LEICESTER CITY
HEALTH AND WELLBEING BOARD

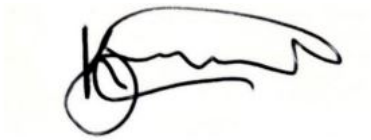
Date: THURSDAY, 5 MARCH 2026

Time: 9:30 am

Location:
MEETING ROOM G.01, GROUND FLOOR, CITY HALL,
115 CHARLES STREET, LEICESTER, LE1 1FZ

Members of the Board are summoned to attend the above meeting to consider the items of business listed overleaf.

Members of the public and the press are welcome to attend.



For Monitoring Officer

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City Mayor healthwatch Leicester Leicestershire Police Protecting our communities NHS Leicester, Leicestershire and Rutland Integrated Care Board NHS England


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Caring at its best

POLICE & CRIME
COMMISSIONER
for Leicestershire
Your voice in Leicester, Leicestershire & Rutland

Leicestershire Partnership NHS
NHS Trust

LEICESTERSHIRE
FIRE and RESCUE SERVICE
protecting our communities

MEMBERS OF THE BOARD

Councillors:

Councillor Vi Dempster, Assistant City Mayor, Health, Culture, Libraries and Community Centres (Chair)

Councillor Elaine Pantling, Assistant City Mayor, Education

Councillor Geoff Whittle, Assistant City Mayor, Environment and Transport

2 Vacancies

City Council Officers:

Rob Howard, Director Public Health

Kate Galoppi, Director of Social Care and Commissioning

Dr Katherine Packham, Public Health Consultant

1 Vacancy

NHS Representatives:

Caroline Trevithick, Chief Executive, Leicester, Leicestershire and Rutland Integrated Care Board

Nil Sanganee, Chief Medical Officer, Leicester, Leicestershire and Rutland Integrated Care Board

Helen Mather, Associate Director of Elective Care, Cancer and Diagnostics, Leicester, Leicestershire and Rutland Integrated Care Board

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 NHS Trust
Pauline Tagg, Interim Chair, Leicester, Leicestershire and Rutland Integrated Care System

Healthwatch / Other Representatives:

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, Leicester, Leicestershire and Rutland Police and Crime Commissioner

Kevin Routledge, Strategic Sports Alliance Group

Sue Tilley, Head of Leicester, Leicestershire Enterprise Partnership

Barney Thorne, Mental Health Manager, Local Policing Directorate, Leicestershire Police

Professor Bertha Ochieng – Integrated Health and Social Care, De Montfort University

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- ✓ where filming, to only focus on those people actively participating in the meeting;
- ✓ where filming, to (via the Chair of the meeting) ensure that those present are aware that they may be filmed and respect any requests to not be filmed.

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PUBLIC SESSION

AGENDA

FIRE/EMERGENCY EVACUATION

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1. APOLOGIES FOR ABSENCE

2. DECLARATIONS OF INTEREST

Members are asked to declare any interests they may have in the business to be discussed at the meeting.

3. MINUTES OF THE PREVIOUS MEETING **Appendix A (Pages 1 - 16)**

The Minutes of the previous meeting of the Board held on 4th December 2025 are attached and the Board is asked to confirm them as a correct record.

4. CHAIRS ANNOUNCEMENTS

The Chair is invited to make any announcements as they see fit.

5. QUESTIONS FROM MEMBERS OF THE PUBLIC

The Chair to invite questions from members of the public.

6. UPDATE FROM YOUNG VOICES CONSULTATION **Appendix B (Pages 17 - 26)**

Presentation on three-year action plan for CYP. The plan focuses on the following areas:

- CYP Voice
- Prevention
- Digital
- Improving Services.

7. ANDY'S MAN CLUB

Andys Man Club will attend the Board to talk about the work they do.

8. CHANGING FUTURES

Appendix C (Pages 27 - 34)

The Director of Neighbourhood and Environmental Services submits a report to the board on Changing Futures which is a joint funded initiative from the Ministry for Housing, Communities and Local Government (MHCLG) and The National Lottery Community Fund (the Fund).

9. ADULT MENTAL HEALTH SERVICES

Appendix D (Pages 35 - 48)

An update from Leicestershire Partnership Trust (LPT) on change in demand for Adult Mental Health Services and the response

10. CURE

Appendix E (Pages 49 - 70)

The Director of Public Health submits a report to update the Board on the work of the CURE service and the on-going improvements.

11. NEIGHBOURHOOD WORKING UPDATE

The Integrated Care Board (ICB) will provide an update for the Board on Neighbourhood Working.

12. ICB UPDATE

A standing item concerning the reorganisation and work of the ICB.

13. UPDATE FROM THE INTEGRATED HEALTH AND CARE GROUP

Appendix F (Pages 71 - 96)

A standing item around activity at the Leicester Integrated Health and Care Group.

14. DATES OF FUTURE MEETINGS

To note that future meeting dates for the municipal year 2026/27 will be circulated to Board Members following approval at Annual Council in May 2026.

Meetings of the Board are scheduled to be held in Meeting Room G01 at City Hall unless stated otherwise on the agenda for the meeting.

15. ANY OTHER URGENT BUSINESS

Appendix A

Leicester
City Council

Minutes of the Meeting of the
HEALTH AND WELLBEING BOARD

Held: THURSDAY, 4 DECEMBER 2025 at 9:30 am

Present:

Councillor Dempster (Chair)	–	Assistant City Mayor, Health, Cultures, Libraries and Community Centres, Leicester City Council.
Councillor Elaine Pantling	–	Assistant City Mayor, Children and Young People and Education, Leicester City Council.
Councillor Geoff Whittle	–	Assistant City Mayor, Environment & Transport, Leicester City Council.
Rob Howard (Apologies Received)	–	Director of Public Health, Leicester City Council.
Kate Galoppi	–	Director of Social Care and Commissioning, Leicester City Council.
Dr Katherine Packham (Apologies Received)	–	Public Health Consultant, Leicester City Council.
Caroline Trevithick	–	Chief Executive, Leicester, Leicestershire and Rutland Integrated Care Board.
Dr Nil Sanganee	–	Chief Medical Officer, Leicester, Leicestershire and Rutland Integrated Care Board.
Helen Mather	–	Head of Children's and Young People and Leicester Place Lead.
Dr Avi Prasad	–	Place Board Clinical Lead, Integrated Care Board.
Dr Ruw Abeyratne (Apologies Received)	–	Director of Health Equality and Inclusion, University Hospitals of Leicester NHS Trust.
Jean Knight	–	Deputy Chief Executive, Leicestershire Partnership Trust.
Benjamin Bee (Apologies Received – Substitute sent)	–	Area Manager Community Risk, Leicestershire Fire and Rescue Service
Harsha Kotecha (Apologies Received)	–	Chair, Healthwatch Advisory Board, Leicester and Leicestershire.
Kevin Allen-Khimani	–	Chief Executive, Voluntary Action Leicester.
Rupert Matthews	–	Leicestershire and Rutland Police and Crime

(Absent)		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 & Oliver Harrison		Governance Services, Leicester City Council

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150. APOLOGIES FOR ABSENCE

It was noted that apologies for absence were received from Ben Bee, Ruw Abeyratne, Rob Howard and Katherine Packham.

151. 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.

152. MINUTES OF THE PREVIOUS MEETING

The Chair highlighted that the minutes from the meeting held on 25th September 2025 were included in the agenda pack and asked Members to confirm whether they were an accurate record.

AGREED:

- It was agreed that the minutes for the meeting on 25th September 2025 were a correct record.

153. CHAIRS ANNOUNCEMENTS

The Chair highlighted the recent opening of 4 additional beds at a local hospice, which was welcomed as positive news. However, it was noted that concerns had been raised by residents about other available beds that were not currently being funded. The Chair asked that further consideration be given to understanding why these beds were not funded by the Integrated Care Board and invited members to reflect on how they could contribute to this work.

The Chair also raised concerns following a recent visit to Leicester Prison and in light of inspection and national reports on the health of people in prison. It was noted that many individuals entered custody with existing health conditions

and that healthcare outcomes during and after imprisonment were poor. The Chair stated that people in prison should receive the same standard of healthcare as the wider population and that delays in accessing treatment were a serious concern.

The Chair asked whether enough was being done locally to address the health needs of people who were in prison or had recently been released. It was proposed that further work be coordinated by public health officers and that this issue be brought back to the Board for further consideration. The Chair also suggested that clarification was needed on commissioning responsibilities for healthcare in Leicester Prison, including potential engagement with NHS England.

154. QUESTIONS FROM MEMBERS OF THE PUBLIC

It was noted that no questions were received.

155. FIRST STEP PROJECT

The current CEO and her newly appointed successor of the First Step Project gave a verbal update on the First Step Project:

- The project supported male survivors of rape and sexual abuse from ages 13 and over in the Leicester, Leicestershire and Rutland area. The project also offered online support via Teams and Zoom to men outside of LLR as it was highlighted that there were only 7 male survivors centres in the UK. They were a small organisation who had 16 Counsellors and 5 part-time staff.
- Up to 26 weeks of counselling was offered, with clients who ranged from young adults up to people in their seventies. In many cases, it was the first time these men had spoken about their experiences which often happened during childhood. They also offered up to 12 weeks of therapeutic emotional support for men who for whatever reason, were unable to take up the counselling. Another service offered was support and counselling for secondary survivors of sexual abuse, such as family and friends of survivors. A further support group was offered to former clients who have been through the First Step Project, so they could talk with other survivors and keep in contact with the project. They also offered 12 weeks of Counselling to prisoners at HMP Stocken in Rutland, support was also offered at Leicester prison. However, this offer was withdrawn as it became no longer safe for the counsellor to go into that environment due to prison staff shortages at Leicester Prison.
- The challenges which the First Step Project was facing were detailed. It was explained that the charity was receiving multiple inappropriate referrals from the primary care sector which was affecting the charity and members of the public. There were numerous cases of men being signposted to the First Step Project from the Primary Care Sector who in some cases, had attempted suicide in the previous 24 hours. While it was acknowledged that the Primary Care Sector was facing a lot of pressures and that the First Step Project would be happy to help where

they can, it was commented that inappropriate referrals were doing more harm than good. The charity did not have the capacity to support men in such a vulnerable condition.

Comments:

- Members raised questions about the referrals being received by the charity from the Primary Care Sector and whether they thought this was a knee jerk reaction from the health service. In response, it was commented by the CEOs that it appeared to be a tick box exercise by the triage team of the Mental Health Crisis unit. It appeared that they simply checked if a patient had a history of sexual abuse and then signposted them to the charity without assessing if that was appropriate. As mentioned in the presentation, they were contacted by men who in the previous 24 hours had attempted suicide and had been in contact with the Bradgate Unit. It became so frequent an occurrence that the charity developed a prepared statement which was put onto their website and detailed the criteria for an appropriate referral. The Managing Director of Leicestershire Partnership Trust (LPT) advised that she would speak with the Mental Health Crisis Team and discuss the situation. She would also collect the contact details for the CEO of First Step and liaise with them about how they can resolve the situation.
- Members were interested to find out what was the gap in the statutory care services, such as Children's and Adult Social Care, that the charity was filling. It was explained that First Step only dealt with clients who were sexually abused and that because of this niche, their waiting lists were minimal. This topic prompted further discussion about the voluntary and charity sector and their interactions with the Primary Care Sector. It was commented on that the situation of First Step was not unusual and that more communication and transparency was needed between both parties. The chair discussed with the Chief Executive of Voluntary Action Leicester about drafting a report on the voluntary sector which would explore the area in detail.
- The Director of Adult Social Care & Commissioning as well as The Associate Director for Integration & Transformation, advised that they were unaware of the existence of the First Step Project. The members noted that they would like to develop a dialogue and links between themselves and the charity, so that they were able to utilise the service and refer the correct clients to the charity. The CEOs of First Step advised that they were not surprised that many of the members were unaware of their existence as male sexual abuse carried a lot of stigma.
- The chair raised again the situation of prisons in Leicester and that the charity was forced to stop their support for inmates due to safety concerns. The chair also commented on the lack of coverage of mental health on the Board and asked for officers to prepare a report on the topic.

AGREED:

1. The Board noted the presentation.
2. The Managing Director of LPT to speak to the Mental Health Crisis Unit and liaise with First Step Project to help improve the current referral

situation.

3. The Chief Executive of Voluntary Action Leicester to liaise with Public Health about a potential report looking deeper into the voluntary sector.
4. Chair requested a specific mental health focused agenda, specifically on the demand in the system.
5. The ICB and LCC Adult Social Care would make contact with First step.

156. CHANGE PARTNERSHIP PROGRAMME - SEND ALLIANCE

The Director for LLR Send and Inclusion Alliance gave a presentation on the Change Partnership Programme. The following was noted:

- The Alliance branding and identity had been co-produced with local young people and that there were 5 strategic alliances in place.
- A co production lead for children and young people had been appointed, with links into a regional young people forum.
- A report produced by young researchers had been published for young people, parents and carers.
- The Local Inclusion Support Offer is a multi-disciplinary approach to bridge the gap between specialist and mainstream provision
- The Alliance had been formed from the national Change Partnership Programme, which commenced in September 2023.
- The first 2 years of the programme focused on the local area, with the current phase moving towards sustaining and embedding work beyond the end of the programme in March.
- The Local Inclusion Offer was outlined, with a focus on supporting children and young people with special educational needs to remain in mainstream education wherever possible.
- It was reported that a significant amount of testing and learning had taken place, with support in place to continue this work after the programme concluded.
- An overview of the change programme and the Local Inclusion Offer was provided. Key elements included the existing specialist teacher service in the city and a strong focus on alternative provision.
- Partnership working for neurodiversity support was highlighted, alongside a universal support offer for every child.
- It was noted that almost 1000 children had been supported and diverted away from specialist services.
- There was a particular focus on early years and pre-primary provision.
- Community inclusion work was outlined, with similarities noted to other local programmes focused on inclusive practice.
- Work had taken place within local communities to better understand and strengthen the role of the voluntary and community sector.
- Social prescribing for 14 to 18 year olds had been tested, with a particular focus on key trigger points for neurodivergent children.
- Consideration was being given to expanding the social prescribing role to include children and young people as part of a general offer.
- Strong links were reported with the Families First Programme and Family Hubs, with work underway to integrate services more effectively.

- Frustration around navigating the system was acknowledged as a key priority.
- Commissioning for the programme had been aligned, with no additional funding available.
- It was noted that supported services were working well across age boundaries.
- Priorities had been informed through local inclusion plans, local research with children and young people and work undertaken by health partners.
- A data dashboard had been developed to bring together intelligence and improve understanding of need.
- Seven key priority areas had been identified, which included Mental health, particularly for children below the CAMHS threshold and the impact of mental health on school attendance.
- Information, advice and support, highlighted through the local SEND inspection and the need to align local authority and health advice.
- Coordination and navigation of services.
- Preparing for adulthood, including post 16 pathways and learning to be shared across the wider system.
- Speech, language and communication needs, with evidence highlighting vocabulary challenges at age 4.
- Neurodiversity waiting lists, including work on integrated waiting safely offers and neurodevelopment pathways.
- Transport, noting the impact of SEND transport issues on continuing care packages
- Accountability and collective ownership were highlighted as essential, with a focus on strengthening governance arrangements.
- The Board was informed that the Alliance was constituted and funded through a Department for Education funding stream.
- Partners included health providers, integrated care partners, all 3 local authorities, and parent and carer forums, which were described as critical to the work.
- Schools development and local organisations were noted as playing a key role in regional and local support, informing and hosting key roles.
- It was acknowledged that the structure of the Alliance could appear complex, but it had been designed to enable specialists to collaborate flexibly across different areas of interest.
- The Alliance was described as operating alongside existing partnerships, with a focus on joint strategy, neighbourhood inclusion planning and profiling work in schools.
- It was noted that the Alliance was not resourced to resolve all issues but aimed to operate in gaps and take forward specific pieces of joint work, drawing on national models and links with NHS projects.

A test of SEND Local Partnership Maturity Assessment Tool had been designed by the DfE to support Local SEND and Inclusion Partners to evaluate and enhance current practice in a structured way.

1. Co-productions with parents/carers and children and young people.
2. Understanding and evidencing the needs of children and young

people with SEND and those children and young people who may need alternative provision.

3. A clear focus on early identification, intervention and inclusion in mainstream settings through improving mainstream inclusion.
4. Creating collaborative relationships with providers of early years, school and further education places, specialist provision, children and young people health services for 0-25. Social care services and the Local Authority.
5. Improving outcomes based accountability through transparency, communication and trust.
6. Using a range of sources to monitor effectiveness and enable continuous improvement, ensuring targeted, judicious and sustainable use of resources.
7. Driving strategic decision making at the right level.

In discussion with Members, the following was noted:

- Members discussed the limited reference to the voluntary and community sector and noted that formal representation was not currently reflected within the Alliance governance.
- It was acknowledged that while some partnership links existed, there was scope to broaden engagement with local communities and a wider range of voluntary organisations, particularly to support social prescribing and reduce pressure on existing provision.
- Members highlighted the importance of stronger links with academic institutions to ensure that the work was underpinned by research, evidence and data.
- Gaps in alignment with existing SEND partnership governance arrangements were noted.
- Reflections were shared on the long term impact of exclusion and lack of early inclusion, particularly for young people aged 18 to 25 with complex needs.
- Members emphasised that early intervention in mainstream education could prevent later crisis interventions and reduce restrictive and high cost care.
- Concerns were raised about growing unmet need among young people aged 14 to 18, particularly those not in education, and the risk of young people falling through system gaps.
- Members noted that many young people did not identify with SEND terminology and that needs often related to wider social and family circumstances, reinforcing the importance of aligned family based approaches.
- Members welcomed the progress made through the Alliance but noted that funding was limited and time limited.
- It was highlighted that decisions would be required within the next year to sustain the work and retain skilled staff.
- Members discussed diagnostic waiting lists and the significant backlog.
- It was noted that national models showed earlier needs based support could reduce pressure on diagnosis pathways, while recognising that formal diagnosis remained important for some families.

- The Chair highlighted concerns around rising exclusions of children with SEND, including informal exclusions, and the impact this had on families and the wider system.
- Members agreed that inclusive approaches across education and health were essential to address these pressures.
- Members emphasised the need for stronger evidence within reports to demonstrate improved access and outcomes for children and young people with disabilities, including how reasonable adjustments were being made across generic services.

AGREED:

1. That the board notes the report.
2. That the board will scrutinize future reports to ensure it is addressing the health and wellbeing of young people with disabilities.

