Leicester
City Council

MEETING OF THE PUBLIC HEALTH AND HEALTH INTEGRATION SCRUTINY COMMISSION

DATE: TUESDAY, 24 MARCH 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,
, e-mail: governance@leicester.gov.uk
Leicester City Council, City Hall, 115 Charles Street, Leicester, LE1 1FZ

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Further information

If you have any queries about any of the above or the business to be discussed, please contact: Katie.Jordan@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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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 meetings of the Public Health and Health Integration Scrutiny Commission held on 19th January 2026 and 27th January 2026 have been circulated, and Members will be asked to confirm them as a correct record.

4. CHAIRS ANNOUNCEMENTS

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

5. QUESTIONS, REPRESENTATIONS AND STATEMENTS OF CASE

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

6. PETITIONS

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

7. HEALTH PROTECTION

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

8. PUBLIC HEALTH AND RESEARCH **Appendix B**

The Director of Public Health in conjunction with De Montfort University submit a report to outline the first stages of work which includes a public health workforce research capacity audit, the appointment of a Local Authority Research Practitioner (LARP), a new research clinic, the creation of a Public Health Research Working Group, the development of a forward-looking research strategy, strengthened university partnerships, new research governance infrastructure, and a research repository.

9. MENTAL HEALTH AND SUICIDE PREVENTION **Appendix C**

The Director of Public Health submits a report to update the Public Health and Health Integration Scrutiny Commission about the latest work on Suicide Prevention and to promote mental wellbeing in Leicester.

10. WORK PROGRAMME **Appendix D**

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

11. ANY OTHER URGENT BUSINESS

Appendix A

Leicester City Council

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

Held: MONDAY, 19 JANUARY 2026 at 5:30 pm

P R E S E N T:

Councillor Pickering – Chair
Councillor Agath – Vice Chair

Councillor Haq
Councillor Sahu
Councillor March
Councillor Singh Johal

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175. WELCOME AND APOLOGIES FOR ABSENCE

The Chair welcomed everyone to the meeting and led on introductions. It was noted apologies were received from Cllr Clarke and Cllr Westley.

176. DECLARATIONS OF INTERESTS

177. LLR SYSTEM UPDATE WINTER 2025/26

Health Partners from across the Leicester Partnership Trust (LPT) and the Leicester, Leicestershire and Rutland (LLR) Integrated Care Board (ICB) submitted a report to update the Commission on the winter pressures across Leicester. The following was noted:

- It was noted that winter pressures are consistently challenging every year between December and January, regardless of the provisions in place, and this has been the case for over 20 years. This winter had additional complexities, including flu circulating around 3 weeks earlier than expected and periods of industrial action occurring at a critical point in the season. These factors added strain to an already pressured system, though many of the challenges reflected those typically experienced during winter.
- Updates were provided on urgent and emergency care performance, including ambulance response times and handover delays. Improvements had been made across key metrics, particularly ambulance handovers within 45 minutes, pre handover waiting times, and the ability to release ambulances back into communities. These improvements were driven by an improvement plan, increased capacity, and escalation frameworks. While progress had been made, it was

acknowledged that the experience of patients waiting in ambulances was not acceptable and continued work was required.

- Performance against the 4 hour emergency department standard was outlined, covering the time from arrival to being seen, treated, discharged, or admitted. Performance across emergency departments had been improving, with national benchmarking showing positive movement for Leicester, Leicestershire and Rutland compared to other trusts.
- A range of improvement actions were highlighted, including developments at minor injury and urgent care services, the use of appointment slot based systems, and work to improve local blood test processes. It was noted that formal point of care processes were not yet in place but were expected to be introduced in March.
- Work was ongoing to improve access to emergency and urgent care units through direct referrals from GPs, ambulance services, and emergency departments. Progress was also being made towards establishing an urgent treatment centre and demonstrating the impact of recent developments. Efforts were underway to ensure patients were directed to the most appropriate clinical setting rather than defaulting to emergency departments, supported by improved clinical pathways.
- Length of stay and discharge performance were discussed, including work to reduce average lengths of stay and improve ward based discharge processes. Focus had been placed on patients with no ongoing care needs who could return to their normal place of residence. While progress had been made, it was recognised that further work was required, with an aspiration to achieve a 70 percent discharge rate.
- Pharmacy was identified as a critical part of the discharge process. Delays were sometimes caused by medication queries or the preparation of take home medicines. Work was ongoing with pharmacy teams to improve both simple and complex elements of this process.
- In response to questions submitted in advance, updates were provided on corridor care. A release to respond protocol had been implemented, with specific spaces identified to reduce corridor care. This included converting assessment areas, reopening spaces overnight, and better use of emergency department waiting areas.
- Primary and urgent care demand remained a consistent challenge. Capacity continued to meet or exceed commissioned levels, with ongoing expansion of online consultations in line with national strategies. All patients had access to digital appointments, with availability increasing year on year. GP appointment capacity had increased by 2.2 percent, alongside a significant increase in personalised care plans, which local research showed reduced the likelihood of hospital admission.
- Same day access models were discussed, focusing on changes to how appointments were delivered rather than simply increasing volume. Primary care networks were supporting same day access where required. A newly commissioned paediatric service for winter had not been used as expected, partly due to families preferring alternative locations. As a result, some capacity was redirected to adult services to maintain appointment availability.

