Leicester
City Council

MEETING OF THE PUBLIC HEALTH AND HEALTH INTEGRATION SCRUTINY COMMISSION

DATE: TUESDAY, 27 JANUARY 2026
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 and Oliver Harrison, Governance Services,
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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@leiceser.gov.uk and Oliver.harrison@leicester.gov.uk of Governance Services. Alternatively, email committees@leicester.gov.uk, or call in at City Hall.

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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

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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 Public Health and Health Integration held on the 9th September 2025 and 4th November 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. DRAFT GENERAL FUND REVENUE BUDGET 2026/27 Appendix B

The Director of Finance submits a report setting out the City Mayor's proposed Draft General Fund Revenue Budget for 2026/27.

8. HEALTH PROTECTION

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

9. PREVENTION AND HEALTH INEQUALITIES STEERING GROUP ANNUAL REVIEW Appendix C

The Director of Public Health submits a report to update the commission on the Prevention and Health Inequalities Steering group.

10. COST OF LIVING, FOOD POVERTY AND FUEL POVERTY Appendix D

The Director of Public Health submits a report to update the Commission on cost of living projects being managed by the Health in All Policies (HIAP) team.

11. LEICESTER CITY DRUG & ALCOHOL STRATEGY PHASE 3: 2025 - 2027 Appendix E

The Director of Public Health submits a report to update the commission on Phase 3 of the Leicester City Drug and Alcohol Strategy for 2025-27.

12. LEICESTER CITY OUR NEIGHBOURHOOD APPROACH Appendix F

The Integrated Care Board (ICB) submits a presentation to update the Commission on the Leicester Neighbourhood Approach.

13. WORK PROGRAMME Appendix G

Members of the Commission will be asked to consider the work programme

and make suggestions for additional items as it considers necessary.

14. 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 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. For the new Chief Executive and the new Chair of the LNR to attend the next meeting.
4. 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.

Leicester
City Council

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

Held: TUESDAY, 4 NOVEMBER 2025 at 5:30 pm

P R E S E N T:

Councillor Pickering – Chair
Councillor Agath – Vice Chair

Councillor Byrne
Councillor Haq
Councillor Kitterick
Councillor Westley

Assistant City Mayor – Councillor Dempster

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162. WELCOME AND APOLOGIES FOR ABSENCE

Apologies were received from Cllr Clarke and Cllr Sahu.

163. DECLARATIONS OF INTERESTS

There were no declarations of interest.

164. MINUTES OF THE PREVIOUS MEETING

It was raised that the action from the previous meeting regarding attendance at the next meeting from the Chair and the Chief Executive of the LNR. The Governance Officer noted this and the minutes will go to the next meeting on 27th January to be approved.

165. CHAIRS ANNOUNCEMENTS

There were no announcements.

166. QUESTIONS, REPRESENTATIONS AND STATEMENTS OF CASE

None were received.

167. PETITIONS

None were received.

168. HEALTH PROTECTION

The Director of Public Health gave a verbal presentation of the latest position of health protection. It was noted that:

- Tuberculosis (TB) rates had increased nationally in recent years although they were not as high as before. Changes were linked to demographic patterns, migration and links to countries with higher prevalence, including India. Leicester's position was considered in comparison to other higher incidence areas.
- The renewed strategy for TB work following a recent workshop had explored late TB case identification, stigma reduction and improved engagement with GPs and communities on screening.
- One case of Measles recorded this year following a peak in 2023 and 2024. Members heard that coverage remained below the required ninety five percent and further work was needed to increase vaccine uptake.
- MMR coverage linked with wider vaccination rates and that less than half of school age children had received vaccines that prevented Cervical Cancer. Work was taking place with the ICB to address stigma and simplify consent processes for families and young people.
- Bowel cancer screenings work was taking place on reducing stigma through targeted campaigns and encouraging more people to complete the screening programme.
- The Covid vaccine uptake remained lower than expected. Covid outbreaks had recently peaked and were now reducing, and further seasonal waves were anticipated each year.
- Concerns were raised regarding flu due to current rates being aligned with previous years but with indications of an early season and greater variation of influenza A, which showed evidence of immune escape in some people.

In response to comments from Members, the following was noted:

- Members sought clarification on the procedure for isolating people with tuberculosis. It was explained that tuberculosis was not highly infectious and that close contact was usually limited to those living with or staying overnight with a patient. Latent tuberculosis was the most common form, which showed no symptoms and could not be passed on.
- Members enquired why Leicester's rates were higher and where the main issues were arising. It was reported that Leicester's position reflected other deprived areas with complex needs and vaccine hesitancy. Engagement work had not always been effective in the past but recent activity, including roving vaccination units in schools and places of worship, had achieved positive results. This approach required significant time and funding but had helped increase uptake and the approach would be to continue to support wider vaccination and screening programmes.
- Concerns were expressed about families being unable to see the same GP consistently. Members commented that the lack of continuity made it more difficult for people to ask questions or feel reassured about

vaccinations or screening. It was noted that GP to patient ratios and vaccine apathy were also contributing to pressures on emergency departments.

- Members commented on partnership working and access to GP services. Confidence was expressed in the local public health team although concerns were raised about the need for stronger collaboration across organisations. GP access had been considered at the previous meeting and would return in January. Senior representatives from the ICB would continue to attend future meetings to provide updates on their functions and priorities.
- A query was raised on the progress in improving access to people's usual GPs and whether the new service model would support this. Concerns were also expressed about how appointment processes within the ICB had been managed. It was agreed that all five health prevention items would be taken to the next meeting.
- Members discussed the low HPV vaccination rate which was described as particularly worrying. It was felt that this would lead to preventable cases of cervical cancer in the future due to limited awareness, low engagement with screening and delays in seeking medical help. The Commission was assured that HPV was a key prevention priority and that further work would be undertaken.

AGREED:

1. That the report be noted.
2. That the 5 Health Prevention items be taken to the next meeting.

169. DIRECTOR OF PUBLIC HEALTH ANNUAL REPORT

The Director of Public Health submitted his annual report to the Commission. The following was noted:

- The Director detailed how he discovered a library of old council minutes from 1894-1895 which documented levels of disease in Victorian Leicester
- The minutes detailed the impact of when smallpox vaccinations were compulsory and the subsequent local impact including, riots and arrests
- This demonstrated the Leicester method of isolation and contact tracing which parallels methods used during the COVID pandemic.
- Population and ethnicity changes shown in the data, particularly over the last 20 years and examined life expectancy changes for men and women, which highlighted the effects of Covid.
- The Director also featured a 1948 book which was a compendium of chief medical officer annual reports dating back 100 years. This included references to the management of Smallpox and infectious disease, the development of new housing programmes and Slum clearances. The establishment of the isolation hospital at Glenfield was also featured, which again was noted as having parallels with

the Covid isolation wards of the early 2020s.

- Lessons learned from past public health practice were outlined. Links were again drawn again with Covid with a focus on how understanding communities and maintaining clear communication had been essential in supporting vaccine uptake.
- Secondary factors where from the past were considered such as slum clearance and the introduction of clean water supplies. Present day challenges such as the energy crisis which is creating similar conditions that impact people's health.
- The presentation featured a historic photo of two children, one with and one without smallpox that was taken in Leicester in 1901 and was circulated nationally at the time and had supported public awareness of the benefits of vaccination.
- The future direction of public health was explored, including potential developments in personalised care, genetics and the increased use of AI. The final chapter of the report had been drafted with Chat GPT to demonstrate how AI could support local government work.

Following member discussions, the following was noted:

- Members referenced historic use of clinical vans in the1950swhich visited council estates to vaccinate against Polio and achieved a very high uptake. In responses it was highlighted that the Council still have a roving heath unit who go to schools and places of worship to offer this service. They offer vaccines such HPV and MMR, as well as services such as blood pressure checks, unfortunately they only have one van. If there were 10 vans, a real difference could be made.
- Concerns were raised that the report did not reflect today's problems such as the notable decrease in the uptake of the HPV virus, 10 years ago 90% today 48%.
- In response it was confirmed that this was not the purpose of this report and there were lots of other reports that have previously come to scrutiny which go into detail on the issues mentioned.
- There was a lengthy discussion on GP waiting times and the difficulties of obtaining an appointment. It was suggested that people often attended their GP when their needs could otherwise have been met by other NHS services, which placed additional pressure on GP practices. It was also noted that people were hesitant to contact their GP due to widespread media coverage of service pressures.
- The issue of vaccine apathy was discussed and the impact of information people were reading online.. The discussion focused particularly on the HPV vaccine uptake which had been affected by perceptions of asexual link in certain communities. Therefore, a new approach had been adopted which framed the vaccine as an anti-cancer vaccine, alongside work to engage community leaders such as Imams.
- The use of AI within public health and the wider health service was considered. Members noted that AI had potential to be beneficial or harmful depending on how it was used, and it was emphasised that organisations shared a collective responsibility to use it ethically.

AGREED:

1. The report was noted.
2. The Chair requested figures for vaccinations within Leicester City communities to be collected. This is with the aim of collecting more data to contact Wes Streeting and discuss more funding for Leicester vaccine programmes.

170. WHOLE SYSTEMS APPROACH TO HEALTHY WEIGHT

The Director of Public Health submitted a report to update the Commission on the current position regarding the approach to healthy weight in Leicester. It was noted that:

- The mission for the Whole System Approach to Healthy Weight was shared with the Commission “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 citywide 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.”
- The Adoption of the action plan and Healthy Weight Declaration included 3 key themes: Building a stronger system, Changing environments to increase opportunity and empowering workforces and communities.
- A detailed three year action plan was outlined which set out how the various aims would be met. Excess weight was defined as a BMI of twenty five or twenty three for people from Asian, Chinese, Middle Eastern, Black African or African-Caribbean backgrounds.
- Data for children in year six indicated higher levels of excess weight then reception age children in 2023/24. Inequalities were highlighted across different groups, age ranges and people with poor mental health.
- Weight stigma and bias across the city were noted, including during contact with primary care and other services. Work was underway to understand how information could be shared with partners to support residents.
- Work on maternal weight was described. Women were expected to gain weight in pregnancy but not excess weight. Work continued with Live Well services across the city to address myths about weight during pregnancy and confidence in physical activity. Leisure centre and Live Well staff had been trained to support pregnant women. Support from the hospital was provided for women with a BMI over forty during pregnancy. There was currently no equivalent offer for those below a BMI of forty.
- Support from early childhood onwards was described to promote healthy habits and reduce the influence of advertising and unhealthy products. Work was linked to family hubs and parenting programmes. The HENRY programme provides programmes and workshops for parents of children aged nought to five to support healthy eating and parenting.
- For school age children a targeted approach was taken with schools that

had the highest rates of excess weight. This aimed to improve the overall school environment, including breakfast clubs and after school provision, to ensure nutritious food was available throughout the school day.

- Work with adults focused on the impact of the cost of living crisis and the need to help people eat as healthily as possible on a limited budget. Cooking sessions were provided across the year including courses on cooking on a budget and food with friendship. Improvements in participants' skills were reported.
- Only thirteen percent of people with a learning disability in the city had a healthy weight. Special training was being developed for social care settings, officers and care navigators. Training for managers had been introduced on quality assurance checks and nutrition. Work was being rolled out across several workforces to help professionals support people within the restrictions and budgets of their daily lives.
- Work was taking place with NHS partners on the healthy weight declaration, including reviewing food available in hospital trusts and considering what council contracts could do to promote healthy choices for staff and residents.
- National policy changes were noted including restrictions on advertising high fat, salt and sugar products. Local work was underway to implement these changes.

In response to comments from Members, the following was noted:

- Concerns were expressed about the high levels of sugar in many manufactured foods, particularly for people with diabetes. Members felt that national action was needed to address this and noted that many residents were not fully aware of the health impacts associated with excessive sugar intake.
- The discussion highlighted reformulation as a key part of the overall system response. The soft drinks sugar levy was referenced as a successful national example where reduced sugar content had been achieved through reformulation.
- Members discussed whether the programme should expand its focus to influence secondary schools. The current emphasis remained on reception to year six, where excess weight levels were most prominent. There was recognition that engagement with older age groups could be more challenging due to established habits and the availability of food purchased outside the school environment.
- It was acknowledged that delivering the programme would require sustained effort and coordination across a wide range of partners.
- Recent NICE guidance had introduced waist to height ratios alongside BMI to assess health risk. While BMI remained a population level tool, services were expected to incorporate the additional measurement in future.
- Concerns were raised about the number of children visiting takeaways after school and the influence this had on dietary habits.
- Questions were asked about food imported from abroad and whether nutritional information requirements applied consistently. Officers agreed to clarify which shops this related to and provide a follow up for

members.

- The role of trading standards in monitoring compliance with food guidance was noted. A new pilot project was being developed with local takeaways to encourage healthier options, including gradual reformulation of oils and fat content. Fifteen businesses had already engaged and the project aimed to support both takeaways and restaurants to improve the local food environment.

AGREED:

1. That the report be noted.
2. That information would be clarified on food imported from abroad and whether nutritional information requirements applied consistently

171. SMOKE FREE GENERATION

The Director of Public Health introduced an officer from Public Health to update the Commission on the smoke Free Generation programme.

- Gave an overview of the services offered by LiveWell Leicester. Which includes the Stop Smoking Service, Healthy Lifestyles Service, Nutrition Guidance and Reducing Alcohol Service
- Stop smoking service is a 12- week programme for people who live, work or go to a GP practice in Leicester which supports people as young as 12. Support can be face to face or over the phone and can either be one to one or group orientated. All treatment is tailored to the client. There is weekly support, check ins, a supporting app and Nicotine Replacement Therapy/ E-cigs is offered as part of the programme.
- Extra funding was received from the government in the year 24/25 as part of the Government's plan to create a smoke free generation. The funding was allocated based on the average smoking prevalence between the years 2021-2023. Targets are based on the number of clients who set a quit date.
- Leicester has seen a decline in people smoking but this is still below the average nationally. Leicester 14.6% of residents smoke compared to 11.6% nationally.
- Target for Leicester 2024/2025 was to achieve 1,531 quit attempts so to achieve this, an action plan was created which was led by the Live well team and Tobacco control team. There is now a community engagement team who support the wider live well team by providing more stop smoking appointments, attending several events and holding drop-in centres at GPs with text notification to members of the public. While the target was not met last year (1,303 attempts) there was a marked increase each quarter of the numbers using the service and people successfully quitting.
- The Officer from Public Health then introduced the manager of the Community Engagement Team to provide more detail on the work.

- The engagement work carried out during Stoptober was highlighted. During which, the engagement team went to an event each day of the month and brought back more referrals. Numerous GP partnerships have been fostered across Leicester. Practices in areas of the city with high levels of smoking such as Saffron Health, have been fantastic partners.
- Third party partnerships with charities have also been beneficial. Community-based drop in events were held with 'Be Inspired' charity in Braunstone, which were valuable as Braunstone is another area with high smoking levels. Attempts to engage with businesses and get a workplace stop smoking package have been more challenging but attempts will continue to be made.
- Work has been carried out with UHL to create an outpatient referral scheme, which works on a non-opt out basis. Work has been carried out with the lung cancer, the mini-stroke and the Emergency Departments. The team have contacted any smokers who are receiving treatment from these departments and offered them the stop smoking services which has resulted in hundreds of referrals.
- Case studies were shown to demonstrate the impact of the community engagement team and how they are able to adapt to more complex needs of individuals using the service.
- Future action plans involve ensuring that there is always cover for appointments to prevent absence causing appointments to be cancelled and increasing contact attempts for people who miss appointments. The potential of widening the outpatient referral scheme to include dentistry is being explored. Opportunities to further develop joint working initiatives with other Council departments are being probed in areas such as Social Housing, Mental Health services, Adult Social Care, the Leisure Sector and Education.

In discussions with Members, the following was noted:

- There was a discussion surrounding the issue of quitting smoking with several Councillors sharing their own personal experiences with quitting or attempting to quit. There was further talk about some of the consequences of quitting such as weight gain with it being highlighted that this is why the stop smoking service has a nutrition wing.

- The topic of Shisha consumption in the city was discussed as shisha is comparable (if not worse for health than smoking) and if there were any plans to tackle it with a similar scheme. The Commission was advised that the smoke free services are already open to people who smoke shisha. There is also a project being carried out alongside the University of Leicester to investigate the issue of shisha and how to tackle it.

- Comments were raised about the use of vapes as an alternative to smoking as vapes are still bad for your health. It was argued that while vaping is not healthy, it is healthier than smoking. So, offering vapes as a short-term solution is practical. Building on this it was stated by the officer from public health that the problem is non-smokers who have adopted vaping. There is also currently research taking place with

schools to explore what would discourage vaping.

- Further conversations delved in to the matter of smoking cessation success rates and what research is there into relapses as well as support offered. It was revealed that the cessation success rate is measured by if a person has quit for 4 weeks which is the nationally collected model. In Leicester, 55% of people who have used the scheme have quit. But Leicester Public Health follow people's progress for longer than that as relapses do happen. There is an awareness of this fact and support in place to encourage people to try again as many times as needed. They have recently started recoding data for scheme users after a year to provide better data of the success of the scheme.

AGREED:

1. The report was noted.

172. UPDATE ON SEXUAL HEALTH SERVICE

The Director of Public Health gave a presentation to update the commission on Sexual Health Services. It was noted that:

Public Health Sexual Health Portfolio:

- Integrated Sexual Health Service (ISHS)
- Long acting Reversible Contraception (LARC)
- Emergency Hormonal Contraception (EHC)
- HIV Self Sampling Service
- HIV IAG Service
- HIV Peer Support Service (New)

- The service covered testing, both complex and noncomplex contraception, sexual counselling, education in schools and colleges, work with the HPV team, community outreach and responses to HPV exposure.
- The service was reported to be functioning well, with high levels of walk in and online activity. For city residents in July there were 1680 contacts, including 1463 orders and 729 distributions of free condoms. Service users continued to express appreciation for the staff and the quality of care provided.
- Ongoing challenges remained around bookings and access to the service.
- There had been operational pressures over the summer. The city service was now delivered solely within Leicester as Leicestershire County Council and Rutland Council had moved to a different provider. Walk in access at the city site had been temporarily closed to encourage behaviour change among county residents. Staffing had now increased and walk in access had reopened. Demand from county residents to use the city service remained high. The previous condom distribution scheme had operated irrespective of where people lived, but county arrangements had since changed which reduced confusion. There remained a potential financial risk if a high number of county residents continued to use the city service.
- Work was underway with primary care to support the delivery of long acting

reversible contraception. People requiring these procedures were directed to Haymarket Health, with a clear pathway for fitting and removal. Efforts were being made to make access as easy as possible and to support general practice with the associated costs.

- Emergency hormonal contraception had previously been commissioned locally and delivered through both the clinic and pharmacies. Most activity had taken place at the clinic. From 29th October the entire pharmacy provision transferred to the national NHS pharmacy contraception service. This made emergency contraception free for all age groups and increased reimbursement for pharmacies. Local contracts were therefore being decommissioned. Pharmacies could seek payment from the council or primary care networks during the transition period. Mystery shopper work had been undertaken to assess accessibility and findings had been shared with colleagues to support service improvement.
- HIV self-sampling kits were being used by around forty people in the first quarter through a provider called SH24. Future commissioning intentions were still to be confirmed.
- The HIV information, advice and guidance service based at the clinic supported people to access and engage in treatment, with case studies demonstrating positive outcomes.
- A HIV peer support pilot was in place. Under national policy people attending emergency departments were now routinely tested for blood borne viruses unless they opted out. Those identified with HIV were able to receive immediate support through the pilot.

The following was noted in Members discussions:

- Questions were asked about the financial risk associated with county residents using the city service and why arrangements had changed. It was noted that the issue remained a concern due to the open access nature of sexual health services. Work was underway with partners to understand data trends and encourage people to use services closer to where they lived.
- Concerns were raised about the wider NHS structure and the extent to which patients were required to work around service changes. It was acknowledged that the situation was complex and that regular discussions were taking place across the system.

AGREED:

That members note the update on Sexual Health Services.

173. WORK PROGRAMME

In discussion with members it was agreed that GP Access and Annual review of Health Inequalities would be added to the work programme for the January meeting.

174. ANY OTHER URGENT BUSINESS

The Chair added they would like the Commission to take a focus on Rheumatology in Leicester as an informal task group.

With there being no further business, the meeting closed at 8:08pm.

Appendix B

Draft General Fund Revenue Budget 2026/27

Decision to be taken by: Council

Date of meeting: Draft for 25 February 2026

Lead director: Amy Oliver, Director of Finance

Useful information

- Ward(s) affected: All
- Report author: Catherine Taylor/Amy Oliver
- Author contact details: amy.oliver@leicester.gov.uk
- Report version number: 1

1. Purpose

1.1. The purpose of this report is to present the City Mayor's strategy for balancing the budget for the next 3 years and to seek approval to the actual budget for 2026/27. The strategy is a continuation of the medium-term strategy established last year and includes the use of one-off money and reductions in annual service spending through savings and work to reduce the growth areas such as social care and homelessness. It. It is designed to ensure we remain financially sustainable for as long as possible, while we continue to seek ways to reduce the ongoing budget gap.

1.2. Whilst the strategy is forecast to provide sufficient reserves to balance the budget for at least the next three years, and is a significant improvement on previous forecasts, an ongoing budget gap continues. The Council continues to annually spend more than the income received and is using one-off monies to balance the budget. The City Mayor will continue to make these points to the Government.

1.3. The proposed budget for 2026/27 is described in this report, subject to any amendments the City Mayor may wish to recommend when he makes a firm proposal to the Council.

