Leicester
City Council

MEETING OF THE PUBLIC HEALTH AND HEALTH INTEGRATION SCRUTINY COMMISSION

DATE: TUESDAY, 4 NOVEMBER 2025
TIME: 5:30 pm
PLACE: Meeting Room G.01, Ground Floor, City Hall, 115 Charles Street, Leicester, LE1 1FZ

Members of the Committee

Councillor Pickering (Chair)
Councillor Agath (Vice-Chair)

Councillors Clarke, Haq, March, Sahu, Singh Johal and Westley

Youth Council Representatives

To be advised

Members of the Committee are invited to attend the above meeting to consider the items of business listed overleaf.

For Monitoring Officer

Officer contacts:

Katie Jordan (Governance Services), Governance Services (Governance Services) and Oliver Harrison (Governance Services)
Tel: , e-mail: committees@leicester.gov.uk
Leicester City Council, City Hall, 115 Charles Street, Leicester, LE1 1FZ

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Further information

If you have any queries about any of the above or the business to be discussed, please contact: Katie.Jordan@leicester.gov.uk and Oliver.Harrison@leicester.gov.uk of Governance Services. Alternatively, email committees@leicester.gov.uk, or call in at City Hall.

For Press Enquiries - please phone the **Communications Unit on 0116 454 4151**.

USEFUL ACRONYMS RELATING TO PUBLIC HEALTH AND HEALTH INTEGRATION SCRUTINY COMMISSION

Acronym	Meaning
AEDB	Accident and Emergency Delivery Board
BCF	Better Care Fund
CAMHS	Children and Adolescents Mental Health Service
CHD	Coronary Heart Disease
CVD	Cardiovascular Disease
COPD	Chronic Obstructive Pulmonary Disease
CQC	Care Quality Commission
CQUIN	Commissioning for Quality and Innovation
DES	Directly Enhanced Service
DoSA	Diabetes for South Asians
DTOC	Delayed Transfers of Care
ED	Emergency Department
EDEN	Effective Diabetes Education Now!
EHC	Emergency Hormonal Contraception
ECMO	Extra Corporeal Membrane Oxygenation
EMAS	East Midlands Ambulance Service
FBC	Full Business Case
FIT	Faecal Immunochemical Test
GPAU	General Practitioner Assessment Unit
GPFV	General Practice Forward View
HALO	Hospital Ambulance Liaison Officer
HCSW	Health Care Support Workers
HEEM	Health Education East Midlands
HWB	Health & Wellbeing Board
HWLL	Healthwatch Leicester and Leicestershire
ICB	Integrated Care Board
ICS	Integrated Care System
IDT	Improved discharge pathways
ISHS	Integrated Sexual Health Service

JSNA	Joint Strategic Needs Assessment
LLR	Leicester, Leicestershire and Rutland
LTP	Long Term Plan
MECC	Making Every Contact Count
MDT	Multi-Disciplinary Team
NDPP	National Diabetes Prevention Pathway
NEPTS	Non-Emergency Patient Transport Service
NICE	National Institute for Health and Care Excellence
NHSE	NHS England
NQB	National Quality Board
OBC	Outline Business Case
OPEL	Operational Pressures Escalation Levels
PCN	Primary Care Network
PICU	Paediatric Intensive Care Unit
PHOF	Public Health Outcomes Framework
PPG	Patient Participation Group
QNIC	Quality Network for Inpatient CAMHS
RCR	Royal College of Radiologists
RN	Registered Nurses
RSE	Relationship and Sex Education
STI	Sexually Transmitted Infection
STP	Sustainability Transformation Plan
TasP	Treatment as Prevention
UHL	University Hospitals of Leicester

PUBLIC SESSION

AGENDA

This meeting will be webcast live at the following link:-

http://www.leicester.public-i.tv

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1. WELCOME AND APOLOGIES FOR ABSENCE

To issue a welcome to those present, and to confirm if there are any apologies for absence.

2. DECLARATIONS OF INTERESTS

Members will be asked to declare any interests they may have in the business to be discussed.

3. MINUTES OF THE PREVIOUS MEETING **Appendix A**

The minutes of the meeting of the Public Health and Health Integration Scrutiny Commission held on 9th September 2025 have been circulated, and Members will be 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, REPRESENTATIONS AND STATEMENTS OF CASE

Any questions, representations and statements of case submitted in accordance with the Council's procedures will be reported.

6. PETITIONS

Any petitions received in accordance with Council procedures will be reported.

7. HEALTH PROTECTION

The Director of Public Health will provide the Commission with a verbal update.

8. DIRECTOR OF PUBLIC HEALTH ANNUAL REPORT **Appendix B**

The Director of Public Health will present his Annual Report to the Commission.

9. WHOLE SYSTEMS HEALTHY WEIGHT **Appendix C**

The Director of Public Health submits a report to update the commission on Leicester City Councils Whole System Approach (WSA) which outlines the complexities of weight and the comprehensive approach being taken within Leicester to promote healthy weight across the system.

10. SMOKE FREE GENERATION **Appendix D**

The Director of Public Health submits a report to outline the commission on the work that has been carried out over the past year to increase the number of smokers setting a quit date in Leicester, and outlines plans to meet the smoke free generation targets.

11. UPDATE ON SEXUAL HEALTH SERVICE

The Director of Public Health will give a verbal update to the commission on Leicester's Sexual Health Service.

12. WORK PROGRAMME **Appendix E**

Members of the Commission will be asked to consider the work programme and make suggestions for additional items as it considers necessary.

13. ANY OTHER URGENT BUSINESS

Appendix A

Leicester
City Council

Minutes of the Meeting of the
PUBLIC HEALTH AND HEALTH INTEGRATION SCRUTINY COMMISSION

Held: TUESDAY, 9 SEPTEMBER 2025 at 5:30 pm

P R E S E N T:

Councillor Pickering – Chair
Councillor Agath – Vice Chair

Councillor Haq
Councillor Orton
Councillor March
Councillor Sahu

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150. WELCOME AND APOLOGIES FOR ABSENCE

The Chair welcomed everyone to the meeting and led on introductions. Apologies had been received from Councillor Singh Johal and Councillor Westley, with Councillor Orton attending as substitute for Councillor Westley.

151. DECLARATIONS OF INTERESTS

There were no declarations of interest made.

152. MINUTES OF THE PREVIOUS MEETING

The minutes of the Public Health and Health Integration Scrutiny Commission held 8th July 2025, were confirmed as a correct record.

153. CHAIRS ANNOUNCEMENTS

The Chair advised the Commission that Blood Centres across the East Midlands had issued an urgent appeal for more donors, due to missed and cancelled appointments over the summer holidays.

154. QUESTIONS, REPRESENTATIONS AND STATEMENTS OF CASE

It was noted that none had been received.

155. PETITIONS

It was noted that none had been received.

156. RESTRUCTURING UPDATES - ICB & NHS ENGLAND

The Chief Strategy officer for the Leicester, Leicestershire and Rutland Integrated Care Board submitted a report to update the commission on national reform of the NHS operating model across England which will involve the integration of the Department of Health and Social Care and NHS England, and a changed role for ICBs.

It was noted that:

- Dr Sanganee provided a brief update on the presentation slides and the reconfiguration process, including the clustering arrangements with Northamptonshire to form the LNR.
- LLR and Northamptonshire ICBs remain separate statutory bodies. Working in partnership, however over time they would work as one cluster with
  - Single Board Governance
  - Unified Leadership Team
  - Shared staffing structure
- Building a transformational cluster between NICB and LLR ICBs provided the opportunity to drive forward the Ten-Year Plan within communities and neighbourhoods, to continue improving health outcomes, while at the same time rising to the very real financial challenges faced
- It was reported that the 10-year health plan had been launched, alongside structural changes within NHS England, with ICBs required to reduce their running costs by 50%. This would have significant impacts nationally.
- The clustering process was explained as not being a merger, but separate bodies working in partnership under a single board governance structure. Progress was continuing at this stage.
- Nationally, chair arrangements had been announced. For the LNR cluster, Anu Singh (former chair in the Black Country) had been appointed, and Toby Sanders, Chief Executive, would be the Chief Executive across the cluster. Further national announcements were still awaited.
- Reference was made to the model ICB blueprint and running cost requirements, noting that Northamptonshire was already implementing these changes.
- The Leicester, Leicestershire and Rutland ICB replaced the Leicester City, East Leicestershire and Rutland and West Leicestershire clinical commissioning groups. The ICB manages the budget for the provision of NHS services in LLR
- The commission cycle was described as something already in practice, supporting stronger organisations through reductions in operational work.
- The focus remained on the health and wellbeing of the population, delivering high-quality care, reducing waiting times and improving patient experience.
- Partnership working with organisations and community leaders was ongoing, and the role of local authority colleagues was highlighted as increasingly important.
- The cluster design and functions were outlined as a developing process, with an emphasis on keeping partners informed.

In discussions with Members and Youth Representatives, it was noted:

- Members raised concerns that documents presented to the commission in March had been out of date.
- It was confirmed that Paula Clark remained ICB Chair until 1 October when Anu Singh would take over a new Chair.
- Concerns were raised around the complexity of the new structure, the lack of visibility of leaders attending Scrutiny Commission Meetings and how accountability would be maintained across Leicester, Leicestershire and Northamptonshire.
- Concerns were expressed that the reports provided contained little information about Northamptonshire, and it was questioned how accountability would be ensured.
- Members acknowledged the challenges for staff and suggested it would be helpful for the new Chief Executive and Chair to attend scrutiny in future
- It was explained that both ICBs would remain statutory organisations with accountability through health overview and scrutiny, supported by a joint leadership team working across the LNR footprint.
- Job losses were expected to be around a third, though exact figures were still subject to national negotiations.
- Assurances were given that access and quality of care would remain the same, with further updates to follow as the national process developed.
- Discussion took place on who the new structure would ultimately be accountable to. It was confirmed that accountability would remain dual, with scrutiny continuing in both LLR and Northamptonshire.
- It was noted that under the national ICB blueprint, some functions would be transferred to providers, local authorities or other partners. This was still being worked through nationally and locally, with assurances that any transfers would be carried out safely, with engagement and without adverse impact on partners. Engagement with scrutiny would continue and updates would be provided.
- Concerns were expressed that some changes had already been identified without wider awareness, and members requested early sight of such developments. It was clarified that organisational functions and commissioning decisions were distinct. Commissioning decisions would continue to be taken in partnership and subject to equity and quality impact assessments, with input from public health colleagues.
- It was confirmed that preventing miscommunication between sectors was a high priority. Work was underway to improve interface working between GPs, hospitals and specialists, strengthen handovers, and integrate services around primary care and communities through the neighbourhood model. Communication with patients and the public was also being strengthened.
- Members highlighted the importance of community leadership in shaping services. It was reported that strong relationships already existed with community teams and leaders, and more work would be undertaken to

allow services to develop locally. Patient and citizen voices were identified as central to future service design.

- Concerns were raised about the role of GPs as coordinators of services given reliance on locums and high staff turnover. It was confirmed that primary care networks would be fundamental building blocks of neighbourhood teams. In some areas GPs would lead, while in others community services would do so. Mapping work was being carried out to align GP, community, local authority and voluntary sector services.
- Clarification was sought on the appointment of a new Chief Executive. It was explained that national guidance was being followed and the update was the most accurate available. Once confirmation was received, positions would be announced and new leaders would engage directly with scrutiny. Interim arrangements remained complex, with leadership currently working across two patches.
- Members questioned how prevention, neighbourhood working and high-quality care could be delivered with reduced budgets and frozen posts. It was explained that the changes reflected the national agenda and the 10-year health plan. While impacts would not be immediate, the intention was to reduce duplication, particularly between NHS England and ICBs, and to streamline governance. The principles of accessible, local and high-quality care remained central, though commissioning and governance processes would evolve.
- The NHS acute trust league table was discussed following the publication of a new national oversight framework. It was reported that the local trust had been placed in segment 3, reflecting its financial deficit but also recognising improvements in patient experience, quality and financial governance. The trust had exited the recovery support programme, showing progress compared to three or four years ago, though further improvement was required. The framework was acknowledged as complex, but the results reflected both challenges and areas of positive progress.

AGREED:

1. That the report be noted.
2. That acute trust performance would be brought back to a future meeting for further scrutiny
3. The structure of the LNR be added to the work programme.

157. WINTER PROTECTION

The Chief Medical Officer introduced the item. It was noted that:

- The winter plan was developed annually.
- There were urgent emergency care challenges throughout the year, with increased challenges over winter, due to respiratory viruses and seasonal pressures.

The LLR ICB Head of Emergency Care gave an overview of the planning process and detailed the steps in place to ensure correct intervention levels were in established. Key points to note were as follows:

- NHS England had adopted a different approach when asking ICB's to develop their winter plans, with an increased emphasis on detail and mandated content.
- All ICB's develop Winter Plans, which were tailored to meet their particular area requirements.
- Plans must include the Health and Care position on surge and super surge. (Suge being increased activity owing to flu, COVID or RSV and Super Surge pertaining to a combination of respiratory challenges.)
- Workforce deficit planning was vital to allow for winter illness and infection outbreaks.
- NHS England mandated planning timelines.
- Regional stress testing events enabled further planning consideration.
- The NHS currently developed its own plans. The LPT plan had been to board that week, while the UHL plan was scheduled at their board at the end of the week.
- Engagement was ongoing with a variety of working groups.
- The vaccination plan was a key focus for the upcoming winter, covering Covid 19, Flu & respiratory vaccines, targets were in place.
- Key prioritised groups included pregnant women, young children, school age children, older adults, those with existing health issues and staff.
- The approach consisted of two key components:
    - Ensuring accessible access to vaccination services.
    - Increasing awareness among key groups.
- GPs surgeries would continue to provide the core offer, with community pharmacies also providing the service. Mobile vaccination units would be in place 3 days a week throughout the winter.
- This year the vaccine offer would be extended to children aged two to three years.
- A community sites pilot had been initiated to address the low vaccine uptake in pregnant women.
- Every care home across LLR would be included in the vaccine programme.
- Those discharged from Care Homes would be eligible for vaccination, through agreed arrangements with LPT and UHL acute providers.
- The parental consent process was to be made more accessible to increase children's vaccine uptake during the course of the school day.
- Vaccine awareness promotions would include national invites, GP recall, voluntary sector work with key groups and promotion of the vaccine hub website.

In response to comments from members, it was noted that:

- Leicester childhood vaccine uptake was below half the national average. Improvement efforts were ongoing, particularly in identified concerning areas.
- Engagement work included the school age immunisation link nurses.

- Improvements to the childhood vaccine consent process would enable better liaison with parents. An HPV vaccine pilot had shown early evidence of improved consent rates.
- The school age immunisation service provider was Leicestershire Partnership Trust.
- Member support and promotion within the communities was welcomed.
- The National Covid Fund enabled the vaccine buses. There had been a 69% funding reduction, and numbers of clinics would be halved. Targeted resourcing continued.
- Funding of Super Vaccinators continued for areas with notably low uptake.
- Services currently remained commissioned by NHS England, but it was hoped that when delegation occurred there could be more efficient use of funding.
- There was a clear emphasis on working with local communities to raise vaccine awareness.
- Vaccine uptake improvement targets included the:
    - 5% improvement for staff Flu vaccine.
    - 3% improvement for 2-3 year olds.
- Childhood immunisation statistics could be shared which showed an improvement for the city.
- Numbers would be shared on website traffic, success with vaccine site was noted and a QR code was available.
- Funding for outreach services was designed for short-term purposes and it was not yet known how much would be allocated in the next financial period. There had been a 69% reduction in outreach funding, which was created in response to COVID. Bidding was in place to secure short term-funding.
- The majority of the funding was long-term and in budget.
- Historically health data had been analysed across LLR but was now more focused on local priorities.
- Services remained stretched and risk of critical incidents remained, due to increased hospital admissions and primary care. Patient waiting times were still excessive and a hard winter could take a toll.
- Community engagement was vital to mitigate public vaccination concerns.
- A communications toolkit was distributed widely and could be issued to the committee.
- Paediatric staff worked solely with children and children's KPI's were in place to enable priority.
- Vaccinations didn't always require a pre-booking and there was a roving health care unit.
- Primary Care Networks received funding for enhanced access.
- Injectable antibiotics could be administered by community teams and pharmacies to reduce the strain on GPs and hospitals.
- A range of consultation options were available and could be tailored to patient's needs, these included telephone, online and AI contact.
- Campaigns were in place to promote mental health support and signpost to help.
- There were an increased number of dental appointments available. Dental practices self-managed triaging.

- Winter planning had not reduced but there was a tougher financial environment. Funding from NHS England for Primary Care was less likely to be available this year. Resource management was a key focus.
- New initiatives had come in to reduce ambulance waiting times.
- There was a focus on access points for early intervention to ease the strain on hospital admissions.
- There was not a freeze in place in hospital bank staff.
- LLR had one of the highest utilisations of pharmacies and work was ongoing to meet with capacity. LLR had around 200 community pharmacies, around 100 of these were within Leicester. All but 2 of the Leicester pharmacies were signed up to the Pharmacy First Scheme.
- There were around 88k planned Pharmacy First consultations with around 86k being delivered across LLR last year. Data showed a delivery of 8-10k for the first quarter of this year which was in line with targets.

AGREED:

1. The Commission notes the report.
2. Childhood immunisation statistics would be shared with the committee.
3. Statistics on website traffic would be shared with the committee.
4. The Communications Toolkit would be distributed to the committee.

158. GP ACCESS

Leicester, Leicestershire and Rutland ICB Deputy Chief Operating Officer for Integration and Transformation presented the report.

The LLR ICB wanted to create a service that was easier to use, fairer for everyone, and made the best use of NHS resources. That meant:

- A simpler system where people would only need to remember two main contact points: their GP practice and NHS 111
- A consistent offer across the city, including evening and weekend GP appointments
- Reducing unnecessary steps so people would spend less time navigating the system and more time getting the care they need

It was noted that:

- The main focus moving into 2026/27 would be on meaningful engagement rather than lengthy discussions.
- Access to care could be simplified into two steps. The first step encouraged residents to consider self-care options such as the NHS App, the NHS website, 111 online or local pharmacies before seeking appointments. The second step involved contacting GP practices or calling NHS 111 to ensure the right care was accessed in the right place.
- It was highlighted that traditional literature was often ineffective as many residents did not read leaflets. Instead, investment had been made to commission VCSE organisations to deliver targeted engagement work.

Surveys were planned across the city, county and Rutland, with the Leicester survey including questions on same day access appointments. Messaging would be targeted at specific groups including families with children under 10, young professionals, homeless people, refugees, and other groups facing barriers to healthcare.

- The programme in Leicester was funded to provide practical support through VCSE groups, with materials such as business cards and reference guides designed to be accessible in community settings. The approach would focus on real-life options, self-care, and engagement by people already embedded in communities. Work was also underway with PCNs and local authorities to ensure consistent messaging. The same day access model was due to go live in October 2025.
- Further detail was provided on the commissioning of approximately 20 VCSE organisations to deliver services. These groups represented the diversity of the city and had received training to tailor messages to their own communities. The emphasis was on teaching people to support others and raising awareness of what the NHS is, beyond hospitals, in multiple languages.
- Outreach activity was being delivered across areas such as Belgrave, Spinney Hills and Braunstone, and through collaboration with GPs, pharmacies, community groups and local initiatives including sports clubs, gospel groups and neighbourhood hubs. Work was also taking place with LPT mental health neighbourhood leads to support access to NHS services, including mental health care.
- Partnerships extended to Leicester City Council, housing, adult education and ESOL teams, with basic first aid training delivered jointly. Engagement also included universities, schools, wardens in halls of residence, supermarkets and shopping centres. Translation services were available to reduce language barriers.
- Feedback was being gathered through community channels, with findings independently evaluated to ensure accurate reflection of community needs and experiences.

In response to member discussions, it was noted that:

- It was confirmed that feedback from patients and clinicians had shown some required longer than the standard ten-minute appointment. Same day access would therefore include GP-led appointments, with PCNs linked across ten hubs. Pharmacy First had supported longer appointments, particularly in evenings and weekends. It was explained that same day appointments after 6pm would be with a GP if required.
- Members queried the targeting of specific population groups and raised concerns about whether white men over 40, who are at high risk of suicide, and elderly residents were sufficiently included. It was explained that the targeted groups were identified from A&E attendances and reflected those most likely to face barriers to care, while the whole population would still be included. Elderly people and those with long-term conditions would move directly into step two of the model, with step one designed for generally healthy individuals. It was noted that suicide prevention work could also be incorporated.

- Members highlighted that engagement of this kind could be very effective and asked what metrics would be used to measure success. It was explained that behaviour change took time, but metrics would include GP attendances and A&E activity. Success would be demonstrated by reductions in inappropriate A&E attendances, with the programme starting in September to provide early impact ahead of winter pressures.
- Clarification was sought on the use of terms such as “GP led,” “GP access” and “GP appointments.” It was explained that general practice had changed significantly since 2017, with PCNs expanding the workforce to include advanced nurse practitioners, mental health practitioners and other professionals. Access would depend on patient need, with GP input provided for cases where other healthcare staff could not meet the requirement.
- Members requested data on the overall number of GP appointments for 2024/25 and 2025/26. It was confirmed that historically hubs had been commissioned to provide same day appointments and that data would be brought to the next meeting, including the impact of longer GP-led appointments during evenings and weekends.
- Members welcomed the focus on simplicity and online access. It was noted that national work was ongoing to ensure NHS sources appeared first in search results, with further community education to be provided.
- It was confirmed that five-minute extensions to appointments would be treated separately from GP appointments. Patients contacting their practice during the day would be triaged and offered a same day evening appointment where necessary. Standard ten-minute appointments with other healthcare professionals would continue, with GP appointments available for those unable to wait. Training would include the importance of recording additional information.
- Members asked when the changes would begin. It was confirmed that a questionnaire would be launched on 10 September with supporting engagement events, and changes to GP access in the city would commence on 1 October. Feedback would be collated and used to refine the model.
- Members welcomed the increased promotion of the NHS App and asked whether doctors would use its features. It was confirmed that training was being provided to encourage this and that many patients were unaware of how to enable notifications.

Agreed:

1. That the Commission note the report.
2. That GP appointments would be an agenda item at the nest meeting.

159. NHS APP AND DIGITAL INCLUSION

The Group Director of Strategy and Partnerships gave an overview and presentation on the NHS App and Digital Inclusion initiatives. Key points to note were as follows:

- Some surgeries currently had more functions available, this was dependent on capacity and IT capability.
- Referrals and hospital appointments could now be viewed on the app, but dialogue functionality was not present.
- The app sourced information from multiple systems.
- Additional features enabling collaborative efforts were upcoming, pending national funding outcome.
- Connecting the app to the LLR care record opened up more options for patient care, such as patient follow ups.
- The plan was to introduce a two-way interaction, with patients contributing to their care plans.
- Benefits to the environment where anticipated due to the app reducing travel requirements.
- The more efficient ways of working would improve productivity.
- There was a focus on building digital inclusion amongst the 60 LLR hubs.

In response to questions and comments from members, it was noted that:

- The App would help to reduce missed appointments with notification reminders and rescheduling functionality.
- The aim was for the app to become the 'front door' for all NHS services for those wanting electronic access.
- Functions for carers were upcoming.
- Two-way messaging would feature on the app in the future. Current services having text-based chat included school nurses, health care visitors and mental health crises services. Sexual Health chat health was in trial.
- Other areas had received development funding but there were no indications that LLR was disadvantaged in the roll out of funding.
- GP appointment capacity would need to be managed efficiently.
- Digital literacy support could be built into the programme.
- The General GP contract was expected for implementation in 2026 and would establish national standards.
- Work was ongoing in the area of patient initiated follow up.
- Members surmised that the digital offer freed up resources for those not utilising digital services.
- Prescription control would improve with the app.

AGREED:

The Commission notes the report.

160. WORK PROGRAMME

The Chair invited Members to make suggestions. The following were noted:

- A visit to the A&E department
- Ambulance wait times
- NHS England Vaccination data

161. ANY OTHER URGENT BUSINESS

With there being no further business, the meeting closed at 8.33pm.

