University Hospitals of Leicester NHS Trust

From sickness to prevention
Making it mainstream

UHL Annual Prevention Report 2024/25

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Foreword

‘An ounce of prevention is worth a pound of cure’

The Works of Benjamin Franklin (1840), Vol 1, 134

I am proud that we have embraced our responsibility of preventing ill health in the communities we serve, as clearly outlined in our latest prevention report.

By making prevention part of our everyday work, we have prevented countless heart attacks, strokes, infections, and hundreds of other medical problems that would have affected people and families in Leicester, Leicestershire and Rutland (LLR), most often experienced by those who are the least advantaged in our society.

In taking this stance, we have actively addressed the need to improve health equity and reaped the benefits of reducing health and social care demand, to reinvest the financial savings across our services.

Good things do not happen by accident. The progress described in this report is down to determined UHL colleagues working together with the LLR Integrated Care Board (ICB), primary care providers, local authorities, and voluntary sector partners. Behind the scenes, work to enable seamless pathways of care, case finding, digital integration, and the provision of medicines and services should not be underestimated. I thank all of those involved in these achievements.

Over the next year, we hope to consolidate and expand the work described in this report, providing more people than ever before with effective interventions by improving case finding and using digital technology.

We will not stop here with our work on prevention. Frankly, we cannot afford to do so, due to the rising number of people affected by preventable medical problems. The national ambition to ‘mainstream’ prevention, as a critical pillar of the 10 Year Health Plan for England, is entirely aligned to our objectives at UHL.

Richard Mitchell
Group Chief Executive

University Hospitals of Leicester NHS Trust and
University Hospitals of Northamptonshire NHS Group

At University Hospitals of Leicester NHS Trust (UHL), we know that prevention is not optional - it is central to creating a healthcare system that is sustainable, effective, and equitable. Guided by the Government's 10 Year Health Plan, we aim to embed and amplify prevention throughout our clinical pathways and in the delivery of our organisational strategy to improve outcomes, safety, and quality of care for all.

Health inequalities are unfair and avoidable, and they impact our patients today. They are concentrated in our most vulnerable communities and are made worse by reactive systems of care. By focusing on prevention, we can direct attention and resources to those at greatest risk - narrowing gaps, improving access and delivering better outcomes.

Impactful prevention requires a truly system-wide approach, with coordinated pathways, resource allocation, and strong partnerships across organisations. It is central to the success of Neighbourhood Health. By understanding and owning our contribution, we can ensure that patients receive the right care, in the right place, at the right time, while building a more effective, efficient, and equitable healthcare system.

With this in mind, we acknowledge all our partners in the making of this report and, more importantly, the successful delivery of these services. This would be impossible without their specific contribution, be it time, expertise, or access to funding.

Through embedding prevention into routine care - including smoking cessation, alcohol support, and weight management - we help our patients to make sustainable lifestyle changes and live healthier, longer lives.

Prevention is our opportunity - and our responsibility - to transform health, reduce inequality and secure a better future for the communities we serve.

Dr Ruw Abeyratne
Director of Health Equality and Inclusion

University Hospitals of Leicester NHS Trust

UHL prevention priorities

Health inequalities continue to grow across England, with a nearly 20-year gap in healthy life expectancy between the most and least deprived areas of England[1]. These disparities are driven by a range of factors influenced by the wider determinants of health, such as income, housing, environment, and education, as well as health-related behaviours such as smoking, alcohol use, poor diet, and access to healthcare.

The current government has set out a health mission built around three transformational shifts[2]:

1. **Hospital to community**
2. **Analogue to digital**
3. **Sickness to prevention**

Their ambition is to halve the gap in healthy life expectancy between the most and least affluent areas, and to raise the healthiest generation of children ever. To achieve this, the plan outlines preventive strategies, including helping people to stop smoking, and tackling obesity and alcohol-related harm.

Major structural changes lie ahead for the NHS, including NHS England being brought back into the Department of Health and Social Care, and the introduction of ICB clusters. When these changes are combined with unprecedented financial constraints across the health service, there is the potential to distract systems from embedding prevention into everyday practice. Despite these challenges, prevention funding has been provided in long-term ICB baseline funding, there is a commitment to prevention in the 10 Year Health Plan, and prevention priorities are specified in NHS medium-term planning guidance.

At UHL, we recognise that prevention is key to reducing health inequalities, and to reducing long-term demand on our services. We are proud to be publishing our third annual prevention report, which demonstrates our ongoing commitment to prevention as an acute trust, in collaboration with system partners including the ICB, primary care providers, local authorities and the voluntary sector. This commitment is also reflected in the growing emphasis on prevention within the Trust's policies and strategic planning, as outlined in the UHL Annual Report 2024-25[3] and the UHL-UHN Group Clinical Strategy 2025-2035[4]. The commitment to prevention can be seen in NHS datasets such as the 'Model Hospital', and will be available to provide assurance in governance frameworks between commissioners and providers.