157. IMMUNISATIONS AND VACCINATIONS

The Head of Immunisations and Screening for the ICB submitted a presentation on the current vaccine and immunisation rate in LLR:

- The ICB was not currently a commissioner of vaccines but was due to be by April 2027. The ICB was preparing for the delegation of commissioning responsibilities and increasing uptake of vaccinations in the city across the whole age board by incorporating the lessons learned during Covid.
- An uptake in the Maternal Pertussis was seen. The dip in uptake following the Covid period was gradually reduced from its nadir in 2023 by several projects to boost engagement with the community. These projects included clinical phone calls and text messages to unvaccinated women, a community pharmacy pilot, a roving healthcare unit who offered vaccines, stabilised staffing levels and bookable appointments at hospital sites.
- For the last decade there was a decline in uptake of children's vaccination and the City was falling below the World Health Organisation goal of 95% vaccine coverage for children. The 2024-2025 data was a lot more positive and indicated an upward trajectory in vaccine uptake. It was commented by the Head of Immunisation and Screening that the current operational data which was not currently published was showing even more improvement.
- LPT introduced their e-consent forms for school vaccines and there was an increase in uptake in school children being seen. There was also an increase in contacting parents whose children are eligible and an attempt to standardise the contact methods and attempts across the GP practices. Feedback was collected from parents about the language of the form to make the information less technical and more accessible to the public.
- The LLR Vaccine Hub website had 22,000 views in the past 12 months and the 'Walk in Immunisation Finder' which details the

location of local walk-in clinics saw 9,700 hits since October 2025.

- Strategic priorities of the service were to secure sustainable funding that specifically targets health inequalities as well as improve on the two key doctrines of allocating efficiently and universal proportionalism. Embed vaccination into the NHS prevention plan, expand the community outreach and engagement, prepare for commissioning responsibilities and optimise opportunities for NHS reorganisation.
- Overall, it was stated that LLR is in a better situation than most others in the midlands and was above the regional and national averages. This year's winter vaccination campaign saw a much higher profile awareness campaign in the media and the ICB senior leadership, which helped to increase uptake. Areas for improvement were increasing vaccine rates among pregnant women, the clinically vulnerable and those who were eligible for the RSV vaccine.

Comments:

- Members enquired about the maternal RSV vaccines and what the potential risks were if the vaccine wasn't administered. It was explained that by not taking the vaccine, mothers were exposing their child to respiratory viruses when they were born. A further question was raised by members about the possible legal implications of not vaccinating children and were there any laws about child endangerment regarding this. In response, the Chief Medical Officer for the ICB detailed that there were no laws in the UK which compel vaccination and it was not covered under child safeguarding. Culture in the UK was always angled towards personal choice for the individual rather than compulsion, it was noted that apathy and scepticism was a large factor because of this. It was also commented that scepticism and apathy was even an issue amongst healthcare and social care workers.
- The joint work occurring between the ICB and Public Health to increase engagement and uptake of vaccines in the City was discussed. The situation regarding the HPV vaccine in Leicester and the various engagement programmes to increase its uptake in schools were mentioned. The new e-consent form was due to be rolled out in January 2026 which combined with the other engagement work was hoped to improve uptake. It was raised by the Head of Immunisations and Screening that she would like to come back to the Scrutiny Board with a presentation specifically on the HPV issue as it was arguably the biggest challenge in the City.
- Representatives for the ICB announced that they were discussing the potential of shift to an outreach provider based in the community, rather than a roving health unit. It was argued that these community outreach providers would achieve the main future goal of prevention rather than treatment.
- The chair stated that she would like the topic of engagement with

members of the public who have mental health problems or a learning disability to be explored. She also supported a future in depth look at the HPV vaccine and a further progress update on the immunisation and vaccine rate.

Agreed:

1. The report was noted by the Board.
2. The ICB to bring forward a future report which explores the HPV vaccine uptake in the City.

158. HEALTHY WEIGHT

The Deputy Director of Public Health presented a report on Leicester's Whole System Approach to Health Weight:

- This presentation arose from a previous presentation to the Health and Wellbeing Board on the NHS Healthy Weight Declaration. In said meeting, members requested a deeper look into the wider work being undertaken as part of the Healthy Weight Declaration.
- The project was developed as a preventative service. The goal was to stop people becoming overweight in the first place by changing the system.
- The initiative was built on 3 key pillars: The first pillar was building a stronger system. This was through embedding healthy weight goals into the infrastructure and strategies. So that the goals of the project were known and striven for.
- The second was changing the environments to increase opportunity. It was highlighted that society doesn't make healthy choice easy and therefore work was needed to help combat that. The projects for this pillar were developing more cycle and walking routes to promote exercise as well as work with takeaways to offer heathier options and reduce fat and salt content.
- The final pillar focused on empowering workforces and communities. Training was provided to social care staff about healthy weight, nutrition and healthy conversations programmes. This was combined with outreach to communities to better understand and tackle the root causes behind obesity rates.
- The excess weight stats for the City were a cause for concern. In the City, 62.8% of adults, 19.3% of reception age children and 39.1% of year 6 age children were classed as living with excess weight. It was commented that for adults and reception age children, the percentages were levelling out which shows progress was being made. However, the figure for year 6 age children was above both the regional and national average and was still increasing year on year.
- The project was keen to focus on tackling the weight stigma and bias that can put people off from engaging with weight loss services. Focus groups were held in October and December 2025 to help inform the language and communication toolkit of the work. This was with the aim

of avoiding the language of blame or lecturing which could be off putting to members of the public.

- In 2018, 23.8% of pregnant women in Leicester at appointments were defined by BMI as living with obesity. Work had been done to help support pregnant women with keeping healthy such as aqua natal and buggy fit classes. There was also myth busting such as the eating for two myth and being unable to do exercise.
- Projects that were helping keep children healthy were detailed. The HENRY Parenting Programme, for children aged zero to five years old, had proved to be quite successful in Leeds. It was piloted in Leicester with future plans for full adoption of the programme underway. The Leicestershire Nutrition and Diet Service (LNDS) had built on the work of food for life in changing the culture in schools around food. The project targeted areas such as tuck shops in schools and children bringing in cakes and sweets for their birthdays.
- The link of food poverty and unhealthy eating was identified, and projects were set up to reduce food insecurity through skills-based cooking sessions and support. 'Food with Friendship' and 'Cooking on a Budget', taught members of the public how to cook as well as how to reduce food waste and had a community aspect, which helped to tackle social isolation.
- Specific work had been implemented in social care as part of the learning disability collaborative. This helped to support people with disabilities who were living with excess weight. Around 70% of people with learning disabilities were living with excess weight and to help reduce this, a healthy weight toolkit was created with an LPT nutritionist.
- Notable attention was paid to food commissioning as the City Council had 30 contracts linked to food procurement. The Public Health department spent time analysing these contracts and assessed whether making healthier food could be a requirement of the contract. There was also a drive towards engraining healthy eating into the future procurement process.
- There was also collaboration between Public Health and the Festivals and Events Team regarding food stalls at events. The main aim of this was to explore if healthier options could be offered by some of the catering businesses at events.

Comments:

- The Managing Director of LPT highlighted the topic of mental health and weight gain. It was explained that LPT was supporting people with a severe mental illness to maintain a healthy weight as the drugs supplied can cause notable weight gain. It was advised that they supported those people with dietary advice and healthy eating. The Deputy Director of Public Health responded that mental health was another target of the initiative, and they were planning to release a programme specifically targeting certain groups, including people suffering with mental health.
- There was a lengthy discussion about tackling childhood obesity and the various methods which could be implemented to lower it. The Chief

Medical Officer for the ICB suggested that tackling obesity at a young was one of the most vital preventative health measures and should be prioritised. It was argued that there needs to be a shift away from the traditional methods of treating obesity towards a broader more global programme.

- The Director for Adult Social Care & Commissioning asked the Deputy Director of Public Health about their involvement with Children's Social Care and Education colleagues. It was mentioned that there was some work underway, but they were unsure of the progress at that time. They agreed to have a discussion regarding this in a separate meeting.
- Members raised concerns about schools as it was highlighted that Healthy Weight initiatives in the past have approached certain schools and been refused access. School meals were also featured as a concern as well as breakfast clubs, while it was commented that they were a good idea, there were fears of high sugar options being offered. The Deputy Director of Public Health advised that it had become easier to build relationships with schools and that they were getting much more access with breakfast clubs as schools welcome external support. It was explained that school meals was a more complex issue as this is organised by private companies and varied from school to school.
- The Chair argued that a greater focus was needed on families as parents control the vast number of meals which children eat, and the change needed to starts there. She further suggested that healthcare professionals should comment on excess weight more when assessing patients' health and wellbeing. The Deputy Director of Public Health echoed this comment and explained that a survey was conducted last year with healthcare professionals, to check if they asked members of the public questions about their weight. It was found that most of the health practitioners surveyed did not ask patients about their weight as they felt uncomfortable raising the issue or felt unsure how to constructively discuss the matter. The Deputy Director of Public Health advised that they were conducting work with primary care workers to help address these concerns.
- The Chair requested a further update on the initiative and how it was being implemented by LPT and UHL.

AGREED:

1. The presentation was noted by the Board.
2. The Director of Adult Social Care & Commissioning and the Deputy Director of Public Health to have a separate meeting about the Healthy Weight programme in Children's Social Care and Education.
3. A future update on the work progress of UHL and LPT to be brought to a future meeting.

159. UPDATE FROM YOUNG VOICES CONSULTATION

Due to time limitations this item was deferred to the next meeting. It was agreed it would be the first item on the agenda.

160. UPDATE FROM THE ICB

The Chief Medical Officer from the Integrated Care Board (ICB) gave the board a verbal update on national changes to NHS England and the resulting reduction in running costs for Integrated Care Boards. The following was noted:

- There had been significant change over recent months, including revised timelines and the need to implement running cost reductions, supported by redundancy resources.
- Integrated Care Boards had clustered, bringing boards and leadership teams together, while resources and finances remained separate and were allocated based on population.
- The number of Integrated Care Boards nationally had reduced from 42 to 26, with a cluster arrangement now in place locally alongside a neighbouring system.
- Executive leadership arrangements for the cluster were outlined, with national appointment processes led by NHS England.
- Announcements on redundancy had been made, with consultation expected to take place in January.
- It was acknowledged that this was a difficult period for staff, particularly during winter pressures, but that there was relief in having greater clarity following national announcements.
- A blueprint document had been produced to reduce duplication and support new ways of working with partner organisations.
- It was emphasised that the new model would require delivery with a reduced organisational footprint.
- Reconfiguration work was ongoing, with further financial information expected in the new year.
- Partners were asked to note the challenging context while maintaining a focus on delivering a safe winter, financial planning for the year ahead, and the longer term 10 year plan.

An update was provided on neighbourhood working across Leicester, Leicestershire and Rutland by the ICB.

- It was explained that neighbourhoods were aligned to geographic boundaries, although local alignment had required agreement across partners and had not been straightforward.
- All partners had committed to this approach, recognising the challenges around funding flows and financial pressures.
- Members were informed that neighbourhoods aimed to provide access to a wide range of support in one place, spanning health, care and the voluntary and community sector.
- The Board discussed why neighbourhoods mattered, with a focus on improving population health, strengthening communities and supporting people to stay well for longer.
- It was highlighted that early intervention needed to start with children

and families, noting that many existing services focused on adults.
- The importance of using hospital services for specialist care only was emphasised.
- Data was shared showing that life expectancy in the city was lower than in the county and that 2 in 5 children were living with obesity.
- Members were informed that neighbourhood planning would include health alongside wider determinants of health.
- Plans were outlined for engagement activity, including workshops in each area towards the end of January involving communities, partner organisations and providers.
- Engagement with the voluntary and community sector had already begun, including webinars and in person events.
- It was emphasised that staff training would be critical to ensure awareness of available services and appropriate support for residents.
- The importance of using population data was highlighted, including understanding patterns of attendance at emergency departments and discharge outcomes.
- The approach would be evidence based, with a framework to support planning and delivery.
- Initial priorities would focus on achievable improvements in 2026 and 2027, recognising that neighbourhood and provider level change would take 2 to 3 years to embed.

In discussion with Members, the following was noted:

- Members discussed the importance of strong engagement with the voluntary and community sector and reflected on the value of community insight in shaping neighbourhood based approaches.
- It was suggested that voluntary and community sector representation within governance arrangements could further strengthen understanding of local need and support effective partnership working.
- Members reflected on the current financial context and the pressures being experienced across the system, including within the voluntary and community sector.
- The importance of open, ongoing dialogue with partners was emphasised to support shared understanding and collaborative planning.
- The scale and pace of change underway was acknowledged, with members recognising the impact on staff and partner organisations, with the importance of clear and timely communication during this period of transition.
- Members welcomed the focus on neighbourhood working and agreed that approaches should continue to be shaped by local priorities and community need.
- It was stated that the ambition to deliver care closer to home would require services to move from hospital settings into neighbourhoods, with funding and workforce capacity moving alongside those services.
- That the neighbourhood delivery would require changes to workforce models, including training and the use of different professional roles, and

that collaboration across providers would be necessary.

- Members stated that it was important to ensure the appropriate organisations were involved in neighbourhood discussions, including local authority services already operating neighbourhood based models.

AGREED:

1. Slides from the presentation would be circulated to Board members.
2. A short update on neighbourhood working would be included at each Board meeting, with a focus on tackling inequalities and improving outcomes for residents across the city.

161. UPDATE FROM THE INTEGRATED HEALTH AND CARE GROUP

This item was deferred to the next meeting due to officer absence.

162. DATES OF FUTURE MEETINGS

The Board noted that future meetings of the Board would be held on the following dates:-

Thursday 5th March 2026 – 09:30 am

Meetings of the Board are scheduled to be held in Meeting Rooms G01 at City Hall unless stated otherwise on the agenda for the meeting.

163. ANY OTHER URGENT BUSINESS

With there being no further business, the meeting closed at 12.35pm.

NHS
Leicester, Leicestershire and Rutland

Children, young people and families' voices on healthcare across LLR: Report of Findings

17

Leicester City Health and Wellbeing Board December 2025

Appendix B

Children's Young People and Families Engagement

A proud partner in the:

Leicester, Leicestershire and Rutland
Health and Wellbeing Partnership

Recap: ‘What You Saying?’ Young Voices on Healthcare

- Over 3,000 voices heard – including young people, parents/carers, and healthcare professionals across Leicester, Leicestershire & Rutland.
- Insight from **What You Saying?** was combined with findings from the **Darzi Report** and the **NHS 10 Year Plan**.
- Together, these shaped the creation of **LLR ICB’s 3-Year Children, Young People & Families Engagement Plan** (2025–2028).

The plan sets out how the voices of children, young people, and families will shape local health and care services.

The cross over of local voices, and national direction.

Darzi Report	NHS Ten Year Plan	Young Voices
Patient Voice	Hospitals to Community	Improved Comms
Mental Health		Young People's Identity
Digital Access & Navigation	Analogue to Digital	Better Services & Experiences
Health Inequalities		Stronger VCSE Pipeline
Workforce Challenges	Sickness to prevention	Mental Health
		Sleep

ICB's 3-Year Children, Young People & Families Engagement Plan (2025–2028)

Delivery Priorities for the next three years

Delivery Priorities over the next 3 years			
CYPF Voices	**Digital**	**Prevention**	**Influencing Health and Social Care**
Co-produced CYP Engagement Policy.	Young people's views on digital and AI in healthcare	Understanding barriers to accessing healthcare – E.g vaccinations, stigma etc.	Improving services, including: • Transitioning to adult services – both Mental Health and Physical.
Improving CYP insight on the ICB's Insight and Behaviour Hub.	Coproduction: • Evaluation framework of digital apps and tools. • Design and pilot digital services, apps, websites.	How health inequalities are impacting on CYPF and their health outcomes.	NHS CYP Voice and participation Network. – LPT, UHL, ICB, VCSE – once a quarter. Chaired by senior figure.
Improve our pipeline with VCSE Alliance and local partners, including Education.	Understanding how young people consume digital information which can inform our communication and engagement strategy.	Promoting healthy lifestyles and health literacy. • Sleep. • Mental and physical wellbeing.	Improving healthcare staffs CYP understanding – Listening, gender identity, stigma.

Work currently taking place

Prevention	Building CYP Voice Capacity	Improving Service
Health webinar for parents/carers • Sleep, Screen Demic, Asthma, Dealing with anxiety at school	Lundy Training for schools taking part in the Partnerships for Inclusion of Neurodiversity in Schools (PINS) project	Same Day Access – City, County Rutland
Vaccination communications HPV	Co-produced CYP Evaluation framework for new digital tech / apps / platforms	Transitions to adult service – Physical and Mental Health
	Strengthening LPT's Youth Advisory Board and UHL's Youth Forum influence in the ICB	

Young Voices on Healthcare

Download the full Report of Findings and watch the video

https://leicesterleicestershireandrutland.icb.nhs.uk/be-involved/young-voices-on-healthcare/

Delivery Plan: Year 1 (subject to change)

Year 1			
Task	Method of delivery	Outcome measure	Delivery Priorities
NHS CYP Voice and Participation Network - Mapping	Desk based research	Network database created	CYPF Voice
SEND: PINS: Lundy Training for schools Offer to more schools – Rolling two-year refresher course	Webinar	Attendance and feedback	CYPF Voice
CYPF Engagement Policy	Co-production with young people	Policy created	CYPF Voice
Primary Care Engagement	Bespoke engagement with under 16's	Report of findings from CYP	
Same Day Access – City and County	Engagement activity	Report of findings	
Webinar to parents/carers. 1. Sleep 2. Screen Demic 3. Physical exercise Sleep Information into easy read version	LLR wide Webinar Co-production	Attendance and feedback Content created	Prevention / Digital
CYP: Vaccination communications HPV	Co-produced with young people	Content created. Uptake figures	Prevention / CYPF Voice / influencing service / Digital
MH Transitioning to adult services	Co-produced with young people	Improved pathway. 12-month patient feedback	Influencing services
'What You saying?' You said, we did	Event	Feedback from young people	CYPF Voice, Influencing services, Prevention
Digital: Create CYP evaluation framework of digital tech / apps / platforms	Co-production – CYP, NHS digital, Private sector	Framework	CYPF Voice, Influencing services
Reactive engagement work			
Year 1 evaluation	End of Year Report		

Delivery Plan: Year 2

Year 2 - Expanding and deepening impact			
Task	Method of delivery	Outcome measure	Delivery Priorities
NHS CYP Voice and Participation Network – 4 meetings	Meetings	Attendance, and action log	CYPF Voice
Lundy Training for schools continued	Webinar	Attendance and feedback	CYPF Voice
CYP training on how to engage CYP – built upon the work done to understand CYP, MH stigma	Co-produce with Youth forums, and VCSE	Training resource produced.	CYPF Voice, Improving services
CYP / MH Transitioning to adult services. Reviewing of framework	Young inspectors review transitions	Report of findings	CYPF Voice, Improving services,
VCSE Pipeline Development:	Establish Youth Advisory Boards within local Voluntary, Community, and Social Enterprise (VCSE) hubs and schools to strengthen youth engagement.	Establishment of at least three Youth Advisory Boards in local VCSE hubs and schools. – one in each of LLR	CYPF Voice, Improving services,
Digital – review CYP digital framework	Applying it to digital tools	CYPF evaluation report on digital tools	Digital
Develop health literacy in pre-school, primary and secondary school			Prevention
CYPF Voice Reporting Mechanism:	Develop and implement a clear structure for reporting CYP feedback into the ICB Governance framework.	Strategy presented to senior team	CYPF Voice, Improving services
Reactive engagement work			
Year 2 Evaluation	End of Year report	Submitted to ICB Board and LLR HWB	

Delivery Plan: Year 3

Year 3 - Sustainability			
Task	Method of delivery	Outcome measure	Delivery Priorities
Scaling CYP Awareness training	Extend and embed training across all relevant sectors.	Webinar and face to face training. LPT, UHL, ICB, LA - LLR	CYPF Voice, Improving services
Establish clear CYPF Voice reporting mechanism into the ICB Governance structure		Start producing reports for ICB Governance. Co-produced by CYP	CYPF Voice, Improving services
VCSE Pipeline			
Strengthened mental health frameworks with improved access and support for CYP.			
CYP / MH Transitioning to adult services. Reviewing of framework	Young inspectors review transitions	Report of findings	CYPF Voice, Improving services,
Primary Care Engagement	Bespoke engagement with under 16's	Report of findings from CYP	Influencing services
Reactive engagement work			
Year 3 Evaluation			

Changing Futures Leicester

Health and Wellbeing Board – 5th March 2026

Rebecca Lopez – Changing Futures Programme Manager

Ministry of Housing, Communities & Local Government

COMMUNITY FUND

Appendix D

Changing Futures Phase 1:

We have been working operationally in Leicester since September 2021, and Phase 1 of Changing Futures is due to end on 31st March 2026.