The History, Present and Future of Public Health in Leicester City

ROB HOWARD, APRIL 2025

Leicester Isolation Hospital staff with patients on porch c. 1916

The Annual Report of the Director of Public Health for Leicester City

APRIL 2024 TO MARCH 2025

Leicester City Council

Appendix B

14

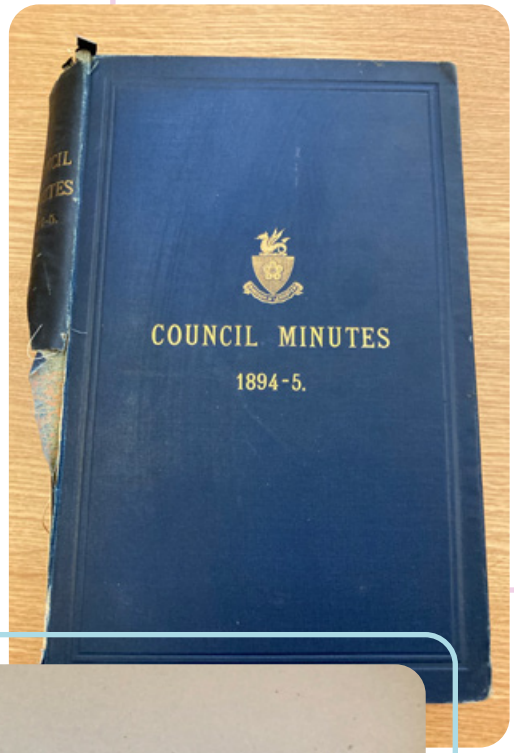
“Those who fail to learn
from history
are doomed to repeat it”

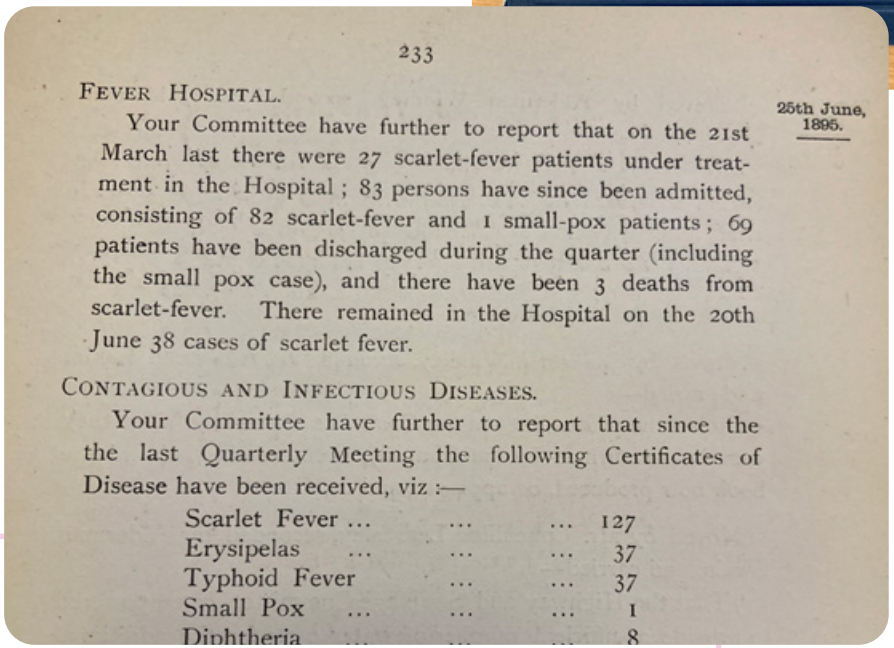
GEORGE SANTAYANA (1863–1952)

Preface

At the end of the first-floor corridor in Leicester Town Hall is a small, square room, with the smell of dusty old books and a view onto the Town Hall Square and Fountain. Loitering before a public health workshop, shortly after starting as Director of Public Health in September 2023, I notice two of the walls are filled with bookshelves containing Council minutes dating from the 1890s until the 1960s. Like a child playing only the lowest and highest notes on a piano, I reach for the very oldest; 'Council Minutes 1894–95'. These contain the minutes of several meetings of the 'Sanitary Committee', with reports from the Medical Officer of Health (MoH) and Public Analyst, Dr Joseph Priestly, my equivalent from 130 years ago.

The first paragraph I see lists the cases of Scarlet Fever and Small Pox at the 'Fever (or 'Isolation') Hospital', temporarily constructed in 1871 (on Freak's Ground just north of Northfoundpool). There is a paragraph listing the latest figures for 'Contagious and Infectious Diseases' — including typhoid fever, diphtheria and cholera, and sections on buildings 'unfit for habitation', and a report from the Food Inspector listing 'articles unfit for human food' found during inspections of shops, stalls and slaughter houses.





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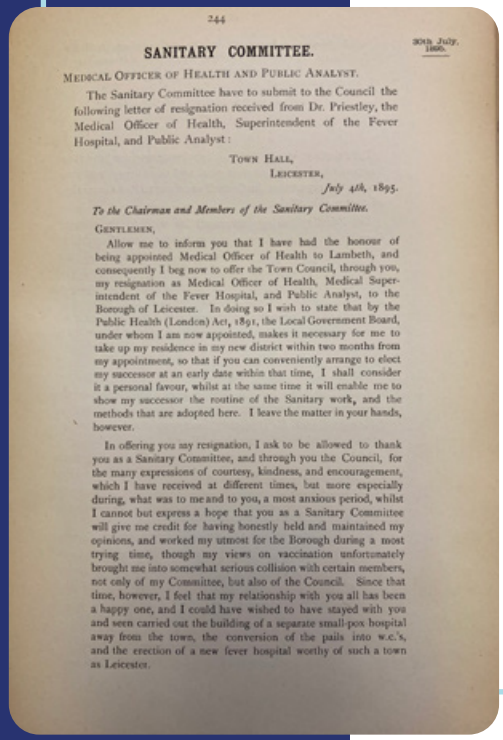
FEVER HOSPITAL. 25th June, 1895.

Your Committee have further to report that on the 21st March last there were 27 scarlet-fever patients under treatment in the Hospital; 83 persons have since been admitted, consisting of 82 scarlet-fever and 1 small-pox patients; 69 patients have been discharged during the quarter (including the small pox case), and there have been 3 deaths from scarlet-fever. There remained in the Hospital on the 20th June 38 cases of scarlet fever.

CONTAGIOUS AND INFECTIOUS DISEASES.

Your Committee have further to report that since the the last Quarterly Meeting the following Certificates of Disease have been received, viz :—

Scarlet Fever	127
Erysipelas	37
Typhoid Fever	37
Small Pox	1
Diphtheria	8



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SANITARY COMMITTEE. 30th July, 1895.

MEDICAL OFFICER OF HEALTH AND PUBLIC ANALYST.

The Sanitary Committee have to submit to the Council the following letter of resignation received from Dr. Priestley, the Medical Officer of Health, Superintendent of the Fever Hospital, and Public Analyst:

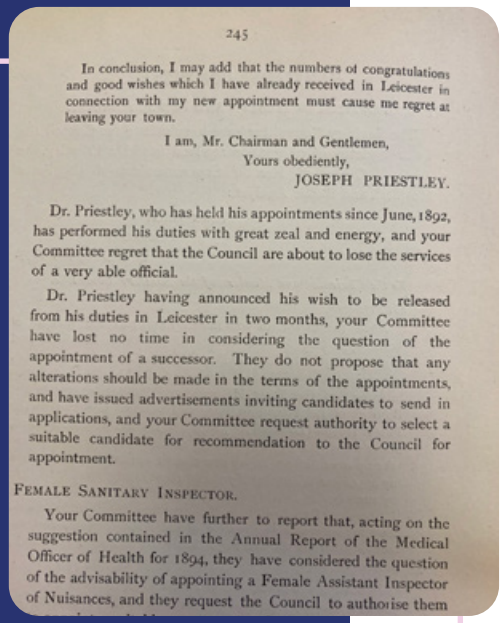
TOWN HALL,
LEICESTER,
July 4th, 1895.

To the Chairman and Members of the Sanitary Committee.

GENTLEMEN,

Allow me to inform you that I have had the honour of being appointed Medical Officer of Health to Lambeth, and consequently I beg now to offer the Town Council, through you, my resignation as Medical Officer of Health, Medical Superintendent of the Fever Hospital, and Public Analyst, to the Borough of Leicester. In doing so I wish to state that by the Public Health (London) Act, 1891, the Local Government Board, under whom I am now appointed, makes it necessary for me to take up my residence in my new district within two months from my appointment, so that if you can conveniently arrange to elect my successor at an early date within that time, I shall consider it a personal favour, whilst at the same time it will enable me to show my successor the routine of the Sanitary work, and the methods that are adopted here. I leave the matter in your hands, however.

In offering you my resignation, I ask to be allowed to thank you as a Sanitary Committee, and through you the Council, for the many expressions of courtesy, kindness, and encouragement, which I have received at different times, but more especially during, what was to me and to you, a most anxious period, whilst I cannot but express a hope that you as a Sanitary Committee will give me credit for having honestly held and maintained my opinions, and worked my utmost for the Borough during a most trying time, though my views on vaccination unfortunately brought me into somewhat serious collision with certain members, not only of my Committee, but also of the Council. Since that time, however, I feel that my relationship with you all has been a happy one, and I could have wished to have stayed with you and seen carried out the building of a separate small-pox hospital away from the town, the conversion of the pails into w.c.'s, and the erection of a new fever hospital worthy of such a town as Leicester.



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In conclusion, I may add that the numbers of congratulations and good wishes which I have already received in Leicester in connection with my new appointment must cause me regret at leaving your town.

I am, Mr. Chairman and Gentlemen,
Yours obediently,
JOSEPH PRIESTLEY.

Dr. Priestley, who has held his appointments since June, 1892, has performed his duties with great zeal and energy, and your Committee regret that the Council are about to lose the services of a very able official.

Dr. Priestley having announced his wish to be released from his duties in Leicester in two months, your Committee have lost no time in considering the question of the appointment of a successor. They do not propose that any alterations should be made in the terms of the appointments, and have issued advertisements inviting candidates to send in applications, and your Committee request authority to select a suitable candidate for recommendation to the Council for appointment.

FEMALE SANITARY INSPECTOR.

Your Committee have further to report that, acting on the suggestion contained in the Annual Report of the Medical Officer of Health for 1894, they have considered the question of the advisability of appointing a Female Assistant Inspector of Nuisances, and they request the Council to authorise them

Intrigued I start thinking about how despite our advances, much remains quite familiar in the world of public health today. I turn the page to the next meeting of the Sanitary Committee from 30th July 1895, and am stopped in my tracks by the first item on the agenda; a letter of resignation by Dr Priestly to take up a new post in Lambeth. Between the formal lines of thanks to the committee for kindness and encouragement is a statement offering clues as to the resignation and the anxiety produced as a result of an extraordinary conflict on the role of small pox vaccinations in the city:

"I cannot but express a hope that you as a Sanitary Committee will give me credit for having honestly held and maintained my opinions, and worked my utmost for the Borough during a most trying time, though my views on vaccination unfortunately brought me into somewhat serious collision with certain members, not only of my Committee, but also of the Council".

Behind this is a fascinating story of riots, protests and rebellions in opposition to mandated vaccinations, fines and imprisonment; the development of an alternative 'Leicester Method' (in today's language, contact tracing and isolation), and the gradual emergence of a consensus for both the Leicester Method and vaccinations leading to the eradication of small pox, and lifesaving reductions in a multitude of other diseases, locally, nationally and indeed worldwide.

Our recent experience of responding to the Covid-19 pandemic (see previous DPH annual report 2022[1]) as well as on the more recent outbreak of measles in the city, shows how public health continues to be contested 'Plus ça change, plus c'est la même chose'[2] (the more that things change, the more they stay the same). This has cemented my view that we need to learn from history; to listen to our communities and address their concerns, but at the same time give sound objective advice and guidance. The now classic definition of public health is never truer nor more relevant — we need to use the "science and art of preventing disease, prolonging life and promoting health through organised efforts of society".[3]

1 **https://www.leicester.gov.uk/content/beyond-the-lockdowns-lessons-learned-from-leicester-s-covid-story/**
2 **https://en.wiktionary.org/wiki/plus_%C3%A7a_change,_plus_c%27est_la_m%C3%AAme_chose**
3 Faculty of Public Health, UK Faculty of Public Health Strategy 2020-2025, (London: FPH, 2019), p. 1

1945 - Town Hall in snow

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This, my first annual report since taking up my post, will:

- Give a snapshot of the health and wellbeing of the people of Leicester City
- Reflect on the history of public health in the city, from communicable diseases and vaccinations to living and social conditions with a focus on fuel poverty; and the differences, similarities, and lessons we can learn for public health today
- Present a view on the future of public health for Leicester in the coming decades — highlighting some challenges and opportunities along the way.

[4] **https://www.adph.org.uk/resources/adph-awards-2022/**

It is an absolute privilege to serve as the Director of Public Health for this fantastic city, and I want to pay particular tribute to my team — the Division of Public Health within Leicester City Council — officially,[4] and for ever in my mind, the best public health team in the country.

Special thanks to those from the team who have contributed to this report:

- Mark Wheatley
- Helen Reeve
- Liz Rodrigo
- Gurjeet Rajania
- Pooja Bakhshi-Thaker
- Diana Humphries

ROB HOWARD

APRIL 2025

Leicester — a history of boundary and demographic changes, and a summary of health in the city

With around 368,600 residents, Leicester is the ninth largest city in England and the most populous urban centre in the East Midlands.[5] At 5,026 residents per km, Leicester is one of the most densely populated authorities outside of London in the country. The usual resident population has increased by around 38,700 since the 2011 census (11.7%). This is a greater increase than England (6.6%) and around twice the rate of Nottingham and Derby.

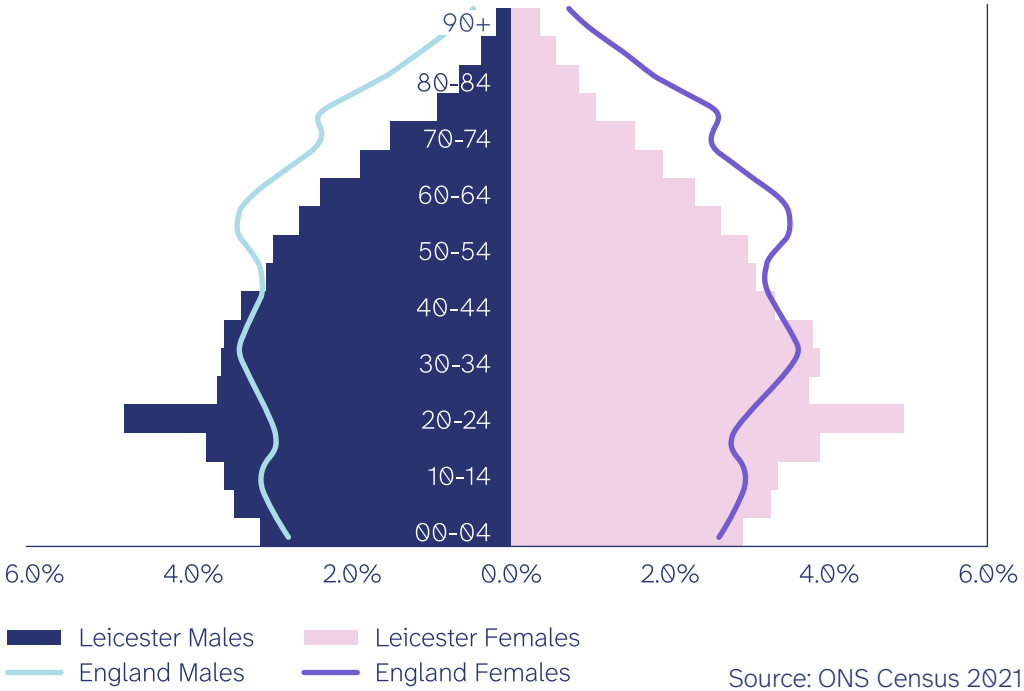
[5] Office for National Statistics, Census 2021

LEICESTER DEMOGRAPHY

Leicester's population is relatively young compared with England; 17% of Leicester's population (63,300) are aged 20–29 years old (13% in England) and 12% of the population (43,500) are aged over 65 (18% in England).

Leicester is home to a diverse range of faiths and communities. Just over 40% of Leicester residents were born outside of the UK, with 22% from Asia and the Middle East, 10% from Europe (excluding the UK) and 9% from Africa. Over the last three decades, ethnic diversity has grown. The percentage of Leicester residents reporting as White has reduced from 64% in Census 2001, to 51% in 2011 to 41% in 2021. Residents reporting as Asian have increased from 30% in 2001 to 37% in 2011 to 43% in 2021. Other minority ethnic groups have also experienced an increase over the last 30 years.

POPULATION STRUCTURE IN LEICESTER AND ENGLAND BY AGE AND SEX



Source: ONS Census 2021

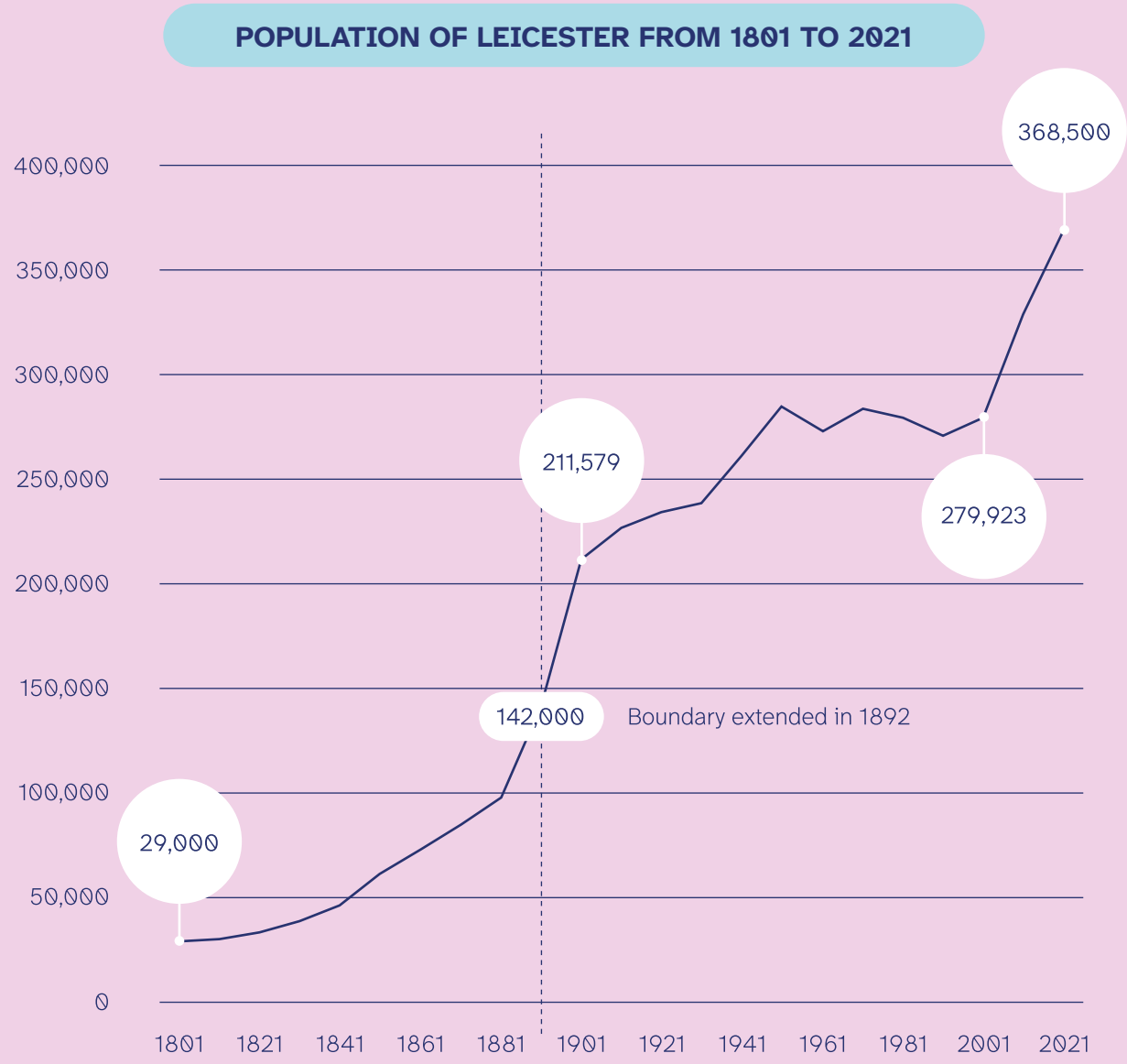
LEICESTER BOUNDARY CHANGES OVER TIME

The first official census in 1801 recorded around 29,000 people in Leicester.

The growth rate accelerated during the mid-19th century, particularly with the onset of the Industrial Revolution. Leicester became a major centre for textile manufacturing, especially the hosiery industry. The city boundary extended in 1892 and the population boomed at the turn of the century, due to the city's industries continuing to expand. The period following World War II marked significant population growth for Leicester due to various factors including global political and military events and economic migration. The city saw rapid urbanisation, with new housing developments and infrastructure projects to accommodate the growing population.

Leicester continues to grow, as one of the youngest populations in the UK, with a median age considerably lower than the national average. This youthfulness, combined with high birth rates, contributes to a growing population.

We have also seen huge changes in life expectancy over the past 200 year summarised below.



MALE AND FEMALE LIFE EXPECTANCY 1800s TO PRESENT

Period	Male Life Expectancy	Female Life Expectancy	Key Influences
1800–1850	35–40 years	35–40 years	High infant mortality, poor sanitation, infectious diseases (e.g., cholera, smallpox), industrialisation.
1850–1900	40–45 years	40–45 years	Improvements in sanitation and public health, but high infant mortality continued, and industrial working conditions.
1900–1950	50 years	55–60 years	Early public health reforms, improved medicine, decline in infectious diseases. World Wars impacted short-term trends.
1950–1980	60–65 years	65–70 years	Growth in healthcare access (NHS established in 1948), post-war recovery, economic improvements.
1990–2000	70–74 years	75–79 years	Increased awareness of lifestyle issues, growth of the NHS, but still challenges with health inequality in some areas.
2000–2020	74–78 years	79–82 years	Continuing healthcare access, focus on preventative care, but continued health inequality.

