Leicester
City Council

Minutes of the Meeting of the
HEALTH AND WELLBEING BOARD

Held: THURSDAY, 5 JUNE 2025 at 9:30 am

Present:

Councillor Dempster (Chair)	–	Assistant City Mayor, Health, Culture, Libraries and Community Safety, Leicester City Council.
Councillor Elaine Pantling	–	Assistant City Mayor, Education, Leicester City Council.
Councillor Geoff Whittle	–	Assistant City Mayor, Environment & Transport, Leicester City Council.
Rob Howard	–	Director of Public Health, Leicester City Council.
Laurence Jones	–	Strategic Director of Social Care and Education, Leicester City Council.
Dr Katherine Packham	–	Public Health Consultant, Leicester City Council.
Caroline Trevithick	–	Chief Executive, Leicester, Leicestershire and Rutland Integrated Care Board.
Rachna Vyas	–	Chief Operating Officer, Leicester, Leicestershire and Rutland Integrated Care Board.
Helen Mather	–	Head of Childrens and Young People and Leicester Place Lead.
Dr Avi Prasad	–	Place Board Clinical Lead, Integrated Care Board.
Dr Ruw Abeyratne	–	Director of Health Equality and Inclusion, University Hospitals of Leicester NHS Trust.
Jean Knight	–	Deputy Chief Executive, Leicestershire Partnership Trust.
Paula Clark	–	Interim Chair, Leicester, Leicestershire and Rutland Integrated Care System.
Benjamin Bee	–	Area Manager Community Risk, Leicestershire Fire and Rescue Service
Harsha Kotecha	–	Chair, Healthwatch Advisory Board, Leicester and Leicestershire.
Kevin Allen-Khimani	–	Chief Executive, Voluntary Action Leicester.
Rupert Matthews	–	Leicestershire and Rutland Police and Crime Commissioner.

Kevin Routledge	–	Strategic Sports Alliance Group.
Phoebe Dawson	–	Director, Leicester, Leicestershire Enterprise Partnership.
Barney Thorne	–	Mental Health Manager, Leicestershire Police.
Professor Bertha Ochieng	–	Integrated Health and Social Care, De Montfort University.

In Attendance

Sharon Mann	–	Public Health, Leicester City Council.
Katie Jordan and Kirsty Wootton		Governance Services, Leicester City Council

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122. APOLOGIES FOR ABSENCE

Apologies for absence were received from the following:
Dr Avi Prasad, Place Lead, Leicester, Leicestershire and Rutland Integrated Care Board
Benjamin Bee, Area Manager Community Risk, Leicestershire Fire and Rescue Service
Jean Knight, Deputy Chief Executive, LPT
Kevin Routledge, Strategic Sports Alliance Group
Rachna Vyas, Deputy Chief Executive & Chief Operating Officer, Leicester, Leicestershire and Rutland Integrated Care Board

123. DECLARATIONS OF INTEREST

Members were asked to declare any interests they may have in the business to be discussed at the meeting. No such declarations were received.

124. MEMBERSHIP OF THE BOARD

The membership for 2025-26 was noted and was approved at Full Council.

125. MINUTES OF THE PREVIOUS MEETING

RESOLVED:

The Minutes of the previous meeting of the Board held on 18th April 2025 be confirmed as a correct record.

126. QUESTIONS FROM MEMBERS OF THE PUBLIC

It was noted that none had been received.

127. BETTER CARE PLAN 25/26

The Chair agreed to combine items 6 and 10 of the agenda together.
The Director of Adult Social Care and Safeguarding presented the items.
It was noted that:

- The governance for the Better Care fund was managed through the Integrated Care Group for Leicester City and there was not a distinct Better Care Group that meets monthly to manage the operational detail, support the planning process, ensured that the fund is delivered in line with the national conditions and achieves the right outcomes for the people of the Leicester.

- The Better Care fund for 2025-2026 had received approval from the national team as a plan. The Quarter 3 template had also been submitted to the national team and had been accepted.

AGREED:

That the board notes and approves the Better Care Plan 2025/26 and the Better Care Fund Quarter 3 Template 2025/26

128. HEALTH INEQUALITIES USING SOCIAL PRESCRIBING

The Digital and Transformation Lead for Primary Care presented the report, it was noted that:

- There was two key projects underway, the first being "3 Conversations" part of the approach to population health management was working with ICB, Midlands and Lancs partners, and clinicians within the organisation to get their insights in to the people in the area and develop a model.