- Pharmacy First services had grown significantly and were described as highly effective, with positive impact in primary care. However, challenges remained in ensuring patients were directed to the right services without being passed between different parts of the system. A bed bureau was in place to support appropriate placement, though it was acknowledged this was not yet being used consistently across all areas.
- It was emphasised that the aim was to provide high quality care as close to home as possible, with further work needed to expand services across the city and improve signposting so residents could easily access the support they needed.
- Significant progress was highlighted compared to previous winters, particularly in ambulance handovers and Category 2 response times. Previously, between 15 and 20 ambulance crews had been waiting over 3 hours on Category 2 calls. Reductions in these delays had delivered major patient safety benefits, and thanks were extended to staff across the system for their work.
- An update was provided on flu vaccination delivery. Data reporting had improved following commissioning through NHS England. Work continued to reach vaccine hesitant and hard to reach populations through pharmacies, community leaders, and local radio. All trial pharmacy sites were based within the city, alongside a vaccination hub and walk in vaccine centres across Leicester, Leicestershire and Rutland. There had been concern about an early flu epidemic, but this had not materialised to date. Targeted work continued with children and vulnerable groups. The link to the nearest immunisation clinic to you, can be found here - LLR Vaccine Portal - NHS Leicester, Leicestershire and Rutland
- Industrial action was discussed, with it noted that there had been no significant performance deficit. The timing, just ahead of winter, had temporarily reduced bed occupancy, which provided useful learning. However, industrial action was described as extremely expensive, and consideration was needed on how learning from this period could inform future planning.
- Overall, it was reported that the majority of key metrics and winter schemes were showing improvement. Interventions focused on reducing demand, improving flow through hospitals, increasing access to diagnostics such as imaging, and strengthening leadership capacity during winter periods.
- An update was provided on the care home at Preston Lodge. It was reported to be operating well, with full capacity and smooth patient transfers. Positive feedback had been received. It was clarified that while residents receive rehabilitation support, the facility is not a formal rehabilitation unit

Comments:

- Members commented on the fact that the data provided to the scrutiny Commission on LLR emergency performance only went up to October. Members raised concerns that as the meeting was covering winter pressures, data from November and December would have been

appropriate. The ICB acknowledged this and advised that the data for those months was not available at the time of the report's creation.

- Members raised concerns about the current state of Urgent treatment centres. One member highlighted their experience over New Year's Eve where they were advised by two different call handlers that the Urgent Treatment Centres were full and that all patients needed to go to A&E. In response the Chief Medical Officer explained that this was a communication error, the centres were not at capacity and that they had put out a communication already addressing this issue. The Clinical Director for UEC elaborated that New Year's was always a busy period but, in this case, judgement had been made in the heat of the moment, and the wrong advice was given to the public.
- Members requested a deeper explanation of the ambulance release to respond performance and what the full process entailed. The Divisional Director of EMAS explained that the timer for this began the moment the ambulance pulled into A&E and put on the handbrake to them taking the handbrake off and going to the next case. It was detailed that in December 2025, the process was taking LLR around 45 minutes with only 2% of ambulances being over this figure. It was commented that last year this figure was 45% which showed a clear improvement. Nationally, it was noted that the mean average is 18 minutes but historically ambulances services were not hitting that goal. By the end of March 2026 EMAS wish to bring the average down to 30 minutes across the trust.
- Escalation spaces were mentioned on numerous occasions by Members. Members wished to understand more about escalation spaces, if they were fit for purpose and how long patients would spend in them. It was explained by the ICB representatives that escalation spaces were not a new idea and were useful during surge periods. It was noted that they were not repurposed offices, and they provided patients with privacy and dignity. The patients who were put in escalation rooms were treated in a timely manner and the ICB was monitoring the hours that patients spend in them. Assurance was given that it would be hours and not days. The Clinical Director for UEC argued that in an ideal world they would not be used but they are currently needed during the high intensity periods.
- The overall capacity of the LLR was queried by Members who sought a greater understanding about the potential capacity of the wards and if it could be increased. The Chief Medical Officer detailed that beds were incredibly expensive to commission and the ICB was operating under tight financial strains. It was commented that 10-15% of patients who were currently in beds at the hospital did not need to be in them. The overall strategy was to prevent non-essential patients going into hospital by promoting Primary Care and getting patients out of Hospital as soon as they were recovered. It was further noted that an additional 20 beds had been provided at Leicester General Hospital and 10 at the Glenfield Hospital as a supplement to the original winter plan. It was highlighted that this along with additional projects would see another £1.5 Million being invested into care in the LLR.
- Concerns were raised by Members about the 111 service and the

redirection of patients between different Practices and Treatment Centres. Members commented that constituents had contacted them regarding their experiences with 111 who had told them to go to A&E and then A&E told them to go elsewhere. The Clinical Director for UEC sympathised with the Members concern but stressed the difficult position of 111 call handlers, who were expected to make a quick judgement call on patients over the phone. Regarding A&E redirections, LLR hospitals operated under a triage process, meaning patients were directed to the best place for their condition.