In line with the 10 Year Health Plan and the direction set out in the reports above, we recognise the importance of including a dedicated children's prevention chapter for the first time, focusing on childhood obesity. This reflects our commitment to giving every child the best start in life through early intervention and prevention.

The 2024/25 UHL prevention priorities presented in this report are:

- **Tobacco**
- **Alcohol**
- **Obesity**
- **Tuberculosis**
- **Blood-borne viruses**
- **Workforce wellbeing**
- **Childhood obesity**

Local context

Across Leicester, Leicestershire and Rutland (LLR), we serve a diverse and growing population of around 1.1 million residents, according to 2021 census data[1]. Our footprint includes some of the most culturally rich urban communities in the country, alongside more rural market towns and villages. Leicester is one of the UK's most diverse cities, and is recognised as the UK's first plural city, where no single ethnic group forms a majority. In contrast, more rural areas across Leicestershire and Rutland have challenges in terms of ageing populations, people living with multiple long-term conditions, and access issues.

This year's report will focus on UHL services. However, we acknowledge the merging of health services with the University Hospitals of Northamptonshire NHS Group to form the UHL-UHN Group, which widens our reach to around 1.9 million residents and nearly 30,000 colleagues. This brings with it huge opportunity and responsibility, as anchor institutions, to support our communities with a wide range of health needs, expectations and lived experiences.

While many communities experience relatively good health, others, particularly in parts of Leicester, face some of the highest levels of deprivation in England. Updated measures of deprivation have recently ranked Leicester as the 12th most deprived local authority in England[2].

These inequalities influence how people access and use services, with lower uptake of preventative care such as screening, vaccination and chronic disease management, and a heavier reliance on urgent and emergency pathways. Over the last 12 months, those in the 20% most deprived neighbourhoods accounted for 21% of emergency attendances, compared to only 15% of overall inpatient admissions.

As a result, people living in our most deprived neighbourhoods experience poorer health outcomes and shorter healthy life expectancy than those in less deprived areas only a few miles away. For example, women living in Rutland can expect to live up to 13 years more in good health compared to those in Leicester[3].

Over the last 12 months, UHL has provided care to:

- **286,116 emergency attendances**
- **297,323 inpatients**
- **1,024,899 outpatients.**

By embedding prevention into every interaction - whether at admission, discharge, or an outpatient appointment - we can help individuals **stay well for longer, reduce avoidable ill health and provide health equity.**

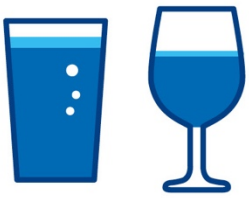
You can download the previous UHL Prevention Reports by visiting:

https://www.uhleicester.nhs.uk/publications/prevention-report-2022-23/
https://www.uhleicester.nhs.uk/publications/prevention-report-2023-24/

Prevention in numbers

297,323
Admissions across UHL this year

1,848
engaged in a smoking quit attempt



~30% fewer annual ED admissions on average
for frequent attenders following an ACT* intervention

↑64% in TB testing
since 2022/23 for migrant screening

118 new BBV (Hep B, C & HIV)
identified through the ED Opt-out BBV Screening

223 children and young people
supported to lose weight

Tobacco

Tobacco addiction is the single largest preventable cause of ill health, disability and death in the UK, and accounts for half of the health inequality gap between the most and least advantaged in society.

Local context

In Leicester, smoking remains a significant public health concern. According to 2024 Fingertip data[1], adult smoking prevalence in Leicester is 9.8% overall, but as high as 16.5% in routine and manual workers. Figures from the 2024 Leicester Health and Wellbeing Survey[2] suggest that around half of smokers express a desire to quit.

Smoking is increasingly concentrated in the most deprived communities, contributing to widening health inequalities. The difference in life expectancy between smokers and non-smokers is around 10 years, regardless of wealth[3].

At UHL, there is a tobacco dependence treatment service, made up of five in-house tobacco dependency advisors working across all three hospital sites, five days per week. They receive opt-out referrals for inpatients identified as smokers, and provide bedside support, including nicotine replacement therapy and tablet pharmacotherapy and onward referral to community smoking cessation services (Live Well and Quit Ready). They also provide training on treating tobacco addiction to UHL colleagues.

Why does it matter?

The harmful effects of tobacco are widely acknowledged. It is a major risk factor for many diseases, such as cancer, heart disease, stroke, diabetes, and COPD.