- A lot of data was used to support and identify different themes across the Primary Care Network (PCN) and some tailored interventions were developed to address the at risk population in the area.

- A cohort of patients were identified that were not engaging with the general practice services for health needs and were often presenting in crisis at out of hours services.

- The process of contacting a patient was reviewed and a particular theme was identified where 2 forms of contact were made to try and engage a patient and get them back on track. Due to pressures and resources in PCN these patients were not followed up with after the second form of contact was attempted.

- Reports from the emergency department and Police Protection

Notifications (PPNs) were used to identify high-contact individuals not accessing support and showed significant health concerns, this led to the clinical directors to assess this across the whole primary care network and review who they were trying to engage.

- When the 3 Conversations training was delivered, this cohort of patients were looked at to be supported and engage with their health needs.
- The population chosen for the project were registered across 3 practices based in Saffron and Eyres Monsell, individuals over 18 years old and had received a PPN with mental health issues raised in the last 6 months.

The "3 Conversations" Approach:

- Conversation 1: Understanding what matters to the individual and connecting them to local resources to live independently.
- Conversation 2: Supporting people in crisis.
- Conversation 3: Helping individuals build a good life and take responsibility for their health and wellbeing.
- Conversations were made with individuals from SystmOne via GP Surgeries and recording all notes on the progress and type of contact made.
- Due to the number of non-engagements an initial letter was produced. It was found that the reading age in the area meant that sometimes the letters were not understood. So it was broken down into tailored engagement methods included letters adapted for local reading age, with short sentences, limited information visuals and the key message being to get in touch.
- No timescale was decided for how long they would try to contact the patient, rather as much time that the patient needed to get on their journey.
- Contact was recorded on a templated entry, to capture the different support that was being provided.
- Check ins were taking place with Leicester City Councils Adult Social Care and usage of their Liquid Logic System to assess notes and understand what other workers were involved in their care to avoid duplication and manage timely communication between organisations.
- Local team huddle meetings were held once per week to discuss strength and progress updates, risks and ending involvement with patients.
- Local teams also met on the ground regularly with VCSEs to explain what the service provision was in case they identified patients that

could be suitable for support.

- Increased support was offered during a period of crisis and there were instances of this. Rather than connecting with the crisis team, it was decided to work with them and try and support them to avoid getting to conversation 2.
- The overall aim of working in this method was to prevent people requiring conversation 3 and to avoid them needing the longer term commissioning services.
- Average of 6 community engagements needed to establish connection.
- Templated data entry introduced to capture support offered and improve consistency.
- 12.43
- Over 7 months, project contacted individuals across a 12-month cycle.
- 23% engaged but did not take up the offer.
- 9% attempted engagement but dropped off.
- 15 individuals not suitable, 9 declined, 1 deceased.
- Only 1% moved into Primary Care Networks.
- Weekly drop-in held at Pork Pie Library to offer a safe space for community discussions.
- Common themes: debt (23%), substance misuse (5%), social isolation (23%), therapy needs (29%), employment/education support (15%).
- Challenges were present and they included:
- The time between a patient receiving a PPN and the information being shared by the police to the practices varied due to resources. It was never managed to address the governance issue with police.
- Record keeping on multiple systems. Using the patient record and governance and safeguarding involved in what was shared on the patient record. Moved to sharing patient information on record.
- Practice engagement practices did not have the time to process and refer the correct patients to the team. This was addressed by providing additional support through a flow chart and MDT
- Patient lack of engagement: 2 letters were created, door knocking and hand delivering them in attempt to make contact. On average it took 6 attempts to engage with the patients.