- GP access was highlighted by Members who believed this was a key underlying cause as patients who can't receive treatment from GPs will end up at A&E. The digitisation of GPs and the erratic nature of the rollout amongst GP practices was commented on by Members who argued that it was creating a two-tiered system of GP access. The Chief Medical Officer for the ICB explained that there were 126 GP practices in LLR and there was bound to be some variation. Currently, it was detailed that 45% of patients in Leicester got an appointment in 48 hours and the main goal was to ensure that over 80% saw a GP within 2 weeks. Digital booking had become mandatory in October 2025, and it was hoped that over time there would be an improvement. There was still a commitment to face to face and paper routes. The introduction of the Pharmacy First Programme had also helped to reduce pressures on GPs and bring down wait times.
- The nature of patient feedback regarding issues with their GP Practices was commented on by Members. Members argued that constituents were afraid to complain to about their Practices for fear of being blacklisted and therefore the ICB was not getting an accurate picture. In response it was featured that patients can comment anonymous via the link on their GP's website or by contacting the ICB and Healthwatch. The ICB also had a system in place to target over and under referred Practices so it was stressed that these Practices would not go under the radar.

AGREED:

1. That the commission note the report.
2. Data on how long patients are kept in escalation space to be shared with members.
3. 4 hour response data for November and December 2025 to be shared with members.
4. Data on late representations and incident processes to be shared with members.
5. How winter pressures effect services in the community to be added to the work programme.
6. LNR Strategy going forward to be added to the work programme.
7. Finalised report on how winter pressures

178. VERBAL UPDATE ON ADDITIONAL LOROS BEDS

The Chief Medical Officer and the Chief Executive of the ICB gave a verbal update on the additional LOROS beds.

The ICB had undertaken work with LOROS Hospice to increase bed capacity. Currently, 4 beds had been made available for use, with this expected to increase to 6 shortly. The beds had been used to transfer end of life care patients out of LPT, thereby freeing up beds for other patients. Further work was being undertaken to explore whether capacity at LOROS could also be increased to support UHL patients.

Comments:

- Members commented on the number of beds available at LOROS and the potential to increase capacity. One Member advised that he had personally contacted LOROS and had been informed that an additional 10 beds were available and could be staffed. The Chief Medical Officer explained that the ICB had commissioned a formal contract with LOROS, which provided a more stable funding arrangement than the previous grant funding. It was further confirmed that the Chief Medical Officer and Chief Executive were due to meet with LOROS to discuss increasing capacity further.
- Members raised questions regarding the disparity in hospice funding between Northampton and LLR. It was stated that Northampton received between 60% and 70% of hospice funding from the ICB, whereas LLR received approximately 20%. Members questioned whether funding would be equalised under the new cluster arrangements. In response, the Chief Executive explained that this reflected the differing financial positions of the two systems. It was noted that LLR's budget plan for the year was forecasting a £15 million deficit, whereas Northampton was projecting a surplus. It was acknowledged that the ICB was exploring ways to harmonise arrangements across both regions, although this would take time.
- Members expressed concern about how services would be equalised between LLR and Northampton and emphasised the need to recognise the distinct circumstances and experiences within Leicester.

AGREED:

The Commission noted the verbal update.

179. ANY OTHER URGENT BUSINESS

With there being no further business, the meeting closed at 7.40pm.

Leicester
City Council

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

Held: TUESDAY, 27 JANUARY 2026 at 5:30 pm

P R E S E N T :

Councillor Pickering (Chair)
Councillor Agath (Vice Chair)

Councillor Haq Councillor March
Councillor Sahu

Assistant City Mayor – Councillor Dempster

1. WELCOME AND APOLOGIES FOR ABSENCE

Apologies were received from Cllr Clarke and Cllr Westley.

2. DECLARATIONS OF INTERESTS

The Chair asked members to declare any interests in proceedings for which there were none.

3. MINUTES OF THE PREVIOUS MEETING

The Chair highlighted that the minutes from the meetings held on 9th September 2025 and 4th November 2025 were included in the agenda pack and asked Members to confirm whether they were an accurate record.

AGREED:

It was agreed that the minutes for the meeting on 9th September 2025 and 4th November 2025 were a correct record.

4. CHAIRS ANNOUNCEMENTS

The Chair announced that an additional LLR Joint Health Scrutiny was being scheduled for April.

5. QUESTIONS, REPRESENTATIONS AND STATEMENTS OF CASE

It was noted that none were received.

6. PETITIONS

It was noted that none were received.

7. DRAFT GENERAL FUND REVENUE BUDGET 2026/27

The Director of Finance submitted a report to the Commission 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 Head of Finance, Education and Social care presented the report. The following was noted:

- The Draft General Fund Revenue Budget set out the budget for 2026/27 and the medium term financial strategy for the following 2 years. It was based on the government's Fair Funding consultation which ran over the summer. While the results were awaited, a forecast budget gap remained. As a result, the 5 strand strategy from the previous year would continue as follows:
  - To deliver budget savings
  - Constrain growth in areas such as Social Care and homelessness
  - A reduction in the Capital Programme
  - Releasing one off monies
  - A programme of property sales
- The budget built in growth to meet ongoing costs in Social Care, homelessness and housing benefits. The scope for additional investment was limited but provision was made, particularly where services had previously been funded through grants which were no longer received.