Opt-out inpatient smoking cessation services are critically important for helping people to quit smoking, and are proven to improve health equity[4]. Hospitalisation creates a unique, high-impact opportunity for intervention, as patients are more motivated to quit smoking, especially if they have been admitted for smoking-related illnesses. These services will expand as part of the NHS' 10 Year Health Plan.

Smoking cessation services offer immediate access to support at the bedside and link patients directly with community services upon discharge. Patients are 37% more likely to quit if they receive intensive hospital-based cessation support with follow-up, compared to those who don't[5].

Highlights 2024/25

Between September 2024 and August 2025, the service saw 4,186 patients, of whom **1,848 (44%) engaged with a quit attempt.**

- The team saw 5% more inpatients compared to the previous year, which resulted in a **9% increase in quit attempts.**

Characteristics of those referred to the service are:

- **Male** (62%)
- **White British** (68%)
- **More deprived background** – 39% were in Index of Multiple Deprivation (IMD) deciles 1-3, with those in the most deprived decile accounting for 16% of referrals.

Of those that were seen, **just under half engaged in a quit attempt across all IMD deciles** (42-50%).

Team highlights include:

- **Team expansion** - this year, the team included an additional tobacco dependency advisor (funded by Leicester City Council), and an acting consultant in public health, to push forward quality improvement work
- **Introduction of varenicline** - the service is now able to offer varenicline alongside cytisine, another stop smoking tablet medication. Good partnership work across organisations allows patients to receive the full 12 weeks of varenicline from UHL as part of their discharge
- **Improved data collection** - the service is now texting patients to see how their quit attempt is going five to six weeks after their admission. As a result, the service is now recording approximately 50% more quits than in previous years
- **Innovation funding to expand outpatient referrals** - The service has received innovation funding from NHS Midlands to expand the existing outpatient referrals from lung cancer clinics to community stop smoking services. This funding has also allowed the team to expand into the Emergency Department (ED). Between July and November 2025, 681 referrals were made from ED to the services

Using the ASH Tobacco Dependence Treatment Service Impact Calculator[6] we are able to estimate return on investment over the last 12 months in which **1,848 patients set a quit date,** resulting in:

83
reduction in all-cause 30 day A&E presentations

3 bed spaces
created per day, based on 1 year readmissions

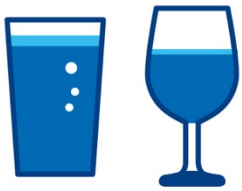
216
reduction in all-cause 1 year readmissions

113
lives saved in a year

~£561,384
saved due to reduction in 1 year readmissions*

**estimates based on average cost of a UHL admission*

Alcohol



Alcohol use is responsible for 10% of the UK burden of death and disease, making it the third biggest modifiable risk factor.

Local context

According to the Leicester Health and Wellbeing Survey (2024), more than half of Leicester's population do not drink alcohol (55%)[1], which is significantly higher than the national average of 19%[2]. Despite this, alcohol-related harm remains a concern.

Despite most drinkers being low risk, men in Leicester experience higher rates of alcohol-related hospital admissions (2,928 per 100,000, compared to the national average of 2,837) and deaths (73.5 deaths per 100,000, compared to the national average of 59.5)[3].

For 2023/2024, the Leicester alcohol-related admission rate per 100,000 people was similar to the national average of around 1,831, whereas Leicestershire and Rutland continue to see significantly lower rates compared to the national average[3].

At UHL, we have an in-house alcohol care team (ACT) consisting of one band 7 nurse, three band 6 nurses, three Turning Point advanced recovery practitioners, a Turning Point recovery practitioner and a senior data analyst. The team is based at the Leicester Royal Infirmary, and receives referrals across all three hospital sites, seven days per week.

Why does it matter?

ACTs provide early, specialist intervention during admission. They provide brief interventions, initiate detox or treatment plans, and ensure follow-up through community services.

It has been found that ACTs can **reduce unplanned hospital admissions by up to 42%** and cut bed days by 39%[4]. They are also highly cost-effective, saving the NHS an estimated £3 for every £1 invested[5].

Alcohol-related harm is significantly higher in deprived communities, even though alcohol consumption levels are often similar to those in less deprived areas. This pattern is known as the ‘Alcohol Harm Paradox’[6].

People living in the most deprived areas in England are twice as likely to die from alcohol-specific causes[6] and to be admitted to hospital for alcohol-related conditions. This inequality is influenced by a combination of factors, including limited access to healthcare and support services, greater exposure to other health risks, psychosocial stress, and the impact of poverty on long-term alcohol use.

Highlights 2024/25

Between October 2024 and October 2025, ACT received **3,018 alcohol-related referrals** for 1,768 patients and provided **1,658 completed brief interventions** – around 126 interventions per month.