LEICESTER POPULATION BY ETHNICITY

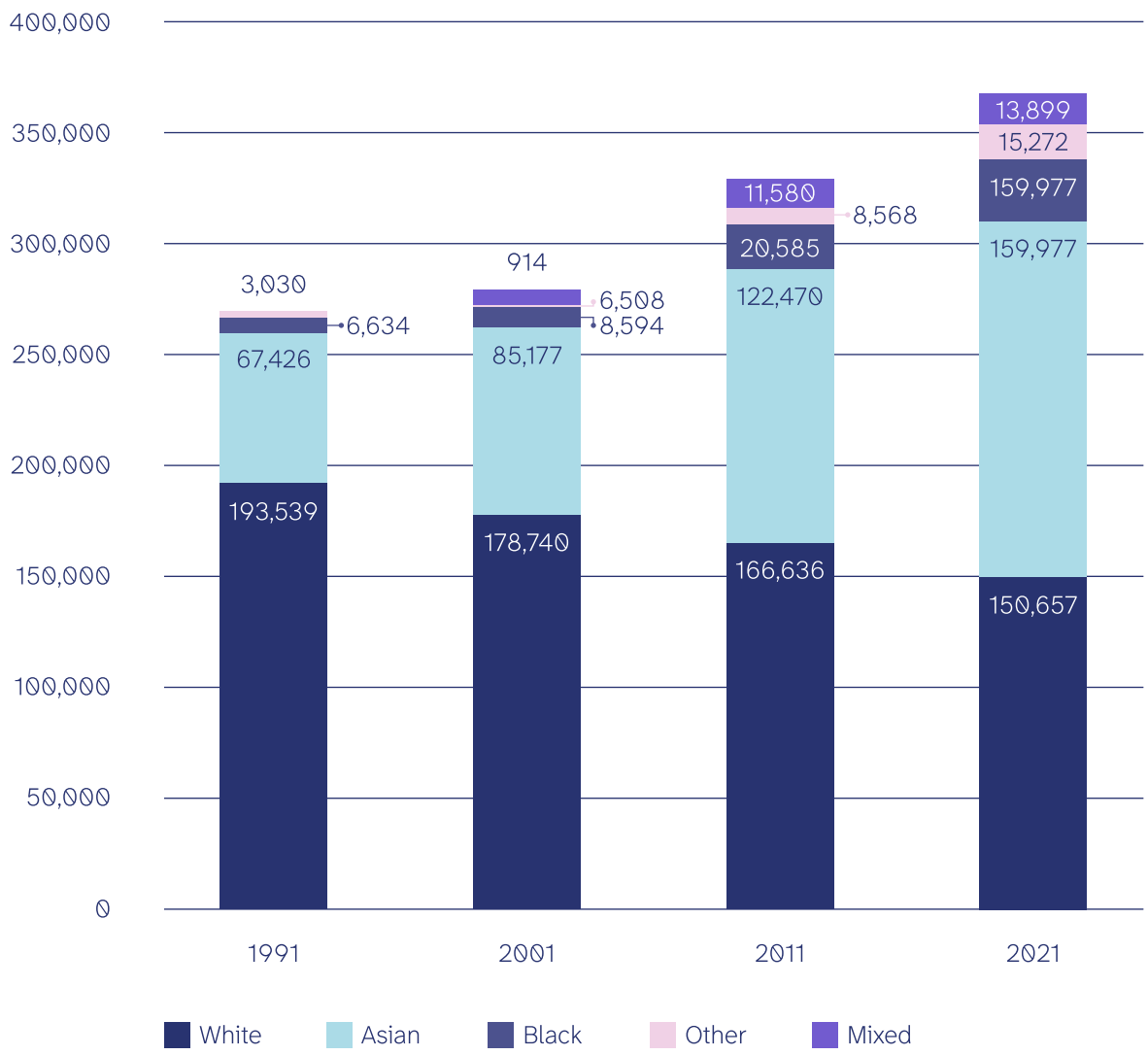
1800s: Predominantly White British, with small Irish and other European communities (including Italian and Jewish communities). The city attracted many Irish migrants, especially in the 1840s, during the Irish Famine.

Mid-1900s: Caribbean and South Asian migration becomes significant, especially post-WWII.

The first census to include a question on ethnicity was 1991. Between 1991 and 2021, Leicester's total population has increased by almost 100,000 from, 270,629 to 368,571.

Over the last forty years, the number of White residents has decreased while the number of residents from all other broad ethnic groups has increased.

LEICESTER POPULATION CHANGE BY BROAD ETHNIC GROUP



Ethnic groups in Leicester over the last 3 decades, Source: Census 1991, 2001, 2011, 2021

LEICESTER DEPRIVATION

Leicester is one of the most deprived areas in England and is ranked 32nd out of 317 local authority areas on the 2019 national Index of Multiple Deprivation (where 1 is worst). In Leicester, 36% of Leicester's population live in the most deprived 20% of areas in England and a further 38% live in the 20–40% most deprived areas. Only 2% of the Leicester population live in the 20% least deprived areas.

Areas of high deprivation usually have relatively low income, few good employment opportunities, and a high prevalence of poor health and disability compared to less deprived places. Deprivation is associated with a range of poor health behaviours and outcomes such as high smoking rates, high obesity rates, and experience of dental decay in children. In England, men in the most deprived areas can expect to live in good health for almost 20 years fewer than those who live in the least deprived areas.[6]

LEICESTER GENERAL HEALTH AND LONG-TERM CONDITIONS

Census 2021 asked respondents to assess their general health on a five-point scale as Very good, Good, Fair, Bad or Very bad. 82% of Leicester residents described their general health as either 'Very good' (49%) or 'Good' (33%). 5% described their health as either 'Bad' (4%) or 'Very bad' (1%). Levels of general health are similar for Leicester and England. Census 2021 asked respondents whether they had any physical or mental health conditions expected to last 12 months or more and then a further question for those answering yes as to whether these conditions or illnesses reduced their ability to carry out day-to-day activities.

Age-standardised rates are reported to allow for comparisons between populations that may have different age profiles. For example, Leicester has a younger population profile than England. Age-standardised proportions show 18.6% of Leicester residents have a disability limiting day-to-day activities compared with 17.7% in England.

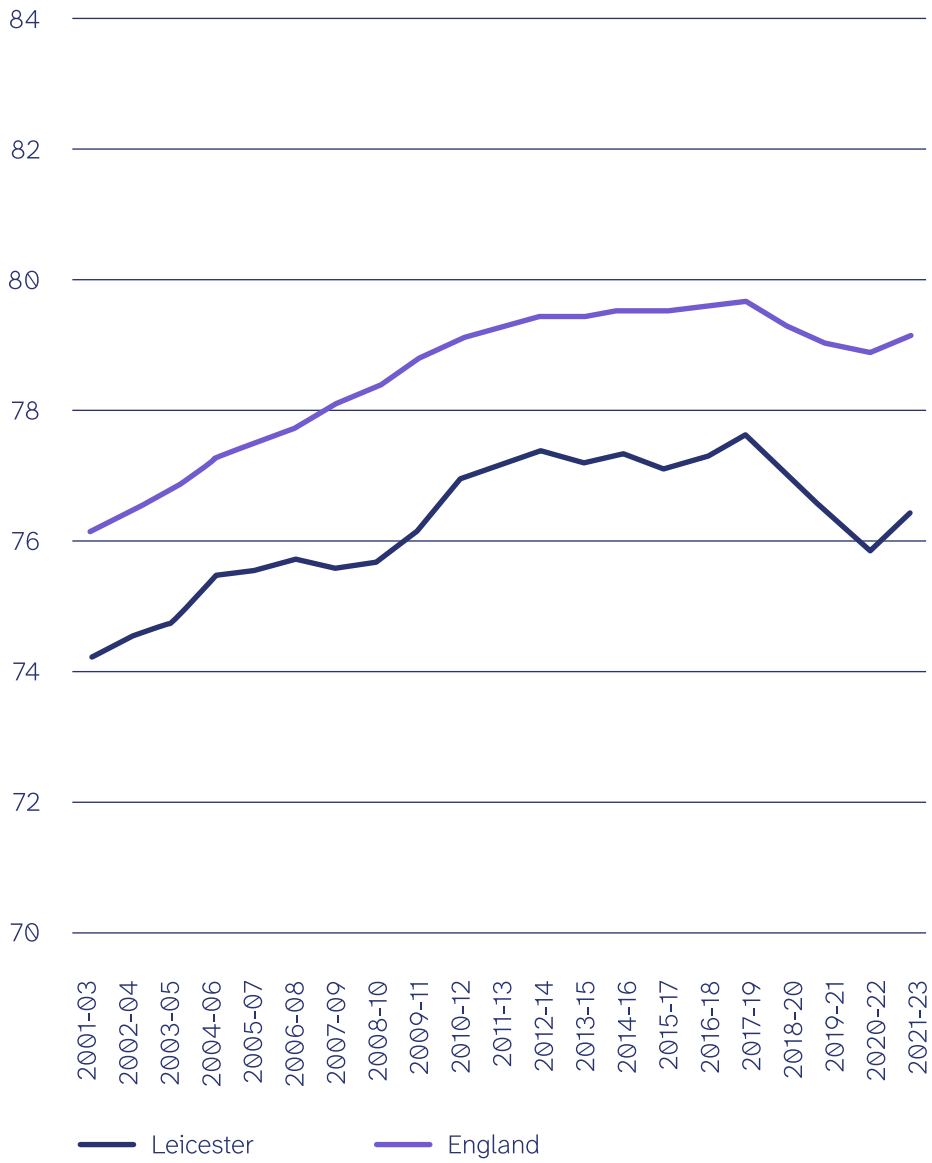
LEICESTER LIFE EXPECTANCIES

Life expectancy data from 2001–03 to 2021–23 shows Leicester residents have consistently had shorter life expectancies compared to the national average for many years, and life expectancy had plateaued in the decade to 2019. Following the Covid-19 pandemic there was sharper drop in life expectancy in Leicester compared to England.

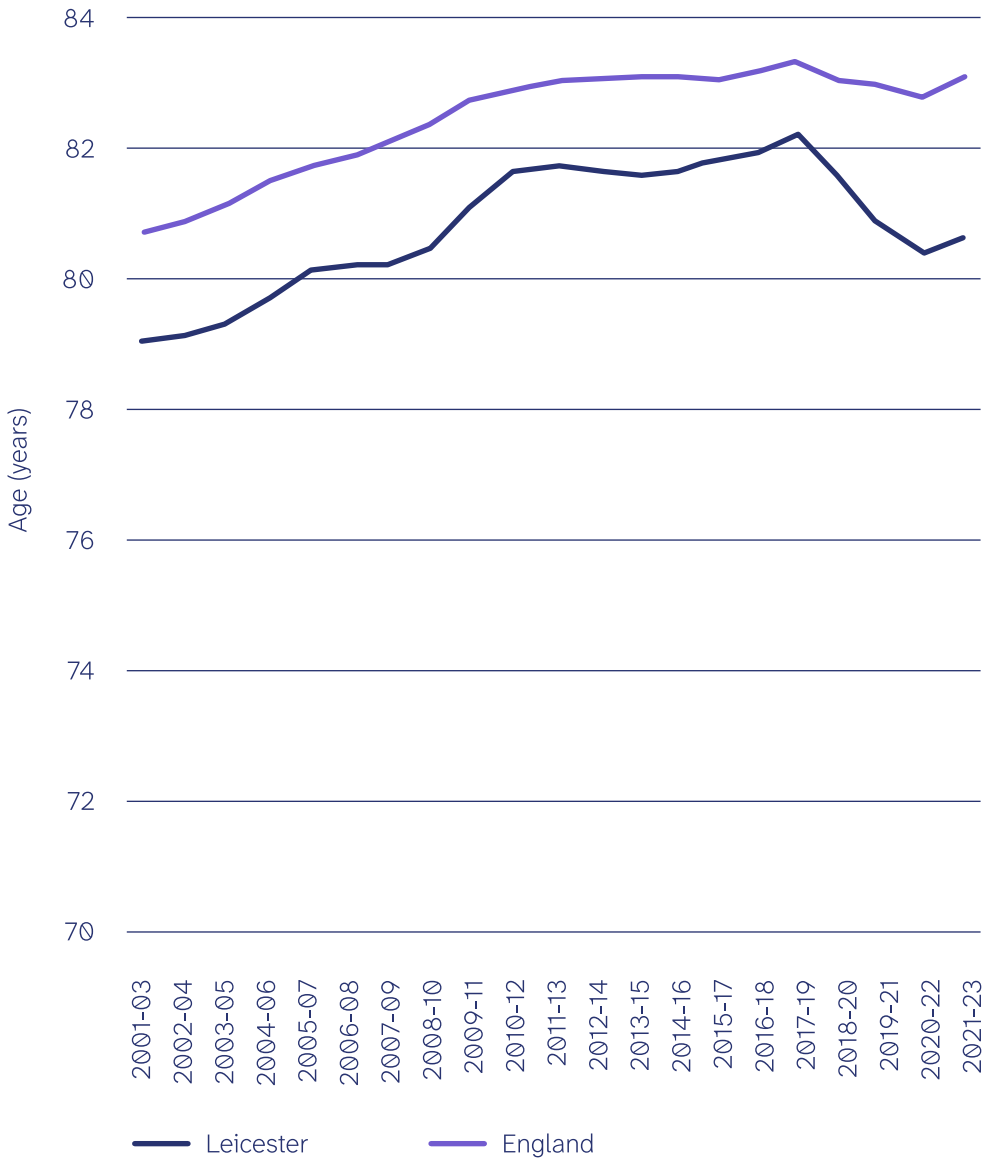
Life expectancy peaked for both Leicester males and females in 2017–19 at 77.7 and 82.2 respectively, and is now currently 76.5 for males and 80.6 for females in 2021–23. The life expectancy gap between Leicester and England is wider now compared to pre-pandemic years at 2.7 years for males and 2.4 years for females.

[6] English Indices of Deprivation: **https://www.gov.uk/government/statistics/english-indices-of-deprivation-2019**

MALE LIFE EXPECTANCY 2001-03 TO 2021-23



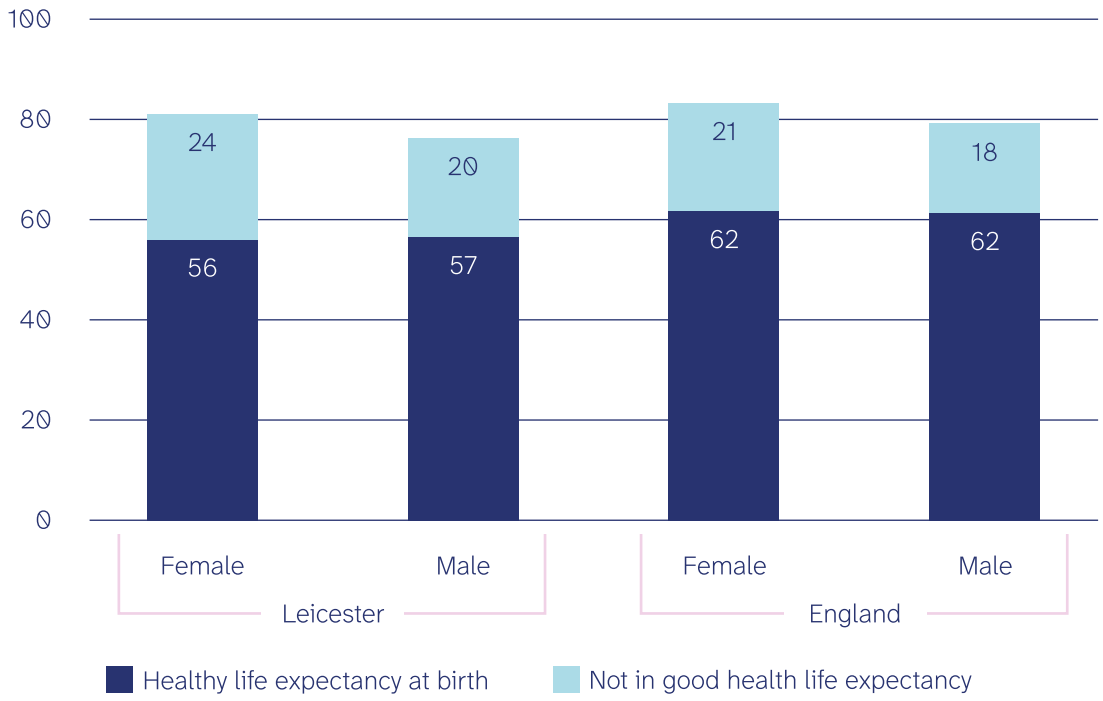
FEMALE LIFE EXPECTANCY 2001-03 TO 2021-23



Office for National Statistics (ONS) National Life Tables

In addition to having shorter life expectancies Leicester residents can expect to have more years in ill health compared to the national average. Leicester females can expect 56 years healthy life and a further 24 in ill health compared to 62 healthy years and 21 ill health years for the England average. Leicester males have a slightly longer healthy life expectancy and a shorter ill health life expectancy leading to a shorter life expectancy overall.

LIFE EXPECTANCY AND HEALTHY LIFE EXPECTANCY 2021–23



Source: OHID Fingertips / ONS mortality data Age Standardised Rates 2021–23.

LEICESTER MAIN CAUSES OF DEATH

The main causes of death in Leicester are cardiovascular diseases (23%), cancer (20%) and respiratory diseases (10%). Mental disorders (9%), nervous diseases (6%), and digestive diseases (5%) also are contributors to deaths in Leicester.[7]

Leicester reports significantly higher rates of premature/under 75 mortality from:

- Cancer (132.7 per 100,000) compared to national rate of 121.6 in England.
- Cardiovascular diseases 108.3 per 100,000) compared to national rate of 77.1.
- Respiratory disease 39.8 per 100,000 compared to national rate 30.3.
- Liver disease 28.4 per 100,000 compared to national rate 21.5.
- Dementia and Alzheimer's disease 159.2 per 100,000 compared to national 109.9.

[7] Office for National Statistics mortality data, 2021–23

One Hundred Years of Public Health — 1848–1948

The 1948 Medical Officer of Health (MoH) for Leicester annual report (by Dr E.K. Macdonald) marked the 100 year anniversary since the introduction of the 1848 Health Act which made appointing a MoH mandatory for local authorities. To celebrate this milestone, his Deputy MoH, Dr Hutchison, wrote a short chapter summarising key issues from these reports. This is a fascinating read and contains the following examples and highlights:

1846

Town Improvement Committee appointed Dr Barclay and Mr Buck as medical officers 'for the purpose of removing nuisances and annoyances' in advance of the 1848 Health Act mandating Medical Officer of Health (MoH).

1849

Mr Buck was appointed MoH and immediately put forward schemes for removal of obnoxious material from cesspools, cleaning and ventilation of lodging houses, closer inspection of slaughter houses and work to reduce diarrhoeal diseases in infants to reduce infant mortality.

1851

Infant mortality 194.5 per 1000, (peaked 1871 at 252, by 1948 dropped to 38).

1852

Deaths from diarrhoea 139 (peaked 1897 with 472 deaths). The MoH expresses concern on the slow progress of the construction of mains sewers.

1856

MoH reported a steady increase in cases of TB (Consumption).

1858

174 deaths from scarlet fever and 117 from diarrhoea. MoH commented on overcrowding in schools being 'injurious to health'.

1859

86 deaths from "hooping cough" (pertussis). The MoH also condemned the fact that many parents worked in factories, leaving children in the care of older siblings or neighbours. When children were not quiet, it was reported that some resorted to "remedies of an alcoholic and narcotic character, such as gin or Godfrey's cordial."

1861

A sharp increase in TB among factory workers. Dr Moore, the MoH states that the Local Health Board had not adequate powers to improve working conditions.

1863

236 deaths from scarlet fever (none since 1942).

1864

MoH commented on shortage of nurses to look after patients with smallpox.

1867

Saw the introduction of a social insurance scheme allowing sick pay for females on the condition that they breastfed their children! This year also saw birth of health education with leaflets advising on avoiding diarrhoea and infant feeding advice.

1868

249 deaths from measles. The report also had commentary on work with local registrar that found cases where deaths for same person had been registered 3 times by different 'unqualified quacks and herbalists' meaning the family were given funding for funeral costs 3 times!

1870

Made a plea for an isolation hospital for scarlet fever. The suggestion was turned down.

1872

314 deaths from smallpox. This year also saw the construction of a smallpox hospital (became a fever hospital in 1873) on Freake's ground.

1874

MoH put forward theory that summer diarrhoea was caused by the heat.

1876

The Assistant MoH put forward alternative theory that diarrhoea was caused by 'the introduction of minute living organisms into the system by means of air or by food' and that in areas with poor sewers and cesspit milk was often infected.

1879

Introduction of compulsory registration of infectious disease (now known as notifiable diseases). Despite significant complaints by medical professionals for creating 'new onerous and unnecessary obligation' in practice no complaints were made to the MoH and the birth of one of the most significant developments for understanding and controlling infectious diseases was born.

1882

MoH concerned about increasing cases of TB and gave advice on opening windows and better ventilation.

1883

Recommended systematic food sampling be introduced.

1885

A laboratory opened in the Town Hall postulating that TB from infected milk was causing human infection.

1886

The Lancet sent a special commissioner to Leicester to investigate the “Leicester Method’ to control smallpox.

1887

The opening of Spinney Hill Park encouraging fresh air and exercise bringing ‘pleasure to the local inhabitants’.

1888

MoH commented favourably on arrangement for sharing of data with colleagues in large towns in the area. Eventually taken over by the Local Government Board as a national surveillance system.

1889

The medical officer referred to a statement in the Manchester Guardian which asked, “would not our own (Manchester) City Council do well to send a selected deputation in order to learn what is be learned at Leicester of the means by which the death rate can be reduced by nearly 30% in eight years?”

1889

MoH made a plea for the replacement of ‘pail’ system for modern Water Closets (WCs).

1891

Saw health education become part of the school curriculum.

1898

211 measles deaths and the start of construction of the new fever hospital.

1898

Marked the 50th from the local medical officer and presented the following comparative data on child mortality as a proportion of all deaths in 1849 and 1898:

Population		Total number of births	Total number of deaths	% of deaths <age 5 to the total death rate
1849	58,000	2,807	1,681	49.8
1898	208,662	6,152	3,480	50

Isolation Hospital, Leicester. Nurse with 2 female patients reclining on porch area of hospital

1899

Large outbreak of diphtheria and 331 deaths from TB. 9/22 milk samples taken contained TB.

1900

Completion of the Groby Rd Isolation Hospital. Peak of deaths from diphtheria — 316 deaths (1948 1 death). Corporation opens a milk sterilization depot.

1902

MoH arranged for free diphtheria antitoxin supplies to GPs.

1905

Municipal milk depot established for babies not being breastfed. Infantile diarrhoea much diminished.

1907

MoH commented on growth of a garden suburb at Humberstone, developed on garden city lines.

1913

Attention was given to housing, with efforts to demolish old houses and construct new ones that could be maintained.

1918

Influenza epidemic — 1100 deaths, mostly during October and November. Undertakers were unable to cope. In week ending November 2nd 262 persons died. Hospital wards were evacuated to create space for patients.

1919

Post WWI a second influenza wave caused a further 500 deaths.

1920

MoH complained about the slow progress of house building.

1924

429 cases of diphtheria and 34 deaths. There were now 12 health visitors and 184 ante-natal sessions were held.

1926

Outbreak of Polio (81 cases and 7 deaths). Leicester Corporation had built more than 1,000 houses, with a further 667 constructed by private enterprise — described as homes for working-class people.

1928

Infant mortality rate dropped to 70.71 per 1000 births — the lowest on record.

1929

Local Government Act and North Evington Poor Law Infirmary transferred to the Public Health Department and became the City General Hospital.

1930

Infant mortality rate dropped again to 55.7 per 1000 births. A report on alcohol abuse which was increasing.

1936

No deaths from measles or scarlet fever reported.

1937

1709 families had moved into new housing.

1938

Infant mortality 45.9 / 1000 births — another record. Most work focussed on Air Raid Precautions.

1939

WWII.

1945

Opening Radiography Centre (Mass X-Ray Service).

1946

Infant diarrhoea rose again. National Health Service Act passed.

1947

Large outbreak polio — the most severe in history of the city. Health Visiting and School Nursing Services integrated.

1948

The year the NHS was created. This year saw only 1 death from diphtheria, and no deaths from scarlet fever or measles.

Despite the successes over this period for public health services, Dr MacDonald has the humility to state “It would be wrong to assume that all these improvements in the health of the population were solely due to the influence of the Public Health Department. Many other agencies have helped to improve the all-round standard of health among the community e.g., hospitals... GPs... better housing, better standards of nutrition, better education, and social legislation”.

A LIFETIME OF PROGRESS: PUBLIC HEALTH IN LEICESTER FROM 1948 TO TODAY

Since the founding of the NHS in 1948, the landscape of public health in Leicester has transformed in ways that would have once seemed unimaginable. From the near elimination of infectious diseases that once dominated annual health reports, to rising life expectancy and improved living conditions, the progress over the last 75 years is a testament to the power of coordinated public health and local authority action.

Vaccination has played a central role in this transformation. In the immediate post-war years, childhood diseases like diphtheria, polio, and measles caused significant illness and death. But thanks to the development and rollout of effective vaccines, these conditions are now rare. In 1948, Leicester saw one death from diphtheria, a disease that had killed hundreds in previous decades. By the 1950s, mass immunisation campaigns — supported by schools, GPs, and public health nurses — had begun to change the trajectory of many diseases that once devastated communities. The introduction of the MMR vaccine in the 1980s, offering lifelong protection against measles, mumps, and rubella, marked another major milestone.

As we will see in the next chapter, the eradication of smallpox in 1980, following global mass vaccination efforts, was the ultimate validation of the combined approach of both vaccination and effective social measures, pioneered in Leicester nearly a century earlier. The development of new treatments has also played a key role in improving health outcomes. In the 1970s, new antibiotics dramatically reduced the duration and severity of Tuberculosis (TB) , which had once required years of treatment in sanatoriums. Diseases that were once fatal or debilitating could now be managed, cured, or prevented altogether. The widespread availability of these treatments through the NHS has meant that health outcomes have improved not just for the wealthy, but across the population.