- Support for individuals facing Multiple Disadvantage
- Identifying and driving forward System Change
- Involvement of people with Lived Experiences throughout the programme.

Changing Futures Phase 2:

We have been advised by MHCLG that the Changing Futures Programme will move into Phase 2 in April 2026 and Leicester have been invited to take part. Funding is for 3 years, with funding amounts still to be confirmed.
Commitment to develop a strong local partnership at strategic and operational level involving:

•Adult Social Care
•Public Health including substance misuse commissioning
•Housing support
•Other Local Authority representatives e.g. community safety, youth offending services and health and wellbeing boards
•Strategic NHS partners, including the Integrated Care System, Integrated Care Board and Mental Health Trust
•Police, Police and Crime Commissioner and Deputy Mayors for Policing
•National Probation Service e.g. representation from prison and HM Courts and Tribunals.
•Voluntary, social and community sector partners.
•Jobcentre Plus

Data and Evaluation

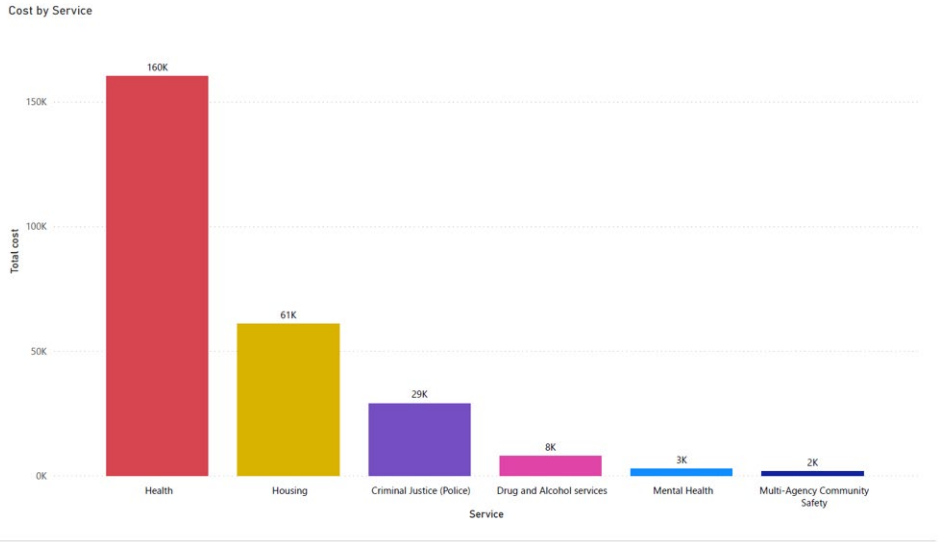
Cost Benefit Analysis
The aim of the analysis is to quantify the financial impact of individuals with multiple disadvantages on public services in Leicester, and to use this data to inform and drive system-level change. This feeds into a broader conversation about whether people with MD and complex needs are more responsive to intensive, targeted support.

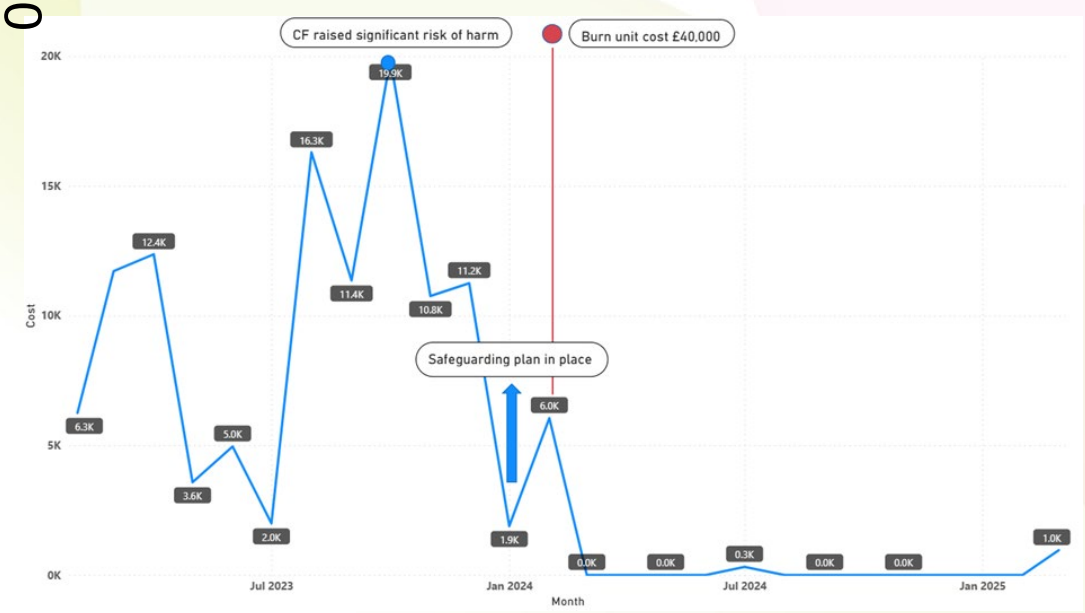
Public service	Service intervention	Unit	Notes	Unit cost	
Health					
	Ambulance	35		£ 13,195.00	
	Amulance service calls	35		£ 3,220.00	
	A&E Admissions	79		£ 24,727.00	
	Walked out A&E Admissions	45	Did not wait to be seen. Cost of no investigation and no significant treatment.	£ 6,345.00	
	Non-elective short stay inpatient	7		£ 6,713.00	
	Non-elective long stay inpatient	13		£ 62,946.00	
	CT Head scan	7		£ 953.12	
	X-ray	3		£ 225.00	
	Burn unit (Feb - March 24)	1	Mean cost of resource use per burn over 24 months from initial presentation	£ 40,576.66	
					£158,900.78
Police					
	Arrests	5		£ 2,035.00	
	Anti-social behaviour incidents - further action necessary	5	Cost of dealing with incident	£ 3,995.00	
	Anti-social behaviour incidents	21	Police intervention (remedial action) and Community Safety anti-social behaviour with Police involvement. (Including Safeguarding PPN)	£ 4,200.00	
	Police call-outs	47	Simple police reporting of incident, no further action taken and Community Safety reporting	£ 2,632.00	
	Police intervention taken to LRI	5		£ 785.00	
	Robbery	3		£ 3,591.00	
	Violence with injury	9		£ 12,051.00	
	Theft	3		£ 141.00	
					£ 29,430.00
Mental Health					
	A&E mental health liaison services	3		£ 912.00	
	Crisis resolution team for adults with mental health problems	1		£ 47.00	
	Mental health initial assessment	3		£ 903.00	
					£ 1,862.00
Drug and Alcohol					
	Drug and Alcohol advice and information	8		£ 488.00	
	Drug and Alcohol crisis management intervention	41		£ 4,961.00	
	Residential rehabilitation for people who misuse drugs or alcohol	20	Number of days	£ 2,328.60	
					£ 7,777.60
Housing					
	Temporary accommodation	296	Number of days	£ 5,920.00	
	Rough sleepers cost for local authority	68	Number of days homeless	£ 1,971.32	
	Support costs for homelessness services (accomodation based)	296		£ 10,022.56	
	Homelessness application	1		£ 3,266.00	
	Administering a decision on a homelessness application	1		£ 490.00	
					£ 21,669.88
Social Care					
	VARM Meetings	10	Cost of MARAC used	£ 1,517.00	
TOTAL					

£221,157.26

Cost Benefit Analysis

This analysis shows the part of the system (Health) where the most financial impact was felt (£160,000).





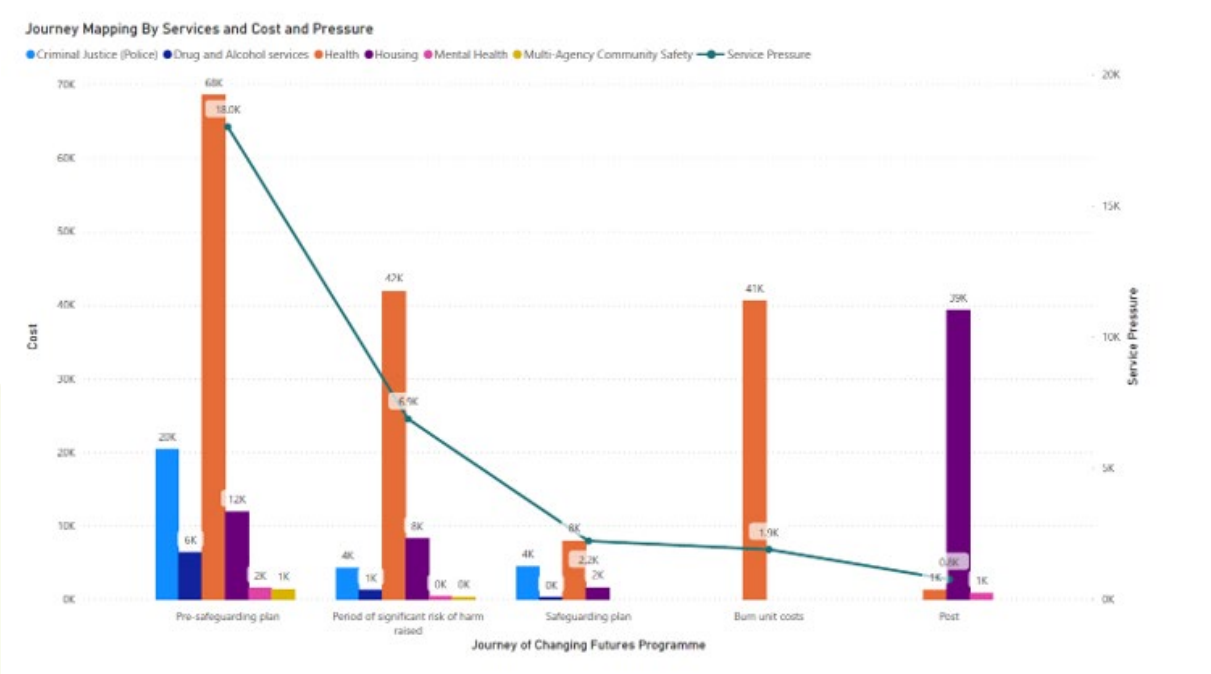
It also shows that targeted, intensive support can reduce the financial impact on the system.

Systems Pressure Mapping

Cost Benefit Analyses can be flawed when applied to individuals with multiple disadvantages and complex needs, as engaging appropriately with services may initially increase costs to the system.

A more meaningful question is: “Does this reduce pressure on acute and urgent services?”

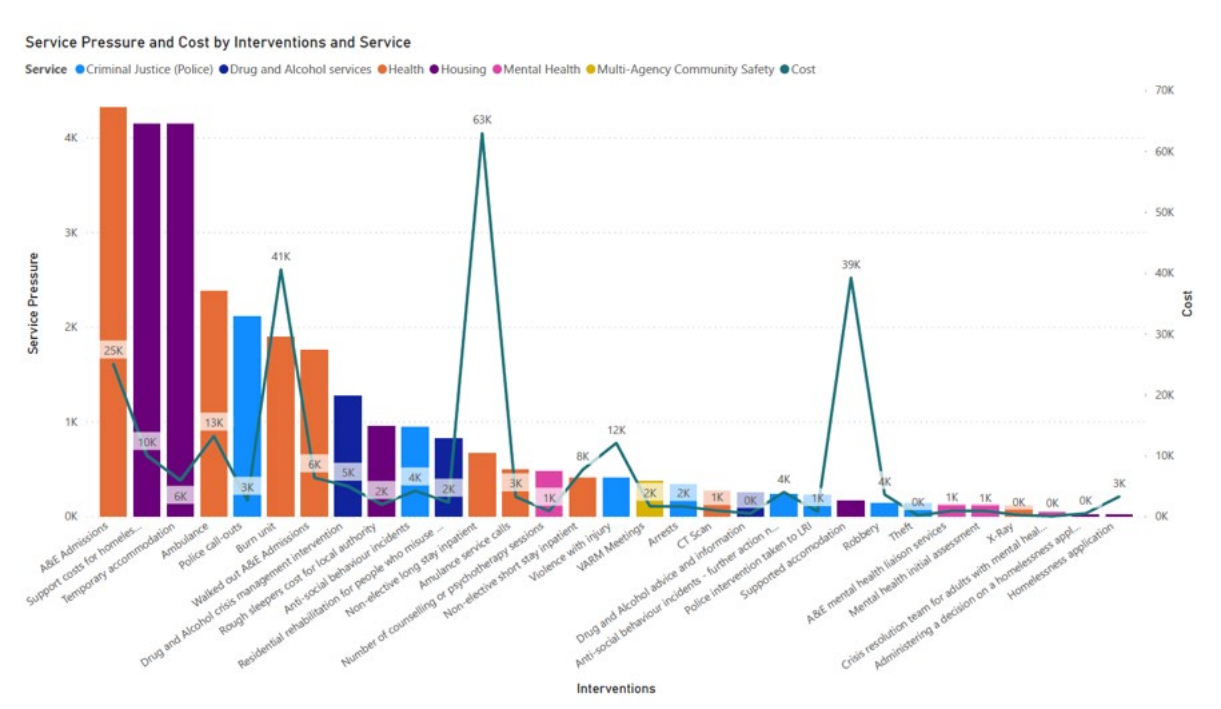
We have compared the systems pressure for the same individual for comparison



The highest system pressures were linked to health emergencies, police callouts, and unstable housing prior to interventions.

Following coordinated support this individual stopped using emergency services as often and because of this, the overall system pressure dropped significantly.

The individual began engaging with planned, preventative mental health and housing services, demonstrating a clear shift from crisis driven system use to sustained stable support – achieving both improved outcomes and cost efficiency.



Children's Social Care Data

Following a dip sample of CF beneficiaries showed that 80% of beneficiaries with Children, had children known to CSC, but that only 0.8% of new referrals to CSC had a parent with MD, We are currently working with Children's Social Care to look at how indicators of Multiple Disadvantage are recorded.

Homeless High Frequency Users of UHL Emergency Department

A 21.2% reduction in individuals attending ED from within tl overall cohort.

An average reduction of 7.9 ED attendances per month.

60% reduction in "did not wait" episodes at a patient level.

Leicester Women's Network – Supporting Women Together

Baseline Survey of Women who are Rough Sleeping in preparation for taking part in the annual Women's Rough Sleeping Census Women's Rough Sleeping Census .

The distribution of the Safer Sex Working Packs across the network began during August and September and we will be using this

Changing Futures Leicester

Thankyou!

https://www.leicester.gov.uk/content/changing-futures/

ChangingFutures@Leicester.gov.uk

Ministry of Housing, Communities & Local Government

COMMUNITY FUND

Leicestershire Partnership NHS Trust

Changing Demand for Mental Health Secondary Care in Leicestershire Partnership NHS Trust

Samantha Wood – Head of Service

Our group strategy

- T Technology
- H Healthy Communities
- R Responsive
- I Including everyone
- V Valuing our people
- E Efficient and effective

Appendix D

Executive Summary & Context

Rising demand and system pressures

We will cover : what has changed, what we've done, what we need next

Overview of LLR population needs

Demographic and socioeconomic drivers

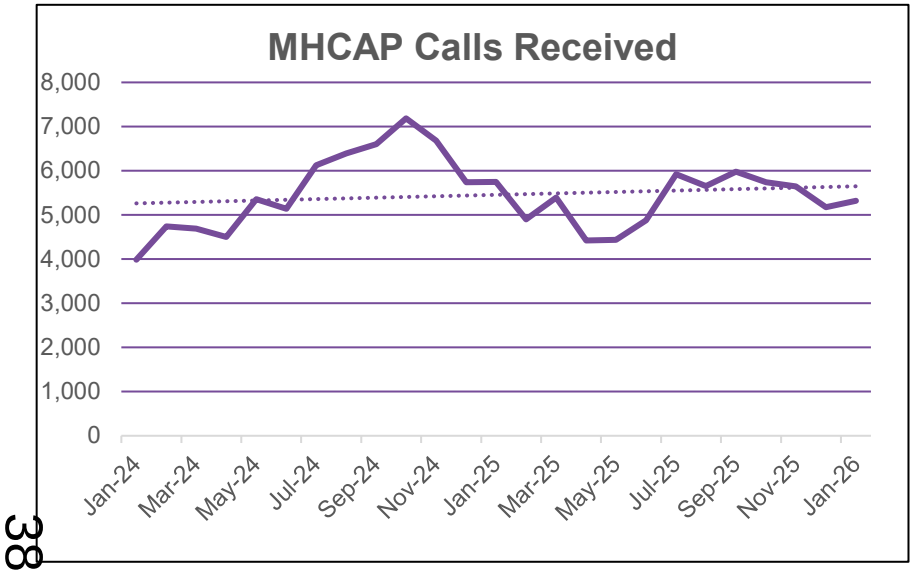
National policy context (e.g., NHS Long Term Plan, community transformation)