Of these referrals:

- 48% were already known to Turning Point and have an assigned key worker
- 16.3% were referred into Turning Point
- 35.7% were not referred

Most referrals received are via Nervecentre (40%), followed by ACT identifying referrals from wards (20.4%), telephone calls (15.1%) and ICE referrals (11.7%).

Characteristics of those referred to the service are:

- **Male** (71.8%),
- **Over the age of 45** (around 60%)
- **White British ethnicity** (60.2%).
  - The second most represented ethnic group among ACT referrals is Asian or Asian British (11.6%).
- **More deprived backgrounds** - IMD deciles 1-3 (40.9%)

For patients with a high number of admissions (at least one emergency admission every two months, or a total of six in a year) who are referred to ACT, we have seen a **decrease of 28.6%** (from 8.4 to 6.0) in average emergency admissions per year following an ACT intervention.

The **fibro scanner service** aims to identify liver disease early. From August 2025, the team have been scanning between four and five patients per month on average.

A cost-analysis evaluation, using the benefit cost ratio from a minimum case model, found that ACT was cost-saving for the first two financial quarters of 2025 (without September data). On average, between April and August 2025, every £1 spent on ACT generated between £1.53 - £3.36 worth of savings.

Obesity

Around two in three adults across Leicester, Leicestershire and Rutland are overweight or obese.

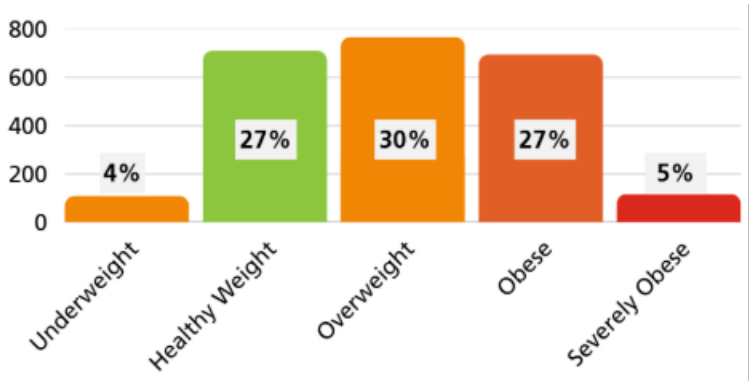
Local context

Obesity remains a significant public health challenge across Leicester, Leicestershire and Rutland (LLR). In 2023/2024, around two in three adults (65.2%) were classified as overweight or obese, which is a similar rate to the national average of 64.5%[1]. This presents a major concern given the strong association between obesity and chronic conditions such as type 2 diabetes, cardiovascular disease and certain cancers[2].

A similar trend is evident among children. In the early years of primary school, approximately one in five reception-age children in LLR are already overweight or obese. By Year 6, this figure rises to around one in three (34.8%), highlighting how excess weight becomes increasingly established as children grow older[1].

Furthermore, there is a pronounced obesity-deprivation gradient across the population. Children living in the most deprived areas experience obesity rates around twice as high as those in the least deprived areas[3]. This stark inequality underscores the need for a targeted and proportionate approach, directing greater investment and preventive action toward those communities most affected by the wider social determinants of health.

A snapshot across UHL inpatients for seven days in October 2025 showed that just one in four patients were of a healthy weight, according to BMI (N=2,587 patients).



Why does it matter?

It is well documented that obesity increases the risk of chronic health conditions such as type 2 diabetes, heart disease, and certain types of cancer[2]. It also has adverse psychosocial consequences and significant economic impact, with obesity and excess weight estimated to cost the NHS around £12 billion per year, and the total impact on the economy and wider society reaching around £126 billion[4].

In the hospital setting, we know that those who are obese are more likely to have longer hospital stays[5-6], higher risk of complications[7] and healthcare costs[5]. A moderate weight reduction of 5-10% is associated with health benefits, including reducing the incidence of certain cancers and type 2 diabetes, as well as improved quality of life and reduction in mortality[8].

Highlights 2024/25

NICE approved tirzepatide for the treatment of obesity in 2025, with an expectation that it would be made available to patients in 2025-26 across England. Each ICB was asked to inform NHS England how the medication would be made available to patients.

As of June 2025, the LLR ICB made the decision to use a community-based model for the roll-out of tirzepatide, providing the medication to people with a BMI greater than 40, with at least five pre-specified comorbidities. Tier two weight loss referrals to digital weight loss service providers are made by GPs for patients with a BMI of greater than 30 (or BMI greater than 27 for some ethnicities), and comorbidities of either diabetes, hypertension, or both.

The UHL tier three pilot service has 478 patients actively involved in the service. Those in the service have received wraparound care, including psychology, diet, physical activity, and medical treatment such as pharmacotherapy.