- A team from Public Health led a project focused on patients aged 18–64 with five or more comorbidities, living within a Primary Care Network (PCN).
- The project aimed to understand the challenges faced by this group and explore how to improve access to services, uptake of support, and self-management to enhance quality of life and life expectancy.
- The approach began with contacting 60 patients, which was later expanded based on interest and engagement.
- Focus groups and one-to-one discussions were held to explore lived experience, barriers to access, and existing service gaps.
- Patients co-produced interventions and provided insight into barriers related to physical health, daily living, social isolation, special educational needs, technology use, personal resilience, routines, and stigma.
- Voluntary and community sector organisations (VCSE) were involved to help shape the questions used in discussions and to observe and understand patient needs in greater depth.
- It was found that many patients were unaware of the available support, including care navigators, GP practice services, health and wellbeing coaches, and social prescribing options.
- Signposting patients to appropriate activities for working-age adults proved challenging in some local areas due to limited options.
- Medication use emerged as a key theme, particularly regarding non-medical alternatives, side effect monitoring, and understanding how to use medication properly.
- A notable example of good practice was identified at Saffron Health, where a dedicated phone access system was in place for digitally excluded patients to request prescriptions, fit notes, smear tests, health checks and other requirements.
- The system supported patients in identifying whether their issue was urgent, whether they could see a pharmacist or social prescriber instead of a GP, and helped navigate available options.
- Social prescribing was being used to support this cohort, including the development of a revised leaflet explaining Structured Medication Reviews (SMRs) in more accessible language.
- Patients were also signposted to videos and websites via QR codes, with support from social prescribers to assist those with limited digital literacy.
- Community pharmacists played a key role in continuing support, and

group sessions remained part of the broader health inequalities strategy.

In discussions with Members, the following was noted:

- Members highlighted that a number of pilot schemes had been trialled prior to wider rollout, and all PCNs had been offered support and training. It was noted that while over 1,300 VCSE organisations were listed in the database, more referrals could be made. Due to oversubscription, decisions had to be made to reallocate resources.

- It was suggested that conversations about service access and navigation were wide-ranging, and work was ongoing to ensure a consistent platform such as the Joy App was accessible and fit for purpose.

- A chatbot had also been introduced on the website to direct users to relevant organisations and services, particularly those supporting refugee communities. However, efforts were still needed to bring more organisations onto the platform.

- The persistence in connecting with vulnerable individuals was praised. It was acknowledged that face-to-face communication yielded stronger engagement, and there was hope that this work would continue beyond the initial pilot. Questions were raised about sustainability and the next steps for ensuring long-term impact.

- The importance of learning from experiences during the COVID-19 pandemic was emphasised, including proactive outreach and door-knocking campaigns. Members stressed the need to direct resources where health inequalities were greatest and to provide evidence that the work delivered value for money.

- There was support for capturing both qualitative and quantitative data to demonstrate the economic and social value of the work. It was noted that some reports had not been published, and there was a risk that if projects stalled, priorities would shift before they were completed.

- Opportunities for collaboration on evaluation were welcomed, with suggestions to align with existing projects in acute settings and to submit work for national recognition as a gold standard approach to integrated care and neighbourhood working.

- Members noted the strength of the project as an example of true neighbourhood-level collaboration, incorporating data, governance, and a range of system partners. It was felt that more could be done to enable access to this data, especially for frontline services like the police.

- It was recommended that evaluation should be embedded from the outset of any PCN-funded project, with a suggested 10% of the budget allocated for this purpose. The importance of drawing on collective

expertise across the system was noted.

- Proportionate universalism was raised as a key principle ensuring services were available to all, but with additional support targeted where needs were greatest. Members encouraged linking available funding, such as CAPE, to support these efforts at a PCN level.
- Challenges with staff recruitment and retention were discussed, particularly around staff trained under local authority terms not wanting to transfer to NHS roles due to concerns over pensions and banding.
- Data sharing and the lack of integrated record-keeping systems were identified as ongoing barriers. Members questioned what could be done to improve access to shared care records.
- The importance of standardisation was highlighted, to ensure data from projects could feed into the LLR Shared Care Record. An IT process was underway to improve visibility via the system's viewer.
- Members asked who would be responsible for taking this work forward, and what role the Board would play in enabling continued progress.
- It was suggested that neighbourhood-level governance structures were key to driving the work forward. The proposal was made to take the findings to the neighbourhood group meeting at the end of the month for further discussion.

AGREED:

1. The board notes the report.
2. The Chair to send a letter to the Neighbourhood Board outlining the work to date.
3. A follow up report to return to the board in 6 months' time.

129. NURSING CARE STANDARDS

UHL Quality Care Standards submitted a report to highlight the current position of actions being taken to continuously improve the position. It was noted that:

- A new quality assurance framework was being rolled out across the whole organisation to understand the areas requiring support where the standards fell below the expected target. New tools were developed to ensure recording and visibility foe patients cared for in temporary escalation spaces (TES), during times of escalation across the system. This includes care for patients receiving care on ambulances, awaiting transfer into the Emergency Department.
- It was explained that rising pressures in emergency care formed the

context for understanding the challenges in maintaining quality standards.