In discussions with Members, the following was noted:

- Members stated that it was difficult to scrutinise the budget without clarity on how the additional £5m would be spent and asked for greater transparency ahead of Budget Council in February. It was acknowledged that confirmation of the Public Health Grant was still awaited, however members requested sufficient detail to allow questions to be addressed in advance.
- Officers advised members not to assume that the additional funding represented new money. It was explained that in recent years funding had been received through several separate streams, including the core Public Health Grant, additional funding for substance misuse and alcohol services, and further funding that was ringfenced for specific purposes such as increasing access to treatment. In addition, in the previous year, and potentially the year before, additional funding had been received for stop smoking services as part of the government's

smoke free generation initiative.

- It was further explained that these funding streams had now been amalgamated into a single allocation. As a result, the grant appeared to increase from approximately £32m to £37m, however this did not represent a real increase in funding. It was stated that the actual uplift was likely only sufficient to cover inflationary costs and that there was no additional new money. Officers confirmed that, notwithstanding this, the total Public Health budget for the year was approximately £37m and that a breakdown of planned spend could be provided to members.
- Members raised questions about whether funding had been lost through ICB investment and whether any reductions were expected in the current year. In response, it was explained that this did not represent a direct reduction in funding but related to the way services were delivered. Challenges were highlighted around running costs and the impact on staffing availability, particularly in relation to vaccination programmes and outbreak response, and it was noted that additional resources were required to support this work.
- Concerns were also raised about vaccination uptake and whether the ICB had a responsibility to continue funding vaccination programmes to enable greater investment in other preventative services. It was suggested that a stronger focus on prevention would deliver longer term savings and members asked whether additional funding was being sought.
- It was clarified that the £10m figure referenced was not recognised and that plans were in place to spend the same amount on vaccination programmes in the next financial year as in the current year. It was confirmed that close joint working with the ICB continued and that staffing costs accounted for approximately one third of running costs. Members were advised that immunisation and screening teams would continue to operate across the Leicester's, Northampton and Rutland (LNR) Cluster, with efficiencies introduced through new ways of working. It was also stated that there was a strategic intention to shift further towards prevention, with increased investment in this area, and assurance was given that there would be no direct reduction in screening or immunisation resources.
- Members sought confirmation that there would be no direct or indirect cuts to current Public Health services over the next 12 months. It was confirmed that, at that point in time, officers were not aware of any service reductions. It was explained that a reduction of approximately one third in ICB running costs related to commissioning, coordination, and organisational structures as clusters were brought together in line with national expectations, and that frontline service provision, including vaccinations delivered through general practice, pharmacies, and roving units, would continue. Members were assured that any future changes would be subject to impact assessments and further discussion with partners.
- Members also referred to previous discussions regarding a potential 6% reduction in mobile vaccination and immunisation support. It was confirmed that since the previous meeting an allocation had been received from NHS England and that officers were hopeful the roving

vaccination service would continue.

AGREED:

1. The Public Health and Health Integration Scrutiny Commission note the report.
2. A breakdown of the previous year's Public Health budget and the final budget for 2026/27 be provided to members to support scrutiny and improve understanding of growth and new programmes.

8. HEALTH PROTECTION

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

- It was reported that a key highlight was the work undertaken to increase MMR uptake in the city, which was beginning to show positive results. A range of engagement activity had taken place within communities, including work with faith groups and the deployment of the roving vaccination unit. As a result, 81.2 percent of 5 year olds had received the MMR vaccine, which was higher than comparable cities. However, it was emphasised that 95 percent coverage was required to achieve herd immunity and further work was needed.
- It was noted that influenza had arrived early but had not escalated to the level initially feared, and rates were now decreasing. Vaccine rollout remained key to controlling flu rates, although overall uptake was lower than required. Additional targeted work was ongoing to improve vaccination rates amongst priority groups.
- Covid rates in the city were reported as remaining steady. Although occasional peaks had occurred, they had not reached the levels seen in previous years. New variants had emerged which were not covered by earlier vaccines, making updated vaccine uptake important. Covid vaccination rates remained below target, with a significant disparity between uptake in the city and the county. This difference was highlighted as a continuing health inequalities issue.
- Leicester was reported as having the highest tuberculosis rates in the country.
- It was confirmed that there had been no new cases of measles. However, vaccination rates remained below target and cases in Birmingham were noted, meaning the situation continued to be monitored closely.

In discussion with Members, the following was noted:

- Members raised concerns regarding the proposed merger of LLR with Northamptonshire to create a new NHS cluster and queried the potential impact on vaccine resources and focus on the city. It was confirmed that resources would continue to be directed to areas experiencing the greatest health inequalities. The work of Public Health outreach teams,

particularly engagement with faith groups, was commended, and it was noted that public confidence and appetite for vaccines remained an important factor.

- Members queried whether the current increase in tuberculosis cases represented a true surge or was linked to increased screening activity. It was explained that the city was experiencing a genuine increase in active TB cases, partly reflecting patterns of travel and migration from high prevalence countries. It was clarified that the figures presented related to active TB cases only and did not include latent cases referenced during the presentation.
- Concern was expressed regarding low vaccination rates in the city, particularly the Covid vaccination rate of 23.1 percent compared to 50.9 percent in the county. Members stressed the need for appropriate resourcing and funding to address Leicester's position at the lower end of national uptake tables. In response to questions regarding additional funding, it was explained that community engagement work was resource intensive. It was further noted that substantial work was already underway, although behavioural factors and public confidence continued to influence uptake.
- Members suggested that partnership working with social media influencers could support engagement with younger people regarding vaccine hesitancy. It was reported that this approach was already being implemented in relation to HPV vaccination, including work through schools to identify students with social media platforms who could help promote positive messaging.