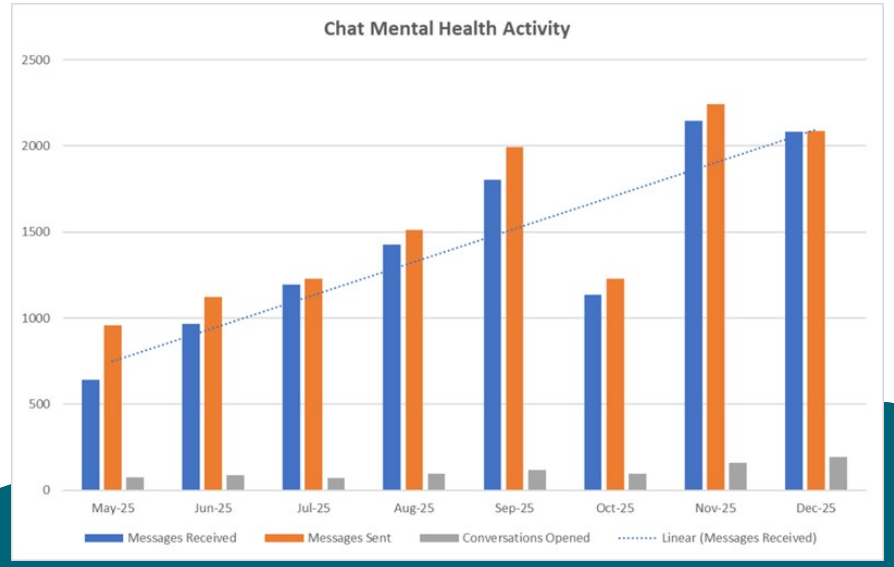
Local inequalities and priority groups

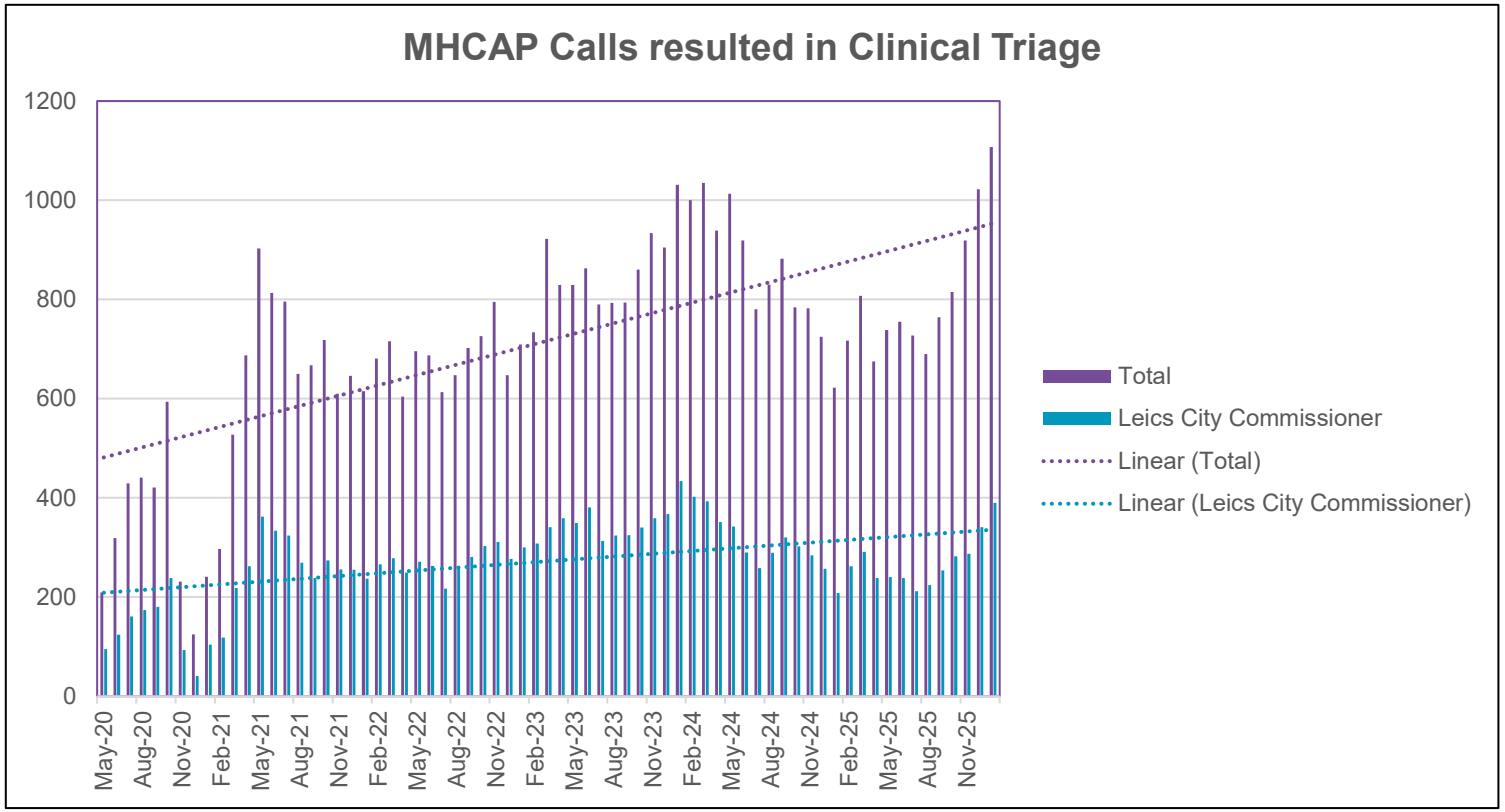
Demand Trends: What We Are Seeing

- Increase in referrals to secondary care services
- Changes in acuity, complexity, and risk profile
- Pressures on inpatient beds, crisis pathways, and community teams
- Waiting times and caseload trends
- Notable shifts post-COVID and due to cost-of-living pressures

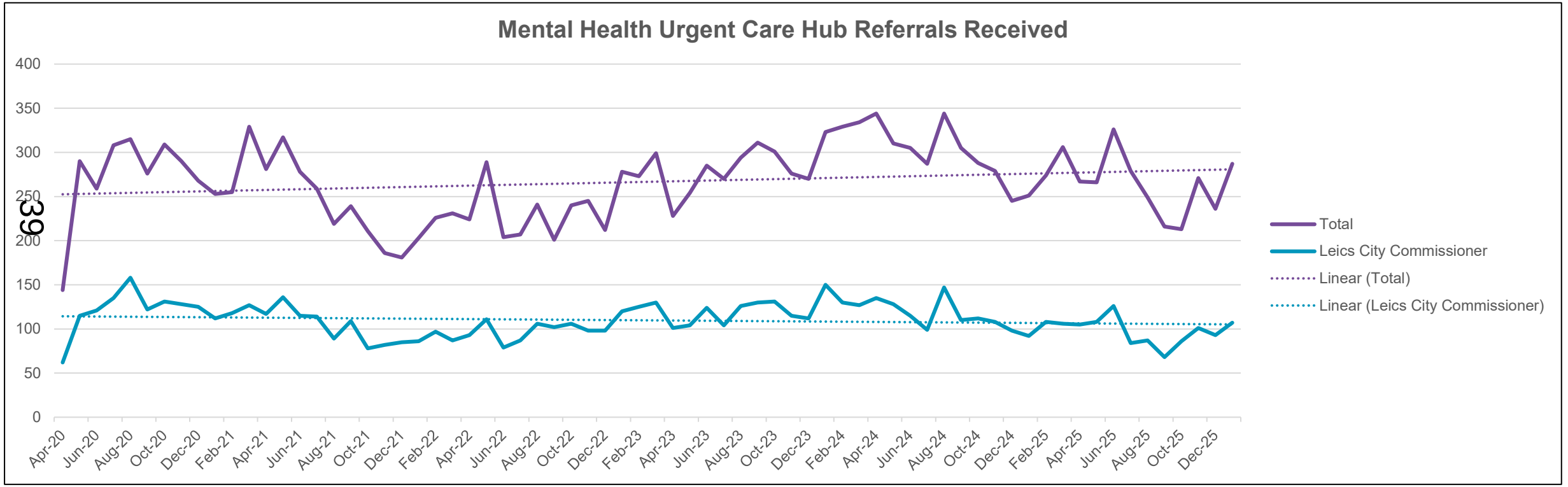
Demand Trends: Secondary Care Front Door



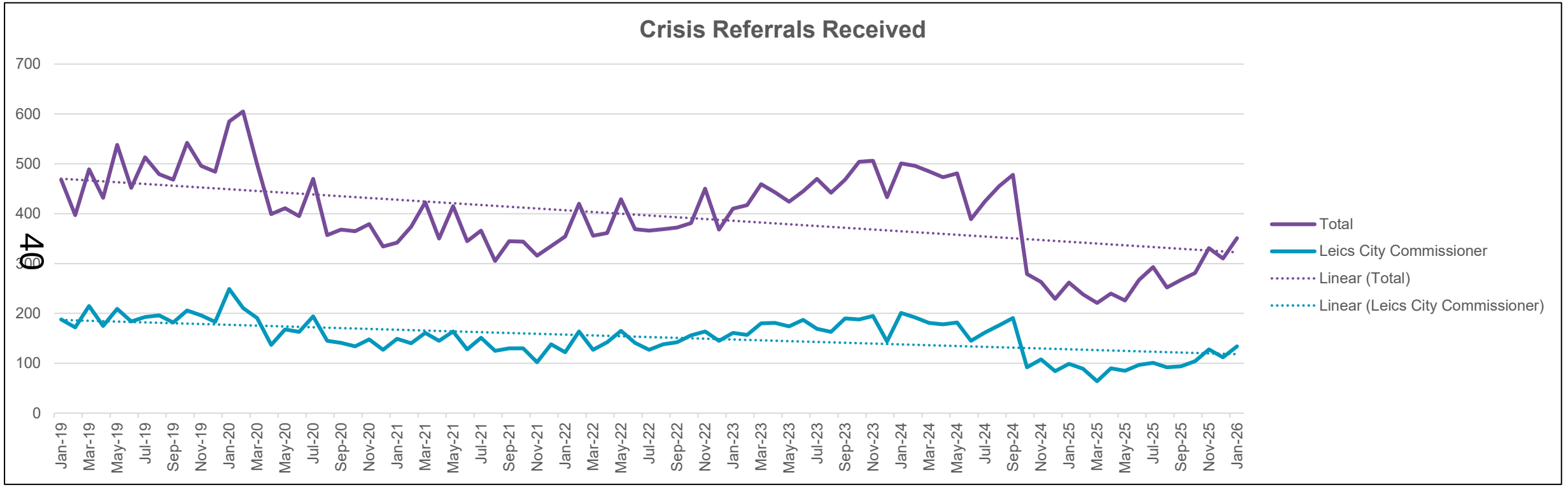




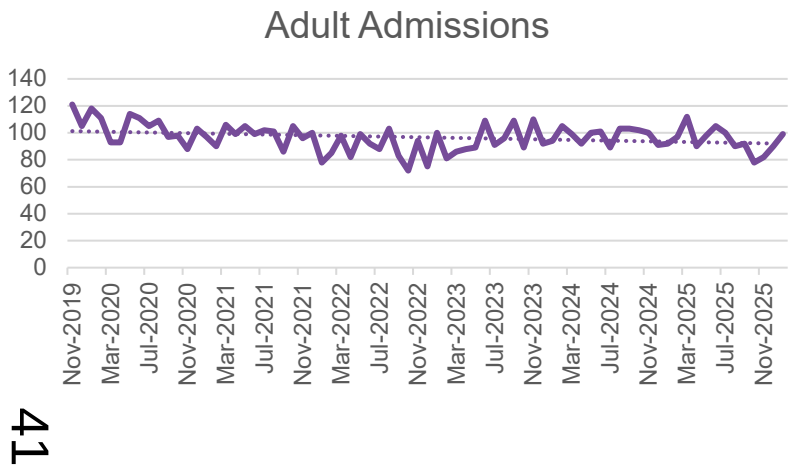
Demand Trends: MH Urgent Care Hub

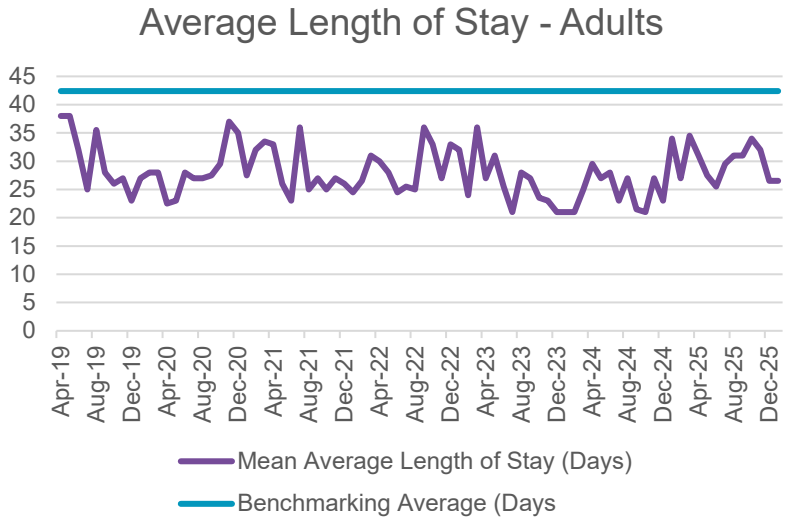


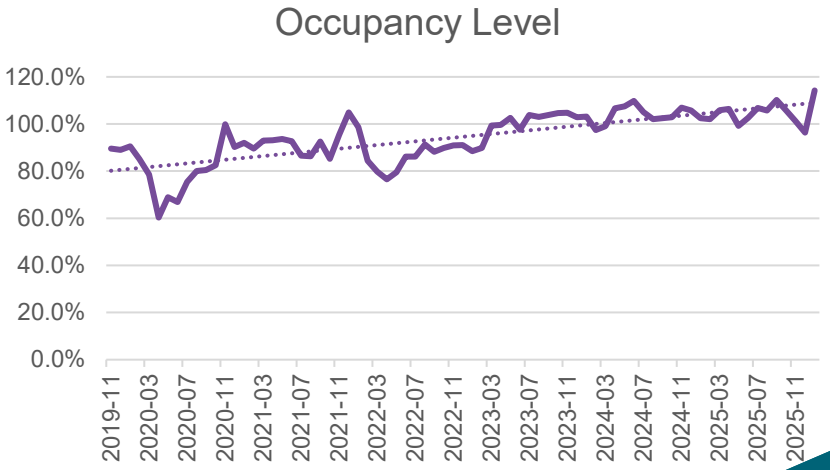
Demand Trends: Crisis Home Treatment



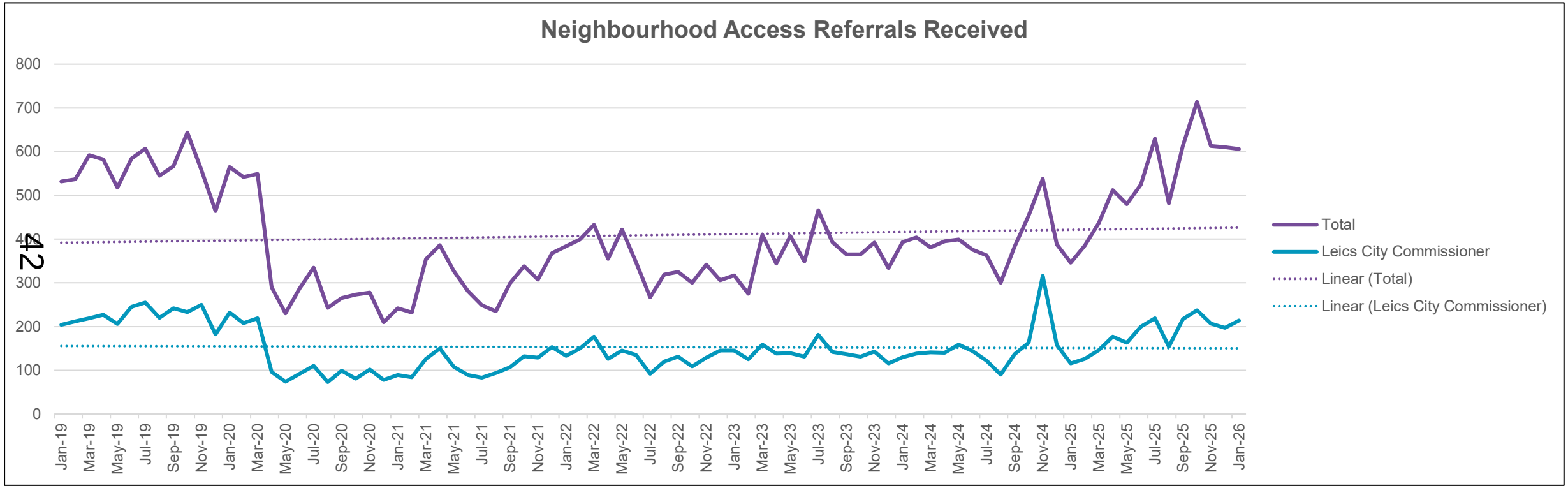
Demand Trends: Inpatient Treatment







Demand Trends: Neighbourhood Access



Drivers Behind the Increased Demand

01

Rising prevalence of mental health conditions

02

Workforce shortages across the system

03

Gaps in early intervention or community capacity

04

Social determinants: housing, deprivation, safeguarding

05

Increased public awareness and help-seeking

What We Have done So Far (LPT Actions)

Actions

- Strengthened triage and front-door pathways
- Expansion or redesign of community mental health transformation
- Crisis pathway improvements (e.g., crisis cafés, home treatment teams)
- Recruitment and retention initiatives
- Digital tools and remote support options
- Partnership working with primary care, VCSE, social care
- Quality improvement initiatives to reduce restrictive practice and improve flow

What Still Needs to Change

- Capacity constraints in both community and inpatient services
- Workforce shortages – National Challenge!
- Need for more integrated support across health, social care, and VCSE with streamlined processes to reduce timescales for actions
- Primary Care mental health support – early-stage interventions before escalating to secondary care
- Housing and social care placement challenges – Saturated Market and High Costs
- Digital limitations
- Financial sustainability longer term

Future Steps: LPT's Next Phase of Action

1. Scaling community mental health transformation
2. Further strengthening crisis alternatives and early intervention at primary care and VCS level
3. Workforce development and new roles
4. Improving flow and reducing length of stay by reducing delayed discharges into community setting
5. Real-time data-driven demand modelling and predictive analytics to support earlier intervention – feed into Strategic Needs Assessment
6. Further co-production with service users, carers and trusted others
7. Tackling inequalities through targeted interventions working with our communities

What We Need from System Partners

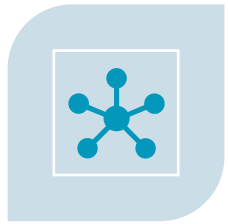
SUPPORT FOR INTEGRATED PATHWAYS AND STREAMLINED GOVERNANCE

JOINT WORKFORCE PLANNING ACROSS SECTORS

INVESTMENT IN PREVENTION AND EARLY HELP AT PRIMARY CARE LEVEL

HOUSING AND SOCIAL CARE COLLABORATION TO IMPROVE MARKET PROVISION

SHARED DATA AND INTELLIGENCE



CONTINUED COMMITMENT TO SYSTEM-WIDE TRANSFORMATION

Summary and Call to Action

- Summary of the challenge
- What LPT has delivered
- What is required to meet future demand
- Clear ask of the Health and Wellbeing Board

Questions and Discussion

Appendix F

Acute CURE service report

Health and Wellbeing Board

Date of meeting: 05/03/2026

Lead director/officer: Rob Howard

Useful information

- Ward(s) affected: all
- Report author: Alex Hammant, Claire Mellon
- Author contact details: alex.hammant@leicester.gov.uk, Claire.mellon@leicester.gov.uk
- Report version number: 1

1. Summary

In hospital smoking cessation programmes are supported by both the NHS Long Term Plan and the 10 year “Fit for the Future” plan.