- Data showed that emergency department (ED) attendances continued to increase, with no signs of reduction. As a result, performance against the national four-hour standard had been impacted.
- UHL was operating at approximately 60% compliance with the four-hour standard, compared to a national average of around 100 trusts, placing the trust below expected performance levels.
- The ED was becoming increasingly busy, with delays in patient transfers contributing to ambulance handover challenges. Approximately 30% of ambulance arrivals were experiencing extended waiting times outside the department.
- In response, the Trust had expanded urgent treatment capacity, increased alternative pathways, and made changes to the ED footprint.
- It was noted that a requirement to respond to ambulance releases within 45 minutes had added pressure to maintain rapid patient flow, further compounding complexity.
- Hospital-acquired pressure ulcers had previously placed UHL as an outlier nationally. While new equipment and beds had been introduced, early rollout lacked sufficient staff training. Improvements had since been made, although further work remained.
- Specialist services, which had been paused during the COVID-19 pandemic, had now returned to ward settings to support care. It was also highlighted that some patients arrived with pre-existing pressure ulcers, which were not always recorded in time due to early system constraints.
- 85% of patients were now being seen within the agreed timeframe, which had positively impacted pressure rates.
- Falls in hospital remained a key challenge, particularly among patients with dementia or delirium. The unfamiliar hospital environment increased risk, and additional specialist care was being introduced.
- A business case had been approved for sensor mats that alert staff when patients attempt to move, aiming to reduce the incidence of falls.
- The Trust was using a quality platform called MEG to monitor nursing metrics, including screening and care planning. Some red and amber ratings were noted, indicating areas for improvement. Nursing assessments were expected to be completed within six hours.

- A quality improvement framework known as the LEAF (Leicestershire Excellence Assurance Framework) had been introduced in the previous year. This tool assessed ward performance based on 12 standards covering quality, safety, efficiency, patient and staff experience, with measurable metrics.

LEAF is structured around 5 key pillars:

- Quality & Safety
- Efficiency
- Patient Experience
- Staff Experience
- Improving

- These pillars are further defined by 12 standards and underpinned by 69 measurable metrics
- LEAF had been rolled out across all adult inpatient areas and was due to be extended to specialist areas in the coming months.
- Early findings from LEAF indicated that efficiency was the category requiring the most improvement.
- A new metric was being used to monitor care in Temporary Escalation Spaces (TES), such as ‘corridor care’, to evaluate how these settings affected patient experience and quality.
- While the majority of indicators in TES settings were rated green, suggesting patients continued to receive appropriate medical and nursing care, red indicators remained around dignity due to the nature of the environment. It was acknowledged that dignity screens were used, but the patient experience was not equivalent to a ward setting.
- The Trust confirmed this work formed part of a continuous improvement plan, with a forward focus in LEAF Phase 2.

LEAF - Phase 2:

Phase 2 of LEAF implementation will focus on specialist areas

Scoping sessions will be set up with representatives from the Emergency Department and Critical Care to agree on the specific metrics to be included in their LEAF dashboards

Quality Improvement:

Continued focus on embedding LEAF principles and driving quality improvement across all areas.

Harm Reduction:

Ongoing work to address key areas identified in the Temporary Escalations Audits and other harm reduction initiatives.

In discussions with Members, it was noted that:

- It was confirmed that the LEAF framework would eventually be rolled out to paediatrics.
- Significant variability in ambulance waits was highlighted. Trusts with better performance typically had improved patient flow due to stronger internal systems and greater capacity.
- While UHL had previously increased NHS England had introduced new standards for ambulance handovers, prompting further work in this area. However, the underlying issue remained a lack of physical space, resulting in some patients being placed in corridors a situation no one supported. Capacity, this only led to short-term improvements, as it did not address flow through the wider hospital. Sustained improvements had not been achieved.
- Corridor care was described as a compromise on patient dignity and staff wellbeing, though sometimes necessary to release ambulances and save lives. The system was acknowledged as fundamentally broken.
- Concerns were raised about the UK's performance compared to other European healthcare systems, where such issues were reportedly less severe.
- The issue of hospital falls was discussed. Reduced movement was linked to a decline in postural stability, and deconditioning was recognised as a contributing factor. A direct correlation between falls and hospital-acquired pressure ulcers was noted.
- Members expressed appreciation for the openness of the report and acknowledged the difficulty of the issues discussed.
- Corridor care was recognised as harmful for both patients and staff, with questions raised about what plans were in place to reduce its occurrence. Staff morale and patient experience were understood to be

closely connected.