AGREED:

1. The Commission note the report.
2. An update on vaccinations to come to the first meeting of the new municipal year.

9. PREVENTION AND HEALTH INEQUALITIES STEERING GROUP ANNUAL REVIEW

The Director of Public Health submitted a report to update the Commission on the Prevention and Health Inequalities Steering group which was established in June 2024. The following was noted:

- The Leicester City Prevention and Health Inequalities Steering Group was a strategic group that provides direction and alignment on prevention priorities to address health inequalities in Leicester.
- A strategic group had been established which reported to the Leicester Health and Wellbeing Board and operated as a formal subgroup of the Board.
- In June 2024, the Director of Public Health established a new initiative in Leicester to address health inequalities with urgency and focus.
- It was explained that a wide range of stakeholders had been involved in selecting 5 priority topics. The group had considered the contributors to health inequalities and reviewed supporting evidence.
- 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
- The approach had been designed using an incident management model, similar to the measles response, and this methodology was now being applied to the prevention of long term conditions, tackling health inequalities and improving outcomes for local communities.
- Hypertension had been identified as a priority, with work including the use of a roving health unit and encouraging follow up activity.
- Targeted work on healthy weight had also been undertaken.
- A focus on HPV had included engagement with secondary schools in the city, with HPV vaccinations delivered via the roving unit.
- Social isolation amongst people with severe mental health needs had been identified, particularly noting that there was currently no clear pathway for homeless people. A bowel cancer pathway for this cohort was due to be launched in the spring.
- Data analysis was being reviewed and refined, with a final version expected in March.
- It was noted that the programme would continue to meet quarterly and would identify priorities for the next 18 months.

In discussions with Members, the following was noted:

- Members requested further detail in March on early indications, ongoing priorities and what investment was being made, and sought clarification on whether the current priority strands would continue beyond the initial phase. It was advised that data analysis was being finalised and would provide greater clarity on impact and next steps, and that the programme would continue to review priorities over the next 18 months in line with emerging evidence and need.
- It was commented that the evaluation approach was thorough and innovative, drawing on outbreak management principles and applying them to long term conditions. In response, it was explained that the programme was intentionally data and intelligence driven, starting with an understanding of the contributors to inequalities and impacts on life expectancy, before identifying evidence based interventions. The approach focused on proactively reaching communities and delivering practical short and medium term actions, although it was acknowledged that some areas, such as social isolation, may require longer term programmes to demonstrate measurable impact.
- Members noted the significant interest in the programme and queried how data was being used more widely. It was reported that discussions were taking place across the Midlands on how data analysis could be applied differently, including at neighbourhood level to allow for more detailed breakdowns by area, with inequalities remaining central to the work.
- A suggestion was made that suicide prevention and public health emergencies be added as priorities, alongside concerns raised about

access to mental health services and the difficulty of navigating support, particularly in relation to suicide rates. It was explained that a wide range of topics had been proposed by stakeholders and had been considered through an agreed assessment process, and that any additional topics would need to be reviewed through that same process to ensure consistency and fairness.

- While welcoming the focus on long term conditions, members emphasised that wider determinants of health also needed to be recognised, including social isolation, limited community interaction, poor bus services and access to transport, all of which contributed to inequalities.

10. COST OF LIVING, FOOD POVERTY AND FUEL POVERTY

The Director of Public Health submitted a report to update the Commission on Cost of Living, Food Poverty and Fuel Poverty. The Project Manager for Public Health presented the item, the following was noted:

- It was highlighted that poverty was strongly linked to poor health. People living in deprived communities were more likely to have lower life expectancy, spend fewer years in good health and experience greater barriers in accessing healthcare, contributing to both physical and mental health conditions.
- Low income made it difficult for residents to afford essentials including food, heating and hygiene products.
- A 2 year Fuel Poverty programme concluded in 2024. The programme raised awareness of fuel poverty issues and worked closely with National Energy Action. Although the formal programme had ended, partnership working continued, particularly in supporting complex cases. It was noted that deep and meaningful advice had been provided in some instances, including support with debt write offs.
- The priority remained strengthening referral pathways and continuing to promote awareness of available support.
- Period poverty was highlighted as a significant issue, defined as the inability to afford essential menstrual products. It was noted that stigma meant the issue often remained hidden. Data suggested over 25% of individuals had experienced period poverty, including borrowing products or using unsuitable alternatives such as socks, toilet roll or nappies, or using the same product for longer than recommended, increasing risk of infection.
- Since December 2024, free menstrual products had been made available in 16 libraries across the city. The approach was designed to remove stigma by making products freely accessible without the need to ask. The scheme had also expanded into substance misuse centres and gyms. It was described as low cost with strong uptake and significant impact.
- It was reported that 12% to 11% of adults had struggled to access food, with nearly 4% reporting having skipped food for a whole day due to lack of money.
- Feeding Leicester, the local arm of Feeding Britain, brought together a

wide range of organisations focused on addressing food insecurity. It was noted that many of the same communities experiencing food insecurity were also those with lower vaccination uptake.
- At the start of the Cost of Living crisis, agencies had been brought together to coordinate support. It was noted that difficulty affording basics, including heating, had become normalised for many residents.