2. Summary

2.1. As members will be aware, the financial outlook is difficult. Like many authorities, we have ongoing difficulties in being able to balance our budget. A number of authorities have previously applied to the Government for "exceptional financial support", and/or to issue a formal report under section 114 of the Local Government Finance Act 1988. We are unaware if further authorities will be applying for EFS as part of this year's budget setting

2.2. We have so far been able to avoid reaching a financial crisis point, by the use of a "managed reserves strategy" and a multi-strand budget strategy approved last year. This is progressing, and the underlying financial position – while still difficult – has improved from last year's forecasts. As a result, this report proposes continuing the existing financial strategy and extending it to March 2029.

2.3. We are continuing with our £60m asset sales program, however we are not envisaging requiring a capitalisation direction over the three-year period of this financial strategy. Therefore, we will look to use this to fund some of the previously approved capital budget to relieve the borrowing pressures in the years the capital receipts are received.

2.4. Achieving our strategic vision for the Council is dependent on establishing a sustainable budget position, which enables decisions to be made that balance the resource implications against the financial constraints. This strategy does not make specific decisions about how any service will be delivered, but provides a framework within which those decisions will be made. In particular, it reinforces our commitment to providing high quality care services, and provides additional resources in this area. We are also looking to maintain our economic development to support the long term vision for the City and invest in areas that improve the city for the people that live here.

2.5. In addition, to this we are continuing to mitigate the pressures within temporary accommodation by investing in additional accommodation for these households. This strategy looks to provide the revenue support to continue with our positive approach to preventing homelessness, alongside significant capital investment included in the capital budget strategy.

2.6. Estimates of our available funding are particularly uncertain this year. The government is undertaking a substantial review of support to local authorities; at the time of writing, the outcome of a consultation has just been published, and we do not expect to have the finance settlement for 2026/27 until just before Christmas. As a result, this draft budget report is based on estimates that could change significantly. However, given the wider position of the public finances, it is very unlikely that any changes will eliminate the substantial gap between our annual spending and income.

2.7. Local government reorganisation (LGR) could deliver significant efficiency savings to support the Council's budget, depending on the option chosen by the Government. As these would not start to materialise until 2028/29 at the earliest, the impact has been disregarded for the purposes of this report.

2.8. The report proposes a council tax increase of just under 5%, which is the maximum we believe we will be allowed to set without a referendum.

2.9. The medium-term outlook is attached at Appendix 4 and shows the escalating scale of the financial pressures facing the council.

3. Recommendations

3.1. At the meeting in February, the Council will be asked to:

a) approve the three year budget strategy described in this report;

b) approve the proposed budget and council tax for 2026/27, including the recommendations in the formal budget resolution, subject to any changes proposed by the City Mayor when he makes his final proposal to the Council;

c) approve the budget ceilings for each service, drafts of which will be at Appendix 1 to the final report;

d) approve the scheme of virement described in Appendix 2 to this report;

e) note my view on the adequacy of reserves and the estimates used in preparing the budget;

f) note the equality implications arising from the proposed tax increase, as described in paragraph 15 and Appendix 3;

g) note the medium-term financial strategy and forecasts presented at Appendix 4, and the significant financial challenges ahead;

h) note the earmarked reserves position that will be set out at Appendix 5 to the final report;

i) note the policy on council tax premiums and discounts set out at Appendix 6;

j) note the council tax support scheme has been reviewed by the Executive, and reported to OSC, during the year;

k) approve the inflationary increase to Council Tax Support Scheme thresholds as shown at Appendix 7 and approve further inflationary increases in future years (to be calculated with reference to published CPI inflation for the September prior to the start of the year in question);

l) approve the capital receipts flexibility policy that will be at Appendix 8.

4. Background and Financial Strategy

4.1. Between 2010 and 2020, a “decade of austerity” meant that services other than social care had to be reduced by 53% in real terms, limiting our scope to make further cuts. This was followed by the covid-19 pandemic which led to “stop gap” budgets whilst we dealt with the immediate emergency, and saw the budgets being supported by reserves.

4.2. This is alongside cost pressures shared by authorities across the country. These include pressures on the costs of children that are looked after and support for homeless households, as well as the long-standing pressures in adult social care and the hike in inflation. The budgets for 2024/25 and 2025/26 were supported by a further £61m and £31m of reserves respectively.

4.3. Plans for a “fair funding” review of grant allocation have been repeatedly delayed. This has left us providing services to a population far in excess of our last needs assessment (population has grown faster than elsewhere in the country, so an equitable system ought to give us a greater share of the national pot). The review is now being introduced for the 2026/27 financial year, although full implementation will take several years.

4.4. In February 2025, the Council approved a multi-strand budget strategy aimed at balancing the budget for a minimum three years. This includes:

Strand 1 - Releasing one-off monies to buy time, including the release of £90m from the capital reserve, and replacing this with borrowing to fund the capital programme;

Strand 2 - Reductions in the capital programme to reduce the borrowing required, and therefore reduce the cost of this borrowing;

Strand 3 – A programme of property sales aiming to secure an additional £60m of one-off monies. These receipts cannot be used to support the revenue budget without permission from the Secretary of State. It is now planned to use some of the capital receipts to support the capital programme and reduced the revenue cost of borrowing.

Strand 4 – Steps to constrain growth in those statutory services that are under demand led pressure (i.e. adult and children's social care services, and homelessness).

Strand 5 – Ongoing savings totalling £23m per year by 2027/28.

4.5. Progress against each of these strands is set out in the sections below, along with a limited number of areas of additional investment to assist in meeting corporate priorities.

4.6. Given the progress already made, and some improvements in factors outside our direct control, we now expect to have reserves available at the end of the forecast period (March 2029). However, these reserves are one-off funding and an underlying budget gap remains (although improved) which will need to be met in the longer term.

5. Strands 1-3: releasing one-off monies and reductions in the capital programme

5.1. Last year's forecasts included the release of £90m from the capital reserve, and £20m from other earmarked reserves. Since the budget was approved, a further £12m has been added to the budget reserve from subsequent reviews and additional one-off income.

5.2. Given the difficult financial outlook, earmarked reserves are kept under regular review, and amounts that are no longer required for their original purpose are released to the budget strategy reserve. This has now identified a further £0.5m that can be used to support the overall budget position.

5.3. The programme of property sales is continuing, and has achieved £21m in completed or legally contracted sales, with a further £55m of sales being progressed.

5.4. Originally, it was forecast that these receipts would be required to balance the budget after the 3-year strategy (which would require specific permission from the government). To do this, we would need to borrow money to fund the capital programme, which increases our revenue costs in the longer term. Given the improvement in reserves balances in the latest forecasts, options are now being explored to use some of these receipts to reduce our borrowing requirements.

5.5. Available one-off funding has also been reviewed to ensure future costs are provided for. As detailed in paragraph 9 below, it is proposed to set monies aside towards transitional costs associated with local government reorganisations, and the DSG cumulative deficit when the current statutory override ends.

6. Strand 4: Constraining Growth in Service Demand

6.1. For several years, one of the chief reasons for our budget gap is growth in the costs of statutory services, particularly social care (and, more recently, homelessness), which have outstripped growth in our income.

Adult Social Care

6.2. The budget for **Adult Social Care** requires growth to take account of demographic and inflationary pressures. Demographic pressures can be the result of increased packages of support to those people already receiving care, or a change in the mix of people we provide care for, for example more working age people are diagnosed early with life-long health conditions such mental health and dementia. Inflationary pressures arise from increases in National Living Wage (NLW) and general inflation.

6.3. Calculating future growth is a complex process taking into account current care packages and future projections. The growth required can be seen in the following table:

	2026/27 £m	**2027/28** £m	**2028/29** £m
Underlying budget	179.1	179.1	179.1
Placement growth	14.8	29.8	45.1
Additional income	(2.0)	(2.0)	(2.0)
Vacancy factor	(0.4)	(0.2)	0.0
TOTAL	**191.5**	**206.7**	**222.2**

6.4. The department continues to reduce growth in the costs of care by reducing new entrants, preventative and early support, and by enhanced partnership working. Tracking of current package costs indicate that the department may have spent £24m more in 2025/26 (rising to £41m in 2026/27) if cost mitigation work had not taken place. This programme of work continues, and the future growth pressures identified above takes this into account. Despite this work, it is forecast that costs of care will increase by over £40m over the three years of this strategy.

6.5. The council has undertaken significant work to ensure that other local authority and health partners are contributing their fair share towards care costs. Through this work, adult social care have generated an additional £2.6m in 2025/26. Although we do not anticipate a sudden drop in future, this additional income is subject to the changes that

occur in care packages following reassessments or changes in a person's health conditions.

6.6. Adult Social Care was rated as 'Requires Improvement' by the CQC in July. They recognised that we have an effective care and support system, there is clear governance in place and that we are committed to staff development. However, as there were areas for improvement identified, we are implementing an action plan focussing on this.

6.7. Adult social care continues to struggle with recruiting and are undertaking significant work to reduce vacancies. However, we need to recognise that they are unlikely to be fully established in 2026/27, so have included a vacancy factor that will reduce over the three strategy period.

Education and Children's Services

6.8. The budget for **Education and Children's Services** will require growth in future years. This is due to the increasing costs of providing children's social care, particularly where a small number of care packages incur a significant cost due to the specific needs of those children.

6.9. The growth required has been estimated as shown in the following table.

	2026/27 £m	**2027/28** £m	**2028/29** £m
Underlying budget	120.1	120.1	120.1
Growth already in the strategy	1.0	2.1	0
Additional growth required	3.3	4.9	8.7
Vacancy factor	(1.0)	(0.5)	(0.2)
TOTAL	**123.4**	**126.6**	**128.6**

6.10. There is a strategy in place to increase our in-house offer providing better quality accommodation, improved quality control, lower likelihood of placement breakdowns and better matching to the needs of young people. This is also anticipated to provide better cost efficiency than external placements. It costs on average £260,200 per annum across our internal provision compared to £302,667 externally in residential settings; costs are lower by about 14% in our internal homes, along with having better outcomes.

6.11. This cost differential will be greater as we plan to improve our capabilities for providing in-house support for children and young people with complex needs, particularly those at risk of deprivation of liberty orders (DOLs) or living in accommodation unregulated by Ofsted. This may also benefit children who are living in care out of the city in need of a local residential placement. The capital build costs will be funded jointly with the Department of Education (DFE) and these two new children's homes are expected to be operational in 2027.

6.12. We are part of a pilot Families First Partnership (FFP) programme where we are working with our safeguarding partners to transform and expand preventative support. The overall aim is to keep more families together by strengthening kinship support and ultimately gain a significant reduction in the numbers of looked after children. Several work strands are underway including family group decision making, improving the role of education in multi-agency safeguarding arrangements and information sharing between partners. Through this work, the department has avoided costs of £1.3m in 2025/26 and this is expected to continue in future years.

6.13. The Dedicated Schools Grant (DSG) cumulative deficit at the end of 2024/25 was £22.5m and is forecast to be £44.8m by the end of the current financial year 2025/26. The government has extended the statutory override to the end of 2027/28 whilst it considers reform to the funding for SEND and children's social care. The government have indicated that they will resolve (or centrally fund) DSG deficits occurring after April 2028, but it is not clear how deficits already accrued will be resolved; our cumulative deficit could be as high as £78m by the end of 2027/28. Therefore, it is planned to set aside the funding of the deficit to date from the budget reserve. This transfer will be made in the outturn monitoring report once the final deficit figure is known. Local authorities are not allowed to charge borrowing costs of the cumulative deficit to the DSG but have to pay it from the General Fund.

General Fund Housing

6.14. The budget for **homelessness** has been under severe pressure due to increased numbers of households presenting as homeless, and growth of £11m, in addition to a £6m contingency, was included in the 2025/26 budget. Mitigating work, including £45m of investment in temporary housing, has avoided an estimated £59m of costs by 26/27. However, the number of cases continues to increase and (without further action) will put further pressure on future years' budgets.

6.15. The 2026/27 General Fund Capital Programme Report (also on your agenda) includes the addition of £50m for the direct acquisition of properties for use as temporary accommodation. The revenue implications of this investment are covered within that report. Alongside acquisitions, it is proposed that we grow the number of properties leased from private sector landlords by 110; the cost of leasing a property is significantly less than hotel stays, and is estimated to result in the avoidance of annual revenue costs. Given the increasing number of homelessness presentations, additional staff are required to ensure that the focus remains on prevention rather than alleviation of need, and funding for additional staff is included in this budget.

6.16. The overall revenue impact of the above is estimated as:

	26/27 £m	27/28 £m	28/29 £m
Additional growth required without further mitigations	5.9	12.0	12.0
Net revenue impact of property acquisitions	(2.2)	(6.2)	(6.2)

Net impact of additional leased properties	(1.7)	(3.9)	(3.9)
Additional staffing cost	1.8	1.8	1.8
Total	**3.8**	**6.6**	**6.6**

6.17. In recent years, nationally the cost of Housing Benefit linked to supported housing has continued to rise and this is the same for us. Unlike the majority of Housing Benefit, these elements are not fully funded through government subsidy, and we have limited ability to influence either the level of rents charged or the claims themselves. The forthcoming changes to licensing and rent setting under the Supported Housing Act should improve our ability to manage these cases, but this will take time to have a material impact. To reflect the ongoing pressure, growth of £1.5m per year has been included in the proposed budget.

7. Strand 5 – Savings Programme

7.1. The budget strategy approved last year required achievement of savings totalling £23m by 2027/28. Progress against these savings targets has been regularly monitored and reported in the quarterly budget monitoring reports. By period 6 in 2025/26, over 60% of the £23m total had already been achieved:

	Target (full year) £m	Achieved to date £m
Estates & Building Services	2.8	1.0
Housing	1.0	0.9
Neighbourhoods & Environmental Services	7.2	2.1
Planning, Development and Transportation	4.0	4.0
Tourism, Culture & Inward Investment	2.3	2.3
Children's Services	1.0	1.0
Corporate Services	2.0	0.9
Financial Services	1.1	0.4
Adult Social Care	1.2	1.2
TOTAL	**22.6**	**13.7**

7.2. More details on these savings can be found in the regular quarterly monitoring reports. Work is ongoing to realise the balance of the savings total.

8. Additional Investment

8.1. Given the underlying financial pressures, the scope for additional investment is limited. However, growth has been built into the budget for some priority areas:

8.2. During the redevelopment of the central market there is a shortfall of income as a consequence of a reduction in the number of traders and a lower fee being charged.

£450k is being made available in 2026/27 to cover this shortfall in income until the new market becomes operational.

8.3. This budget includes funding for a permanent team, building on the pilot work already underway, to better manage public spaces across the city. At a cost of £0.3m per year, the hybrid team will work 7 days a week to tackle anti-social behaviour and environmental enforcement, working alongside the existing City Warden, Public Health and Housing teams.

8.4. The UK Shared Prosperity Fund (UKSPF) is a government grant to invest in communities, businesses, people and skills, which runs until March 2026. This funding has been supporting some Council services such as festival, inward investment and business/retail support team. Without the addition of the £1m to the budget this would lead to this work not continuing.

8.5. Ash dieback is a disease which ultimately leads to the death of ash trees, of which there are 19,000 across the City. The disease increases the chance of branches becoming brittle and falling. Whilst this risk has been appropriately managed, existing budgets have become strained and a dedicated team is needed to deal with this going forward. £0.3m is being made available for a team to monitor sites and prioritise trees for removal.

9. Budget Strategy Reserve

9.1. When the 2025/26 budget was set, the budget strategy reserve was forecast to be £163.6m at 1st April 2025, reducing to £25m by March 2028. There have been improvements to the forecasts, offset by the need to set aside amounts to meet the historic DSG deficit as described in 6.13 above. Updated forecasts show that we are now expecting a balance of £27.2m by March 2029:

	2025/26 £m	**2026/27 £m**	**2027/28 £m**	**2028/29 £m**
At the beginning of the year	**193.8**	**129.9**	**101.7**	**71.2**
Add: Forecast rates pool surplus	7.5			
Reserve restatements:				
From earmarked reserves		0.5		
Set aside for DSG deficit	(44.8)			
Set aside for LGR transitional costs		(14.0)		
Minus budget gap	(26.6)	(14.7)	(30.5)	(44.0)
At the end of the year	**129.9**	**101.7**	**71.2**	**27.2**

10. Construction of the 2026/27 budget

10.1. By law, the Council's role in budget setting is to determine

a) The level of council tax;
b) The limits on the amount the City Mayor is entitled to spend on any service ("budget ceilings") - proposed budget ceilings are shown at Appendix 1;

10.2. In line with Finance Procedure Rules, the Council must also approve the scheme of virement that controls subsequent changes to these ceilings. The proposed scheme is shown at Appendix 2.

10.3. The budget is based on a proposed Band D tax for 2026/27 of £2,121.87, an increase of just under 5% compared to 2025/26. This is the maximum which will be permitted without a referendum.

10.4. The tax levied by the City Council constitutes only part of the tax Leicester citizens have to pay (albeit the major part – 84% in 2025/26). Separate taxes are raised by the Police and Crime Commissioner and the Combined Fire Authority. These are added to the Council's tax, to constitute the total tax charged.

10.5. The actual amounts people will be paying, however, depend upon the valuation band their property is in and their entitlement to any discounts, exemptions or benefit. Almost 80% of properties in the city are in band A or band B, so the tax will be lower than the Band D figure quoted above. The Council also has schemes for mitigating hardship.

10.6. The Police and Crime Commissioner and Combined Fire Authority will set their precepts in February 2026. The formal resolution will set out the precepts issued for 2026/27, together with the total tax payable in the city.

11. 2026/27 Budget Overview

11.1. The table below summarises the proposed budget for 2026/27 (projections for a full three-year period are included in the medium-term strategy at Appendix 4):

	2026/27
	£m
Net service budget	**456.8**
Provision for pay inflation	6.0
Corporate budgets (including capital finance)	12.4
Housing Benefits	1.5
General contingency for risk	1.0
Expenditure total	**477.7**
Income:	
Council tax	179.3
Collection Fund surplus	0.8

Settlement Funding Assessment	275.5
Extended Producer Responsibility for Waste	7.4
Income total	**463.0**
Remaining budget gap (to be met from reserves)	**14.7**

12. Departmental Budget Ceilings

12.1. Budget ceilings have been prepared for each service, calculated as follows:

a) The starting point is last year's budget, subject to any changes made since then which are permitted by the constitution (e.g. virement);

b) An allowance is made for non-pay inflation on a restricted number of budgets. Our general rule is that no allowance is made, and departments are expected to manage with the same cash sum that they had in the previous year. Exceptions are made for the budgets for independent sector adult social care (2%) and foster care (2%) but as these areas of service are receiving growth funding, an inflation allowance is merely academic (we pay from one pot rather than another). Budgets for the waste PFI contract have been increased by RPI, in line with contract terms.

c) Unavoidable growth has been built into the budget. This has been mitigated by action that has already been taken to control costs in demand-led areas, as detailed in paragraph 6 above. Budgets have also been increased for the investment described at section 8.

d) Savings requirements for 2026/27, as set out in last year's budget strategy, have been deducted from service budgets, along with additional savings that have been approved subsequently to the strategy being set.

e) Budget ceilings have been reduced to reflect the reduction in employers' pension contributions from April 2026. The pension fund is managed by the County Council and its performance is reviewed by independent actuaries every 3 years. The actuaries examine investment performance in particular, and seek to ensure that all councils in the scheme make future contributions that are sufficient to pay all pensions when they become due. Our contributions are paid as a percentage of payroll costs, and previous reviews have usually led to an increase. As a consequence of the most recent review, we will be paying around £9m per year less than we are now. Members are asked to note that this does not reflect any reduction in the Council's overall liabilities: ultimately, we have to pay sufficient contributions to the County Council to ensure that all future pension costs are paid. Note that employees also pay a percentage of their earnings to the fund – these amounts are fixed by law.

12.2. The proposed budget ceilings are set out in Appendix 1.

12.3. In recent years, the pay award for local government staff has not been agreed until part way through the financial year. A central provision is held to fund the 2026/27 pay award, forecast at 3% and will be added to budget ceilings once agreed.

12.4. A substantial review of government funding is under way (see paragraph 14 below). It is likely that this will lead to some current grant funding streams being rolled into general funding, which will require amendments to the budget ceilings. (These are largely presentational changes to government funding that will not, in themselves, affect the amount we have available to spend).

12.5. The role of the Council is to determine the financial envelopes within which services are delivered. Delivering the services within budget is a function of the City Mayor.

13. Corporately held Budgets and Provisions

13.1. In addition to the services' budget ceilings, some budgets are held corporately. These are described below.

13.2. As discussed above, a provision has been set aside for **pay awards**, which are not (in recent years) agreed until some time into the financial year. The provision is based on an assumed 3% pay award each year

13.3. The budget for **capital financing** represents the cost of interest and debt repayment on capital spending, less interest received on balances held by the council. Decisions to borrow money to fund capital expenditure have led to an increase in the budget, although this increase will reduce where capital receipts are used to fund expenditure in lieu of borrowing. The budget also reflects the scale of the Dedicated Schools Grant deficit, impacts the level of interest received and must be met from the general fund.

13.4. **Miscellaneous central budgets** include external audit fees, pension costs of some former staff, levy payments to the Environment Agency, bank charges, general insurance costs, money set aside to assist council taxpayers suffering hardship and other sums it is not appropriate to include in service budgets. Miscellaneous central budgets are partially offset by the effect of recharges from the general fund into other statutory accounts of the Council.

13.5. The **housing benefits** budget funds the difference between benefits payments and the amount of subsidy received from central government. This gap has been increasing in recent years, particularly around supported housing (see para. 6.17 above.