- It was reported that corridor boarding often took place during the day when patients were known to be awaiting discharge. At night, this practice was distressing for staff, despite the support put in place by senior nurses and matrons.
- Trigger points for initiating corridor care were monitored to ensure it remained a temporary escalation measure and did not become routine practice.
- Members emphasised the exceptional demand on Leicester's ED, which served a highly deprived, elderly, and frail population. Demand in Leicester was noted as higher than in many other areas.
- It was stressed that the fundamentals of care should not rest solely with nurses, and that a whole-system cultural approach was required to reduce corridor care and manage demand.
- There was concern about how frequently corridor care occurred. It was acknowledged that medicine used it more than other specialties, particularly at weekends and during winter pressures. Although not a daily occurrence, it happened regularly more than was considered acceptable.
- Patients were provided with letters informing them that corridor care might occur. However, there were concerns that vulnerable individuals had less choice and were more likely to be treated in such environments.
- Historically, UHL had taken a strong stance against corridor care, including designing the new ED without corridors to avoid the practice. However, current pressures had resulted in its reintroduction, primarily on ward areas.
- Surgical wards experienced less pressure, though demand remained high at peak times. Corridor care was described as a frequent, though not daily, occurrence.
- A number of plans were underway to improve the situation. Some were long-term, including prevention strategies, while others were more immediate, such as opening a new facility for patients who no longer required medical therapy.
- Alternative pathways were being explored to reduce ED demand, and plans were in place to expand urgent response capacity and build a larger facility at LRI by next winter.

- There was an interest in improving care for older people and preventing unnecessary hospital admissions. While many projects were underway, their impact would take time to materialise.
- It was clarified that patients were not simply placed in corridors at UHL. Instead, temporary boarding occurred in ward areas while waiting for space to become available, with clinical oversight in place.
- Members expressed strong support for collaborative working and emphasised the need not to make assumptions based solely on data. It was noted that high ED attendance was not always linked to deprivation, and that children aged 0–5 had the highest attendance rates.
- Deeper data analysis was being undertaken to understand which populations were attending ED and why. A report on this analysis was due to go to the Trust Board in August and could also be shared with the Commission.
- It was noted that many patients attended ED without requiring any intervention, which distorted the picture and highlighted the need for better-targeted support and alternative services.
- Members stressed that resolving this required joint working across acute, secondary, and community services. Many individuals presented to ED due to a lack of available alternatives.
- The importance of community-level support was highlighted. Preventing ED attendance often involved addressing basic needs, which were not always health related.
- It was also noted that while population health data was generally strong for adults, it was less reliable for children. High levels of attendance among young children were often linked to a lack of support for young parents, especially those without extended family.

AGREED:

1. Members note the report.
2. An item on deprivation to come to a future board meeting.

130. PHARMACEUTICAL NEEDS ASSESSMENT

Public Health submitted a report on the Pharmaceutical Needs Assessment 2025 for a approval to proceed to statutory consultation. It was noted that:

- Health and Wellbeing boards have a statutory duty to complete a Pharmaceutical Needs Assessment (PNA) every 3 years to assess

current and future pharmaceutical services within their area. It is used to inform planning and commissioning of pharmacy services and to inform decision making in response to applications made to provide a new pharmacy.

Legislation specifies that the document must include:

- A statement of necessary services to meet current needs.
- Services required to meet future demand or current needs not currently provided.
- Recommendations to secure improvements or better access, now and in the future.
- Additional contextual and supporting information.

- Slides accompanying the report provided further detail on the required content and methodology.
- There was a noted higher concentration of pharmacies in certain areas of the city.
- Leicester currently had 83 pharmacies, equating to approximately 2.2 pharmacies per 10,000 residents.
- All pharmacies were required to open for a minimum of 40 hours per week, with five pharmacies open for 100 hours.
- While all pharmacies offered essential services, there was variation in the provision of advanced services, which could require patients to travel further for specific support.
- The analysis included a pharmacy in Evington that had since closed, as the closure occurred after the data collection period.
- Recommendations considered equity of access and explored how to encourage pharmacies to open in areas with lower provision.
- Digital literacy and its impact on service access was also highlighted, alongside the role of pharmacies in broader commissioning strategies.
- It was proposed that any new policy or funding changes be reviewed and reported to the Health and Wellbeing Board (HWB), with an annual update to be provided.
- The statutory consultation period would run for 60 days, and subject to approval, the final version would be signed off and published in October.