In discussion with Members, the following was noted:

- Members welcomed the pilot programme which auto enrolled eligible pupils for free school meals and noted that over 1,000 students had been identified as eligible. Members asked when wider rollout would take place and what the timeline was for implementation across the city.
- In response, it was explained that the main challenge was data protection legislation governing how eligibility data could be accessed and used. It was noted that the authority already held data indicating eligibility, however significant data analysis and cross referencing with DWP and NHS records was required. Other councils had developed frameworks which Leicester was reviewing and adapting. There was a commitment to progress this work further.
- Members asked whether implementation was more difficult for academies compared to maintained schools.
- Members also queried the future of the period poverty scheme and whether it would be expanded further. It was explained that the initial aim had been to demonstrate that provision was lower cost and more straightforward than anticipated. The scheme had been supported by a £10,000 grant and had been running for 15 months, with potential to continue for a further period subject to funding.
- A suggestion was made regarding food bank cooking clubs. It was confirmed that a cooking scheme was already delivered through Public Health.
- Reference was made to the Company Shop model as a dignified and affordable alternative to traditional food banks. It was noted that this provided a respectful and lower cost food offer.
- It was suggested that the Council could utilise its relationships with companies and organisations to explore further partnerships, and this approach was welcomed for consideration.

AGREED:

1. The Commission noted the report.
2. A further update be brought back to the Commission in April.

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

The Director of Public Health submitted a report on Phase 3 of the Leicester City Drug and Alcohol Strategy 2025-2027. The following was noted:

- The latest phase of the Leicester City Drug and Alcohol Strategy followed a national review of drugs and alcohol services in 2021 and the launch of the Government strategy “From Harm to Hope”. Local areas had been required to review their work and strategies, supported by a

refreshed needs assessment which had highlighted the scale of need within the inner city.

- A comprehensive drug strategy had been developed through the Combating Drugs Partnership. The strategy focused on four cross cutting themes and 32 actions were developed for implementation:
  - 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.
- A 1 year progress summary was presented. The number of adults accessing treatment had increased by approximately 500, from around 2087 to 2500. The proportion of prison leavers leaving treatment successfully had increased from 21% to 55.2%.
- A wide range of harm reduction programmes had been expanded, supporting people to use drugs more safely and increasing engagement. The work had received an LGA award in the previous year.
- Police officers had received training to carry naloxone, and outreach services had been expanded with additional specialist staff and programmes.
- It was noted that the programme had started from a relatively low base but had made significant progress within a short period of time and was being recognised as good practice. Reducing inequalities remained central to the strategy.
- A stock take of the strategy had been undertaken during the previous year, leading to a refresh and the commencement of Phase 3. The original 3 year period had concluded and 6 working groups, involving a range of stakeholders and partners, had been established. Each group was developing detailed action plans through a series of workshops.
- Governance arrangements were outlined, including links to city and LLR partnership structures. It was noted that Phase 3 was at an early stage, with action plans now being implemented.

In response to Members comments, the following was noted:

- Members welcomed the significant progress against key metrics and sought clarification on what constituted “treatment”. It was explained that treatment covered a wide range of interventions, including structured treatment through Turning Point, therapy, management of substance use, harm reduction measures and residential rehabilitation. The reported metrics related to structured treatment programmes.
- Further clarification was sought regarding the 2500 individuals accessing treatment and how this compared to the wider population. It was acknowledged that this represented a relatively small proportion of the overall population and that there remained a significant level of unmet need. A breakdown of the data was to be shared with members.

- Members highlighted the importance of evidence, oversight and harm prevention, particularly in relation to alcohol related harm. It was reported that the city had one of the highest rates in the country for alcohol related harm and deaths. The alcohol harm paradox was noted, whereby people living in more deprived areas experienced higher levels of harm despite not necessarily consuming more alcohol, often linked to wider deprivation and long term health inequalities.
- Questions were raised regarding prison leavers and the support available on release, particularly for women returning from Peterborough prison. It was explained that additional recovery workers were working directly with prisons to build relationships prior to release and to support effective transition planning. It was recognised that women in particular faced challenges on return to the city, including environmental triggers. Work was ongoing through the criminal justice team and in partnership with colleagues focusing on prison health to strengthen pathways and post release support. It was noted that responsibility for some establishments such as Glen Parva and Fosse Way sat with the county, although partnership conversations were taking place.
- Concerns were raised regarding drug related death rates, reported as 14.7 per 100000, and the availability of drugs, vapes and alcohol across the city, including 24 hour access through some premises. It was noted that public health colleagues were exploring how to provide a more robust input into licensing decisions, working with legal services and Trading Standards within the existing legislative framework. The misuse of substances such as synthetic cannabinoids and THC was also highlighted, and it was confirmed that these issues were considered within the Combating Drugs Partnership and relevant enforcement and partnership networks
- In response to a question regarding how the strategy addressed health inequalities and access to rehabilitation, it was emphasised that drug and alcohol misuse was a significant driver of reduced life expectancy and ill health. The strategy targeted areas of highest need and sought to improve access to services such as Turning Point. Access to residential rehabilitation involved a structured process, often including detox and at least 3 months preparation, with improved outcomes where appropriate support structures were in place before and after treatment.
- Members asked about current drug trends and emerging risks, including fentanyl use in the United States. It was reported that alcohol and opioids remained the most common substances locally, although trends were evolving. Nationally there had been an increase in ketamine use, a decline in treatment for some opioid users, and an increase in combined crack and opioid use. Services were described as responsive and data driven, regularly reviewing treatment data and national intelligence to raise awareness and adapt to emerging trends.