13.6. A corporate contingency budget of £1m has been set aside, which will only be allocated if necessary. Following a number of years of having limited requirement to use the corporate contingencies the budgets have been reduced. However, it should be noted if we do have any unexpected pressures in 2026/27 the budget strategy

reserve is available to be used. This would however reduce the one-off funding available for the future year budget strategies.

14. Resources

14.1. The majority of the council's core funding comes from business rates; government grant funding; and council tax. Service-specific sources of funding, such as fees & charges and specific grants, are credited to the relevant budget ceilings, and are part of departmental budgets.

14.2. A major review of government funding is in progress, which will update funding allocations for the first time since 2013. At the time of writing, we do not have the outcome of this review and this draft budget is necessarily based on estimates, informed by modelling work commissioned from external advisors. The provisional settlement, which will give us figures for the major funding streams, is expected shortly before Christmas.

Business rates and core grant funding

14.3. Local government retains 50% of business rates collected locally, with the balance being paid to central government. In recognition of the fact that different authorities' ability to raise rates do not correspond to needs, there are additional elements of the business rates retention scheme: a top-up to local business rates, paid to authorities with lower taxbases, and Revenue Support Grant (RSG).

14.4. The government's planned reforms from April 2026 include several overlapping strands:

- Fully equalising for differences in council tax bases across the country. We should gain from this as our tax base is relatively low;
- Revised and updated formulae that measure each area's "need to spend" on different service areas. It appears from the information we have to date, that we will lose funding from some of these changes;
- Rebasing business rates income to redistribute growth achieved since 2013; and to reflect the rates revaluation that will be implemented from April;
- Transitional arrangements to phase in the effect on individual authorities.

14.5. The split of funding between different funding streams (business rates, top-up and RSG payments) is not yet known. For this draft budget, the total "settlement funding assessment" (SFA) is shown as a proxy for the totality of government grant and the proportion of business rates that are kept by the City Council. Overall, our current assessment is that the Council should benefit from these changes, but not as significantly as we might have anticipated.

Council tax

14.6. Council tax income is estimated at £179m in 2026/27, based on an assumed tax increase of just below 5% (the maximum we believe will be allowed to set without a

referendum). The 5% limit will include a "social care levy" of 2%, designed to help social care authorities mitigate the growing costs of social care. Since our tax base is relatively low for the size of population, the levy raises just £3.5m per year.

14.7. The estimated council tax base has grown by 2.3% since last year's budget was set. The final council tax base is calculated on data from the end of November, and will be included in the final budget report to Council in February.

14.8. While the major elements of Council Tax banding and discounts are determined nationally, some discounts and premiums, as well as the Council Tax Support Scheme for those on low incomes, are determined locally. Appendix 6 sets outs these discounts and premiums.

Other corporate income

14.9. The majority of grant funding is treated as income to the relevant service departments and is not shown separately in the table at paragraph 11. Other grants which existed in previous years are expected to be rolled into the general settlement, and are not shown separately.

14.10. From 2025/26, a new (unringfenced) funding stream relating to Extended Producer Responsibility (EPR) in respect of waste packaging has been received, for which our provisional allocation for 2026/27 is £7.4m. We have only limited information about likely levels of income in later years, which will depend on producers' responses to the new levy. Regardless of the position, we expect waste costs to increase by up to £3m per year when there is a new contract in May 2028.

Collection Fund surplus / deficit

14.11. Collection fund surpluses arise when more tax is collected than assumed in previous budgets. Deficits arise when the converse is true.

14.12. The Council has an estimated **council tax collection fund surplus** of £2.4m, after allowing for shares to be paid by the police and fire authorities. The reasons for this include a reduction in bad debt provision, following significant work to improve collection rates; and a continuing fall in the cost of the council tax support scheme (CTSS).

14.13. The Council has an estimated **business rates collection fund deficit** of £1.5m.

15. Budget and Equalities (Surinder Singh, Equalities Officer)

15.1. The Council is committed to promoting equality of opportunity for its residents; both through its policies aimed at reducing inequality of outcomes, and through its practices aimed at ensuring fair treatment for all and the provision of appropriate and culturally sensitive services that meet local people's needs.

15.2. In accordance with section 149 of the Equality Act 2010, the Council must "have due regard", when making decisions, to the need to meet the following aims of our Public Sector Equality Duty :-

(a) eliminate unlawful discrimination;
(b) advance equality of opportunity between those who share a protected characteristic and those who do not;
(c) foster good relations between those who share a protected characteristic and those who do not.

15.3. Protected groups under the public sector equality duty are characterised by age, disability, gender reassignment, pregnancy/maternity, race, religion or belief, sex and sexual orientation.

15.4. When making decisions, the Council (or decision maker, such as the City Mayor) must be clear about any equalities implications of the course of action proposed. In doing so, it must consider the likely impact on those likely to be affected by the recommendation; their protected characteristics; and (where negative impacts are anticipated) mitigating actions that can be taken to reduce or remove that negative impact.

15.5. A number of risks to the budget are addressed within this report (section 16 below). If these risks are not mitigated effectively, there could be a disproportionate impact on people with particular protected characteristics and therefore ongoing consideration of the risks and any potential disproportionate equalities impacts, as well as mitigations to address disproportionate impacts for those with particular protected characteristics, is required.

16. Risk Assessment and Estimates

16.1. Best practice requires me to identify any risks associated with the budget, and Section 25 of the Local Government Act 2003 requires me to report on the adequacy of reserves and the robustness of estimates.

16.2. Assessing the robustness of estimates requires a judgement to be made, which is now hard given the volatility of some elements of the budget. The most significant individual risks are described below.

16.3. Like most (probably all) upper tier authorities, we run the risk of further demand and cost increase in adults' social care and children's placements, despite mitigating work that is continuing.

16.4. Like many housing authorities, we run the risk of further cost pressures from homelessness. However, the Council has a significant programme of investment in temporary accommodation to mitigate this risk.

16.5. In addition to the above, we have a cumulative overspend of £22.5m on the schools' "high needs" block, which we have not had to write off against general fund reserves due to a special dispensation given by the Government, and available until 31st March 2028; by which time it could be as high as £78m. It remains unclear how this national issue will be resolved; a planned White Paper has been delayed to next year which is expected to propose ways to reduce the ongoing costs deficit, but the historic deficit will still need to be met.

16.6. We are also exposed to any further inflationary cost pressures, which may result from world events.

16.7. Significant progress has been made on achieving the savings target, however failure to deliver the savings would have significant impact on the strategy.

16.8. A key part of our strategy is the use of one-off monies to balance the budget gap. This has a multiplicative effect of any risks which crystallise into annual cost pressures. For instance, an additional £5m per year of unavoidable cost will, all other things being equal, use £15m of reserves by the end of 2028/29.

16.9. The proposed budget contains a reduced level of corporate contingency (£1m per year) compared to previous years. As our budget is supported by reserves, this is largely presentational – a lower call on reserves is initially budgeted for each year, but with a greater chance that pressures will exceed the available contingency and further use of reserves will have to be made. If the call on reserves is required this will reduce the future one-off monies available in future budgets.

16.10. However, there is a clear plan: that shows the improvements that have been made in our financial strategy and the budget gap is closing, we continue to work on a programme to further reduce it. This involves the continuation of the cost mitigation work in areas of service under pressure, transformation of services and the potential to reduce borrowing by using capital receipts to fund the capital programme.

16.11. Subject to the above comments, I believe the estimates made in preparing the budget are sufficiently robust to allow the budget for 2026/27 to be approved.

16.12. In addition, we have a substantial level of reserves available to support the budget strategy. This means that, in the short term, reserves can be used in substitution for any savings which cannot be made, or for unexpected cost pressures; and there is limited risk of being unable to balance the budget in 2026/27. I regard our level of reserves as adequate.

16.13. As a last resort, a £15m General Fund emergency balance is held. I do not expect to have to call on this balance in the time period set out in this strategy.

17. Financial, Legal and Other Implications

17.1. Financial Implications

This report is exclusively concerned with financial issues.

17.2. ***Legal Implications (Kamal Adatia, City Barrister & Head of Standards)***

17.2.1. The budget preparations have been in accordance with the Council's Budget and Policy Framework Procedure Rules – Council's Constitution – Part 4C. The decision with regard to the setting of the Council's budget is a function under the constitution which is the responsibility of the full Council.

17.2.2. At the budget-setting stage, Council is estimating, not determining, what will happen as a means to the end of setting the budget and therefore the council tax. Setting a budget is not the same as deciding what expenditure will be incurred. The Local Government Finance Act, 1992, requires an authority, through the full Council, to calculate the aggregate of various estimated amounts, in order to find the shortfall to which its council tax base has to be applied. The Council can allocate greater or fewer funds than are requested by the Mayor in his proposed budget.

17.2.3. As well as detailing the recommended council tax increase for 2026/27, the report also complies with the following statutory requirements:-

(a) Robustness of the estimates made for the purposes of the calculations;
(b) Adequacy of reserves;
(c) The requirement to set a balanced budget.

17.2.4. Section 65 of the Local Government Finance Act, 1992, places upon local authorities a duty to consult representatives of non-domestic ratepayers before setting a budget. There are no specific statutory requirements to consult residents.

17.2.5. The discharge of the 'function' of setting a budget triggers the duty in s.149 of the Equality Act, 2010, for the Council to have "due regard" to its public sector equality duties. These are set out in paragraph 15. There are considered to be no specific proposals within this year's budget that could result in new changes of provision that could affect different groups of people sharing protected characteristics. Where savings are anticipated, equality assessments will be prepared as necessary. Directors and the City Mayor have freedom to vary or abort proposals under the scheme of virement where there are unacceptable equality consequences. As a consequence, there are no service-specific 'impact assessments' that accompany the budget. There is no requirement in law to undertake equality impact assessments as the only means to discharge the s.149 duty to have "due regard". The discharge of the duty is not achieved by pointing to one document looking at a snapshot in time, and the report evidences that the Council treats the duty as a live and enduring one. Indeed, case law is clear that undertaking an EIA on an 'envelope-setting' budget is of limited value, and that it is at the point in time when policies are developed which reconfigure services to live within the budgetary constraint when impact is best assessed. However, an analysis of equality impacts

has been prepared in respect of the proposed increase in council tax, and this is set out in Appendix 3.

17.2.6. Judicial review is the mechanism by which the lawfulness of Council budget-setting exercises are most likely to be challenged. There is no sensible way to provide an assurance that a process of budget setting has been undertaken in a manner which is immune from challenge. Nevertheless the approach taken with regard to due process and equality impacts is regarded by the City Barrister to be robust in law.

17.2.7. Schedule 1A to the Local Government Finance Act 1992 states that the Council must "make" a Council Tax Reduction scheme for each financial year, and if it wishes to change it, it must "revise" or "replace" it. The deadline for making, revising or replacing a Scheme is 11th March. There are no proposals to change the CTSS so recommendation 3.1(j) reflects the decision to keep the existing Scheme, subject to inflationary changes to thresholds for support.

17.3. **Climate Change Implications**

17.3.1 The climate emergency remains one of the key long-term challenges facing the council and the city, creating increasing real-world consequences, including financial costs, as we have seen from recent flooding incidents.

17.3.2 In broad terms, the financial pressures facing the council, and the strategy proposed for addressing them, are likely to have the following implications for addressing the climate emergency:

- Reductions in service delivery and sale of council buildings may result in reductions in the council's own carbon footprint i.e. the emissions caused by our own use of buildings and travel. These savings may not always be reflected in those of the wider city if reductions in council activity are offset by increases in community or business activity. For example, where council facilities need to be closed and sold/transferred, their use by community groups or businesses will still generate emissions.

- The constraints on both revenue and capital are likely to reduce opportunities for the council to invest in projects to reduce carbon emissions and to make the city more resilient to the changing climate, except where a compelling 'spend-to-save' business case can be made or external grant funding can be secured.

17.3.3 Efforts should continue to develop financial and environmental 'win-win' climate projects, such as those which can cut council energy/fuel bills and carbon emissions. Likewise, any opportunities to secure external funding for climate work should be sought.

17.3.4 More specific climate emergency implications will continue to be provided for individual decisions regarding projects and service/policy changes relating to implementing the budget strategy.

APPENDIX 1

Budget Ceilings

[to follow]

APPENDIX 2

Scheme of Virement

1. This appendix explains the scheme of virement which will apply to the budget, if it is approved by the Council.

Budget Ceilings

2. Directors are authorised to vire sums within budget ceilings without limit, providing such virement does not give rise to a change of Council policy.

3. Directors are authorised to vire money between any two budget ceilings within their departmental budgets, provided such virement does not give rise to a change of Council policy. The maximum amount by which any budget ceiling can be increased or reduced during the course of a year is £500,000. This money can be vired on a one-off or permanent basis.

4. Directors are responsible, in consultation with the appropriate Deputy/Assistant Mayor if necessary, for determining whether a proposed virement would give rise to a change of Council policy.

5. Movement of money between budget ceilings is not virement to the extent that it reflects changes in management responsibility for the delivery of services.

6. The City Mayor is authorised to increase or reduce any budget ceiling. The maximum amount by which any budget ceiling can be increased during the course of a year is £5m. Increases or reductions can be carried out on a one-off or permanent basis.

7. The Director of Finance may vire money between budget ceilings where such movements represent changes in accounting policy, or other changes which do not affect the amounts available for service provision. The Director of Finance may vire money between budget ceilings to reflect where the savings (currently shown as summary figures in Appendix One) actually fall.

8. Nothing above requires the City Mayor or any director to spend up to the budget ceiling for any service. At the end of the year, underspends on any budget ceiling shall be applied:

   (a) Firstly, to offset any overspends in the same department;

   (b) Secondly, to the corporate reserve for future budget pressures.

Corporate Budgets

9. The following authorities are granted in respect of corporate budgets:

   (a) the Director of Finance may incur costs for which there is provision in miscellaneous corporate budgets, except that any policy decision requires the approval of the City Mayor;

   (b) the Director of Finance may allocate the provision for pay awards and other inflation;

Earmarked Reserves

10. Earmarked reserves may be created or dissolved by the City Mayor. In creating a reserve, the purpose of the reserve must be clear.

11. Directors may add sums to an earmarked reserve from a budget ceiling, if the purposes of the reserve are within the scope of the service budget, and with the agreement of the Director of Finance. This cannot take place at year end (see para. 8 above).

12. Directors may spend earmarked reserves on the purpose for which they have been created.

13. When an earmarked reserve is dissolved, the City Mayor shall determine the use of any remaining balance.

14. The City Mayor may transfer any sum between earmarked reserves.

Other

15. The City Mayor may amend the flexible use of capital receipts policy, and submit revised policies to the Secretary of State.

Equality Impact Assessment

Equality Impact Assessment (EIA) Tool:

Title of proposal	Council tax increase for 2026/27
Name of division/service	Corporate
Name of lead officer completing this assessment	Catherine Taylor, Financial Strategy Manager
Date EIA assessment commenced	3rd November 2025
Date EIA assessment completed *(prior to decision being taken as the EIA may still be reviewed following a decision to monitor any changes)*	
Decision maker	Council
Date decision taken	25 February 2026

EIA sign off on completion:	**Signature**	**Date**
Lead officer	Catherine Taylor	21 November 2025
Equalities officer (has been consulted)	Surinder Singh	21 November 2025
Divisional director	Amy Oliver	4 December 2025

Please ensure the following:

a) That the document is **understandable to a reader who has not read any other documents** and explains (on its own) how the Public Sector Equality Duty is met. This does not need to be lengthy but must be complete and based in evidence.
b) That available support information and data is identified and where it can be found. Also be clear about highlighting gaps in existing data or evidence that you hold, and how you have sought to address these knowledge gaps.
c) That the equality impacts are capable of aggregation with those of other EIAs to identify the cumulative impact of all service changes made by the council on different groups of people.
d) That the equality impact assessment is started at an early stage in the decision-making process, so that it can be used to inform the consultation, engagement and the decision. It should not be a tick-box exercise. Equality impact assessment is an iterative process that should be revisited throughout the decision-making process. It can be used to assess several different options.
e) Decision makers must be aware of their duty to pay 'due regard' to the Public Sector Equality Duty (see below) and 'due regard' must be paid before and at the time a decision is taken. Please see the Brown Principles on the equality intranet pages, for information on how to undertake a lawful decision-making process, from an equalities perspective. Please append the draft EIA and the final EIA to papers for decision makers (including leadership team meetings, lead member briefings, scrutiny meetings and executive meetings) and draw out the key points for their consideration. The Equalities Team provide equalities comments on reports.

1. Setting the context

Describe the proposal, the reasons it is being made, and the intended change or outcome. Will the needs of those who are currently using the service continue to be met?

Purpose

The Council has a legal obligation to set a balanced budget each year. There remains a difficult balance between funding services for those most in need, maintaining support for most vulnerable and the investment required to ensure the effective delivery of services. Council Tax is a vital funding stream for the Council to fund essential services. This appendix presents the draft equalities impact of a proposed 4.99% council tax increase. This includes a precept of 2% for Adult Social Care, as permitted by the Government without requiring a referendum.

Alternative options

The realistic alternative to a 5% council tax increase would be a lower (or no) increase. A reduced tax increase would represent a permanent diminution of our income unless we hold a council tax referendum in a future year. In my view, such a referendum is unlikely to support a higher tax rise. It would also require more cuts to services in later years (on top of the substantial cost savings already required by the budget strategy).

The budget situation is already extremely difficult, and it seems inevitable that further cuts will have severe effects on front-line services. It is not possible to say precisely where these future cuts would fall; however, certain protected groups (e.g. older people; families with children; and people with disabilities) could face disproportionate impacts from reductions to services.

Mitigating actions

The Council has a range of mitigating actions for residents. These include: funding through the new Crisis & Resilience Fund, which replaces the Household Support Fund and Discretionary Housing Payments from April 2026, direct support through Council Tax Discretionary Relief (which increased by 50% from £500,000 to £750,000 from April 2025 for two years) and Community Support Grant awards; the council's work with voluntary and community sector organisations to provide food to local people where it is required – through the network of food banks in the city; through schemes which support people getting into work (and include cost reducing initiatives that address high transport costs such as providing recycled bicycles); and through support to social welfare advice services.

2. Equality implications/obligations

Which aims of the Public Sector Equality Duty (PSED) are likely be relevant to the proposal? In this question, consider both the current service and the proposed changes.

a. Eliminate unlawful discrimination, harassment and victimisation

- How does the proposal/service aim to remove barriers or disproportionate impacts for anyone with a particular protected characteristics compared with someone who does not share the same protected characteristics?
- Is this a relevant consideration? What issues could arise?

The Council Tax decision, as part of the overall budget strategy, aims to balance the funding of services for those in need, maintaining support for most vulnerable and the investment required to ensure the effective delivery of services. It does not, in itself, make specific decisions about the delivery of those services; which will be the subject of separate decisions with their own equality assessments, where appropriate.

b. Advance equality of opportunity between different groups

- Does the proposal/service advance equality of opportunity for people?
- Identify inequalities faced by those with specific protected characteristic(s).
- Is this a relevant consideration? What issues could arise?

By securing funding, the proposal aims to advance equality of opportunity by maintaining services that support independence and quality of life for these key protected groups, thereby reducing inequalities they face.

c. Foster good relations between different groups

- Does the service contribute to good relations or to broader community cohesion objectives?
- How does it achieve this aim?
- Is this a relevant consideration? What issues could arise?

Securing a sustainable budget for local services contributes to community stability and social cohesion. Effective, well-funded services that support vulnerable residents can help indirectly in fostering good relations.

3. Who is affected?

Outline who could be affected, and how they could be affected by the proposal/service change. Include people who currently use the service and those who could benefit from, but do not currently access the service. Where possible include data to support this.

Who is affected by the proposal?

As at October 2025, there were 133,220 properties liable for Council Tax in the city (excluding those registered as exempt, such as student households).

Under the CTSS scheme, “vulnerable” households with low income are eligible for up to 100% support, limited to the amount payable on a band C property. Other low income households are eligible for up to 80% support, limited to the amount payable on a Band B property. Households deemed vulnerable are defined in the scheme which uses proxies to identify disability and/or caring responsibilities.

Council tax support for pensioner households follows different rules. Low-income pensioners are eligible for up to 100% relief on the total amount payable.

How are they affected?

The table below sets out the financial impact of the proposed council tax increase on different properties, before any discounts or reliefs are applied. It shows the weekly increase in each band, and the minimum weekly increase for those in receipt of a reduction under the CTSS for working-age households who are not classed as vulnerable. [Under the scheme introduced last year, households classified as vulnerable can access up to 100% CTSS support]

Band	No. of Properties	Weekly increase (£)	Minimum Weekly Increase under CTSS (£)
A-	411	1.08	0.22
A	77,960	1.29	0.26
B	26,994	1.51	0.30
C	15,571	1.72	0.52

D	6,667	1.94	0.73
E	3,432	2.37	1.16
F	1,530	2.80	1.59
G	613	3.23	2.02
H	42	3.88	2.67
Total	133,220		

In most cases, the change in council tax (around £1.51 per week for a band B property with no discounts; and just 30p per week if eligible for the maximum 80% reduction for non-vulnerable households under the CTSS) is a small proportion of disposable income, and a small contributor to any squeeze on household budgets. A council tax increase would be applicable to all properties - the increase would not target any one protected group, rather it would be an increase that is applied across the board. However, it is recognised that this may have a more significant impact among households with a low disposable income.

