for 26-27 of a further reduction of 2% on the actuals for 25-26. This equates to an approximate average reduction of 48 patient admissions per month throughout the year to an average rate per month of 1626. This has been aligned to the UHL (and wider NHS acute targets) supporting an overall requirements to increase productivity in elective activity. We aim to support this by increasing capacity in community and intermediate care and proactive care in neighbourhood health teams. The target has also been mirrored across other HWBB's within the wider ICB cluster. How BCF funding will aim to achieve this reduction is detailed in question 3. The Urgent and Emergency Care (UEC) strategic group will be aligned to the monitoring of this metric to ensure there is adequate read across from BCF to acute provider strategy and performance.

Throughout 25-26, Leicestershire performance has been off target for the 'Proportion of adult patients discharged from acute hospitals on their discharge ready date' indicator requirements. The target was to achieve 89% by the end of the financial year. This has not been achieved, with the best individual monthly performance in June of 86.2%. Improvements have also not increased as the year has progressed. Looking at the current performance levels, it has been agreed to apply a target of a 1.5% improvement on the best performing month of 25-26. Therefore, the target for 26-27 overall will be 87.7%. This represents a stretch target on current performance and if met, would be better than the England average. In 25-26, Leicestershire consistently performed better than the East Midlands average.

For the average number of days from discharge ready date to discharge, a target of 3.9 days has been set as an average for all months. This was the best achieved performance recorded in June 25, with an overall average performance throughout 25-26 of 4.4 days. This target is therefore a 0.5 day improvement on last year. Currently Leicestershire is in the top quartile nationally for this indicator and 3.9 days represents an ambitious stretch target to achieve across all months. Collectively, all partners have been involved in workshops to look at managing the discharge processes more effectively to help to meet this target. This includes community health services and community hospitals along with acute providers and local authorities and EMAS. The development and adherence to Standard Operating Procedures (SOP's) for discharges will focus on how and where timescales in discharges and discharge planning can be reduced to create the 0.5% improvement.

For long-term admissions to residential or nursing care, the target for 25-26 was a rate of 563.1 per 100,000 population. To date this has been exceeded in 25-26. For 26-27 the target will be set at the current 25-26 projected rate of 552 per 100,000 population, a reduction of 2% on the 25-26 target. This is against a projected notable increase in demand over the next quarter and the following twelve months based on demographics and the impact this has had on current upward trends since 2024. Currently, Leicestershire performs better than the England average and is equal to the East Midlands average. We are investing funds into a Discharge Project to underpin the reasons for use of temporary bedded care (which leads to permanent admission 12 weeks later for 45% of people) and look at ways of improving the way we commission. With our planned improvements within HART Reablement and Intermediate care pathways and preventing need through Neighbourhood care programmes focusing on frailty, we aim to keep up with the demand if not to further reduce the long term admissions to residential or nursing care where possible.

Reablement performance, particularly the proportion of older people who remain at home 12 weeks after discharge, is expected to improve through enhanced capacity in reablement and intermediate care pathways. Based on our own data on reablement outcomes at 12 weeks, we are broadly stable compared with the previous year. The proportion of discharges to ASC who were in reablement at one week increased from 29% (Apr 2024–Mar 2025) to 33% (Apr 2025–18 Jan 2026). At 12 weeks, the majority in both periods had 'no onward services' (69%), with HC maintenance remaining similar (19% in 2024/25; 18% in 2025/26 YTD). The later period shows a higher proportion recorded as deceased (9% vs 7%) and a lower proportion in other services (3% vs 5%). It is worth noting that the proportions are comparable, but the counts are not directly comparable as the earlier figures and the later period are not both full-year '12 weeks later' views. Our target for 26/27 is based on the numerator from the metric. Current performance indicates that we will maintain a performance in line with the national average.

The HWB will continue to review the accuracy and completeness of data relating to the metrics on a quarterly basis with bi-monthly performance reported to the Integration Executive where any changes in performance are monitored and actioned.

3. Please provide a short explanation of the planned impact of BCF funding on achievement of goals.

Please provide a concise statement of around one page (e.g. around 500 words). Please provide your response below:

As part of the Health and Wellbeing Board development session, all areas of spend were discussed in relation to outcomes, performance and value for money. Looking at performance in 25-26, the large majority of BCF funding has maintained the current position in terms of performance goals. Taking into account the increase in demand from the projected population increase, we feel the majority of the current investment is working well to sustain performance levels against rising ageing population needs. However, as part of contractual arrangements, the domiciliary care contracts will be re-let in 26-27 and part of this exercise aims to increase value for money (VFM). The new framework will commence in October 2026 with VFM and performance improvements projected from quarter 4 onwards. A review of current contracts for community health services is also taking place led by the ICB. There will be a review of the Key Lines of Enquiry (KLOE) document with regard to community health care services in quarter 2 expecting an increase in performance from quarter 4 onwards. This will help to drive the additional 2% productivity and capacity in community services detailed in the demand and capacity table 1. This will include reviewing commissioning for value principles that will include quality, performance and any variation or duplication in service delivery. These two areas account for approximately 50% of the overall BCF funding.

Table 2 below shows the current approximate split of the total BCF allocation against areas of spend and the overall percentage that this represents.

Table2:

Area	Total Spend for each area (M)	% of spend for each area
Prevention, Neighbourhood and Community care	£56.3	65%
Crisis & Intermediate Care	£15.4	17%
Discharge & acute	£4.2	6%
End of Life	£6.8	7.5%
Other	£4.0	4.5%
Total Spend	£86.5	100%

Recognising that a large proportion of the investment is committed to staffing and contracted spend, we have identified approximately £1m of funds that are available to focus on achieving goals related to national priorities and local areas of performance improvement in 26-27.

Table 3 below shows all new or enhanced areas of funding designed and allocated to meet the emerging goals for 26-27. It shows which spend area and a rationale and timescales for delivery.

Table 3:

Scheme/Area	Value	Metric, rationale and timescale
DHU falls car Prevention, Neighbourhoods and Community Care	£550,000	Avoidable admissions: Supporting people to remain at home after a fall and reducing need for A and E attendance or EMAS. Prevents long-lies and deterioration 34% Increase in referrals in 25-26 from 24-25. Aiming to increase capacity further during 26-27. Circa 95% people remain at home after referral. Circa 50% referrals are from care homes.

		Contract in place for 26-27 full year.
Steady steps / Fame / Active together Prevention, Neighbourhoods and Community Care	£152,000	Reducing admissions due to falls / reduced long-term care admissions – This agreement expects a minimum of 516 participants across a minimum of 37 courses across Leicestershire and Rutland to prevent falls. Contract in place for full 26-27 year
Therapy support for step up Discharge and acute	£100,000	Avoidable admissions: 1 x FTE Therapist for proof of concept to avoid admissions in frail elderly cohort from the Emergency Department by 48 per month as per target reduction in metric performance (this aligns to the unmet need study). UHL Therapy currently discharge 77% of patients assessed on the day of admission but have an 'unmet need' of up to 72 patients per month who could be assessed but can't due to staffing levels and capacity. Reduce usage of spot purchased residential care D2A: 1 x FTE Therapist for proof of concept – earlier Therapy intervention at the 'front door' for patients who require medical admission, in order to reduce overall LOS and support improved outcomes, leading to less usage of residential care step-down. Patients seen by Therapy within 48 hours of admission have a shorter LOS (average 4.8 days) and have a much higher chance of returning home (P0 or P1) or transferring to a Rehabilitation facility, than those seen after 48 hours who are at significantly higher risk of requiring D2A placement. Fixed term contracts can be in place Q1
Project management support to P2 system solution Intermediate Care	£35,000	Reduction in P2 D2A bed usage and business case development for overall bed requirements in Leicester Leicestershire and Rutland (LLR). Can be in place Q1
VCSE hub and spoke contract Prevention, Neighbourhoods and Community Care	£58,333	Avoidable admissions / Reduced admissions to long term care: This aims to support Multi-disciplinary Teams (MDT's) to utilise local voluntary sector groups to support people at home and reduce emergency care usage and long term care home admissions as part of neighbourhood care. Contract will commence Q4 due to procurement timescales
NMC support to INT's and MDT's Prevention, Neighbourhoods and Community Care	£100,000	As above but for Integrated Neighbourhood Teams (INT's) to support MDT's. Ad hoc dependent on INT needs and national guidelines on deliverables.
Partnership wide Discharge and flow training event Acute and discharge	£5000	A system-wide training and information event for frontline staff to increase awareness of community-based services and referral pathways to support timely discharges and improved performance on discharge timescales. Est June 26

4. Please outline how ICBs and local authorities have confidence that the services funded through the BCF represent value for money, and how they will seek to raise the productivity of services.

Please provide a concise statement of around one page (e.g. around 500 words) please provide your response below:

ICBs, local authorities and the HWB have taken a structured, evidence led approach to ensuring BCF funded services represent value for money. This includes assessment of inputs (costs and workforce capacity), outputs (activity and throughput), and impact (outcomes and avoided demand). This aligns with the guidance recommending optimal use of resources and transparent assessment of impact.

Annual KLOE documents are completed for each scheme line which outlines (where applicable) the outputs of services, staffing levels and how they each meet the metrics and provide value for money. Benchmarking, both actual and planned, informs the review of cost and performance across key BCF funded services. Insights from benchmarking exercises are used to guide future service improvement and commissioning decisions.

The partnership has identified clear opportunities to enhance productivity, including: Reviewing longer term and larger contracting arrangements – see above Dom care and Community services contracts. This supports the overall aim of a left-shift into community and prevention services that aims to contribute to increased acute productivity including completion of elective admissions. This is aligned to increases in reablement and care co-ordination productivity that both prevent or delay need for formal or acute services.

Optimisation of reablement workforce skill mix – We are aiming to recruit a net increase of at least 30 FTE direct support staff by May 2027, enabling delivery of around 700 additional HART reablement service starts per year. This will be achieved through a combination of improved recruitment practices, enhanced pay for direct care staff, permanent job advertising, and data-driven targeting of candidates. Further measures include offering full-time contracts, streamlining recruitment processes, increasing administrative support to reduce delays, and implementing a new roster system to improve capacity utilisation. Together, these actions are expected to increase recruitment by an average of 3.2 FTE per month between July 2026 and April 2027.

Improved deployment models in key community services – Care Co-ordinators have been deployed to accommodate delivery changes in the national neighbourhood health programme. This includes additional BCF support to INT's and MDT delivery alongside investment from health partners of 1.8 million into neighbourhood health to support the left shift from acute care and increase their productivity by supporting providers to meet elective care targets as a result. This reflects the national expectation for NHS providers to deliver 2% year-on-year productivity improvement over the next four years and recognises how BCF funded services contributes to this ambition. For Leicestershire, the focus on the frail cohort equates to a population size of approximately 24,439 who attend or are admitted to acute care approx. 1.65 times annually at an indicative cost of £3787 per person per year. Based on the current levels of MDT productivity in the implementer site, there is scope to work with approx.400 people annually which has the maximum benefit of reducing 600 admittances or attendances to acute care at a cost of approx. £1.5 million.

Table 4 below, shows increased or new BCF funding that will contribute to improved productivity during 26-27.

Table 4:

Scheme	Value	Increased productivity rationale
Shared care tasks	£150,000	Increases productivity in community health services. Dom care providers trained on low level health care tasks to

		reduce duplication of daily visits by professionals and releases capacity back to community health
RVS contract	£16,000	Increased demand to support pathway 0 discharges and reduce delays also increased capacity to take P0 work from Care Co-ordinators to release capacity for them to only work on proactive and preventative neighbourhood health case management
Home First additional management	£120,000	Supporting increase in workforce capacity in Home First teams (mainstreamed as previously funded through discharge grant)
Housing Enablement Team	£14,280	This represents a 13% uplift in contract value with an overall increase in productivity of 38% across the service. The four self-contained temp discharge housing units freed up 12 hospital beds, releasing over 317 acute and community bed-days back to clinical use in 25-26 this has been extended to continue in 26-27
Armed Forces	£25,000	Increased funding to ensure the area is well positioned for emerging regional and national opportunities, including VALOUR Centres. This will shift support towards earlier, preventative engagement and strengthening connectivity between statutory services, the VCSE sector and the Armed Forces community
S1 unit for CC's	£45,000	This unit will allow the Care Co-ordinators to access S1 patient records across INT areas allowing better case management and improved productivity. With the implementation of the NMC it is anticipated that this will generate an extra 96 referrals per month. Having a combined unit rather than 72 separate ones will increase productivity across the team and give the ability to keep up with the increased demand providing better value for money whilst still providing good outcomes contributing to the effectiveness of avoidable admissions and Neighbourhood Models of Care.

Existing, new and increased investment and productivity is monitored in year by the governance set out in question 5 below. The KLOE documents for each scheme are reviewed annually as part of the HWB BCF development session and are refreshed to include any new or additional information in regards to staffing, re-contracting and added VfM. The Integration Executive meets bi-monthly and includes both general and focused performance reviews on schemes that impact on VfM. It also receives the quarterly BCF returns on income, expenditure and performance.

5. Please outline your robust joint governance for managing the expenditure of BCF funding, including assessing impact of funding, value for money and continuous improvement.

Please provide a concise statement of around one page (e.g. around 500 words). Please provide your response below:

Our governance arrangements are well established with relationships across partners embedded into our service delivery. We continually evolve and adapt to meet requirements and always look for new ways to assess value for money.

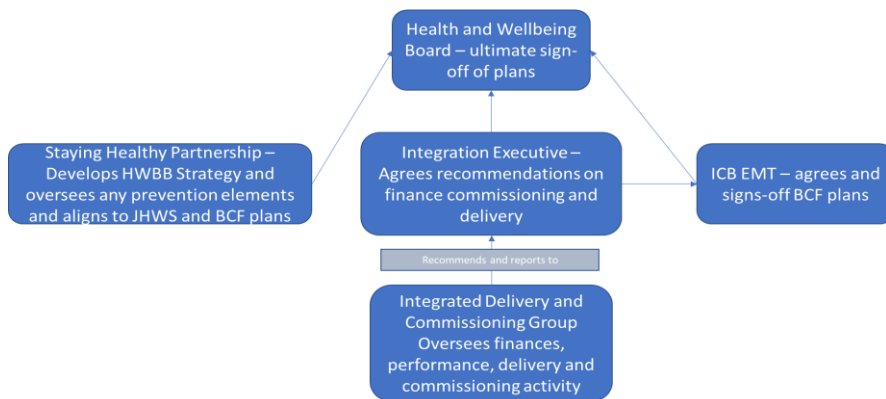
Bodies involved strategically and operationally in preparing the plan (including NHS Trusts, social care provider representatives, VCS organisations, housing organisations, district councils):

Leicestershire County Council
 Leicestershire, Northamptonshire and Rutland ICB
 University Hospitals Leicester Trust
 Leicestershire Partnership Trust
 Blaby District Council
 Charnwood Borough Council
 Harborough District Council
 Hinckley and Bosworth Borough Council
 Melton Borough Council
 Northwest Leicestershire District Council
 Oadby and Wigston Borough Council
 Rutland County Council
 Healthwatch
 Royal Voluntary Service
 Voluntary Action Leicestershire
 Homecare Alliance

For the 26-27 BCF plans, a workshop with Health and Wellbeing Board members was held in January to look at the progress of schemes during 25-26. This was attended by elected members, NHS partners, LA's, Healthwatch and VCSE representatives with an introduction from the Midlands BCF team within NHSE to discuss the changes for the forthcoming year. Schemes were grouped into the BCF themes of Prevention, Preventative care and neighbourhoods, Crisis response and Intermediate care, Acute and Discharge and End of Life and nursing care. Each scheme has a KLOE document that details the spend, staffing, contracts and outputs for partners to gain a full understanding of the vfm and the workshop offers an opportunity to discuss any improvements required against the activity. The KLOE document has been shared both regionally and nationally as an example of good practice. These are updated annually.

Below is a diagram of the governance arrangements for reporting of the BCF showing the HWBB with the statutory responsibility and the supporting executive and operational group. This responsibility includes receiving annual and quarterly reports including quarterly expenditure which measures the current spend and any changes, additional spend or areas of slippage. This enables joint decision making across partners to any in year changes or areas and ideas for improvements. The board also receives and agrees the section 75 agreement and agreement for the DFG amounts to be transported to each District Council within Leicestershire. This is passed on in its entirety with top slicing agreed by partners for wider housing related schemes. Where a HWBB is not meeting prior to submission the Integration Executive signs off the documentation with the Chief Executive of the County Council using powers of delegation to sign off on behalf of the HWBB.

Governance diagram



Demand and capacity modelling is undertaken to look at the impacts of schemes and their effectiveness both as part of contractual arrangements or annually to establish VFM and if there are any improvements required as part of the ongoing performance management of the BCF.

The administration of this process is conducted by the local authorities Integration team who are supported by finance colleagues and commissioning support colleagues. This resource is financed through the BCF fund. This includes working with other local authority areas on their plans to ensure that this aligns to the ICB and wider system plans for integrated services across LLR.

The BCF is also aligned with the Joint Health and Wellbeing Strategy (JHWS) priorities (Living and Supported Well and Dying Well) of the HWBB and the ICB and NHS respective 5/10 year strategy delivery. An additional sub-group of the HWB has been formalised to support the delivery of Neighbourhood Health priorities. This will include the development of the Leicestershire strategy on Neighbourhood Health which will form an addendum to the JHWS. This group will also be responsible for BCF funding elements and contractual arrangements for Leicestershire aligned to this area of work.

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Better Care Fund (BCF) Planning Principles

2026-27

Better Care Fund



Introduction and Guidance

For the Better Care Fund (BCF) 2026-27 planning submission, you will need to complete two mandatory returns: the numerical return and the narrative return. This document has been developed in collaboration with partners to support completion of the BCF 2026-27 narrative return.

The planning principles are intended to support high-quality submissions and promote a consistent approach to integrated planning for the 2026-27 BCF cycle. It aims to help integrated care boards (ICB), local authorities and health and wellbeing boards (HWBs) prepare their narrative responses and directing them to relevant resources, tools and guidance. It includes sections on:

- Cross cutting principles – to consider when completing the numerical return and the narrative return.
- For the three national conditions:
 - The planning requirements and how the two returns (numerical and narrative) need to demonstrate these (as set out in the Better Care Fund Framework)
 - Reference to the four assurance statements included in the numerical return
 - Reference to the five narrative questions and an outline of what a good practice response may include for each narrative question – this is provided as a guide only. These do not substitute or add to the formal planning requirements and published guidance on how these requirements should be demonstrated, and it is important that submissions as a whole respond to all the requirements. There is flexibility for areas to use alternative wording or approaches when answering the narrative questions, rather than necessarily following the ‘good practice’ structure.

For guidance and support in developing the numerical return, please use the BCF 2026-27 Metrics Handbook: this provides the technical specifications for the BCF national metrics, including the rationale, methodology, required data inputs and worked examples.

All supporting documents can be found on the BCF Exchange: [Supporting Documents & Templates - Better Care Exchange - Better Care Fund](#)

Cross-cutting principles

Outcome-Focused



Planning should be anchored in delivering tangible and measurable improvement in outcomes for people and communities, across both health and care. It should reflect shared accountability for public value and be shaped by the voices of local service users, carers and citizens.

Accountable and Transparent



Effective joint planning requires clarity and shared understanding of roles, responsibilities and accountabilities across local areas. Governance structures should support transparent, inclusive decision making, enable joint oversight and constructive challenge, and ensure alignment with strategic objectives at a health and wellbeing board, neighbourhood, place and system level. HWBs play a central role in convening partners, embedding shared ownership and accountability and maintaining public trust.

Evidence-Based and Locally Informed



Decisions made as part of joint planning should be underpinned by robust and inclusive analytical foundations, drawing on population health and wellbeing data, demand and capacity modelling, workforce insights, productivity analysis and local intelligence. Analysis should reflect both health and care perspectives, be informed by lived experience and benchmarked against best practice to support continuous improvement and equitable outcomes.

Collaborative and Delivery Focused



Planning should bring together staff from across health, care and wider local area functions, including finance, commissioning, workforce, operation delivery, therapy leadership and those with lived experience, to ensure that work is co-ordinated, inclusive and shaped by those responsible for implementation. Joint planning should reflect the expertise and insight of all partners, enabling confident delivery and continuous improvement.

Ambitious, Realistic and Co-Owned



Joint returns should aim to achieve the purpose of BCF: support ICBs and local authorities in designing and delivering more integrated and preventative care, particularly for people with more complex health and social care needs, helping people stay independent for longer. The returns should be realistic and based on understanding of resources required such as workforce and funding. Reference to strategies for managing risks regarding performance of metric goals should be underpinned by robust triangulation across governance and data quality.

National condition 1: effectively support the delivery of integrated and preventative care



ICBs and local authorities must develop joint plans, agreed by health and wellbeing boards, outlining how ICBs and local authorities intend to use BCF funding to deliver more integrated and preventative care, linked to the relevant areas of neighbourhood health and social care services.