The CURE programme is the in-hospital smoking cessation programme for Leicester. Tobacco Dependency Advisors (TDAs) work with patients to advise and support them in their smoking cessation journey.

This programme is a unique opportunity to interact with people who may previously not have considered smoking cessation, but because of their admission to hospital, they are more likely to give up if they receive timely support.

In-hospital smoking cessation narrows health inequalities: the team see more patients, and generate more successful “quits” in those from lower IMD quintiles than higher.

In-hospital smoking cessation has been shown in studies from two other areas to have significant return on investment, not just for the NHS, but also for wider communities. (In Manchester, for every £1 invested in in-hospital smoking cessation, there was a return on investment of £30.49 for the wider public health of the local community).

The current programme works across all three hospital sites in Leicester and generated 245 new quits October 2024 – October 2025.

Work is ongoing to make the programme as efficient and effective as possible. This includes a new text-based programme, more streamlined transfer of care to community smoking cessation services, increased pharmacological support and workforce training and education.

2. Recommendation(s) to Health and Wellbeing Board:

Health and Wellbeing Board are invited to:

- Note the work of the CURE service and the on-going improvements
- Recognise the potential cost-effectiveness and reductions in inequalities the service provides

3. Detailed report

1.1. Background

There is a national push for in-hospital smoking cessation services. In 2019, the NHS Long Term Plan (LTP) outlined a requirement to provide all people admitted to hospital who smoke with an NHS-funded in-house tobacco treatment service by 2023/24.

The NHS Long Term Plan:

"*2.9. First, the NHS will therefore make a significant new contribution to making England a smoke-free society, by supporting people in contact with NHS services to quit based on a proven model implemented in Canada and Manchester [26]. By 2023/24, all people admitted to hospital who smoke will be offered NHS-funded tobacco treatment services."* (NHS Long Term Plan, 2019)

This was further supported by the publication of the "Fit for the future 10-year health plan" which stated:

"We will deliver our manifesto commitment to integrate opt-out smoking cessation interventions in all routine care within hospitals" (Fit for the future 10-year health plan, 2025)

The programme was started after funding, guidance and delivery models were issued by NHSEI in 2019, services were to be implemented across three key settings: acute inpatients, mental health inpatients and pregnant women. This report focuses on the acute inpatients service (all three services are currently running across UHL and Leicestershire Partnership NHS Trust).

The work currently undertaken follows the "CURE model". Manchester developed the CURE programme by adapting the Ottawa Model for Smoking Cessation (OMSC) to a UK context. CURE stands for Conversation, Understand, Replace, Experts and Evidence-based treatments (CURE). This model aims "to change healthcare practices so that smoking cessation treatment is provided as part of routine care to all patients who are tobacco users". This model is evidence based, validated, and has shown favourable outcomes.

Figure 1: CURE acronym

The service is currently funded by the ICB, UHL and Leicester City Council. The ICB provide 4 Tobacco Dependency Advisors (TDAs), a co-ordinator, pharmacotherapy, communications team input, and QuitManager software. UHL contribute the majority of pharmacotherapy and Leicester City Council provide an additional TDA.

The TDAs work in all three of Leicester's hospitals. They are given a list of patients each day who have been identified at initial triage as current smokers. They will visit these patients and conduct motivational interviews; they also provide NRT. If anyone would like to quit smoking then they will discuss the most suitable options for each person (which can include NRT or other pharmaco-therapy including varenicline and cytisine), they will then refer the patients to their local stop smoking service. Most referrals are made to either LiveWell for city residents or QuitReady for county and Rutland residents, but they can be further afield.

We have a bold vision within Leicester City Council "to make Leicester smoke-free by 2030". To achieve this aim we need to have a high-performing service meeting the needs of our population. CURE is one part of the wider current smoking cessation programme operating in the city.

1.2 Why in-hospital support for smoking cessation is important for individuals

Smoking is the leading cause of all premature and preventable deaths. Tobacco kills up to half of its users [1]. After the age of 35, for every year of continued smoking, a person loses about 3 months of life expectancy [2].

Furthermore, smoking has a direct effect on people's wealth. At today's prices smoking 20 cigarettes per day will cost an individual £67,267 over 20 years if they buy cigarettes in packets, and £31,450 over 20 years if they use hand rolled tobacco [2].

In-hospital smoking support is able to reach people from all backgrounds, at a time where they are more likely to consider quitting.

1.3 Why in-hospital support for smoking cessation is important for our communities

In Leicester, we as a city are worse off when it comes to smoking. The Leicester Health and Wellbeing Survey in 2024, which conducted a total of 2100 interviews across the city, found that Leicester's current smoking prevalence is approximately 16%. This means that almost 50,000 individuals are smokers. 50% of those would like to quit. This 16% prevalence figure is higher when compared to the England average of 13.6%.

According to the Health and Wellbeing Survey smoking rates vary within different communities in the city. However, there is no area where smoking rates are zero. Prevalence in West locality 24%, and Northwest locality 23% are significantly higher than Leicester overall. North and Central localities are significantly lower than Leicester, 9% and 12% respectively.

[1] Facts at a Glance - ASH
[2] Stopping Smoking - ASH

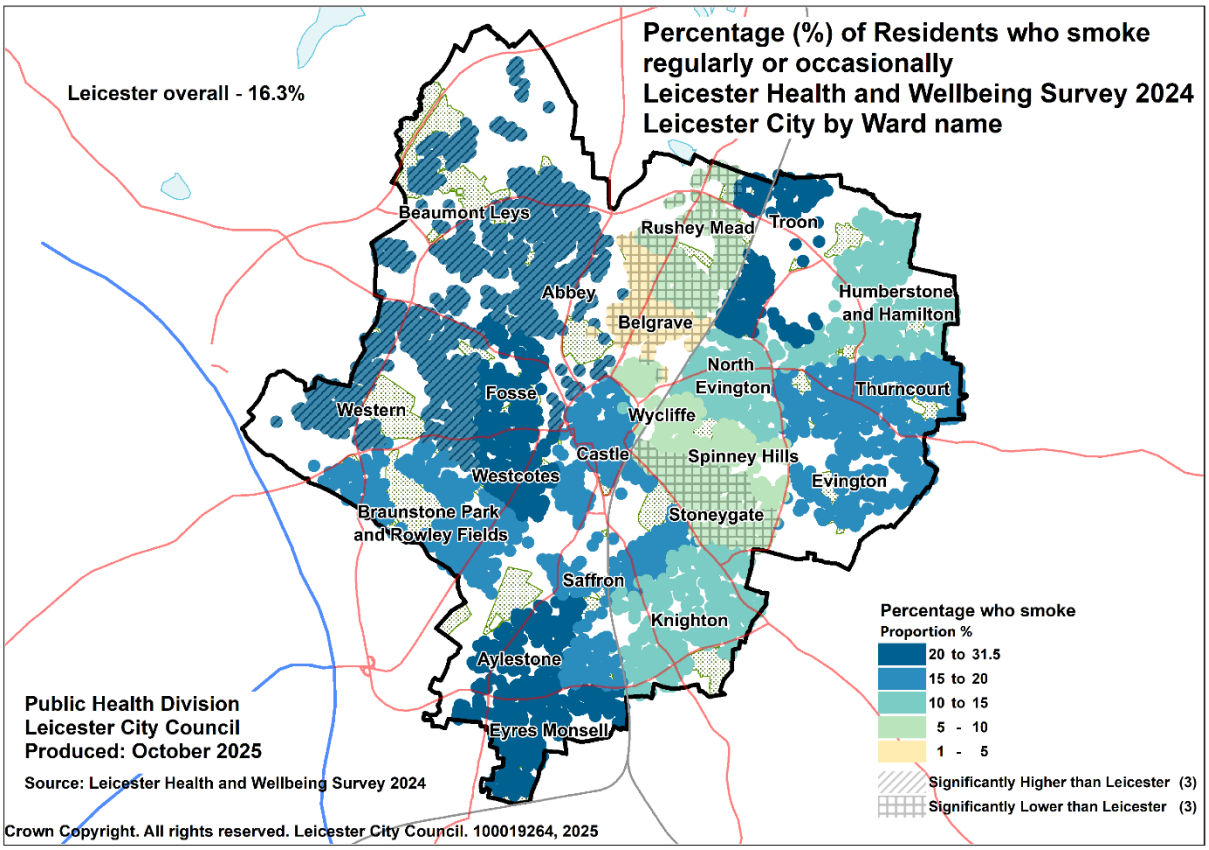


Figure 2: Percentage of residents who smoke by Ward

Smokers in Knighton, North Evington, Troon and Wycliffe are significantly more likely to want to quit. Smokers in Abbey, Fosse, Braunstone and Rushey Mead are significantly less likely to want to quit. Noticeably some areas with high smoking prevalence have a low proportion who would like to stop, e.g. Abbey has a significantly higher (23%) smoking prevalence but a significantly lower (29.5%) who would like to quit.

Arguably, this makes the work of the CURE team even more important. Being unwell, in hospital, often as a direct result of an individual's smoking, is a unique opportunity to encourage behaviour change. Particularly for those who had not considered quitting before. The CURE team see individuals from all these different communities (as well as those individuals from outside of the city), and they see them directly related to their health needs, even those from communities who may less frequently interact with healthcare. This is a key strength of the programme.

National health inequalities data show that in hospital smoking cessation programmes engage with those from all IMD quintiles. What makes this programme unusual is that it shows the opposite of the usual trend for health promotion programmes, usually those from higher IMD quintiles are more likely to access and engage in services. In contrast, in-hospital smoking cessation services data nationally shows that those from the lowest IMD quintiles were involved in more successful quits compared to those in the least deprived quintiles.[3]

[3] Is the provision of a national opt-out tobacco dependence treatment service in acute hospitals in England equitable? A national cohort study | Thorax

This national picture is also seen in UHL where those in the most deprived quintile commenced over triple the quit attempts than those in quintile 5. This is likely to be at least partly explained because those in quintile 1 are more likely to be in hospital, and that those in quintile 1 are more likely to smoke compared to quintile 5. The service success rate in persuading those people they see to commence a quit attempt is similar across the quintiles.

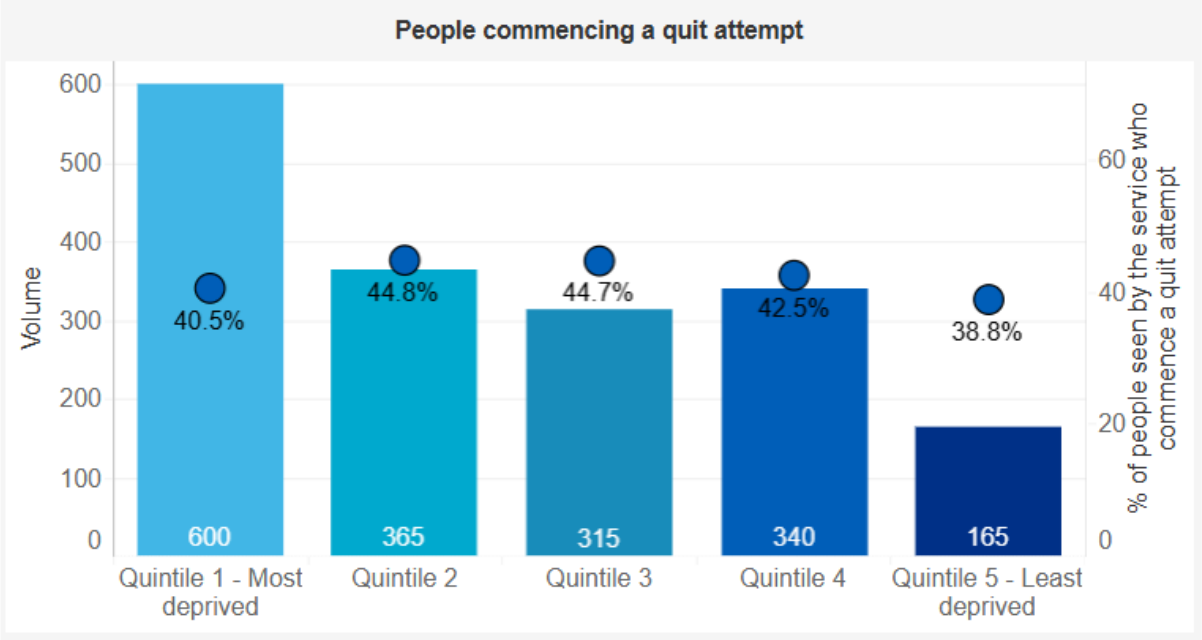


Figure 3: UHL quit attempts by IMD quintile (October 24 – September 25)

In Leicester, in the last 3 months of published data (September – December 2025), 33.73% of the patients the CURE team saw, were from the most deprived quintile of the population. Therefore, based on current data the CURE team provide a service which reduces rather than widens health inequalities in our communities.

In total, nationally in 2024, after the work of in hospital smoking cessation programmes, more people in lower IMD quintiles quit smoking compared to those in higher quintiles.

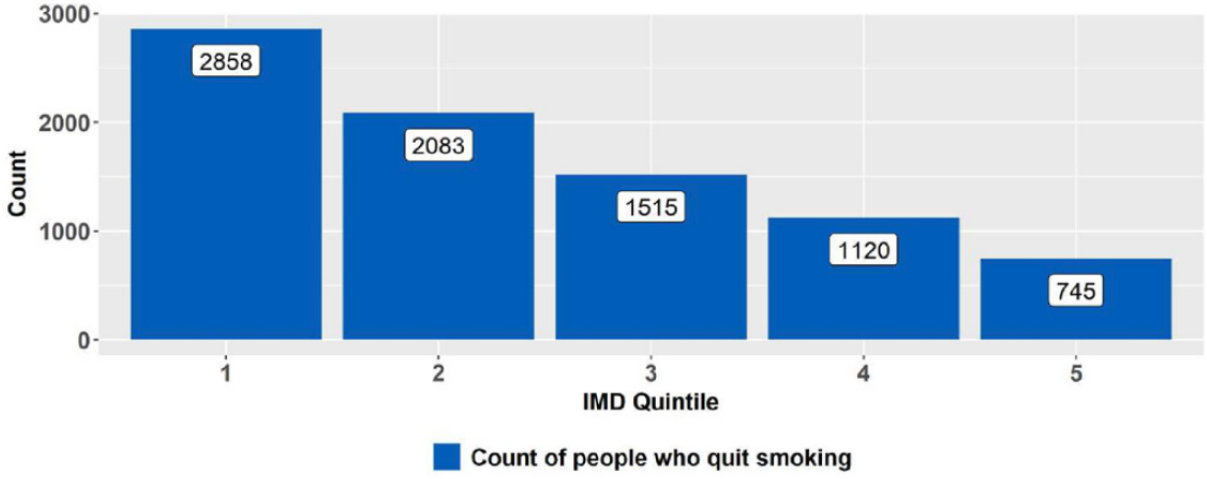


Figure 4: People successfully quitting after a supported quit attempt which started after an in-hospital smoking cessation intervention [3]

This is likely due to the facts that those in quintile 1 are more likely to smoke and are also more likely to be in hospital. In UHL this trend was the same as the national picture.

Therefore, the CURE service is an unusual service because it is more likely to engage, and be used by, those in lower IMD quintiles. It is more likely to narrow rather than widen health inequalities. This is down to the demographics of those admitted to hospital and those who smoke. Due to the hospital setting, it represents a unique opportunity to provide targeted health promotion interventions to individuals who may have less access to this material outside of acute healthcare.

1.4 Why in-hospital support for smoking cessation is important for the economy

Nationally, the NHS bears a heavy cost from smoking – £1.8 billion annually,[4] with one person admitted to hospital nearly every minute due to smoking-related disease. Up to 75,000 GP appointments each month are linked to smoking - more than 100 every hour.[5] Therefore, the more quits that can be generated the more capacity is created across the whole health system.

An economic evaluation was made for an in-hospital smoking cessation service in Southeast London in 2024 [6]. They have a very similar service to Leicester where TDAs would perform motivational interviews to patients whilst they were in hospital and then refer those interested in stopping smoking to the local community smoking cessation services. They calculated that their "cost per quit" was £1712.55. The ICER (Incremental cost-effectiveness ratio) was £3325 per life year gained i.e. for every £3325 spent on this scheme 1 additional year of life in full health was gained. This would be significantly under the threshold of £25000-35000 that NICE currently uses, showing that this method is very cost-effective at improving health.

The Southeast London study then looked at all the patients that their TDAs had seen and calculated that re-admissions of these patients were significantly lower than those who were not seen (5% vs 11%). (This was all patients who were seen, not just those who agreed to a quit attempt). They calculated that there was a return on investment for the NHS of £1.37 for every £1 spent. It should be stressed that this was just the financial benefit to the NHS and that quitting smoking also leads to financial benefits to individuals, families and wider society (through increased productivity and reduced inequality).

Another health economic study was performed looking into the Manchester CURE project, published in 2021 [7]. This calculated that their cost-per-quit was £475 and their ICER was £487. This, therefore, represents even better value. The return on investment was £2.12 for every £1 invested. They also calculated that the "public value", which considered longer term cost savings related to improved health of those who quit, meant that the return on investment was £30.49 per £1 invested in this wider context.

[4] ashresources.shinyapps.io/ready_reckoner/
[5] Ending smoking could free up 75,000 GP appointments each month
[6] Economic evaluation of a hospital-initiated tobacco dependence treatment service | BMJ Open
[7] Health economic analysis for the 'CURE Project' pilot: a hospital-based tobacco dependency treatment service in Greater Manchester | BMJ Open Respiratory Research

We predict that our own health economic figures would be somewhere between these two studies, this is because of the relative sizes and ages of the services. Our approximate cost per quit is between £900 - £1,200 per quit. Furthermore, public health interventions typically generate greater cashable cost savings when implemented at scale and when implemented over longer time scales. The Manchester project is larger and has been going for slightly longer than the Leicester project. Therefore, we would expect its return on investment to be larger at this stage.

1.5 Our current service performance

The most recent performance data of the service over one year (October 2024 – October 2025) is below.