Households at all levels of income have seen their real-terms income decline in recent years due to cost-of-living increases, and wages that have failed to keep up with inflation; although inflation has fallen more recently. These pressures are not limited to any protected group; however, there is evidence that low-income families spend a greater proportion of their income on food and fuel (where price rises have been highest), and are therefore more affected by price increases.

A 3.8% uplift to most working-age benefits, in line with CPI inflation, will come into effect from April 2026, while the State Pension and pension-age benefits will increase by 4.8%. The Local Housing Allowance rates for 2026/27 have not yet been announced. [NB council and housing association tenants are not affected by this as their rent support is calculated differently and their full rent can be compensated from benefits].

4. Information used to inform the equality impact assessment

- What **data, research, or trend analysis** have you used?
- Describe how you have got your information and what it tells you
- Are there any gaps or limitations in the information you currently hold, and how you have sought to address this? E.g. proxy data, national trends, equality monitoring etc.

Information on the properties subject to Council Tax is obtained from the Council's own systems. We do not hold detailed information on council taxpayers' protected characteristics; national and local economic data has been used to help assess the likely impact on different groups.

5. Consultation

Have you undertaken consultation about the proposal with people who use the service or people affected, people who may potentially use the service and other stakeholders? What did they say about:

- What is important to them regarding the current service?
- How does (or could) the service meet their needs? How will they be affected by the proposal? What potential impacts did they identify because of their protected characteristic(s)?
- Did they identify any potential barriers they may face in accessing services/other opportunities that meet their needs?

Draft budget will be published in early December in advance of the final decision in February

6. Potential Equality Impact

Based on your understanding of the service area, any specific evidence you may have on people who use the service and those who could potentially use the service and the findings of any consultation you have undertaken, use the table below to explain which individuals or community groups are likely to be affected by the proposal because of their protected characteristic(s). Describe what the impact is likely to be, how significant that impact is for individual or group well-being, and what mitigating actions can be taken to reduce or remove negative impacts. This could include indirect impacts, as well as direct impacts.

Looking at potential impacts from a different perspective, this section also asks you to consider whether any other particular groups, especially vulnerable groups, are likely to be affected by the proposal. List the relevant groups that may be affected, along with the likely impact, potential risks and mitigating actions that would reduce or remove any negative impacts. These groups do not have to be defined by their protected characteristic(s).

Protected characteristics

Impact of proposal:
Describe the likely impact of the proposal on people because of their protected characteristic and how they may be affected. Why is this protected characteristic relevant to the proposal? How does the protected characteristic determine/shape the potential impact of the proposal? This may also include **positive impacts** which support the aims of the Public Sector Equality Duty to advance equality of opportunity and foster good relations.

Risk of disproportionate negative impact:
How likely is it that people with this protected characteristic will be disproportionately negatively affected? How great will that impact be on their well-being? What will determine who will be negatively affected?

Mitigating actions:
For disproportionate negative impacts on protected characteristic/s, what mitigating actions can be taken to reduce or remove the impact? You may also wish to include actions which support the positive aims of the Public Sector Equality Duty to advance equality of opportunity and to foster good relations. All actions identified here should also be included in the action plan at the end of this EIA.

a) Age

Indicate which age group/s is/ are most affected, either specify general age group (children, young people, working aged people or older people) or specific age bands.

What is the impact of the proposal on age?

Older people (pension age and older) are least affected by a potential increase in council tax and can access more generous (up to 100%) council tax relief. However, in the current financial climate, a lower council tax increase would require even greater cuts to services in due course. While it is not possible to say where these cuts would fall exactly, there are potential negative impacts for this group as older people are the primary service users of Adult Social Care.

While employment rates remain high, earnings have not kept up with inflation in recent years so working families are likely to already be facing pressures on households' budgets. Younger people, and particularly children, were more likely to be in poverty before the current cost-of-living crisis and this is likely to have continued.

What is the risk of disproportionate negative impact on age?

Working age households and families with children – incomes squeezed through reducing real-terms wages.

What are the mitigating actions?

Lower-income households will have access to the Council Tax Support Scheme, providing up to 100% support for "vulnerable" households and up to 80% for other low income households.

In addition, households will have access to council discretionary funds for individual financial crises; access to council and partner support for food; and advice on managing household budgets.

b) Disability

A person has a disability if she or he has a physical or mental impairment which has a substantial and long-term adverse effect on that person's ability to carry out normal day-to-day activities. If specific impairments are affected by the proposal, specify which these are. Our standard categories are on our equality monitoring form – physical impairment, sensory impairment, mental health condition, learning disability, long standing illness, or health condition.

What is the impact of the proposal on disability?
Disabled people are more likely to be in poverty. Many disabled people will be classed as vulnerable in the proposed new CTSS scheme and will therefore be protected from the impact of a council tax increase.

However, in the current financial climate, a lower council tax increase would require even greater cuts to services in due course. While it is not possible to say where these cuts would fall exactly, there are potential negative impacts for this group as disabled people are more likely to be service users of Adult Social Care.

What is the risk of disproportionate negative impact on disability?
Further erode quality of life being experienced by disabled people.

What are the mitigating actions?
The CTSS scheme has been designed to give additional support (up to 100%) to vulnerable households. It also allows support at the level of the band C tax, rather than band B as applies to non-vulnerable households.

In addition, households will have access to council discretionary funds for individual financial crises; access to council and partner support for food; and advice on better managing budgets.

Ensure all information and advice relating to the CTSS scheme, discretionary funds, and support services is available and provided in a range of accessible formats.

c) Gender reassignment

Indicate whether the proposal has potential impact on trans men or trans women, and if so, which group is affected. a trans person is someone who proposes to, starts, or has completed a process to change his or her gender. A person does not need to be under medical supervision to be protected.

What is the impact of the proposal on gender reassignment?
No disproportionate impact is attributable specifically to this characteristic.

What is the risk of disproportionate negative impact on gender reassignment?
N/A

What are the mitigating actions?
N/A

d) Marriage and civil partnership

Please note that the under the Public Sector Equality Duty this protected characteristic applies to the first general duty of the Act, eliminating unlawful discrimination, only. The focus within this is eliminating discrimination against people that are married or in a civil partnership with regard specifically to employment.

What is the impact of the proposal on marriage and civil partnership?

No disproportionate impact is attributable specifically to this characteristic

What is the risk of disproportionate negative impact on marriage and civil partnership?
N/A

What are the mitigating actions?
N/A

e) Pregnancy and maternity

Does the proposal treat someone unfairly because they're pregnant, breastfeeding or because they've recently given birth.

What is the impact of the proposal on pregnancy and maternity?

Someone who is pregnant or recently given birth often have lower incomes during the period immediately before and after childbirth, when they may be receiving statutory maternity pay or no pay at all.

What is the risk of disproportionate negative impact on pregnancy and maternity?

Household may have a lower income during this period and be disproportionated impacted by the increase in Council Tax.

What are the mitigating actions?

Lower-income households will have access to the Council Tax Support Scheme, providing up to 100% support for “vulnerable” households and up to 80% for other low income households.

In addition, households will have access to council discretionary funds for individual financial crises; access to council and partner support for food; and advice on managing household budgets.

f) Race

Race refers to a group of people defined by their race, colour, and nationality (including citizenship) ethnic or national origins. A racial group can be made up of two or more distinct racial groups, for example Black Britons, British Asians, British Sikhs, British Jews, Romany Gypsies and Irish Travellers.

What is the impact of the proposal on race?

Those with white backgrounds are disproportionately on low incomes (indices of multiple deprivation) and in receipt of social security benefits. Some ethnic minority people are also low income and on benefits.

What is the risk of disproportionate negative impact on race?

Household income being further squeezed through low wages and reducing levels of benefit income.

What are the mitigating actions?
Lower-income households will have access to the Council Tax Support Scheme, providing up to 100% support for “vulnerable” households and up to 80% for other low income households.

In addition, households will have access to council discretionary funds for individual financial crises; access to council and partner support for food; and advice on managing household budgets.

Where required, interpretation and translation services will be provided to remove barriers in accessing support/advice.

g) Religion or belief

Religion refers to any religion, including a lack of religion. Belief refers to any religious or philosophical belief and includes a lack of belief. Generally, a belief should affect your life choices or the way you live for it to be included in the definition. This must be a belief and not just an opinion or viewpoint based on the present state of information available and;

- be about a weighty and substantial aspect of human life and behaviour
- attain a certain level of cogency, seriousness, cohesion, and importance, and
- be worthy of respect in a democratic society, not incompatible with human dignity and not in conflict with fundamental rights of others. For example, Holocaust denial, or the belief in racial superiority are not protected.

Are your services sensitive to different religious requirements e.g., times a customer may want to access a service, religious days and festivals and dietary requirements

What is the impact of the proposal on religion or belief?
No disproportionate impact is attributable specifically to this characteristic

What is the risk of disproportionate negative impact on religion or belief?
N/A

What are the mitigating actions?
N/A

h) Sex

Indicate whether this has potential impact on either males or females.

What is the impact of the proposal on sex?
Disproportionate impact on women who tend to manage household budgets and are responsible for childcare costs. Women are disproportionately lone parents, who are more likely to experience poverty.

What is the risk of disproportionate negative impact on sex?
Incomes squeezed through low wages and reducing levels of benefit income. Increased risk for women as they are more likely to be lone parents.

What are the mitigating actions?
If in receipt of Universal Credit or tax credits, a significant proportion of childcare costs are met by these sources.

Lower-income households will have access to the Council Tax Support Scheme, providing up to 100% support for “vulnerable” households and up to 80% for other low income households.

In addition, households will have access to council discretionary funds for individual financial crises; access to council and partner support for food; and advice on managing household budgets.

i) Sexual orientation

Indicate if there is a potential impact on people based on their sexual orientation. The Act protects heterosexual, gay, lesbian or bisexual people.

What is the impact of the proposal on sexual orientation?
Gay men and Lesbian women are disproportionately more likely to be in poverty than heterosexual people and trans people even more likely to be in poverty and unemployed. This would mean they are more likely to be on benefits.

What is the risk of disproportionate negative impact on sexual orientation?
Household income being lowered wages and reducing levels of benefit income.

What are the mitigating actions?
Lower-income households will be have access to the Council Tax Support Scheme, providing up to 100% support for “vulnerable” households and up to 80% for other low income households.

In addition, households will have access to council discretionary funds for individual financial crises; access to council and partner support for food; and advice on managing household budgets.

7. Summary of protected characteristics

a. Summarise why the protected characteristics you have commented on, are relevant to the proposal?
Some protected groups are more likely to be in poverty or have low disposable income, and therefore a council tax increase may have a more significant impact.

b. Summarise why the protected characteristics you have not commented on, are not relevant to the proposal?
For some groups no disproportionate impact has been identified. Individuals in these groups will still be able to access CTSS and discretionary support based on their specific circumstances.

8. Armed Forces Covenant Duty

The Covenant Duty is a legal obligation on certain public bodies to 'have due regard' to the principles of the Covenant and requires decisions about the development and delivery of certain services to be made with conscious consideration of the needs of the Armed Forces community.

When Leicester City Council exercises a relevant function, within the fields of healthcare, education, and housing services it must have due regard to the aims set out below:

a. **The unique obligations of, and sacrifices made by, the Armed Forces**
   These include danger; geographical mobility; separation; Service law and rights; unfamiliarity with civilian life; hours of work; and stress.

b. **The principle that it is desirable to remove disadvantages arising for Service people from membership, or former membership, of the Armed Forces**
   A disadvantage is when the level of access a member of the Armed Forces Community has to goods and services, or the support they receive, is comparatively lower than that of someone in a similar position who is not a member of the Armed Forces Community, and this difference arises from one (or more) of the unique obligations and sacrifices of Service life.

c. **The principle that special provision for Service people may be justified by the effects on such people of membership, or former membership, of the Armed Forces**
   Special provision is the taking of actions that go beyond the support provided to reduce or remove disadvantage. Special provision may be justified by the effects of the unique obligations and sacrifices of Service life, especially for those that have sacrificed the most, such as the bereaved and the injured (whether that injury is physical or mental).

Does the service/issue under consideration fall within the scope of a function covered by the Duty (healthcare, education, housing)? Which aims of the Duty are likely be relevant to the proposal? In this question, consider both the current service and the proposed changes. Are members of the Armed Forces specifically disadvantaged or further disadvantaged by the proposal/service? Identify any mitigations including where appropriate possible special provision.

No specific impacts have been identified on members, or former members, of the Armed Forces.
Individuals facing a significant impact will have access to a range of mitigating measures as above.

9. Other groups

Other groups

Impact of proposal:
Describe the likely impact of the proposal on children in poverty or any other people who we may consider to be vulnerable, for example people who misuse substances, care leavers, people living in poverty, care experienced young people, carers, those who are digitally excluded. List any vulnerable groups likely to be affected. Will their needs continue to be met? What issues will affect their take up of services/other opportunities that meet their needs/address inequalities they face?

Risk of disproportionate negative impact:
How likely is it that this group of people will be negatively affected? How great will that impact be on their well-being? What will determine who will be negatively affected?

Mitigating actions:
For negative impacts, what mitigating actions can be taken to reduce or remove this impact for this vulnerable group of people? These should be included in the action plan at the end of this EIA. You may also wish to use this section to identify opportunities for positive impacts.

a. Care Experienced People

This is someone who was looked after by children's services for a period of 13 weeks after the age of 14', but without any limit on age, recognising older people may still be impacted from care experience into later life.

What is the impact of the proposal on Care Experienced People?
No disproportionate impact is attributable specifically to this characteristic. Indeed, many pay no council tax at all as a result of a specific discount and will therefore not be affected by the increase.

What is the risk of negative impact on Care Experienced People?
N/A

What are the mitigating actions?
Qualifying care experienced people up to the age of 25 can apply for a 100% discount on their council tax.

b. Children in poverty

What is the impact of the proposal on children in poverty?
Even a relatively small increase in the amount payable may

What is the risk of negative impact on children in poverty?
A relatively small increase in the amount payable may have a more significant impact among households with a low disposable income.

What are the mitigating actions?
Lower-income households will be have access to the Council Tax Support Scheme, providing up to 100% support for “vulnerable” households and up to 80% for other low income households.

In addition, households will have access to council discretionary funds for individual financial crises; access to council and partner support for food; and advice on managing household budgets.

c. Other (describe)

What is the impact of the proposal on any other groups?
N/A

What is the risk of negative impact on any other groups?
N/A

What are the mitigating actions?
N/A

10. Other sources of potential negative impacts

Are there any other potential negative impacts external to the service that could further disadvantage service users over the next three years that should be considered? For example, these could include:

- other proposed changes to council services that would affect the same group of service users;
- Government policies or proposed changes to current provision by public agencies (such as new benefit arrangements) that would negatively affect residents;
- external economic impacts such as an economic downturn.

Government policy on welfare benefits (including annual uprating) will also have an impact, although it is not yet possible to predict what this will be.

11. Human rights implications

Are there any human rights implications which need to be considered and addressed (please see the list at the end of the template), if so, please outline the implications and how they will be addressed below:

N/A

12. Monitoring impact

You will need to ensure that monitoring systems are established to check for impact on the protected characteristics and human rights after the decision has been implemented. Describe the systems which are set up to:

- monitor impact (positive and negative, intended and unintended) for different groups
- monitor barriers for different groups
- enable open feedback and suggestions from different communities
- ensure that the EIA action plan (below) is delivered.

If you want to undertake equality monitoring, please refer to our equality monitoring guidance and templates.

Click or tap here to enter text.

13. EIA action plan

Please list all the equality objectives, actions and targets that result from this assessment (continue on separate sheets as necessary). These now need to be included in the relevant service plan for mainstreaming and performance management purposes.

Equality Outcome	Action	Officer Responsible	Completion date
Ensure residents are aware of available financial help.	Clearly signpost support available about the Council Tax Support Scheme (CTSS) and Discretionary Relief funds.	Cory Laywood, Head of Revenues & Benefits and Transactional Finance	ongoing

Human rights articles:

Part 1: The convention rights and freedoms

Article 2: Right to Life

Article 3: Right not to be tortured or treated in an inhuman or degrading way

Article 4: Right not to be subjected to slavery/forced labour

Article 5: Right to liberty and security

Article 6: Right to a fair trial

Article 7: No punishment without law

Article 8: Right to respect for private and family life

Article 9: Right to freedom of thought, conscience and religion

Article 10: Right to freedom of expression

Article 11: Right to freedom of assembly and association

Article 12: Right to marry

Article 14: Right not to be discriminated against

Part 2: First protocol

Article 1: Protection of property/peaceful enjoyment

Article 2: Right to education

Article 3: Right to free elections

APPENDIX 4

MEDIUM TERM PROJECTIONS

1. Summary Forecasts

The table below shows our central forecasts of the position for the next three years, based on the information we have at the time of writing. As funding allocations for future years have not yet been announced, and are the subject of a significant national review, this is necessarily based on some broad assumptions.

We will receive our local settlement for 2026/27 in December; the projections will be updated for the 2026/27 budget report to Council in February. We are expecting this to be a multi-year settlement which will give us some clarity on funding for **The forecasts are volatile**, and the key risks are described at paragraph 2 below. In particular, because we are relying on one off money to balance the budget, a change in annual spending requirement will have a multiplicative effect (e.g. an increase in spending of £5m per year from 2026/27 will lose us £15m from reserves by the end of 2028/29, all other things being equal).

	2026/27	**2027/28**	**2028/29**
	£m	£m	£m
Net service budget	456.8	481.7	506.2
Provision for pay inflation	6.0	12.0	18.0
Corporate budgets (including capital finance)	12.4	13.7	15.6
Housing Benefits	1.5	1.5	1.5
Costs of new waste contract			2.5
General contingency for risk	1.0	1.0	1.0
Planning Total		2.0	4.0
Expenditure total	**477.7**	**511.9**	**548.9**
Income:			
Council tax	179.3	189.4	200.0
Collection Fund surplus	0.8		
Settlement Funding Assessment	275.5	286.0	299.6
Extended Producer Responsibility for Waste	7.4	6.0	5.2
Income total	**463.0**	**481.3**	**504.8**
Recurring budget gap	(14.7)	(30.5)	(44.0)

Based on these forecasts, our budget strategy reserves position is expected to be:

	2025/26 £m	2026/27 £m	2027/28 £m	2028/29 £m
At the beginning of the year	**193.8**	**129.9**	**101.7**	**71.2**
Add: Forecast rates pool surplus	7.5			
Reserve restatements:				
From earmarked reserves		0.5		
Set aside for DSG deficit	(44.8)			
Set aside for LGR transitional costs		(14.0)		
Minus budget gap	(26.6)	(14.7)	(30.5)	(44.0)
At the end of the year	**129.9**	**101.7**	**71.2**	**27.2**

2. Assumptions and Risks

The assumptions in the forecast, and the inherent risks, are explained below.

Spending	Assumptions – central scenario	Risks
Pay costs	We assume a pay award averaging 3% each year	Inflation has fallen since its peak of 11.1% in 2022, although it has increased in recent month and remains above the 2% target. It stood at 3.8% in the year to September 2025.
Non-pay inflation	It is assumed that departments will be able to continue absorbing this. The exceptions are independent sector care package costs, fostering allowances, and the waste management contract; an allowance is built in for these increases.	
Adult social care costs	Demographic pressures and increasing need lead to cost pressures which are reflected in the forecasts. The effect of the mitigation measures is also reflected in the forecasts.	Adult Social Care remains the biggest area of Council expenditure, and is demand led. Small variations have a significant impact on the Council's overall budget.
Costs relating to looked after children	Mitigation work is able to reduce the annual cost increase to 6.5% (lower than the trend in recent years)	Further increase in demand and associated costs. Projections can be volatile as there are a small number of very high-cost placements.
Support to homeless families	Growth in the budget assumes the successful implementation of cost control measures, including a £50m investment in properties for use as temporary accommodation.	Further increase in the number of households presenting as homeless requiring the use of expensive hotel accommodation
Housing Benefit costs	The proposed budget includes £1.5m per year to meet the net subsidy loss on supported housing elements of Housing Benefit.	Will require powers expected under the Supported Housing Act to deliver savings against current trends.
Waste contract	The current contract for waste collection expires in 2028. The tender process for a new contract is underway; it is expected that the new contract will involve an increase in costs from 2028/29 onwards.	Difficult to predict costs of new contract at this stage.
Other service cost pressures	A £1m contingency budget has been built into the forecasts to provide some cushion against uncertainty. Aside from this, it is assumed that departments are able to find savings to manage cost pressures within their own areas.	Costs assume the delivery of proposed savings for which delivery plans will be vital. Some are subject to consultation, which may result in a different decision to that currently proposed.

	A planning provision of £2m has been included for 2027/28 rising to £4m by 2028/29.	
Departmental savings	The budget strategy assumes savings totalling £23m by 2027/28, of which £14m has been achieved to date.	Risk that savings are not achieved or are delayed, leading to a greater call on reserves to balance the budget. Costs assume the delivery of proposed savings for which delivery plans will be vital. Some are subject to consultation, which may result in a different decision to that currently proposed.
DSG deficit	The cumulative deficit on DSG is forecast to reach up to £78m by April 2028, when the current "override" ends. Forecasts in this report do not include this deficit.	It is not clear how this national issue will be resolved, and whether local authorities will have to meet some or all of their costs from general resources.