Planning Requirement	Where is this demonstrated
ICBs and local authorities must have considered how to use the BCF most effectively to support the delivery of more integrated and preventative services, particularly supporting those with more complex health and social care needs. This must include setting out how the funding will be used to develop the quality, efficiency and outcomes from intermediate care.	Numerical return Narrative return Question 1
<p>ICBs and local authorities must set out plans that:</p> <ul style="list-style-type: none"> • show reasonable progress in the metrics of non-elective admissions (for people aged 65 and over) and delayed discharges • show how they will monitor and drive progress in preventing avoidable long-term care home admissions and improving outcomes from reablement • include the specific contribution of BCF-funded services 	Numerical return Narrative return Question 2
ICBs and local authorities must demonstrate that their plans for the use of the BCF represent value for money and improve overall productivity	Narrative return Question 3
To demonstrate these requirements:	
Named ICB and local authority chief executives and a named health and wellbeing board chair must confirm that BCF expenditure is agreed and aligned with wider strategic objectives for neighbourhood health and social care	114
<p>The BCF assurance return must include a short statement setting out how BCF funding will support wider strategic objectives, including those referenced in the ICB 5-year strategic commissioning plan. This statement must include:</p> <ul style="list-style-type: none"> • a short explanation for any substantial changes in allocations compared with the 2025 to 2026 BCF funding and, if doing so, set out how ICBs and local authorities are ensuring continuity of critical services • a summary of assessments in the demand and capacity needed for intermediate care 	
<p>The assurance return must also:</p> <ul style="list-style-type: none"> • set out local goals for non-elective hospital admissions for people aged 65 and over and discharge delays and the rationale for these goals, including alignment with local NHS provider medium-term planning assumptions. It should also set out plans to drive progress in preventing avoidable long-term care home admissions and improving outcomes from reablement and, if agreed locally, the rationale for local goals for long-term admissions to care homes • include an explanation of how BCF-funded services will contribute to meeting these goals 	
Set out how ICBs and local authorities have confidence that the services funded through the BCF represent value for money, and how they will seek to raise the productivity of services. The value for money section of the return must reference how the joint governance set out under national condition 3 will review value for money and productivity	
The planning (numerical) and assurance (narrative) return must be submitted to the national BCF team and to regional better care managers via email, using the provided template on the BCF Exchange by 19 May 2026	



National condition 1

Return	Question in BCF Narrative Return/ Assurance Statement	What does good look like: outlines what a good response to the narrative question could include, as guidance only.	KLOE for assurance
Numerical Return	<p>Assurance statement: Named ICB and local authority chief executives and named HWB chair must confirm that BCF expenditure is agreed and aligned with wider strategic objectives for neighbourhood health and social care.</p>		
Narrative Return	<p>Question 1: Please provide a short statement setting out the rationale for using BCF funding to maximise delivery of integrated and preventative services, linked to the relevant areas of neighbourhood health and social care services.</p>	<ul style="list-style-type: none"> • The response clearly sets out the priorities for BCF funding to deliver integrated and preventative services, aligned to the development of relevant areas of neighbourhood health and social care, and achieve positive outcomes for patients. including those referenced in the ICB 5-year strategic commissioning plan • It provides a brief explanation for any substantial changes in planned spend compared to 2025-26, including any factors that have influenced these decisions. If proposing substantial changes, it sets out how ICBs and local authorities will ensure continuity of key services and avoid disruption. • The response provides a summary of the HWB assessment of demand and capacity for intermediate care and explains how this assessment has informed planning (Please review the section on intermediate care in the BCF Framework 2026-27). The response may also wish to make brief reference to the other specific factors noted in the BCF Framework 2026-27. 	<p>Is there a clear rationale for using BCF funding to achieve delivery of integrated and preventative services and is there alignment with relevant neighbourhood health and social care priorities?</p>

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National condition 1

Return	Question in BCF Narrative Return/ Assurance Statement	What does good look like: outlines what a good response to the narrative question could include, as guidance only.	KLOE for assurance
Narrative Return	<p>Question 2: Please provide a brief explanation of the rationale for how you have set out goals for the metrics of non-elective admissions (for those 65 years old and over) and delayed discharges. Please also set out how you will monitor and drive progress in preventing avoidable long-term care home admissions and improving outcomes from reablement, including through any locally agreed goals for long term admissions to residential care and nursing homes.</p>	<ul style="list-style-type: none"> The response clearly explains the assumptions and evidence behind the goals for non-elective admissions (65+) and average length of discharge delay. These may include, for example, experience over the previous year, comparisons with peer group areas and the impact of service changes. The response describes how HWB goals on non-elective admissions and discharge delays are aligned with NHS provider and ICB planning trajectories, outlining any differences where local expectations vary from NHS planning assumptions. Where goals have been set for reducing long-term admissions to residential care or nursing homes, the response outlines the basis for the goals. If a goal is not set, the response will still set out how planned activity is expected to support progress on this metric. The response will describe how planned activity is expected to improve reablement outcomes, particularly the proportion of older people who remain at home 12 weeks after discharge. The response outlines how the HWB will ensure high-quality data, including accurate and complete recording and routine review of their Discharge Ready Date (DRD) information, and explains how any known data quality issues will be addressed for the BCF metrics. 	<p>Does the rationale:</p> <ul style="list-style-type: none"> Outline their approach to develop metric goals in line with the advice in the 2026-27 Metric Handbook guidance? Provide context/outline previous metric performance and how this has informed 2026-27 goals? Explain alignment of the national metrics with the NHS planning trajectories?
	<p>Question 3: Please provide a short explanation of the planned impact of BCF funding on achievement of goals</p>	<ul style="list-style-type: none"> The response explains how BCF funded services contribute to achieving the metric goals, drawing on evidence from recent delivery. It may highlight insights from reviews or improvement work that have shaped funding decisions, including any shifts toward services demonstrating the greatest impact (Note: we recognise that quantifying the impact of every intervention is unlikely to be feasible). It describes how funding decisions have been informed by identifying which population groups benefit most from particular interventions and how resources have been targeted to maximise impact for those cohorts. 	<p>Does the response outline how the BCF-funded services contribute/ have impact on the achievement of metric goals?</p>

National condition 1

Return	Question in BCF Narrative Return/ Assurance Statement	What does good look like: outlines what a good response to the narrative question could include, as guidance only.	KLOE for assurance
Narrative Return	<p>Question 4: Please outline how ICBs and local authorities have confidence that the services funded through the BCF represent value for money, and how they will seek to raise the productivity of services.</p>	<ul style="list-style-type: none"> • The response describes how ICBs, local authorities and HWBs have taken a structured approach to considering value for money e.g. optimal use of inputs, such as costs and demand management, outputs and impact. • It highlights any benchmarking, or intention to benchmark, the cost and performance of key BCF-funded services against comparable services, and how these insights are being used to shape service improvement. • It summarises how partners have considered opportunities to improve productivity in key services, such as longer-term contracting, digitisation, or changes in workforce skill mix or deployment. (Note: collectively, NHS trusts need to deliver a 2% year on year improvement in productivity over the next 4 years, and relevant spending through BCF may contribute towards these). <p>Note: achieving value for money and improving overall productivity should be a collective endeavour between the NHS, local government and partners. Strong governance arrangements should be in place to monitor efficiency, effectiveness, resource allocation and improvement. The role of joint governance in reviewing value for money should be set out in question 5, referenced briefly in this responses.</p>	<p>Does the statement reference a clear outline of the ICBs, local authorities and HWBs approach to achieve value for money and productivity drawing on learning and with appropriate consideration to relevant opportunities?</p>

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Resources and tools to support with National condition 1:

- BCF Metrics Handbook – [Supporting Documents & Templates - Better Care Exchange - Better Care Fund](#)
- [Supplementary guidance to the Medium term Planning Framework - delivering change together 2026/27 to 2028/29](#)
- [The Government Efficiency Framework - GOV.UK](#)
- [NHS England » Medium-term planning framework: Revenue finance and contracting guidance](#)
- [NHS England » Medium Term Planning Framework – delivering change together 2026-27 to 2028/29](#)



National condition 2: comply with expenditure and grant conditions

ICBs and local authorities must comply with all national grant and funding conditions and deliver in accordance with their approved return. ICBs must maintain the NHS minimum contribution to adult social care and pool NHS BCF contributions into a section 75 (of the NHS Act 2006) pooled fund

Planning Requirement	Where is this demonstrated
ICBs and local authorities must pool their designated minimum contribution (in the case of ICB partners) and the Local Authority Better Care Grant and DFG (in the case of local authority partners). ICBs and local authorities may voluntarily pool additional funding through the BCF where they consider this is likely to lead to an improvement in the services being funded	Numerical Return
The NHS minimum contribution to adult social care must be met and maintained by the ICB in line with the published BCF allocations. This represents an increase of 4.4% in each health and wellbeing board area	Numerical Return
Local authorities must comply with the grant conditions of the Local Authority Better Care Grant and the DFG, including the pooling of funding	Numerical Return
To demonstrate these requirements:	
<p>The BCF assurance return must set out:</p> <ul style="list-style-type: none"> planned expenditure against core categories the sources of this expenditure from different components of the BCF, including the NHS minimum contribution to social care 	
Assurance statements in the return will ask ICBs and local authorities to confirm that funding conditions have been met	
ICBs and local authorities must confirm that they will place the funding into one or more pooled funds under section 75 of the NHS Act 2006 once the BCF 2026 to 2027 assurance return is approved. They must do this no later than 30 September 2026	

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National condition 2

Return	Question in BCF Narrative Return/ Assurance Statement	What does good look like: outlines what a good response to the narrative question could include, as guidance only.	KLOE for assurance
Numerical Return	Assurance Statement: ICBs and local authorities confirm compliance with BCF national grant and funding conditions, and that they will deliver in accordance with approved spend and BCF numerical return, including maintaining the NHS minimum contribution to adult social care.	Provide details on funding contributions within the comments box on the income tab, in the BCF numerical return.	Does the total income match the total planned expenditure?
Numerical Return	Assurance Statement: ICBs and local authorities confirm they will pool funds through Section 75 agreements by 30 September 2026.		

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National condition 3: effective governance, reporting and engagement

ICBs and local authorities must comply and engage with BCF planning, governance and reporting requirements including adherence to any assurance and oversight processes.

Planning Requirement	Where is this demonstrated
ICBs and local authorities must have effective joint governance in place to ensure local accountability for delivery of outcomes, including reviewing performance against plan objectives and local goals, and taking action if necessary to bring delivery back on track	Narrative Return
ICBs, local authorities and health and wellbeing boards are required to engage with BCF reporting, oversight and support processes	Numerical Return
To demonstrate these requirements:	
The BCF assurance return must set out robust joint governance for managing the expenditure of BCF funding, including assessing impact of funding, value for money and continuous improvement	
ICBs and local authorities will need to confirm through assurance statements that they will engage with BCF oversight and support processes if necessary	

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Resources and tools

- Governance: [NHS England » Medium Term Planning Framework – delivering change together 2026-27 to 2028/29](#)



National condition 3

Return	Question in BCF Narrative Return/ Assurance Statement	What does good look like: outlines what a good response to the narrative question could include, as guidance only.	KLOE for assurance
Narrative Return	Question 5: Please outline your robust joint governance for managing the expenditure of BCF funding, including assessing impact of funding, value for money and continuous improvement.	<ul style="list-style-type: none"> • The response describes the governance arrangements agreed by the ICB, local authority and HWB, clearly setting out the roles, responsibilities and decision-making authority for BCF expenditure. Reference to the relationship other relevant governance arrangements e.g. neighbourhood health. • It sets out how the process ensures effective monitoring of expenditure, impact and value for money, as set out in National Condition 1. • The response briefly describes how governance groups routinely review progress against 26-27 performance goals, take timely action when delivery is off track and review the longer-term impact of key BCF funded services. • It describes how the governance structure supports continuous improvement, including how learning is captured, shared and used to refine commissioning and substantial changes in spending plans over time. 	<ul style="list-style-type: none"> • Does the response refer to their joint governance arrangements, with clear roles and responsibilities and escalation routes. • Do the governance arrangements have sufficient capacity and representation to monitor/review in year delivery of BCF 2026-27 specifically to monitor expenditure and value for money.
Numerical return	Assurance statement: ICBs and local authorities confirm full compliance with BCF planning and reporting requirements and will adhere to the BCF oversight and support processes.		

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The Better Care Exchange

The Better Care Exchange is our Future NHS Platform, which aims to support local areas with the planning and implementation of the BCF. The workspace enables you to share, learn and interact with colleagues across the country. The platform includes:

Publications

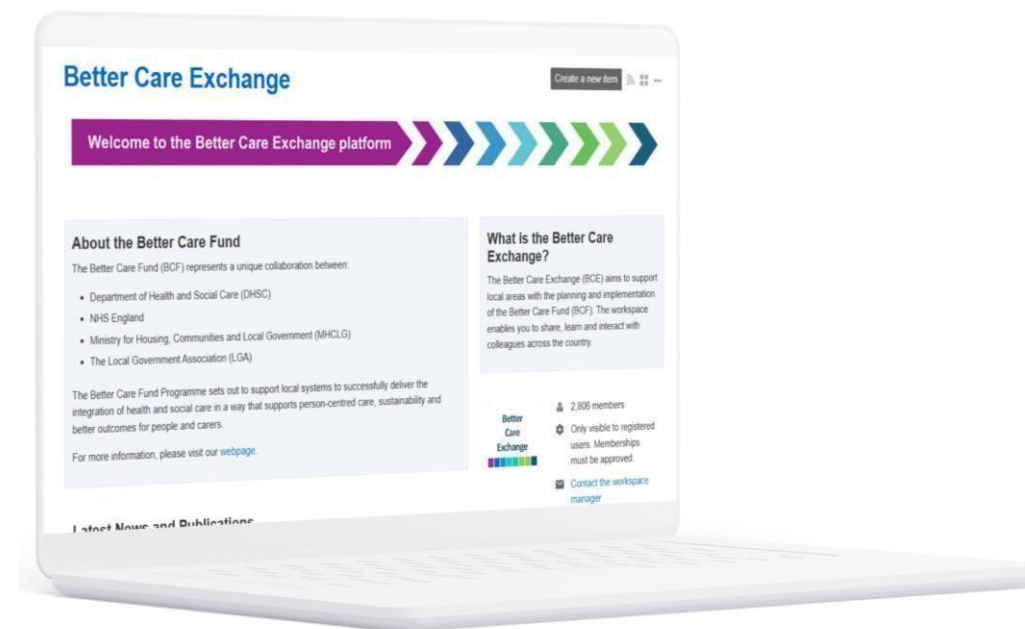
- Key publications relating to the BCF
- Publications from across the health, housing and social care sectors

Learning

- Case studies and shared practice on integration and previous BCF plans
- Webinar recordings

Discussion & Collaboration

- A forum for sharing information, requests, support and learning
- Share and work on documents with other colleagues



There are over 2,800 registered users on the platform working across the integration of health, housing and social care.

To register to join the Better Care Exchange please email:
England.bettercareexchange@nhs.net, including your role, organisation, location and area of interest.

Thank you



England.bettercarefundteam@nhs.net



[Sign up to the Better Care Exchange](#)



[About the Better Care Fund](#)

For more information and regular updates, send an email to our team to sign up to the BCF Bulletin and Better Care Exchange.

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HEALTH AND WELLBEING BOARD: 15th June 2026
REPORT OF VOLUNTARY ACTION LEICESTERSHIRE (VAL)
THE VAL OFFER

Purpose of report

1. This report provides the Health and Wellbeing Board with an overview of the work undertaken by Voluntary Action Leicestershire (VAL) in supporting NHS colleagues, commissioners, local authorities and wider public sector partners across Leicester, Leicestershire and Rutland.
2. The report demonstrates the contribution of the Voluntary, Community and Social Enterprise (VCSE) sector towards:
 - Prevention and early intervention;
 - Reducing health inequalities;
 - Community resilience and wellbeing;
 - Neighbourhood models of care;
 - Partnership working across the health and care system.
3. The report also highlights the strategic role of VAL in strengthening VCSE infrastructure, supporting collaboration and enabling community organisations to contribute effectively to local health and wellbeing priorities.

Recommendation

4. The Health and Wellbeing Board is asked to:
 - (a) Recognise the strategic contribution of VAL and the VCSE sector in supporting prevention, health inequalities reduction and community resilience;
 - (b) Support continued partnership working between statutory organisations and the VCSE sector via VAL;
 - (c) Encourage stronger VCSE involvement within neighbourhood health planning, commissioning and integrated care arrangements;
 - (d) Support ongoing collaboration between NHS partners, local authorities, Public Health and community organisations.

Policy Framework and Previous Decision

5. VAL's work aligns with a range of national and local priorities including:

- Joint Health and Wellbeing Strategies;
 - Integrated Care System (ICS) and Integrated Care Board (ICB) priorities;
 - Public Health prevention and wellbeing strategies;
 - Neighbourhood health and place-based working programmes;
 - Mental health and wellbeing priorities;
 - Safeguarding and community resilience frameworks;
 - Local Government Reorganisation discussions and neighbourhood governance development.
6. During 2025–26, VAL supported VCSE engagement within 18 strategies and plans developed by public sector partners and strategic agencies across Leicestershire ensuring that community perspectives were incorporated into policy development and system planning.

Background

7. Voluntary Action Leicestershire (VAL) is the local infrastructure organisation supporting the Voluntary, Community and Social Enterprise (VCSE) sector across Leicester, Leicestershire and Rutland. VAL works to strengthen communities by supporting voluntary organisations, developing volunteering opportunities, promoting collaboration and ensuring that community voices influence local decision-making.
8. VAL employs 6 staff and 7 volunteers to directly deliver the infrastructure support:
- a) 1 0.6 FTE Team Manager
 - b) 1 0.4 Team Lead
 - c) 1 FTE Development Officer
 - d) 1 0.85 FTE Development Officer
 - e) 1 FTE Support Officer
 - f) 1 FTE Information, Advice and Data Officer
 - g) 1092 volunteer hours per year
9. VAL provides a wide range of infrastructure and development support services to VCSE organisations of all sizes, from small grassroots community groups through to larger charities and social enterprises. Support includes organisational development, governance advice, funding support, volunteer development, safeguarding guidance, training, partnership facilitation and strategic representation.
10. VAL also delivers and supports a number of strategic programmes and partnerships linked to health, wellbeing, employability, volunteering and community resilience. This includes close partnership working with NHS organisations, Integrated Care Boards, local authorities, Public Health teams, safeguarding partnerships and Healthwatch.

11. Through its infrastructure role, VAL acts as a bridge between communities and statutory organisations, helping to ensure that community voice, lived experience, grassroots insight and local need actively shape health and care planning, commissioning and service design.
12. The neighbourhood approach to health is an integrated way of working where the NHS, local government, social care, and VCSE organisations come together to create healthier communities, helping people of all ages live healthy, active and independent lives for as long as possible. VAL plays a significant role in supporting prevention, reducing health inequalities and strengthening neighbourhood approaches by enabling VCSE organisations to:
 - Develop sustainable services;
 - Access funding and resources;
 - Build governance and workforce capacity;
 - Strengthen volunteering and community participation;
 - Improve partnership working and referral pathways;
 - Deliver community-led health and wellbeing support.
12. VAL also supports strategic engagement and consultation activity, helping VCSE organisations and communities contribute to local strategies, commissioning discussions and system transformation programmes.
13. The organisation has developed strong relationships across the health and care system and is recognised as a key strategic partner supporting collaboration between statutory organisations and the VCSE sector.
14. Throughout 2025–26 VAL continued to provide extensive infrastructure support, partnership development and strategic engagement across Leicestershire.
15. VAL has supported VCSE organisations through:
 - Funding advice and grant development;
 - Governance and constitutional support;
 - Volunteer development and training;
 - Safeguarding and Equality, Diversity and Inclusion (EDI) guidance;
 - Partnership facilitation and networking;
 - Impact measurement and organisational development;
 - Strategic representation and consultation activity.
16. During 2025/26, VAL supported across Leicestershire 791 VCSE organisations with advice and support, including 272 intensive one-to-one support referrals involving 190 unique organisations. Across the year there has been increasing demand for support relating to governance, funding sustainability, volunteer management and partnership development.
17. VAL has also contributed to strategic meetings and partnership structures involving NHS organisations, local authorities, Public Health, safeguarding boards, neighbourhood health groups and wider system partners.

18. The organisation has worked closely with partners to support neighbourhood approaches, prevention priorities and reducing health inequalities through community-led delivery.
19. During the reporting period VAL supported 129 VCSE organisations to develop and deliver health and wellbeing services.
20. Support provided to health and wellbeing organisations included:
 - Funding support and sustainability planning;
 - Developing referral pathways and partnerships;
 - Volunteer recruitment and workforce development;
 - Safeguarding and governance support;
 - Equality, Diversity and Inclusion policy development;
 - Impact measurement and outcomes planning;
 - Organisational development and constitution reviews.
21. Areas of support included:
 - Mental health and wellbeing;
 - Dementia support;
 - Community safety and women's wellbeing;
 - Refugee and migrant health support;
 - Tackling loneliness and social isolation;
 - Volunteer training and workforce development;
 - Community food and wellbeing projects.
22. Case study examples included:
 - Support to Leicester Musical Memory Box to strengthen volunteer training and dementia support provision helping increase access to alternative therapeutic support for people experiencing trauma.
 - Partnership support to Amber Mental Health following governance concerns linked to delivery of a Community Mental Health Café.
 - Support to Sense of the Herd to develop mental health and trauma-informed equine therapy programmes.
 - Support to women's wellbeing and violence prevention initiatives through The BWB Collective, strengthening community-led prevention and wellbeing approaches.

Proposals/Options

23. Building on this work, there are opportunities to further strengthen the contribution of the VCSE sector in supporting Health & Wellbeing Board priorities, including:
- Expanding VCSE involvement within neighbourhood models of care;
 - Strengthening collaborative commissioning arrangements;
 - Developing co-production opportunities with communities;
 - Supporting preventative and early intervention approaches;
 - Improving referral pathways between statutory and VCSE services;
 - Increasing access to governance, safeguarding and impact training;
 - Strengthening community resilience and volunteer capacity.
24. VAL will continue to work closely with partners to ensure that local VCSE organisations are equipped to respond to emerging health and wellbeing needs.

Consultation/Patient and Public Involvement

25. VAL engages regularly with:
- VCSE organisations;
 - Community leaders and residents;
 - Volunteers;
 - NHS and Public Health partners;
 - Local authorities;
 - Strategic networks and partnership forums.
26. Engagement activity includes:
- Consultation events and workshops;
 - CEO and VCSE network meetings;
 - Community engagement activity;
 - Partnership forums and strategic boards;
 - Funding and training events;
 - Public sector consultations and responses.
27. Feedback gathered through these processes has informed ongoing discussions regarding:
- Local Government Reorganisation;
 - Neighbourhood health planning;
 - VCSE commissioning and partnership arrangements;
 - Prevention and community wellbeing priorities.

Resource Implications

28. VAL has supported the generation of significant social and economic value across Leicester, Leicestershire and Rutland.
29. Between April 2023 and March 2026:
 - £1.96 million funding secured by VCSE organisations with support from VAL
 - £9.19 million estimated social value generated through volunteering activity
 - £218,562 estimated value created through Healthwatch-related service improvements and reduced unnecessary GP and A&E attendance
 - 2,054 VCSE organisations supported
 - 2,731 individuals supported into volunteering opportunities
 - 262,772 volunteer hours generated
30. Between April 2024 and September 2025 VAL also created an estimated £2.48 million of social and economic value through employability and skills support programmes.
31. Employability outcomes achieved included:
 - 49 individuals supported into employment;
 - 84 individuals progressing into education or training;
 - 20 individuals gaining qualifications;
 - 205 individuals improving employability skills.
32. Healthwatch activity also contributed to wider system efficiencies through:
 - Improved patient access to advice and guidance;
 - Reduced unnecessary GP and urgent care presentations;
 - Service improvements informed by patient feedback and lived experience;
 - Strengthened engagement between communities and health services.
33. These outcomes demonstrate the wider value of investing in VCSE infrastructure, prevention and community-led support services.

Timetable for Decisions

34. This report is intended to inform ongoing partnership discussions and future collaborative working arrangements between NHS organisations, local authorities and the VCSE sector.

Conclusion

35. VAL continues to play a significant strategic and operational role in supporting health colleagues, commissioners, local authorities and wider public sector partners.
36. Through infrastructure support, partnership development and community engagement, VAL enables VCSE organisations to contribute effectively towards prevention, neighbourhood working and reducing health inequalities, while ensuring community voice is actively heard and reflected in system planning and delivery. The evidence presented within this report demonstrates that VCSE infrastructure support creates measurable impact across communities and health systems, including:
 - Increased organisational resilience and sustainability;
 - Greater volunteer capacity and workforce development;
 - Improved partnership working between statutory and VCSE organisations;
 - Increased community voice and engagement in strategic discussions;
 - Reduced pressure on statutory health and care services through prevention and early intervention.
38. VAL's work continues to strengthen the connection between communities and statutory services, ensuring local organisations are better equipped to respond to emerging health and wellbeing needs.
39. Continued investment in VCSE infrastructure and collaborative working via VAL will support:
 - Stronger neighbourhood models;
 - Improved community resilience;
 - Better health and wellbeing outcomes;
 - More effective prevention and early intervention;
 - Enhanced partnership working across the system;
 - Greater community participation and volunteering.
40. As health and care systems continue to evolve, the role of trusted VCSE infrastructure organisations such as VAL will remain essential in embedding community voice, supporting integrated working and delivering equitable prevention focused health and wellbeing outcomes.