In discussions with Members, the following was noted:

- It was noted that the consultation should consider both city and county perspectives, reflecting the needs of individual communities and the

pharmacies that serve them.

- Members highlighted the importance of exploring different consultation models beyond reliance on surveys, suggesting task groups and varied engagement methods to ensure wider participation and ensure the assessment was fit for purpose.
- The importance of ensuring accessibility was emphasised, particularly in addressing why some individuals attend A&E despite pharmacies being well-placed to provide support.
- Gaps in provision across the city were acknowledged, and collaborative work with NHS England and other partners was underway to address them.
- It was noted that a significant proportion of ICB costs related to prescribing, and questions were raised around opportunities to tackle medication waste and improve compliance, including clarity on where responsibility for this lay.
- Members commented that all pharmacies offered a medicine return service, which could help reduce waste if better utilised.
- The link between social prescribing and medication use was discussed. It was suggested that supporting people to understand why they were taking certain medications could improve compliance and reduce unnecessary prescriptions.
- Concerns were raised about medication non-compliance, particularly among elderly patients. Improving understanding of the benefits of medication could help reduce A&E attendance and support better daily living.
- Positive experiences were shared regarding pharmacist-led medication use reviews, which often provided more time and clarity for patients than GP consultations.
- Concerns around medication waste had received less attention recently, despite previous focus. Issues such as automatic ordering by pharmacists and lack of patient involvement especially post-pandemic were highlighted as contributing factors.
- There was interest in potential further investigation into repeat prescribing systems and waste management.
- Concerns were raised about the withdrawal of dosette box provision for frail elderly people when changing pharmacies. It was suggested that such support should be reinstated in community settings, given its value

in supporting medication adherence.

- Serious concern was expressed over the finding that only one pharmacy in the city provided palliative care support, despite this service being offered more broadly across LLR. This was considered a significant gap in provision.

AGREED:

1. That members note the report and approve the PNA for the 60 day statutory consultation.
2. Members will receive an update via email on palliative care support in the city.
3. Members will receive an update via email on dosette box use by pharmacies.

131. BETTER CARE FUND

This item is minuted under item 6.

132. GAMBLING HARMS NEEDS ASSESSMENT

Katherine McVicar, Public Health, Leicester City Council submitted a report on the Gambling Harms Needs Assessment. They were joined by Annie Ashton, a Leicester Resident who had been campaigning for stricter gambling regulations following the death of her husband Luke Ashton.

The Chair welcomed Annie and noted the importance and value of having individuals share personal stories with an academic board.

It was noted that:

- Annie shared that she had lost her husband, Luke, to gambling-related suicide in 2021 in Leicester.
- The gambling operator had been listed as an interested party and appeared on the death certificate.
- Following the inquest, gambling had been included in the local suicide prevention strategy a historic step given the complexity of suicide.
- Annie had since been involved in work relating to gambling harm prevention, including contributions to changes in clinical codes of practice.
- Katherine thanked Annie for attending and for highlighting the real harms of gambling.
- An overview of previous work completed around 18 months earlier was presented, this had not previously been shared with the Health and

Wellbeing Board.

- It was noted that 54% of the population had gambled at least once a year, around 40% excluding the lottery.
- Problem gambling had affected approximately 0.4% of the population, with 0.3% at risk and 7% indirectly affected.
- When applied to Leicester's population, this equated to roughly 1,500 cases of gambling harm, 14,000 problem gamblers, and 26,000 indirectly affected individuals.
- Gambling had been linked to numerous harms including debt, poor mental health, and suicide.
- Leicester had a higher than average population of young people, people from deprived backgrounds, and ethnic minorities all factors increasing vulnerability to gambling harm.
- Gamble Aware data had illustrated the demographics engaging with support services, which had aligned with comparator areas despite small numbers.
- A map had shown the accessibility of gambling premises, which were more concentrated in the city centre and deprived areas.
- Leicester had been identified as one of the highest areas for problem gambling but with low levels of support service uptake.
- Three support services were currently available, including one NHS service accepting referrals across the East Midlands.

Recommendations from the needs assessment included:

- Developing a local strategy to address gambling harms through collaboration.
- Improving data collection and screening for those at risk.
- Increasing training, signposting, and public education especially targeting children and families.
- Influencing advertising and licensing regulations to protect the public.
- The work was in its early stages and stakeholders were being engaged.
- Support from the Health and Wellbeing Board was requested to take the work forward.