But the progress hasn't only come from medical advances. As we see in Chapter 4, living conditions in Leicester have also changed beyond recognition. Post-war housing programmes, slum clearance initiatives, and the expansion of social housing provided many families with warm, safe, and sanitary homes for the first time. The provision of clean drinking water, proper sewerage systems, and waste collection continued to reduce the spread of disease and improve quality of life.

Mass radiography unit demolition Castle Street 1964

From the 1970s onward, improvements in food safety, environmental health, air quality, and workplace standards continued to reduce preventable illness and premature death. More recently, efforts to combat fuel poverty and improve housing energy efficiency have shown how public health today is still deeply rooted in the environments where people live, work, and grow up.

Yet the last 75 years have not been without significant challenges. Inequalities in health outcomes persist. Leicester continues to face higher rates of long-term conditions such as diabetes, cardiovascular disease, and respiratory illness — especially in areas of higher deprivation. Life expectancy in the city lags behind the national average, and too many people spend a significant portion of their lives in poor health. The Covid-19 pandemic exposed and, in some cases, deepened these health gaps.

Today, we also face new challenges. Climate change, antimicrobial resistance, rising mental health needs, and the cost-of-living crisis all threaten to reverse some of the gains of previous decades. And while vaccines remain one of our most effective tools, vaccine confidence cannot be taken for granted. The recent outbreak of measles in Leicester reminded us of the importance of sustained public engagement, access, and trust in health services.

Despite these pressures, the story of public health in Leicester since 1948 is one of extraordinary achievement. Deaths from many infectious diseases are now vanishingly rare. Housing, sanitation, and access to care have improved dramatically. And where once there was little support for those in poor health, we now have a universal health system and a public health team rooted in communities.

The task ahead is to protect and build on these gains — to ensure that progress is not only maintained, but shared more fairly across our city. The foundations are strong, but the work continues.

LIST OF MEDICAL OFFICERS OF HEALTH IN LEICESTER SINCE 1849

1849–1852	John Buck
1852–1866	John Moore
1866–1878	J. Wyatt Crane
1878–1885	William Johnstone
1885–1891	Hy. Tompkins
1891–1895	Joseph Priestly
1895–1901	Henry G. H. Monk
1901–1935	C. Killick Millard
1935–1960	E. K. Macdonald
1960–1973	B. J. L. Moss

The responsibility for public health was taken over by the NHS from 1974 until 2013 when it returned to local government. Since then the Directors of Public Health have been:

2013–2015	Deb Watson
2015–2019	Ruth Tennant
2019–2023	Ivan Browne
2023–	Rob Howard

Communicable Disease Control — past and present

In order to compare the experiences and attitudes to infectious disease historically and in the present day, I will look at 2 main topics:

- Smallpox and attitudes to compulsory vaccination in the 19th century, and the lessons learnt from this and our recent experience with Covid-19 and measles
- Tuberculosis (TB) — historic and current challenges.

Smallpox in 19th Century Leicester: Public Resistance, the "Leicester Method", and Lessons for Public Health Today

The experience of smallpox in 19th-century Leicester offers a rich historical case study of public health, community resistance, and innovation in disease control. Amid widespread fear of the disease and growing state involvement in health, Leicester became a focal point for resistance to compulsory vaccination and the development of alternative approaches, culminating in the "Leicester Method". While initially controversial, the eventual compromise between vaccination and broader public health measures (including what we now call contact tracing and isolation) was instrumental not only in managing outbreaks locally but also in shaping strategies that contributed to the global eradication of smallpox.

THE CONTEXT OF SMALLPOX AND COMPULSORY VACCINATION

Smallpox was one of the deadliest infectious diseases of the 19th century, causing high mortality and morbidity. Following Edward Jenner's development of the smallpox vaccine in 1796, vaccination became a central pillar of disease control in Britain. The Vaccination Acts of 1853, 1867, and 1871 progressively made vaccination compulsory and enforceable, particularly targeting infants and young children.[8] The intention was to create population-level immunity, but in cities like Leicester, these laws provoked considerable backlash.

Opposition stemmed from concerns about the safety and efficacy of vaccination, infringements on personal liberty, and distrust of the medical profession. Many working-class residents viewed the enforcement of vaccination as punitive and authoritarian, particularly as non-compliance could lead to fines and imprisonment.

[8] Porter, D. and Porter, R. (1988) 'The Politics of Prevention: Anti-Vaccinationism and Public Health in Nineteenth-Century England', Medical History, 32(3), pp. 231–252.

PROTESTS AND THE ANTI-VACCINATION MOVEMENT

Leicester became a centre of organised resistance to compulsory vaccination. The anti-vaccination demonstration of 1885 is emblematic of this sentiment, attracting an estimated 80,000 protesters.[9] The scale and organisation of the protest — complete with banners, marching bands, and speeches — demonstrated the depth of local opposition. Anti-vaccination candidates were elected to the Board of Guardians[10], enabling them to reduce enforcement and promote alternative measures.

THE LEICESTER METHOD: AN ALTERNATIVE MODEL

Leicester residents, with liberal and radical leanings, strongly opposed the mandate and formed the Leicester Anti-Vaccination League in 1869. Between 1869 and 1881, 1,154 prosecutions were recorded, including 61 imprisonments. The Leicester Corporation Act 1879 introduced an alternative method of disease control, later known as the Leicester Method. Now referred to as Test, Trace and Isolate, it emphasised immediate isolation of cases, thorough contact tracing, disinfection of infected households, and the use of dedicated isolation hospitals.

Voluntary vaccination was still offered, particularly for close contacts during outbreaks, but the emphasis was on hygiene and containment. Despite official warnings, Leicester experienced relatively few smallpox deaths during subsequent outbreaks, which bolstered the community's belief that their alternative approach — focusing on sanitation and isolation — was superior to enforced vaccination.

THE ROLE OF COMPROMISE: FROM CONFRONTATION TO COLLABORATION

The success of the Leicester Method highlighted the value of environmental and social measures in disease control. However, the limitations of a largely non-vaccination approach also became apparent in subsequent years, particularly during more severe outbreaks. Over time, a more balanced model of public health emerged in the UK — one that retained the importance of vaccination while also recognising the role of sanitation, education, and consent. This shift was codified in the Vaccination Act of 1898, which introduced a "conscientious objection" clause. Parents could now opt out of compulsory vaccination on ethical grounds.

GLOBAL IMPACT AND THE ERADICATION OF SMALLPOX

While Leicester pioneered local non-vaccination approaches, vaccination remained central to the global eradication of smallpox in the 20th century. The World Health Organization's (WHO) intensified smallpox eradication campaign, launched in 1967, used mass vaccination combined with many of the principles trialled in Leicester — surveillance, contact tracing, containment, and isolation. Smallpox was declared eradicated in 1980, a remarkable feat that required widespread immunisation to create herd immunity, supported by rigorous public health infrastructure and community cooperation.[11]

[9] Durbach, N. (2005) Bodily Matters: The Anti-Vaccination Movement in England, 1853–1907. Durham: Duke University Press.
[10] **https://en.wikipedia.org/wiki/Board_of_guardians**
[11] Fenner, F., Henderson, D. A., Arita, I., Ježek, Z. and Ladnyi, I. D. (1988) Smallpox and Its Eradication. Geneva: World Health Organization.

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Two boys with smallpox, photographed by Dr. Allan Warner, Assistant Medical Officer of Health, at the Isolation Hospital at Leicester in 1901. Atlas of Clinical Medicine, Surgery, and Pathology, 1901[12]. Shows two boys, both aged 13 years. The one on the right was vaccinated in infancy, the other was not vaccinated. They were both infected from the same source on the same day.

[12] **https://archive.org/details/b21513508_0001/page/n425/mode/2up?view=theater**

Lessons for Public Health in Leicester Today

COVID-19

The legacy of Leicester's 19th-century experience with smallpox informed the city's response to Covid-19, particularly in tackling vaccine hesitancy. Just as public resistance to compulsory vaccination in the 1800s was rooted in concerns around safety, liberty, and trust in authority, similar themes emerged during the Covid-19 pandemic. Leicester recognised early on that building trust was fundamental to increasing vaccine uptake, especially in communities historically underserved or marginalised by state systems.[13]

Drawing on behavioural science, our local public health teams developed tailored communication strategies that reflected the real-world contexts in which people make health decisions. Rather than relying solely on national messaging, we crafted locally relevant campaigns that were empathetic, culturally sensitive, and framed around collective responsibility. These campaigns were informed by insights from behavioural science on what motivates behaviour change — such as the influence of trusted messengers, social norms, and the importance of clarity and repetition.[14] Our work using the COM-B behaviour science model[15] emphasised that addressing vaccine hesitancy requires both emotional resonance and factual accuracy — combining data with storytelling to speak directly to community concerns.[16]

A cornerstone of Leicester's response was the creation of the Vaccine Community Champions programme. Community members from diverse backgrounds were trained and supported to become advocates for vaccination within their own networks. These Champions were not merely conduits for information; they were active listeners who helped bridge the gap between communities and health services. They played a critical role in identifying barriers, addressing concerns, and countering misinformation circulating on social media — particularly in relation to vaccine safety, fertility myths, and conspiracy theories.[17]

In addition to vaccine outreach, Leicester also developed its own contact tracing programme, staffed by people who lived and worked in the same communities they were serving. This localised approach improved the speed and effectiveness of tracing efforts, and more importantly, helped to foster trust. People were far more likely to answer the phone or open the door when contacted by someone with a shared cultural background or local knowledge, and who could offer practical support and advice alongside public health guidance.

By investing in community-based solutions and listening to people's lived experiences, Leicester was able to build the trust necessary for a successful public health response. The historical lesson — that health interventions must be done with communities, not to them — was not only remembered, but actively applied. In doing so, Leicester demonstrated how the principles of consent, communication, and collaboration remain as vital today as they were in the era of the Leicester Method.

[13] Royal Society for Public Health (2021) New polling shows vaccine hesitancy highest in BAME groups. Available at: **https://www.rsph.org.uk/about-us/news/new-poll-finds-bame-groups-less-likely-to-want-covid-vaccine.html** [Accessed 9 Apr. 2025].

[14] Behavioural Insights Team (2021) Four principles for developing effective COVID-19 vaccine communications. Available at: **https://www.bi.team/blogs/four-messages-that-can-increase-uptake-of-the-covid-19-vaccines/** [Accessed 9 Apr. 2025].

[15] **https://social-change.co.uk/files/02.09.19_COM-B_and_changing_behaviour_.pdf**

[16] Michie, S. and West, R. (2021) 'Behavioural, Environmental, Social and Systems Interventions Against COVID-19', BMJ, 372, n92. DOI: 10.1136/bmj.n92.

[17] **https://www.leicester.gov.uk/content/beyond-the-lockdowns-lessons-learned-from-leicester-s-covid-story/healthy-places/#Community%20Champions**

MEASLES 2024 OUTBREAK

Measles is one of the most contagious diseases in the world. It is caused by a virus that can spread through the air when someone who is infected coughs or sneezes. The virus can stay in the air for up to two hours and infect people who breathe it in. On average, one person with measles can pass it on to 12 to 18 other people if they aren't protected. Leicester, like many industrial cities in the UK, experienced regular and sometimes severe outbreaks of measles throughout the 19th and early 20th centuries. These outbreaks were particularly devastating for young children and often occurred in overcrowded urban areas where poor housing, sanitation, and limited access to healthcare made the spread of infectious diseases more likely. Measles was a common childhood illness, but it could lead to serious complications, including pneumonia and encephalitis. The introduction of the measles vaccine in the late 1960s significantly reduced cases across the UK, including in Leicester. The MMR vaccine, which protects against measles, mumps, and rubella, is given in two doses. It is very safe and works extremely well — giving 97% protection for life — and helps stop the disease from spreading in the community.

In 1868, 249 people died from measles in Leicester. The 1898 report recorded 211 deaths during an epidemic. In England and Wales in 1941 saw 1145 measles deaths. Last year there were 3, with none in Leicester.

2024 saw a significant increase in measles cases in Leicester with around 150 confirmed cases. To keep everyone safe, especially babies and those who can't have the vaccine, at least 95% of people need to be vaccinated. However, vaccination rates have fluctuated over time, and occasional outbreaks have reappeared in areas or communities with lower uptake. The 2024 measles outbreak in Leicester tested the city's public health system once again — but also demonstrated how the lessons of history had been meaningfully applied. As with the Covid-19 pandemic, addressing vaccine hesitancy was central to the response. While concerns about the MMR (measles, mumps, and rubella) vaccine have persisted for decades, the legacy of misinformation stemming from Andrew Wakefield's now-discredited claims of a link between the vaccine and autism continued to influence public perceptions.[18]

However, vaccine hesitancy during the measles outbreak proved to be more complex and nuanced than misinformation alone.

In some communities, particularly among certain religious groups, concerns were raised about the porcine-derived content in some formulations of the MMR vaccine. While these concerns were not new, they had not always been adequately addressed in previous public health campaigns. In 2024, Leicester's public health team and LLR Integrated Care Board (ICB) responded proactively by ensuring that non-porcine gelatine-free vaccine formulations were made available at vaccination sites across the city. This practical accommodation, made in consultation with religious leaders, helped address a key barrier to uptake.[19]

Just as we had mobilised Vaccine Champions during Covid-19, the city adapted this approach through its Community Wellbeing Champions network. Alongside the excellent team from the LLR ICB and our own brilliant public health officers, these individuals and organisations (now over 600 members), already embedded in local communities, were trained to support the measles response by listening to concerns, providing accurate information, and helping to dispel persistent myths.[20] Crucially, they worked in partnership with schools, GPs, local places of worship, and community centres — spaces where trust was already established.

[18] Godlee, F., Smith, J., and Marcovitch, H. (2011) 'Wakefield's article linking MMR vaccine and autism was fraudulent', BMJ, 342, c7452. DOI: 10.1136/bmj.c7452.
[19] British Islamic Medical Association (2023) MMR and Islam: Guidance on the use of porcine products in vaccines. Available at: **https://britishima.org** [Accessed 9 Apr. 2025].
[20] Leicester City Council (2024) Community Wellbeing Champions Programme: Interim Evaluation Report. Leicester: Public Health Team.

To ensure accessibility, we deployed roving vaccination units that brought the service directly to the heart of communities. These mobile teams visited schools, religious venues, and community hubs, removing logistical barriers such as travel, time, or unfamiliarity with health settings.[21] As a result, nearly 600 people received the MMR vaccine helping to end a potentially very serious outbreak. This approach was particularly effective in reaching children and young people who had missed their routine childhood vaccinations during the Covid-19 pandemic or due to longstanding hesitancy.

Once again, the city's response was shaped by the understanding that community trust, cultural sensitivity, and local partnership are as important as clinical effectiveness in any vaccination campaign. By applying the lessons of Leicester's own past — combining historical awareness with practical compassion — we were able to contain the outbreak and rebuild confidence in routine immunisation.

Social media post promoting roving vaccination unit in community settings, 2024.

IN SUMMARY, THE LEGACY OF LEICESTER'S HISTORY OF INFECTIOUS DISEASE CONTROL CONTINUES TO OFFER IMPORTANT LESSONS:

- **Trust and Consent Matter:** Public health interventions are most effective when communities understand, trust, and consent to them. Heavy-handed enforcement can backfire and erode compliance.
- **Vaccination and Public Health Infrastructure Must Work Together:** Vaccines are essential tools, but they work best within broader systems of hygiene, housing, education, and healthcare access.
- **Community-Led Innovation Has Value:** Leicester's community response, while controversial, contributed valuable insights into disease control that shaped national and global policy.
- **Tailored Responses Are Crucial:** As seen during the Covid-19 pandemic, one-size-fits-all approaches can be less effective than strategies adapted to local conditions and cultures.

[21] BBC News (2024) 'Measles outbreak: Leicester uses mobile vaccine teams to reach affected communities', BBC News, 12 February. Available at: **https://www.bbc.co.uk/news** [Accessed 9 Apr. 2025].

Tuberculosis (TB)

A HISTORY OF TB IN ENGLAND AND WALES.

Tuberculosis (TB) posed a significant public health challenge in Leicester during the 19th and early 20th centuries. The city's rapid industrialisation led to overcrowded housing and poor sanitation, creating ideal conditions for the spread of TB, commonly known as "consumption." The disease primarily affected the lungs and was highly contagious, thriving in densely populated working-class neighbourhoods.

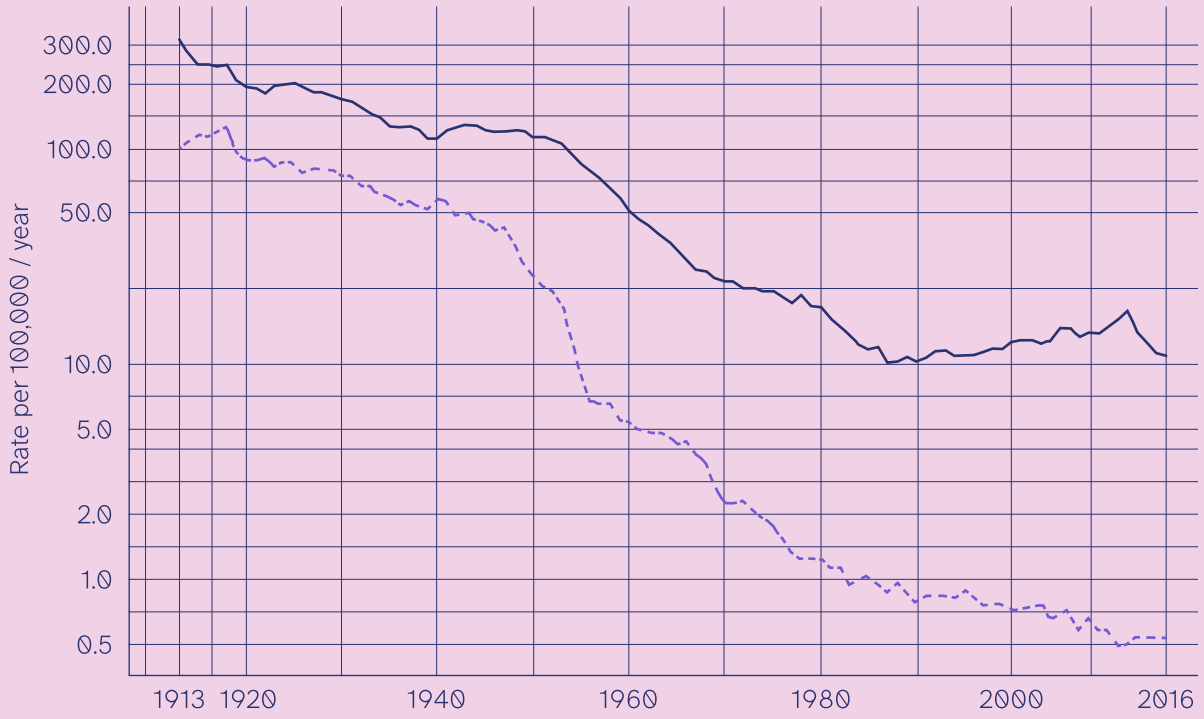
Medical understanding of TB evolved notably after Robert Koch's discovery of the tuberculosis bacillus in 1882, confirming its infectious nature. This breakthrough prompted targeted public health interventions in Leicester, including the establishment of open-air schools and specialised hospitals aimed at controlling the disease.

[22] Philippe Glaziou et al. Thorax 2018;73:702-703

One prominent example is the Western Park Open Air School, Leicester's first open-air school for children with respiratory problems, which opened on 7 November 1930. The school was designed to provide a healthy environment with ample fresh air and sunlight, believed to be beneficial for children susceptible to TB. The school's design featured wide-opening windows to maximise ventilation.

In 1937, it was recognised by the Royal Institute of British Architects for its modern design and was later granted Grade II listed status by Historic England. Leicester's Chief School Medical Officer, Allan Warner, described the school as offering a "healthy environment" aimed at restoring children's health and developing them into "hardy men and women," reflecting the interwar emphasis on building robust citizens.

TB INCIDENCE AND MORTALITY RATES 1913–2016



TB incidence (solid line) and mortality (dashed line) rates per 100,000 populations per year in England and Wales, 1913–2016. The introduction of Isoniazd and Rifampicin in the 1970s enabled treatment to be reduced from 18 months to 9 months and in the 80s, adding pyrazinamide reduced this further to 6 months.

In addition to educational initiatives, Leicester developed specialised medical facilities to treat TB patients. Founded in 1771, The Leicester Royal Infirmary expanded its facilities over time to address various health needs, including the Groby Road Isolation Hospital and Santorium for the treatment of many infectious diseases including TB. With the arrival of the NHS in 1948, it was renamed the Leicester Isolation Hospital and Chest Unit. As conditions began to improve after the war and antibiotics and vaccinations were introduced, the burden of TB was hugely reduced, with the rate falling from 60 deaths per 100,000 population in 1945, to just 2 by 1970.

The establishment of these open-air schools and specialised hospitals in Leicester reflected a broader public health strategy aimed at combating TB through environmental and educational interventions. These efforts, championed by medical professionals like Dr Allan Warner and supported by public health officials, laid the groundwork for modern approaches to disease prevention and health promotion in the city.

Charles St 1920, now location of Leicester City Council

TB TODAY

Sadly this initial progress has not continued. In 2023, TB became the world's leading cause of death from a single infectious agent. More than 10 million people continue to fall ill with TB every year and in 2023, 1.25 million died from the disease. The World Health Organisation's 'End TB' strategy aims to reduce incidence and burden of TB disease. The UK reaffirmed its commitment to these aims in 2023 but to date neither the WHO or the UK are on target to meet any of the long term or intermediate outcomes.

England is a low TB incidence country but a decline in notifications over the last decade has now reversed, notifications are increasing at a faster rate and we are moving further away from the trajectory needed to achieve the WHO's End TB targets. 2023 data showed an 11% increase compared with 2022 and provisional data for the first three quarters of 2024 indicated a further 13.7% increase against the same period in 2023. The 2023 increase is the largest reported rise in the current reporting period (1971 to 2023) and while rates remain below the peak in 2011 (15.6 per 100,000), the ongoing increase in notifications means England is moving further away from the WHO End TB targets and from its low incidence status.