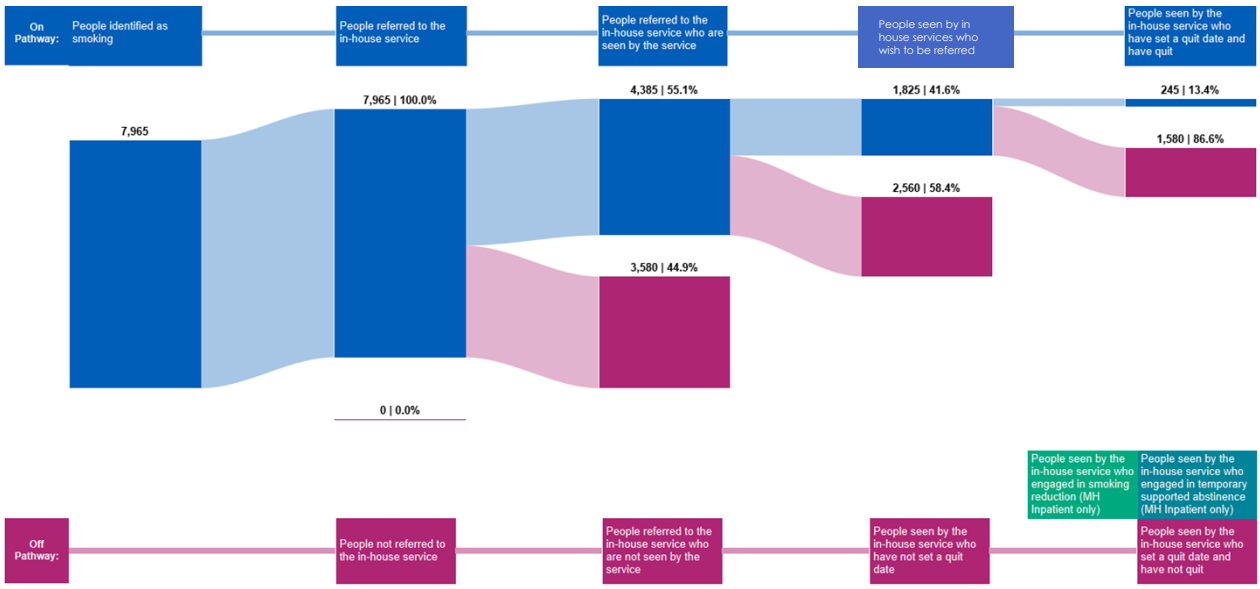


Figure 5: 1 year overview of the current service.

In the year between October 2024 and October 2025 (the most recent available published data from NHSE) the service had individual motivational interviews with 4,385 individuals. This led to 1,825 people wanting to undertake a quit attempt, and of these 245 were successful (13.4%). The successful quit percentage has steadily increased over the last year. The last month's quit percentage was 19.2%. This compares to all-time the national average of 18.2%.

These quit percentages are much lower than the quit rates seen in community stop smoking services (LiveWell's current quit rate is over 55%). However, LiveWell's quit rate is based on people being motivated enough to refer themselves to LiveWell, and then, after they have a discussion with an advisor being motivated enough to set a quit date. LiveWell's quit rate is calculated as the number of people in this group who then successfully quit. Conversely the 19.2% figure for CURE is a percentage of those people who are seen by the CURE team whilst in hospital and wish to be referred to community

services to then have a further discussion to set a quit date. Furthermore, the CURE team are not seeing a predetermined group of people who already have some motivation to quit, they are seeing everyone in hospital whether they are part of the 50% of the population who are thinking about quitting or not. Therefore, there are often individuals who wish to be referred whilst in hospital and then change their minds or who are later uncontactable.

More recent data than October 2025 is presented below. This is taken directly from the TDA patient software “Quit Manager” from July 2025 and January 2026.

CURE is usually referred between 600-800 patients to see each month. The team typically sees between 55%-65% of these patients. It should be noted though that the TDAs do usually see all those referred patients who are still in the hospital. There are many patients who are admitted and discharged in the evening or weekend who are unable to see a TDA. The numbers of patients seen by each individual TDA compares favourably to other areas and has increased over the last year (see successes section).

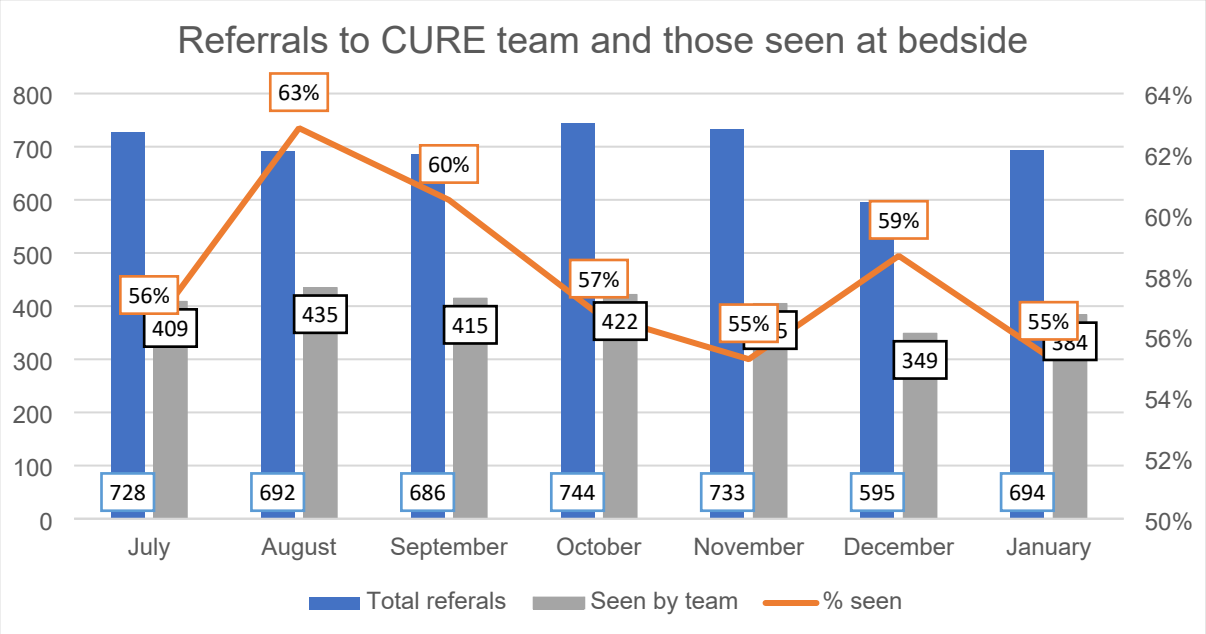


Figure 6: Referrals to CURE team and numbers seen by CURE team

Those who are referred to, but not ultimately seen by, the CURE team are part of a cohort of patients who we are actively exploring how we might contact more regularly. When TDA capacity allows they call some of these patients post-discharge. However, this is only a small percentage currently as it is dependent on workforce capacity.

After a patient is seen by a TDA many are then referred on to the relevant community smoking cessation services. This is usually between 100 and 160 patients each month. These patients are prioritised by LiveWell and phoned, normally, within a week of their discharge. This is to ensure that momentum is not lost in their quit journey.

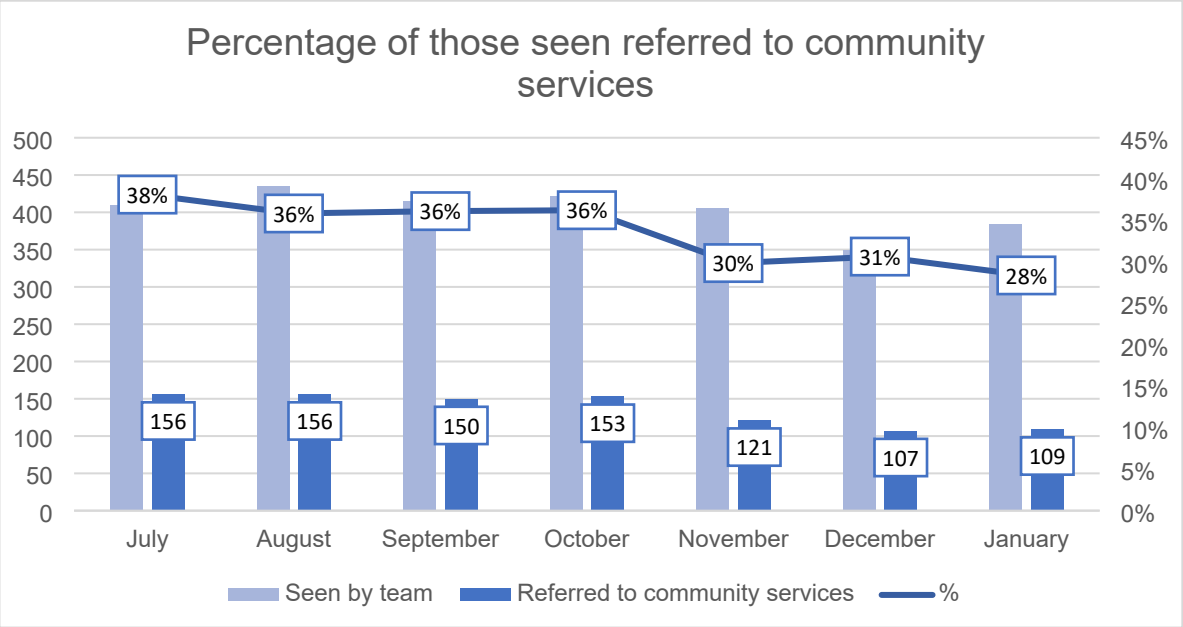


Figure 7: Percentage of those seen who are then referred to community services.

The total number of quits is shown in the next figure. Please note that the January quit data is not yet available as the measure is taken 28 days after they have set their quit date. We also expect the December number to increase as there is often a lag in reporting. (Usually, this increase is between 1 and 5 each month).

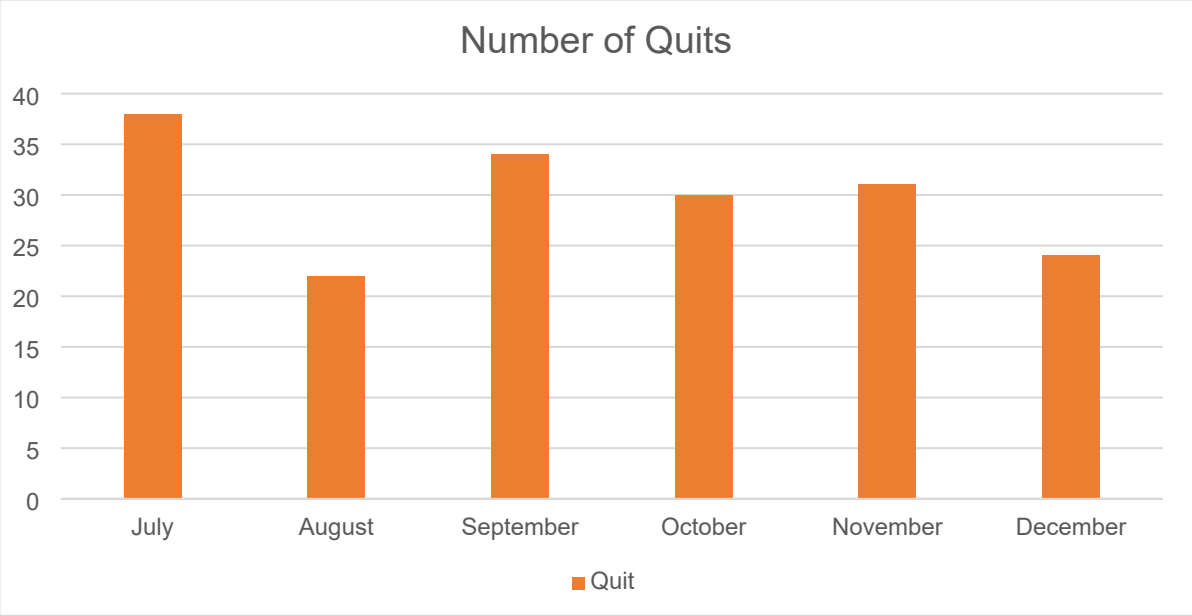


Figure 8: Total quit numbers per month, July – December 2025.

The service feeds into different reporting groups. There are regular (every 2 months) steering group meetings between CURE, in-patient mental health services, and maternity services, with representatives from the ICB and UHL present. There are also data working group meetings (every 2 months) where data issues are specifically covered with IT and informatics representatives also present. The group feeds into the UHL prevention board.

1.6 Service successes

As already stated above the percentage quits has increased over the last year. This is likely due to several factors. One of the most important is the introduction of a new texting service. We are now sending out texts, to those who consent to it, after they leave hospital. If they want to consider a quit attempt at this point we can then refer into community services. We have also found that we hear of more successful quits from those individuals who did not engage with local services but successfully quit by themselves. This further emphasises the importance of connecting with people whilst they are in hospital and are more focussed on their health.

Texts sent	**514**
Number replied -"quit"	**86**
Number replied – "not quit"	**61**
Percentage of people who replied to text	**29%**
Percentage of people who replied to say they quit	**17%**

Table 1: Most recent texting results September – November 2025

Another factor is likely to be that the TDAs are seeing a higher number of patients in hospital. This is because an additional TDA was appointed one year ago and reflects a more mature service - our TDAs have recently been contacted by two other local trusts to discuss this increase in efficiency as other areas want to copy our model.

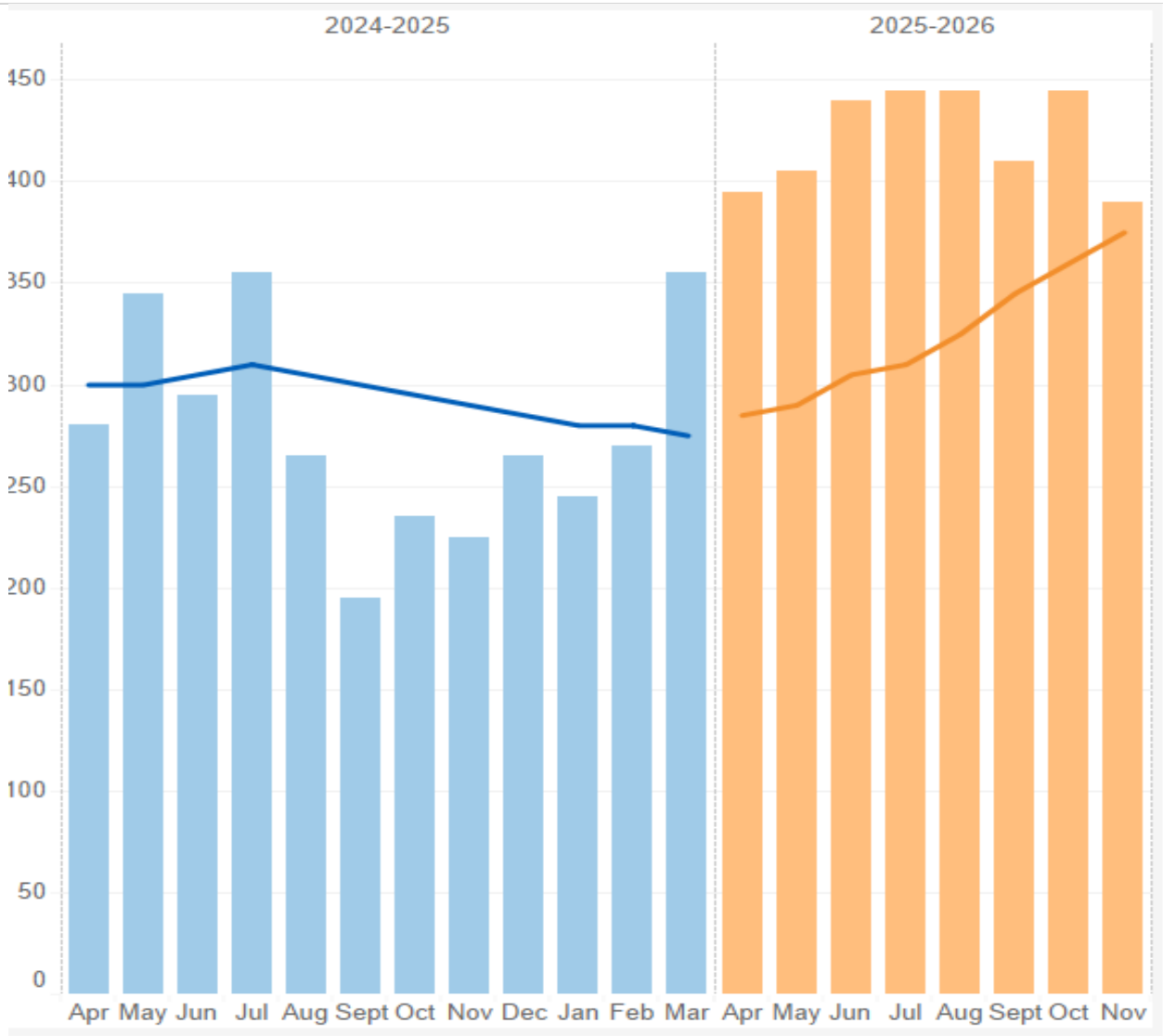


Figure 9: Number of patients seen by CURE team over time

Another on-going quality improvement project is trying to reduce the drop-off in people being referred to LiveWell and ultimately engaging in the service. Previously individuals were contacted by a hub advisor and then booked in with a smoking advisor. The hub advisor would complete a survey of general health questions to see if there were any other areas of the LiveWell service the patient might benefit from. Feedback suggested that this sometimes put individuals off as they wanted to focus on smoking cessation. QuitReady (the county community service) did not have this additional survey set of questions and had less drop off in engagement. Therefore, a new pathway is currently being reviewed where this survey is not completed at the point of booking. Initial reports suggest that this is leading to improved engagement.

Some patient testimonials about the service from those patients who successfully quit are below:

"[I have] *never felt so good. I feel great! Approaching 70 and feel 45. Those 10 days in hospital changed my life; it was for the best I fell down. Giving up smoking means I am saving £2,500 a year. I have booked two holidays, and it's not stopping there! The help I received was excellent".*

“The thing I am most pleased with is not coughing in the morning. I used to cough a lot. I can also smell more and taste things better. Overall, I feel so much better, feel my lungs are healthier. I’ve also saved some money.”

“My bank balance is better. I used to buy x4 packs a week at £12 so saving £48 a week now and I feel a lot better. You’ve all been brilliant!”

1.7 Areas for improvement

There has recently been an expansion of smoking cessation work into the outpatient setting. Those who are identified in A&E, lung cancer clinics and TIA clinics as being current smokers enter an opt-out pathway where they are called and then referred into their local community smoking cessation service. This is an area which we are looking to expand.

The quit rates for those people who are referred into lung cancer clinic are particularly high. Over a 4-year period (August 2021 – August 2025) 1204 patients were referred via the opt-out pathway. The service successfully contacted 417 people who then went on to engage in a quit attempt. Of these 258 successfully quit. The overall quit rate among all current smokers who were successfully contacted was 31% (258/834).

It is likely that lung cancer clinic patients are the most highly motivated to quit smoking so their quit rates are significantly higher than those who are current inpatients. It is likely that those referred from other related outpatient settings would have lower quit rates. However, this represents another route where the smoking cessation advisors have an interaction with a person when they are much more likely to be focused on their health and are therefore, more likely to consider a quit attempt. Work is underway to try and automate and expand the current service.