Background papers

- VAL Performance Reports 2025–26
- VAL Impact Report
- Local Health and Wellbeing Strategies
- Integrated Care System priorities and partnership plans

Circulation under the Local Issues Alert Procedure

41. This report relates to Leicester, Leicestershire and Rutland and is relevant to all local authority and NHS partner areas.

Appendices

- Appendix 1 – VCSE Case Studies
- Appendix 2 – Social Value and Impact Data
- Appendix 3 – Partnership and Engagement Activity

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Relevant Impact Assessments

Equality Implications

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

42. VAL's work actively supports inclusion, community cohesion and reducing health inequalities across diverse communities.

43. Many supported projects focus on:

- Mental health and wellbeing
- Refugee and migrant communities
- Women's wellbeing and community safety
- Dementia support
- Tackling loneliness and social isolation
- Volunteer inclusion and accessibility

44. There are positive equality implications arising from the recommendations within this report.

Human Rights Implications

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

Crime and Disorder Implications and Environmental Implications

46. Some supported initiatives contribute positively towards community safety, social cohesion and environmental wellbeing.

Partnership Working and associated issues

47. VAL works closely with:

- NHS organisations
- Integrated Care Boards
- Public Health teams
- Local authorities
- Safeguarding partnerships
- Healthwatch
- Educational institutions
- VCSE organisations and community groups

48. Partnership working remains central to neighbourhood health, prevention and wellbeing priorities.

Risk Assessment

49. Risks include:

- Increasing demand on VCSE organisations
- Funding pressures and sustainability challenges
- Workforce and volunteer capacity pressures
- Challenges associated with system transformation and Local Government Reorganisation

50. VAL continues to mitigate these risks through:

- Governance and organisational support
- Partnership facilitation
- Training and development opportunities
- Strategic engagement and advocacy
- Funding and sustainability support

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HEALTH AND WELLBEING BOARD: 15 JUNE 2026

REPORT OF HEALTHWATCH LEICESTER AND LEICESTERSHIRE

**IMPROVING HOSPITAL DISCHARGE WHAT PATIENTS AND
CARERS TOLD US**

Purpose of report

1. The purpose of this report is to present Healthwatch Leicester and Leicestershire's findings from two pieces of work on hospital discharge:
 - Improving hospital discharge: what patients and carers told us report, capturing patient and carer experiences of recent discharge
 - An Enter & View report following visits to community hospital discharge wards
2. The report provides independent insight into what is working well and where further improvement is needed and sets out recommendations to support ongoing discharge and flow improvement across the system.

In what capacity is the Health and Wellbeing Board required to act:

3. Hospital discharge remains a key system issue affecting patient experience, flow and health inequalities. The Health and Wellbeing Board is asked to maintain oversight of this work, noting the findings and supporting system partners to use the learning to inform ongoing improvement activity.

Recommendation

4. The Health and Wellbeing Board is asked to:
 - (a) Note the findings and recommendations from Healthwatch Leicester and Leicestershire's hospital discharge work;
 - (b) Support system partners to consider how the learning can inform ongoing discharge improvement, patient experience and inequality-reduction work;
 - (c) Note that Healthwatch Leicester and Leicestershire will continue to gather patient and carer feedback to help assess progress over time.

Policy Framework and Previous Decision

5. The Health and Social Care Act 2012 introduced statutory duties on local authorities to deliver effective local Healthwatch services.
6. 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 Integrated Care Systems (ICS) and HWE, among others specified in previous legislation.

These statutory functions underpin Healthwatch Leicester and Leicestershire's role in gathering patient and carer insight on hospital discharge and presenting independent findings to system partners and the Health and Wellbeing Board.

Background

7. HWLL undertook a research project on hospital discharge in October 2020 to follow up on visits to the discharge lounges at local hospitals in July 2019. There were interviews with 23 people between 29 October and 9 November 2020 to understand how the discharge process worked.
8. In 2025, Leicestershire County Council approached HWLL to look at gathering independent insights from patients and carers. The project was designed with the following objectives in mind:
 - Evaluate progress since 2020: Assess whether the key issues identified in the previous report have improved.
 - Collect qualitative and quantitative data from patients and carers about their recent hospital discharge experiences.
 - Include the voices of patients, carers and family members to ensure comprehensive insights.
 - Present the patient's views of the discharge process and highlight areas for improvement.

- Provide actionable, evidence-based recommendations to health and social care providers.

Consultation/Patient and Public Involvement

Improving Hospital Discharge what patients and carers told us

9. This work involved consultation with patients and carers who had recent experience of hospital discharge. Engagement took place between March and August 2025 through surveys and direct discussions, ensuring patient and carer voices were central to the work.
10. In addition, Enter & View visits were conducted in four community hospital discharge wards in October – December 2025, involving conversations with patients and observations of ward environments and discharge processes.
11. The feedback gathered has directly informed the findings and recommendations in the published Healthwatch reports.

Key findings

12. The key findings were:
 - 58% of respondents felt involved in discussions about their discharge.
 - 38% said they did not receive clear information about follow-up care, medication or support after leaving hospital.
 - 71% received a copy of their discharge summary, though some reported inaccuracies.
 - 60% were discharged within the timeframe they expected; medication delays were the most common cause of frustration.
 - Only 16% of carers were informed of their right to a Carers' Assessment.
 - Three-quarters (76%) of respondents felt ready to go home, though some described feeling unsupported once home.

What are the outcomes

13. The consultation identified a range of positive experiences, particularly within community hospital discharge wards, including calm environments, strong multidisciplinary working and good patient satisfaction.
14. It also highlighted ongoing challenges, including communication gaps, medication delays, limited carer involvement and uncertainty about aftercare once home.

Next Steps

15. The findings and recommendations have been shared with Leicester Hospitals, Leicestershire Partnership NHS Trust, Local Authorities and relevant system partners to support ongoing discharge and flow improvement work.
16. Healthwatch Leicester and Leicestershire will continue to gather independent patient and carer feedback on hospital discharge, using future engagement activity and Enter & View visits where appropriate to assess whether improvements are being felt in practice and to identify any emerging issues.

Scrutiny Comments

17. On 3 June 2026 the Health and Communities Overview and Scrutiny Committee considered the Healthwatch reports on Discharge at a public meeting. Representatives from University Hospitals of Leicester NHS Trust and Adult Social Care were present at the meeting. Committee members echoed the findings of the Healthwatch reports and reported that they had received similar comments from local residents particularly in relation to communication with patients and medication readiness. In response UHL provided assurance that work was taking place to improve the clarity and consistency of communication with patients about their discharge.

Appendices

[Improving hospital discharge | Healthwatch Leicester and Leicestershire](#)
[Discharge Wards Enter and View | Healthwatch Leicester and Leicestershire](#)

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Relevant Impact Assessments

Equality Implications

1. 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.

2. 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.
3. 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.
4. 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.
5. We will not tolerate any form of harassment or victimisation.

Human Rights Implications

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

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HEALTH AND WELLBEING BOARD: 15TH JUNE 2026

JOINT REPORT OF THE DIRECTORS OF ADULTS AND CULTURAL SERVICES AND CHILDREN AND FAMILY SERVICES
LEICESTERSHIRE COUNTY COUNCIL

DRAFT LEICESTERSHIRE CARERS STRATEGY 2026-2030

Purpose of report

1. The purpose of this report is to seek the comments of the Health and Wellbeing Board on the draft Leicestershire Carers Strategy 2026-2030, attached as an Appendix to this report. The report will also explain the development of the strategy and the priorities for delivery.

Recommendation

2. The Board is asked to:
 - a. Note the development of the Strategy for carers in Leicestershire and consider the draft priorities and implementation plan.
 - b. Comment on the draft strategy for the care and support of Leicestershire carers.

Policy Framework and Previous Decisions

3. The Adults and Communities Strategy 'Delivering Wellbeing and Opportunity in Leicestershire' details the ambitions, aims and goals of the Department over the next four years (2025– 2029). It reflects the ambitions of the Council's overall strategic plan.
4. The Joint Carers Strategy Refresh 2022-2025, Recognising, Valuing and Supporting Carers in Leicester, Leicestershire and Rutland outlines eight key priorities: carer identification, valuing carers, keeping carers informed, developing carer friendly communities, ensuring carers have a life alongside caring, utilising technology to support caring, accessing the right support at the right time and recognising young carers.

5. The Care Act 2014 gives unpaid adult carers in England the legal right to a support assessment, placing them on an equal footing with the people they care for. If the assessment identifies eligible needs, local authorities have a duty to meet them, such as through respite care or direct payments. Local authorities must focus on the carer's wellbeing, including their physical, mental, and emotional health, as well as their ability to work and have a life outside of caring.
6. The Children and Families Act 2014 was introduced to set out what the support local authorities may offer for carers, as well as the cared for person for young people and their families.
7. The Joint Carers Strategy Refresh 2022-2025, Recognising, Valuing and Supporting Carers in Leicester, Leicestershire and Rutland, was approved by the Cabinet in November 2022. This was a joint strategy for Leicester City, Leicestershire County and Rutland residents.
8. The Carers Leave Act 2023 came into effect in April 2024 to support carers to balance their work with their unpaid caring responsibilities. This Act gives full time employees the right to take one week (of up to five days) of unpaid leave per year to allow carers to provide or arrange care for a dependent.

Background

9. On 3 December 2025, a meeting of the County Council resolved to:
 - a) Formally recognise carers as a group requiring particular consideration and support, specifically:
 - To ensure carers are consulted and involved in shaping services;
 - To review service delivery to remove barriers for carers.
 - b) Assess future decisions, services and policies made and adopted by the Council to determine the impact of changes on carers.
 - c) Ensure that these commitments are incorporated into the refresh of the LLR Carers Strategy and any other relevant policies and strategies.
10. In April 2026 the Cabinet agreed to launch a public consultation on the draft strategy.

Proposals

11. From 2026 onwards, it is intended that each authority develop individual carers' strategies tailored to the unique needs and requirements of its respective area. Having a specific Leicestershire Carers Strategy will be reflective of

Leicestershire carers and will highlight what they need and how the Council can help carers continue with their caring role. The new strategy will be aligned with the Council's values and priorities whilst working in partnership with Health (Integrated Care Board, University Hospitals of Leicester NHS Trust and Leicestershire Partnership NHS Trust) to ensure that the overall approach to support carers in Leicestershire remains a joint arrangement.

12. The new Leicestershire Carers Strategy 2026-2030 will address the areas to improve and strengthen support to carers. This will include actions resulting from the Care Quality Commission's (CQC), Leicestershire County Council: local authority assessment, published in September 2025. The report highlighted areas of good practice and also some areas where improvements can be made.
13. The Census 2021 data indicates a total of 61,300 of Leicestershire respondents, aged five years and above, declaring that they provided unpaid care (9% of population). The highest rate of caring in the population was among those aged 45 to 64 (15%), followed by those 65 to 84 (11.3%), with women predominating in all but the eldest (aged 85 years and above) group of carers.
14. There is some geographical variation amongst carers in Leicestershire with the highest rate being in Oadby and Wigston (9.8%) and lowest in Harborough (8.3%), unadjusted for age. The rate of employment among carers is slightly higher in Leicestershire compared to the national average, with slightly lower unemployment rate (2% versus 3%).
15. In 2024/25, 1,455 carers assessments were completed in Leicestershire. So far for 2025/26, 1,398 have been completed with 15% of these being joint assessments with the cared-for person.
16. There are currently 2,304 carers in receipt of a service from the Council of whom, 1,581 people have a weekly carers direct payment and 716 people have a one-off carers direct payment. A weekly direct payment ensures a regular amount (following an assessment) is transferred to the persons account to pay for ongoing services such as cleaning. A one off payment can be up to £250 per year to pay for a larger item such as a washing machine or to put towards several things that will enable the carer to continue caring, for example an exercise class and lawn mowing. They are not means tested and free to the carer but a regular payment does require a more in-depth assessment compared with the one off payment. In addition, around 2,500 carers are supported by the commissioned carers service per year.
17. In 2025, a total of 116 assessment referrals were received, with 69 full assessments being completed by the young carer team. In addition, 94 young carers passports were issued and a total of 341 have been issued since the

scheme was launched in 2022. The school census data recorded 289 young carers in 2025.

Consultation/Patient and Public Involvement

18. During the period of October to December 2025, a number of key engagement activities have been undertaken across the county. Carers have been offered a variety of ways to get involved and have their say and help shape the new Leicestershire Carers Strategy.
19. The engagement methods have included:
 - *face to face group-based engagement* - this took place at commissioned provider carers groups, community groups and a Carers Rights Day event.
 - *online via Microsoft Teams* - from previous engagement, carers have fed back to say they prefer having an option to meet virtually as they do not have to worry about transport and getting back for their loved ones.
 - online survey.
 - one-to-one engagement with carers.
20. As of January 2026, over 300 adult carers have been involved in the development of the strategy.
21. The County Council's Young Carers Team have also engaged with young carers via the online survey. A total of 19 young carers provided feedback on what is important to them and how they would like to be supported.
22. Feedback from upcoming scheduled engagement activities due to take place will be added to any future reports and evidence. It is not expected to significantly change the themes already identified or the new Leicestershire priorities.
23. Over 20 people have completed the professionals survey on the carer's strategy. Professionals who participated include County Council staff, key partners including Leicestershire Partnership NHS Trust, GPs and local charities who work closely with carers.

Key themes from the engagement activities

24. The following themes have been identified through analysis of the survey and verbal feedback.

- a) Recognition of the caring role - Carers want to be recognised and feel valued and appreciated for what they do for their loved ones on a day-to-day basis. Carers are not always recognised. They want to be listened to by all professionals working with them. At times, carers feel their voices are not always heard or professionals do not always understand their caring situation and feel professionals know better than them. They do not want to keep repeating their story.
- b) Respite from caring responsibilities - When caring for someone daily, it can be overwhelming and lead to carer strain and breakdown. To reduce the impact carers need time for themselves to take a break and take their minds away from their daily caring responsibilities. Where informal carers can access paid support for a couple of hours during the week, it has helped to allow them to have a break; but not all carers are able to get support in place to take a break. Some carers want long respite for their loved ones at a care home.
- c) Tackling loneliness and isolation of carers - Caring can be very lonely and isolating, especially when there are no family members living locally and no one to turn to. Carers would like someone to call and check in with them occasionally to make sure they are okay and have an opportunity for them to talk to somebody. Sometimes carers do not talk to anyone all day apart from their loved one they are caring for.
- d) Information and advice - Carers are not all aware of the range of support available to them or know what to look for. The information available can be overwhelming and information can be hard to process, especially when the content is not easy to read and contains jargon and acronyms. Some carers feel they are provided with an overload of information/leaflets/booklets which they do not have time to read and understand. Sometimes carers are given information by professionals and expected to get on with caring for their loved ones. Carers want to be included with all information and advice that is available to them. Sometimes they feel excluded especially with a digital format because not all carers can access online materials.
- e) Easier access to services outside of working hours - It would be helpful to carers, to have support where they can find all information and advice in one location. Carers have expressed how difficult and how long it takes them to get through to speak to someone. Carers feel they would like a service which supports carers beyond the working hours. Often working carers have separate jobs to carry out during normal office hours and by the time they have finished work, the telephone lines are closed and thus they are unable to follow things up.
- f) Carers support groups - Carers have found attending carers support groups, have been a lifeline for them, as they allow carers to be part of a community and to be able to connect with other carers who are in similar situations to

them. It has also given carers the opportunity to speak to others to provide mutual support, share information and advice and what has worked for them. This has been particularly useful for carers who do not have a good support network around them.

- g) Cost of support - The direct payment provided to carers, does not always cover the cost of all the support they require, for example, support from a cleaner or a gardener. This means carers have to provide the top up for the service/support.
 - h) Access to health service - Carers have struggled at times to get through to their GPs to get an appointment for either themselves or for their cared for person. They have also experienced difficulties with getting repeat prescriptions. There also appears to be some inconsistencies with whether carers are being registered as a carer with their GP.
 - i) Young carers often find it difficult balancing their education and caring for their family member. It is important young carers are supported in the right way to ensure they have a bright future ahead of them. Young carers have expressed they would like a break from their caring responsibilities. A way to connect with other carers who are in similar situations and have benefited from attending youth groups. Young carers said they would like to have support with their mental health, especially when they find times difficult.
25. A report was presented to the Cabinet 24 March 2026 meeting, seeking approval to commence a public consultation on the draft strategy. Cabinet approved the commencement of the public consultation which started in April 2026 and concludes 14th June 2026.
 26. The public consultation documentation includes a summary and explanation of the strategy, along with appropriate and proportionate monitoring information of protected characteristics.
 27. Consultation will take place through online surveys, online meetings and face to face sessions.
 28. As part of the consultation, it is proposed that engagement with Parent Carers is undertaken to ensure that the new strategy works to include Parent Carers' needs and roles as carers.
 29. In addition to this, key engagement with Health partners will continue to establish those areas to support carers that are deliverable by Health, either solely or jointly with the Council, are integrated within the strategy and action plan.

Actions/Options

30. As a direct result of the engagement activities, the following priorities have been generated.

Priority	Description
Priority one	Carers are recognised, valued, listened to, and supported to continue caring
Priority two	Carers are provided with accurate, timely and relevant information and advice
Priority three	Carers are supported with their wellbeing and access services when needed

31. The actions to implement the priorities are detailed in the draft strategy.

Resource Implications

32. In 2024/25 the Council spent £3,547,094 on direct payments services for adult carers and the hospital discharge grant.
33. The majority of this spend was delivered via direct payments enabling carers to have choice and control over their support.
34. Inclusive of the above spend is the contract with Voluntary Action South Leicestershire (VASL) which is commissioned to provide advice and support to carers at an annual cost of £181,260. The existing carers support service that is operated by VASL has been extended until 30 April 2027. Any new commissioned services will be developed to deliver the priorities in the strategy once finalised. It is expected that some procurement will be necessary.
35. The Support at Home service commenced in October 2025 and has acted as a managed service for carers where a direct payment was not wanted or suitable. Support at Home supports people with eligible social care needs who need assistance with non-personal care tasks such as cleaning, grocery shopping and befriending. The service has proved to be very popular amongst carers. The service is a pilot and contracted for a year with an option to extend for a further year.
36. There is a specific Carers Team located within the Adults and Cultural Services department to support carers assessments, and this team work closely alongside VASL in relation to completion of assessments.

Timetable for Decisions

37. A report will be presented to the Cabinet in September 2026, seeking to implement the Strategy that will be redrafted following engagement and consultation activities.

38. Commissioned services will commence in May 2027.

Conclusion

39. The Board are asked to comment on the draft strategy for the care and support of Leicestershire carers.

Background papers

- Delivering Wellbeing and opportunity in Leicestershire – Adults and Communities Strategy 2025-29 – <https://resources.leicestershire.gov.uk/adult-social-care-and-health/our-approach/policies-and-strategies>
- Leicestershire, Leicester City and Rutland (LLR) Carers Strategy 2022-2025 <https://www.leicestershire.gov.uk/sites/default/files/2023-01/Leicestershire-County-Leicester-City-and-Rutland-Carers-Strategy.pdf>
- County Council – 3 December 2025 – Support for Family Carers - <https://democracy.leics.gov.uk/ieListDocuments.aspx?MId=7861> – item 48 a)I
- Report to the Cabinet: 25 November 2022 - LLR Carers Strategy 2022-2025 - <https://democracy.leics.gov.uk/ieListDocuments.aspx?CId=135&MId=6751&Ver=4>
- CQC Assessment of Leicestershire’s Social Care Department - <https://www.cqc.org.uk/care-services/local-authority-assessment-reports/leicestershire-0925> -

Circulation under the Local Issues Alert Procedure

40. A copy of this report will be circulated to all members of the County Council

Appendices

41. Draft Carers Strategy for Leicestershire 2026-2030

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Relevant Impact Assessments

Equality Implications

42. An Equalities Impact Assessment (EIA) has been conducted for the Carers Strategy. This will be updated following the public consultation. The current EIA has been approved by the Adults and Communities Departmental Equality Group.

Human Rights Implications

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

Other Relevant Impact Assessments

44. A health impact assessment has been conducted on the draft strategy and this will be updated following a public consultation.
45. Although it is proposed that the strategy focuses on Leicestershire, a formal group will continue to have an important role in ensuring that partnership working across the geographical system is in place. The group represents both adult and young carers groups with representatives from both adults and children's services across key partners (Integrated Care Board/Council's, NHS community services). The impact on partnership working is therefore considered to be positive.
46. A new Leicestershire governance model will be developed to oversee the specific deliverables of the strategy and actions with associated Key Performance Indicators and metrics in place and informed by carers throughout the duration of the strategy.

Risk Assessment

47. There is a risk that without appropriate commissioned services carers may not be able to continue in their caring role. This may lead to a deterioration in wellbeing of carers and the cared for person, and financial cost to the Authority.

48. The draft strategy has been written with the support and assistance of carers in Leicestershire, however a risk remains that a proportional amount of carers have not been consulted and this can be mitigated by conducting a public consultation to further reach carers and interested parties.

DRAFT Leicestershire County Council Carers Strategy 2026-2030

Recognising, valuing and supporting Leicestershire carers to make a positive difference

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Introduction

This Leicestershire Carers Strategy 2026-2030 has been informed by carers who have engaged extensively with us through surveys, online meetings and face to face carers groups and community groups across the County. Over 300 carers have participated and provided an insight to how they would like to be supported to continue caring.

Thank you to all our carers who took the time to talk to us and completed the survey. Many thanks and gratitude to our key partners and professionals who participated and engaged. All input has been valuable to us in developing the Leicestershire Carers Strategy: 2026-2030.

Carers across Leicestershire play a vital role in caring for and supporting people. Every carer and caring situation is unique and different. Some carers might care for one person, whereas others might care for more than one person, such as a sandwich carer, who might care for their child and also a parent.

This strategy is a framework for developing support for carers. It recognises the increasingly important role that carers play in Leicestershire, alongside the wide variety of caring roles and the diversity of people within these roles.

Scope

This strategy applies to adults (over 18 years of age) who care, informally for a person who is living in Leicestershire or is registered to a GP in Leicestershire. This may mean that the carer lives outside of Leicestershire but would still be entitled to an assessment from Leicestershire County Council. The strategy also applies to young carers under 18 years and the support they receive will be determined by the Council's Children and Families Service, such as offering an assessment, young carers group and passport ID card.

Leicestershire County Council commitment to carers

On 3 December 2025 the Council resolved to:

- a. Formally recognise carers as a group requiring particular consideration and support, specifically:
 - To ensure carers are consulted and involved in shaping services;
 - To review service delivery to remove barriers for carers.
- b. Assess future decisions, services and policies made and adopted by the Council to determine the impact of changes on carers.
- c. Ensure that these commitments are incorporated into the Carers Strategy and any other relevant policies and strategies.

Who is a carer?