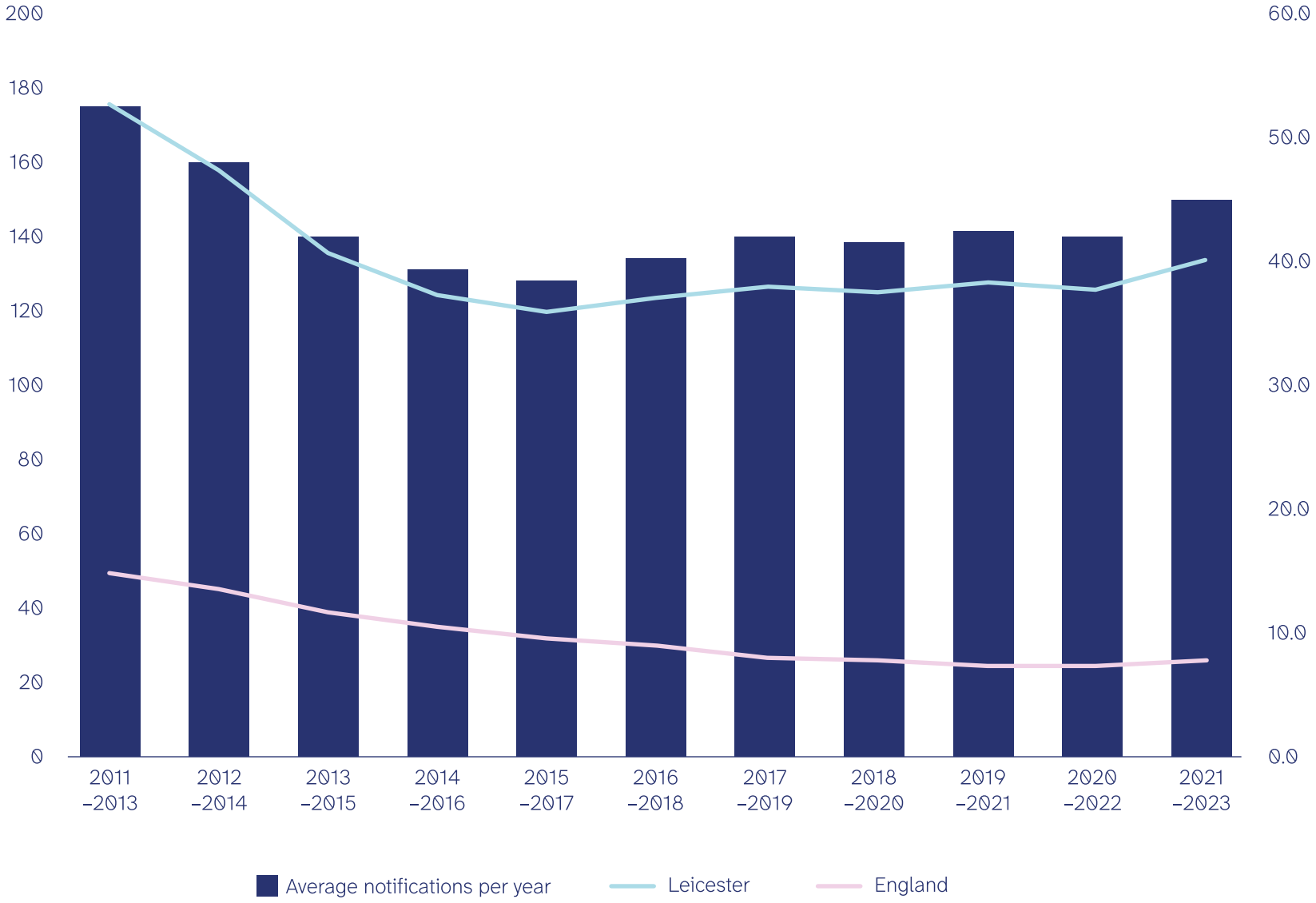
Notification rates in Leicester are now at their highest point for a decade at 40.7 per 100,000 and are the highest in England. Country of birth is the single biggest contributor to case numbers with over 90% of cases in those born in a country of high incidence with the majority of these born in India. Since Brexit, a large increase in non-EU migration is likely to be a contributory factor to increasing notifications in younger males between 25 and 34 years of age. Economic migrants bring much needed skills to the city and county and it is vital that we have adequate latent TB screening processes to ensure those that may previously have been exposed to TB are supported and treated to prevent activation of the disease.

This changing pattern of migration is projected to continue with an increasing number of economic migrants from high incidence countries. The workforce shortages in our health and social care sector mean that offering latent screening and treatment to migrants must be a priority. Increased complexity of cases including drug resistance, comorbidities and the presence of social risk factors creates additional pressure on TB services and long stays in hospital place financial and resource pressure on our health systems. TB is a preventable and curable disease but should not be treated in isolation from its wider contributing determinants such as access to housing and other social support.

A TB Health Needs Assessment (HNA) recently completed by Leicester City Public Health shows increasing case numbers and increasing risk of a continued upward trajectory in the future. However joint work across the system has recently increased the numbers of latent TB screening tests being undertaken, and boosted the size of the local TB Treatment Service.

Recommendations from the HNA are being incorporated into the local TB strategy and implementation plan. This will aim to increase detection and control of TB, support a skilled and resilient workforce, and raise awareness and reduce stigma in communities and professionals.

AVERAGE NUMBER OF TB NOTIFICATIONS IN LEICESTER AND TB NOTIFICATION RATES PER 100,000 IN LEICESTER AND ENGLAND: 3-YEAR RATES



Average TB notification rates: Leicester and England

INCREASE DETECTION AND CONTROL OF ACTIVE AND LATENT TB

Increase LTBI screening in the eligible population

- Develop a flag for System One that triggers eligibility for LTBI
- Develop business case for targeted expansion of LTBI programme

Increase early identification of active TB disease

- Increase proportion of cases starting treatment within 4 months

Strengthened links between TB services and GPs

- Identify GP champions

Increased awareness of TB in GP and other health professionals

- Develop information package on TB

Increased awareness of TB in key local employers and organisations

- Develop and provide training package on TB for all relevant organisations
- Develop employer engagement action plan

ENSURE A SKILLED WORKFORCE BUILDING ON ITS SUCCESSES AND WORKING WITHIN ITS CAPACITY AND RESOURCES

TB workforce aligns with RCN, NICE and WHO standards

- GIRFT reports are used alongside audits of current services
- Business case developed to increase staffing to align with recommended standards

Build on successful completion rates for active and latent TB

- Carry out a feasibility study looking at additional methods of support such as community pharmacies

Increase TB knowledge in other health professionals

- Development of a package of information material including referral pathways and access to treatment

People accessing services are provided with a holistic package of care

- Develop a directory of other organisations that could provide support to a person undergoing treatment e.g. housing support etc
- Carry out patient pathway process maps on latent and active TB pathway
- Quality assurance framework on TB services

RAISE AWARENESS AND REDUCE STIGMA OF TB WITHIN OUR POPULATION

Ensure the voice of those with lived experience is heard

- Set up a process for involvement in all parts of the strategy and services

Increase awareness for those at risk of TB

- Focus groups to understand knowledge, barriers and enables to accessing treatment
- Information packages developed

Increase awareness of TB in wider professional groups

- Development of a package of information material including referral pathways and access to treatment

Increase general population awareness of TB

- Focus groups with community wellbeing champions to understand stigma and enablers
- Develop a suite of information material to include signs and symptoms, transmission, where to go if concerned and other key messages
- Ensure all material is produced using behavioural insights methodology

PREPARE FOR THE FUTURE AND PLAN ACCORDING TO NEED

Understand current demand and future projections

- Carry out a LLR JSNA
- Modelling of future projected demand
- Identify potential gaps in resources and provision based on JSNA, GIRFT report etc

Allocate resources based on need

- Ensure TB rate projections for the most vulnerable are separated from overall population projected figures
- Provide a flexible adaptive response appropriate for our diverse community settings
- Ensure the strategy has SMART objectives targeting resources based on evidence of need

Living and Social Conditions — past and present

Leicester has a long spanning history of planning and development dating back to the Roman period. The earliest evidence of this is our records of the Roman town of Ratae Corieltavorum, with its ordered street network linking key civic buildings. It is estimated that Ratae reached a population peak of around 6,000 in the late 2nd and 3rd centuries[23]. When the Romans conquered Britain in the 1st century, they built extensive public health facilities, such as public baths, toilets, fountains and sewers. The Jewry Wall Roman Baths[24] located in Leicester is one of the largest pieces of Roman masonry still standing in Britain.

Through the Medieval era, Leicester grew slowly. Diseases like the plague were widespread due to poor sanitation.

In the late 18th century, the town started to grow dramatically. This was due to transport infrastructure and demand for labour from the town's expanding hosiery, boot and shoe trades.

In the 19th century the workforce was accommodated by cheap, badly built cottages centred around a courtyard only accessible through narrow entries. This often-lacked sunlight, fresh air and proper ventilation. Most of the cottages had two rooms- one up and one down. Cooking would have taken place over a fire or on a range, there would have been no internal water supply, and the washing would have been done outside. In the 1840s death and disease were shown to be more prevalent in the streets with no drainage.

Slum Clearance Braunstone 1930s

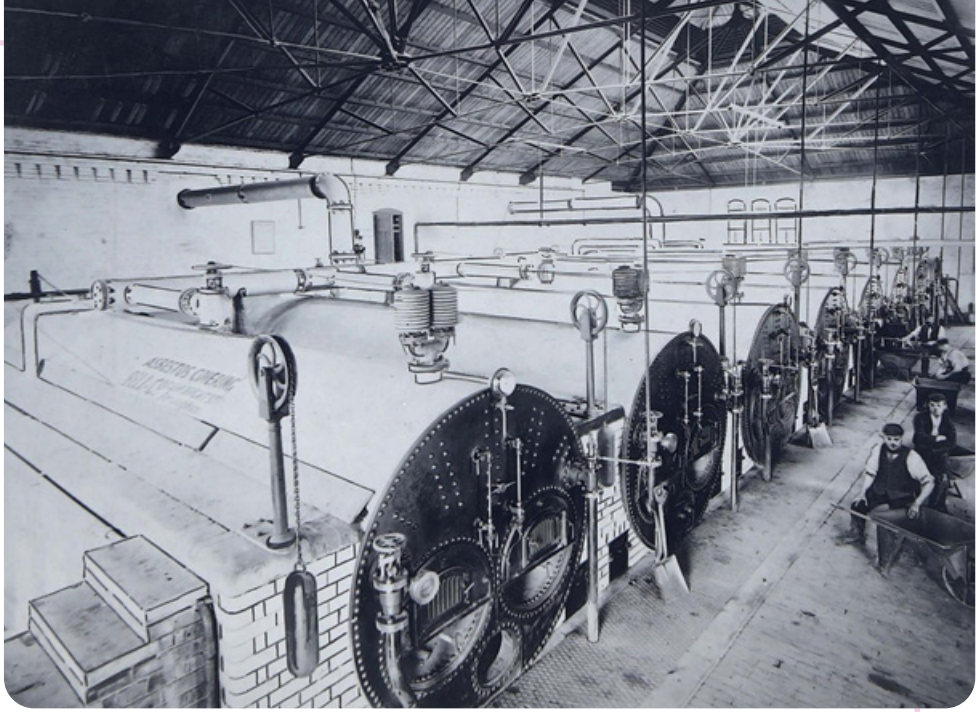
[23] Reinventing Ratae: exploring Roman and medieval Leicester — The Past
[24] Jewry Wall Roman Baths - Story of Leicester

In 1851 there was the summer epidemic of diarrhoea which killed many of the elderly and the very young.[25] In 1871 this was killing one in four Leicester children before their first birthday. As a result, Leicester had the child mortality rate which was twice the national average and on par with London, Manchester and Liverpool. Sadly, this continued into the 20th century. The causes of the epidemic were believed to be poor sanitation and water contamination. The outbreak highlighted the urgent need for reform in urban sanitation systems, which would become a focus of public health authorities in the following decades. Leicester started to receive piped water in 1853 and was the first town to set up a wastewater treatment works.[26]

In 1898, a new sewage system powered by the Abbey pumping station enabled the Town Council to phase out the use of pail closets in the slums.[27] Ashpits were removed as pail closets were converted into water closets. Once this was rolled out at a large-scale Leicester's public health improved dramatically, overtaking many other large towns such as Nottingham. Pail closets were associated with diseases such as Cholera, Typhoid fever, Dysentery etc. Leicester council was distinguished as a progressive authority, although inequalities amongst the poor and the rich remained.

Aerial view of Leicester 1867

[25] Annual Reports of the Medical Officer of Health for Leicester (1849-1859).
[26] 3 SW_WaterInTheHome_p1
[27] The History of Leicester" by Michael P. G. Harris



Abbey Road Pumping Station[28]

Family at Eaton Square, c.1930

SLUM CLEARANCES

In the 20th century slum clearance changed the face of Leicester again. Slum clearances became a part of improving the city's living conditions. Many buildings were destroyed, and new roads and housing took their place. Between 1932 and 1976 around 16,000 houses were cleared. Until then, the slums housed thousands of people in often cramped and unhealthy conditions.

Following WW1, the shortage of housing in Leicester meant that the Council did not continue its limited attempts to close and demolish some of the worst slums until the mid-1920s. Instead, its strategy was to seek the improvement of slums. The post-World War I period marked a significant turning point in housing policy across Britain, with the 1919 Housing Act[29] aiming to tackle the housing crisis by improving conditions and constructing new homes. The Act introduced government subsidies to encourage local authorities to build homes for the working class, and local councils, including Leicester, began to clear slums and build new housing estates. Leicester Corporation acted by building large estates of new homes to replace the old slum areas. In some cases, these new homes were built in nearby areas such as Knighton and Spinney Hills[30].

The Housing Act of 1930 gave local authorities more powers to demolish slums and replace them with new homes. This act was crucial for the continuation of slum clearance efforts in Leicester, where the clearance of unhealthy homes became a key priority. In the 1930s tenants from 78 different clearance areas scattered around the city were concentrated in North Braunstone and Northfields estates.

[28] **https://www.storyofleicester.info/a-working-town/abbey-pumping-station/**
[29] Council housing - UK Parliament
[30] Leicester: A History" by Geoffrey T. Martin

This situation was set out by the financial regime for rehousing by the government and so the City Council was unable to offer tenants much choice. The end of general means building meant that only families from the slums were moved to North Braunstone. Moving a high concentration of lower income families away from their known communities and social support created new challenges to tenants. It was probably hoped that the improved housing conditions would be sufficient to counter poverty or disadvantage.

WW2 efforts brought work on housing to a virtual standstill by 1940. It was another 14 years before the programme was restarted. The 1949 Housing Act further increased government funding for the construction of new homes and slum clearance. In 1952, Lewin Street became the first post-war clearance area. With 247 houses, it was thought to be the largest clearance area in the country at the time[31].

Houses continued being demolished and by mid-1970s the plans drawn up in the 50s were all but complete. At the end of 1976 around 12,500 houses had been demolished, leaving only Martin Street and Laurel Road to be cleared. The city was divided into 54 zones, covering about 35,000 houses which were to be improved during the period of 1976–1991 using renovation grants[32]. Renewal rather than clearance was the preferred methods.

Recent governments have reverted to the belief that private enterprise is better able to meet people's needs. However, it is important to remember that slum housing was the result of unfettered enterprise and that it was through government intervention through slum clearance and the offer of more suitable social housing that improvements were made. Although this did improve housing conditions, poverty and inequality prevailed, for example St Matthew's estate has changed significantly, however it remains the most deprived neighbourhood of Leicester. A 2007 survey showed that, based on income it was the poorest area in England.[33]

Aerial view of Elston Fields
1927, now Saffron Lane Estate

[31] The Slums of Leicester
[32] The Slums of Leicester **https://www.leicestermercury.co.uk/news/history/gallery/the-slums-of-leicester-541382**
[33] St Matthew's, Leicester - Wikipedia

FUEL POVERTY

After the Romans, Leicester's homes were heated by fires, then coal, stoves, and eventually gas central heating by the 1960s. However, recent years have seen an energy crisis driven by soaring gas prices and inefficient housing. In England in 2024, 36.4% of households spent over 10% of their income on energy — up from 27.4% in 2022.[34]

The fuel poverty rate in Leicester remains among the highest in England. In 2001 19% of households in Leicester were fuel poor (compared to 13.6% in the East Midlands and 13.1% in England). A report from The Energy Helpline indicated that Leicester is the joint 8th area most impacted by fuel poverty.[35]

Fuel poverty varies across Leicester with areas in the east reporting highest levels of fuel poverty[36]. Spinney Hill has the highest proportion of fuel poor households (47%) and surrounding areas of Spinney Hill and Charnwood, areas within Newfoundpool, West End and Aylestone have 30-40% of households unable to afford to heat their homes to adequate safe levels.

Households showing lowest levels of fuel poverty are generally located on the outskirts of Leicester in Beaumont Leys and Rushey Fields due to the better insulation and heating standards in social housing, and in Hamilton and South Knighton[37], where incomes are higher.

The health impacts of fuel poverty are widespread. At a basic level it can cause respiratory issues, cardiovascular problems, and can worsen chronic conditions such as chronic obstructive pulmonary disease (COPD). But fuel poverty is also linked to mental health impacts such as anxiety and depression, social isolation and loneliness. Vulnerable populations are particularly impacted; children, the elderly and those with pre-existing medical conditions. There are also many indirect health consequences, for example having to spend more on heating and so being able to spend less on nutritious food, adoption of unsafe heating practices, and even disrupted sleep. Even in the early stages of the energy crisis, estimates suggested that some 10 per cent of excess winter deaths are directly attributable to fuel poverty and 21.5 per cent are attributable to cold homes. (Fuel Poverty, Cold Homes and Health Inequalities in the UK (2022) Institute of Health Equity[38].

LOW TEMPERATURE IMPACTS

- 18–24˚C (64-75˚F) — no risk to healthy people
- Below 16˚C (61˚F) — diminished resistance to respiratory infections
- Below 12˚C (54˚F) — increased blood pressure and viscosity
- Below 5˚C (41˚F) — deep body temperature falls

[34] **https://www.endfuelpoverty.org.uk/fuel-poverty-statistics-reveal-households-hit-hard-by-crisis/#:~:text=The%20number%20of%20households%20who,in%202022%20(6.7%20million)**
[35] **https://energyadvicehelpline.org/top-10-worst-areas-for-fuel-poverty-in-the-uk/**
[36] LIVING IN LEICESTER, adult joint strategic needs assessment
[37] LIVING IN LEICESTER, adult joint strategic needs assessment
[38] **https://www.instituteofhealthequity.org/resources-reports/fuel-poverty-cold-homes-and-health-inequalities-in-the-uk/read-the-report.pdf**

LEICESTER ENERGY ACTION

To address this, Leicester City Council and the Division of Public Health realised we needed a programme of work that would offer high quality energy advice, income maximisation advice, and support to access improvements in heating and insulation measures. With £1m funding from the LLR Integrated Care Board (ICB) - the largest NHS donation for a fuel poverty programme we are aware of nationally - we established in partnership with National Energy Action (NEA) the 'Leicester Energy Action' Programme.

The programme focussed on combatting fuel poverty in Leicester through a series of channels.

- The Advice Service provided a small, dedicated team of NEA energy advisers to help clients with energy efficiency, managing energy debt, applying for funding and support, and addressing crisis situations with interventions such as warmth packs and energy vouchers. The team worked with many community and charity organisations in the city, the NHS, and front-line Leicester City Council teams to identify and work with those in need of support.
- The Outreach workstream saw NEA advisors and Leicester City Council Public Health Officers visiting communities and events across the city to delivery energy advice sessions, raising awareness of the health issues associated with fuel poverty, and providing direct support for those who needed it, as well as access into the advice service for more complex cases.
- The Training workstream delivered webinars to front line teams covering topics such as the impact of fuel poverty on vulnerable clients, how fuel poverty effects mental health, and how to recognise fuel poverty — all underpinned by a focus on methods of supporting clients. The programme also delivered a series of City and Guilds Level 3 Award in Energy Awareness courses to staff from front-line teams and community groups from across the city, giving them qualifications in delivering energy advice and support, and allowing them to deliver valuable guidance to the clients and communities they're already working with, as well as connecting a network of teams and individuals focussed on addressing fuel poverty.
- Finally, the programme visited primary schools with Energy in Mind sessions, delivering engaging advice and resources around energy and energy management in the home to children. These sessions linked to the broader topics the children are taught in that age group, making energy management and efficiency relevant and interesting while fostering long-term behavioural change.

We've supported thousands of people during the Leicester Energy Action Programme, and Public Health's work with NEA and other providers of energy support continues into 2025 and beyond as we continue to raise awareness of both the impacts of fuel poverty, and the remedies that can be introduced to make meaningful, material differences to people's home energy use.

Public Health Officers Edd and Rumaysa ready for (energy) action!

The Future of Public Health in Leicester

Public health in Leicester has always stood at the crossroads of innovation, resistance, resilience and reform. From the “Leicester Method” of smallpox control in the 19th century, to our recent community-led responses to Covid-19 and the 2024 measles outbreak, the city’s public health story has been shaped by an evolving dialogue between people, science, and the state.

So what of the future? What will define the next chapter in this long story? If the past tells us anything, it is that future progress will rely not only on technological advancement, but on social justice, equity, and the enduring importance of trust.

LOOKING AHEAD: CHALLENGES AND OPPORTUNITIES

As we look to the coming decades, many of the challenges we face remain depressingly familiar. Poverty, poor housing, and unequal access to education and employment continue to drive health inequalities in Leicester. The data in this report shows a city where life expectancy still lags behind the national average, where too many people live in overcrowded or inadequate homes, and where deprivation is closely linked to long-term conditions and premature mortality.

But we also live in an era of breathtaking technological change. Advances in personalised medicine, genomics, digital health, and artificial intelligence offer radical new possibilities for prevention, diagnosis, and care. These developments could redefine what it means to deliver public health, but only if we remain guided by the principles that have always mattered most: fairness, inclusion, and the belief that everyone — regardless of background — deserves the opportunity to live a long and healthy life.

Let’s explore these possibilities — and their pitfalls — in more detail.

THE RISE OF PERSONALISED PUBLIC HEALTH

Public health has traditionally focused on population-level measures. Clean water. Safe housing. Vaccination campaigns. Behavioural interventions. But the rise of personalised and precision medicine is beginning to shift that paradigm. Increasingly, we are able to tailor health advice, risk prediction, and even treatments to the individual — based on their genetics, lifestyle, environment, and behaviours.

Wearable technology, from fitness trackers to continuous glucose monitors, already enables people to track and respond to real-time data about their bodies. These devices could play a role in early intervention and chronic disease prevention, offering public health teams new ways to support healthy lifestyles.

In Leicester, where rates of diabetes, cardiovascular disease, and obesity remain high — especially in certain communities — this personalised approach could help to improve outcomes. But only if access to these tools is equitable. A future where personalised public health is only available to those with the money, education, or digital literacy to use it is a future that will deepen health inequalities, not resolve them.

The challenge, then, is not just to develop the tech, but to democratise it.

GENOMIC MEDICINE AND THE PROMISE OF PREVENTION

The next major frontier is genomics. Our increasing ability to read, interpret, and act on genetic information opens the door to a new era of preventative health care. We can already identify individuals at higher genetic risk of certain cancers or heart conditions, allowing for early screening or preventative treatments.

In the future, this could become routine — particularly for populations where early detection could have a profound impact. Leicester's diverse population offers a unique opportunity to apply genomic insights across a range of ethnic and genetic backgrounds. Done well, this could reduce health inequalities that have historically seen certain groups underdiagnosed or underserved.

However, the ethical, cultural and privacy implications are profound. How do we ensure genetic data is used responsibly? How do we protect against discrimination, commercial misuse, or stigmatisation? And how do we have meaningful conversations with communities — many of whom may already feel over-scrutinised or distrusted by systems of authority?

The future of genomic medicine will not just be written in labs, but in dialogue with our citizens.

ARTIFICIAL INTELLIGENCE AND DECISION-MAKING

No conversation about the future of health would be complete without mentioning artificial intelligence (AI). Already being used in diagnostic imaging, predictive analytics, and administrative systems, AI offers incredible potential to make health systems faster, smarter, and more efficient.

Imagine AI tools that can forecast outbreaks of infectious disease based on social media trends, school absences, or wastewater data. Or virtual assistants trained to help residents navigate health services, explain vaccine information in multiple languages, or support people living with dementia in their own homes.

In Leicester, where language, literacy and cultural barriers can sometimes create obstacles to care, AI could help remove friction points — if designed with care, compassion and community input.

But we must also be honest about the risks. Poorly trained algorithms can perpetuate bias. Over-reliance on automation can erode human relationships. And the digital divide remains a real barrier for many in our city. Let us not forget: the best public health practitioners are still the ones who listen, empathise, and connect — not just compute.

The greatest promise of AI lies in what it can enable humans to do better — not in replacing them altogether.

TECHNOLOGY ALONE IS NOT ENOUGH

While the future is digital, we cannot allow it to become disembodied. The social determinants of health — housing, income, education, environment — remain the most powerful predictors of how long and how well we live. The greatest gains in public health over the last 200 years came not from apps or algorithms, but from clean water, decent homes, better working conditions, and universal education.

In Leicester today, we still see how poor housing fuels fuel poverty, how unemployment limits access to good food, and how insecure immigration status drives mental health problems. The city's public health future must not just be wired into servers — it must be grounded in streets, schools, homes, and workplaces.

The challenge is to weave technology into this fabric, rather than treating it as a separate thread.

That means:

- **Building healthy neighbourhoods**, with walkable spaces, clean air, green areas, and community hubs.
- **Creating fair work and lifelong learning opportunities**, especially for young people and new arrivals.
- **Ensuring energy-efficient housing**, reducing fuel poverty and protecting against extreme weather.
- **Designing inclusive services**, that meet the needs of all residents, not just the digitally confident.

If we don't invest in these fundamentals, the health gap will widen — even as the tech gets smarter.

EQUITY BY DESIGN

Every innovation must be tested against a simple question: will this reduce health inequality, or exacerbate it?