Income	**Assumptions – central scenario**	**Risks**
Council Tax	Band D Council Tax will increase by 5.0% per year in line with expected referendum limits. Council taxbase (the number of properties that pay tax) will increase by 500 Band D properties per year.	Further economic downturn leading to increased costs of council tax support to residents on a low income. The government may make changes to the council tax banding system or to discounts and exemptions,
Business rates	The net impact of the current revaluation and rates reset will be neutral, i.e. any gain or loss in rates income is balanced by government support. No significant movements in the underlying baseline for business rates. Government changes to business rates (e.g. new reliefs) will continue to be met by additional government grant, in line with recent years.	Significant empty properties and / or business liquidations reduce our collectable rates.
Government grant	The results of the Fair Funding review will not be announced until the local government finance settlement in December. Up to date figures will be included in the budget report to Council in February. For this draft report, forecasts are informed by modelling work commissioned from external consultants.	Key elements of the review are still subject to government decisions and data updates. Our available resources will inevitably change from these forecasts, and this could be substantial. In future years, the overall quantum of funding for local government may change as a result of the wider fiscal and economic position.
Extended Producer Responsibility funding	The provisional allocation for 2026/27 (£7.4m) is included in the draft budget. It is assumed that income from the scheme falls thereafter as producers take steps to reduce their charges payable.	Income in future years is highly uncertain, and partly depends on the response from producers to the new charges.

Appendix 5

Earmarked Reserves

(to follow)

Appendix 6

Council Tax Premiums - Empty Property and Second Homes

1. This appendix sets out our policy on charging council tax premiums on empty properties.

2. In general, our policy is to use premiums to help bring empty properties back into use, as owners take steps to avoid the extra charges. There is a shortage of housing in Leicester. We want to see as many empty homes as possible made available for occupation. The changes will also raise additional revenue for the Council (to the extent that properties remain empty).

Substantially Unfurnished Empty Properties (referred to as long term empty properties)

3. Since 2013, councils have had considerable discretion over the levels of tax payable on unfurnished empty properties (Local Government Finance Act, 1992 and associated regulations). Our policy seeks to use this discretion to support our empty homes policy by charging the maximum permitted premiums for these homes, subject to any applicable exemptions

4. Assuming the recommendations in this report are approved, our policy for charging council tax on substantially unfurnished empty properties from 1st April 2026 will be:

Description	Tax charge as a percentage of the standard tax (inclusive of premium)
Empty for less than one year	100%
Empty for at least one year	200%
Empty for at least five years	300%
Empty for at least ten years	400%

Substantially Furnished Empty Properties (referred to as second homes)

5. The Levelling Up and Regeneration Act 2023 permits authorities to charge a council tax premium of up to 100% on substantially furnished homes, only occupied periodically, and which are no one's main residence, often referred to as second homes.

6. Our policy for charging council tax on substantially furnished empty properties from 1st April 2026 is:

Description	Tax charge as a percentage of the standard tax (inclusive of premium)
Empty (substantially furnished)	200%

Exemptions to premiums

7. From 1st April 2025, the Government has introduced the following mandatory exemptions to premiums, in addition to those already in place for unoccupied properties under the Council Tax (Exempt Dwellings) Order 1992. A local policy has been published on our website to give further guidance on how each premium exemption will be applied in practice.

Classes of Dwellings	Applies to	Exemption
Class E	Already applies to long term empty homes but extended to second homes from 1st April 2025	Dwelling which is or would be someone's sole or main residence if they were not residing in job-related armed forces accommodation.
Class F	Already applies to long term empty homes but extended to second homes from 1st April 2025	Annexes forming part of, or being treated as part of, the main dwelling
Class G	Long term empty homes and second homes	Dwellings being actively marketed for **sale** (12 months' limit)
Class H	Long term empty homes and second homes	Dwellings being actively marketed for **let** (12 months' limit)
Class I	Long term empty homes and second homes	Unoccupied dwellings which fell within exempt Class F and where probate has recently been granted (12 months from grant of probate/letters of administration)
Class J	Second homes only	Job related dwellings
Class K	Second homes only	Occupied caravan pitches and boat moorings
Class L	Second homes only	Seasonal homes where year-round, permanent occupation is prohibited, specified for use as holiday accommodation or planning condition preventing occupancy for more than 28 days continuously
Class M	Long term empty homes	Empty dwellings requiring or undergoing major repairs or structural alterations (12 months limit)

Appendix 7

Council Tax Support Scheme

1. The Council is required to maintain a Council Tax Support Scheme (CTSS) in respect of dwellings occupied by persons we consider to be in financial need. A new scheme was approved by Full Council in January 2025.

2. No substantive changes to the scheme are proposed for 2026/27. The only revision proposed is to uprate thresholds by 3.8% in line with the majority of welfare benefits (and the CPI measure of inflation from September 2025) (and used to uprate the majority of benefit rates from April 2026). The previous scheme maintained between 2013 and 2024 was also uprated annually on the same basis. The new bands including this uprating will be as shown:

		Vulnerable					Other				
Band	**Discount**	**Single Person**	**Couple with no children**	**Couple or Lone Parent with one child/ young person**	**Couple or Lone Parent with two children/ young persons**	**Couple or Lone Parent with three or more children/ young persons**	**Single Person**	**Couple with no children**	**Couple or Lone Parent with one child/ young person**	**Couple or Lone Parent with two children/ young persons**	**Couple or Lone Parent with three or more children/ young persons**
		Weekly Net Income									
1	100%	£0 to £155.70	£0 to £155.70	£0 to £155.70	£0 to £207.60	£0 to £259.50	N/A	N/A	N/A	N/A	N/A
2	75%	£155.71 to £233.55	£155.71 to £233.55	£155.71 to £311.40	£207.61 to £363.30	£259.51 to £415.20	£0 to £155.70	£0 to £155.70	£0 to £155.70	£0 to £207.60	£0 to £259.50
3	50%	£233.56 to £311.40	£233.56 to £311.40	£311.41 to £389.25	£363.30 to £415.20	£415.21 to £467.10	£155.71 to £233.55	£155.71 to £233.55	£155.71 to £311.40	£207.61 to £363.30	£259.51 to £415.20
4	25%	£311.41 to £389.25	£311.41 to £389.25	£389.26 to £467.10	£415.21 to £519	£467.11 to £570.90	£233.56 to £311.40	£233.56 to £311.40	£311.41 to £389.25	£363.30 to £415.20	£415.21 to £467.10
5	0%	£389.26+	£389.26+	£467.11+	£519.01+	£570.91+	£311.41 +	£311.41 +	£389.26 +	£415.21 +	£467.11 +

3. The alternative would be to freeze the bandings at their 2025/26 cash levels. This would lead to some households receiving lower levels of support or dropping out of the scheme entirely.

APPENDIX 8

Flexible Use of Capital Receipts policy

(to follow)

Appendix C

Prevention and Health Inequalities Steering Group Annual Review

Public Health and Health Integration Scrutiny Commission

Date of meeting: 27th January 2026

Lead director/officer: Rob Howard

Useful information

- Ward(s) affected: All
- Report author: Dr Katherine Packham, Consultant in Public Health, Sharon Mann, Programme Manager
- Author contact details: Katherine.packham@leicester.gov.uk
- Report version number: 1

1. Summary

1.1 The Prevention and Health Inequalities Steering group was established in June 2024. It was designed to take an 'incident management team' (IMT) approach to build on the successful approach, learning and outcomes of the Measles IMT-based response. The group is chaired by the Director of Public Health, with the vision that the group would focus on a few priorities at a time and take an action-oriented approach to the identified priorities, identifying areas of particular concern based on health and wellbeing outcomes in Leicester.

2. Recommended actions/decision

2.1 Public Health and Health Integration Scrutiny Commission (Scrutiny Commission) are asked to note the contents of this report, and future plans. Members are invited to comment or ask questions about the work.

3. Scrutiny / stakeholder engagement

3.1 Stakeholder engagement remains ongoing. The Prevention and Health Inequalities Steering Group maintains links with the Voluntary, Community, and Social Enterprise (VCSE) Alliance and Healthwatch, involving them as appropriate. A wider stakeholder group was involved in the initial workshop (see below). This report will be taken to Scrutiny Commission on 27th January 2026.

4. Background and options with supporting evidence

4.1 The Leicester City Prevention and Health Inequalities Steering Group is a strategic group that provides direction and alignment on prevention priorities to address health inequalities in Leicester. It reports to both the Leicester Integrated Health and Care Group, and Health and Wellbeing Board (HWB) and is a subgroup of HWB.

4.2 In June 2024, the Director of Public Health established a new initiative in Leicester to address health inequalities with urgency and focus. The group brings together senior officers from Public Health and Social Care, the NHS Integrated Care Board, and major NHS provider organisations. Its purpose is to take an action-oriented approach to prevention activities, targeting the root causes of inequality and improving outcomes for local communities.

4.3 The first meeting of the group was in June 2024 with a workshop of a much wider range of stakeholders held in August 2024 to inform the decision of which health and wellbeing challenges would form the initial set of priorities for the steering group. The group decided on the following five priorities for the next 18 months:

- Hypertension (High Blood Pressure) case finding
- Healthy weight (neighbourhood focus)

- HPV (Human Papillomavirus) vaccine uptake
- Social isolation in people with severe mental illness
- Bowel cancer screening uptake

4.4 Each of these issues would be tackled through a task and finish group consisting of subject experts and interested partners, with updates and reporting back to the steering group on a regular basis, including barriers and challenges that may require intervention, support or resources from the steering group. The Task and Finish (T&F) groups are encouraged to focus on actions that can be quickly implemented at a local/neighbourhood level, in a similar way to the solutions identified from the Measles Incident Management Team. The T&F groups were set up in autumn/winter 24/25 and have now been running for 12 months.

4.5 This work has already gained national recognition. The Local Government Association (LGA) highlighted Leicester's efforts in its case study *Leicester City Council: Treating health inequalities as a public health emergency | Local Government Association*, showcasing the city's commitment to tackling disparities in health with the same seriousness as an emergency response.

4.6 A summary of the progress of the task and finish groups follows.

Hypertension (High Blood Pressure) case finding
Chair: Amy Endacott (Public Health)

- Identified priority communities at higher risk of hypertension, including Westcotes, City Central, and residents aged 40+, enabling more targeted outreach.
- Delivered over 100 blood pressure checks through partnership with the roving health unit, alongside follow-up advice to support early detection and management.
- Expanded community pharmacy hypertension case-finding into off-site community settings, including two Leicester City Council health events providing more than 150 tests combined.
- Raised awareness of blood pressure and cardiovascular risk at major community events such as the Caribbean Carnival, Leading Better Lives, local mosques, and within the Sri Lankan/Tamil community.
- Conducted around 50 additional blood pressure tests in community venues including men's sports groups and food hubs, supported by GP registrars and public health staff.
- Developed a standard operating procedure to enable consistent, safe delivery of blood pressure testing by the public health team.
- Planning to scale delivery through workplace engagement, particularly among routine and manual workers aged 40+, and through collaboration with local VCSE organisations.
- Strengthening partnership with primary care to deliver targeted NHS Health Check invitations, ensuring those at greatest risk are reached and supported.

Healthy weight (neighbourhood focus)
Chair: Amy Hathway

- NHS Healthy Weight Declaration adopted across University Hospitals of Leicester (UHL), Leicestershire Partnership Trust (LPT), the NHS Integrated Care Board and Primary Care Networks, demonstrating strong system-wide commitment.

- Lead officer identified within LPT and a dedicated UHL working group established to support implementation.
- Declaration successfully progressed through UHL governance processes, with a system update presented to the Health and Wellbeing Board on 25 September 2025.
- Targeted neighbourhood work delivered, including parenting programmes to support healthy family lifestyles, with strong uptake of healthy lifestyle courses.
- Two-year contract for continued delivery of parenting and healthy lifestyle programmes due to be awarded, ensuring stability and ongoing community engagement.
- Activity contributes to the wider whole-systems approach to healthy weight, combining strategic commitments with practical community-based interventions to drive sustainable change and improved health outcomes.

HPV (Human Papillomavirus) vaccine uptake
Chair: Annie Traynor (NHS Integrated Care Board)

- HPV data dashboard now operational, capturing data from a range of delivery partners to enable breakdown by different groups to consider health inequalities in the delivery of the HPV programme.
- The NHS e-consent system introduced in September 2025 has streamlined the consent process, and GPs are now actively calling and recalling unvaccinated 16 to 18-year-olds.
- Engagement with secondary school heads, school nurses, and education settings has strengthened efforts to support uptake, alongside targeted communications to FE colleges, sixth forms, and universities.
- Community-focused work has expanded through partnerships with faith leaders, community representatives, and VCSE organisations to improve culturally sensitive outreach.
- Local insight has improved through an Leicester, Leicestershire and Rutland survey and a University of Leicester research project exploring knowledge among parents, teachers, and students.
- School Aged Immunisation Service has increased accessibility by using sexual health clinic space at The Haymarket to deliver mop-up vaccinations during school holidays.

Social isolation in people with severe mental illness
Chairs: Kate Galoppi (Adult Social Care) and Kate Huszar (Public Health)

- Questions about social activity have been built into the Leicestershire Partnership Trust client journal, helping ensure that loneliness and social isolation are routinely recognised in the client journey for people with severe mental illness.
- Mapping of venues and activities has created a clearer picture of local provision and strengthened the foundation for coordinated support.
- Key delivery partners across sectors have been identified, improving collaboration and enabling more joined-up work to support people with severe mental illness.

- A toolkit will be developed for voluntary, community and social enterprise organisations to strengthen their skills, confidence and consistency when supporting people with severe mental illness.
- Professionals will be provided with clear signposting information to help connect individuals to appropriate activities and support.

Bowel cancer screening uptake
Chair: Sally Le-Good (NHS Integrated Care Board)

- Implemented a new bowel screening pathway for asylum seekers, with development underway for a similar pathway for people experiencing homelessness.
- Secured East Midlands Cancer Alliance funding for a city-wide bus-back advertising campaign to raise awareness of bowel screening.
- Delivered engagement and awareness sessions with care home forums to encourage screening completion.
- Introduced text reminders and secured funding for instructional videos within South Leicester City Primary Care Network, informed by patient interviews on screening barriers.
- Provided targeted support for people with learning disabilities through Leicestershire Partnership Trust nurses to ensure equitable access.
- Implemented the extension of bowel screening eligibility to people aged 50+ from November 2024.
- Next steps include rolling out video-based text reminders, finalising the homelessness pathway, launching the advertising campaign, and continuing city-wide awareness work with VCSE partners, the NHS Integrated Care Board and University Hospitals of Leicester.

Next steps

4.7 Prevention and Health Inequalities Steering group continues to meet quarterly and receive progress updates from the five task and finish (T&F) groups. The steering group can provide direction and support or can assist with overcoming barriers and challenges faced in implementing the actions identified in each of the T&F groups.
The five priorities described above continued throughout 2025 and have been running for approximately 12 months.

4.8 A review of priorities will take place at the start of 2026. The ongoing evaluation, which includes a desk-based review of the work, alongside focus groups and interviews with the five task and finish groups, will be considered together with updated health and wellbeing data to shape priorities for the following 18 months. The evaluation is expected to be completed in March 2026.

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

5.1 Financial implications

There are no direct financial implications arising from this report.
Signed: Mohammed Irfan
Dated: 09/01/26

5.2 Legal implications

There appear to no adverse legal implications arising from the content of this report.
Signed: Mannah Begum, Principal Solicitor, Commercial Legal Team
Dated: 08 January 2026

5.3 Equalities implications

When making decisions, the Council must comply with the public sector equality duty (Equality Act 2010) by paying due regard, when carrying out their functions, 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. 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.

This Report provides an annual review of the Prevention and Health Inequalities Steering Group, detailing the progress made on five specific health priorities over the last year. The work of the Prevention and Health Inequalities Steering Group is inherently designed to address disparities in health outcomes that disproportionately affect residents based on their protected characteristics.

To address systemic health disparities, current initiatives focus on removing barriers for specific protected groups through community-based outreach and tailored clinical support. The use of the HPV data dashboard and JSNAs allows the Council to monitor outcomes by protected characteristic, ensuring that "due regard" is informed by robust local evidence. The transition to the 2026 priority review should continue to use Equality Impact Assessments where significant service changes are proposed to ensure no group is inadvertently disadvantaged.

Equalities Officer, Surinder Singh, Ext 37 4148
Dated 9 January 2026

5.4 Climate Emergency implications

There are limited climate emergency implications directly associated with this report. However, as service delivery 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. In addition, work which encourages and enables sustainable behaviours such as increased levels of physical activity and healthy eating may have further co-benefits for tackling the climate emergency. Where relevant, information about the climate benefits of such actions could also be included in communications as part of the programmes.

Phil Ball, Sustainability Officer, Ext 372246
8th January 2026

5.5 Other implications (You will need to have considered other implications in preparing this report. Please indicate which ones apply?)

6. Background information and other papers:

7. Summary of appendices:

8. Is this a private report (If so, please indicate the reasons and state why it is not in the public interest to be dealt with publicly)?

9. Is this a "key decision"? If so, why?

Leicester Prevention and Health Inequalities Annual Review

Public Health and Health Integration Scrutiny Commission

Tuesday 27th January 2026

Leicester City Council

Leicester Prevention and Health Inequalities Steering Group: Introduction

- Established in June 2024 by the Director of Public Health
- Comprises senior officers from Public Health and Social Care, NHS Integrated Care Board, large NHS provider organisations
- Created to take an action-oriented approach to focused prevention activities to reduce health inequalities in Leicester
- Reports to Leicester's Health and Wellbeing Board
- Evaluation to identify future areas best suited to this incident management type approach
- LGA case study highlighted our work Leicester City Council: Treating health inequalities as a public health emergency | Local Government Association

Leicester City Council

Leicester City Council: Treating health inequalities as a public health emergency

Leicester City Council enjoyed great success in curbing an outbreak of measles by developing a rapid response involving a mobile vaccination service

Public health | 28 May 2025

Overview

Leicester City Council enjoyed great success in curbing an outbreak of measles by developing a rapid response involving a mobile vaccination service. The success prompted the council's public health team to ponder what would happen if they deployed public health emergency techniques to tackling health inequalities. The result has been a new approach with five priority areas targeted for action with the aim on getting some quick, high-impact wins.

> "There is a tendency when it does not involve an infectious disease to try to spread ourselves too thinly and try to do a bit of everything. So we thought we would look at what in terms of prevention and health inequalities we could treat as a public health emergency and see what impact it could have" – Rob Howard, Director of Public Health

Leicester City Council

Leicester City – Prevention and Health Inequalities Steering Group

Purpose

The Leicester City Prevention and Health Inequalities Steering Group is a strategic group that provides direction and alignment on prevention priorities to address health inequalities in the City. It reports to both the Leicester Integrated Health and Care Group and Leicester Health and Wellbeing Board

Leicester City Council

Priorities Highlights

Priority	Achievements
Hypertension (High Blood Pressure)	Targeted high-risk communities and delivered 300+ blood pressure checks through expanded community, pharmacy and event-based outreach.
Healthy weight (neighbourhood focus)	System-wide NHS organisations adopted the Healthy Weight Declaration, supported by neighbourhood programmes and a new two-year contract to continue delivery.
HPV (Human Papillomavirus) vaccine uptake	Strengthened HPV uptake through improved data, school and community engagement, GP follow-up, and more accessible catch-up clinics.
Social isolation in people with severe mental illness	Built stronger support by identifying loneliness in the LPT client journey, mapping local activities, improving signposting, and developing a VCSE toolkit.
Bowel cancer screening uptake	Introduced new pathways for vulnerable groups, expanded reminders and awareness campaigns, and increased targeted support to boost screening uptake.

Leicester City – Prevention and Health Inequalities Steering Group

Next steps

- Steering group continues to meet quarterly.
- Review of priorities in early 2026
  - Evaluation and review of data due for completion in March 2026.
- Agree priorities for next 18 months.

Leicester City Council

Appendix D

Leicester City Council

Cost of Living, Food Poverty and Fuel Poverty

Public Health and Health Integration Scrutiny Commission

Date of meeting: 27/01/2026

Lead director/officer: Edward Quick

Useful information

- Ward(s) affected: All
- Report author: Edward Quick/Rumaysa Jassat
- Author contact details: Edd.Quick@Leicester.gov.uk
- Report version number: 5

1. Summary

This report aims to update around cost-of-living projects being managed by the Health in All Policies (HIAP) team.

Through this update we intend to bring Public Health and Health Integration Scrutiny Commission up to speed in terms of our current positions and priorities across a series of operational delivery areas.

Please note that the matters reported on here have progressed through Public Health Departmental Management Team, and Public Health Lead Member Briefing and so where data is included it is captured up to the end of August 2025. The figures included are intended to provide an indication of direction of travel. If required, end of year figures can be provided in due course.

The report covers:

Fuel Poverty
Involving the raising of awareness of the health impacts of fuel poverty, and the provision of support for those experiencing fuel poverty in Leicester.

Access to period products
Involving the operational delivery of free period products made available without stigma within Leicester City Council libraries.

Food Poverty & Feeding Leicester
Involving the coordination and development of the Feeding Leicester group, and the operational development and implementation of free school meal auto-enrolment within Leicester.

Cost of Living meetings
Involving changes to the cost-of-living meetings that HIAP facilitate.

2. Recommendation(s) to scrutiny:

Public Health and Health Integration Scrutiny Commission Scrutiny Commission are invited to:

- Recognise and approve the direction of travel for Fuel Poverty work
- Recognise and approve the direction of travel of work relating to access to period products.