For the purposes of this strategy, a carer is defined as a person who provides unpaid physical, practical and/or emotional support to a family member or friend who needs help due to physical or mental ill health, a learning disability, neurodivergent needs, age-related frailty, or problems related to drug and alcohol use. Without this support, the person being cared for would find it difficult to manage their day-to-day life or to cope. Carers can be of any age, including children, young people and adults.

Types of carers: *please note this list is not exhaustive*

Adult carer

An adult who provides care for another adult (e.g. partner, family member, friend or neighbour).

You may be working or in education and caring for an adult. You do not have to be living with the person and the help you give doesn't have to be physical care. You may be providing emotional support or practical help.

Adult carer story

'S' used to work as a receptionist at the Leicester Royal Infirmary hospital on the premature baby unit - Neo Natal Unit and is now retired. S now cares for her husband and mother who both have dementia.

S's husband was diagnosed with dementia seven years ago. The dementia is maintained by medication and he is able to do most things by himself. S is there to

support him if he needs her support. Both like to keep active, by going on regular walks and swims. S believes regular exercise helps keeps her husband active and occupied, which helps with his dementia.

S's mother recently had a CT scan which revealed, her having mixed dementia following a couple of falls. Prior to the diagnosis, S's mother was calling her on a regular basis during the day and at night and making complaints against her. This impacted on S's mental health. S's mother's mixed dementia is maintained by medication and S visits frequently to make sure she is okay and attends to her needs. S does have a sister who helps with online food shopping and telephone calls on a regular basis but does not live locally. S has put measures in place for her mother including a Lifeline key safe, where emergency services can use a pin to retrieve the key to gain access to the house.

S is registered with Voluntary Action South Leicestershire (VASL): Support for Carers and Alzheimer's Society, where they have provided support, information and advice. S has built up a good relationship with both organisations and know they are only a phone call away if she ever needs their support or need someone to talk to.

S has her own health conditions but has a positive outlook in life. S makes the most of her caring responsibilities and is an advocate for people living with dementia. S is a very active member of the community and attends many dementia local charity events, talking about her caring journey and providing information and advice to other carers in a similar situation. S is very passionate about helping others and feels her experience can help carers who are looking after someone living with dementia.

Working carer

A working carer balances their paid employment along with unpaid care for someone (e.g. partner, family member, friend or neighbour).

Parent carer

A parent or guardian who supports an ill or disabled child (under 18 years) including a child or young person who is misusing or abusing substances and/or alcohol, to a degree greater than would be expected in a parenting role.

Parent carer story

'K' is a parent carer who cares for her 21 year old son, 'P'. P was diagnosed with autism when he was two years old. K gave up her work to care for P.

During P's first year in college, he had autism burnout and sensory issues. K found caring for P stressful at night because he was having a sensory issue every few hours which resulted in him feeling low, annoyed, frustrated and upset. A Doctor prescribed medication however this was not working. The situation gradually worsened and his sensory issues were not initially addressed and sometimes their voices were not always heard. P lost weight and was not able to stand. K persisted with professionals and it revealed that he was suffering from side effects from the medication. Support was put into place with regular visits by the crisis team, a specialist consultant was assigned and new medications were prescribed.

P's autism is now managed well. He has the support from their social worker, occupational therapist and physio. K supports her son with keeping him calm, encouraging, reassuring and supporting him when he is frustrated and also with personal care, medication and appointments.

K gets support and meets with other carers once a month which helps with supporting one another, talking through problems and giving some advice. K is also involved with the adult social care engagement panel where she can connect with like-minded people and can work together with them to make a difference.

Sandwich carer

A sandwich carer provides care for another adult (e.g. partner, family member, friend or neighbour) as well as their own children.

Young carer

A child or young person, aged 18 years or under, who provides regular and ongoing care and emotional support to a family member who is physically or mentally ill, disabled or misuses substances.

Becoming a Young Carer: R's story

My dad has been ill since I was three years old, with multiple cancers and strokes. And my sister has special needs meaning she experiences the world differently and

requires a lot of attention. Growing up in this environment meant that, even from a young age, I took on responsibilities that shaped my childhood in ways most children don't experience.

I began to properly understand my role when I was about 11 years old, after my sisters support worker reached out to places to ensure that I had support in place. This is when I learned what a young carer was and how much my life was related to this.

Honestly, my first reaction was confusion. I knew my life was different from other people, but I wasn't sure if it was something to feel proud about or sad and frustrated.

What changed for me

Once I understood what a young carer was, my responsibilities stood out to me much more and I started wondering why I had to take on adult roles whilst my friends were out playing and having fun.

My routine would change when my dad had hospital appointments, and I would constantly have to be at my grandparents. I always had the best time with them, but I could never fully relax and enjoy myself as the hardest part was not knowing what was happening to my dad.

I have always been sporty and loved playing football. This helped me escape from my caring responsibilities at home and gave me somewhere to be a kid again. My friendships did not change, mainly because I never told my friends that I was a young carer. Perhaps if I did, they would have been supportive, but I was constantly worried that if they found out then they wouldn't understand, and I wasn't used to putting my needs first and allowing myself to express my emotions.

How it made me feel

I felt worried, anxious, and overwhelmed, and I struggled to trust people as I wasn't able to predict their responses or reactions. What if they got more people involved? In the end I would tell them I'm fine as it was easier to keep myself to myself. Because I was so used to putting others before me, being vulnerable was not an option as it felt too uncomfortable and risky.

The hardest part was hiding my emotions at school whilst still being expected to achieve good grades. None of my friends had ever saw me cry, and it just felt safer that way. I didn't want to have to explain myself. But what I found out was that crying isn't a weakness, its possibly one of the strongest emotions to exist. I physically felt like I couldn't talk to anyone, and crying became a way to release everything I couldn't put into words.

What I learned

Being a young carer has helped me develop patience and empathy, which have supported me in my everyday life. I have also become more mature as I have had to grow up much quicker than most people my age.

Being a young carer has shaped the way I look at situations and people making me more understanding and resilient. Although it is challenging, I wouldn't be half the person that I am today.

Who or what helped me

When I think about it, I have been incredibly lucky as everyone has supported me in their own little ways. Even when I said I didn't need it, even without them realising I was a young carer, everyone has helped. My friends supported me the most (and still do!), by getting me out of the house when I'm at my lowest. I have also joined a young carers group which has helped me realise that I'm not alone.

Sports has helped me massively! It has made sure I did something for myself and helped clear my mind of any worries. Music has also become a huge coping strategy, helping me to relax and manage my feelings.

Looking back

Looking back to when I was 11, I feel immensely proud of how far I have come. If I would've known what the next 7 years would look like, I probably would have given up. I do still sometimes wonder why I got given this life, but I also strongly believe that everything happens for a reason and that I was chosen to be a young carer to support those who need it most.

Being a young carer now means being gifted the ability to understand other people on a whole new level, and to carry strength and determination into whatever life throws at you.

I hope for a future where young carers are not recognised for what they are forced to go through, but for all the strength, love and responsibilities that they hold quietly every day. It will be a future where support reaches them before they have to ask, because asking is the hardest and scariest part, especially when you've spent your life being the strong one.

I hope for a future where young carers are supported and reminded that their lives are allowed to be just as full of endless possibilities as anyone else's.

What might a carer do?

Carers often do not recognise themselves as carers, especially when they are caring for someone close to them, like a family member; including a husband, wife, partner, mother, father, sister and brother or a child, or extended family members. If you look after or support someone who would not be able to manage everyday life without your help, it is important that you identify yourself as a carer so you may receive the help and support you are entitled to. Carers may also care for their friends or neighbours.

Here are some examples of what a carer might be supporting the cared-for person with:

- to wash and dress
- help with personal care and housework
- food shopping
- food preparation and cooking
- picking up and administering medication
- taking someone to hospital and GP appointments
- providing company and emotional support
- help with financial paperwork
- Helping with communication and caring for siblings

Carers in Leicestershire

The Census 2021 data indicates a total of 61,300 of Leicestershire respondents, aged five years and above, declared that they provide unpaid care (9% of population). The highest rate of caring population was among those aged 45 to 64 (15%), followed by those 65 to 84 (11.3%), with women predominating in all but the eldest group of carers (aged 85 years and above). There is some geographical variation amongst carers in Leicestershire with the highest rate being in Oadby and Wigston (9.8%) and lowest in Harborough (8.3%), unadjusted for age. The rate of employment among carers is slightly higher in Leicestershire at 3% compared to the national average of 2%.

These carers provide essential support to family members and friends who could not manage without their help, forming a vital part of the county's early-intervention and prevention system. As Leicestershire has a larger and faster-growing older population than the national average, the demand for unpaid care is expected to continue rising, driving increasing pressure on both carers and local services.

In 2024/25, 1,455 carers assessments were completed in Leicestershire.

In January 2026 there were over 2,300 carers in receipt of a service from the local authority in Leicestershire: including 1,581 who have a weekly carers direct payment and 716 who have a one-off carers direct payment, 632 reviews have taken place in 2025/26 for carers, with 292 (46%) being joint reviews.

In addition to this, the commissioned carers service Voluntary Action South Leicestershire known as VASL provide support to approximately 2,500 carers a year. The VASL service aims to support carers with information and advice activities such as contingency planning, finances, benefits, as well as provide help to complete carers assessments.

VASL also promote social inclusion and prevent carers from being isolated by running support groups across the County, offer one to one support and telephone befriending services. A carers' passport identifies and supports carers in workplaces,

hospitals, communities and schools. The passport can also minimise repeating the carers' journey and help carers access benefits such as discounts. VASL issue and renew these passports.

Rural carers

Carers living in rural areas are at a particular disadvantage, more likely to experience social isolation, transport issues and housing challenges. They may experience limited access to respite, fewer peer support opportunities, higher financial strain (especially from transport and fuel costs), and digital exclusion where connectivity is poor. Smaller local networks intensify emotional strain, isolation, and the feeling of carrying sole responsibility. Cultural expectations to “manage independently” can further discourage carers from seeking support.

This strategy will help to ensure isolated carers have an equitable opportunity to receive support.

“In rural settings, where distances are greater and access to services is often more constrained, the issues faced by unpaid carers can be even more pronounced. It is imperative that we recognise and address these unique challenges to ensure that all carers, regardless of their geographic location, receive the support they need.” *Kerry Booth, Chief Executive, Rural Services Network*

National Policy Context

The Care Act (2014) The Care Act 2014 gives unpaid adult carers in England the legal right to a support assessment, placing them on an equal footing with the people they care for. If the assessment identifies eligible needs, local authorities have a duty to meet them, such as through respite care or direct payments. Local authorities must focus on the carer's wellbeing, including their physical, mental, and emotional health, as well as their ability to work and have a life outside of caring.

The **Children and Families Act (2014)** set out what support local authorities must provide for carers, as well as the cared for person for young people and families.

The Carers Leave Act 2023 came into effect in April 2024 and support carers to balance their work with their unpaid caring responsibilities. This Act gives full time

employees the right to take one week (of up to five days) of unpaid leave per year to allow carers to provide or arrange care for a dependent. Employees can take the unpaid leave as either full days, half days or in a block.

The **Young Carers Needs Assessment Regulation 2015** enforces the Children and Families Act 2014, for local authorities in England to assess any young carer under 18 upon request or if it appears they have support needs.

Leicestershire County Council Adults and Communities Strategy 2025-2029

This Adults and Communities Strategy 'Delivering Wellbeing and Opportunity in Leicestershire' details the ambitions, aims and goals of the department over the next four years (2025–2029). It reflects the ambitions of the Council's overall Strategic Plan.

To deliver our aims and goals, we have developed a layered model that is designed to maximise a person's independence whilst promoting their wellbeing. This strategic approach has four key areas which are surrounded by a person's wellbeing. These key areas are designed to offer the right support, at the right time and will vary in the amount of intervention needed by services to promote wellbeing and independence.



Further details about the departmental strategy is available on the local authority website - <https://resources.leicestershire.gov.uk/adult-social-care-and-health/our-approach/policies-and-strategies>

The Council currently spends around £3.5 million per year directly on supporting carers. The majority of this is through a weekly direct payment which carers can use

to purchase support directly with providers. The Council also commissions support for carers across the County with information and advice, carers passports and support groups.

A new service called 'Support at Home' commenced in October 2025 to act as a council-managed service for carers who do not want to use a direct payment. The service offers a cost-effective alternative to traditional home care by focusing on practical, non-personal care tasks such as shopping, social inclusion, and household support.

Building on our achievements

The following are some of the achievements from the Leicester, Leicestershire and Rutland (LLR) Joint Carers Strategy Refresh 2022-2025:

- Between January 2022 and November 2025 over 4,400 carers passports were issued and over 5,000 carers' passports were renewed
- Celebrated the fifth year anniversary of the carers passport
- Successful early intervention care technology for people living with dementia
- Recommissioned the Carers' Support Service to support unpaid carers across Leicestershire with information and advice
- Launched the hospital discharge grant for carers in January 2023 and successfully supported carers following the cared-for person being discharged from hospital. To date we have provided over £198 thousand in discharge grants.
- Worked with carers to review and updated the LLLR carers information and advice
- Supported working carers with the new Carers Leave Act 2023
- Issued over 330 young carers passports
- Ibstock school and Kibworth Mead Academy have been awarded a young carers award, these are the first two schools in Leicestershire to receive this award

Leicester, Leicestershire and Rutland Carers Information Webpage Development

The county and partners, alongside carers and local carers-support organisations, are co-producing an enhanced digital carers webpage. The purpose of this platform is to ensure carers can more easily navigate the health and social care system and access clear, reliable information. This approach aligns with local authority commitments to signposting carers to advice, assessments, emergency planning and community support. Carers who do not have access to digital platforms will still be able to access the same information and advice through leaflets and booklets.

Digitalisation of the Carers Passport

The Carers Passport—which is a recognised identification resource across LLR - is being digitalised so carers can download and print their own copies. Carers can still access a non-digital version of their carers passport by contacting their local support for carers service. Carers Passports help carers be more easily recognised and unlock access to a range of local support, as highlighted by both Rutland County Council and Support for Carers Leicestershire.

Development of a Consistent Carers Emergency Plan

A shared Carers Emergency Plan has been co-designed with carers, operational practitioners and carers-support services across the LLR footprint. This work ensures a consistent emergency-planning approach for carers and those they support, aligning with existing emergency-contingency tools available through local authorities. Implementation of the finalised LLR-wide form is planned for 2026, strengthening the safety and continuity of care when carers are unable to provide support.

Hospital-Discharge Support

Funding has been used to expand support for carers during hospital discharge, delivered through the carers-support provider Voluntary Action South Leicestershire (VASL), which already plays a significant local role in supporting carers in Leicestershire. This initiative has successfully improved the experience of carers and those they care for during transitions home.

Carer Identification and Professional Training

Recognising the need to improve carer identification across health, social care and provider services, LLR partners have commissioned a dedicated training course for professionals and providers across the County, City and Rutland. This training will strengthen workforce capability to identify and support carers earlier and more consistently.,

Vision for the Leicestershire Carers Strategy

We have worked together to determine a clear vision for the future. Carers, people who have a carer, staff and other stakeholders want the following for each carer in Leicestershire:

- To recognise they are performing a caring role
- To know where to go to ask for support
- To receive help and support to remain physically and mentally well
- To be able to carry on in the caring role if they choose to
- To have access to timely, good quality information and advice
- To receive training in the condition for the person they care for, if they want it
- To be able to work, take part in education and activities alongside their caring role
- To take a break from caring when they need it

From October 2025 to January 2026, over 300 carers took part in engagement activities across the County. This inclusive engagement used a range of communication mechanisms to support carers' participation including face to face carers' and community groups, individual based engagement, online meetings and surveys. The results were analysed and have helped to shape our priorities.

Priority one:

Carers are recognised, valued and listened to and supported to continue caring.

We will:

- Identify and recognise carers at all points in their caring journey.

- Increase the number of carers assessments and reviews ensuring they are personalised, proportionate, and timely
- Further develop respite services in partnership with carers
- Promote the use of a direct payment to ensure carers have choice and control over their support. This includes young carers who are not in education, employment or training (known as NEET)
- Work with small groups and communities to support adult carers to be part of their local communities. Develop support for carers groups to access to enable them to continue their group and increase membership
- Commission support groups for specific conditions or areas of interest e.g. sport
- Improve our approach to respite and support in a crisis
- Partner with adult learning to look at how carers can be supported with their wellbeing
- Ensure that there is a range of training available for carers such as:
 - understanding Carers Rights and Carers Assessments
 - manual handling techniques
 - first aid and emergency planning for young carers
 - Lasting Power of Attorney, Wills, and Trusts
- Ensure people are informed about technology to support the Carer and cared for person
- Provide training for staff regarding carers to be embedded in new starter induction with a focus on: -
 - Carer Awareness
 - Carers Assessments
 - Recognition and Valuing Carers

Priority two:

Carers are provided with accurate, timely and relevant information and advice

We will

- Co-produce information and advice with carers and agency partners, to include:
 - digital and non-digital formats
 - easy to read information
 - use of alternatives to written word e.g. videos
 - support digital inclusion
- Ensure information and advice we provide carers is in plain English, easy to read and understand and minimise jargon and acronyms
- Ensure that systems exist to improve access to information in relation to finance and benefits, including:
 - identifying what information and organisations are available to advise on benefit claims and other financial advice
 - supporting carers to break out of the 'benefits trap' where Carers are looking for employment or training
 - providing carers and the cared for with accurate information about charging for services
 - supporting 'self-funders' to understand what support is available to them
- Ensure young carers and families understand what to expect from a transition to adult services and what is available to them. This includes working closely with adult commissioned services.
- Developing a 'no wrong door' approach for young carers

Priority three:

Carers are supported with their wellbeing and access services when needed

We will

- Work with wellbeing and social care sector organisations in Leicestershire to improve access to support
- Promote contingency and emergency planning
- Support people to access Carers Support groups and networks for specific health conditions
- Promote the different channels to contact adult social care

- Ensure equitable support is in place to enable carers to attend appointments about their own wellbeing
- Support working carers at times that suit them outside of business working hours
- Supporting young carers outside of school hours. This includes support with signposting, self-help and online services

Achieving the priorities

To achieve these priorities, Leicestershire County Council aim to:

- Identify and recognise more carers
- Increase the number and quality of carers assessments and assessment reviews completed, ensuring they are personalised, proportionate, and timely
- Offer information and advice about things that matter to carers e.g. benefits, contingency planning, respite
- Signpost and support carers to access specialist support
- Develop a reliable and equitable respite service in partnership with carers
- Promote the use of a direct payment to ensure carers have choice and control over their support
- Develop support for carers groups to access to enable them to continue their group and increase membership
- Commission the establishment of support groups for specific conditions or areas of interest e.g. sport
- Co-produce information and advice with carers and agency partners, to include
 - digital and non-digital formats
 - easy to read information
 - translation and interpretation approaches
 - use of alternatives to written word e.g. videos
- Support carers via digital inclusion
- Ensure families understand what to expect from a transition to adult services and what is available to them.
- Improve our approach to respite ensuring an equitable offer and support in a crisis
- Partner with adult learning to look at how carers can be supported with their wellbeing

- m. Ensure that there is a range of training available for carers such as:
 - understanding Carers Rights and Carers Assessments
 - manual handling techniques
 - health and safety
 - Lasting Power of Attorney, Wills, and Trusts
- n. Ensure people are informed about technology to support the Carer and cared for person
- o. Work with wellbeing and social care sector organisations in Leicestershire to improve access to support
- p. Promote contingency and emergency planning
- q. Support people to access Carers Support groups and networks for specific health conditions for example carers of people with learning disabilities

Measuring success

This strategy will be measured on the impact the outcomes of the priorities identified have. This will include increased numbers of carers assessments, increased number of timely reviews, increased number of carers identified and registered) including increased number of carers passport issued, improved levels of satisfaction in services, increased completion of school census data return, improved education, health and wellbeing outcomes.

Future engagement and co-production

Following the publication of the strategy it will be essential to continue to work with carers and organisations to co-produce information and advice and to develop services.

Appendix

Signposting to organisations

Leicestershire County Council: Adult Social Care Customer Service Centre can be contactable on 0116 305 0004.

Voluntary Action South Leicestershire (VASL) Support for Carers is

Leicestershire County Council commissioned providers to support unpaid carers. This is a service for adult carers caring for someone who is aged 18+ and lives within Leicestershire County boundaries. Support for Carers provide a range of services including: information or advice to carers including monthly newsletter. Supporting carers with their finances, benefits, completing carers assessments, providing on-going one to one support and calling carers to check their wellbeing, issuing carers passport and support with completing and thinking about contingency/ emergency planning. VASL: Support for Carers can be contacted on: VASL: Support for Carers can be contacted on:

Tel: **01858 468543**, Email: maureen@supportforcarers.org, or

www.supportforcarers.org

Young carers team: for more information, click [here](#)

Carers can access general information and advice on caring responsibilities, carer's assessment, planning for emergencies, support on carer's health and wellbeing, carer's breaks, financial, useful helplines and also ways to connect with other carers. Below provides a useful list:

- [Leicestershire County Council](#)
- [Carers UK](#)
- [Carers Trust](#)

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HEALTH AND WELLBEING BOARD: 15 JUNE 2026

REPORT OF THE DIRECTOR OF PUBLIC HEALTH

LEICESTERSHIRE HEALTH PROTECTION ANNUAL REPORT 2025

Purpose of report

1. This report provides an overview of health protection activity in Leicestershire from January to December 2025. It covers system performance, significant incidents, emerging risks and areas requiring ongoing assurance. This report supports the statutory duties of the Director of Public health and aligns with local and national health protection priorities.
2. A comprehensive report, including appendices and supporting data, is provided in Appendix 1.

Recommendations

3. The Health and Wellbeing Board is recommended to:
 - (a) Note the annual Health Protection Report 2025;
 - (b) In noting the report, recognise the key health protection issues that have arisen locally, the actions taken in response and the main areas of focus for 2026.

Policy Framework and Previous Decision

4. This report supports the statutory duties of the Director of Public Health and aligns with local and national health protection strategies. It builds on previous annual reports and reflects current health protection priorities.

Background

5. The report summarises key health protection domains including infectious disease control, immunisation, screening, sexual health, tuberculosis (TB), healthcare-associated infections (HCAIs), emergency planning (EPRR), and air quality. It highlights successes such as improved flu vaccine uptake and challenges like rising gonorrhoea rates and TB concerns. The report also outlines preparedness for emerging threats and system changes.

Health Protection Overview

Outbreaks and communicable disease

6. **COVID-19:** Activity in Leicestershire remained low for much of 2025, with a small autumn wave from late August peaking in early October. Continued surveillance, infection prevention in higher-risk settings and booster uptake in eligible cohorts remain important.
7. **Measles:** National activity reduced compared to 2024. Locally, Leicestershire recorded fewer than 10 confirmed cases (suppressed in national UTLA breakdowns under disclosure control), with enhanced surveillance and outbreak control measures in place as required.
8. **Mpox:** UKHSA reporting identified clade 1b cases in the UK, with ongoing consideration of importation risk considerations. Locally, preparedness measures include action cards, pathways and access to vaccination when required.
9. **Pertussis:** Following the increased number of cases in 2024, 2025 activity was described as substantially lower. Local assurance highlights ongoing focus on maternal vaccination and timely infant immunisation.