AGREED:

1. The Commission note the report.
2. A breakdown of the 2500 individuals accessing treatment, including further detail on cohort and demographic profile, to be circulated to members.

12. LEICESTER CITY OUR NEIGHBOURHOOD APPROACH

The Integrated Care Board (ICB) submitted a report to update the Commission on Leicester City Our Neighbourhood Approach. The following was noted:

- The approach was not new but was now progressing through a 10 year plan.
- There had been considerable debate regarding the configuration of neighbourhoods in Leicester. While not strictly geographical, the model had been designed to work across partner organisations.
- The approach aimed to develop new ways of working that maximised staff capacity and involved the public more effectively.
- Two health related priorities had informed the model, namely increased attendance at Accident and Emergency and rising emergency admissions. Although performance was comparatively better at University Hospitals of Leicester, it was recognised that too many people were attending hospital unnecessarily. Outpatient pressures within the city were also highlighted
- It was emphasised that neighbourhoods mattered in delivering care closer to home. Distance to treatment and ease of access often led people to attend A and E as it was perceived to be simpler. It was noted that individuals often experienced multiple interconnected issues, for example asthma linked to housing conditions or mental health concerns in children associated with screen time and lack of exercise. Supporting residents to help themselves was described as crucial.
- A strong partnership was described between health, social care and the voluntary sector, with a focus on directing people to support within their local communities and ensuring fair access for all.
- The overarching aim was prevention. The 10 year plan was structured around three key areas: shifting care from hospital to community, moving from analogue to digital systems including use of artificial intelligence and technology to reduce waiting times, and embedding prevention. It was noted that this was a long term transformation and that plans needed to be measurable and auditable.
- Key challenges included deprivation, life expectancy gaps, cancer outcomes and low vaccination uptake.
- It was reported that there were 4 city neighbourhoods. Funding became available in pockets over time and partners would need to be creative in progressing priorities.
- University Hospitals of Leicester had identified patterns of A&E discharge by area, including patients discharged without the need for treatment.
- A neighbourhood steering group and workshops had been established to influence future practice. The Integrated Care Board, University Hospitals of Leicester and Public Health were developing a data pact to assess needs and inform priorities.
- The model was moving towards a multi year locally led planning

approach covering 2026 to 202

- Proposed targets included reducing timeframes for cancer assessment and undertaking a full review of community paediatrics, which had not been analysed for some time.
- The Initial priorities would focus on achievable improvements in 2026 and 2027, recognising that neighbourhood and provider level change would take 2 to 3 years to embed.

In response to members comments the following was noted:

- Members expressed concern regarding what was perceived as another reorganisation and questioned the rationale behind the size differences between neighbourhoods. It was noted that one neighbourhood appeared significantly larger than another and this was seen as potentially inconsistent with the principle of fair access for all.
- Members queried how areas had been grouped together and whether some areas, such as Stoneygate and Highfields, aligned well from a health inequality perspective.
- In response, it was explained that the current configuration was a starting point and could evolve. It reflected what worked best for partners, including Primary Care Networks, and all partners had agreed the model.
- Members reiterated concerns regarding population size differences between neighbourhoods and questioned whether resources would be proportionate. Assurance was provided that resources would be allocated proportionately.
- It was emphasised that the focus should not solely be on population numbers but on building effective relationships between partners within neighbourhoods. Services themselves would remain unchanged.
- Concerns were raised that combining areas such as Knighton and Spinney Hills could mask health inequalities, including significant differences in life expectancy between communities.
- Members highlighted the scale of the transformation at a time of significant staffing reductions and asked for clarity on implementation timescales.
- It was explained that the national programme remained in its early stages and there was no formal go live date. The approach would evolve over time, with further work planned in areas such as frailty and vaccination.
- Members stressed the importance of strong local leadership and understanding of local communities. A lengthy debate took place regarding the value of local links and representation within leadership structures.
- It was confirmed that Public Health had been involved in developing the areas to ensure deprivation data could be analysed appropriately.

AGREED:

1. The Commission noted the report.
2. Assurance be provided that data would continue to be maintained and analysed at community level to avoid masking health

inequalities.

13. WORK PROGRAMME

The Chair reminded Members that any suggested items for inclusion in the work programme should be shared with the Chair and the Senior Governance Officer.

It was noted that an in depth review of Rheumatology would be scheduled for the April meeting.

Walk in Centres were also proposed for inclusion as a future agenda item.

14. ANY OTHER URGENT BUSINESS

With there being no further business, the meeting closed at 8.36pm.