- Recognise and approve the direction of travel relating to food poverty and Feeding Leicester
- Recognise and approve the direction of travel around Free School Meals (FSM) auto-enrolment
- Note the direction of travel around the cost-of-living group

3. Detailed report

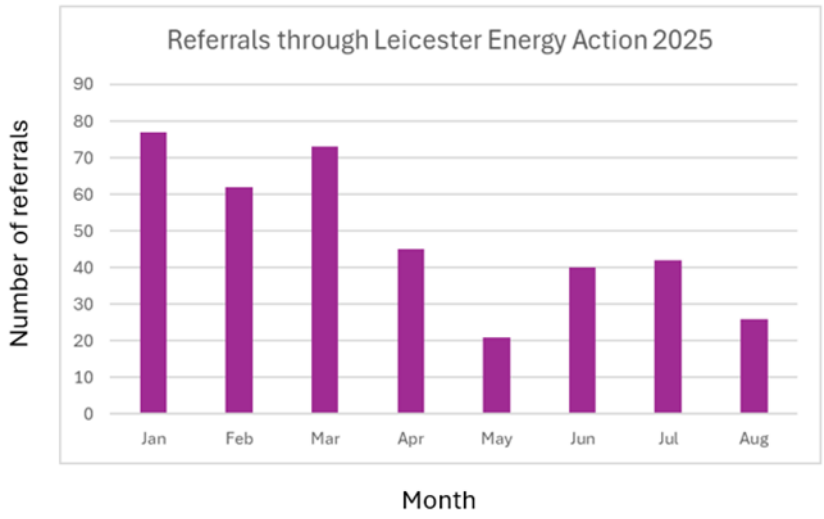
3.1 Fuel Poverty

Fuel Poverty has a devastating impact on physical and mental health. Although the formal Leicester Energy Action programme ended in winter 2024, the support infrastructure that was built remains in place, well-maintained, and well-used. While National Energy Action (NEA) continue their fantastic work nationwide, not least through the Warm Homes, Healthy Futures programme, HIAP keep a close relationship with our NEA counterparts, and continue to work to raise awareness and open access channels to support within Leicester. The NEA team can work with clients around energy debt, to ensure that they are able to manage energy in their home, and to make their home as energy efficient as it can be.

3.1.2 2025 (post Leicester Energy Action) referral data

The referral channels created through the Leicester Energy Action project remain active and well-used by referral partners, in particular front-line LCC teams such as Supporting Tenants and Residents (STAR). We have worked to ensure that there is no referral criteria into support. We also promote self-referral channels including a direct contact telephone number.

Number of referrals per month (January-August 2025)



Since the programme closed in December 2024 we've received 386 referrals – similar numbers to those we received during the programme and following a similar pattern of higher referral numbers during colder months. Although the clients referred to the service

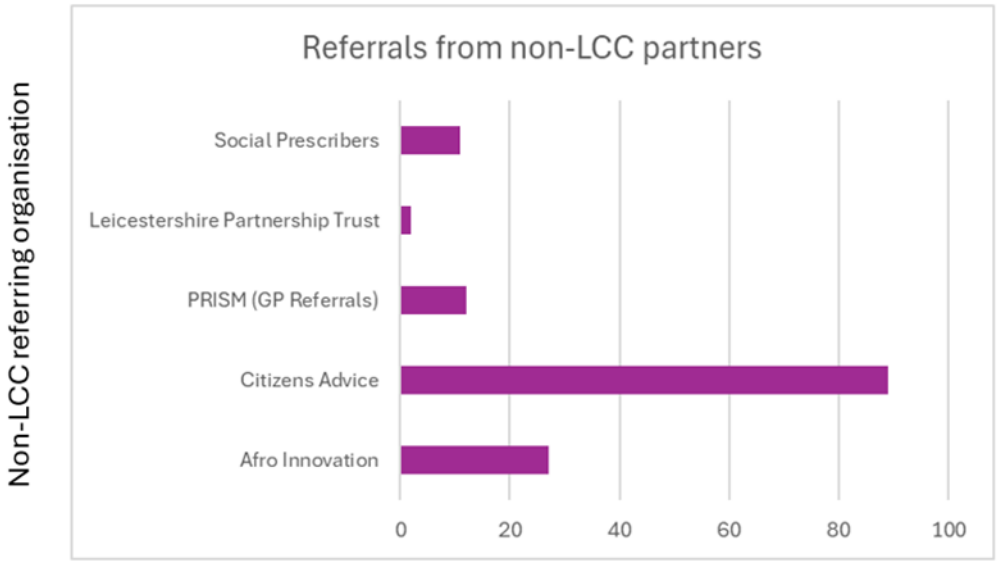
are no longer linked to a dedicated Leicester-based team, the service they receive remains in line with the high standards delivered throughout the Leicester Energy Action project. The NEA team also continue to escalate cases to HIAP where there is a concern that direct Leicester City Council intervention is needed, particularly around housing repair issues.

Number of referrals by referring organisation (January-August 2025)

Referrals by referring organisations

66% of the 2025 referrals have come from Leicester City Council teams, with 29% of total LCC referrals coming from STAR who have historically been (and continue to be) our most prolific referring service.

Referrals by non-LCC partners (January-August 2025)



Number of referrals

44% of referrals came from external partners.

Note that PRISM referrals are administered by HIAP after being completed within the GP office. We receive a formal referral from the PRISM system to a dedicated email inbox. This referral is then transcribed onto the Leicester Energy Action form. This process is in place because PRISM and the NEA systems cannot integrate, and although long-term alternatives are being explored the process functions adequately (note that only referrals from GP offices use PRISM).

There is a lot of scope for higher referral numbers from external partners, particularly from within the NHS and we are working to link key NHS teams with NEA directly.

Number of referrals by broad area

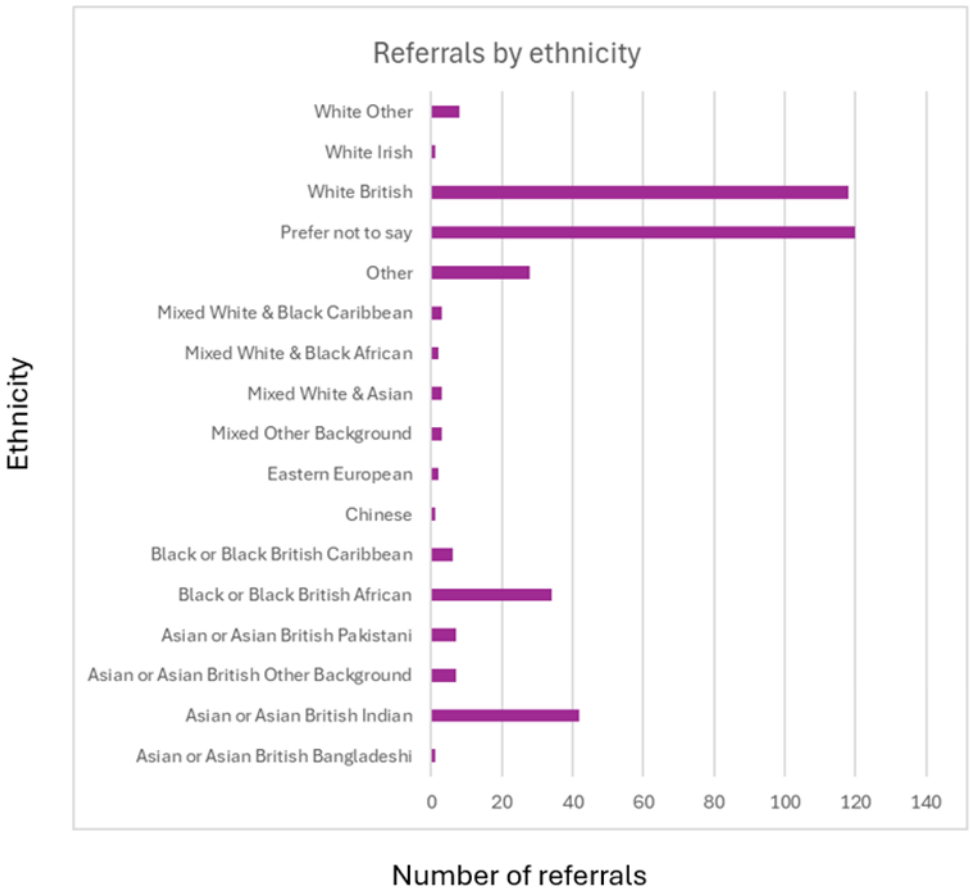
Broad area	No of referrals	Percentage of referrals (%)
Central	75	19.4
East	62	16.1
North	50	13.0
Northwest	51	13.2
South	54	14.0
West	81	21.0
#N/A	13	3.4
Overall Total	386	100.0

Number of referrals by IMD deprivation quintile

IMD Deprivation Quintile 2019	No of referrals	Percentage of referrals (%)
1	236	61.1
2	85	22.0
3	36	9.3
4	11	2.8
5	5	1.3
#N/A	13	3.4
Overall total	386	100.0

We've historically seen a spread of referrals from across all postcodes. This has continued into 2025. We also continue to see a higher level of referrals from more deprived parts of the city.

Referrals broken down by ethnicity (January-August 2025)



NEA continue to use a high-quality translation service ensuring that clients are contacted using their preferred language.

It is noted that the highest category is prefer not to say, and that this limits the usefulness of the data. NEA do work to encourage staff to obtain ethnicity, but it has historically been an area of data collection that returns a high level of these responses.

3.1.3 Moving forward

As we move through winter, we will be running promotional campaigns to reinforce the importance of getting clients connected to support around managing home energy and managing energy costs/debt issues.

Our key actions are:

Raising profile of PRISM access to service within GP surgeries

- Sending patients home to cold homes impedes recovery and worsens existing medical conditions. The PRISM process streamlines referrals from the GP office. Autumn/winter campaign to put the service in the forefront of GP's minds.

Raising awareness of health issues connected to living in a cold home, and promoting support channels within communities through engagement events, and promotion through Community Wellbeing Champions

- Teams will be attending community events, raising awareness of the impacts directly with those affected, and providing access channels to meaningful support, including providing the Leicester Energy Action referral links to staff within interested organisations so that they can refer people in need of help.

Engagement presence within LCC warm spaces

- LCC runs a programme of warm spaces within Libraries during the key winter period. Fuel poverty awareness and access to support channels will be represented and promoted at these warm spaces.

Referral channels within food aid hubs connected to Feeding Leicester and Leicester Food Partnership

- HEAT stations delivered by HIAP within food aid projects (providing hot drinks to people in the cold while simultaneously engaging with them around fuel poverty), and the ability for food hub staff to refer independently.

Support for staff within the NHS offered through Health and Wellbeing channels

- Working with UHL Head of Health and Wellbeing (after being connected through LCC's cost of living meetings) to provide links to support for internal communications. Will once again be representing support offer within hospital canteens during the winter.

Mirror of winter 2024 promotion campaign including social media and electronic boards within Leicester

- We'll be working with our comms team again to get important awareness-raising messages out to the public.

3.1.4 Evaluation

DMU are currently carrying out a formal evaluation of the Leicester Energy Action project. They are in the process of reaching out to stakeholders and clients, supported by both HIAP and DMU. We're anticipating that the evaluation report will be available in early 2026.

NEA have carried out their own internal evaluation which demonstrates some of the impacts and lessons learned from the project (appendix A, B, and C)

3.2 Access: Period Products

In 2024, the Health in All Policies team received £20,000 in funding from Household Support Fund to run 2 pilot schemes. The £20k funding has been split perfectly in half between the two workstreams.

1. Supporting members of the public to access sanitary products in their local libraries

2. Encouraging usage of sustainable period products, such as menstrual cups and period pants

3.2.1 Initial stages

3.2.1.1 Naming the project

In the planning stages, we wanted to ensure that this project would support in breaking down the stigma attached to periods and start to help in providing equitable access to sanitary products. As such, we wanted to avoid attaching the word ‘poverty’ to the project. The name, ‘Access: Period Products’, was chosen which clearly outlines what the project entails and seeks to avoid stigma and shame around the scheme.

3.2.1.2 Engaging with key teams and stakeholders

- We met with the Children’s Centre staff to learn best practice on how their 2022 pilot scheme was run and how they sustained the provision of free period products across all their sites.
- We worked alongside the libraries team to work out the logistics of running the pilot in library buildings. The team provided us with information on which libraries offered toilet facilities to the public and data on their current footfall. Beaumont Leys does not have toilet facilities accessible by the public and were excluded from the pilot. We developed a document for staff in libraries highlighting the importance of this scheme and our delivery requirements (Briefing document available on request).
- We engaged with Hey Girls, a social enterprise with an aim to eradicate period poverty in the UK, to set up the project. Through Hey Girls, we ordered our stock of menstrual products and obtained posters to display in library toilets.

3.2.2 Project initiation

3.2.2.1 Process documentation

To ensure a smooth launch of the scheme, a process map (available on request) and Gantt chart (available on request) were developed outlining the operational processes.

3.2.2.2 Launch

In December 2024, we received our first order of period products, which we subsequently organised into packs for each participating library. Each pack contained an appropriate amount (suitable for the footfall of the library) of day and night pads, regular and super tampons, baskets to present the products in toilets and 2 posters to be displayed in the toilets (available on request). We delivered the first batch of stock personally to meet the libraries teams and explain the processes of the programme; we were already receiving stock reports by Christmas.

3.2.3 Project established

Once the project was up and running smoothly, the libraries team supported us further by offering a member of staff to support on the operational delivery side of the project. We worked alongside the staff member to improve the programme's efficiency in terms of keeping on top of stock levels, packing and posting out products. This has proved to be effective and ensures the libraries are receiving a top-up of products in a timely fashion.

3.2.3.1 Current uptake from the beginning of the project

The figures below are correct as of end of August 2025. 15537 products have been distributed to libraries in total.

	Total products distributed to libraries	Total products remaining in libraries	Take up of products	% uptake against total sanitary products distributed
Day pads	6302	2500	3802	24.4%
Night pads	4280	2586	1694	10.9%
Regular tampons	2575	1145	1430	9.2%
Super tampons	2380	1052	1328	8.5%

3.2.4 Our activity

Through the Cost-of-Living IMT meeting, we linked up with the Head of Health and Wellbeing within the LPT to support NHS staff accessing sanitary products. Access: Period Products featured in the Health and Wellbeing newsletter which goes out to NHS staff, letting the NHS teams know about the offer within libraries.

We attended an events in August, October and December 2025 aimed at supporting families in temporary accommodation. Families in attendance were made aware of and encouraged to use the support offer in their local libraries.

3.2.5 2026 activity

- Evaluating the pilot scheme to understand the uptake levels, need and effectiveness of the project.
- Launching Access: Sustainable Period Products for residents in Leicester to try out more environmentally friendly sanitary products including period pants and menstrual cups. Products will be obtained through a web-link.

3.3 Feeding Leicester

Feeding Leicester is a collective of individuals and organisations within Leicester that seeks to address food poverty at both local and national level in cooperation with other organisations and as a partner of national charity Feeding Britain.

Leicester City Council has successfully facilitated Feeding Leicester since its inception in 2017.

Historically Feeding Leicester has focused on developing food aid projects from being food banks delivering emergency and free food, into affordable food provisions – development closely supported by Leicester Food Partnership and Leicester's Food Aid Coordinator.

It has also championed provision of wrap-around services in food projects, including provision of Food Bank Plus, and increasing Healthy Start and Free School Meals uptake. Public Health provide a support function to the group, supporting the independent chair to plan agendas, take forward actions where appropriate, and maintaining the group's action plan.

HIAP began facilitation of the group in March 2025 and have worked to formalise the steering group and make the group constituted (constitution documentation available on request)

Constituting the group was something that had been being discussed for some time; members wanted to be able to present a formal and unified voice through Feeding Leicester, reflecting work that collectives within other cities had undertaken under the Feeding Britain banner. There was also a drive for the group to be more independent of the local authority, while maintaining key local authority links – something supported by Public Health.

The Feeding Leicester approach to constituting was developed following exploration of how other groups had proceeded and was co-produced with members of the Feeding Leicester steering group.

We are now working to support Feeding Leicester in its key aims:

- Recognising, embracing and supporting the diverse groups and organisations providing affordable and emergency food in Leicester.
- Recognising both the diverse needs of the city, and the diversity of support provision, and seeking to provide a platform for networking, partnerships, information sharing, learning, and where necessary providing a unified voice representing member groups.
- Seeking to celebrate the efforts of local organisations, recognising the contributions being made to support the people of Leicester, and to support any member organisation where appropriate and within the constraints of Feeding Leicester's abilities.

3.3.1 Moving forward

From a Public Health perspective, we recognise that many of the communities accessing emergency food are the same communities that we want to support with public health

interventions. We will be working with Feeding Leicester to co-produce meaningful solutions to both introducing support channels and generating support uptake within food aid projects, building on the long-standing focus on provision of wrap-around services focusing on debt, welfare and mental health.

We have introduced NHS membership to the steering group and intend that NHS interventions are also introduced to food aid projects with support and promotion from the organisations that have trust and leadership within their communities.

We are in the process of creating and publishing a Feeding Leicester website which will provide a landing point for those seeking connection to the network, support and advice.

3.4 Free School Meals Auto Enrolment

As a further part of our Feeding Leicester facilitation, we are working to introduce auto enrolment to free school meals for eligible students within Leicester schools. Using an approach template provided by the Local Government Association (LGA) and following an action steer from the cost-of-living IMT we began the undertaking in 2025 and have established an operational group, developed an approach plan, and begun implementation of phase one; establishing that the IT processes involved can operate correctly and safely, and establishing the staffing resource necessary.

We are moving quickly toward phase two: presenting a full report including evidenced outcomes and costings to Heads of Service and which can then be taken forward for full approval.

We have recently carried out our first IT process test with promising results. Although the dataset we were able to obtain from finance was limited due to system issues with a third party supplier, our process identified 1157 students who are entitled to and are not currently receiving free school meals.

We have engaged with the Head of Revenues, Benefits and Transactional Finance to support us in obtaining the full data set that we need.

3.5 Cost of Living Group
It was requested that the Cost-of-living IMT meeting be reviewed to establish whether continuation of the meeting was necessary.

As group facilitators we surveyed members and produced a report into the meeting's activities (report available on request).

As a result, we have updated the meeting's terms of reference (available on request) and have provided the following recommendations:

- Cost-of-living meeting to continue but with the revised terms of reference reflecting that we are no longer managing a single incident, rather an ongoing issue. Meeting to be called Cost of Living Group
- Recommendation that we continue with 1-hour-long monthly meetings, particularly as we head into winter.
- HIAP to provide quarterly updates around meeting activity and deliverables

- Current members to decide whether to continue to attend themselves or to introduce a well-placed substitute
- HIAP to invite other suggested representatives in coordination with chair (education/employment hub/Care navigators etc)
- HIAP and CWC work to explore engaging community organisations around cost of living, but separately to the Cost-of-Living group.

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

4.1 Financial Implications

'There are no direct financial implications arising from this report. The report provides an update to the cost-of-living projects being delivered through Public Health within current available resources'. – Georgia Anderson, 19 January 2026

4.2 Legal Implications - There are no direct legal implications arising from this report.

Mannah Begum 16.01.26

Commercial Legal

4.3 Equalities Implications

Under the Equality Act 2010, the council has statutory duties, including the Public Sector Equality Duty (PSED). This requires that in carrying out their functions, they have due regard to the need to eliminate unlawful discrimination, harassment and victimisation, to advance equality of opportunity between people who share a protected characteristic and those who do not, and to foster good relations between those groups. Protected characteristics under the Act are age, disability, gender reassignment, pregnancy and maternity, race, religion or belief, sex, and sexual orientation.

Surinder Singh, 19 January 2026

4.4 Climate Emergency Implications

There are strong synergies between the climate and public health agendas. In the context of cost of living, primarily improving the energy efficiency of homes and promoting the use of sustainable period products will help to reduce energy consumption, consumer costs and waste in addition to the co-benefits of improved health and wellbeing.

Community engagement activities as described in the report can generate carbon emissions where they lead to additional travel by Public Health staff, members of the public or staff of partner organisations using private cars, taxis/private hire vehicles or buses. Consideration should be given to minimising these emissions where possible by following the 'travel hierarchy' in the Corporate Travel Policy for staff travel and by running engagement activities in settings close to the target audiences, or at events they are already attending.

Service delivery by the council and partners generally contributes to the council's carbon footprint so any potential impacts could be considered within delivery of related projects, such as encouraging the use of sustainable travel options, using buildings and materials efficiently and adopting updated practices that could help reduce the associated carbon emissions.
Signed: Phil Ball, Sustainability Officer, ext 372246
Dated: 19th January 2026

4.5 Other Implications None
Signed:
Dated:

5. Background information and other papers:

6. Summary of appendices:

Appendix A, B and C – National Energy Action Internal Evaluation of the Leicester Energy Action Project.

Health in All Policies

Fuel Poverty

Continuing provision – Leicester Energy Action changed the landscape

Building through Winter 2025

Evaluation

Access: Period Products

- Continuing operational success
- Permanent provision?
- Sustainable products initiative
- Potential for provision within locations connected to substance misuse
- Pilot evaluation

Food poverty

- Constituting and change of approach
- Resolving membership
- Website and more
- Holistic support offer including health support
- Free School Meals auto-enrolment

Cost of Living

‘’I think it is a useful and successful partnership meeting.’’

‘’As a group it would be good to be as flexible as possible to react to the changing landscape.’’

‘’From a health perspective it feels like a good opportunity to hear about things happening in the LA and to randomly share some NHS info - but it's not a vehicle for managing or tracking joint projects. I think we need a programme of work and a programme board.’’

‘’COL is still a big issue for many people and the meetings help to retain a focus on that’’

Leicester Energy Action: our impact

National Energy Action is the national fuel poverty charity, working to ensure that everyone in the UK can afford to live in a warm and safe home

Leicester Energy Action was funded by NHS Leicestershire, Leicester & Rutland, and worked in partnership with Public Health at Leicester City Council.