Findings from the service show that:

- There has been an average weight change of 8.4% for the whole cohort using tier three services, although this is significantly greater in the pharmacotherapy group (-12.2%) compared to non-pharmacotherapy (-3.9%)
- Psychological treatment increased confidence, reduced emotional eating and reduced binge eating
- Physical activity (Steps4Health) – patients saw an increase of 974 steps per days on average over the first six weeks, nearly double the minimum clinically important difference of 500 steps per day (Herring et al, 2025)
- 172 patients are currently being prescribed pharmacotherapy
- Patient feedback indicated improvements in mental and emotional wellbeing, as well as improvement in energy levels, blood pressure, or other health markers
- Overall, outcomes indicate that this person-centred approach is popular and clinically highly effective

However, the tier three pilot service has not received further funding and is therefore due to close in March 2026.

UHL tier four bariatric surgery

There were 45 bariatric operations in 2024, less than half the number of operations carried out in 2023 (103). Of these, 26 were performed at UHL, and 19 outside of the Trust.

Childhood obesity

Currently, one in three children leave primary school obese.

Local context

Childhood obesity is one of England's most pressing public health challenges, with around one in three children leaving primary school obese. In Leicester, rates are even higher, with 38% of Year 6 pupils classified as overweight or obese[1]. Obesity remains strongly linked with deprivation, and inequalities continue to widen.

While multifactorial, excess weight ultimately reflects an imbalance between energy intake and expenditure. Locally, only 19% of children meet recommended fruit and vegetable targets, and more than a third complete less than 30 minutes of daily physical activity[1].

The Leicester Complications of Excess Weight service provides a specialist, child-centred pathway focused on early identification and coordinated management of obesity-related complications. The model combines paediatric medical assessment, metabolic screening, psychology input, physiotherapy, dietetics, and links with community services to ensure integrated, timely care.

Key features

1. Early clinical risk stratification
2. Comprehensive metabolic complication screening
3. Integrated paediatric psychology support
4. Coordinated management of multiple comorbidities
5. Personalised care plans aligned with community provision

Why does it matter?

Childhood obesity has immediate health consequences, as well as future risks. Children and young people with excess weight may develop early complications such as type 2 diabetes, hypertension, fatty liver disease, sleep-disordered breathing, musculoskeletal pain, and reduced respiratory function. These conditions can begin during primary school and progress rapidly if unsupported.

Obesity also impacts mental health, school attendance, physical activity, and social participation, contributing to bullying, low self-esteem, and emotional eating. The impact is greatest in deprived communities, widening existing health inequalities and increasing demand across paediatric services including diabetes, hepatology, respiratory/sleep, orthopaedics, and Child and Adolescent Mental Health Services (CAMHS).

The service has reviewed 223 children and young people to date. The cohort includes a high proportion of children from groups known to experience greater health inequalities:

- 18.4% are of Asian ethnicity
- 29.1% live in areas with a deprivation score greater than four, and a further 22.9% live in areas with a deprivation score of three to four
- Neurodiversity is common, with 23% of the patients having a recorded neurodevelopmental diagnosis
- Almost half (42.5%) have one or more complications related to excess weight, illustrating the significant clinical and psychosocial complexity within the service

Clinical outcomes show sustained improvement. The overall mean BMI standard deviation score (SDS) reduction is -0.23, representing a clinically significant change. Among those prescribed semaglutide, the mean BMI standard deviation score reduction is -0.32, with an average absolute BMI reduction of 3.8 kg/m².

These findings show that a multidisciplinary, person-centred model combined with pharmacotherapy can achieve meaningful benefits for children and young people with more severe obesity or obesity-related comorbidities.

The service has confirmed funding until March 2027. Due to the long waiting list and current capacity constraints, referrals are temporarily paused while existing caseloads are managed safely. Alongside this, a system-wide weight management strategy is being formulated across LLR, to ensure a coordinated, equitable and sustainable pathway for children, young people and adults.

Overall, the children and young people's weight management service continues to reach a diverse, high-need population and deliver measurable clinical benefits, while contributing to the development of longer-term system solutions for obesity care across the region.

Tuberculosis

Leicester currently has the highest rate of tuberculosis in the country, and cases are rising.

Local context

There has been a steady rise in tuberculosis (TB) cases across the UK as communities have emerged from the pandemic. TB notification numbers in England saw a significant rise of 13.6% in 2024, compared to 2023, which is the largest annual increase since national surveillance began. The rate of TB incidence is currently 9.4 per 100,000[1]. If the rise in rate continues, England will pass the World Health Organization threshold of 10 for a low incidence country by the beginning of 2026.

In 2024, cases increased in Leicester to 42.1 cases per 100,000, compared to 40.7 the previous year, making it the **highest TB rate in the country**[1]. A critical factor contributing to the rise in cases is increasing migration from high TB prevalence countries. In 2024, 93% of the active TB cases in Leicester were foreign-born people[2].