A city as diverse as Leicester — with its young, multi-ethnic, multilingual, multi-faith population — needs future health systems that are designed for inclusion from day one. That means ensuring new technologies reflect our communities in the data they use, the languages they speak, and the cultures they recognise.

We must resist the lure of "one size fits all" models, and instead embrace pluralism, participation, and co-design. Our experience with Vaccine Champions, Community Wellbeing Champions, and outreach teams during Covid-19 and the measles outbreak shows what is possible when people are empowered to lead from within their communities. The future must build on these foundations.

A CITY PREPARED FOR THE UNEXPECTED

If recent years have taught us anything, it is to expect the unexpected. Pandemics. Cost of living crises. Environmental emergencies. Technological disruptions.

A resilient public health system must be agile, collaborative, and alert. It must use data intelligently, while protecting privacy. It must nurture its workforce, while embracing innovation. And it must listen — to science, to communities, to lived experience.

Leicester has all the ingredients to be a leading city in this next phase of public health: a rich history of radical thinking, a diverse and vibrant population, and a public health team with deep roots and wide vision.

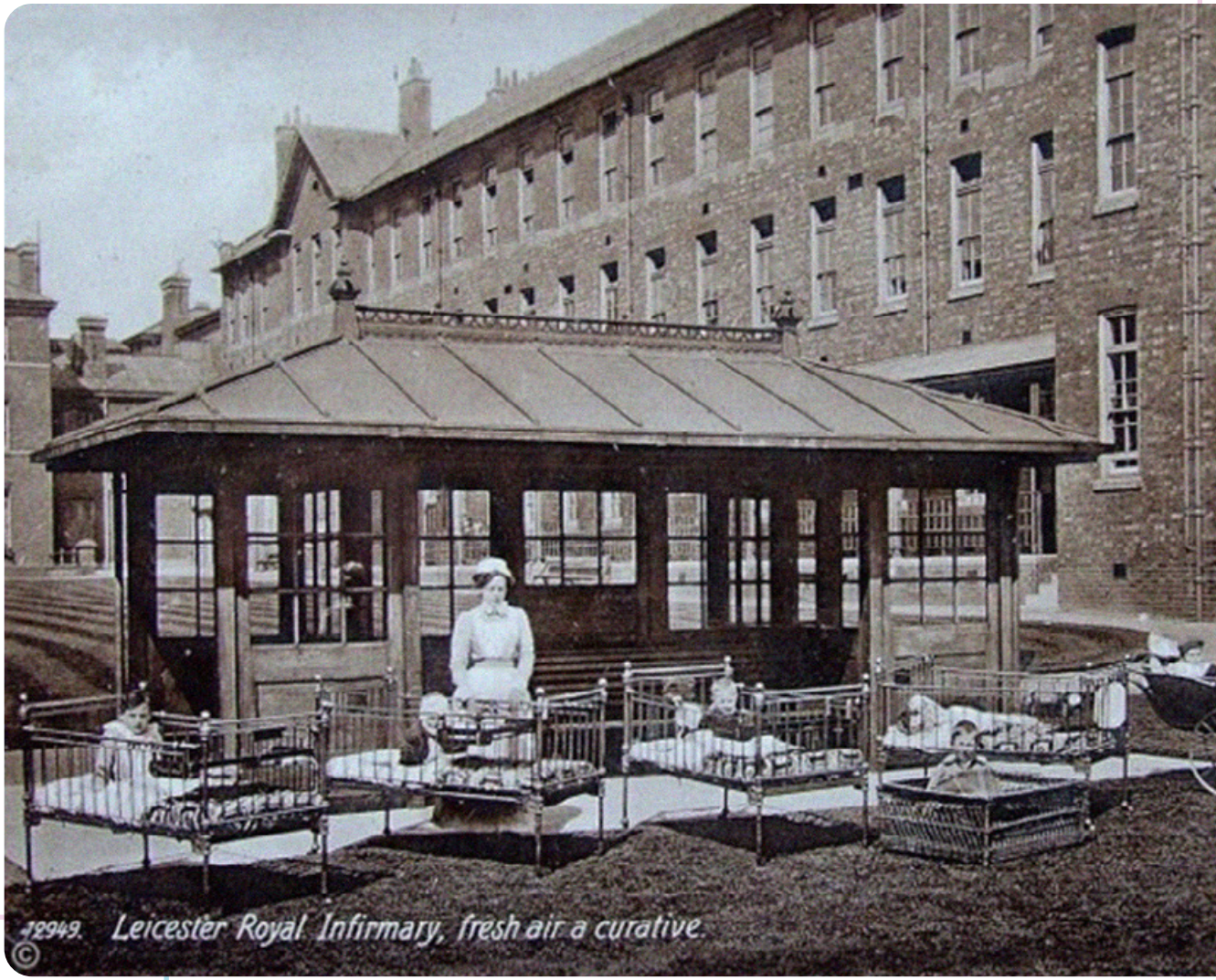
A FINAL THOUGHT...

In 1895, Leicester's Medical Officer of Health, Dr Joseph Priestly, resigned amidst fierce public debate about vaccination. In 2025, I write this report in the shadow of those same tensions — updated for our time, but familiar nonetheless.

It seems likely that whoever writes the future reports will face challenges we can scarcely imagine today. By 2050 will Leicester have eradicated TB? Will life expectancy gaps finally have closed? Will every child grow up in a warm home, with access to green space, good food, and a hopeful future?

Will the next Director of Public Health even be a human? Perhaps an AI Agent will sit in this very seat, calibrated to optimal empathy, programmed to quote historical data and respond in perfect Leicester dialect.

Let's just hope they remember to say please and thank you![39]



Leicester Royal Infirmary Children's Ward 1907

[39] This chapter 'The Future of Public Health in Leicester' was written by ChatGPT4. I loaded the annual report to date with the instruction "Please write a final chapter for this annual report entitled 'the future of public health in Leicester'. Write around 1500 words in UK spelling. Reflect on the main elements of the report so far, but also focus on the potential for future technological advances including personalised care, genomic medicine and the use of AI. However also reflect on the need to continue to create healthy environments with decent housing, good jobs and reduced inequalities. You can joke at the end that the future DPH may well be an AI Agent". It took around 9 seconds.

Rob Howard | Director of Public Health

Leicester City Council, City Hall, 115 Charles Street, Leicester LE1 1FZ

Tel: 0116 454 4829 (internal: 37 4829) | Mob: 0774 8428689 | Rob.howard@leicester.gov.uk

Leicester
City Council

Appendix C

Leicester City Council

Whole System Approach to Healthy Weight

Public Health and Health Integration Scrutiny Commission

Date of meeting: 4/11/2025

Lead director/officer: Rob Howard

Useful information

- Ward(s) affected: All
- Report author: Amy Hathway
- Author contact details: amy.hathway@leicester.gov.uk
- Report version number: 1

1. Summary

Maintaining a healthy weight is important for overall health and wellbeing. People who have excess weight, compared to those with a healthy weight, are at increased risk for many serious diseases and health conditions including cardiovascular and respiratory disease, as well as mental health conditions. In addition, excess weight is known to contribute to factors such as poorer sleep, self-esteem and body image. Maintaining a healthy weight can reduce the risk of these adverse impacts. A balanced weight also supports better energy levels, mental health, and helps people to stay active and enjoy a higher quality of life.

Leicester City Council's Whole System Approach (WSA) to Healthy Weight supports collaborative action across a variety of areas to support the promotion of healthy weight, moving away from individual blame of weight status to an approach that focuses on the power and cumulative effect of systems changes. If every single player made a positive change of 2 or 3%, rolled out across the entire system, we would see improvements in healthy weight in Leicester. This incremental gain made collectively adds up to sustained and system wide change.

The below report outlines the complexities of weight and the comprehensive approach being taken within Leicester to promote healthy weight across the system.

2. Recommendation(s) to scrutiny:

Public Health and Health Integration Scrutiny Commission are invited to:

- Read and comment on the current position regarding the approach to healthy weight in Leicester.
- Offer suggestions on the planned and future work of the approach, suggesting opportunities for engagement with system partners.

3. Detailed report

Language used when communicating about weight

Obesity is a complex issue that can be attributed to a combination of environmental and medical factors. The sensitive nature of the topic, and stigma that those living with obesity can face, has supported widespread work to neutralise the language used when referring to individuals whose weight is above or below what is clinically healthy. Terminology relating to clinical definitions of weight outside of healthier parameters is used within this report, but communication relating to weight will be compassionate and person-first.

4.1. Healthy weight in Leicester

Maintaining a healthy weight is important for overall health and wellbeing. People who have excess weight, compared to those with a healthy weight, are at increased risk for many serious diseases and health conditions including cardiovascular and respiratory disease, as well as mental health conditions. In addition, excess weight is known to contribute to factors such as poorer sleep, self-esteem and body image. Maintaining a healthy weight can reduce the risk of these adverse impacts. A balanced weight also supports better energy levels, mental health, and helps people to stay active and enjoy a higher quality of life.

People living with excess weight are more likely to develop a range of conditions including diabetes, cancer, hypertension, and stroke. Leicester has a significantly higher prevalence of diabetes than England. Leicester's communities are diverse, and members of these communities, specifically those from South Asian backgrounds, are at an increased risk of experiencing life-limiting long-term conditions such as diabetes at a lower Body Mass Index (BMI).

62.8% of adults, 19.3% of Reception aged children and 39.1% of Year 6 age children in Leicester have excess weight. Higher prevalence exists in those aged 44-64 years, people living with disability, people with poor mental health, people with low level of education and people from Black communities.

However, the world we live in is not conducive to maintaining healthy weight and individuals cannot be blamed. Wider influences on health play a huge role in individual and community capability, opportunity, and motivation to maintain a healthy weight. The complexity of the many influences on healthy weight means the approach to try and improve healthy weight must be comprehensive and draw on the whole system.

A sample of influences on weight are summarised:

- Biological influences – genetics, hormone changes, slowing of metabolic rate across life course.
- Psychological influences – depression, sleep, eating disorders, anxiety, substance misuse, mental health treatments, body image and experience of abuse.
- Environmental influences – fast food outlet density, transport used, travel methods, marketing exposure, employment, air quality, access to services, access to green spaces and access to good food.
- Economic influences – high deprivation, low income, and cost of living crisis.

The complexity of the many influences on healthy weight means the approach to try and improve healthy weight must be comprehensive and consider the whole system, whilst acknowledging what is within and outside of our control as a Local Authority.

4.2 Whole system approaches overview

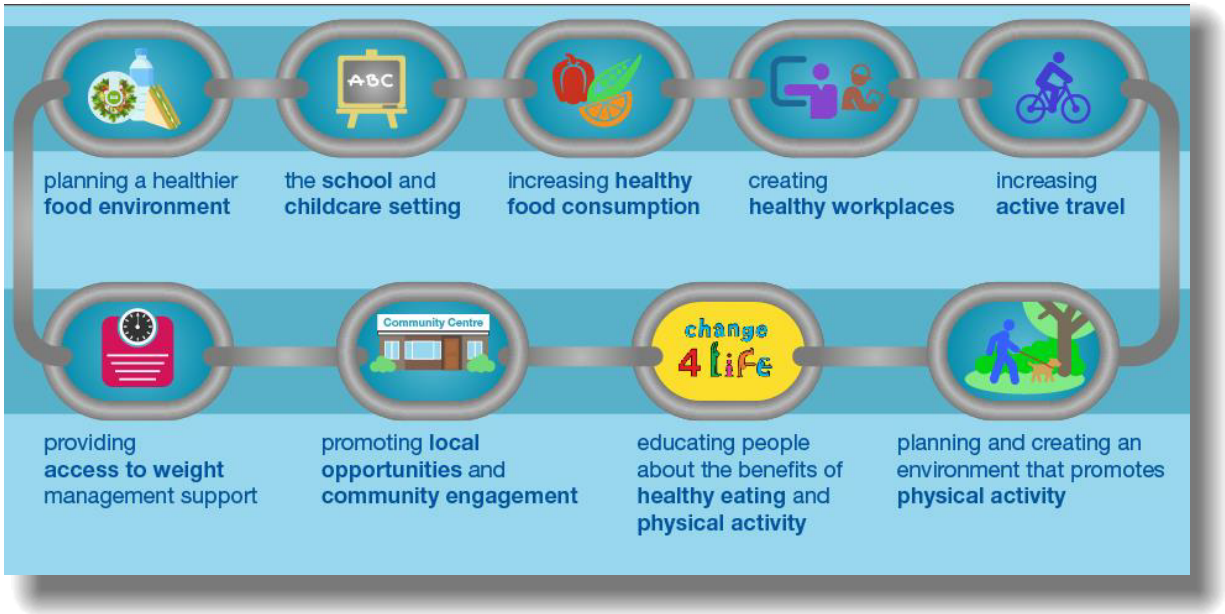
Approaches towards reducing excess weight remained unchanged and focused upon individual intervention and responsibility for years, whilst rates of excess weight have increased globally[1]. Evidence of successful approaches to addressing complex public health challenges such as excess weight suggest that full engagement with relevant partners and the community, time to build relationships, trust and capacity, good governance, embedding within a broader policy context, evaluation and finance are important contributing factors[2].

A WSA works by allowing us to respond to a complex problem with a comprehensive approach that considers the many influences on weight. As a Local Authority, we play a guiding role, and the approach draws on the strengths in our relationships with organisations and learns from and builds on these. It provides the opportunity to foster new relationships through a shared agenda.

Wider influences on excess weight including living and working conditions, education, and policy must be considered when trying to promote healthy weight. If every single player and area made a positive change of 2 or 3%, rolled out across the entire system, we would see improvements in healthy weight in Leicester. Incremental gain made collectively adds up to sustained and system wide change.

The below figure outlines common areas of excess weight activity that can be identified and prioritised when implementing a WSA to healthy weight. Leicester's system actions broadly align with these main areas of activity and focus, as well as reflecting existing strategy operating within the City, without duplication.

Figure 1: Common areas of activity identified as part of a WSA to healthy weight.[3]



4.3. Adopting the Food Active Healthy Weight Declaration for Local Authorities

To support the implementation of the WSA, Leicester City Council adopted the Food Active Local Authority Declaration on Healthy Weight in December 2022, committing to action on healthy weight. Representatives from Local Authority attended the launch, with many Heads of Service and Officers pledging their support and making tailored commitments to their department. These pledges were followed up after 6 months, and were reviewed and renewed at an event in late 2024. The 16 commitments within the Declaration that are embedded within the WSA action plan are outlined in Appendix 1.

4.4. Leicester's mission, guiding principles and key themes

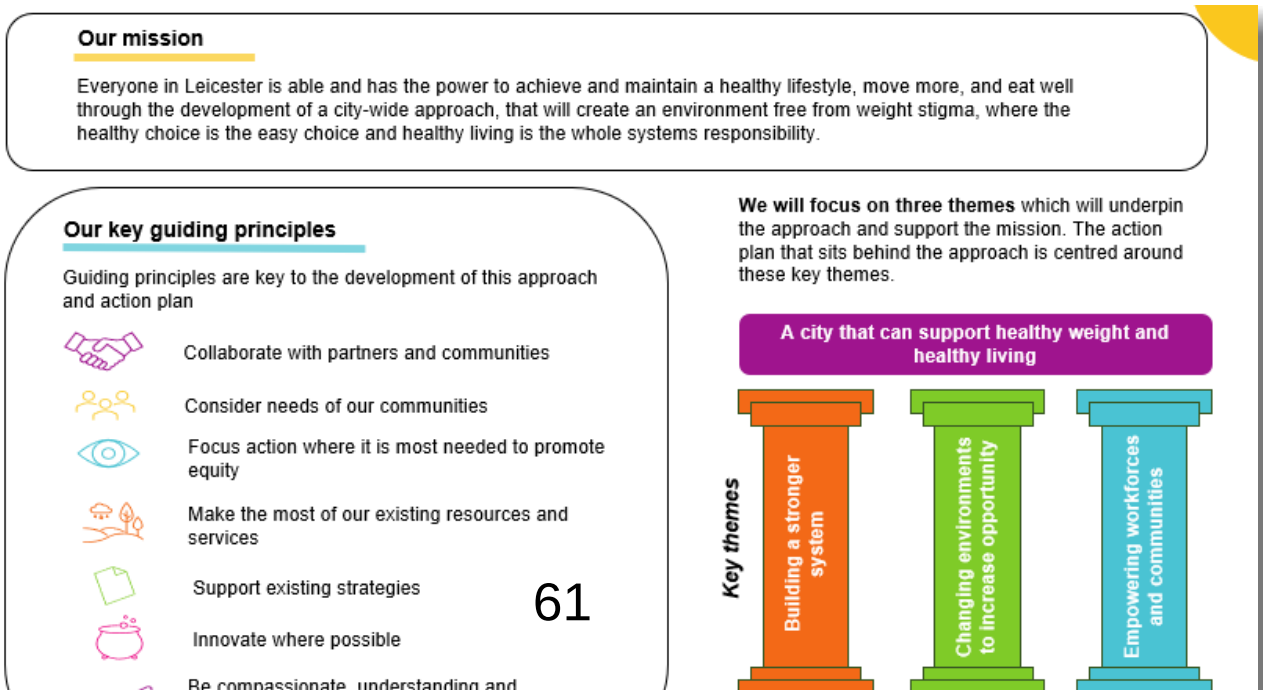
As a long-term approach aiming to influence generational change, qualitative and quantitative outcomes and outputs are not the focus but are monitored through an action plan and yearly reports.

To support long term action, short term aims, and smaller projects sit as part of the approach. Long term systems change and a long-term vision of reducing excess weight across Leicester is the focus. We must continue to do what we can upstream, and we must acknowledge that doing nothing to reduce excess weight is not an option. The approach aims to contribute towards the development of a city where healthy weight can be maintained, and good health is the systems responsibility.

The work of numerous Public Health activities is supported and interwoven within the approach including; Leicester's Food Plan, Healthy Conversation Skills (Making Every Contact Count approach), health in all policies, mental health, social isolation, and physical activity. Wider departments such as SEND and Education, Children's Social Work and Early Help, Adult Social Care and Commissioning, Housing, Transport, Planning, Public Safety and Organisational Development all play a role within the approach and have benefits to obtain.

The approaches existing mission, guiding principles and key themes are outlined in Figure 2.

Figure 2: Leicester City Council WSA to Healthy Weight mission, guiding principles and key themes.



4.5. Life course approach to healthy weight

Addressing excess weight takes a life course approach that spans a variety of organisations and embeds healthy living as the responsibility of all. Leicester's approach reflects the life course perspective, whilst prioritising work around maternal weight, children and families, and promoting equity within areas of deprivation and those with disability. Work in recent years and plans for work across the life course are provided.

4.5.1. Preconception, pregnancy and post-partum

Data from 2018 showed that 23.8% of pregnant women/ people* in Leicester at booking appointment were defined by BMI as living with obesity. Pregnancy alone can be a significant factor in developing obesity. A high BMI during pregnancy can also have negative health impacts on the mother, foetus and child as they grow[4]. Children born to women of a higher weight are likely to experience overweight as a child and into adulthood.

**transgender and non-binary people also give birth*

Existing local programmes and initiatives

A vast array of work is occurring to support the first 1001 critical days of life. The Healthy Pregnancy Birth and Babies Group works to reduce incidence of infant mortality and has maternal obesity as an identified priority. A new working group is being established to support strategic development of focused actions surrounding maternal obesity across a Leicester, Leicestershire and Rutland footprint. The work of Family Hubs within Children Young People and Family Centres across the 0-19 age range around elements such as infant feeding, bonding, communication and family wellbeing contribute to healthier living.

Elements of WSA to highlight

- Bumps to Babies (Leicester City Council antenatal class provision) content on healthy living during pregnancy amended to include clearer messaging on healthy eating and physical activity during pregnancy, and myth dispelling.
- Focus groups carried out in 2023 with women from Leicester Mammas to support direction of maternal excess weight work which supported development of Live Well Walk More offering walks for families.
- Health Needs Assessment on maternal weight worked on throughout 2025 to support direction of work.
- Live Well Leicester integrated lifestyle physical activity instructors trained in Level 3 Pre and Post Natal Physical Activity Training to enable pregnant women/ people to access service.
- Live Well Leicester open to pregnant women/ people with long term conditions (as of September 2025).
- Active Leicester staff at Aylestone Leisure Centre trained in Level 3 Pre and Post Natal Physical Activity Training.
- Buggy Boot camp and Aqua-natal classes added to offer at Aylestone Leisure Centre for pre-and post-partum women for pilot period.

- Specific infant feeding space at Aylestone Leisure Centre set up (timescale to be confirmed) as a pilot alongside staff training on infant feeding to support a welcoming environment for infant feeding.
- A training needs analysis has been conducted with a small sample of Midwives (community and hospital based) to support the development of a new training package. This insight from Leicester based professionals has supported assumptions made from national research that practitioners are concerned about the response of individuals when raising the issue of weight, fear of damaging the relationship with the individual, and have a lack of time.

Planned work

- Focus groups for pregnant women/ people or who have had a baby in the past 2 years to support understanding of weight related experiences, eating well, staying active, how culture and religion affects choices during pregnancy and how health workers have spoken about these topics. These will inform the creation of new resources for healthy weight during and after pregnancy and inform staff training. Additional engagement sessions with a local organisation that supports migrant families around pregnancy, birth and parenting are also being explored.
- Training for Midwives, Health Visitors and other health care professionals engaging with women antenatally to support raising the issue of weight, nutrition and physical activity during and post pregnancy in a compassionate and informed manner.
- Work towards recommendations outlined in the Maternal Weight Health Needs Assessment once finalised, facilitating the development of a shared action plan through the Maternal Weight Working Group reporting into the Healthy Pregnancy Birth and Babies Strategy Group.

4.5.2. Early years (0-5 years)

Being overweight in childhood is associated with being overweight in adulthood and an increased risk of cardiovascular disease and other non-communicable diseases. Childhood healthy weight has been approached in a variety of ways across Local Authorities that have seen downward trends in childhood obesity. The most common areas include a strong focus on early years nutrition and exercise[5].

Existing local programmes and initiatives

A variety of organisations work towards promoting healthy weight by promoting healthy relationships with food and physical activity in the early years. Leicestershire Nutrition and Dietetic Service (LNDS) offer a variety of support to nurseries and childminders to improve their nutritional offer under the “Eat Better Start Better” Award for City Nurseries including; nutritional training sessions, nursery visits, network events and packed lunch engagement with parents/carers. The Big Cook Little Cook programme takes place in nurseries, community venues and offers weekly cooking and education sessions for parents/carers and their children. This train the trainer programme is well received by parents and highlights positive outcomes.

The Healthy Teeth, Happy Smiles! Oral Health service aims to improve the oral health of children and adults in Leicester and reduce tooth decay and associated health issues. The service provides support and resources for Supervised Toothbrushing in schools and

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

4.1 Financial Implications

There are no direct financial implications arising from this report.

Signed: Rohit Rughani

Dated: 13/10/2025

4.2 Legal Implications

The Council has a statutory duty under Section 12 of the Health and Social Care Act 2012 to take such steps as it deems appropriate to improve the health of people in its area.

There are [illegible] in relation to current and future approaches to service delivery, appropriate legal and procurement advice should be sought as necessary.

Signed: Mannah Begum, Principal Lawyer, Commercial and Contracts Legal

Dated: 13 October 2025

4.3 Equalities Implications

When carrying out their functions the Council must comply with the public sector equality duty (PSED) (Equality Act 2010) by paying due regard, to the need to eliminate unlawful discrimination, advance equality of opportunity and foster good relations between people who share a 'protected characteristic' and those who do not.

We need to be clear about any equalities implications. In doing so, we must consider [illegible] to be affected by the options in the report and, in particular, the proposed option; their protected characteristics; and (where negative impacts are anticipated) mitigating actions that can be taken to reduce or remove that negative impact.

Protected characteristics under the public sector equality duty are age, disability, gender re-assignment, pregnancy and maternity, marriage and civil partnership, race, religion or belief, sex and sexual orientation.

The report outlines the comprehensive approach being taken within Leicester to promote healthy weight across the system. It highlights Leicester's city-wide strategy to encourage healthy weight while acknowledging that excess weight disproportionately affects certain groups within the city. Actions are targeted to address the needs of these vulnerable groups. It is important that any engagement is accessible. The initiatives should lead to positive impacts for people from across many protected characteristics.