Targeting the most vulnerable households in the city, our Leicester-based team offered affordable warmth and energy efficiency advice directly to clients.

We delivered one-to-one advice, community engagement and group advice sessions, educational opportunities in schools, and training for front line workers.

Between February 2023 and November 2024

1,557

Clients supported

93%

Vulnerable in one or more ways

112

Community events held

1,264

People reached at events

We helped some of the most vulnerable households in Leicester

88%
were living on an income of less than £16,001 a year

54%
had a mental health condition

Physical health

- 18% had a physical impairment
- 17% had a cardiovascular condition
- 16% had a respiratory condition

26 languages, 16 communities

- 39.4% were White British
- 15.7% were Asian or Asian British
- 10.1% were Black, British African or British Caribbean

77% living in the rented sector

- 65% in socially rented sector
- 12% in private rented sector

62%
of those we supported said they had struggled to find help with their problem elsewhere

One quarter
of clients were single parents with dependent children

19%
had at least one child under the age of 5

36%
were lone person households

100% of our community outreach partners said there is a high level of need for our services in the area and that the information covered in the sessions:

- **Was of direct relevance to their service users**
- **Will help their service users to resolve issues themselves**
- **Was delivered in an accessible way for their service users**

'I was listened to empathetically and advised according to my needs' - client

'LEA are a quick, responsive service' - referral partner

'I found it helpful and a life saver, amazing advisor and caring team.' - client

We increased the number of households in Leicester that can manage their energy bills and keep warm and healthy at home

30%
reduction in experience of subjective fuel poverty

Almost a third
said that mould or dampness in their home had been reduced

81%
reduction in clients turning heating down or off all or most of the time due to worries over cost

75%
reduction in clients turning off essential devices such as medical equipment due to worries over cost

More than two fifths
said that the temperature in their home had improved

53%
said it was easier for them to control their heating system now

'I'm very grateful of all the help I was provided with! I'm very satisfied of the team that kept calling and making sure I don't need anything ! I'm so blessed' - client

'Very helpful people at NEA! I couldn't have done this without them. I can't fault them' - client

'LEA are local and sit within the council's public health team making them reliable and trustworthy for customer. They also have good link to other teams in the council such as the housing team so they are excellent at providing energy efficiency advice to council tenants who often don't qualify for advice from other services due to tenure.' – referral partner

We changed energy behaviors, improving residents' ability to navigate the energy market and make positive energy saving choices

59% felt more able to use and understand their smart meter

62% felt more confident in communicating with their energy supplier

59% knew more about saving energy at home while keeping comfortable and healthy

53% felt more able to understand and manage their energy bills

'[It's] more relaxing [now]. We can sit all comfortably. My son has special needs - he likes to sit and play with the family' - client

'Top service and have had great outcomes for tenants' – referral partner

We strengthened household resilience by relieving stress about fuel debt or problems with their energy supplier

£146,000

in client financial gains through energy advice

£21,690

secured for clients in fuel debt relief

£119,375

value of energy vouchers unlocked

£19,905

value of crisis fund support unlocked

21%

were enabled to reduce or pay off other debts, too

'As my only income is a state pension which barely covered the usual outgoings, the additional financial support from NEA enabled things to improve sharply, thereby reducing the constant concerns and worry.' - client

We achieved subjective improvement in health and wellbeing for residents

58%

of clients said their physical health had improved

58%

of clients said their mental health had improved

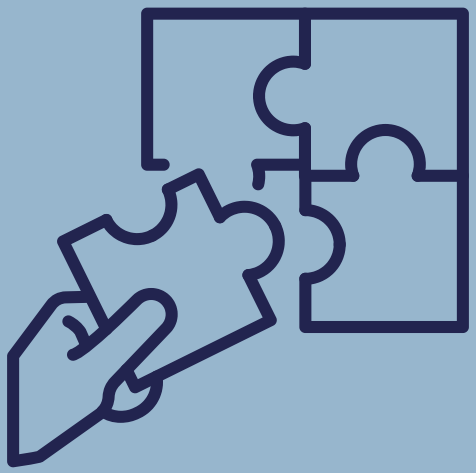
58%

of clients said their ability to cope with illness had improved

'With the support received my son was able to use his electric wheelchair all the time as we could afford to charge it. This helped him go out more.' - client

'Talking to a professional person and getting guidance made mental worry less and made me feel better' - client

We contributed to long-term strategic action in the area



Tackling fuel poverty is a key part of Leicester City Council's Public Health Strategy 2022-27

Eileen's story

Eileen is 65 years-old and lives in social housing. She is disabled and has long-term illnesses that are exacerbated by the cold, and she is on a low income. Eileen is house-bound and bedbound due to mobility issues and has care needs. She lives with her son who is in his late twenties and who has a learning disability as well as health issues.

Eileen was struggling to manage her bills and household costs. When she received gas bill of around £800 which she could not pay, her supplier said that a prepayment meter would need to be installed. Eileen begged them not to, particularly as she is bedbound and can't go outside to top up the meter. As a result, she stopped using gas at all. When the council came to conduct a gas safety check, they then capped the supply. Eileen had no gas or hot water for months.

The National Energy Action adviser supported Eileen by liaising with her supplier and raising a complaint. She liaised with the local council to arrange for her gas to be uncapped. The supplier repeatedly tried to close Eileen's case and insisted the complaint couldn't be kept open. After lengthy conversations with the supplier, they agreed that the debt could be paid back at £3.65 a week and that they would provide compensation of just over £100 due to the issues on their end. They also admitted that Eileen's meter was faulty.

As a result of receiving the support from National Energy Action, Eileen was able to live with heating and hot water, as well as able to top up her meter.

Leicester Energy Action: our learnings

National Energy Action is the national fuel poverty charity, working to ensure that everyone in the UK can afford to live in a warm and safe home

Leicester Energy Action was funded by NHS Leicestershire, Leicester & Rutland, and worked in partnership with Public Health at Leicester City Council.

Between February 2023 and November 2024, we delivered one-to-one advice, community engagement and group advice sessions across the city. We also provided innovative educational opportunities in schools, and crucial training for frontline workers.

Working with local and strategic partners to provide targeted, localised support

Use local datasets

to identify areas of high need (such as deprivation, fuel poverty and poor health).

Identify allies

in key sectors (like health and public health) who understand the impact of cold homes and fuel poverty upon health, and who are well placed to implement a process of systematic change to tackle local health inequalities.

Find where

you can work in partnership with others to reach common goals and achieve shared aims. Articulate the things you have in common in a way that is meaningful to those partners.

Embedding yourself

in a local area often requires a local presence. Someone who can reach out, network, and make personal connections on the ground.

That doesn't just happen within one single window or through a few connections – your local presence needs to be ongoing, flexible and able to diversify approaches and engagement techniques. It also needs to be visible.

Align actions

to address need with key local strategies and plans (like a public health or fuel poverty strategy) when engaging local authorities and health bodies like the NHS.

Take time

to understand the systems, practices and tools that are used by key allies and gate keepers (such as health sector funders or partners).

Gaining an in-depth understanding of data sharing opportunities (and having a clear understanding of local limitations for this) at programme outset can help you to identify how to best build a successful referral mechanism early on.

Take advantage

of local networks that you can tap into and through which you can grow your contacts. Be open to working with different kinds of partners and always have in mind how you could help those that they support (and vice versa). Help them to see the co-benefits of working with you.

Reach

those who can be challenging to engage by building strong relationships with partners who are already working with them and are trusted.

Building trust (with partners and clients) can take time. To make use of a service, people need to have confidence in it. Maximise the opportunities that early engagement can bring to demonstrate your commitment and perseverance. Evidence your good practice and share it. Be open and honest. Be ready to help.

Delivering high quality support and achieving the right outcomes

Take the time to understand the work that your referral partners carry out, and how they do it. Use opportunities to maximise contact, engagement and support for clients through partners, and to reduce duplication of effort.

If a partner carries out home visits, for example, they could assist with the completion of paperwork and submission of evidence while at a property.

Use opportunities to act through a single point of contact, to avoid overwhelming clients who may be vulnerable or likely to disengage.

Be clear on the scope and nature of support that will be provided through the project. Is it straightforward energy advice? Is it casework? Is it advocacy?

Deciding upon and understanding the nature of the support that is to be delivered can help inform your targeting approach, the type of referral relationships you develop, and the nature of outcomes you look to achieve for clients.

It can also help with capacity planning, and set staff expectations around how much time they are able to spend with a client and the depth of support they can provide.

Aligning different models of support provision within a project can help to reach different groups with varying levels of need/vulnerability in the most effective way.

For example, employing outreach techniques to deliver accessible advice within a community, while being able to refer through to in-depth casework via professionals for those who need additional/the most help.

The format and nature of support that you focus on should inform and be reflected in the size and extent of any target-based performance criteria placed upon a project.

Take an open and person-centred approach to the delivery of advice. Take time to ask questions that will help you to understand what is going on and how it is affecting someone. Avoid judgement. Be empathetic. Tease out the issues at play.

At the same time, understand and be clear on your organisational boundaries. Assess which of their issues you can support with directly, and where you may need to harness your local networks to put them in touch with the right agencies instead.

Ensuring that your service can advocate for clients can help make sure those who are vulnerable or unlikely to reach out/communicate by themselves can still access meaningful outcomes. Such models can have long lasting impact on confidence and capabilities, adding to the longevity of support.

Understanding the communities where you are working and ensuring you have the tools at hand to enable equal opportunities for engagement can make a huge difference to client advocacy.

For example, if you are working in communities where there are language barriers, ensure your service has adequate access to translation and interpretation services.

Incorporate assessments of client need and capabilities into onward referrals processes. Where clients are felt to require additional support to schedule and confirm appointments, ensure that this can be built into your processes to guarantee a high quality and successful referrals.

Taking the time to understand clients as people can help you to identify how to provide advice and support in the best and most effective way possible, to ensure meaningful outcomes and longer-lasting impacts.

Employing local people means you can maximise and build upon local connections – to generate referrals and to make referrals yourself. To engage with clients on the basis of shared community.

Raising standards and standardising behaviours through education and training

Build capacity

among the partners and stakeholders that you engage across a local area through training and education. This can help to raise and standardise the support landscape of a locality and improve the confidence and ability of different actors to give advice on key issues. This can in turn help to alleviate capacity demands on your own service, freeing up time to spend on the most vulnerable and most complex cases.

Aligning

your training offering with the local networks that you are working with to deliver direct support can help to generate high quality referrals and embed your service even further. This will also allow you to direct diverse training offerings (such as professional qualifications) to where they will make the most difference to both organisational practice and infrastructure.

Develop

educational offerings for schools that are tailored in ways that can be linked to National Curriculum and Schemes of Work objectives. This will help to make the opportunities you are offering a more viable and attractive activity for school partners to engage with.

Encourage

strategic and standardised approaches to the issues you want to tackle by encouraging and enabling networks of practitioners to come together – for example, by establishing a 'Let's Talk Energy group' for energy advice partners across a locality.

Link

your education offering with localised education networks and settings, securing buy-in from engaged individuals who can help recommend and promote what you have to offer. Cultivate positive relationships with partners to build trust with others in the sector. Take advantage of existing relationships and engagement routes held by gatekeeper allies (such as public health or local authorities).

Think about how your educational outreach work can align with your support service delivery. Identifying households and families in need through educational activities, and providing mechanisms through which they can access support if needed. Capitalise on the ability of education to increase knowledge and cascade energy advice directly into homes via young people and children.

Leicester Energy Action: training and education

National Energy Action is the national fuel poverty charity, working to ensure that everyone in the UK can afford to live in a warm and safe home

Leicester Energy Action was funded by NHS Leicestershire, Leicester & Rutland, and worked in partnership with Public Health at Leicester City Council.

Between February 2023 and November 2024, we delivered one-to-one advice, community engagement and group advice sessions across the city. We also provided innovative educational opportunities in schools, and crucial training for frontline workers.

We increased the number of frontline professionals, healthcare workers and volunteers with awareness of fuel poverty

313
professionals trained via interactive and informative webinars

66
frontline workers trained on the impacts of fuel poverty on mental health

65
professionals working to support households enabled to identify vulnerability in the energy market

38
local stakeholders with improved understandings of living with the energy crisis

34
frontline workers enabled to advise on paying for fuel

52
frontline workers with improved understanding of changing energy related behaviour

16
professionals with better knowledge on tackling the cold

42
introduced to domestic energy efficiency

18
professionals helping to standardise advice provided through City & Guilds Level 3 qualifications in Energy Awareness

We reached over 1,000 professionals across project engagement activities. We established our Leicester Energy Champions quarterly network – building systems, support and strength together to tackle the many challenges people living in fuel poverty face.

Embedding advice and support

94%
increase in delegates who rated their knowledge of the subject as excellent following our webinars

'Thought provoking ideas to save money for those on low income'

'I will use when dealing with people who struggle with mental health issues'

88%
increase in those who rated their confidence to give advice on the subject as excellent following our webinars

'I will be more proactive with asking patients questions about their heating and finances'

'It gives me more confidence to talk about energy saving measures'

87%
increase through our qualifications in those who rate their knowledge of the subject as good or excellent

87%
increase through our qualifications in those who rate their confidence to give advice on the subject as good or excellent

'I will definitely begin to have those conversations with families about their energy usage and their worries, now that I have the confidence to advise them and point them in the direction of funding and practical help too.'

'I will use the information to better help clients understand how to manage their environment in the most cost-effective way. I will test each case to check eligibility for grants and help clients apply.'

Atifa's learning journey

Atifa works with a group that supports people in Leicester communities with an array of issues. She attended the City & Guilds Level 3 Award in Energy Awareness training with Leicester Energy Action.

Since getting her qualification, she's started to run drop-in and appointment-based sessions in places like Wesley Hall, Belgrave Neighbourhood Housing Association, Angels and Monsters, Belgrave Library, Highfields Library, and Freedom Refugee Youth Club - all focusing on energy advice.

'I really enjoyed the course, honestly – it was great. I thought three days was going to feel long, but it didn't! I really did enjoy it. I was quite proud when the examiner emailed me. I was in the office. I ran downstairs to tell everyone I'd passed the exam! I was screaming because everyone knew I was waiting for the results.'

'One of my first cases came into a library to see me. They felt their energy bills were too high. I went through their bills with them, and we looked at other providers, and we had a conversation about behaviour change, about what habits they could change around the house. Everyone's worried about their bills, the prices of cost of living are just affecting everyone.'

We ensured that children are more energy knowledgeable, able to make better choices at home and cascade information to family and friends

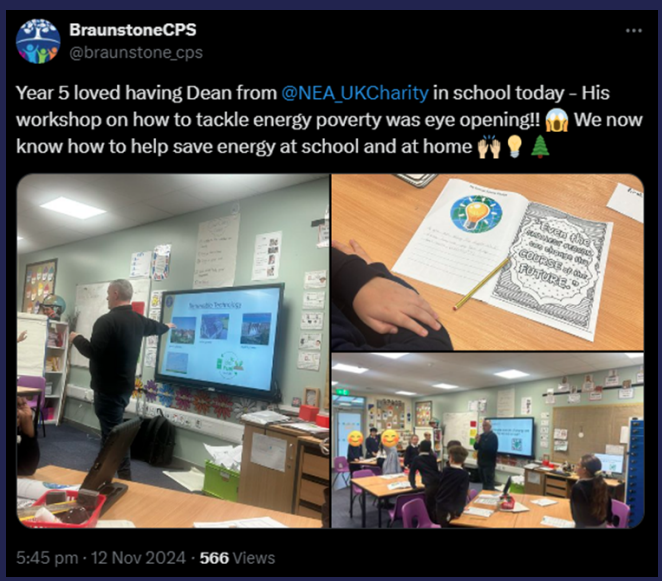
55
education workshops for Upper and Lower Key Stage Two children delivered in schools

1,646
primary school pupils empowered to learn about energy

96%
of schools were either very satisfied or satisfied with their workshop

100%
of schools rated the knowledge gained by children from the workshop as either good or excellent

100%
of schools rated the resources used during the workshop as either good or excellent



'I am going to tell my parents about this and that way we can as a family help save energy.'

'That was so cool I want to do energy jobs'

'I can't wait to go and talk to my parents about this and get them to turn the tv off standby'

'This will help me to protect our planet.'

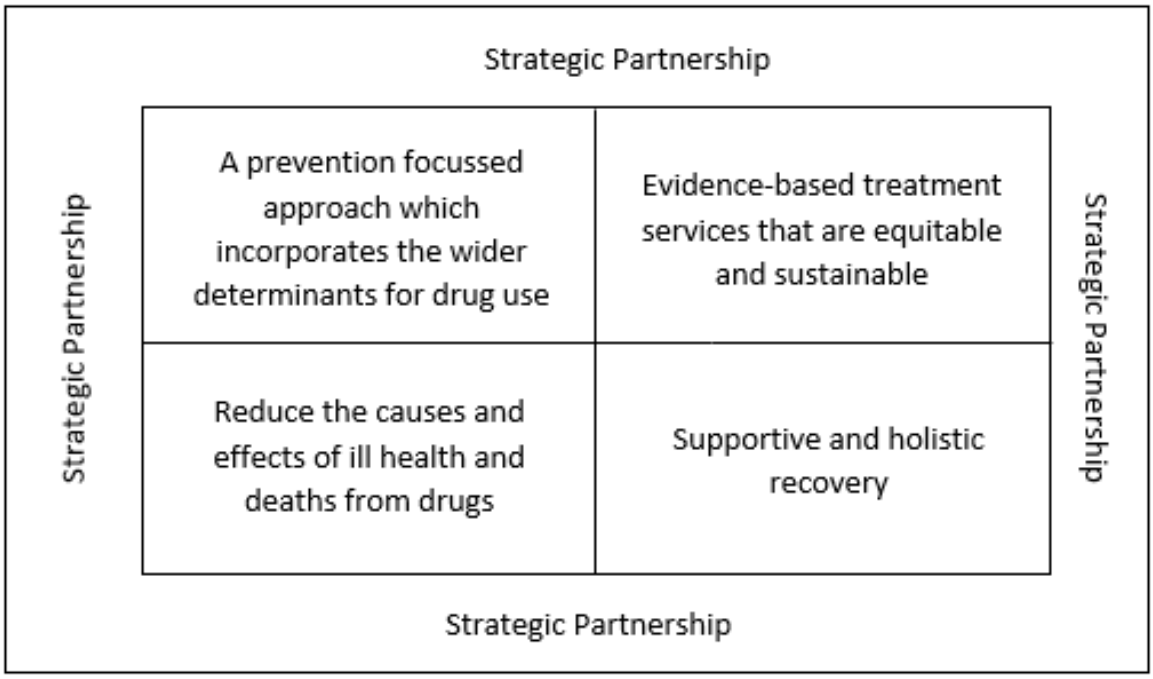
Appendix E

Leicester City drug and alcohol strategy Phase 3: 2025 - 2027

Background context

In 2021 the government published it's 10-year drug and alcohol strategy: From harm to hope detailing its plans and expectations for the coming years. Accompanying guidance outlined expectations for each locality to develop a Combatting drugs and alcohol partnership (CDAP).

A comprehensive drug and alcohol needs assessment was carried out in Leicester which formed the basis for a Leicester drug and alcohol strategy, developed during a series of multi-agency stakeholder workshops. Four cross-cutting themes were identified, underpinned by a principle of strategic partnership and 32 actions developed for implementation:



Work has been ongoing since then to implement the strategy with significant progress across all themes including:

- A significant increase in the number of adults accessing treatment from 2,087 in 2021 to 2,500 in 2024 (12 month rolling figure).
- People leaving prison more likely to engage in treatment upon release from 21% in 2021/22 to 55.2% in 2024/25.
- Increased harm reduction programmes including carriage of naloxone across multiple organisations and stakeholders. Partnership work with Leicestershire

police to carry naloxone was recognised with a LGA partnership award in June 2025.
- Significant expansion of outreach services including underserved communities.

Partners have always strived for a programme of continuous improvement and in December 2025 a further workshop was carried out to review and update the city drug and alcohol strategy. This third phase of the strategy builds on the successes and learning of the previous two years and:

a) Amalgamates with the original strategy to ensure no original objectives are lost.
b) Provides an overview of business-as-usual original objectives.
c) Introduces new objectives identified at the workshop alongside identified need.

Whilst the original strategy had three working groups and a city-wide oversight group to meet its objectives, feedback suggested that there was some overlap between groups. The new approach of six working groups attempts to provide a more focused approach with broader attendance and less duplication:

1) Service development and evaluation
2) Comms and engagement
3) Training, Education & Employment
4) Lived Experience
5) Night-time economy
6) Housing support and rough sleepers

Governance arrangements

Each working group feeds into the Leicester City CDAP delivery group which has oversight of:

- Required metrics
- The overall city drug and alcohol strategy
- Broader objectives within the strategy including police and probation
- City wide interventions
- Highlight reports from each working group.

The delivery group provides updates to the LLR CDAP Operational group which amalgamates city and county/Rutland needs assessments and strategies into a joint LLR drug and alcohol strategy. The operational group oversees implementation of the strategy including managing and responding to broader challenges and risks. In turn, it reports into the LLR Strategic Partnership CDAP developed and run in accordance with national guidance and accountable to the national Joint Combating Drugs Unit (JCDU) using the national combatting drugs outcomes framework. The strategic CDAP is jointly chaired by the respective Directors of Public Health.

Six Key Statements

Leicester has a high level of drug and alcohol need that is complex, detailed and difficult to summarise. However, we have developed six key statements that attempt to provide an overview of the scale and complexity of need in Leicester. More detailed and in-depth analysis is available via a comprehensive needs assessment.