Immunisation

10. Overall, **childhood immunisation** coverage in Leicestershire remains above the England average, though the report notes a continuing downward trend and a need to reduce variation and inequalities in uptake.
11. The **human papillomavirus (HPV) programme** continues as a single-dose programme with coverage remaining lower than pre-pandemic levels.
12. **Seasonal flu** vaccination coverage is stronger in older adults (65+) compared to the under-65 clinical risk cohort and pregnant women.
13. The **RSV** vaccination programme, introduced in September 2024, requires improvement in the maternal cohort, with a system objective to increase uptake to 60% through tailored outreach.

Screening Programmes

14. Uptake of **breast** and **bowel** screening show improving coverage over time, consistent with recovery efforts. **Cervical** screening is trending downward across age bands. **Newborn indicators** show no significant change.
15. The reports highlights planned national policy direction to delegate vaccination and screening commissioning responsibilities to ICBs alongside legislative changes, requiring clear governance and strong intelligence to avoid widening inequalities.

Sexual Health

16. The diagnostic and detection rates for key indicators are listed in the appendix. Leicestershire County Council commissions the integrated sexual health services (ISHS) to detect, prevent and treat sexually transmitted infections (STIs). A new integrated provider commenced delivery from 1 April 2025 with a hub model and intentions to expand sessional access in additional local venues.
17. Leicestershire rates are lower than England for **syphilis** (6.7 vs 16.5 per 100,000) and **gonorrhoea** (57 vs 124 per 100,000), while **chlamydia screening** in females aged 15–24 is 17.9% (England 18.0%). **HIV late diagnosis** is high (63.3% vs England 43.3%, 2022–2024), supporting a continued focus on increasing testing and earlier diagnosis.

Tuberculosis (TB)

18. TB remains an important health protection issue. The TB burden is unevenly distributed locally, with Leicestershire generally below the England average. TB can be associated with deprivation and inclusion health factors. Services are delivered via a multidisciplinary pathway hosted by University Hospitals of Leicester.
19. Priorities for 2026 include earlier recognition and referral, timely latent TB infection (LTBI) assessment and treatment for eligible cohorts, and targeted approaches for higher-risk groups.

Healthcare Associated Infections

20. Although local thresholds were breached for some organisms in 2024/25, LLR as a system was not considered an outlier overall against national/ peer comparisons. Overall MRSA and MSSA was rated green, although some sub-measures remained red and require continued attention.
21. System IPC teams monitored infection rates, investigated incidents and outbreaks, and shared learning across partners. An LLR outbreak framework is being developed to strengthen system assurance and clarify response arrangements.

Emergency Planning and Response (EPRR)

22. As a Category 1 responder, the Council's duties and partnership arrangements are coordinated through the Local Resilience Forum (LRF) and Local Health Resilience Partnership (LHRP). System partners participated in multiple pandemic preparedness exercises during 2025.

Air Quality

23. Poor air quality is a major environmental risk to health, with impacts across the life course and inequalities in exposure and harm. The report references the local Air Quality and Health Needs Assessment (2024) and the Partnership action plan (2024-28), including a focus on planning/ urban design, travel choices and improving information for the public and stakeholders.

Priorities for 2026

24. The priorities for 2026 include:

- (a) Maintain and improve progress on key immunisation programmes by addressing declining trends and inequalities, sustaining delivery for children and improving uptake in under-65 risk groups and pregnant women.
- (b) Improve maternal RSV uptake through targeted outreach.
- (c) Maintain focus on cervical screening decline and equitable access across screening programmes, alongside readiness for system commissioning changes.
- (d) Strengthen HIV testing and support earlier diagnosis.
- (e) Continue targeted TB approaches including earlier recognition/ referral and LTBI pathways for eligible cohorts
- (f) Maintain preparedness capabilities and embed learning from exercises, and continue partnership working through the LRF and LHRP.
- (g) Continue to implement the air quality action plan and improve public-facing information and cross-system accountability.

Consultation/Patient and Public Involvement

25. This report is for noting and does not contain new policy proposals; therefore, a formal consultation is not required.

Resource Implications

26. The activities outlined are funded through existing public health budgets. The local authority does not commission the majority of services described within the report, but the Director of Public Health should be assured that arrangements are appropriate for the population of Leicestershire.

Background papers

- [Leicestershire Health Protection Report – Annual Report 2024](#)

List of Appendices

Appendix 1- Leicestershire Health Protection Annual Assurance Report 2025

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Relevant Impact Assessments

27. The JSNAs give due regard to the equality and human rights of different population groups, with particular focus within the JSNAs. Sources of inequalities and recommendations are designed to alleviate issues created through identified inequalities.

Equality and Human Rights Implications

28. There are no equality implications arising from this report. The report would seek to have a positive impact overall and would not have an adverse effect on any section of the community.

29. There are no human rights implications arising from this report.

Environmental Implications

30. Air quality is an important element within the Leicestershire Environment Strategy.

Partnership Working and Associated Issues

31. Partnership working across health, local authorities and emergency services is essential to ensure robust health protection and emergency planning arrangements are in place.

Appendix 1



Leicestershire Health Protection Annual Assurance Report

January 2025- December 2025

Health and Wellbeing Board

June 2026

Report of the Director of Public Health

Purpose of the report

1. The purpose of this report is to provide a summary of the assurance functions of the Leicester, Leicestershire, and Rutland (LLR) Health Protection Board. It also updates the Health and Wellbeing Board on health protection performance, key incidents and risks and other significant matters.

Link to the local Health and Care System

2. Health protection assurance is a statutory duty of the local authority, via the Director of Public Health. It is therefore a key element of the Joint Health and Wellbeing Strategy and of Leicestershire County Council's core business. It is an essential element in local health and social care strategies and initiatives.
3. The Director of Public Health is a mandated member of the local health and wellbeing board (section 194(2)(d) of the 2012 Act).
4. Links to LCC strategic plan:
 - Safe & Well: Ensuring people are safe and well protected from harm, live in a healthy environment and have the opportunities and support they need to live active, independent and fulfilling lives.
 - Improved opportunities: All children and young people get the best start for life and have the opportunities they need to fulfil their potential, regardless of their circumstances.
 - Great communities: Communities are prepared for and resilient to emergencies.

Recommendations

5. It is recommended that:
 - a. The Health Protection Annual Report 2025 be noted.
 - b. In noting the report, the Health and Wellbeing Board recognise the specific health protection issues that have arisen locally, the steps taken to deal with them, and the areas of focus for the coming year.

Policy Framework and Previous Decisions

6. The statutory responsibilities of the Director of Public Health are outlined in the Health and Social Care Act 2012, the NHS Act 2006 and regulations issued under these. Section 30 of the Health and Social Care Act requires local authorities, acting jointly with the Secretary of State, to appoint a Director of Public Health. The Director of Public Health has an overarching duty to ensure the local health protection system works effectively.
7. Under section 18 the Secretary of State can use regulations to delegate his health protection duties to local authorities or to require local authorities to undertake their health improvement duties in particular ways. Each local authority is now required, via its Director of Public Health to assure itself that relevant organisations have

appropriate plans in place to protect the health of the population and that all necessary action is being taken.

8. Integrated Care Boards (ICBs) were legally established on 1 July 2022, replacing clinical commissioning groups (CCGs), taking on the NHS planning functions and absorbing some planning roles from NHS England. The former Public Health England organisation was abolished in 2022 and a new organisation, the United Kingdom Health Security Agency (UKHSA), established.

The key strands of health protection activity are:

- i. Outbreaks and communicable disease (including COVID-19)
- ii. Screening Programmes
- iii. Immunisation Programmes
- iv. Healthcare associated infections
- v. Preparedness and response to incidents and emergencies

9. The local authority does not commission the majority of services which contribute to protecting the health of the population, but the Director of Public Health should be assured that arrangements are robust and that they are implemented in a way which meets the needs of the population for which they are responsible.
10. The Leicester, Leicestershire, and Rutland (LLR) Health Protection Board reports into each of the three Health and Wellbeing Boards for Leicester, Leicestershire and Rutland and enables local authorities to discharge their health protection assurance responsibilities.
11. Dashboards, reports and/or updates are received and reviewed at the quarterly Board. They cover the key domains identified above. This data is reviewed by the group and if needed, stakeholders are asked to produce more detailed assurance for the group on an exception basis. The LLR Health Protection Board is linked into a number of other Health Protection groups across the local system

Key Domains of Health Protection Assurance

Prevention and Control of Infectious Diseases

Organisational Roles/Responsibilities

12. The United Kingdom Health Security Agency (UKHSA), formerly Public Health England (PHE), is an executive agency made up of both national specialist teams and regional health protection teams. UKHSA have established programmes to reduce the impact of common infectious diseases through detecting, analysing, responding, delivering and engaging with the wider health system. UKHSA lead on the epidemiological investigation and the specialist health protection response to public health outbreaks/incidents and has responsibility to declare a health protection incident, major or otherwise.
13. NHS England is responsible for ensuring its contracted providers are mobilised to deliver an appropriate clinical response to outbreaks/incidents. This responsibility devolves down to local Integrated Care Boards (ICBs) to use contractual

arrangements with provider organisations to make relevant resources available (including screening/diagnostic and treatment services).

14. The local authority, through the Director of Public Health, has overall responsibility for the strategic oversight of an incident/ outbreak and to gain assurance that the local health protection system is robust enough to respond appropriately.

COVID-19

15. An overview of COVID-19 cases recorded in 2025 is shown in Appendix 1. COVID-19 activity in Leicestershire during 2025 remained low for much of the year, with daily case counts and rolling average rates fluctuating at minimal levels through winter and spring. From late August, a small Autumn wave was observed, peaking in early October. This pattern reflects seasonal transmission dynamics and waning immunity. Whilst absolute numbers were modest compared to previous years, ongoing transmission highlights the importance of autumn booster uptake (for those who remain eligible), infection prevention in high-risk settings, and ongoing surveillance.
16. A Spring COVID-19 vaccination programme has been confirmed for 2026. Vaccination should begin from 13 April 2026 and end on 30 June 2026 for adults aged 75 and over, residents in care homes for older adults, and immunosuppressed individuals (aged 6 months and over). Care home residents and eligible housebound patients should be prioritised.

Measles

17. From 1 January to 31 December 2025 there were 959 laboratory-confirmed measles cases in England. 51% were in London, 14% in the North West and 8% each in the East of England and West Midlands; 68% of cases were in children aged 10 years and under.
18. In accordance with UK Health Security Agency (UKHSA) disclosure control protocols, counts for upper-tier local authorities with fewer than 10 confirmed measles cases are suppressed in national publications to safeguard individual confidentiality. For the reporting period, Leicestershire recorded fewer than 10 confirmed cases and therefore does not appear in the published UTLA breakdown. These cases would be included within the East Midlands regional total. Despite the low incidence across Leicestershire, local health protection teams maintained enhanced surveillance and implemented proactive vaccination and outbreak control measures as necessary to minimise transmission risk and protect population health¹.

Mpox

¹ For further details, see UKHSA guidance: [Confirmed cases of measles in England by month, age, region and upper-tier local authority](#).

19. UKHSA's epidemiological overview² confirms that the UK has reported 19 clade Ib mpox cases (17 England, 1 Scotland, 1 Wales), with most cases linked directly or indirectly to travel, and importation risk now assessed as high given emerging transmission outside Africa in specific GBMSM networks; at the same time, the UK risk of onward transmission remains low to medium, supported by vaccination in at-risk groups.
20. Preparedness measures are in place in Leicestershire: action cards have been shared with system partners, clinical pathways and incident triggers are in place, and vaccination supply is available should escalation be required. In line with UKHSA guidance, sexual health services continue routine pre-exposure vaccination for eligible GBMSM and offer post-exposure vaccination to indicated contacts, with two doses providing high levels of protection.

Pertussis

21. Pertussis is a cyclical disease, peaking every 3-5 years. 2024 was considered a peak year with 11 reported deaths in infants who developed pertussis in England. In 2025, pertussis activity remained substantially lower than the 2024 peak at a national level, with UKHSA reporting 169 laboratory-confirmed cases in England from April to June 2025. In Leicestershire, the system continued to emphasise prevention of severe disease in infants, particularly through maternal vaccination and timely infant immunisation. Local immunisation assurance reporting indicates that maternal pertussis uptake remains above the Section 7A 'optimal performance' standard (60%), while system partners continue work to improve uptake and reduce variation across settings and populations. There are limitations to available data due to coding and maternal records.
22. Taken together, these indicators suggest that Leicestershire entered 2026 with no sustained large-scale communicable disease incident, but with continued need for vigilance, particularly where national epidemiology indicates persistent or re-emerging risk. Assurance remains dependent on timely surveillance, vaccine uptake, outbreak readiness and effective cross-system coordination

² <https://www.gov.uk/government/publications/monkeypox-outbreak-epidemiological-overview/mpox-outbreak-epidemiological-overview-11-december-2025>

Immunisation and Screening

Organisational Roles/ Responsibilities

23. Integrated Care Boards (ICBs) were legally and operationally established on 1 July 2022. Under the Section 7A NHS public health functions framework, commissioning responsibility for national immunisation programmes, national population screening programmes and Child Health Information Services (CHIS) remained with NHS England in 2025/26. NHS England regional teams began closer working arrangements with ICBs from April 2025 to support readiness and joint ways of working. Nationally, subsequent policy statements indicate that transfer of commissioning responsibility for vaccination and screening services is now proposed to take place alongside legislative changes in April 2027, with ICBs expected to take a more central role in shaping these services during 2026/27 through closer collaboration with NHS England. Sector guidance highlights that successful transfer will depend on addressing declining and variable uptake through stronger national prioritisation, more effective contractual arrangements, sustainable funding, and improved data availability and sharing to support targeted local delivery.
24. JCVI and the UK National Screening Committee are expert advisory bodies that advise UK ministers and the NHS on vaccination and screening respectively. UKHSA supports implementation through authoritative clinical guidance and through vaccine system functions including publishing the routine immunisation schedule and supporting vaccine procurement/ supply.
25. Local authorities, through the Director of Public Health, require assurance that screening and immunisation services operate safely and maximise coverage and uptake, including providing public health advice locally and supporting collaborative activity to improve uptake and reduce inequalities.

Immunisation

26. The national routine immunisation schedule is published and regularly updated by the UK Health Security Agency (UKHSA) (see Appendix 3). In Leicestershire, routine pre-school vaccinations are delivered through local GP practices, and the school-age vaccination programme is delivered by the School Aged Immunisation Service (SAIS) commissioned by NHS England. SAIS works with schools to arrange clinics and ensure all eligible children are offered the scheduled vaccines, including opportunities to catch up missed doses.
27. Childhood immunisation coverage in Leicestershire remains relatively high compared to England overall (see Appendix 4), helping to maintain population protection and reduce susceptibility to vaccine-preventable disease outbreaks. Some published datasets combine Leicestershire and Rutland for disclosure control; where this occurs it is stated explicitly. Where national datasets are published on financial-year or quarterly cycles, the latest available publication is used; this may include early 2025/26 releases where these were the most recent at the time of writing.
28. National data show a sustained decline in routine childhood immunisation uptake since 2019. Leicestershire has followed this trend, although coverage remains above the England average in the latest available reporting (Appendix 4). Work continues

with system partners to support timely vaccination and reduce inequalities in uptake.

29. The LLR Immunisation Board (established in 2024) brings together system partners to oversee delivery of the local vaccination strategy and provide an outcome-focused approach aimed at reducing vaccine-preventable morbidity and mortality. The Board also supports system governance and preparedness for the future transfer of vaccination commissioning responsibilities to the ICB.

Childhood Immunisations

30. Numbers for Rutland are combined with and reported as Leicestershire. Routine childhood immunisation coverage at 12 months remains relatively high in Leicestershire compared with England overall, supporting population protection and reducing susceptibility to outbreaks of vaccine-preventable diseases (Appendix 4). Nationally, routine vaccination uptake has declined since 2019 and Leicestershire has followed this trend; however, coverage remains above the national average in the most recent reporting.
31. At 24 months, Leicestershire continues to report strong coverage relative to England (Appendix 4), but maintaining high uptake remains important given wider declines in routine immunisation.
32. Coverage at 5 years remains a key assurance point as it reflects completion of the pre-school programme and catch-up before school entry. Local analysis indicates that while Leicestershire has remained above national and regional averages for a key 5-year booster measure (89.8% in 2022/23), this has trended downwards in recent years, consistent with national patterns and indicating persistent pockets of under-coverage.

Human Papillomavirus (HPV)

33. HPV vaccination is a key cancer-prevention intervention delivered primarily through the school-age immunisation programme. The programme moved from a two-dose schedule to a single-dose offer from 1 September 2023 for eligible adolescents and men who have sex with men aged under 25 years, in line with JCVI advice. National HPV coverage data for England is published annually enabling benchmarking across areas and year groups.
34. Fingertips population coverage data show that HPV one-dose coverage in Leicestershire for 12-13-year-olds has remained below pre-pandemic levels, with recent years showing no significant improvement. Male one-dose coverage was at 73.4% and female one-dose coverage at 80.9% (2023/24).

Seasonal Flu

35. Seasonal flu vaccine uptake in Leicestershire is reported as a combined Leicestershire & Rutland figure for disclosure control, so data within the appendix should be interpreted as a joint position rather than Leicestershire alone. Overall, the data shows stronger uptake in older adults (65+) compared with other cohorts, with lower uptake in under-65 clinical risk groups and pregnant women, and moderate

uptake in the early years (2-3-year-olds) and primary school-age children. The most recent published season shown indicates a reduction compared with the preceding year across several cohorts, though comparisons for adult cohorts should be made cautiously as eligibility start dates changed in 2024/25 (adults excluding pregnant women became eligible later than in previous seasons).

RSV

36. A national RSV vaccination programme commenced in September 2024, offering vaccination to pregnant women to protect newborn babies and to older adults aged 75 years (including a one-off catch-up offer for those aged 75-79), reflecting the higher risk of severe RSV disease in these cohorts. In Leicester, Leicestershire and Rutland (LLR), the older adult offer is delivered primarily through primary care and the maternal offer is delivered through University Hospitals of Leicester (UHL).
37. Local programme monitoring indicates that maternal RSV uptake across LLR requires ongoing work to target improvement activity to increase coverage. A system-wide improvement approach has focussed on addressing access barriers through tailored outreach to eligible unvaccinated pregnant women, with an explicit objective to increase maternal uptake to 60% over the winter. Detailed provider-level and operational uptake data are reviewed through internal system assurance reporting and are not published in this report.

Mpox and gonorrhoea

38. The Government has accepted JCVI advice for the NHS to implement: (i) a routine mpox pre-exposure vaccination programme and (ii) a routine opportunistic gonorrhoea vaccination programme, both delivered through sexual health services.
39. Providers were able to begin vaccinating from 1 August 2025. Eligibility is focused primarily on gay, bisexual and other men who have sex with men (GBMSM) at highest risk of exposure, with scope to vaccinate a small number of others with a similar incidence profile. Individuals should be identified via sexual health services using markers of high risk (e.g., recent multiple partners or recent bacterial STI). Full cohort details are set out in the Green Book chapters for mpox and gonorrhoea

Key issues for 2026 (Immunisation)

- Childhood immunisation coverage in Leicestershire remains above the England average overall but continues to show a downward trend, and local work needs to remain focused on reducing variation and improving equitable access.
- Challenges remain in under-65 clinical risk groups and pregnant women seasonal vaccinations, alongside the need to sustain delivery in children.
- The maternal RSV programme requires ongoing targeted work to increase coverage, with system improvement activity explicitly aiming to increase maternal uptake to 60% over winter through tailored outreach to eligible unvaccinated pregnant women
- HPV uptake remains below pre-pandemic levels and challenges remain to improve coverage in those eligible.

Screening

Overview

40. National population screening programmes are designed to identify disease or risk factors early so that timely intervention can reduce morbidity and mortality. In England, NHS population screening is delivered through established programmes with published standards and quality assurance arrangements, and performance is routinely reported through national screening publications.
41. The Director of Public Health has a statutory responsibility to seek assurance that arrangements are robust, safe and equitable, and that system partners are addressing variation and inequalities in access and outcomes. This assurance is supported through local governance, including regular updates and exception reporting to the Leicester, Leicestershire and Rutland (LLR) Health Protection Board and system screening governance arrangements.
42. The NHS population screening programmes delivered to eligible residents include: abdominal aortic aneurysm (AAA), breast, bowel cancer, cervical, diabetic eye screening, foetal anomaly screening, newborn blood spot, newborn and infant physical examination (NIPE), and newborn hearing screening.
43. The appendix summarises key coverage indicators and benchmarks them against the England average where available. Across the cancer screening programmes, breast screening and bowel screening are both showing an improving coverage over time, in line with recovery efforts seen nationally. Cervical screening is trending downward across both age bands (25-29 and 50-64).
44. The newborn indicators show no significant change.
45. As part of the cervical programme, an extended recall interval of 5 years has been implemented for eligible people aged 25-49 who test negative on a routine primary hrHPV test, in line with people aged 50-64.

Key issues and priorities for 2026 (Screening)

- Preparation for commissioning delegation: NHS England has set out proposals to delegate the significant majority of vaccination and screening commissioning responsibilities to Integrated Care Boards (ICBs), while retaining some functions for national consistency. This is a major system change requiring clear governance, defined quality assurance responsibilities, and strong population health intelligence to avoid widening inequalities.
- Maintaining focus on uptake and equitable access remains essential, including targeted approaches for underserved groups.

Sexual Health

46. Leicestershire County Council Public Health commissions integrated sexual health services (ISHS) to detect, prevent, and treat sexually transmitted infections (STIs) locally. ISHS offers thorough STI testing and several HIV testing options.
47. A new provider began delivery of the ISHS contract covering Leicestershire and Rutland from 1st April 2025. The focus continues to be on self-managed care while maintaining high standards in testing, results notification, and partner notification. Primary service delivery for Leicestershire will be based at the Loughborough Hub, with supplementary support provided by satellite spoke clinics throughout the county.
48. A separate online service commenced on 1 April 2025, offering a range of testing options for STIs and treatment for chlamydia. From June 2025, this service also commenced an online pre-exposure prophylaxis (PrEP) service providing an additional route of access to HIV prevention for those in need. Online service access has increased since the COVID-19 pandemic enabling our most rural areas to access services.
49. Post commissioning exercises there is a renewed focus on the Sexual Health Strategic Plan for Leicestershire and Rutland, supported by a newly formed Leicestershire and Rutland Sexual Health Steering Group. The strategic group comprises of Local Authority representatives, service providers and voluntary sector organisations established to:
 - champion the work of the sexual health system
 - align pathways across the system to ensure no wrong doors
 - set the strategic priorities to form a Sexual Health plan for L&R in line with the national strategy
 - review local data to inform programmes of work to support the Sexual Health plan
 - agree and monitor strategic priorities
 - co-ordinate transformation and link in with wider opportunities through other collaboratives

Key Issues for 2026 (Sexual Health)

Appendix 7 summarises key sexual and reproductive health indicators for Leicestershire.