Signed: Equalities Officer, Surinder Singh, Ext 37 4148

Dated:16 October 2025

4.4 Climate Emergency Implications

Increasing the proportion of journeys made by active travel - which produces no, or minimal, carbon emissions - is an important part of the council's strategy for working towards a 'climate ready' net zero city. Work which encourages and enables sustainable behaviours such as increased levels of physical activity through active travel and healthy eating may have further co-benefits for tackling the climate emergency.

Service delivery also generally contributes to the council's carbon emissions. Impacts of delivery can be managed through measures such as encouraging partners to use sustainable travel and transport options and use buildings and materials efficiently.

Where relevant, information about the climate benefits of such actions could also be included in communications as part of the programme.

Signed: Phil Ball, Sustainability Officer, Ext 372246

Dated: 14 October 2025

4.5 Other Implications

Signed:

Dated:

5. Background information and other papers:

6. Summary of appendices:

Appendix 1: 16 commitments within the Local Authority Declaration on Healthy Weight adopted in 2022 by Leicester City Council

	Strategic/system leadership
1	Implement the Local Authority HWD as part of a long term 'systems wide approach' to obesity
2	Advocate plans that promote a preventative approach to encouraging a healthier weight with local partners, identified as part of a 'place-based system' (e.g Integrated Care System)
3	Support action at national level to help local authorities promote healthy weight and reduce health inequalities in our communities (this includes preventing weight stigma and weight bias)
4	Invest in the health literacy of local citizens to make informed healthier choices ensuring clear and comprehensive healthy eating and physical activity messages are consistent with government guidelines
5	Local authorities who have completed adoption of the HWD are encouraged to review and strengthen the initial action plans they have developed by consulting Public Health England's, Whole Systems Approach to Obesity, including its tools, techniques and materials
	Commercial determinants
6	Engage with the local food and drink sector (retailers, manufacturers, caterers, out of home settings) where appropriate to consider responsible retailing such as, offering and promoting healthier food and drink options, and reformulating and reducing the portion sizes of high fat, sugar and salt (HFSS) products
7	Consider how commercial partnerships with the food and drink industry may impact on the messages communicated around healthy weight to our local communities. Such funding may be offered to support research, discretionary services (such as sport and recreation and tourism events) and town centre promotions
8	Protect our children from inappropriate marketing by the food and drink industry such as advertising and marketing in close proximity to schools; 'giveaways' and promotions within schools; at events on local authority controlled sites
	Health Promoting Infrastructures/Environments
9	Consider supplementary planning guidance for hot food takeaways, specifically around schools, parks and where access to healthier alternatives are limited
10	Review how strategies, plans and infrastructures for regeneration and town [illegible] physical activity, active travel, the food environment and food security (consider an agreed process for local plan development between public health and planning authorities)
11	Where Climate Emergency Declarations are in place, consider how the HWD can support carbon reduction plans and strategies, address land use policy, transport policy, circular economy waste policies, food procurement, air quality etc
	Organisational Change/Cultural Shift
12	Review contracts and provision at public events, in all public buildings, facilities and 'via' providers to make healthier foods and drinks more available, convenient and affordable and limit access to high-calorie, low-nutrient foods and drinks (this should be applied to public institutions [illegible] new contracts for food and drink provision, where possible)
13	Increase public access to fresh drinking water on local authority controlled sites (keeping single use plastics to a minimum) and encouraging reuseable bottle refills
14	Develop an organisational approach to enable and promote active travel for staff, patients & visitors, whilst providing staff with opportunities to be physically active where possible (e.g. promoting stair use, standing desks, cycle to work/school schemes)
15	Promote the health and wellbeing of local authority staff by creating a culture and ethos that promotes understanding of healthy weight, supporting staff to eat well and move more
	Monitoring and Evaluation
16	Monitor the progress of our action plan against the commitments, report and publish the results annually

Reference list

[1] A secondary analysis of the childhood obesity prevention Cochrane Review through a wider determinants of health lens: implications for research funders, researchers https://doi.org/10.1186/s12966-021-01082-2

[2] Whole systems approaches to obesity and other complex public health challenges: a systematic review https://doi.org/10.1186/s12889-018-6274-z

[3] Health Matters: whole systems approach to obesity Health matters: whole systems

Leicester's Whole System Approach to Healthy Weight

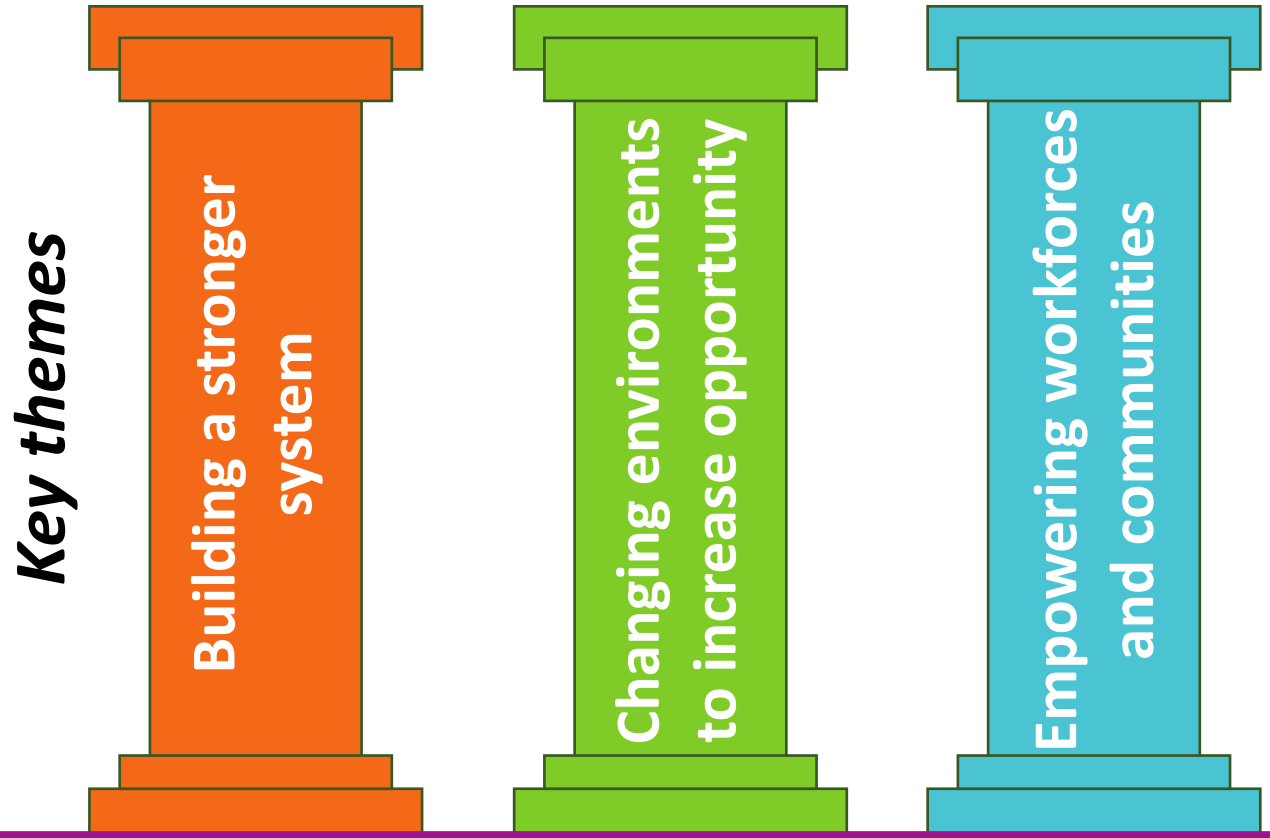
Working towards a system that enables healthy weight across the life course

Whole System Approach to Healthy Weight

Our mission

Everyone in Leicester is able and has the power to achieve and maintain a healthy lifestyle, move more, and eat well through the development of a city-wide approach, that will create an environment free from weight stigma, where the healthy choice is the easy choice and healthy living is the whole systems responsibility.

A city that can support healthy weight and healthy living



Adoption of the action plan and Healthy Weight Declaration

Excess weight in Leicester

62.8% adults aged 18+ living with excess weight

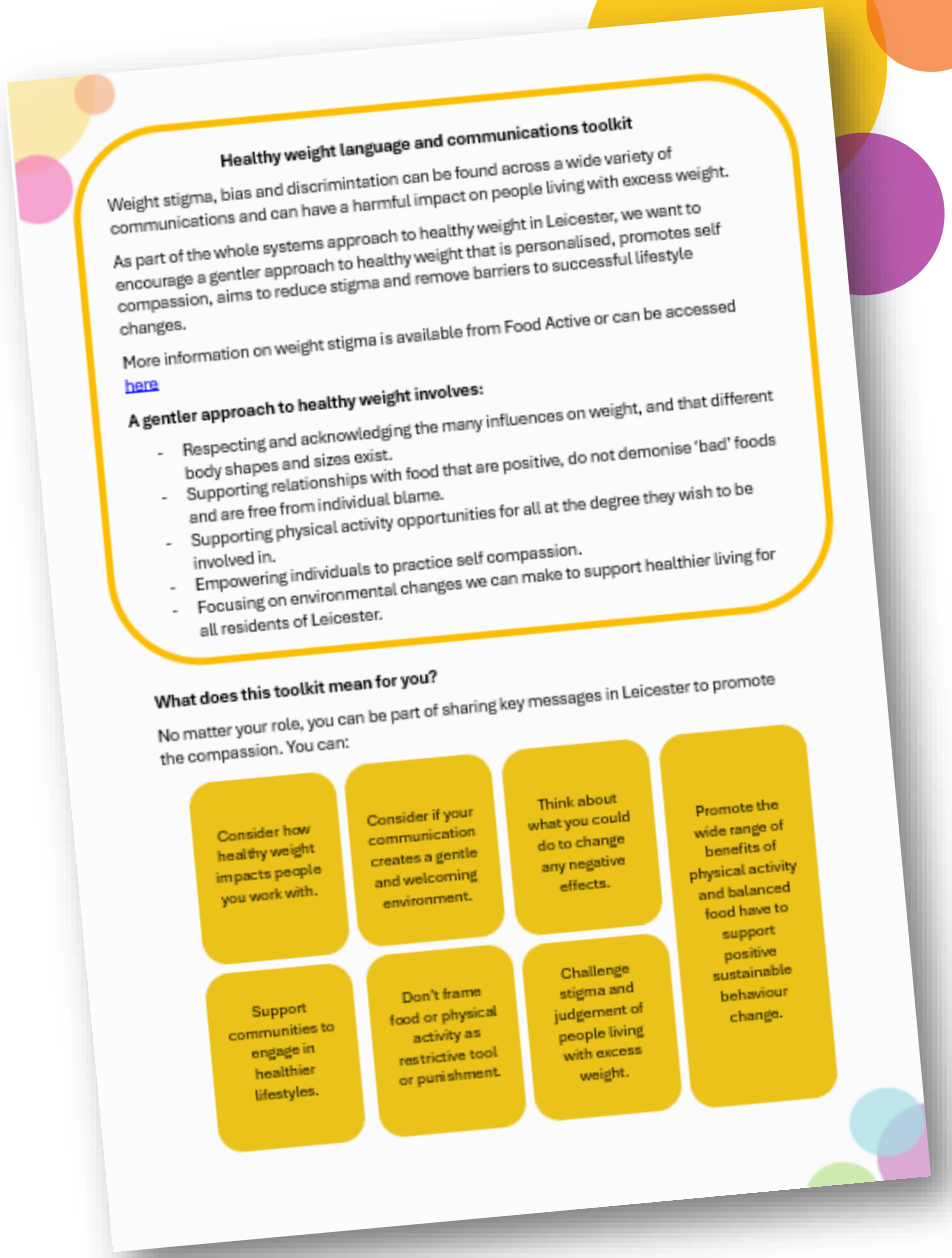
19.3% reception age children living excess weight

39.1% Year 6 age children living excess weight

Conversations around weight

- Weight stigma and weight bias have implications for people living at a higher weight such as poor engagement with services and poor mental health

- Focus groups occurring October-December 2025 across the City to inform a language and communication toolkit



Healthy weight language and communications toolkit

Weight stigma, bias and discrimintation can be found across a wide variety of communications and can have a harmful impact on people living with excess weight.

As part of the whole systems approach to healthy weight in Leicester, we want to encourage a gentler approach to healthy weight that is personalised, promotes self compassion, aims to reduce stigma and remove barriers to successful lifestyle changes.

More information on weight stigma is available from Food Active or can be accessed here

A gentler approach to healthy weight involves:

- Respecting and acknowledging the many influences on weight, and that different body shapes and sizes exist.
- Supporting relationships with food that are positive, do not demonise 'bad' foods and are free from individual blame.
- Supporting physical activity opportunities for all at the degree they wish to be involved in.
- Empowering individuals to practice self compassion.
- Focusing on environmental changes we can make to support healthier living for all residents of Leicester.

What does this toolkit mean for you?

No matter your role, you can be part of sharing key messages in Leicester to promote the compassion. You can:

Consider how healthy weight impacts people you work with.

Consider if your communication creates a gentle and welcoming environment.

Think about what you could do to change any negative effects.

Promote the wide range of benefits of physical activity and balanced food have to support positive sustainable behaviour change.

Support communities to engage in healthier lifestyles.

Don't frame food or physical activity as restrictive tool or punishment.

Challenge stigma and judgement of people living with excess weight.

Maternal weight

Pre-conception, pregnancy and post-partum

In 2018 23.8% of women in Leicester at booking appointment were defined by BMI as living with obesity

Live Well Leicester accepting referrals for pregnant women with long term conditions

Antenatal physical activity classes pilot

Health needs assessment and training needs analysis with Midwives

Childhood healthy weight

New to Leicester - HENRY Parenting Programmes

Commissioned agreement in partnership with Family Hubs for parents with children aged 0-5 years to attend 'Healthy Families Right from the Start' courses

Leicestershire Nutrition and Dietetics Service (LNDS) whole school food approach

Working with staff, children and parents to create a whole school culture around food and hydration through putting in place policies alongside smaller scale interventions such as packed lunch improvements, staff training, parental engagement and empowering children to be informed about food.

Adult and family

Contributing to reducing food insecurity through the provision of skills-based cooking sessions and support

Food with Friendship

‘Everyone was very friendly and helping each other. After cooking we enjoyed our food and talking to each other’

Cooking on a Budget

‘To get to meet new people, to get new ideas, to be inspired’
‘Fantastic course, I made my very first sandwich’
‘I now understand how to use leftovers and not throw it away’

Adult and family

Specific work led by colleagues in social care and as part of the Learning Disability Collaborative **to improve healthy weight within people living with learning disability** includes: Training session for managers to explore further emphasis on nutrition during setting quality assurance checks, Nutrition and Healthy Living Training for social care staff.

LNDS Nutrition and Healthy Living Training *for a variety of workforces*
Training delivered on a quarterly basis, with specific packages of support for priority workforces. Staff trained so far include; Social Prescribers, Service Coordinator, sports coaches, Housing related support worker, STAR officer, Community Engagement Lead.

Wider elements supporting healthy weight

NHS Healthy Weight Declaration

- University Hospitals Leicester (UHL) and Leicestershire Partnership Trust (LPT) have both formally committed to working towards commitments outlined in the NHS Healthy Weight Declaration.

Leicester City Council contract register review

- 576 contracts listed, 30 identified with possible links to food.
- Exploratory conversations with relevant colleagues.
- Development of guidance for Commissioners – Food and Drink impact assessment for procurement and contracts

National policy that if enforced correctly positively impact upon health and wellbeing include:

2018 industry guidelines published for sugar, salt and calorie reduction and reformulation (voluntary) and Soft Drink Industry Levy

April 2022 mandatory calorie labelling in the out of home sector introduced in England.

October 2022 restrictions on HFSS product location promotions in England introduced.

December 2024 reforms to the National Planning Policy Framework

June 2025 announcement that over half a million more children will receive free school meals.

July 2025 Early Years Foundation Stage Framework released with greater emphasis on nutrition.

October 2025 ban on multibuy deals on less healthy foods in supermarkets.

2025 advertising ban on HFSS products on television (pre-9pm) and online.

Appendix D

Leicester City Council

Smoke free generation

Public Health and Health Integration Scrutiny Commission

Date of meeting: 04/11/2025

Lead director: Rob Howard

Useful information

- Ward(s) affected: All within Leicester City
- Report author: Angatu Yousuf/ Carla Broadbent
- Author contact details: Angatu.Yousuf@leicester.gov.uk
- Report version number: 4

1. Summary

Tobacco is the single most important entirely preventable cause of ill health, disability and death in this country. Leicester has seen a decline in smoking prevalence, but it is still estimated that 14.6% of residents smoke, compared to 11.6% nationally. This figure hides considerable differences across the city with many areas in the west of the city having much higher rates than areas in the east.

Stopping the Start is the government's plan to create a smoke free generation, this was published by the government in October 2023 and included a commitment of an additional £70 million per year into stop smoking services.

This report outlines the work that has been carried out over the past year to increase the number of smokers setting a quit date in Leicester, and outlines plans to meet the smoke free generation targets.

2. Recommendation(s) to scrutiny:

Leicester City Health Scrutiny Commission are invited to:

- Read and comment on the current actions being taken to increase the number of smokers coming into the smoking cessation service, ultimately aiming to achieve the smoke free generation targets.
- Offer suggestions regarding further areas of action that could be taken.

3. Detailed report

Introduction

Leicester's stop smoking service forms part of Live Well, an integrated lifestyle service in Public Health. The stop smoking service is delivered by trained advisors who offer behavioural support to clients either over the phone or face to face every week for a 12-week period. During this time the stop smoking advisor and client work together to change habits and behaviours associated with smoking. Clients are provided nicotine replacement therapy (NRT) or an e-cigarette free of charge to aid their quit attempt.

In 2024/25 community smoking cessation services saw a considerable increase in funding from the government. *Stopping the start:* the government's plan to create a smokefree generation which was published in October 2023, included a commitment of an additional £70 million funding per year for local stop smoking services.

The funding is allocated based on the average smoking prevalence over a 3-year period between 2021 and 2023.

The 2024/25 target set for Leicester was to achieve 1,531 quit attempts, the team managed to achieve a total of 1,303 quit attempts.

For 2025/26 Leicester has been allocated £485,361 and a target of 1,848 clients setting a quit date. The targets are ambitious and continue to increase year on year.

The table below details the comparison data for the last two years for individual smokers:

KPI's	Q1 23/24	Q2 23/24	Q3 23/24	Q4 23/24	Q1 24/25	Q2 24/25	Q3 24/25	Q4 24/25
Number of smokers who set a quit date per quarter	423	425	397		300	301	374	328
Cumulative number of smokers who set a quit date per quarter	423	848	**1245**		300	601	975	**1,303**
Number of smokers who successfully quit at 4 weeks	203	218	207		152	148	231	188
Cumulative number of smokers who successfully quit at 4 weeks	203	421	**628**		152	300	531	**719**
% of smokers achieving a 4-week quit	48%	49.6%	50.4%		50%	50%	54%	55%

So far, for the 2025/26 reporting period 352 clients set a quit date in quarter one and 497 clients set a quit date in quarter two. The team have clear plans in place to continue to increase the number of clients setting a quit date to achieve the overall target of 1,848. These plans have been outlined in this report.

The smoke free generation funding for Leicester has been primarily used to increase staffing, this is providing extra capacity to support clients to quit smoking, but also to undertake more engagement in the community to ensure that smokers are made aware the service exists.

Full details of the new community engagement team and the work carried out in 2024/25 has been outlined below.

Community Engagement team

A new Community Engagement team were recruited in 2024 with a focus to work across Leicester building partnerships and driving public outreach, to raise the profile of the stop smoking service and generate more referrals. The team have a particular focus on areas and groups with the highest rates of smoking and are already working with a wide range of staff and organisations including primary care providers, dentists, pharmacists, City Council staff, food banks, voluntary organisations and community groups.

Action Plan

An action plan was developed in 2024/25 with a view to work towards the smoke free generation targets and improve the quit rate. This action plan had a positive impact on the service and overall quit rate and as a result, has been built on further to continue the momentum into 2025/26

Key highlights from the 2024/25 action plan include:

Service delivery optimisation and expansion

Several measures were introduced or adjusted to increase capacity and to ensure maximum retention of clients who engage with the service. This included measures such as:

- Covering appointments instead of rearranging them upon advisor absence.
- Increasing the number of contact attempts made after missed appointments and monitoring completion.
- Facilitating peer-to-peer learning to develop best practice and promote service cohesion.
- Regular quality assurance checks across all appointment modalities to ensure standardised service delivery.
- Offering in-person clinics in partnership with established community organisations in areas with a higher prevalence of smoking – allowing partners to book clients directly into appointments.

GP engagement

The team have worked with multiple GP practices hosting drop-in sessions and delivering clinics for patients who wish to learn more about Live Well services and quit smoking. The team now host regular clinics and/or drop-in sessions with several practices, including Saffron Health, Aylestone Health Centre, Community Health Centre, Merridale Medical Centre, and Hockley Farm Medical Practice. Ad-hoc drop-ins and events have been organised and attended at multiple additional practices and partnerships continue to be developed.

Events

The team organised regular outreach activities and attended several multi-agency events, some examples of the work that was carried out is detailed below:

- For national No Smoking Day, the team held stalls at three major Tesco supermarkets in Hamilton, Westcotes, and Beaumont Leys, and three large GP surgeries across the city (Belgrave Health Centre, Saffron Health, and Merridale Medical Centre) to promote the service and gain referrals.
- The team sought out and attended multi-agency events across the city, such as the Burns Flats Day of Action in New Parks, the Health & Wellbeing Community Drop-In in Highfields, the Safer Saffron Community Day in Saffron, and the Wellbeing Fair at the University of Leicester.
- From January to May 2025, the Engagement team attended 81 outreach activities, including events at Age UK Clarence House, Beaumont Leys Health Centre, various food banks, Eyres Monsell Community Centre, Centre Project, Diabetes Prevention Day, Dear Albert Dridays, Number 5 drop-ins, and many more.

Partnerships

New partnerships have been established with healthcare provider networks, third sector organisations, and businesses to gain more access to underserved groups. Examples of these include; Age UK, Citizen's Advice, Wesley Hall, Soft Touch Arts, b-inspired, Homeless Charter Leicester, Hastings, Recovery College, Kingfisher Youth Centre, Action Homeless, the social prescriber network, LPT Mental Health Services teams, and charity and support organisations such as Leicester Recovery Hub (No.5), The Centre Project and Dear Albert.

The partnership with the social prescriber network has facilitated a major advantage for GP surgery events, allowing for targeted text messages to be sent to registered patients ahead

of drop-ins to increase attendance and deliver desired information, this is proving to be an effective way to get referrals into the service.

Group interventions

Group interventions were included as part of the SFG tiered approach *(see appendix 1)* targeting underserved communities and groups with a high prevalence of smoking, to facilitate peer support and gain bulk referrals into the service. A group intervention was launched in collaboration with Saffron Health in May 2025 to support patients at the practice with weekly sessions. The practice has supported the development of the group with regular targeted text messages to patients registered as smokers. The group has progressed successfully on a rolling basis with a steady influx of new clients at most sessions. The model is being evaluated and refined for expansion to other community-based organisations in line with priority areas.

Outpatient work

An advisor was appointed to support and expand work on smoking cessation in outpatient clinics. This work initially focused on the Lung Cancer and Transient Ischemic Attack (TIA) outpatient clinics but has recently broadened to include the Emergency Department (ED) in June this year. Contact has also been made with the Maxillofacial department.

There has been a total of 343 outpatient referrals during quarter two this year, of which 286 (83%) were received from ED. Of those referred, 47% were able to be contacted, 28% of those were no longer smoking. 36% (42) of those contacted who were still smoking set a quit date.