Despite ambitious prevention programmes since 2016, and with migrant numbers increasing since 2020, even more robust screening and treatment programmes are essential in preventing further spread.

Why does it matter?

TB is both preventable and curable. Despite this, it remains an increasingly significant public health challenge.

TB is a disease that spreads easily, causing severe illness in the acute phase, which requires prolonged hospital treatment and causes significant healthcare costs. It not only has significant impact on morbidity and mortality for those infected, but also poses a wider risk to vulnerable patients within the hospital, as some of those at risk of TB or with latent TB infection (LTBI) are working within healthcare services.

Preventing and treating TB at an early stage is significantly more cost-effective. TB can be latent for years before becoming active, and 5-10% of those with LTBI will go on to develop TB disease. Screening to detect LTBI is effective at preventing future disease and is a critical part of TB prevention. In high-risk populations, up to one in five people will be positive for LTBI when screened[1].

TB disproportionately affects disadvantaged communities and minority ethnic groups, populations that are particularly prevalent in Leicester, Leicestershire and Rutland. By focusing on prevention, we can deliver safer, more equitable, and more sustainable care for all.

Highlights 2024/25

LTBI across LLR

The national LTBI testing and treatment programme has been running since 2015 in local authorities where incidence is high. It aims to test new entrants to the UK, but was heavily impacted by the COVID-19 pandemic. It is available for all new entrants who:

- Have entered the UK in the past five years
- Have lived in sub-Saharan Africa, or a country with a TB rate greater than or equal to 150 per 100,000, for at least six months
- Are between 16 and 35 years of age

An audit of the LTBI programme showed a decline in screening after 2019, with large variation across the city (Leicester City Health and Wellbeing Board update on TB, June 2024).

In 2024/2025, the total number of tests conducted by GPs in LLR as part of the migrant screening programme was 1,554, 237 (15.2%) of which were positive. LLR testing in migrants has increased by 64%, compared to 2022/23.

Overall, in 2024, 28.9% of LTBI cases were identified through new entrant screening, followed by occupational health (25.1%) and contact tracing (21.6%).

Completion rates for LTBI treatment remain above 90%.

UHL TB services

UHL's TB services are managed jointly between respiratory medicine, infectious diseases, and paediatrics. In 2024, the TB rapid access clinic at the Glenfield Hospital assessed 315 people with suspected TB.

- **227 active cases** of TB were diagnosed and treated
- **450** people with newly identified LTBI were supported (up 78% since 2022)

Blood-borne viruses

The World Health Organization has set out strategies to end AIDS and viral hepatitis epidemics by 2030.

Local context

Blood-borne viruses (BBVs) such as HIV, hepatitis B and hepatitis C spread through blood or bodily fluids containing the virus. Some people have no symptoms, while others become seriously unwell.

The World Health Organization aims to end AIDS and viral hepatitis as public health threats by 2030[1], and the UK has committed to achieving this through stronger prevention, testing, and treatment.

Nationally, new HIV diagnoses have fallen by 4% this year, with high treatment and viral suppression rates[2]. However, Leicester continues to face greater challenges. The city's diagnosed HIV rate in 2024 was 2.81 per 1,000, well above the national average of 1.77, and its new diagnosis rate is 14.4 per 100,000, compared with nine per 100,000 nationally[3].

England has made major progress on hepatitis C, with chronic infections falling by about 57% over eight years due to effective testing and treatment[4]. In contrast, hepatitis B remains harder to tackle. Current progress is too slow to meet the 2030 diagnosis and treatment targets, and emergency department (ED) opt-out testing has revealed a substantial number of previously undiagnosed cases[5], highlighting the need for further action.

Why does it matter?

Many people with BBVs are diagnosed late, which increases the risk of transmission and leads to more serious health complications, such as AIDS-related illness, liver cirrhosis, and liver cancer. This results in increased morbidity, mortality, and healthcare costs.

The NHS opt-out testing programme in EDs demonstrates the crucial role that hospitals play in BBV prevention. EDs now account for around 50% of all BBV testing nationally[5] and have identified substantial numbers of new diagnoses, particularly for hepatitis B, allowing patients to access lifesaving treatment earlier. Funding for this programme has been extended to 2029.

Acute hospitals see many high-risk individuals who may have limited contact with GP or community services, including sexual health clinics, where traditional BBV testing is offered. As the programme uses automatic testing alongside routine bloods, individuals do not need to self-identify as 'at risk', or disclose sensitive behaviours. This reduces stigma, removes barriers associated with risk-based testing, and helps to address health inequalities by reaching populations who might otherwise remain undiagnosed.