- Monitor gonorrhoea diagnostic rates. Leicestershire still performs significantly better than England and the East Midlands for the gonorrhoea diagnostic rate per 100,000, and although there has been a dip in the rates (in line with national) there is an overall increasing trend. (Whilst an increase in rates can be positive if resulting from increased testing activity, this needs to be monitored locally to better understand the causes.

- A national benchmarking criterion for chlamydia detection exists:

Benchmarking against goal: <2,400 2,400 to 3,250 ≥3,250

The UK Health Security Agency (UKHSA) recommends that local authorities should be working towards achieving a detection rate of at least 3,250 per 100,000 female population aged 15 to 24, of 153 UTAs only 2 are achieving this figure a further 8 are benchmarked amber with 143 areas including England average marked as red and this is not considered a reliable method for monitoring Leicestershire's performance.

A more reliable method of comparison is to compare with performance over the previous years until 2024 there has been a continuous increase in Leicestershire's chlamydia detection rate and although 2024 is slightly lower this decrease has also been seen in the east midlands and nationally.

- While Leicestershire's Chlamydia screening proportion is not significantly different to the England average it is worse than the East Midlands average. However, all areas have seen a circa a 2% dip in these figures. Increase in screening offered required.
- Note increasing trend in New STI diagnoses – although we remain significantly better than England (and the East Midlands) for new STI diagnoses rates we are encouraging an increase in the STI testing rates and as such this may see diagnoses increase.
- Although Leicestershire remain significantly worse than England there is an increasing trend in the HIV testing rate per 100,000. In line with national trends GBMSM have the highest rates of testing, while heterosexual men and women remain far lower. In Leicestershire there has been year on year increases in the HIV testing rates across most age groups, but a downturn seen in 15-24 years bracket. Aiming to continue increasing trend and encourage increase in HIV testing across the board.
- Although HIV prevalence is low in Leicestershire HIV late diagnosis has been benchmarked above goal for the last two data collection periods. With highest late diagnosis rates in Heterosexual men and rising in heterosexual and bisexual women. This should be linked to increasing HIV testing coverage and promotion of testing in these groups.
- HPV Vaccination Coverage is benchmarked amber however Leicestershire has better proportion of vaccinations than England and East Midlands.
- Total prescribed LARC excluding injections rate/1,000 is not significantly different to England and notes and increasing positive trend.
- The Under 18s Conception rate /1,000 is not significantly different to England however numbers are increasing slightly – Focus on the Sexual Health system supported by strategic plan to ensure contraceptive services are accessible and youth friendly

Tuberculosis (TB)

50. Tuberculosis (TB) remains an important health protection issue because it is preventable and treatable, though it is strongly linked to deprivation and can involve complex clinical and social circumstances. In England, provisional data for 2025 indicates TB notifications were broadly stable compared with 2024, and TB remains more common in large urban areas and among populations experiencing disadvantage.
51. Variation across place: TB burden is not evenly distributed locally. Leicestershire generally experiences lower TB incidence than the England average, while Leicester City has substantially higher rates than England overall. TB is disproportionately associated with social determinants and inclusion health factors (for example, homelessness, substance use, contact with the criminal justice system, and insecure housing), and with some long-term conditions that increase risk of progression from latent infection to active disease.
52. TB services for Leicester, Leicestershire and Rutland are delivered via a comprehensive multidisciplinary service hosted by University Hospitals of Leicester, with respiratory care delivered at Glenfield and infectious diseases services at the Royal Infirmary. Targeted approaches for prevention are supported through national guidance (including TB diagnosis, screening and LTBI pathways) and local partnership working.

Key issues for 2026 (TB)

- Maintain a system focus on earlier TB recognition and referral, and timely LTBI assessment/treatment for eligible cohorts; strengthen primary–secondary communication to minimise avoidable delay.
- Continue targeted approaches for groups at higher risk of TB, including culturally appropriate engagement and strengthened partnership working to address wider determinants
- Use national and local communications resources (e.g., World TB Day messaging) to support symptom awareness and timely testing, particularly for groups at higher risk.

Healthcare Associated Infections

53. Many healthcare associated infections (HCAI) are preventable. When they do occur, they can have a significant impact on patients and on the wider NHS and care systems.

Organisational Roles/Responsibilities

54. The NHS Outcomes Framework (NHS OF) is a set of indicators developed by the Department of Health and Social Care (DHSC) to provide a framework in which to measure and monitor how well the NHS is performing. NHS England hold local ICBs to account for performance against indicators under this domain.
55. UKHSA, through its consultants in communicable disease control, will lead the epidemiological investigation and the specialist health protection response to HCAI outbreaks and has responsibility to declare a health protection incident. UKHSA monitors the number of HCAs through routine surveillance and the spread of antibiotic-resistant infections.
56. The local authority, through the Director of Public Health has overall responsibility for the strategic oversight of a HCAI impacting on their population's health. See Appendix 8 for information about Healthcare Associated Infections Incidence in LLR for January- December 2024.
57. Although Leicestershire County and Rutland breached their nationally set thresholds (2024-25) for E. coli, Klebsiella spp, Pseudomonas and MRSA, the following comparators highlight that the entire LLR system was green RAG rated against overall national and peer recommended system rates, for all alert organisms. As a system LLR was not considered an outlier for alert organism infection rates in 2024-25, when compared to national averages and other comparable systems with similar size and demographics.
- **Clostridioides difficile (C. diff):** Overall C. diff rates for LLR were green RAG rated in the 2nd best performing quartile.
 - Total Community-Onset Community-Associated rates (COCA), female COCA rates and female Healthcare-Onset Healthcare-Associated (HOHA) rates were **red** RAG rated in the 3rd quartile.
 - **MRSA/ MSSA:** Overall LLR rate for MRSA bacteraemias was **green** RAG rated in the 1st quartile.
 - Overall rate for MSSA was **green** RAG rated in the 1st quartile (best performing).
 - **E. coli:** Overall E. coli rates are **green** RAG rated in the 1st quartile.
 - Female Community-Onset Healthcare-Associated (COHA) rates were **red** RAG rated in the 3rd quartile.
 - **Klebsiella spp:** Overall Klebsiella cases were **green** RAG rated in the 2nd best performing quartile.
 - Total COHA and female HOHA rates were **red** RAG rated in the 3rd quartile.

- Female COHA rates were **red** RAG rated in the 4th Quartile.
- **Pseudomonas aeruginosa:** Overall Pseudomonas rates in LLR are **green** RAG rated in the lowest quartile.
 - Total COHA rates were **red** RAG rated in the 3rd quartile.

58. LLR ICS Partner IPC Teams (including ICB, Trusts, Independent Providers and Local Authorities) monitored and reviewed local infection rates, investigated relevant infectious incidents and outbreaks and shared learning outcomes with relevant teams, providing local IPC support where required.

59. LLR ICS Partners attended regular system IPC meetings to share updates, review IPC practices and develop an aligned system response where possible. The LLR home-visiting service continued to support the urgent system response for local infectious outbreaks and incidents. The service continues to be reviewed and amended according to local clinical developments.

60. National, regional and local updates to IPC guidance, along with IPC toolkits and resources were cascaded to relevant health and social care providers by local IPC Teams

Key issues for 2026 (HCAI)

61. An LLR Outbreak Framework was developed by ICS Partners to support the local response to infectious outbreaks and incidents and is expected to be signed off for system assurance.

Emergency Planning and Response (including severe weather and environmental hazards)

62. Emergency Preparedness, Resilience and Response (EPRR) describes the arrangements to prepare for, respond to and recover from events that threaten serious damage to human welfare, including communicable disease incidents and wider environmental public health hazards. As a Category 1 responder under the Civil Contingencies Act (2004), the local authority has civil protection duties including risk assessment, emergency planning, business continuity, arrangements to warn/inform/advice the public, and co-operation and information sharing with other responders.
63. Within the local health protection system, the Council's Public Health function supports the Director of Public Health (DPH) to obtain assurance that relevant partners hold appropriate plans and capabilities and that learning from incidents/exercises is embedded
64. The local authority continues to engage with the Local Resilience Forum (LRF) in its programme of exercising, incident response and organisational learning. The Local Health Resilience Partnership (LHRP) (co-chaired by the LLR ICB and local authority Public Health) provides a strategic forum for health organisations to coordinate preparedness and planning for health emergencies at system and LRF level, and supports NHS England, local government and UKHSA to ensure member organisations maintain effective health planning arrangements for major emergencies and incidents.
65. System partners participated in pandemic preparedness exercising through a number of exercises during 2025:
- Exercise Tangra – ICB led exercise aimed to test and improve the preparedness and response capabilities of organisations in the event of a pandemic. This was a mainly health focussed exercise mandated by NHS England (NHSE) and the Department of Health and Social Care (DHSC).
 - Exercise Solaris – LRF led exercise to gain insights into how different sectors, especially local authorities, and voluntary and community sectors would coordinate a pandemic response. This was a pre-exercise for Exercise Pegasus.
 - Exercise Pegasus – a national Tier 1 pandemic preparedness exercise. The UK Government committed to a National Exercising Programme to deliver annual national exercises on a range of risks to test real-world resilience. The aim was to test the UK's ability to respond to a pandemic arising from a novel infectious disease, involving all regions, bringing together the Cabinet and every UK government department. This was a multi-agency simulation involving NHS, local authority, emergency services and voluntary sector partners to test pandemic response protocols.

Key issues for 2026 (Emergency Planning)

- Maintain clear, shared understanding across partners of major incident response structures, activation triggers, and coordination arrangements; address causes of delay identified through exercises/incidents.
- Continue to review contingency plans as appropriate according to national and local guidance and ensure further testing response arrangements.

Air Quality

66. Poor air quality is the largest environmental risk to the public's health, impacting people at all stages of life³. It affects almost every organ in the body, reducing healthy years of life and causing premature death. The Chief Medical Officer report (2022)⁴ identifies links between pollution exposure and a wide range of health impacts across the life course. Evidence shows that air pollution contributes to adverse birth outcomes, poor early lung and brain development, asthma, coronary heart disease, stroke, chronic obstructive pulmonary disease (COPD), lung cancer, diabetes, reduced cognitive performance and increased dementia risk in later life. Short-term elevations in air pollution (known as episodes) can also increase illness, hospital admissions and mortality within hours or even days of exposure⁵.
67. The risk to health across the life course disproportionately impacts certain groups within the population, such as children and young people, older adults and those who are pregnant or have long term health conditions. There are also inequalities regarding air quality exposure and social deprivation and ethnicity, with a complex relationship by pollutant. Air pollutants have no safe level for health, so it is important that we try to improve the quality of our air. People are exposed to mixtures of both indoor and outdoor pollutants throughout their daily lives, with the COVID-19 pandemic spotlighting the importance of indoor environments on health and the crucial role of ventilation in creating healthy indoor air.
68. The outdoor Air Quality and Health Needs Assessment (2024) recommendations focus on key areas for action which include routinely influencing urban design and planning across Leicestershire to improve air quality, increasing travel choices across the county and improving air pollution and health information for the public and stakeholders.
69. The Health Needs Assessment objectives inform an action plan for the Air Quality and Health Partnership (2024-28). Jointly chaired by the LCC Public Health and Environment and Transport teams. The Partnership is comprised of representatives from all district councils (with the statutory duty for monitoring air quality) and several Leicestershire County Council representatives.
70. Relationships have been maintained this year with the LLR Children and Young People Respiratory Working Group, chaired by the Integrated Care Board and to the Leicestershire Housing Respiratory Illness Project, focusing on health needs assessment of damp and mould in the home.

Key Issues for 2026 (Air Quality)

- Within Leicestershire, lower tier local authorities (district councils) have the statutory responsibility to manage local air quality. This includes a requirement to regularly conduct air quality monitoring to ensure that it meets the required standards for

³ <https://www.rcp.ac.uk/media/hvbeolvx/21072025-update-rcp-full-report-a-breath-of-fresh-air.pdf>

⁴ <https://assets.publishing.service.gov.uk/media/639aeb81e90e0721889bbf2f/chief-medical-officers-annual-report-air-pollution-dec-2022.pdf>

⁵ <https://ukhsa.blog.gov.uk/2025/06/19/what-the-evidence-says-about-interventions-to-reduce-pollution-and-improve-lives/>

certain pollutants. We have two district council air quality leads chairing two newly created subgroups of the Partnership. These new groups aim to increase focus on collective action and accountability against the Partnership action plan.

- Ensuring a strategic approach to identification of shared objectives and benefits that address various health and environmental aspects simultaneously. This is part of our Health in All Policies approach which will now be rolled out at a district level in 2026.
- Improving information to the public and key stakeholders on risk and personal impact on local air quality in a meaningful, easily accessible and understandable way, focusing on inequality groups. This is a key focus of one of the newly established subgroups and we will also link with academic partners and public representatives through our Health Determinants Research Collaboration to achieve this.

Appendix 1 – COVID-19 Cases

Covering Leicestershire 2025.

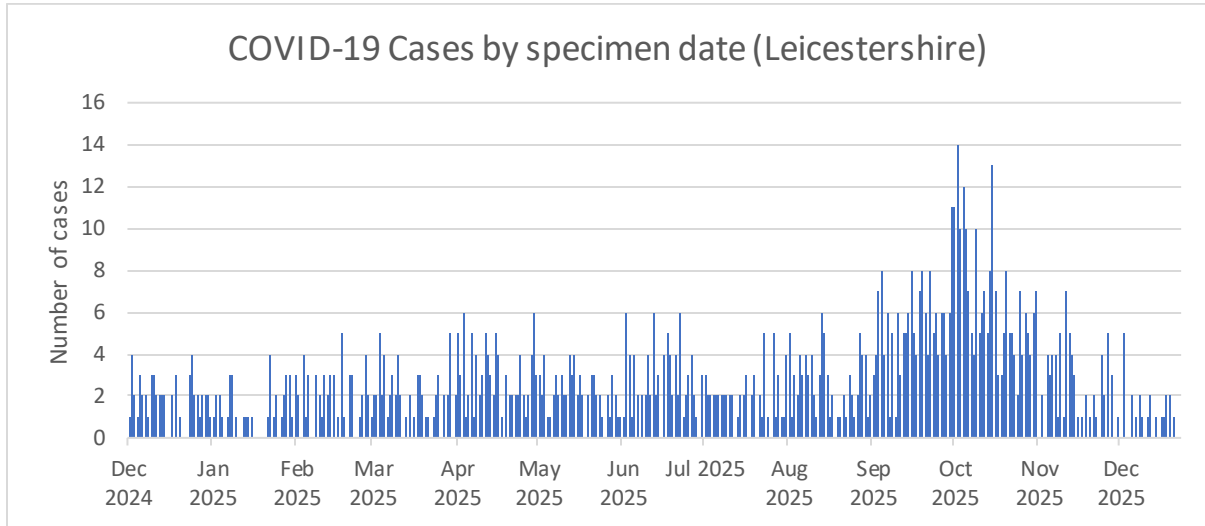


Figure 1- COVID-19 Cases in Leicestershire by Specimen Date. Source: <https://ukhsa-dashboard.data.gov.uk/respiratory-viruses/covid-19?areaType=Upper+Tier+Local+Authority&areaName=Leicestershire>

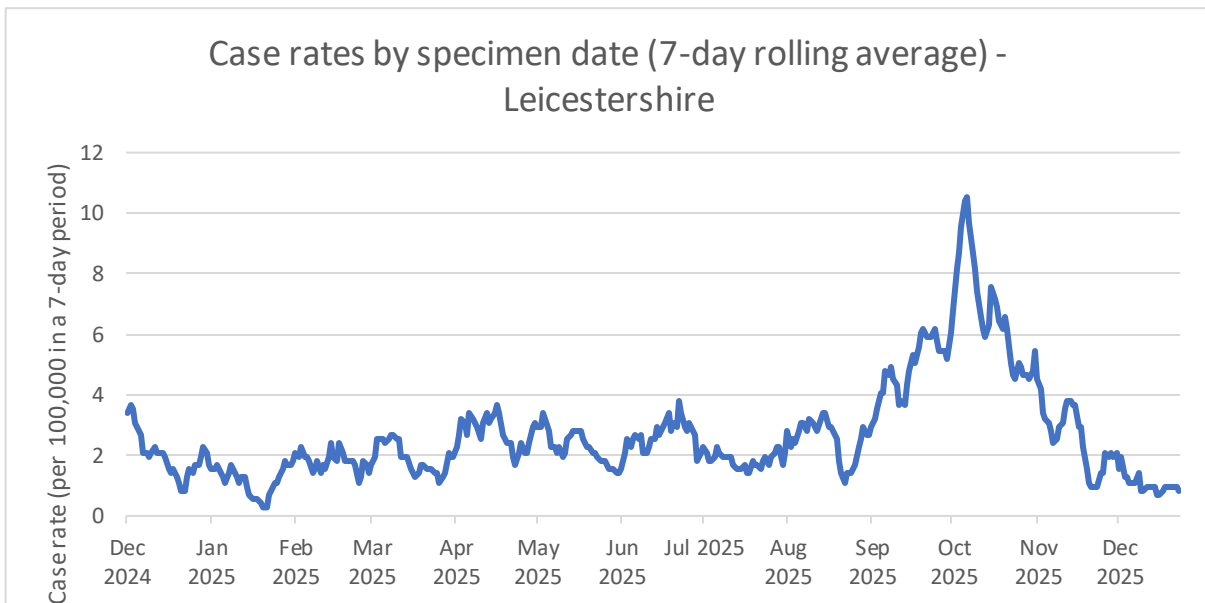


Figure 2- Case rates by specimen date (7 day rolling average) (Leicestershire). Source: <https://ukhsa-dashboard.data.gov.uk/respiratory-viruses/covid-19?areaType=Upper+Tier+Local+Authority&areaName=Leicestershire>

Appendix 2- Measles Cases

Measles cases - national

Cases by week of symptom onset

Laboratory confirmed cases of measles by week of onset of rash or symptoms reported, London and England from 1 January 2025. The data reporting lag has greatest impact on the most recent 4 weeks. Reported figures for this period are likely to underestimate activity. These data points are within the "reporting delay" period on the chart. This chart is different to the measles "cases reported" chart on the landing page. Data affected by the reporting delay is not included in the chart on the landing page.

Up to and including week beginning 8 Dec 2025

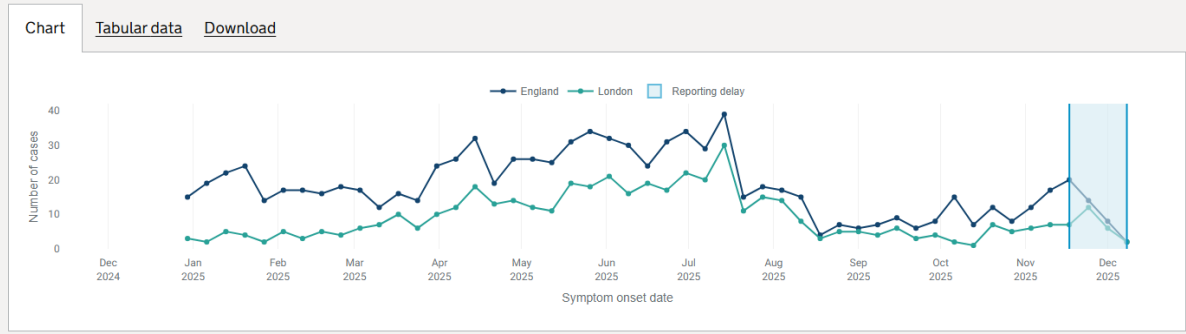


Figure 3 Source: <https://ukhsa-dashboard.data.gov.uk/vaccine-preventable-diseases/measles>

Appendix 3 - Immunisation Schedule 2025



UK Health Security Agency

Routine childhood immunisations				From January 2025
Age due	Diseases protected against	Vaccine given and trade name		Usual site ¹
Eight weeks old	Diphtheria, tetanus, pertussis (whooping cough), polio, Haemophilus influenzae type b (Hib) and hepatitis B	DTaP/IPV/Hib/HepB	Infanrix hexa or Vaxelis	Thigh
	Meningococcal group B (MenB)	MenB	Bexsero	Thigh
	Rotavirus gastroenteritis	Rotavirus	Rotarix ²	By mouth
Twelve weeks old	Diphtheria, tetanus, pertussis, polio, Hib and hepatitis B	DTaP/IPV/Hib/HepB	Infanrix hexa or Vaxelis	Thigh
	Pneumococcal (13 serotypes)	PCV	Prevenar 13	Thigh
	Rotavirus	Rotavirus	Rotarix ²	By mouth
Sixteen weeks old	Diphtheria, tetanus, pertussis, polio, Hib and hepatitis B	DTaP/IPV/Hib/HepB	Infanrix hexa or Vaxelis	Thigh
	MenB	MenB	Bexsero	Thigh
One year old (on or after the child's first birthday)	Hib and MenC	Hib/MenC	Menitorix	Upper arm/thigh
	Pneumococcal	PCV booster	Prevenar 13	Upper arm/thigh
	Measles, mumps and rubella (German measles)	MMR	MMRvaxPro ³ or Priorix	Upper arm/thigh
	MenB	MenB booster	Bexsero	Thigh
Eligible paediatric age group ⁴	Influenza (each year from September)	Live attenuated influenza vaccine LAIV	Fluenz ^{3,5}	Both nostrils
Three years four months old or soon after	Diphtheria, tetanus, pertussis and polio	dTaP/IPV	REPEVAX	Upper arm
	Measles, mumps and rubella	MMR (check first dose given)	MMRvaxPro ³ or Priorix	Upper arm
Boys and girls aged twelve to thirteen years	Cancers and genital warts caused by specific human papillomavirus (HPV) types	HPV ⁶	Gardasil 9	Upper arm
Fourteen years old (school Year 9)	Tetanus, diphtheria and polio	Td/IPV (check MMR status)	REVAXIS	Upper arm
	Meningococcal groups A, C, W and Y	MenACWY	MenQuadfi	Upper arm

- Intramuscular injection into deltoid muscle in upper arm or anterolateral aspect of the thigh.
- Rotavirus vaccine should only be given after checking for SCID screening result.
- Contains porcine gelatine.
- See annual flu letter at: www.gov.uk/government/collections/annual-flu-programme

- If LAIV (live attenuated influenza vaccine) is contraindicated or otherwise unsuitable use inactivated flu vaccine (check Green Book Chapter 19 for details).
- See Green Book chapter 18a for immunising immunocompromised young people who will need 3 doses.

Selective immunisation programmes			
Target group	Age and schedule	Disease	Vaccines required
Babies born to hepatitis B infected mothers	At birth, four weeks and 12 months old ^{1,2}	Hepatitis B	Hepatitis B (Engerix B/HBvaxPRO)
Infants in areas of the country with TB incidence $\geq 40/100,000$	Around 28 days old ⁴	Tuberculosis	BCG
Infants with a parent or grandparent born in a high incidence country ³	Around 28 days old ⁴	Tuberculosis	BCG
Children in a clinical risk group	From 6 months to 17 years of age	Influenza	LAIV or inactivated flu vaccine if contraindicated to LAIV or under 2 years of age
	At any stage of pregnancy during flu season	Influenza	Inactivated flu vaccine
	From 16 weeks gestation	Pertussis	Tdap (ADACEL)
Pregnant women	From 28 weeks gestation	RSV	RSV vaccine (Abrysvo)

- Take blood for HBsAg at 12 months to exclude infection.
- In addition hexavalent vaccine (Infanrix hexa or Vaxelis) is given at 8, 12 and 16 weeks.