We are currently working to ensure that varenicline and cytisine prescriptions are done in a timely and effective manner. In a pilot of targeted prescriptions, there was an almost 40% quit rate for local patients. Therefore, we are keen to ensure that, for those who would like to try these, they have the option. Currently there are three main barriers to prescribing these drugs. Firstly, there is a hesitancy from staff to prescribe as there are warnings in the (British National Formulary) BNF about prescribing due to the risk of mental health crisis. New studies have shown that it is actually the effect of stopping smoking which raises this risk. We are tackling this with an awareness raising campaign (through targeting prescriptions, pharmacy champions and education sessions). Secondly, there can be difficulties ensuring that these medications are added to the discharge letters. This is usually due to communication breakdown between the TDAs, the ward team, and those individuals who are preparing the paperwork. We are tackling this issue with a quality improvement project around new giant stickers for the notes to improve handover to new ward team members and teaching sessions to ward staff. The third barrier is ensuring that the full course is prescribed on discharge. This has improved after pharmacy support and is being further tackled through pharmacy champions to facilitate discharges. To note, there is also work on-going for local community smoking cessation services to also have to capability to provide these drugs. This will also help to improve access to these medications.

1.8 Final comments

The CURE team provides a service to people which benefits their health, their communities' health and the wider economy. Quitting smoking is usually the single best thing someone can do to improve their health [8].

This service drives down health inequalities.

This service is very likely to produce a positive return on investment, both to the NHS and to the wider public health system.

4. Financial, legal, equalities, climate emergency and other implications

4.1 Financial Implications

This service is jointly funded by the ICB, UHL and LCC however this report is not seeking any additional funding, therefore there are no direct financial implications arising. Successful delivery of this service will reduce public expenditure across local authorities and the NHS as outlined throughout the report.

Signed: Mohammed Irfan, Head of Finance

Dated: 17 February 2026

4.2 Legal Implications

There are no apparent adverse legal implications of the content of this report.

Signed: Emma Youn

Dated: 17 February 2026

4.3 Equalities Implications

Under the Equality Act 2010, public authorities have a Public Sector Equality Duty (PSED) which requires them, in carrying out their functions, to have due regard to the need to eliminate unlawful discrimination, harassment, victimisation and any other conduct prohibited by the Act; to advance equality of opportunity between people who share a protected characteristic and those who do not; and to foster good relations between different groups. Protected characteristics under the Act include age, disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion or belief, sex and sexual orientation.

Tobacco use remains one of the leading causes of health inequalities across Leicester. People living in more deprived areas, those in routine and manual occupations, and individuals with mental health conditions are more likely to smoke and to experience smoking-related illness. The CURE service reaches people during hospital admission, including those who may not otherwise access community-based smoking cessation support. Local data shows that patients from the most deprived communities are more likely to engage with the service and successfully quit, helping to narrow health inequalities.

[8] Benefits of Quitting Smoking | Smoking and Tobacco Use | CDC

The service supports equality of opportunity by providing inclusive, free, and evidence-based support to all patients who smoke, regardless of background or circumstance. This includes offering materials in accessible formats, interpreters where required, and ongoing workforce training to ensure that support is sensitive to diverse needs. By reducing smoking prevalence, the service will make a significant contribution to improving health outcomes across protected characteristic groups and to reducing health inequalities across the city.
Signed: Equalities officer, Surinder Singh, Ext 37 4148
Dated: Dated 18 February 2026

4.4 Climate Emergency Implications
There are no significant climate emergency implications arising from this report. As service delivery generally contributes to the council's carbon emissions, any impacts of carrying out new projects can be managed through measures such as requesting partners use sustainable travel options or provide remote services where appropriate, using buildings and materials efficiently and following the council's sustainable procurement guidance, as applicable to the programme.
Signed: Phil Ball, Sustainability Officer, Ext 372246
Dated: 18th February 2026

4.5 Other Implications
Signed:
Dated:

5. Background information and other papers:

6. Summary of appendices:

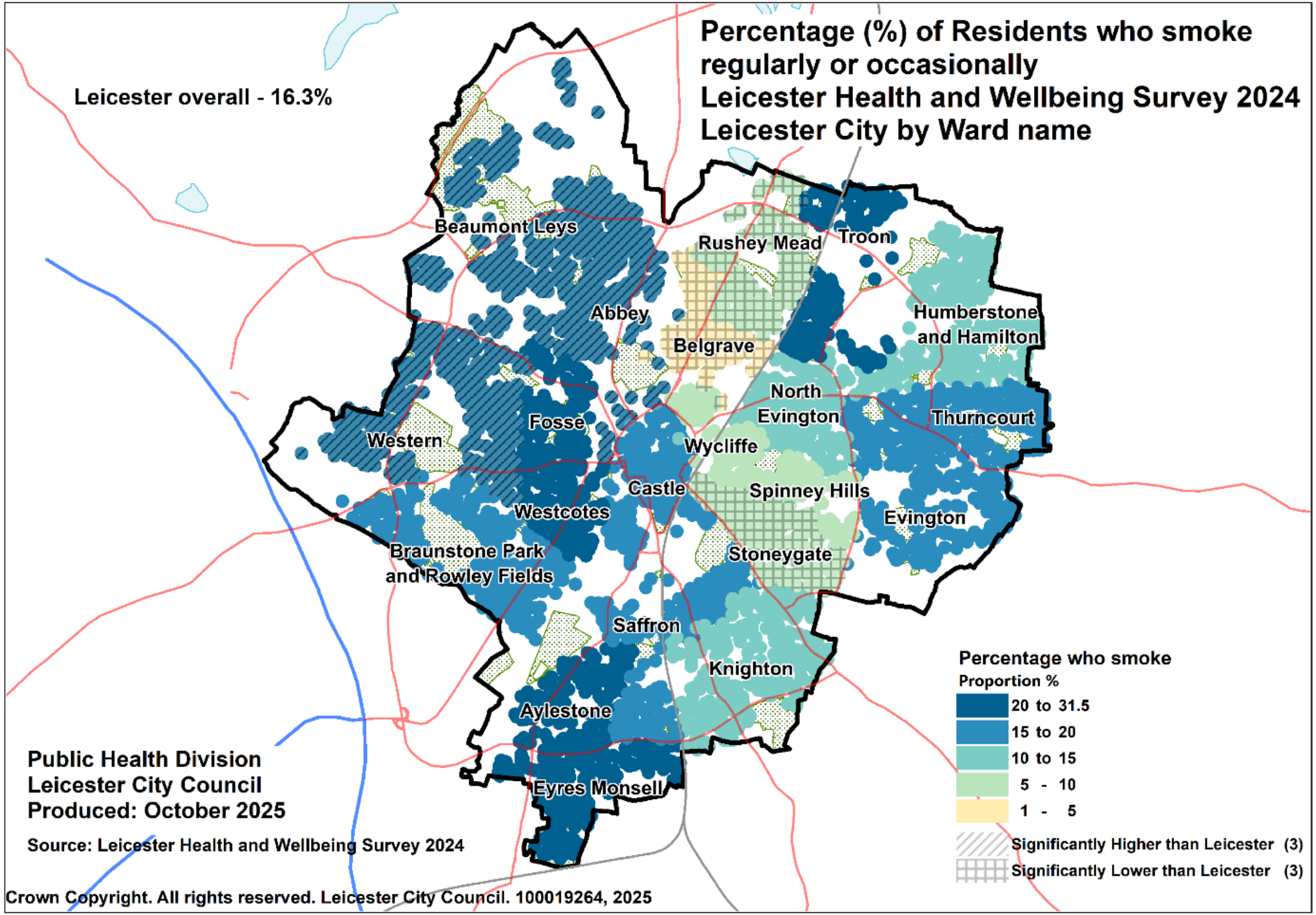
Acute CURE update

Alex Hammant, Claire Mellon

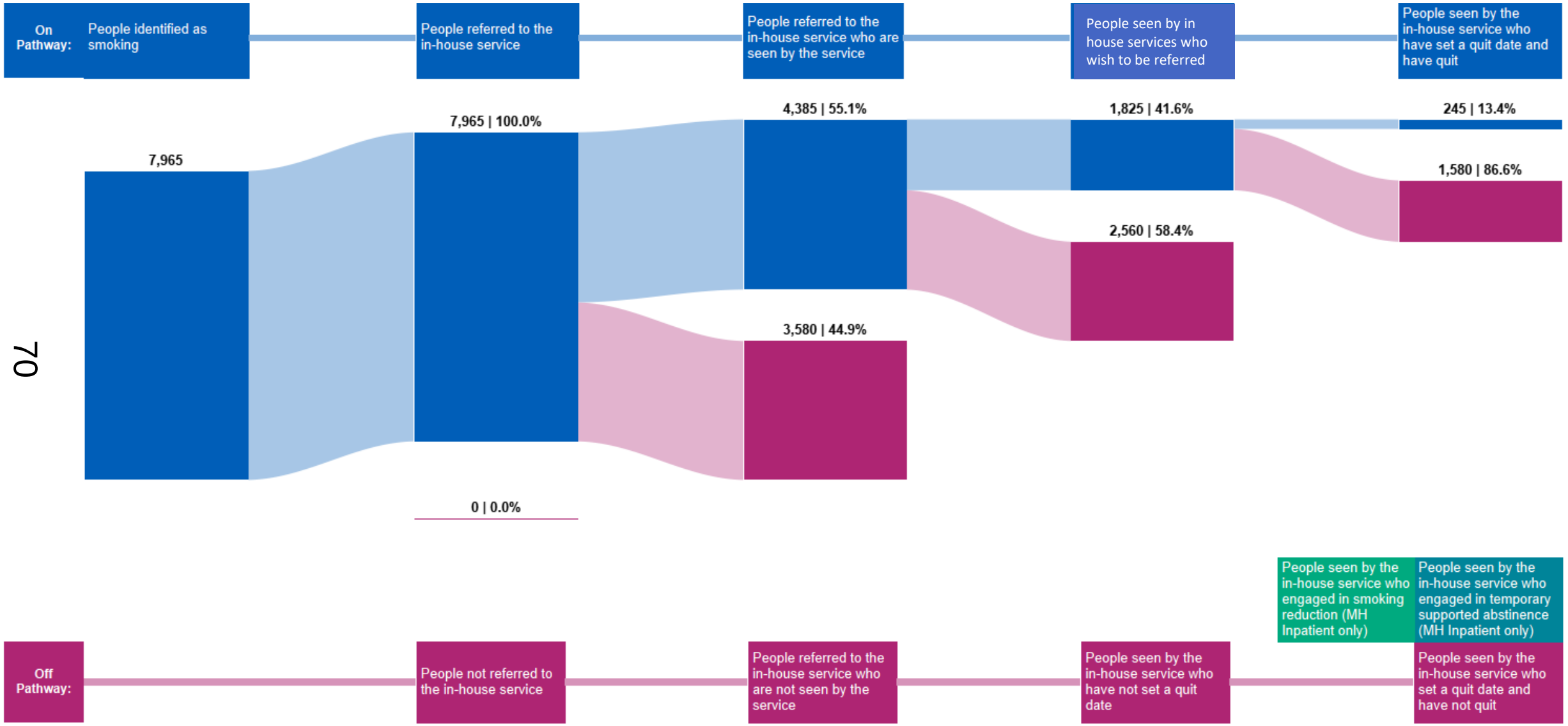
Presentation outline

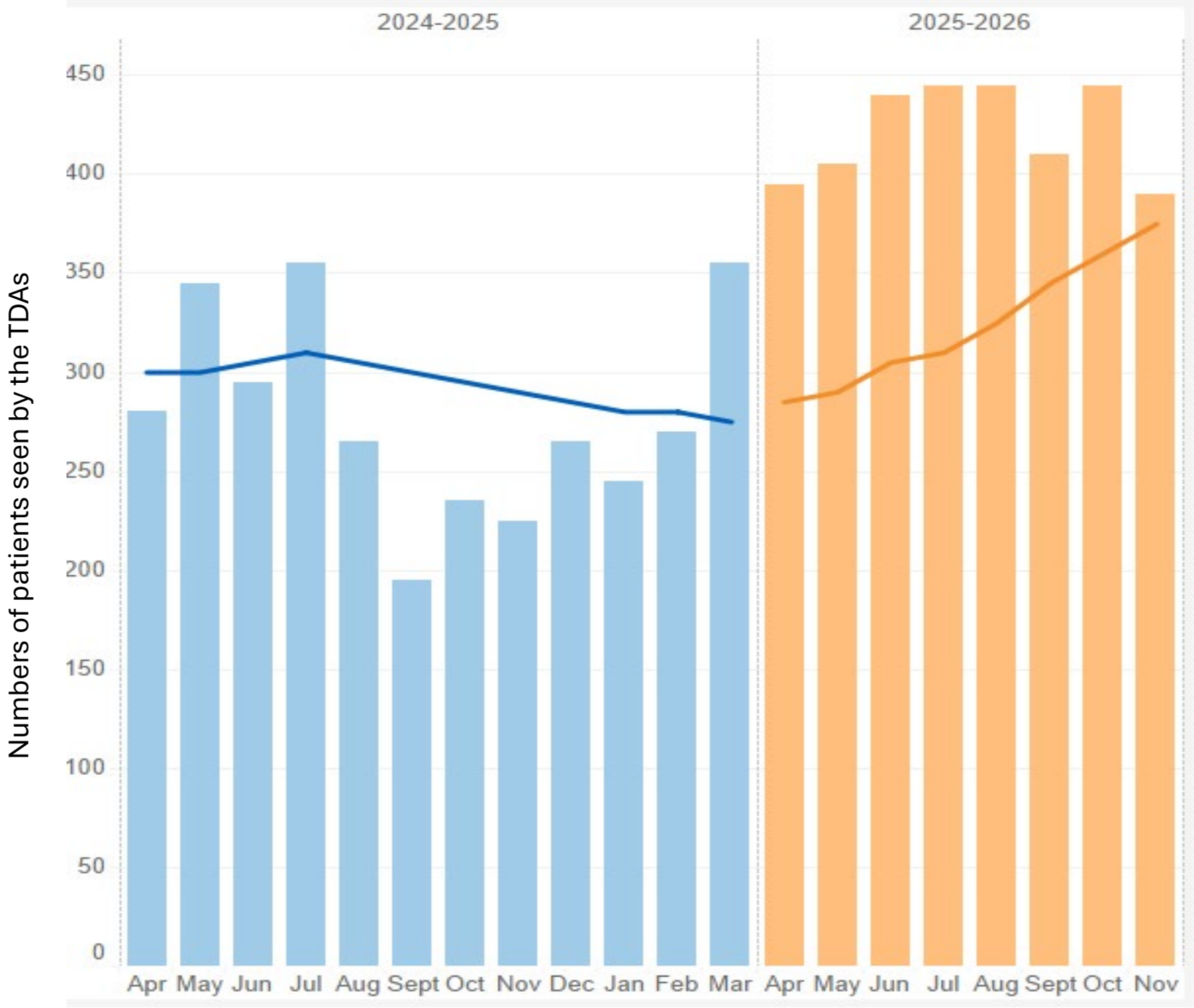
- What is CURE’s impact on individuals, our communities and the economy?
- Current CURE performance
- Areas for improvement

What is CURE's impact?



Current CURE performance




2024-2025
2025-2026
Numbers of patients seen by the TDAs
450
400
350
300
250
200
150
100
50
0
Apr May Jun Jul Aug Sept Oct Nov Dec Jan Feb Mar
Apr May Jun Jul Aug Sept Oct Nov

Areas for improvement

- Seen rates, referral rates and quit rates
- Expand outpatient work
- Increase pharmacological prescribing for those who would benefit

Appendix F

Leicester City Health and Wellbeing Board
5 March 2026

Subject:	Update from the Leicester Integrated Health and Care Group
Presented to the Health and Wellbeing Board by:	Georgia Humby, Integrated Board Lead Officer
Author:	Georgia Humby

EXECUTIVE SUMMARY:

The Leicester Integrated Health & Care Group was established to support the Health & Wellbeing Board in providing leadership, direction, delivery and assurance in fulfilling its aim to 'Achieve better health, wellbeing and social care outcomes for Leicester's population and a better quality of care for children, young people and adults using health and social services'. This summary is intended to provide an overview of the recent work undertaken by the Group to ensure the Health & Wellbeing Board is kept updated and informed.

Over recent months, the Group has continued its focus on developing the neighbourhood model for health and care which intends to bring people together for closer working. The Group have continued to discuss the programme to ensure the implementation of the neighbourhood model is developed in collaboration. An initial series of workshops will be taking place across the four city neighbourhoods over the coming weeks. The workshops will be an opportunity to begin to shape next steps which is envisaged to be steered by neighbourhood boards which will be shared for discussion with the Health & Wellbeing Board.

Other changes to the health landscape have also been discussed by the Group, particularly identifying and managing risks around the clustering of the Integrated Care Board for Leicester, Leicestershire and Rutland with Northampton and Northamptonshire to ensure continued arrangements across the health and care system in Leicester.

The Group are responsible for oversight of joint commissioning activity and have therefore discussed activities including home care, the high dependency residential service and dementia support services. Other discussions have included individual healthcare plans and women's health programmes.

Delivery Plan updates are also reported on a cyclical basis to the Group for monitoring impact and identifying opportunities. The latest updates have included hypertension case finding as well as mental health and wellbeing related to social inclusion, and supportive networks – the full updates can be found below.

The Group also has oversight of the Better Care Fund and have considered business cases for 2026/27. The BCF subgroup are now focussed on planning which will be reported to the Health and Wellbeing Board for approval before submission.

Delivery Plan Updates:

Please note the ask from the Health & Wellbeing Board to alter the deliver plan updates to include information on outcomes associated to projects has been implemented and will be illustrated in the next cycle.