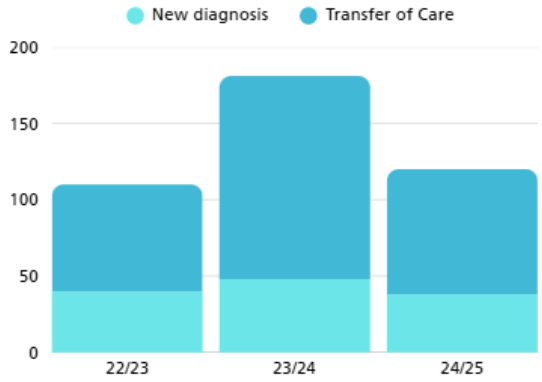
Highlights 2024/25

HIV services at UHL

The HIV service at UHL currently cares for a cohort of **1,688 patients** (a decrease of around 6% compared to 2024).

Between April 2024 and April 2025, there were **120 new HIV patients** (fewer new cases compared to last year).

- **38** new diagnoses
- **82** transfers of care from abroad or from other UK sites



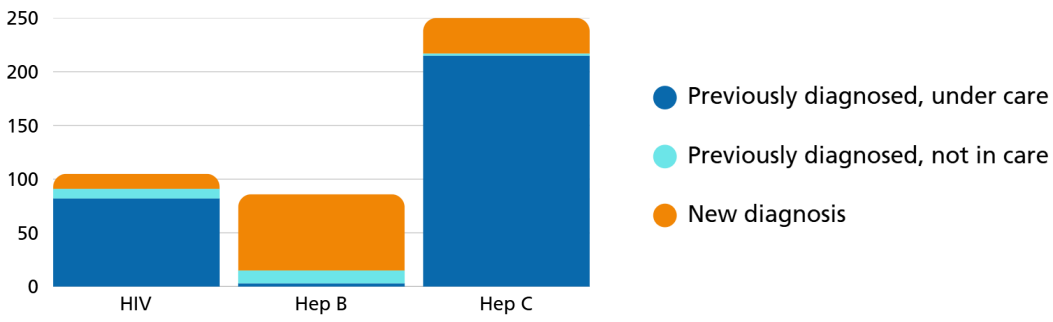
ED opt-out BBV screening programme

UHL rolled out ED opt-out BBV screening at the Leicester Royal Infirmary at the end of November 2024, as part of the national programme.

Between November 2024 and October 2025, ED BBV testing identified:

- **14** new cases of HIV and **9** previously diagnosed but not in care
- **71** new cases of hepatitis B and **12** previously diagnosed but not in care
- **33** new cases of hepatitis C and **2** previously diagnosed but not in care

ED screening has uncovered a substantial number of previously undiagnosed hepatitis B cases. **97% of cases** were new to service, compared to 22% for HIV and 14% for hepatitis C.



Workforce wellbeing

UHL is one of the largest employers in Leicester, Leicestershire and Rutland, with more than 19,000 employees.

Local context

Staff are the NHS' greatest cost and greatest asset, making workforce wellbeing a top priority. Aside from the moral and ethical imperative, there are compelling arguments that prioritising workforce wellbeing improves efficiency, productivity, and patient experience and outcomes. With the NHS representing Europe's largest workforce, supporting colleagues is also an investment in the health of the population[1].

The 10 Year Health Plan for England[2] acknowledges the need to improve staff health and wellbeing, including new standards to improve healthy work conditions, and offering a high-quality occupational health service for all NHS colleagues. Creating healthier workplaces will enable colleagues to stay well and in employment, aligning with the mission to shift from treatment to prevention.

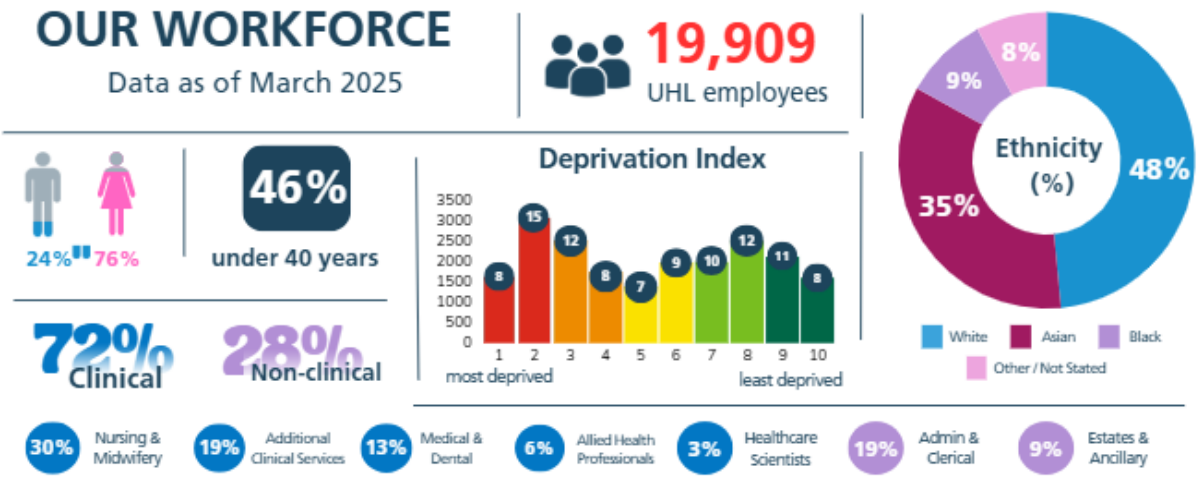
At UHL, we have a workforce of **19,909**, making us the one of the largest NHS trusts in the country. The majority of our colleagues are female, and 46% are aged under 40 years. Just over half of our colleagues are from ethnic minority backgrounds, and nearly a quarter (23%, 4,622 employees) are from the 20% most deprived areas (IMD deciles 1 and 2). The workforce grew by 4% from March 2024 to March 2025.