- Where the annual incidence of TB is $\geq 40/100,000$ – see www.gov.uk/government/publications/tuberculosis-tb-by-country-rates-per-100000-people
- Check SCID screening outcome before giving BCG.

For vaccine supply information for the childhood programme please visit portal.immform.ukhsa.gov.uk and check vaccine update for all other vaccine supply information.

Immunisation schedule 2026



The complete routine immunisation schedule

From 1 January 2026

Age due	Diseases protected against		Vaccine given and trade name		Usual site ¹
Eight weeks old	Diphtheria, tetanus, pertussis (whooping cough), polio, Haemophilus influenzae type b (Hib) and hepatitis B		DTaP/IPV/Hib/HepB	Infanrix hexa or Vaxelis	Thigh
	Meningococcal group B (MenB)		MenB	Boxero	Thigh
	Rotavirus gastroenteritis		Rotavirus ²	Rotarix ²	By mouth
Twelve weeks old	Diphtheria, tetanus, pertussis, polio, Hib and hepatitis B		DTaP/IPV/Hib/HepB	Infanrix hexa or Vaxelis	Thigh
	MenB		MenB	Boxero	Thigh
	Rotavirus		Rotavirus ²	Rotarix ²	By mouth
Sixteen weeks old	Diphtheria, tetanus, pertussis, polio, Hib and hepatitis B		DTaP/IPV/Hib/HepB	Infanrix hexa or Vaxelis	Thigh
	Pneumococcal (13 serotypes)		PCV	Prevenar 13	Thigh
One year old (on or after the child's first birthday)	Pneumococcal MenB Measles, mumps, rubella, varicella		PCV/ MenB MMRV	Prevenar 13 Boxero ProQuad or Priorix Tetra	Upper arm or thigh
Eighteen months old	Born on or after 1 July 2024 Diphtheria, tetanus, pertussis, polio, Hib and hepatitis B Measles, mumps, rubella, varicella	Born on or before 30 June 2024 No appointment	DTaP/IPV/Hib/HepB MMRV	Infanrix hexa or Vaxelis ProQuad or Priorix Tetra	Upper arm or thigh
	Born on or after 1 January 2025 Diphtheria, tetanus, pertussis and polio	Born on or before 31 December 2024 Diphtheria, tetanus, pertussis and polio Measles, mumps, rubella, varicella	dTaP/IPV MMRV	REPEVAX ProQuad or Priorix Tetra	Upper arm
Boys and girls aged twelve to thirteen years	Cancers and genital warts caused by specific human papillomavirus (HPV) types		HPV	Gardasil 9	Upper arm
Fourteen years old (school Year 9)	Tetanus, diphtheria and polio		Td/IPV (check MMR status)	REVAXIS	Upper arm
	Meningococcal groups A, C, W and Y		MenACWY	MenQuadfi	Upper arm
65 years old	Pneumococcal (23 or 20 serotypes)		Pneumococcal polysaccharide vaccine (PPV23) or Pneumococcal conjugate vaccine (PCV20) once PPV23 stock exhausted	Pneumovax 23 Prevenar 20	Upper arm
65 years of age and older	Influenza (each year from September)		Inactivated influenza vaccine	Multiple	Upper arm
Individuals turning 65 from 1 Sept each year (commencing 1 Sept 2023 onwards)	Shingles		Shingles vaccine	Shingrix	Upper arm
70 to 79 years of age (and those severely immunosuppressed over 18 years of age)	Shingles		Shingles vaccine	Shingrix	Upper arm
75 years of age	Respiratory syncytial virus (RSV)		RSV vaccine	Abrysvo	Upper arm

Eligible paediatric age group See annual flu letter at: www.gov.uk/government/collections/annual-flu-programme	Influenza (each year from September)	Live attenuated influenza vaccine (LAIV) • If LAIV is contraindicated or otherwise unsuitable use inactivated flu vaccine (check Green Book Chapter 19 for details)	Fluenz (Contains porcine gelatine)	Both nostrils
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1. Intramuscular injection into deltoid muscle in upper arm or anterolateral aspect of the thigh.

2. Rotavirus vaccine should only be given after checking for SCID screening result.



For vaccine supply information for the routine immunisation schedule please visit portal.immform.ukhsa.gov.uk and check Vaccine Update for all other vaccine supply information: www.gov.uk/government/collections/vaccine-update

immunisation

The safest way to protect children and adults



Selective immunisation programmes

Target group	Age and schedule	Disease	Vaccines required
Babies born to women with hepatitis B infection ^{1,2}	At birth, four weeks • if born before 1 July 2024 give additional dose at one year ¹	Hepatitis B	Hepatitis B (Engerix B/HBvaxPRO)
Infants in areas of the country with TB incidence >= 40/100,000	Within 28 days of birth ⁴	Tuberculosis	BCG
Infants with a parent or grandparent born in a high incidence country ³	Within 28 days of birth ⁴	Tuberculosis	BCG
Children in a clinical risk group	Age under 2 years • if first ever flu vaccine give second dose at 4 weeks	Influenza	Inactivated flu vaccine
	Aged 2-8 years • if first ever flu vaccine give second dose at 4 weeks		LAV (Fluenz) • if LAV contraindicated or otherwise unsuitable give inactivated flu
	Aged 9-17 years • only one dose required each flu season		LAV (Fluenz) • if LAV contraindicated or otherwise unsuitable give inactivated flu
Pregnant women	At any stage of pregnancy during flu season	Influenza	Inactivated flu vaccine
	From 16 weeks gestation ⁵	Pertussis	Tdap (ADACEL) The vaccine given also provides protection against tetanus and diphtheria
	From 28 weeks gestation	RSV	RSV vaccine (Abrysvo)

1. Take blood for HBsAg on or after 12 months to exclude infection. For children born on or after 1 July 2024, test anytime between 12 and 18 months.
2. In addition hepatitis vaccine (Infanrix hexa or Vaxelis) is given at 8, 12 and 16 weeks and, for children born on or after 1 July 2024, also at 18 months.

3. Where the annual incidence of TB is >= 40/100,000 – see www.gov.uk/government/publications/tuberculosis-1b-by-country-rates-per-100000-people
4. Check SCID screening outcome before giving BCG.
5. Ideally before 32 weeks gestation but may still be given after 32 weeks.

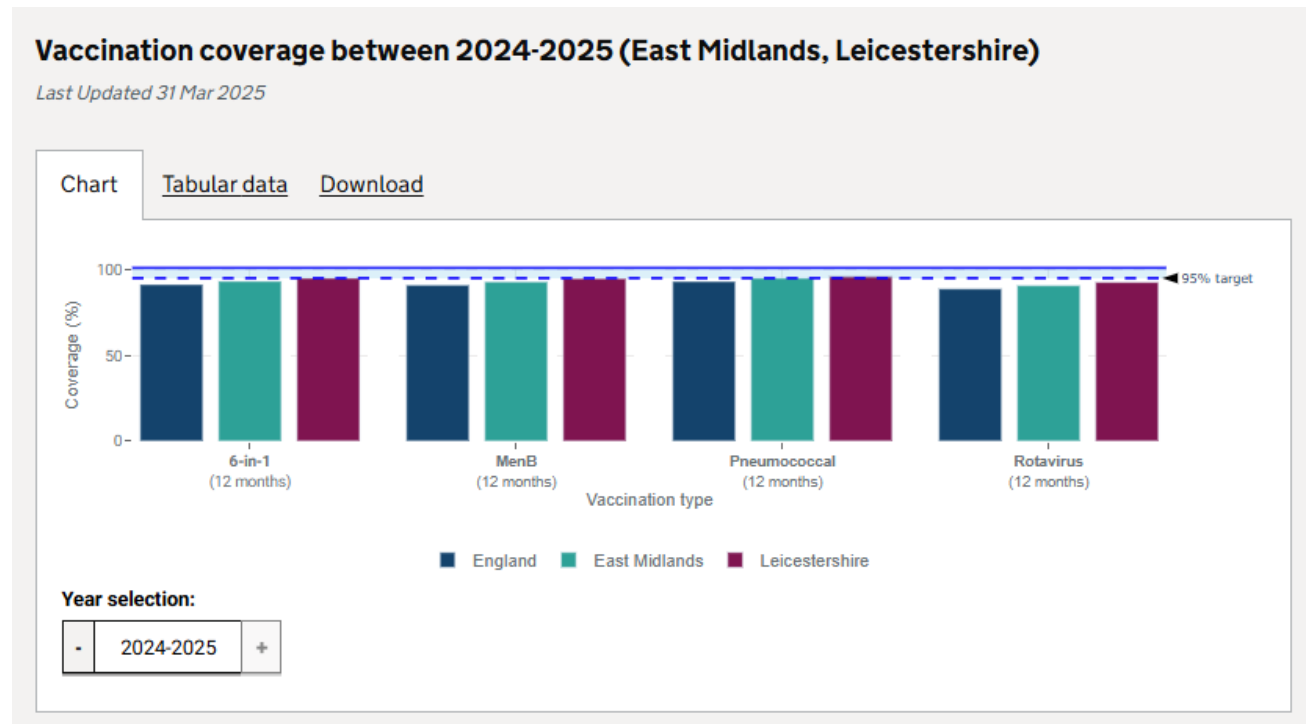
Additional vaccines for individuals with underlying medical conditions

Medical condition (see Green Book for full details)	Diseases protected against	Vaccines required ¹
Asplenia or splenic dysfunction (this also includes individuals with coeliac disease who are diagnosed with splenic dysfunction and all haemoglobinopathies including homozygous sickle cell disease)	Meningococcal groups A, B, C, W and Y Pneumococcal Influenza	MenACWY MenB PCV13 (PCV20 once available) (up to 2 years of age) ² PPV23 (PCV20 once PPV23 stocks exhausted) (from 2 years of age) ² Annual flu vaccine
Complement disorders (including those receiving complement inhibitor therapy)		
Cochlear implants	Pneumococcal	PCV13 (up to 2 years of age) ² PPV23 (PCV20 once PPV23 stocks exhausted) (from 2 years of age) ²
Chronic respiratory and heart conditions (such as severe asthma, chronic pulmonary disease, and heart failure)	Pneumococcal Influenza	PCV13 (up to 2 years of age) ² PPV23 (PCV20 once PPV23 stocks exhausted) (from 2 years of age) ²
Chronic neurological conditions	Pneumococcal (only if the individual is also at increased risk of aspiration) Influenza	PCV13 (up to 2 years of age) ² PPV23 (PCV20 once PPV23 stocks exhausted) (from 2 years of age) ² Annual flu vaccine
Diabetes	Pneumococcal Influenza	PCV13 (up to 2 years of age) ² PPV23 (PCV20 once PPV23 stocks exhausted) (from 2 years of age) ² Annual flu vaccine
Chronic kidney disease (CKD) (including haemodialysis)	Pneumococcal (stage 4 and 5 CKD) Influenza (stage 3, 4 and 5 CKD) Hepatitis B (stage 4 and 5 CKD)	PCV13 (up to 2 years of age) ² PPV23 (PCV20 once PPV23 stocks exhausted) (from 2 years of age) ² Annual flu vaccine Hepatitis B
Chronic liver conditions	Pneumococcal Influenza Hepatitis A Hepatitis B	PCV13 (up to 2 years of age) ² PPV23 (PCV20 once PPV23 stocks exhausted) (from 2 years of age) ² Annual flu vaccine Hepatitis A Hepatitis B
Haemophilia	Hepatitis A Hepatitis B	Hepatitis A Hepatitis B
Immunosuppression due to disease or treatment	Pneumococcal Influenza	PCV13 (up to 2 years of age) ² PPV23 (PCV20 once PPV23 stocks exhausted) (from 2 years of age) ² Annual flu vaccine ³
Severe immunosuppression	Pneumococcal Shingles vaccine Influenza	PCV13 (PCV20 once available) (up to 2 years) ² PPV23 (PCV20 once PPV23 stocks exhausted) (from 2 years of age) ² Annual flu vaccine ³ Shingrix – from 18 years of age ⁴

1. Check relevant chapter of the Green Book for specific schedule: www.gov.uk/government/collections/immunisation-against-infectious-disease-the-green-book
2. Refer to the Green Book Pneumococcal chapter for the number and timing of doses for these individuals

3. Also consider annual influenza vaccination for household members and those who care for these individuals.
4. Check Green Book Shingles Chapter www.gov.uk/government/publications/shingles-herpes-zoster-the-green-book-chapter-28a

Appendix 4 - Vaccination Coverage

**Vaccination coverage by vaccine type - (East Midlands, Leicestershire)**

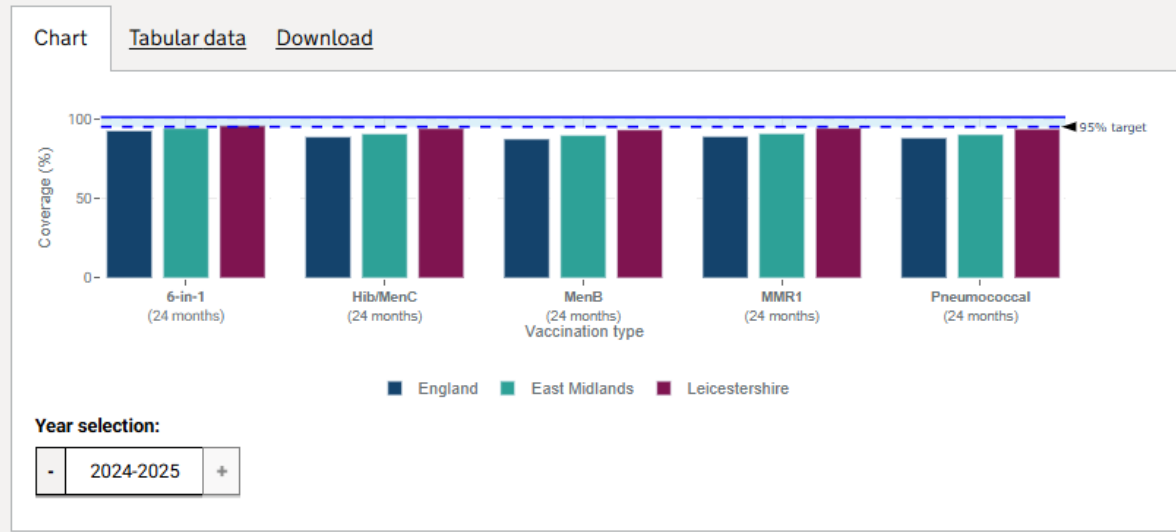
Up to and including 31 March 2025

Location	6-in-1 (12 months)	MenB (12 months)
England	91.30	91.00
East Midlands	93.20	92.90
Leicestershire	95.00	94.80

Location	Pneumococcal (12 months)	Rotavirus (12 months)
England	93.10	88.80
East Midlands	95.00	90.70
Leicestershire	96.10	92.60

Vaccination coverage between 2024-2025 (East Midlands, Leicestershire)

Last Updated 31 Mar 2025



[Chart](#) [Tabular data](#) [Download](#) [Hide filters](#)

Vaccination coverage by vaccine type - (East Midlands, Leicestershire)

Up to and including 31 March 2025

Location	6-in-1 (24 months)	Hib/MenC (24 months)
England	92.50	88.60
East Midlands	94.00	90.50
Leicestershire	95.80	93.90

Location	MenB (24 months)	MMR1 (24 months)
England	87.30	88.90
East Midlands	89.60	90.70
Leicestershire	93.10	94.10

Location	Pneumococcal (24 months)
England	88.00
East Midlands	90.10
Leicestershire	93.60

[Back to top](#)

Last Updated 31 Mar 2025

Hide filters

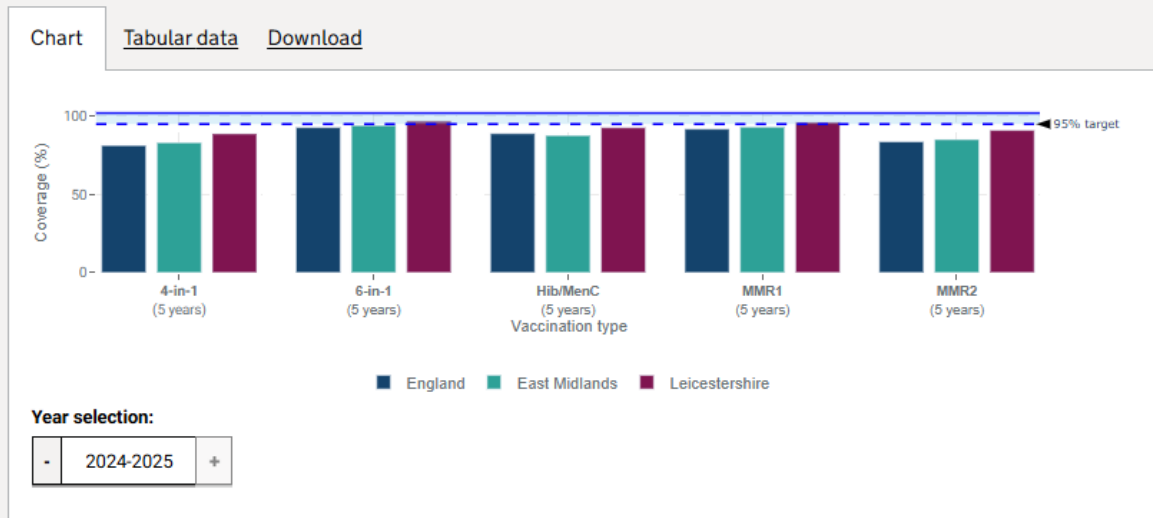


Chart [Tabular data](#) [Download](#)

Vaccination coverage by vaccine type - (East Midlands, Leicestershire)

Up to and including 31 March 2025

Location	4-in-1 (5 years)	6-in-1 (5 years)
England	81.30	92.80
East Midlands	83.10	94.10
Leicestershire	88.80	97.00

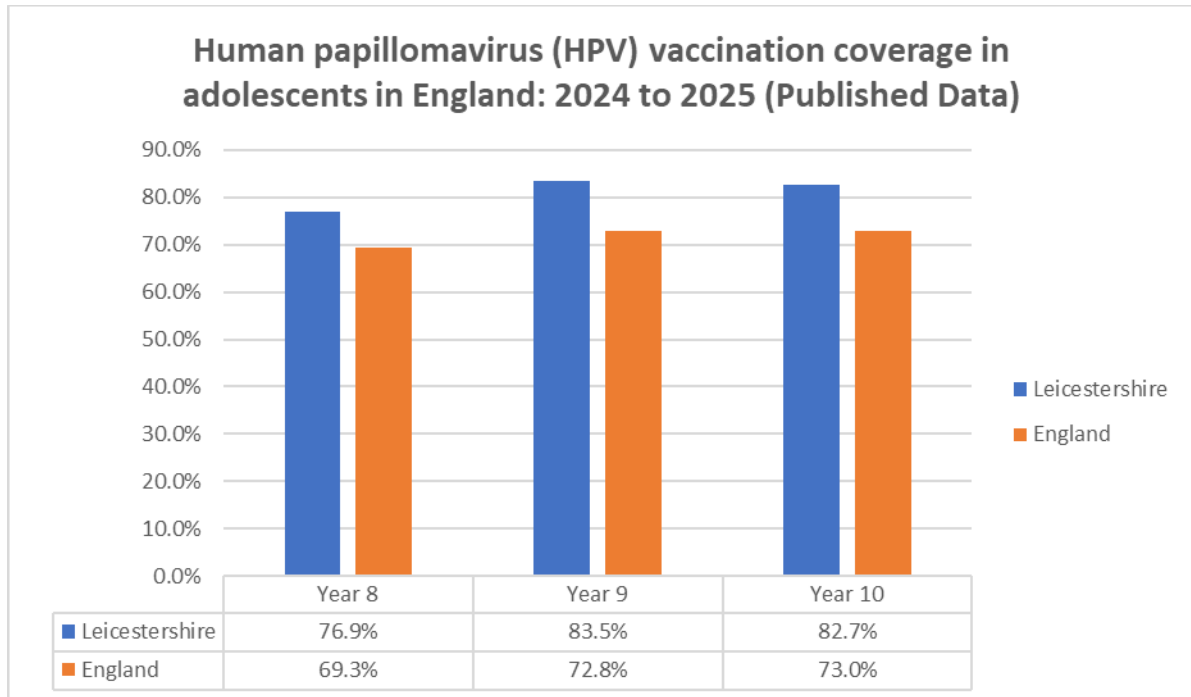
Location	Hib/MenC (5 years)	MMR1 (5 years)
England	88.90	91.80
East Midlands	87.70	93.10
Leicestershire	92.70	96.20

Location	MMR2 (5 years)
England	83.70
East Midlands	85.10
Leicestershire	91.00

HPV Uptake

Human papillomavirus (HPV) vaccination coverage in adolescents in England: 2024 to 2025 (Published Data)

Source: <https://www.gov.uk/government/statistics/human-papillomavirus-hpv-vaccine-coverage-in-england-2024-to-2025>

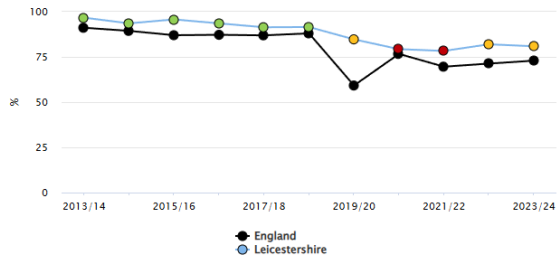


Population vaccination coverage: HPV vaccination coverage for one dose (12 to 13 year old) (Female)

Proportion - %

[Show confidence intervals](#) [Show 99.8% CI values](#)

[More options](#)



Recent trend: ➔ No significant change

Benchmarking against goal: <80% 80% to 90% ≥90%

Period		Leicestershire			England
		Count	Value	95% Lower CI / 95% Upper CI	
2013/14	●	3,510	96.7%	96.1% / 97.2%	91.1%
2014/15	●	3,419	93.5%	92.7% / 94.3%	89.4%
2015/16	●	3,426	95.7%	95.0% / 96.3%	87.0%
2016/17	●	3,561	93.5%	92.7% / 94.3%	87.2%
2017/18	●	3,584	91.4%	90.5% / 92.2%	86.9%
2018/19	●	3,734	91.5%	90.6% / 92.3%	88.0%
2019/20	●	3,440	84.7%	83.6% / 85.8%	59.2%
2020/21	●	3,219	79.3%	78.0% / 80.5%	76.7%
2021/22	●	3,170	78.3%	77.0% / 79.5%	69.6%
2022/23	●	3,487	82.0%	80.8% / 83.1%	71.3%
2023/24	●	3,656	80.9%	79.7% / 82.0%	72.9%