It discussions with Members, the following was noted:

- Members stated that Annie's contribution had a strong impact and thanked her for attending.
- Annie highlighted that 44% of people were in a high-risk gambling category and criticised the limited scope of Gamble Aware, noting it was funded by the gambling industry. She cited more recent Gambling Commission analysis suggesting the problem was far greater.
- Members noted they had attended an online webinar with Leicestershire County Council, Public Health and offered to deliver a similar session for City groups to support affected individuals.
- Annie's work was praised and raised concerns about the prevalence of gambling harms in non-white communities. She referenced research from the Shama Women's Centre, noting that while women may not

typically gamble, their families were heavily impacted. It was emphasised the need for more awareness raising in healthcare.

- Annie referenced NICE guidelines, stressing that GPs and other professionals should ask about gambling and ensure it is recorded in patient notes. She explained that proper coding could lead to appropriate treatment, preventative action, and future funding opportunities.
- Officers confirmed ongoing collaboration with the Shama Women's Centre and highlighted work being done with LPT and the ICB. She invited representation from UHL to join this work.
- Gambling was described as a national crisis, criticising the industry's narrative that gambling is an individual issue, a strategy that was borrowed from the tobacco industry. It was urged that the local strategy needed to reframe the issue, tackle exposure, and address the manipulative tactics used by the industry.
- Annie highlighted Brent Council's six-point plan and praised Sheffield for successfully rejecting a bid for a new gambling centre. She described slot machines as the "crack cocaine" of gambling and urged more councils to act together using Brent's model.
- The Director of Public Health confirmed that the Board had received Annie's letter and wanted it to go through the appropriate political process for full support and further consideration.
- It was asked why support services were underused despite the clear need. It was acknowledged the complexity of gambling harm and explained that the strategy included a recommendation to gather more local lived experience to understand the barriers to accessing support.
- Members agreed that the issue was not confined to Leicester, as online access had made gambling a widespread concern. They reiterated that gambling should not be framed as a personal failing but as a public health issue, especially given that 85% of industry profits came from addiction.
- Concern was raised about the accessibility of gambling and noted that communities who hadn't previously felt targeted were now being drawn in. Members were committed to taking away the importance of proper coding in GP practices and the need to rely less on industry generated statistics.
- Annie reiterated the importance of accurate medical coding to ensure the right treatment pathways and noted that gambling harm was often hidden behind other diagnoses like depression or alcoholism.
- Members described gambling as an addiction that brought misery to families. They supported the development of a strategy and expressed eagerness to help drive it forward.
- A pragmatic concern from acute care was raised, stating that while clear pathways existed for alcohol and drug dependency, there was little clarity on where to refer patients with gambling issues.
- UHL needed to reflect on its own coding practices and the kinds of questions being asked, stressing the importance of neighbourhood-level integrated work.
- Annie shared that during her research, two people had attempted

suicide and their care teams did not know where to refer them. She confirmed the existence of the NHS Gambling Clinic for the East Midlands.

- Annie clarified that if someone disclosed gambling issues to their GP, it needed to be recorded specifically in the medical notes not hidden under general issues like debt or alcohol so that referrals could be made and information captured for inquests if necessary.
- Members agreed, saying that proper coding would allow issues to be flagged and that it was essential to support both professionals and patients in making this process meaningful.

AGREED:

1. It was agreed to send a letter to UHL, LPT and GP practices to highlight the need for consistent coding of gambling harms.
2. The ICB agreed to take leadership on the issue and use the neighbourhood board structure to feedback progress.
3. Webinars were to be developed to help healthcare professionals understand NICE guidance on gambling harm, the importance of coding, and available referral pathways.
4. The issue of referral pathways and coding forward with the East Midlands Chief for further action.
5. To gather more information from the Shama Women's Centre report to better understand the community impact and barriers to accessing support.
6. An update to be brought to the September meeting and Annie to be invited.
7. The draft strategy to come to the board once ready.

133. DATES OF FUTURE MEETINGS

The dates of future meetings were noted by board members.

134. ANY OTHER URGENT BUSINESS

The Chair noted that many organisations had failed to send a representative or apologies despite the statutory status of the Health and Wellbeing Board. Attendance was now a consistent concern.

The meeting was declared closed at 12.28.