Client case studies

The Engagement team has enrolled and supported numerous clients to successfully quit smoking since its establishment. A few brief case studies to highlight the meaningful impact of the targeted and intensive support offered to vulnerable, underserved, or excluded groups by the Engagement Advisors are provided below:

- A 79-year-old woman, who could not read or write, encountered the Engagement team at the Eyres Monsell Community Centre. An advisor initiated a conversation with her as they had seen her smoking outside. She was later advised by her GP that she needed to quit smoking. She remembered the conversation with the Engagement Advisor and had the community centre call them to arrange an appointment. She was supported by the advisor both in the community and over the telephone to quit smoking and is now smoke-free. This case demonstrates how proactive community engagement and tailored support can empower individuals to make positive health changes, even when facing barriers such as low literacy.

- A 42-year-old man with advanced cancer and PTSD was referred to the Live Well Stop Smoking Service through support workers at No.5. Having experienced long periods of homelessness, he often smoked discarded cigarette ends and shared a vape. As he had no phone and was staying with a friend, the advisor completed his first appointment over the phone via No.5 and arranged for nicotine replacement therapy to be sent there. The advisor completed subsequent appointments in person at No.5, and they have now successfully quit. This case highlights how strong community partnerships enable the service to reach and support people facing complex challenges, ensuring they still have access to vital stop smoking support.

- A 37-year-old woman was first met by the Engagement team at a Tesco event. She has a long-term mental health condition and received extended support from the Engagement Advisor. With this support, she successfully quit smoking and is now smoke-free. She described her experience with the service as “5 out of 5”, reflecting her satisfaction with the care and encouragement provided. This case highlights how accessible community outreach and personalised support can help individuals with long-term health conditions achieve lasting behaviour change.

2025/26 plan and progress

The smoke free generation targets for 2025/26 have been set and for Leicester this means we are working towards a target of 1,848 quit dates set. To achieve this target Live Well will need to achieve 545 more quit dates set for 2025/26 than achieved in 2024/25. Detailed below is the work that has been set out to achieve the smoke free generation targets for this year.

Updated Action Plan

To have the best possible chance of meeting the smoke free generation target for 2025/26 a new action plan was developed in consultation with senior management from across the council. The Director of Public Health emphasised that this work must be seen as a council-wide priority and encouraged suggestions for joint working in all areas of the council.

The current action plan driven by Live Well and the tobacco control team now includes new initiatives that are being carried out this year with the view to increase referrals to the stop smoking service and aid more quit attempts.

The areas of work are outlined in the table below:

Area	Objective	Key Developments	Next Steps
Housing Sector Engagement	Work with housing engagement officers, pop-up clinics, and concierge spaces to provide access to residents in priority areas. These are often underserved groups where direct outreach and presence in housing sites can boost referral numbers through both signposting and direct engagement.	Training to Housing Officers in smoking cessation, Very Brief Advice (VBA) and how to refer to Live Well as part of those conversations has been delivered previously. Meetings held with Housing Engagement Officer and opportunities for joint working discussed – agreed on plan of action.	Attend housing pop-ups and develop joint promotional materials for future Housing events where Live Well will attend. Expand training offer in VBA and how to refer to Live Well to teams supporting tenants in social housing including STAR, Anti-social behaviour Officers and those that support tenants with substance use.

Internal Council Staff Engagement	Provide in-house support sessions, using internal comms (e.g. all-staff emails and Vivup), and conduct wellbeing surveys to uncover staff who wish to quit smoking. Explore ways to include teams that do fieldwork (e.g. Fire Services) as partners.	Staff drop-in clinic hosted at City Hall for Stoptober. Presentations to Fire Service Community Educators have been delivered to build confidence in discussing smoking with residents during fire safety checks and to demonstrate how to refer residents to the Stop Smoking service. Flyers provided to support conversations and referrals into the service.	Create toolkit and organise staff sessions with Housing Apprentice, City Highways/ Highways Network and Cleansing teams.
Sporting Venues and Night-time Economy Visibility	Place QR codes and promotional materials in high-traffic venues such as stadiums and nightlife areas to gain spontaneous referrals from smokers who may not be reached through traditional channels.	Work in this area is to be launched in November 2025.	
Community Wellbeing Champions (CWC) Network and Community Organisation Engagement	Tap into ongoing community organisations to enable targeted work in high-prevalence communities.	Presented at CWC Network Forum and agreed plan to include regular service updates in round-up emails.	Present at forum on a quarterly basis and submit copy for monthly round-up emails.
Strategic Communication and Outreach Coordination	Send targeted messages via senior stakeholders to enhance internal and external visibility. Embed cost-of-living messages that can resonate with financially motivated smokers and increase staff confidence in discussing the service.	Promotional video featuring Alison Greenhill discussing her quitting journey in progress with Comms team. Messaging for Stoptober disseminated via Organisational Development. Anti-poverty and stop smoking strategy meeting held and plan of action agreed.	Attend events organised by anti-poverty leads and continue to participate in relevant projects.
Mental Health and Smoking Cessation Integration	Train keyworkers to deliver smoking cessation and free vape starter kits as part of the	Presented the Swap to Stop offer to the Head of Service and Service Lead and they are keen to support this	Keyworkers who already have a relationship with clients will work alongside the Live

	government's Swap to Stop scheme to people attending Neighbourhood Mental Health Cafe's (NMHC's) across Leicester. The aim of the Swap to Stop Scheme is to reach people who would not usually access stop smoking services.	programme and recognise that many people accessing their service would benefit from the offer.	Well Engagement Advisors' group sessions. Switching to a vape as part of the Swap to Stop scheme could be the first step on the path to their quit journey and may lead to a professional or self-referral into Live Well as a result.
Care Homes and Adult Social Care	Train care and supported living staff to feel confident in having conversations with residents about smoking, the Live Well smoking cessation offer, and referring into the service.	Presentations have been delivered to both Care Home Provider and Supported Living Provider Forums and have been followed up with offer of very brief advice training for all staff respectively.	Arrange Very Brief Advice training for care home staff with individual care homes that accept the training offer.
Education Sector and Parent Outreach	Reach parents and education staff, link messaging with national campaigns around smoking and smoking related health topics (e.g. mental health) and highlight the harms of second-hand smoke to young people.	Working to ensure schools are aware that there is support available through Live Well for young people (12 years+) and parents who smoke. Met with education comms officer to discuss integrating smoking cessation messaging across school communication channels.	Attend next Keeping In Touch meeting (with Headteachers) in November to discuss work on updating smoking policy and promotion of stop smoking service in schools.
Employer Outreach and Workplace Wellbeing	Partner with major employers and use workplace health initiatives to reach large numbers of working adults, particularly in routine or manual jobs with high smoking rates. On-site visibility and proactive outreach encourage sign-ups from individuals who	Contact made with large employers of routine and manual workers including Samworth Brothers, Walkers, Biffa, First Bus, and British Gas. Partnership established with Hastings including attendance at company fairs.	Discuss workplace offer and provide employer toolkit to companies that engage. Identify and leverage existing connections within the council to gain access to non-respondent businesses.

	may not access services otherwise		Visit smaller employers to promote service and build connections.
Oral health/Dentistry pathways	Support dentists to be able to easily refer patients who smoke into the Live Well service by potentially building in a referral pathway to existing patient management software systems.	A survey was sent out to LLR Local Dental Committee (LDC) to detail what software they are using to record patient notes.	Next step is to integrate this work with the Oral Health team as they already have an existing relationship with the LDC. We also plan to attend a future LDC meeting to discuss current referral processes and to see how we can support dentists to increase referrals.

Further work that is being carried out in addition to the action plan have been outlined below:

Healthy eating and nutrition offer

A brand-new nutrition and healthy eating offer will be introduced to the service in 2026. Research shows that nutrition interventions, especially when combined with other quit-smoking strategies, can play an important role in supporting smoking cessation by helping the client to manage weight gain, improve mood, and, in some studies, increase quit rates. From a recent consultation exercise with clients currently attending the stop smoking service, 87% said that eating healthily was important to them. We hope this offer will support clients on the stop smoking journey to ensure they have the advice and support to eat healthy and aid a successful quit attempt.

Support for patients in hospital

The acute tobacco dependence treatment service (otherwise known as CURE) supports smokers in hospitals in Leicester. Tobacco Dependency Advisors (TDA) work across the three hospitals receiving referrals from those patients who have been admitted and had an assessment that noted they are a smoker. A TDA visits the patient bedside, offering NRT for the duration of their stay in the hospital. A referral is then made to Live Well to continue to support the patient in the community to achieve a successful quit attempt.

Support for pregnant smokers

All pregnant women who smoke are referred to Live Well on an opt out basis. A Stop Smoking Advisor from Live Well will then support the client for the duration of their pregnancy with regular contact and access to NRT or e-cigarettes. Advisors also provide vouchers to pregnancy women when they reach certain milestones in their quit journey with the final milestone being smoke free at 3 months after birth.

Introduction of stop smoking medication for clients

Live Well currently offers NRT and e-cigarettes to clients, combining stop smoking aids with behaviour support makes someone 3 times as likely to quit as using willpower alone. However, stop smoking medications e.g. Varenicline can be more effective for some clients doubling a person's chances of quitting. Live Well are looking to be able to offer stop smoking medication to clients in 2026.

Social Marketing campaign

An external agency named Social Change has been commissioned to deliver a campaign to target smokers in areas of high prevalence. Social Change is an agency focused on creating positive social and environmental impact through behavioural science and strategic communications. They offer marketing and communications services to aid the development of campaigns that connect with audiences and drive lasting behaviour change. Part of this work involved Social Change conducting behavioural insight research looking at attitudes towards smoking and quitting. The research aimed to identify barriers to quitting, motivators for quitting, and effective ways to engage residents not currently using support services. The study has helped to identify four key behavioural insights and resulted in twelve recommendations, which are informing the campaign's development.

Currently we are in the preparation phase, the campaign is scheduled for launch in November and will run in six-month phases to enable close performance monitoring. The key message emphasises that "support doesn't stop with Stoptober," promoting continued access to stop smoking resources after the national campaign. Initial campaign activities will include PR engagement, social media advertising, stakeholder toolkit dissemination, and the launch of the Habit & Trigger Planner to assist behaviour change.

Tobacco control

The tobacco control department are working to strengthen public health messaging around tobacco use through channels aimed both at professionals and the public, as well as supporting the implementation of the SFG action plan.

The team are developing a communications toolkit to help professionals discuss tobacco and other related topics with the public. The toolkit will comprise of local data, communication aims, social media guidance, key messages, target groups and spotlights on key topics (e.g. pharmacotherapy). The aim is to make discussing the topics easier, ensure all messages are aligned and make discussing smoking cessation less intimidating.

The Live Well and tobacco control team are developing and implementing training offers for professionals seeking to refer clients for smoking cessation support. Health Visitors are receiving training in Very Brief Advice and have been reminded of the referral process into the Live Well Stop Smoking Service. We are working to extend this approach by training professionals working in community mental health support settings. Building their confidence to discuss smoking cessation will form an important part of holistic mental health support.

In order to reduce smoking prevalence, action beyond smoking cessation is also needed. The Step Right Out campaign relaunched in April to encourage residents to maintain smokefree homes and cars by pledging to "step right out" when smoking. The campaign raises awareness of the harms of second-hand smoke, particularly to children and

vulnerable adults while building a supportive community of people who have pledged. Information about the campaign can be found across the city in Libraries, Leisure and Neighbourhood Centres and community hubs. The campaign has been presented to staff in various teams including Live Well Stop Smoking Advisors, Health Visitors, Community Educators from the fire service, Supported Living Provider Forum and is due to be presented to the Fostering Service and Children's Respiratory departments across University Hospitals Leicester and through education teams in schools. The campaign aims to reduce acceptable places to smoke and acts as the first step to a person becoming completely smokefree.

Action is also taken to tackle illicit tobacco across the city, Trading Standards have completed seven seizures over the last 12 months (165,940 cigarettes and 536 packets of hand rolled tobacco). The Tobacco Control and Trading Standards teams are developing a Service Level Agreement to support joint activity. Recruitment is in progress for a dedicated Tobacco Control Trading Standards Apprentice to enhance this work.

Summary

The work that has been carried out so far, is making a positive impact as we are seeing the number of clients coming through Live Well and setting a quit date continue to rise each quarter. We are positive that the work outlined in this paper will continue to ensure the number of smokers accessing support to stop smoking will continue to increase and the overall target set out for this year will be achieved.

The outcomes of the action plan and the activities of the team will continue to be monitored so resources can be allocated according to where we see the greatest need and impact. The Live Well team will remain an agile resource that will adapt its delivery to suit the needs of the clients and the service.

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

4.1 Financial Implications

Leicester City Council has been allocated £485,361 towards local stop smoking services. Receiving all of this funding relies on us reaching the target number of clients (1,848). If the target were not reached, a lower amount of funding will be received, which will reduce the local services offered.

Signed: Mohammed Irfan, Head of Finance

Dated: 23 October 2025

4.2 Legal Implications

This report provides an update on the work undertaken by Leicester City Council in 2024/25 and outlines the new initiatives intended to be carried out over 2025/2026 in order to achieve smoke free generation targets, for the residents of Leicester City Council.

It is noted that the Authority has obtained funding from the Government as part of its plan to create a smokefree generation. The funding thus far has been used to increase staffing which has enabled extra capacity to support clients to quit smoking and to engage better with the community, creating better awareness of the services available and to either work closely or

in conjunction with healthcare provider networks, third party organisations and businesses. For 2025/26 Leicester has been allocated £485,361.00.

Legal Services should be consulted to undertake any necessary subsidy control assessments in respect of any funding to be used towards the plan for 2025/2026, particularly if this is to be awarded by way of a Grant(s).

If any part of the project requires a procurement exercise, this must be undertaken in accordance with the Procurement Act 2023. The procurement process will require engagement from both Legal and Procurement teams to ensure compliance with the Act and the Authority's internal Contract Procedure Rules.

Assistance from Procurement Services should be requested in a timely manner to ensure that all required notices are published in accordance with the Procurement Act 2023.

Ongoing legal advice and support should be sought as the project progresses, and in the event of any changes to the information contained in this report, to ensure continued compliance with all legal requirements.

Signed: Mariyam Suleiman

Dated: 24 October 2025

4.3 Equalities Implications

Under the Equality Act 2010, public authorities have a Public Sector Equality Duty (PSED) which means that, in carrying out their functions, they have a statutory duty to pay 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 don't and to foster good relations between people who share a protected characteristic and those who don't.
Protected Characteristics under the Equality Act 2010 are age, disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion or belief, sex, sexual orientation.

This report outlines the work that has been carried out over the past year to increase the number of smokers setting a quit date in Leicester, and outlines plans to meet the smoke free generation targets. The service is actively working to reach its high targets for the number of people setting a quit date. They successfully helped people quit at a strong rate, with about 50-55% of those who set a date successfully quitting after four weeks.

Smoking attributable hospital admissions and mortality both continue to be significantly higher than the regional and national averages. Tobacco use continues to be a key factor in health inequalities and is a cause for concern, those living in areas of deprivation, or routine and manual workers, are more likely to smoke than those living in wealthier communities. Smoking rates are higher in those with mental health illnesses and they increase with the severity of the mental health issues. Initiatives that aim to reduce this will lead to positive impacts for people from across many protected characteristics. Reducing smoking prevalence will reduce health inequalities. It is important to recognise the importance of providing people with freedom of choice over their lifestyle choices, whilst also acknowledging that tobacco use is an addiction which requires specialist support and encouragement to inform and overcome. The work of the new team has led to specific successes in helping people quit who had complex problems, these cases show the success of targeted support

in reaching those who need it most. By supporting disadvantaged groups in quitting, these initiatives can reduce the health gap, improve life expectancy, and lessen the cycle of poverty associated with smoking.
Signed: Equalities Officer, Surinder Singh, Ext 37 4148
Dated: 21 October 2021

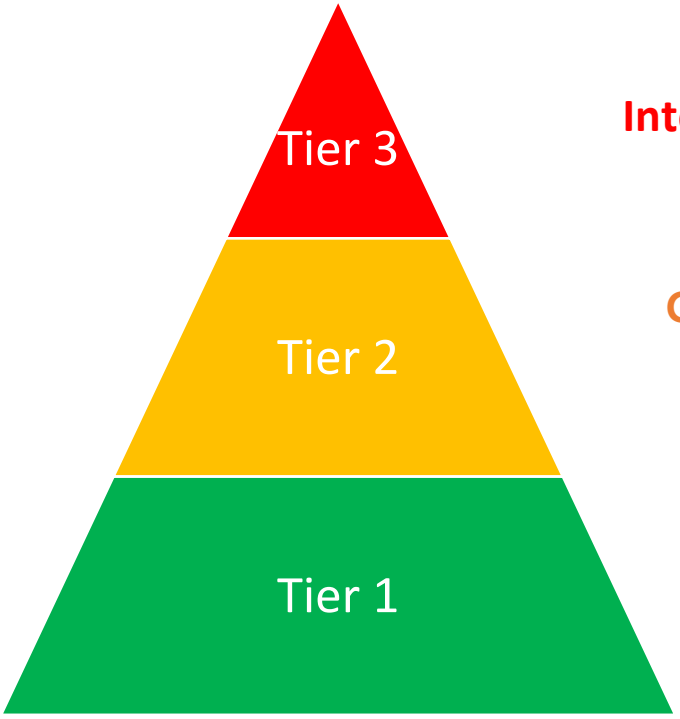
4.4 Climate Emergency Implications
There are no significant climate emergency implications associated with this report, although where outreach work is undertaken, any associated carbon emissions from staff travel should be minimised by following the travel hierarchy provided in the guidance for the council's Business Travel Policy.
Signed: Phil Ball, Sustainability Officer, Ext 372246
Dated: 22 October 2025

4.5 Other Implications
Signed:
Dated:

5. Background information and other papers:

6. Summary of appendices:

Appendix 1 – SFG Tiered Approach



Intensive support

Group interventions in the community

Stop Smoking clients ready to make a quit attempt

Tier 1 – Community referrals for clients who are ready to stop smoking

Through community engagement such as events and drop-in sessions. These referrals will be send through to the Live Well Service for a Stop Smoking Advisor to pick up.

Tier 2

Working closely with Community groups to deliver group interventions across the city, within City Council buildings e.g. Libraries, Leisure Centres and Family Hubs. Establishing links throughout the communities in Leicester to ensure criteria across SFG is met. This will be led by the Community Engagement Team.

Tier 3

Intensive support for harder to reach clients, this could include, more one to one support in order to achieve a successful quit attempt. Targeting the SFG target groups

Tier 3 Target Groups in targeted areas of Leicester City -

- LCC Routine and Manual Staff – Refuse Collectors (Biffa) and Support/Cleaning Staff.
- UHL Routine and Manual Staff – HCA's/Nurses, Cleaners/Porters/Security
- LD Groups – Info taken from LD forums/community groups.
- Adults with LTMHC – Info from MH Forums/Work with MH Cafes.
- Homeless 1-1/Groups – Liaise with Homeless Charities (Action Homeless etc)

Public Health and Health Integration Scrutiny Commission:

Smoke Free Generation

Live Well

Public Health

Leicester City Council

Service Overview

Stop Smoking Service

- 1-1 support
- Group support
- Workplace offer

Healthy Lifestyle Service

- Physical Activity
- Steady Steps
- Live Well Walk More

Nutrition

- Healthy eating advice for SSS clients
- Healthy eating advice for HLS clients

Reducing Alcohol

- Turning Point

LiveWell LEICESTER

Stop Smoking Service

- 12-week programme
- Free nicotine replacement therapy
- Behavioural support

Leicester City Council

Paper Summary

- Slightly under target for 24/25 - updated action plan underway to meet 25/26 target
- Quit dates set rising each quarter
- Integrated working between Live Well & Tobacco Control to steer projects / campaigns toward referrals
- Team will remain agile and adapt delivery to suit the needs of clients and the service

LiveWell LEICESTER

23/24 & 24/25 Outcomes

KPIs	Q1 23/24	Q2 23/24	Q3 23/24	Q4 23/24	Q1 24/25	Q2 24/25	Q3 24/25	Q4 24/25
Number of smokers who set a quit date per quarter	423	425	397		300	301	374	328
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Number of smokers who successfully quit at 4 weeks	203	218	207		152	148	231	188
Cumulative number of smokers who successfully quit at 4 weeks	203	421	628		152	300	531	719
% of smokers achieving a 4-week quit	48%	49.6%	50.4%		50%	50%	54%	55%

*SFG target (first year of SFG funding)

Leicester City Council

25/26 SFG Funding and Targets

- Funding allocation = £485,361
- Target quit dates set = 1,848
- Quarterly target = 462
- Q1 quit dates set = 352 (↓110)
- Q2 quit dates set = 497 (↑35)
- Cumulative quit dates set in Q1 + Q2 = 849 (↓75)
- Remainder of annual target for Q3 + Q4 = 999

Measures to Meet SFG Target

Engagement Team

- Outreach events
- Community drop-ins/clinics
- Group interventions
- Partnerships
  - Primary care
  - Third sector organisations
  - Businesses

Action Plan

- Service delivery optimisation
- Outpatient referral pathway
- Dentistry referral pathway
- Targeted engagement projects:
  - Routine and manual workers
  - Social housing tenants
  - Mental health services
  - Adult social care
  - Leisure sector
  - Education

Further Work

- **Nutrition offer**
- **CURE referral pathway**
- **Pregnancy referral pathway**
- **Introduction of stop smoking medication**
- **Social marketing campaign**
- **Tobacco control**
  - Step Right Out
  - Swap to Stop
  - Communications toolkit
  - Trading Standards collaboration against illicit tobacco

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Case Studies

79-year-old woman – Eyres Monsell Community Centre	42-year-old man – Advanced cancer & PTSD (via No.5)	37-year-old woman – Tesco community event
• Met Engagement team while smoking outside the centre. • Unable to read or write; later advised by GP to quit. • Remembered the advisor and arranged support through the centre. • Received tailored community and telephone support. • **Now smoke-free** – shows how **proactive engagement overcomes barriers** such as low literacy.	• Referred by support workers; previously homeless, no phone, smoked discarded cigarettes. • First appointment completed via No.5 over the phone; NRT sent there. • Follow-up appointments held in person at No.5. • **Successfully quit** – shows how **strong partnerships** enable access for **vulnerable individuals** with complex needs.	• Met Engagement team at local event; has a long-term mental health condition. • Received extended, personalised support from advisor. • **Now smoke-free** and rated service "**5 out of 5**". • Shows how **accessible outreach** and **tailored support** drives positive behaviour change.

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Thank you

Questions welcome

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Public Health & Health Integration Scrutiny Committee

Work Programme 2025-2026

Meeting Date	Item	Recommendations / Actions	Progress
8 July 2025	Brief introduction to PHHI		
	Health Protection	Bowel Cancer to be added to work programme ICB to share work on bowel cancer	
	ICB funding changes – briefing paper	More details to be provided at September meeting.	
	Oral Health - PH	NHS Dentistry to be added to work programme.	
	Same day access – ICB	Further information to be shared on Figures to be shared for uptake of Pharmacy First, 8 hubs and the comms campaign.	
	Community Engagement and Wellbeing Champions round-up		

Meeting Date	Item	Recommendations / Actions	Progress
9 September 2025	Restructuring updates – ICB & NHS England Winter protection GP Access NHS App		
4 November 2025	DPH Annual Report Whole systems healthy weight Smoke free generation Update on sexual health service		

Meeting Date	Item	Recommendations / Actions	Progress
27 January 2026	*Items TBC:* *Annual review of prevention and health inequalities programme* *Cost of living, food poverty and fuel poverty update* *Drugs and alcohol strategy*		
24 March 2026	*Items TBC:* *Public mental health and suicide prevention* *Community wellbeing champions programme*		
28 April 2026	*Items TBC:* *CDOP annual report* *Healthy babies' strategy update*		

Forward plan suggestions 2025/26:

NHS dentistry	A report was requested 8 July for 9 September, the report has been delayed to the next meeting.	
Bowel Cancer report	A report was requested on 8 July for an update on work by Public health and ICB on bowel cancer.	
NHS Dentistry Access	A report had been requested for the September meeting but could not be completed. This will be considered at the next agenda setting meeting to agree a new date.	
Structure of the LNR	A report had been requested for the full structure of the LNR to come to scrutiny once available.	
NHS APP and Digital Inclusion	**A report on the roll out and usage of the NHS App following additional features to come to a future meeting.**	