Source: UK Health Security Agency

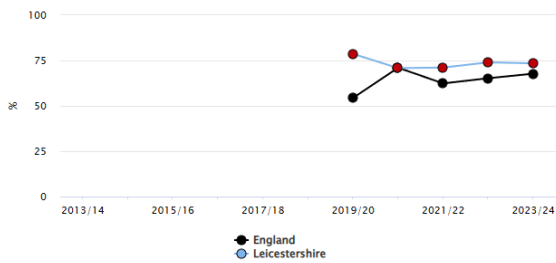
[Indicator Definitions and Supporting Information](#)

Population vaccination coverage: HPV vaccination coverage for one dose (12 to 13 year old) (Male)

Proportion - %

[Show confidence intervals](#) [Show 99.8% CI values](#)

[More options](#)



Recent trend: ➔ No significant change

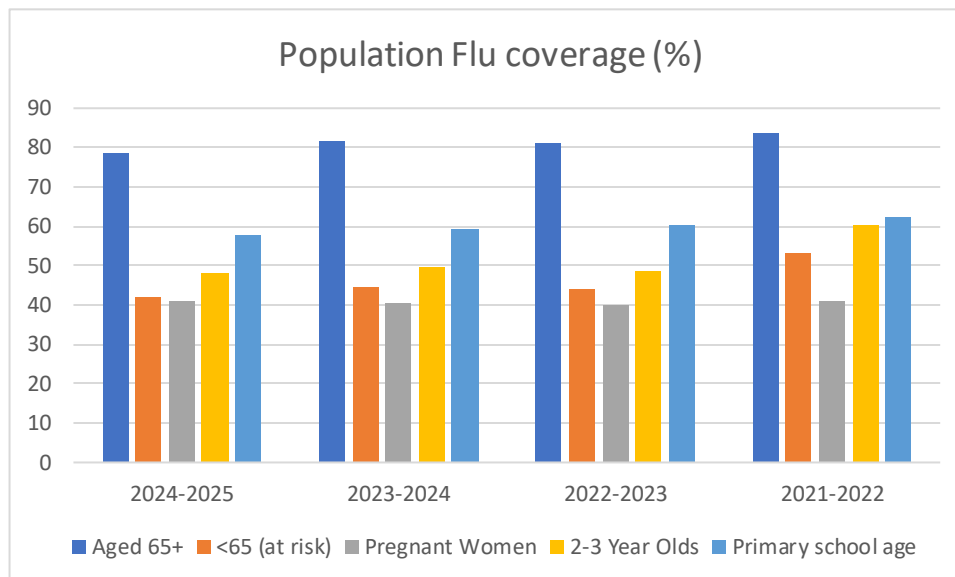
Benchmarking against goal: <80% 80% to 90% ≥90%

Period		Leicestershire			England
		Count	Value	95% Lower CI / 95% Upper CI	
2019/20	●	3,585	78.7%	77.4% / 79.8%	54.4%
2020/21	●	3,225	70.8%	69.4% / 72.1%	71.0%
2021/22	●	3,200	71.1%	69.8% / 72.4%	62.4%
2022/23	●	3,370	74.0%	72.7% / 75.2%	65.2%
2023/24	●	3,349	73.4%	72.1% / 74.7%	67.7%

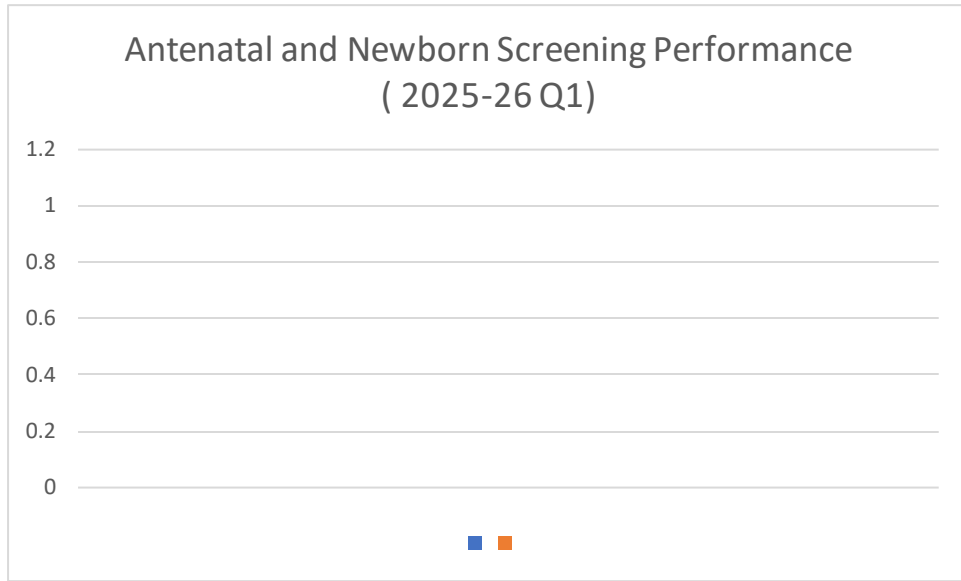
Source: UK Health Security Agency

[Indicator Definitions and Supporting Information](#)

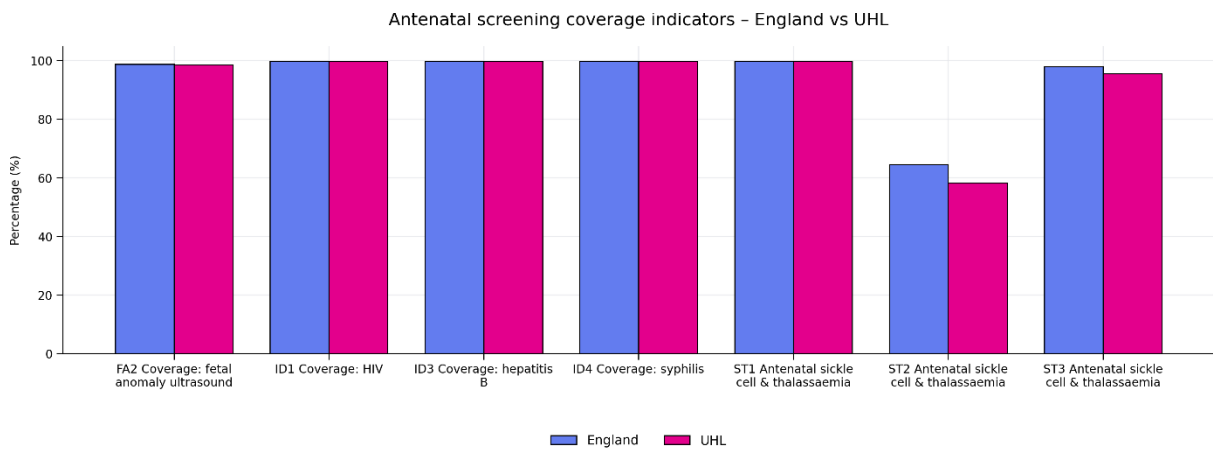
Local Authority	Population coverage (%)				
	65 and over	Under 65 (at risk)	Pregnant women	2-3 year olds	Primary school age
Leicestershire and Rutland (2024-25)	78.6	42.0	41.1	48.1	57.6
Leicestershire & Rutland (2023-24)	81.5	44.4	40.4	49.8	59.2
Leicestershire & Rutland (2022-2023)	81.2	44.0	39.8	48.9	60.3
Leicestershire & Rutland (2021-2022)	83.6	53.2	40.8	60.4	62.3
England (2024-25)	74.9	40.0	35.0	44.4	54.5
Target	75	55	55	48	48



Appendix 5- Screening



Data source: NB1: CHIS
 NH1/ NH2: SMaRT4Hearing (S4H)



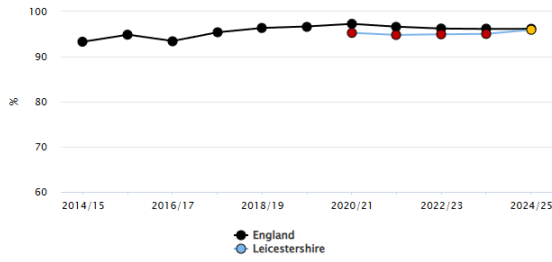
Data source: Maternity service, University Hospital of Leicester (Q1 2025-26)

Newborn and Infant Physical Examination Screening Coverage New data

Proportion - %

[Show confidence intervals](#) [Show 99.8% CI values](#)

[More options](#)



Recent trend: ➔ No significant change

Period	Leicestershire				England
	Count	Value	95% Lower CI	95% Upper CI	
2014/15	-	-	-	-	93.3%
2015/16	-	-	-	-	94.9%
2016/17	-	-	-	-	93.5%
2017/18	-	-	-	-	95.4%*
2018/19	-	-	-	-	96.4%*
2019/20	-	-	-	-	96.7%*
2020/21	6,108	95.3%	94.7%	95.8%	97.3%*
2021/22	6,413	94.8%	94.3%	95.3%	96.6%*
2022/23	6,141	95.0%	94.4%	95.5%	96.2%*
2023/24	6,024	95.0%	94.5%	95.6%	96.1%*
2024/25	5,943	96.0%	95.4%	96.4%	96.2%*

Source: NHS England, Newborn and Infant Physical Examination Programme

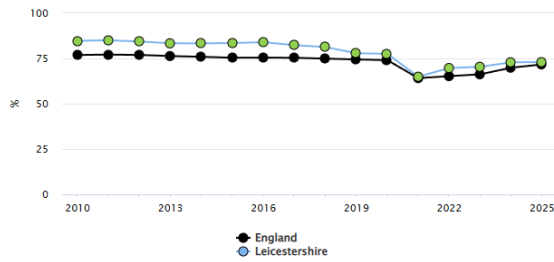
[Indicator Definitions and Supporting Information](#)

Cancer screening coverage: breast cancer New data

Proportion - %

[Show confidence intervals](#) [Show 99.8% CI values](#)

[More options](#)



Recent trend: ↑ Increasing & getting better

Period	Leicestershire				England
	Count	Value	95% Lower CI	95% Upper CI	
2010	60,144	84.7%	84.5%	85.0%	76.9%
2011	61,345	85.0%	84.8%	85.3%	77.1%
2012	62,071	84.3%	84.1%	84.6%	76.9%
2013	62,538	83.4%	83.1%	83.6%	76.3%
2014	63,494	83.3%	83.1%	83.6%	75.9%
2015	64,635	83.5%	83.3%	83.8%	75.4%
2016	65,830	84.0%	83.7%	84.2%	75.5%
2017	65,681	82.3%*	82.1%	82.6%	75.4%*
2018	65,442	81.3%*	81.1%	81.6%	74.9%*
2019	63,176	77.9%*	77.6%	78.2%	74.5%*
2020	63,580	77.6%*	77.3%	77.8%	74.1%*
2021	53,683	64.9%*	64.6%	65.2%	64.1%*
2022	58,666	69.7%*	69.4%	70.0%	65.2%*
2023	60,306	70.4%*	70.1%	70.7%	66.2%*
2024	63,512	72.9%*	72.6%	73.2%	69.9%*
2025	64,322	73.0%*	72.7%	73.3%	71.7%*

Source: NHS England, Breast Screening Programme

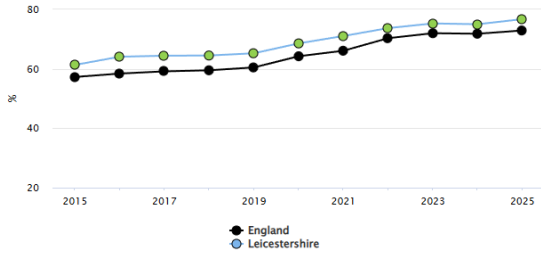
[Indicator Definitions and Supporting Information](#)

Cancer screening coverage: bowel cancer New data

Proportion - %

[Show confidence intervals](#) [Show 99.8% CI values](#)

[More options](#)



Recent trend: ↑ Increasing & getting better

Period		Count	Value	Leicestershire		England
				95% Lower CI	95% Upper CI	
2015	●	70,211	61.3%*	61.0%	61.6%	57.3%*
2016	●	74,804	64.1%*	63.8%	64.3%	58.4%*
2017	●	76,582	64.4%*	64.2%	64.7%	59.2%*
2018	●	77,877	64.5%*	64.2%	64.8%	59.5%*
2019	●	79,490	65.2%*	65.0%	65.5%	60.5%*
2020	●	84,159	68.6%*	68.3%	68.8%	64.2%*
2021	●	88,706	71.1%*	70.8%	71.3%	66.1%*
2022	●	92,484	73.7%*	73.5%	73.9%	70.3%*
2023	●	95,187	75.3%*	75.0%	75.5%	72.0%*
2024	●	95,962	75.0%*	74.8%	75.3%	71.8%*
2025	●	99,619	76.7%*	76.5%	77.0%	72.9%*

Source: NHS England, Bowel Cancer Screening Programme

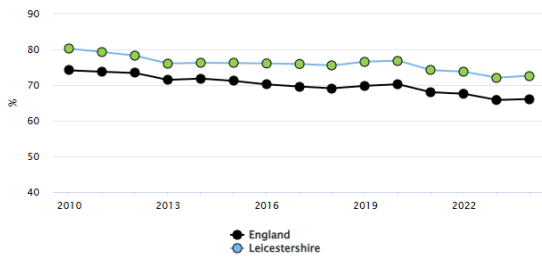
[Indicator Definitions and Supporting Information](#)

Cancer screening coverage: cervical cancer (aged 25 to 49 years old)

Proportion - %

[Show confidence intervals](#) [Show 99.8% CI values](#)

[More options](#)



Recent trend: ↓ Decreasing & getting worse

Period		Count	Value	Leicestershire		England
				95% Lower CI	95% Upper CI	
2010	●	85,670	80.2%*	80.0%	80.5%	74.1%*
2011	●	84,523	79.3%*	79.0%	79.5%	73.7%*
2012	●	83,367	78.2%*	78.0%	78.5%	73.4%*
2013	●	81,016	76.1%*	75.8%	76.3%	71.5%*
2014	●	81,026	76.2%*	76.0%	76.5%	71.8%*
2015	●	81,134	76.2%*	75.9%	76.4%	71.2%*
2016	●	81,680	76.1%*	75.8%	76.3%	70.2%*
2017	●	82,249	75.9%*	75.7%	76.2%	69.6%*
2018	●	83,086	75.5%*	75.3%	75.8%	69.1%*
2019	●	85,157	76.6%*	76.3%	76.8%	69.8%*
2020	●	86,424	76.9%*	76.6%	77.1%	70.2%*
2021	●	83,910	74.2%*	73.9%	74.4%	68.0%*
2022	●	85,050	73.8%*	73.5%	74.0%	67.6%*
2023	●	84,341	72.1%*	71.8%	72.3%	65.8%*
2024	●	86,483	72.6%*	72.4%	72.9%	66.1%*
2025	●	86,483	72.6%*	72.4%	72.9%	66.1%*

Source: NHS England, Cervical Screening Programme

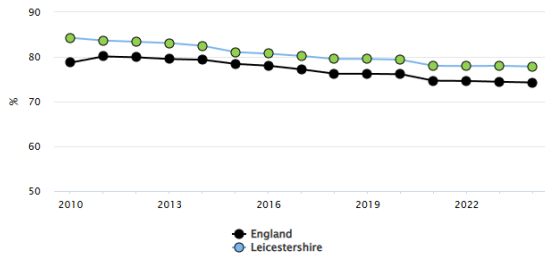
[Indicator Definitions and Supporting Information](#)

Cancer screening coverage: cervical cancer (aged 50 to 64 years old)

Proportion - %

[Show confidence intervals](#) [Show 99.8% CI values](#)

[More options](#)



Recent trend: ▼ Decreasing & getting worse

Period		Leicestershire				England
		Count	Value	95% Lower CI	95% Upper CI	
2010	●	44,669	84.3%*	84.0%	84.6%	78.7%*
2011	●	45,235	83.6%*	83.3%	84.0%	80.1%*
2012	●	45,548	83.4%*	83.1%	83.7%	79.9%*
2013	●	45,913	83.1%*	82.8%	83.4%	79.5%*
2014	●	46,243	82.5%*	82.2%	82.8%	79.4%*
2015	●	46,448	81.1%*	80.7%	81.4%	78.4%*
2016	●	47,513	80.7%*	80.4%	81.0%	78.0%*
2017	●	48,363	80.2%*	79.9%	80.5%	77.2%*
2018	●	49,054	79.5%*	79.2%	79.9%	76.2%*
2019	●	50,309	79.5%*	79.2%	79.9%	76.2%*
2020	●	51,456	79.4%*	79.1%	79.7%	76.1%*
2021	●	51,857	78.0%*	77.7%	78.3%	74.7%*
2022	●	52,995	78.0%*	77.6%	78.3%	74.6%*
2023	●	53,835	78.0%*	77.7%	78.3%	74.4%*
2024	●	54,247	77.9%*	77.5%	78.2%	74.3%*

Source: NHS England, Cervical Screening Programme

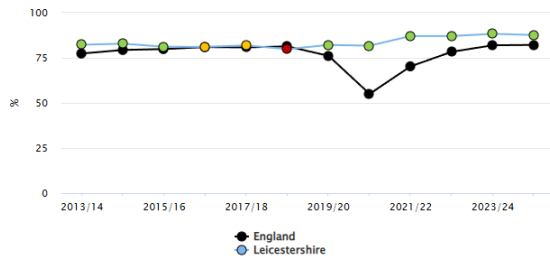
[Indicator Definitions and Supporting Information](#)

Abdominal Aortic Aneurysm Screening Coverage New data

Proportion - %

[Show confidence intervals](#) [Show 99.8% CI values](#)

[More options](#)



Recent trend: ▲ Increasing & getting better

Period		Leicestershire				England
		Count	Value	95% Lower CI	95% Upper CI	
2013/14	●	3,561	82.3%*	81.1%	83.4%	77.4%
2014/15	●	3,371	82.8%*	81.7%	84.0%	79.4%
2015/16	●	3,276	81.1%*	79.9%	82.3%	79.9%
2016/17	●	3,218	81.1%*	79.8%	82.3%	80.9%*
2017/18	●	3,340	81.9%*	80.7%	83.1%	80.8%*
2018/19	●	3,228	79.8%*	78.5%	81.0%	81.3%*
2019/20	●	3,174	82.2%*	80.9%	83.3%	76.1%*
2020/21	●	3,314	81.7%*	80.5%	82.9%	55.0%*
2021/22	●	3,597	87.1%*	86.0%	88.0%	70.3%*
2022/23	●	3,764	87.1%*	86.0%	88.0%	78.3%*
2023/24	●	3,852	88.3%*	87.3%	89.2%	81.9%*
2024/25	●	3,910	87.7%*	86.7%	88.6%	82.2%*

Source: NHS England

[Indicator Definitions and Supporting Information](#)

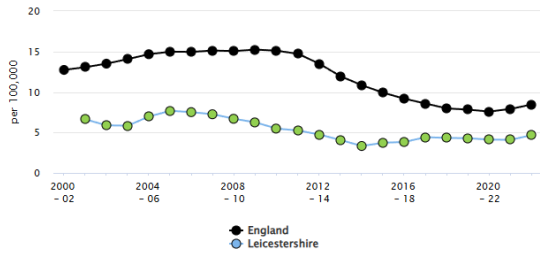
Appendix 6- TB

TB incidence (three year average)

Crude rate - per 100,000

[Show confidence intervals](#) [Show 99.8% CI values](#)

[More options](#)



Recent trend: Could not be calculated

Period	Leicestershire				England
	Count	Value	95% Lower CI	95% Upper CI	
2000 - 02	-	-	-	-	12.7
2001 - 03	122	6.6	5.5	7.9	13.1
2002 - 04	109	5.9	4.9	7.1	13.5
2003 - 05	109	5.8	4.8	7.0	14.1
2004 - 06	131	7.0	5.9	8.3	14.7
2005 - 07	145	7.7	6.5	9.0	15.0
2006 - 08	143	7.5	6.4	8.8	15.0
2007 - 09	139	7.3	6.1	8.5	15.1
2008 - 10	129	6.7	5.6	7.9	15.1
2009 - 11	121	6.2	5.2	7.4	15.2
2010 - 12	107	5.5	4.5	6.6	15.1
2011 - 13	103	5.2	4.3	6.3	14.7
2012 - 14	94	4.8	3.9	5.8	13.5
2013 - 15	81	4.1	3.3	5.0	11.9
2014 - 16	67	3.3	2.6	4.2	10.8
2015 - 17	76	3.7	3.0	4.6	9.9
2016 - 18	79	3.8	3.1	4.8	9.2
2017 - 19	92	4.4	3.6	5.4	8.6
2018 - 20	91	4.3	3.5	5.3	8.0
2019 - 21	91	4.3	3.5	5.3	7.8
2020 - 22	88	4.1	3.3	5.0	7.6
2021 - 23	89	4.1	3.3	5.0	7.9
2022 - 24	103	4.7	3.8	5.7	8.5

Source: UK Health Security Agency and Office for National Statistics

[Indicator Definitions and Supporting Information](#)

Appendix 7- Sexual Health Performance

Sexual Health Key Indicators Leicestershire	Indicator	Time period	Recent Trend	Benchmark	Value	England Value	East Mids. Value
	Syphilis diagnostic rate per 100,000	2024	→		6.7	16.5	7.5
	Gonorrhoea diagnostic rate per 100,000	2024	↑		57	124	71
	Chlamydia detection rate per 100,00- females 15-24	2024	→	<2,400 2,400 to 3,250 ≥3,250	1,564	1,589	1,775
	Chlamydia proportion in females 15-24 screened	2024	-		17.9%	18.0%	19.4%
	New STI diagnoses (excluding chlamydia under 25) per 100,000	2024	↑		237	482	313
	HIV testing rate per 100,000 population	2024	↑		2,138.0	2,842.7	2,001.0
	HIV late diagnosis in people first diagnosed with HIV in the UK	2022-2024	-	<25% 25% to 50% ≥50%	63.3%	43.3%	47.7%
	New HIV diagnosis rate per 100,000	2024	→		1.7	4.7	3.7
	HIV diagnosed prevalence rate per 1,000 aged 15-59	2024	→	<2 2 to 5 ≥5	1.18	2.40	1.92
	HPV Vaccination Coverage for one dose (12-13 year old)	2023/24	→	<80% 80%-90% ≥90%	80.9%	72.9%	71.1%
	Under 25's repeat abortions(%)	2023	→		26.0%	29.0%	27.0%
	Abortions under 10 weeks (%)	2023	↑		90.0%	89.0%	88.0%
	Total prescribed LARC excluding injections rate/1,000	2024	↑		39.0	40.0	41.6
	Under 18s Conception rate /1,000	2022	→		13.5	13.9	14.4
	Under 18's conceptions leading to abortion (5)	2022	→		72.4%	58.2%	53.6%
Violent crime – sexual offences per 1,000	2024/25	→		2.5	3.1	3.2	

DRAFT

Appendix 8- HCAI

Source: HCAI DCS Mandatory Surveillance

Organism	Total Infections for Leicestershire County (including Community-Associated).	Healthcare Associated Infections for Leicestershire County
Clostridioides difficile	207	122
MRSA	8	5
MSSA	121	47
E. coli	417	135
Klebsiella spp	136	58
Pseudomonas aeruginosa	51	27

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