Date: January 2026

Title of workstream: Hypertension prevention and case finding

Objective: *To increase detection of hypertension in Leicester through primary and secondary preventative measures and optimisation of treatment.*

- Meds op design group
- City Place monthly meetings
- Long terms conditions partnership board

Reporting Project	Project KPIs and Targets	Update	Next steps	PLUS Groups - SMI - LD - Homelessness - Care experience young people	Risks and mitigations	RAG for period (please include an explanation for rating)	Outcomes Contributing to RAG Rating
Advanced Pharmacy Meds op design group	• Increase proportion of blood pressure service consultations that are ABPM to 10% • Grow total annual blood pressure check service consultations by	Currently reviewing in LLR ICB best place for oversight. Better understanding of data available to ICB now in place Additional system targets	East Midlands Primary Care Team work on low provision of ABPMs to report. Consider appropriate actions around low ABPM performers	None	BP checks inappropriately targeted drives low quality perception of service. EMPCT quality work to mitigate. Low GP practice engagement in referrals – trial new approaches with new	Amber Overall growth strong, ABPM struggling	

	15% from 2024 baseline.	from NSE region in place and being exceeded. Pilot of appointments booking platform for community pharmacy imminent. October data: 8136 (219% annual growth) BP checks in LLR in total – 297 (3.6%) ABPM.	Appointment booking pilot to go live.		in post pharmacy / PCN engagement leads.		
NHS Health Checks Meds op design group	• N screened • N diagnosed within 12 months of check date • N receiving health check as part of QRISK score >10% recorded	• N screened: 2024-25: Q1= 2802 Q2= 2670 Q3= 2898 Q4= 3652 2025-26: Q1= 2682 Q2= 2502	Work is progressing to identify potential new models of delivery and have been working with the two universities in the city to identify possible ways to develop health check offer via this route. In	This will be largely dependent on eligible population defined within NHS Health Check inclusion criteria, although work will continue to target specific areas of Leicester where uptake is known to be lower, combined with hypertension case finding work and	The NHS Health Check re-procurement has now gone live for GP practices to apply for, this has been under PSR direct award process B. GP practices will have until early January to apply and submit relevant documentation. We	Green- overall performance of NHS Health Check programme is performing strongly and line with anticipated target	NHS Health Check - Data | Fingertips | Department of Health and Social Care Current overall uptake for NHS Health Checks in Leicester is

		• N diagnosed within 12 months: 2023-24: 573 2024-25: 504 • N receiving health check (part 2) 2024-25: Q1= 352 Q2= 224 Q3= 327 Q4= 295 2025-26: Q1= 295 Q2= 254	addition, working to support the hypertension case finding programme to ensure patients are being re-directed and signposted to have their NHS Health Check where appropriate and if deemed eligible.	looking to target higher risk groups.	have set up a number of support sessions for GP practices to attend and help guide them through this process to ensure full engagement. As a result, we will need to monitor how this is progressing over the coming weeks so that all of our current GP practices are complying with the outlined process. We have put in place measures to help mitigate against any practices who may not sign or intend to complete necessary documentation, so that contracts can be awarded and carry on providing NHS Health Check service.	figures for 2024-25 and 2025-26. More detail can be found below: NHS Health Check - Data | Fingertips | Department of Health and Social Care	53.5% compared to national average of 32.5%.

Support case finding and optimisation of Hypertension City Place monthly meetings Long terms conditions partnership board	Outcomes and proposed success measures to be reviewed and amended via task and finish group in 2026. **Outcomes** • Increase in knowledge of risk factors for hypertension and behaviour change amongst target population • Increase in number of people a) accessing a BP test, b) being diagnosed with hypertension, c) being optimised • Increase in number of people receiving risk reduction advice and making appropriate behaviour change to manage risk • Reduction in number of strokes/myocardial infarctions in Leicester City **Proposed success measures** • Significant increase amongst no. of people in target population to have a	Task and finish group met bi-monthly throughout 2025. Key outcomes and areas of progress: - Offsite testing model for community pharmacy hypertension case-finding service developed and piloted at 2 events; 153 BP tests conducted. - Roving Health Unit conducting BP checks alongside vaccinations campaigns; 137 tests conducted Jan – August, 21 tests Oct – Dec.* - Public health have carried out 55 BP checks	Task and finish group to meet in January 2026 for annual review of progress and next steps discussion, including review of KPIs/proposed success measures. Scope for project expansion & development of a more systematic schedule of events attendance and BP testing using SOP to increase testing capacity. Potential opportunities to work with pharmacy/medical students from local universities to deliver BP checks in the community. Continue to work with community	Working with LPT Health Equity on health promotion opportunities for people with LDA, and sharing information about additional support for people requiring this to access/engage with testing. BP testing carried out as part of LD Health Checks with good uptake. BP test included in SMI Health Check.	Key notable risks: remain as per previous reporting. 1. No designated resource attached to this work – intervention options have been developed to maximise on existing capacity/resources. 2. Requires 'buy in' from all key stakeholders – lack of this from any single area could limit reach and effectiveness of project. - Good T&F group representation across all required areas. 3. Possible impact on NHS Health checks (less people attending as a result of additional BP testing interventions)	Green – on track with no areas for escalation at this time.	See column 3 – 'update' for numbers tested and number of health promotion opportunities.

	BP test over a 6-month period (actual number TBC) • Significant increase in the number of newly diagnosed cases of hypertension (actual number TBC, % of estimated 24,000 undiagnosed cases in Leicester) • Increase in use of pharmacy services for measurement of BP (baseline to be established) • 100% of individuals attending a BP check to be assessed for risk factors and offered prevention advice/signposting/referral to support services • 100% of individuals with BP considered within 'dangerous' range referred for immediate management as per NICE guidance/local guidelines • Individuals with a high BP reading via pharmacy outreach testing to be advised to be offered	from November 2025 onwards via GP registrars on placement. Appropriate follow up advice and signposting shared with all receiving a BP check. - Health promotion at events aiming to reach those at greater risk of hypertension-related health inequalities (Mosque, Caribbean Carnival, Leading Better Lives, Sri Lankan Tamil school, Community Wellbeing Champions public health conference).	pharmacy to identify opportunities for offsite testing. Roving Health Unit to continue offering BP checks as part of vaccinations campaigns. Opportunities to work with NHS Health checks programme re. targeted invitation to be revisited following reprocurement exercise.		- Signposting to NHS HC to be embedded within intervention pathway. 4. Participation from target audience is essential. - Engagement with target audience ahead of development of intervention to support co-design/co-production. - Stakeholders include CWC representation. Full risk log to be reviewed as a standing agenda item at T&F group.		

	ABPM as per NICE guidance/local guidelines. - Individuals identified with high BP to be referred to GP for medicines optimisation as per NICE guidance/local guidelines	Outcomes include signposting for BP testing or lifestyle advice, and engagement with services who can promote BP testing to their patrons. Standard Operating Procedure (SOP) developed via Public Health to enable their staff to conduct BP testing where appropriate, thus increasing capacity.					

*Mechanism for collecting /sharing data beyond August 2025 has changed.

Case study/ qualitative examples of progress:

Project	Example

Point for escalation relating to any of the projects:

Bibliography of Projects

Project	Description
Advanced Pharmacy	Most pharmacies in Leicester are signed up to the NHSE hypertension case-finding programme. This involved blood pressure checks.
NHS Health Checks	The programme is a preventative check to assess overall health status for those aged 40-74 years and don't have a pre-existing medical condition, one of the key areas the NHS Health Check measures for is hypertension and risk of cardiovascular disease (QRISK score).
Support case finding and optimisation of Hypertension	i) Place based targeted work to support practices to identify pts , and link to neighbourhood plans (Community Health and Wellbeing plans) ii) a communication plans to support medication adherence (iii) using business intelligence analysis to understand the detection and optimisation gaps. iv) T&F group work to focus on reducing health inequalities in hypertension detection.

Date February 2026

Title of workstream: Mental health and wellbeing related to social inclusion, and supportive networks

Objective: *Improving the mental health of our local population by promoting and facilitating community-based offers that support inclusion, connectedness and wellbeing*

Governance arrangements:

- Leicestershire Partnership NHS Trust
- Early Intervention & Prevention Board (Adult Social Care, Leicester City Council)
- Community Public Health Steering Group
- Leading Better Lives Steering Group (LCC)
- Mental Health Partnership Board
- Leicester City Council – Public Health
- LLR Mental Health Collaborative

Reporting Project (*governance*)	Project KPIs and Targets	Update	Next steps	PLUS Groups - SMI - LD - Homelessness - Care experienced young people	Risks and mitigations	RAG for period	Outcomes Contributing to RAG Rating
Neighbourhood Mental Health Cafés *LLR Mental Health Collaborative*	Case studies demonstrating impact. Quality review of individual cafes. Healthwatch 'Enter and View' Report completed and published.	Monthly data and case studies collated. Reviews of individual cafes ongoing. City: Apr to Dec 2025 X8 VCS Orgs providing cafes	Complete review of cafes by November. Cafes are reviewed twice per year – completed. Webpage live for providers containing all policies and	n/a	No risks		

	High level findings include; • Consistently positive picture of warm, welcoming spaces offering emotional and practical support. •Café staff are widely praised for their compassion, active listening and knowledge of mental health needs. •The availability of one-to-one space was noted as particularly beneficial, giving individuals the privacy and time they needed to talk openly and feel heard. •Cafés are described by many people as a "lifeline"	X19 café sessions per week across Monday to Sunday Total contacts: 3,397 Total new users: 771	procedure documents for the cafes.				

Mental Health Wellbeing & Recovery Support Service *Early Intervention & Prevention Board (Adult Social Care, Leicester City Council)*	Undertake a quality review with a focus on impact of the service and how this offer fits within the wider mental health system.	Review ongoing in conjunction with County and Rutland.	Complete review of service.	n/a	Risk of non-collaboration with other services across the system Mitigation: monitoring and review asks for information on collaboration.		
"Bringing People Together" Social Inclusion Programme *Community Public Health Steering Group*	**Let's Get Together (LGT)** **Offers a range of free activities in community buildings such as arts/crafts, walks, refreshments and gardening** Maintain regular weekly health walks from community locations and encourage social interaction over refreshments	Health Walks are well attended approx. 120 people a month attend health walks and around 18 people attend sociable strolls 3 new health walks started last year Orchard Walks began last year and have been popular	LGT working group members working together to support active travel to undertake Sociable Strolls throughout the year and encourage social interaction afterwards with refreshments	All walks are risk assessed and accommodations made for individual circumstances where appropriate and possible.	LGT operates by close partnership working with other departments. Active travel organise sociable strolls – may be unable to continue this activity past Merch 2026 due to staffing and capacity issues		

	Warm Welcome to take place in all libraries between October and April **An additional offer targeting people who may not use libraries** **Let's Get Digital**	All libraries are offering Warm Welcome in 25/26 A warm welcome operates in the community Hub in the Haymarket Shopping centre on Mondays from 2pm -4pm as part of the 2025/2026 offer. Hosted by the PH team 280 people successfully completed the course (Apr '24-June '25)	Early planning for 26/27 Explore possibility of working with the Haymarket in the future Relaunch of LGD 2026 including full media campaign.	Warm welcome is open to anyone in the city. Anecdotal reports of homeless people participating. People attending the Haymarket centre include non-english speakers and elderly people. The team attend community locations and offer the course as people learn on their own devices.	Potential changes due to the library consultation could have a detrimental impact. Being unable to find a suitable location for warm welcome within the Haymarket. Let's Get Digital is externally funded for 3 years from April		

	Sessions focusing on meeting health and social needs continue with regular activities and 'drop-ins' at several locations in the city. Public Health will fund the programme for another three years from April 2027. Let's Get from A to B (travel training online) has been added to the programme as an additional module. Target to enrol 200 people a term onto this module Enrol 240 people per term on the course Maintain 60% of successful attendees	55% of people continued digital learning after these sessions accessing another course • An additional module 'Let's Get from A to B' is due to start shortly. People will have support with finding information, planning journeys, using google maps and booking tickets online		Targeted work with social housing tenants and people with poor mental health started in January 2026	2026 after which time the programme is at risk unless an alternative source of funding is found. Relaunch media campaign needs to be thorough.		

	accessing follow on courses Work with 10 organisations per annum offering LGD at their sites --- Let's Get Active (contracted service) establish weekly physical activity sessions operate in 5 locations across the city Let's Get Growing (Contracted)	Provider is achieving targets, seeing around 35 people a month. Of which 25% are from priority groups Provider is achieving targets Contract up for recommissioning procurement in April 2026 The Leicester and Rutland TCV project	Explore options for reprocuring the contract acter the pilot period. Encourage community groups to take up community plots	• Identifying and supporting people who are not digitally literate. Increasing accessibility by working with VCSE providing courses in familiar locations increases participation. Women only sessions are held weekly. Promote growing sessions through CWC network Work with VCSE organisations to support more people from plus groups to access activities	None at present time TCV deliver community gardening at LCC owned sites, changes to the ownership/ opening times of sites may disrupt provision.		

	Increase number of community food growing plots at allotment sites Increase access to food growing through the seed library and other initiatives Support educational settings to access food growing	has been assisting Let's Get Growing by using Leicester community food growing sites to host corporate volunteering team days. Besides entry level courses TCV have provided a number of intermediate level courses and workshops tailored towards gardeners with existing experience, to allow community groups and individuals to develop their skills further in a supportive environment	Continue to support school-based initiatives Encourage participation in the seed library and other initiatives Support growing initiatives at the library and community centre		Possibility of receiving no bids or low quality bids for the contract.		

	Community cooking sessions	Internal partnership between public health and adult learning offering free cooking skills courses in community locations, mainly hosted by VCSE organisations .	Sessions are dependent on short-term HSF funding- explore possibility of sessions continuing.	Sessions offered are targeted including young people, older people, people with mental ill health.	Funding is a risk.		
Prevention Concordat for Better Mental Health *Mental Health Partnership Board*	Partnership Board receives reports to address health inequalities Mental health in all policies, such as access to green space, transport, leisure, arts, and culture	Various sources of information looking at addressing Health Inequalities as they pertain to Mental Health in Leicester: Mental Health and Wellbeing Survey on mental wellbeing in Leicester. Real Time Suicide Surveillance Data African Heritage Alliance report	Working with key stakeholders on Patient and Carer Race Equality Framework [PCREF] Raising awareness of suicide risk to MH Collaborative, the Partnership Board, Lead Member and ICB Procurement of Foodbanks Plus for people at risk of poor mental health linked to poverty.	Patients and carers from minority ethnic backgrounds People resident in the most socioeconomically deprived areas of Leicester Women with a serious mental illness	Financial pressures on ICB has risk of sidelining the impetus to address health inequalities and the prevention agenda in favour of supporting services and a reactive approach.		

		Black Mental Health and Me Poverty and Mental wellbeing: Foodbanks Plus Health Equity Audit by Leicester Counselling Centre Working with LLR Mental Health Collaborative, ICB, LPT, Leicestershire County Council, on improved uptake of breast screening for women with serious mental illness.	Mental Health Collaborative for work on Foodbanks and breast screening for cancer. Application submitted for a refreshed Joint Strategic Needs Assessment on Mental Health in Leicester. This has the support of the Mental Health Collaborative and the Partnership Board.				

Joy app rollout *LLR Mental Health Collaborative*	Quality Review of the impact of Joy including data, case studies and partner testimonies.	Work ongoing with social prescribers to collate data, case studies and testimonies.	Joy added to the agenda of Leicester City Learning Disability Partnership Board is on Monday 28th April. Easy Read poster Joy onboarding session with Andy Humpherson and public health team (9th January) Joy steering group meeting is 26th February. (Andy Humpherson in attendance)	n/a			
Mental Health Friendly Places *Leicester City Council - Public Health*	Case studies demonstrating impact Survey collating feedback from the Mental Health Friendly places to measure positive impact	230 organisations signed up to the programme across LLR. • 54 City organisations • 39 organisations that cover LLR as a whole • 16 mental health	Develop more Mental Health Friendly Clubs by working with the local Football Association and Active Together and Sports and recreation team. Develop a business offer for Mental Health Friendly	n/a	Organisational capacity to enable training requires flexible offers		

		friendly clubs (city) 162 people trained in MH first aid aware in City and LLR organisations 132 MH first aiders trained in City and LLR organisations 30 people trained in Samaritans Listening Skills in City and LLR organisations 22 people trained in Healthy Conversation Skills in City and LLR organisations 30 people trained in Real Talk Suicide Prevention training Ongoing work with FA around 'Mental Health Friendly	Places, to include bespoke training to fit with ways of working e.g. lunch and learn. Targeting support for small businesses, e.g. barbers, hairdressers Continue to offer bespoke training on men's mental health				

		Clubs, my space my game' to train committee members and welfare leads of 5 clubs. Current City clubs trained are Friar Lane and Epworth FC, GNG FC and AFC Andrews all will be delivering football sessions in the coming months. Mental Health Friendly Clubs launched summer 2025. 16 MHFC's so far in the City. Working in partnership with Active together to host information webinars for clubs. Sporting clubs being targeted to offer mental health training to support adults attending and can be signposted on to further support if					

		needed to local services. Together For Men conference hosted in Nov 2025 at Leicestershire County Cricket Ground. Over 100 MHFC's, MHFP's and professionals attended. Talks were given from key services that support men and their mental health alongside stalls showcasing their offers of support. Mental Health Friendly Places and Clubs now have social media platforms on facebook and Instagram to encourage sign ups to the programme and promote the work of mental					

		health friendly places and clubs. Working with partners at LPT to roll out trauma informed care training for personality difficulties through mental health friendly places platform.					
Getting Help in Neighbourhoods Projects *LLR Mental Health Collaborative*	Quarterly case study theming takes place to demonstrate the impacts and outcomes of the GHiN projects.	Monitoring of the scheme has been undertaken by the Mental Health neighbourhood leads. An online Provider meeting has been established which focuses on key and essential developments and information to maintain high quality provision across the GHiN projects.	Grant agreements to be negotiated for 26/27 once budget agreed by ICB.	N/A	At present no risks identified.		

		A coproduction group has been established to increase the number of organisations informing developments, such as improving outcomes recording using recognised evidence-based tools.					

Case study/ qualitative examples of progress:

Project	Example
Mental Health Friendly Places	**Saffron Acres:** "We have a small but dedicated staff team, who come from a variety of backgrounds and with different experiences. As a charity, it can sometimes be a little harder to find opportunities for funded training that is relevant to our job roles, and this is where the MHFP experience has really shined. Not only has the training enabled our team to gain uniform understandings so we are all on the same page, it has allowed us to become more confident when we are engaging people that visit us and access our services. It has been directly relevant in the mental health projects we run, but helps support all our other projects we engage people in."
Aunty Sue	 Aunty Sue Case Study.pdf

Network Event Belgrave	Case Study Network Event Belgı

Point for escalation relating to any of the projects:

Bibliography of Projects

Project	Description
Neighbourhood Mental Health Cafés	Drop-in sessions delivered by voluntary sector providers and located in areas with highest levels of mental health need where people can get mental health support and advice – no appointment needed.
Mental Health Wellbeing & Recovery Support Service	Preventative mental health service enabling people to improve and maintain their mental health & wellbeing, or recover from mental illness, through better use of community assets & resources.
Bringing People Together Programme	Free activity sessions at community centres and libraries encouraging people to learn new skills, get more active and get together with others. Projects include: • Let's Get Together (LGT) • Let's Get Growing (LGG) • Let's Get Digital (LGD) • Let's Get Walking LGW) • Let's Get Creative (LGC) • Warm Welcome

Leading Better Lives	Developing a coproduced council-wide approach to prevention and community wellbeing.
Prevention Concordat for Better Mental Health	Underpinned by a prevention-focused approach to improve mental health, which in turn contributes to a fairer and more equitable society.
Joy app rollout	Roll out of the Joy social prescribing app which promotes activities and support and allows people and professionals to make referrals
Mental Health Friendly Places	Encouraging local businesses & community organisations to take up training offer & accreditation to equip them with skills and knowledge to support people with mental health
Getting Help in Neighbourhoods Projects	Grant-funded projects allowing voluntary sector organisations to expand or enhance their existing offer in order to support mental health & wellbeing through activities and support.