- **Leicester experiences high levels of unmet need at similar levels to the national average**. In Leicester, around 80% of people who have problem drinking and around 50% of people who use opiates do not access treatment. Improving access and retention to high-quality treatment services is a key strategic priority.
- Leicester has one of the highest rates of self-reported abstinence in the country yet also has one of the highest rates of alcohol related mortality. **Our population experiences a greater level of harm in its lower number of drinkers.**
- **Drug related deaths are currently at the highest level since records began**. Leicester's rate is significantly higher than England at 14.7 deaths per 100,000 people. Naloxone saves lives by reversing the effect of opiate (e.g. heroin) overdose. It can be administered by anyone following brief training.
- **Treatment works and saves money**: each £1 spent on treatment will save £4 from reduced demands on health, prison, law enforcement and emergency services. We recognise the important role of harm reduction services in addressing substance use, including the wider determinant factors associated to substance use.
- **Leicester City Council Public Health commissions a range of services that together, provide support seven days a week**. These services provide psychological and pharmacological support/treatment, support with housing, mental health, employment, other health issues, harm reduction and ongoing support from people with lived experience. This service is an important element of this provision.
- **Addiction does not discriminate; no-one wakes up one day and decides to be an addict.** Addiction can be the result and cause of many complex

factors including poor physical and mental health, trauma, homelessness, relationship breakdown, crime and more.

Phase 3 strategy working group action plans

1. Service Development and evaluation

1.1. Business as usual activities to:

- Increase the number of people leaving prison and entering community treatment.
- Improve conversion rates of those referred to engaging in treatment.
- Reduce unplanned exits.
- Increase retention including on a long term basis where needed.

1.2. Service review and development:

Review:

- The continuity of care pathway to identify strengths and weaknesses and reasons for disengagement.
- Annual conversion rates, engagement surveys and re-engagement exercises.
- Recommendations of a previous report on buvidal.
- BBV testing, take up and barriers.
- Naloxone carriage by other professionals/organisations.
- Referral pathways into services.

Evaluate

- Police carriage of naloxone.
- Mandela Park drop box.
- Substance use mental health programme.

Carry out a feasibility study on:

- Drug consumption rooms.
- A drug checking service.

Annual review/oversight of:

- Opioid substitution treatment.
- Use of AUDIT C and Assist Lite in primary care.
- Alternative venues for treatment.
- Alternative forms of access.

2. Comms & Engagement

2.1. Development of a comms and engagement plan to include:

- Identification of annual priority groups.
- Comms messaging and material focussing on prevention, treatment, recovery.

- Public engagement campaigns to understand and reduce stigma.
- Targeted campaigns on alcohol harm reduction, morning after drink driving limit, information on alcohol harm.

Engagement with service users to understand perceptions and barriers to BBV testing.

Annual analysis of treatment services engagement survey.

3. Training and Education

3.1. Training needs analysis (TNA) of all drug and alcohol services;

3.2. Develop a package of training based on the TNA for people working in the drug and alcohol sector to include:

- MH first aid
- Health conversations
- Trauma informed approaches
- Twice yearly shared learning event
- Develop a CPD calendar of shared learning and networking.

3.3. Develop a package of training for other professions to include:

- Information and awareness of treatment services and referral routes
- General information on drugs, alcohol, treatment, recovery, harm reductions
- AUDIT C and Assist Lite
- Healthy conversations
- MH first aid

3.4. For communities, schools and universities

- Develop targeted information on drugs, alcohol, treatment and referral routes.
- Strengthen the drugs and alcohol information currently on the school curriculum.

3.5. For people with lived experience

- Develop pathways into employment for people with lived experience.
- Ensure recovery pathways include into paid employment.

4. Lived Experience

- Map and review all current lived experience networks.
- Develop a systematic approach to ensure that the voice of people with lived experience is include in the design, review and delivery of services.
- Hold a development session focussing on the role of peer mentors and people with lived experience in treatment and recovery.

5. Nighttime economy

- Work with our nighttime economy and licensed premises to try to increase the variety and availability of no/low alcohol alternatives.
- Work with our sports clubs in the city, to encourage them to stock low/ no alcohol drink alternatives.
- Work with our licensing colleagues to encourage new licensees when making licensing applications to demonstrate how they will provide alcohol alternatives
- Work with licensing colleagues to develop the statement of licensing policy and use public health information on alcohol harm to assess if any new cumulative impact zones are required.
- Use targeted communications campaigns to inform Leicester citizens of alcohol harms and how they can reduce the harm to themselves from alcohol.
- Work with partners on communications around drink driving and increasing awareness amongst citizens of drink drive limits but also 'morning after' drink driving.
- Communicate information on unknown consumption, such as how drinking at home can increase consumption unknowingly.
- Explore the use of social marketing and social norm approaches to promoting a culture of responsible drinking.
- Work to increase the coverage of alcohol identification and brief advice within Leicester's partners.
- Work with partners and providers to develop our communications around alcohol harm and consumption to make them more effective.
- Work with the recovery community to develop approaches to encourage behaviour change that resonate with those affected.
- Work with our partners in universities to educate students regarding alcohol harm and explore initiatives that could promote a culture of responsible drinking.

6. Housing and rough sleepers

Currently being developed.

Monitoring and progress

Each CDAP partnership is required to report against government development outcomes and metrics and these are reported biannually at the CDAP strategy partnership. Within the city, working groups report into the city CDA delivery group which reviews strategy progress and progress against agreed metrics.

The LLR CDAP operational group brings together all metrics across LLR and any cross city boarder themes, challenges or risks which are then reported into the strategic partnership.

Leicester City drug & alcohol strategy phase 3: 2025 - 2027

PHHI Scrutiny Commission

Date of meeting: 27/01/2026

Lead director/officer: Rob Howard

Useful information

- Ward(s) affected:
- Report author: Mary Hall
- Author contact details: mary.hall@leicester.gov.uk
- Report version number: v1

1. Summary

A 2022 comprehensive drug and alcohol needs assessment formed the basis for the development of a Leicester City drug and alcohol strategy. This coincided with the launch of the national drugs and alcohol ten-year plan 'From Harm to Hope', and the requirement for all local areas to develop a 'Combating Drugs and Alcohol Partnership' (CDAP).

The LLR CDAP meets biannually and is jointly chaired by the respective Directors of Public Health. It has oversight for the LLR drug and alcohol strategy, and corresponding metrics required by the Home Office.

The Leicester strategy is based on the need identified in Leicester. It has four cross cutting themes, 32 actions and is underpinned by a principle of strategic partnership. Since its inception, significant progress has been made across all areas including:

- A significant increase in the number of adults accessing treatment.
- A larger proportion of people leaving prison accessing ongoing treatment.
- An enhancement of harm reduction programmes including carriage of naloxone across multiple organisations and stakeholders.
- A significant expansion of outreach services across our communities.

In December 2024 a workshop was carried out to review progress, review need and update the drug and alcohol strategy. Subsequent work, again with multiple agency input, has resulted in the development of the City's Phase 3 drug and alcohol strategy. This builds on the successes and learning of the previous two years amalgamating with the original strategy to ensure no objectives are lost but also introducing new objectives where needed.

Six working groups have now been set up to drive forward this next phase of the strategy; in the last two months a series of working group sessions have been carried out to develop individual action plans that will feed into the overall delivery group and strategic partnership. The refreshed strategy provides an opportunity to refocus our work and ensure that we continue in our aim to provide inclusive, evidence-based services for all of our communities whoever they may be.

2. Recommendation(s) to scrutiny:

PHHI Scrutiny Commission are invited to:

- Note the updated drug and alcohol strategy and plans for its implementation.

3. Detailed report

Please see the accompanying strategy for full details.

Phase 3 of the Leicester City drug and alcohol strategy has six themes:

1) Service development and evaluation
2) Comms and engagement
3) Training, Education & Employment
4) Lived Experience
5) Night-time economy
6) Housing support and rough sleepers

Working groups have been set up for each theme with Chairs and support personnel from across different agencies involved in drug and alcohol treatment and support. Each working group additionally has support from public health staff. Working groups have carried out a series of workshops to agree activities, responsible persons and timescales for planned actions. Full details of each of the working group activities are available in the accompanying strategy report provided at Appendix 1

Progress will be monitored at a city level by the city CDAP delivery group chaired by the consultant lead for drugs and alcohol. This group will also bring together broader activities from partners such as the police and probation. The delivery group is responsible for oversight of the CDAP metrics as set by the Home Office.

City based reports feed into the LLR CDAP operational group that combines the city, county and Rutland individual strategies into an overall LLR strategy and associated metrics. The operational group identifies and raises key challenges or risks with the CDAP strategic partnership. The strategic partnership is chaired by the respective DsPH and has overall accountable for the LLR CDAP partnership and associated metrics.

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

4.1 Financial Implications
There are no direct financial implications arising from this update.

Signed: Mohammed Irfan
Dated: 5 January 2026

4.2 Legal Implications

There are no direct legal implications arising from this update on the Strategy

Signed: Jenis Taylor
Dated: 7 January 2026

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 and 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. Due regard to the Public Sector Equality Duty should be paid before and at the time a decision is taken, in such a way that it can influence the final decision. Protected Characteristics under the Equality Act 2010 are age, disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion or belief, sex and sexual orientation.

The Phase 3 Drug and Alcohol Strategy is designed to reduce health inequalities across Leicester. A core principle of this phase is the provision of inclusive, evidence-based services that cater to the city's diverse population. It is important to ensure that treatment facilities and communications are accessible to those with physical disabilities or neurodivergent conditions.

We need to ensure equality considerations continue to underpin the work taking place in the city and where relevant Equality Impact Assessments are carried out. Where we are proposing to consult/engage/communicate with people, we need to ensure it is fair, accessible and proportionate, targets the relevant stakeholders and takes into account language needs.

Signed: Equalities Officer, Surinder Singh, Ext 37 4148

Dated:30 December 2025

4.4 Climate Emergency Implications

There are limited climate emergency implications directly associated with this report. As service delivery generally contributes to the council's carbon footprint, any impacts of this work can be managed through working to encourage and enable the use of sustainable travel options, considering the energy efficiency of any buildings used, using materials efficiently and following the council's sustainable procurement guidance, as applicable to the programme.

Signed: Phil Ball, Sustainability Officer, Ext 372246

Dated: 31st December 2025

4.5 Other Implications

Signed:

Dated:

5. Background information and other papers:

Please see accompanying paper: Leicester city drug and alcohol strategy phase 3.

6. Summary of appendices:

Leicester City
Our Neighbourhood Approach

Defined Geography | Partnership Working | Healthier Communities

Appendix F

Partner

Contents

1) What is a Neighbourhood?

A Neighbourhood refers to a **defined local area** — typically aligned to geographic boundaries, where **partners** across health, social care, community, and voluntary services coordinate and **deliver care closer** to people's homes and communities.

They offer a **new way of working** for partners and recognizes and endorses that **communities and people** have an active role in the design and delivery of neighbourhood health and care.

The aim is to **create healthier communities**; helping people of all ages live healthy, active and independent lives, improving their experience of health and social care, and increasing their agency in managing their own care.

Defined Geography | Partnership Working | Healthier Communities

2) Why do Neighbourhoods Matter?

Care closer to home

You can get more help and support you need in your local area — not just at hospitals.

Joined-up support

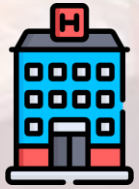
Local doctors, pharmacists, nurses, social care, and community groups work together.

Better health for everyone

Working together helps spot problems early and keeps people well for longer.

Stronger communities

Neighbourhoods build on local strengths — people, places, and groups that already make a difference.



Less strain on hospitals

More care in the community means hospitals can focus on people who need specialist treatment.

Helping you stay well

Neighbourhood teams focus on prevention — things like check-ups, advice, and support to live a healthier life.

Fair access for all

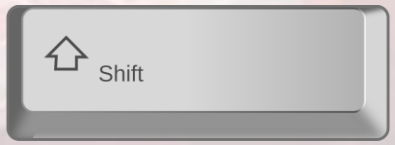
Services designed around the needs of each community, so everyone gets the right care and support

Your voice matters

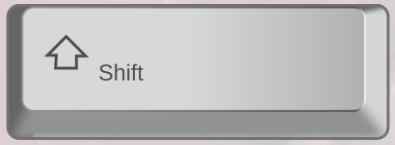
People living in the community help shape how local services work and improve.

2) Why do Neighbourhoods Matter?

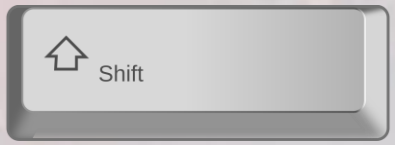
Neighbourhoods are central to the NHS 10 Year Plan and the three shifts.



Hospital to Community



Analogue to Digital



Sickness to Prevention

Aims for all neighbourhoods over the next 5 to 10 years

https://www.england.nhs.uk/long-read/neighbourhood-health-guidelines-2025-26/

3) What are the challenges in the city?

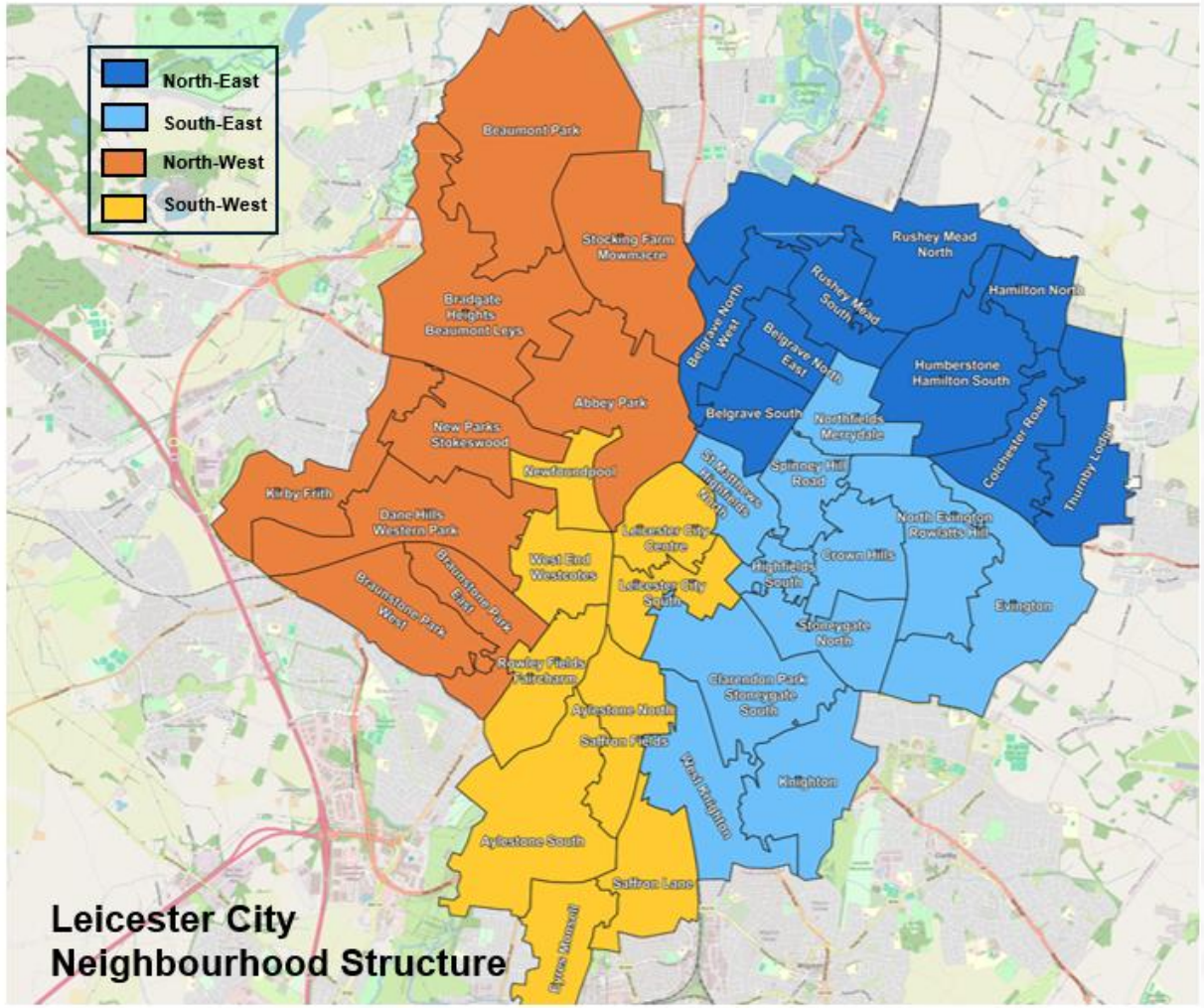
- **Deprivation** – Strong links to poorer health. 72% of the city Population live in quintiles 1 and 2. (1= most deprived, 5=least deprived)
- **Life Expectancy** – Leicester City residents have significantly lower life expectancy than the England average and live more of their lives in poor health.
- **Cancer -** Leicester City has significantly worse screening coverage for all 3 screening programmes (breast, bowel, cervical)
- **Vaccination** - Lower uptake and rates (childhood imms/C19/Flu)
- **Obesity/Activity -** Leicester City has significantly worse Year 6 obesity rates, Adults meeting 5 a day and Physical activity levels for adults.
- **CYP -** Leicester City has significantly worse health outcomes than England for infant mortality, MMR vaccines, school readiness, low-income not in education, employment or training, children in 5-year-olds families, homelessness, low birth weight, under 18 conceptions, year 6 obesity, 5-year-olds with dental decay, breastfeeding rates.

4) What are the City Neighbourhoods?

Four City Neighbourhoods, rational for configuration based on:

- Loosely based on previous working arrangements that worked well pre-pandemic.
- Ensures population of least 50k (national steer)
- Supported by health and care partners across the system.
- Align with Middle layer Super Output Areas (MSOAs) as unit of geography to support datasets/ analysis/ interventions.

- It is likely that these neighbourhood structures will evolve in the future as local government reorganisation
- Naming and Leadership of Neighbourhoods (TBC)
- ICBs to commission but delivery is a provider function



N'hood	Population (GP Practice List Size)	Number of GP Practices	Number of PCNs
1	56,824	8	5
2	170,803	17	7
3	63,754	7	3
4	117,045	19	8
TOTAL	**408,426**	**51**	-

5) What next and how can I get involved?

- We plan to establish **Neighbourhood-level Steering Groups**, made up of both professional leaders (such as health and social care staff) and community representatives. These groups will be responsible for leading, shaping, and delivering action tailored to the needs of each neighbourhood.

- We also plan to hold one **workshop** per neighbourhood in the new year to engage local stakeholders, canvass buy-in, discuss priorities, and co-produce neighbourhood plans.

- We are awaiting national **Neighbourhood Planning Guidance from the DHSC**, which will provide additional direction to shape and steer our local approach. This guidance will help ensure our plans align with national priorities and best practice.

- To support decision-making, we will produce a **Neighbourhood-level Intelligence Packs**, providing robust data and analytics. This will help identify local needs, inform priorities, and guide action across the neighbourhoods.

Medium Term Planning Framework 2026/27 – 2028/29

Purpose

- Shift **to multi-year, locally-led planning** to improve access, quality, and population health.=
- Strengthen NHS, local authority and VCSE partnership working through the Neighbourhood approach.

Key Priorities

- Local empowerment: More autonomy for ICBs and neighbourhood teams to design services.
- Prevention focus: Tackling obesity, smoking, CVD, and improving community-based urgent care.
- Better access: Reduce elective waits, improve cancer pathways, strengthen same-day primary care.
- Digital & data: NHS App growth, shared records, and modernised operating systems.
- Productivity & finance: Deliver 2% annual improvement, reduce variation, and improve efficiency.

What will change

- More services delivered closer to home.
- More proactive care and early intervention.
- Simpler, more coordinated pathways across NHS, public health, and social care.
- Greater transparency on quality, outcomes, and costs.

Key operational performance areas

- Elective, Cancer and Diagnostics
- Urgent and Emergency Care and Primary Care
- Community Health Services, Mental Health and Learning Disabilities

Next steps

- Organisations to submit 3-year numeric returns and 5-year Strategic Plans to deliver 10YP three shifts

https://www.england.nhs.uk/wp-content/uploads/2025/10/medium-term-planning-framework-delivering-change-together-2026-27-to-2028-29.pdf

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 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	The structure of the LNR will be brought to a future meeting Chief Executive and Chair to come to next meeting	
	Winter protection	Performance data to be shared with the commission when available. Uptake of vaccines data for school age children to be shared with members Vaccine commission to attend a future scrutiny meeting Number data on vaccine website to be shared with commission via website Motion to full council to write to SOS for Health on Leicester Cities Vaccine data to be separate from the County.	
	GP Access	Motion to full council to write to SOS for Health on Leicester Cities Vaccine data to be separate from the County.	
	NHS App	An update to be brought to a future meeting.	

Meeting Date	Item	Recommendations / Actions	Progress
4 November 2025	DPH Annual Report Whole systems healthy weight Smoke free generation Update on sexual health service		
19th January 2026 (SPECIAL MEETING)	*Deeper look into winter pressures and ambulance wait times at UHL. GP access, PCNs – Toby Sanders*		
27 January 2026	General Fund Budget Proposals 2026/27 Health Protection Annual review of prevention and health inequalities programme Cost of living, food poverty and fuel poverty update Drugs and alcohol strategy Leicester Neighbourhoods		

Meeting Date	Item	Recommendations / Actions	Progress
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.	