Why does it matter?

Nationally, the health of the working age population is deteriorating, with a record number of people out of work due to ill health[3]. This not only places a significant burden on the NHS and public services, as well as the UK economy, but also greatly impacts on individuals' quality of life.

Being in good employment has a positive impact on your health, and good health enables people to participate in the workforce. Turned the other way, the longer a person spends out of work, the greater the impact it has on their future employment and pay, reducing their standard of living, and resulting in further deterioration of health. Unemployment and poor-quality work are therefore major drivers of health inequalities.

Highlights 2024/25



- **UHL colleagues can self-refer to physiotherapy** via UHL Connect. From October 2024 to 2025, this service saw 524 staff members and received excellent feedback, with an average satisfaction rating of 4.9 out of 5.
- UHL has committed to the **NHS Healthy Weight Declaration,** enabling the Trust to embed a preventive approach to healthy weight.
- The **UHL menopause support service** was launched to provide colleagues with confidential, accessible, and culturally sensitive support.

- In summer 2025, 875 colleagues completed the Workplace Health Needs Assessment, helping us to understand areas to improve the health and wellbeing of colleagues. The results will inform the health and wellbeing work programme in 2026.
- The health and wellbeing service continues to offer physical activity sessions, mental health prevention and signposting to alcohol and substance misuse services.

Summary and reflections

This report highlights the significant breadth of prevention work underway across UHL, involving a wide range of departments and stakeholders. The outcomes presented in this report have demonstrated strong impact and are closely aligned with the national priority to shift from treatment to prevention. As the 10 Year Health Plan for England is introduced, with a major focus on embedding prevention services within hospitals and local systems, UHL is already well positioned to further develop this agenda.

As we enter new collaborative arrangements with the LLR ICB and clustered hospitals, it is important to remain consistent in our approach towards providing prevention pathways. Such an approach is critical to reducing health inequalities and demand on our services, enabling our population to maintain the best possible health.

We therefore suggest the following reflections and learning points to inform our work as we move into 2026.

1. We need to continue **to refine our digital infrastructure,** to ensure that prevention pathways are routinely offered to those who need them most.
    a. National policy has identified the need to move from analogue to digital, to provide more personalised and coordinated care to our patients. This includes joined up working with colleagues in community and primary care, to avoid duplication when it comes to collecting information on patients' health behaviours. Streamlining pathways to ensure shared information and automatic signposting to services will help to remove unnecessary steps in the patient pathway.
        i. Example: The 'Making Every Contact Count' assessment is well established in the electronic patient record, enabling efficient signposting and referral for those who need support. We could refine the assessment to include other relevant measures, such as BMI, which could include automatic text referrals to tier two digital weight management services for those over a certain BMI.
2. **Increased collaboration across the ICB footprint** to ensure joined up system working, particularly with outpatient services and primary care.
    a. As an acute trust, our colleagues have thousands of contact points with patients, offering powerful opportunities to provide proactive support.

With greater communication between services, we can accelerate patient support via shared information giving, opportunistic screening and signposting.

    i. Example: Use the discharge summary to alert primary care to high-risk patients, and for personalised signposting to community services relevant to patients' needs. For example, including BMI, smoking and alcohol status on all discharge summaries, with offers of support.

3. Continue to **improve monitoring of impact** for these services, to bolster recurrent funding grants.

    a. Given the financial constraints on the NHS, it is important to be able to show the positive change our work is having through social impact and economic analysis. It is important to be able to work on appropriate outcomes that we can measure annually in the form of a live dashboard.

        i. Example: an economic cost-effectiveness model that we could design into a dashboard to provide real-time feedback of services and be able to see what works and what doesn't.

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