Appendix B

Public Health and Research

Public Health and Health In Scrutiny

Date of meeting: 24/03/2026

Lead director/officer: Rob Howard

Useful information

- Ward(s) affected: all
- Report author: Alex Hammant, Ivan Browne, Annabelle Long
- Author contact details: alex.hammant@leicester.gov.uk, ivan.browne@dmu.ac.uk, Annabelle.long@leicester.gov.uk
- Report version number: 1

1. Summary

As we know, Leicester is a unique city. As the first city in the country where the global majority constitutes the majority of the population, Leicester presents a distinctive demographic, epidemiological, and social profile that demands a distinctive approach to public health decision-making. Evidence generated elsewhere — in cities with different population structures, different patterns of disease, and different social determinants — often cannot be transposed onto Leicester without critical appraisal. Otherwise, we risk making the wrong assumptions which would ultimately hinder rather than help. To make the right decisions for our population, we must ensure that the evidence base we draw upon is applicable to our communities, and importantly, that it is generated in genuine partnership with them.

This report sets out the rationale and early progress of Leicester City Council's Public Health team in building its research capacity. The team already has some expertise and experience in evidence review, data analysis, and evidence-based practice. This programme of work represents a strategic step to enhance those capabilities further, and in addition, to formalise and facilitate research governance, and to forge the partnerships with universities, with other relevant bodies, and with our own population that will underpin high-quality, locally relevant public health research for the future.

The report outlines the first stage of this work. This includes a public health workforce research capacity audit, the appointment of a Local Authority Research Practitioner (LARP), a new research clinic, the creation of a Public Health Research Working Group, the development of a forward-looking research strategy, strengthened university partnerships, new research governance infrastructure, and a research repository. These are early steps, and the overall aim is to improve the quality and reliability of the work we do with our communities to help improve their help.

2. Recommendation(s) to scrutiny:

Health Scrutiny Commission are invited to:

- Note and support the strategic direction of the Public Health team in building local research capacity, recognising the unique demographic and epidemiological context of Leicester City as the primary driver of this work.

- Endorse the principle that research conducted in or about Leicester's population should be done with our communities rather than at them, and that research partnerships should be held to account in sharing findings with the population they concern.

- Support the expansion of the LARP research clinic beyond the Public Health team to wider council services, enabling colleagues across the organisation to access research support and strengthen evidence-based practice.

- Note the development of a research repository to record and oversee collaborations with external partners and endorse its use as a mechanism for accountability and knowledge transfer back to our population.

- Note the progress on research governance and ethics infrastructure and support efforts to make it easier for Leicester City Council employees to engage in ethical, well-governed research activity.

- Request a further update at [agreed timeframe] on the implementation of the Public Health Research Strategy, including progress on governance framework development and research repository

3. Detailed report

1. Why Build Research Capacity? The Leicester Context

Public health decision-making must be grounded in evidence. That evidence must, however, be fit for purpose — relevant to the population it is meant to serve, sensitive to their circumstances, and generated through approaches that are trustworthy and ethically sound.
Leicester's population is unique in the context of English public health. It is the first city in the United Kingdom where the global majority constitutes the majority of the population. This has implications for the evidence base that informs our decisions. Patterns of disease burden, risk factor prevalence, cultural determinants of health behaviour, access to services, and community trust in institutions all vary in important ways across Leicester's diverse communities. Evidence generated in predominantly white British cohorts, or in cities with very different population profiles, may not translate. Applied uncritically, it risks producing decisions that are poorly matched to the actual needs of the people we serve.
There is also an ethical dimension that cannot be overlooked. Research has historically been done at marginalised communities rather than with them — extracting data, producing findings, and often not returning meaningful benefit to the communities involved. Through this work we are committing to a different model: one in which our

population is a genuine partner in research, not merely a subject of it. This means community involvement in research design, transparent sharing of findings, and a commitment to ensuring that insights generated in Leicester benefit Leicester.
It is important to emphasise that this work builds on existing strengths. The Public Health team already brings some experience in research as shown in the capacity audit. This programme formalises, extends, and connects those capabilities rather than starting from scratch.

2. Workforce Research Capacity Audit

As a necessary first step, the Public Health team undertook a structured audit of existing research capacity across the workforce. This was designed to map current skills, experience, and interests in research activity, and to identify gaps that the broader programme should seek to address.
The audit was delivered online using Microsoft Forms and had a response rate of 41%. It used a validated tool. Just under half the respondents (43%) reported having current involvement in research, with 47% reporting involvement over the last 12 months. There were some research skills which were used more often, for example, 91% of respondents reported they had experience of collecting data. The most used data collection methods were surveys and focus groups.
The levels of confidence that respondents showed in research skills varied widely. Understandably, the team were generally more confident in skills that they were using regularly such as finding relevant literature and evidence, designing questionnaires and collecting data. There was less confidence in skills that may be seen as more classically academic such as securing research funding, submitting an ethics application and writing for publication.
There were high levels of interest in learning new research skills with particular interest shown in analysing data, writing reports and securing funding.
The audit findings have directly informed the priorities of the LARP's work programme, future workforce development, and the design of the Public Health Research Strategy, ensuring that our approach to capacity-building is grounded with an assessment of where we are starting from.

3. The Local Authority Research Practitioner (LARP)

An early investment in research capacity has been the appointment of a LARP - a role jointly funded through the National Institute for Health and Care Research (NIHR) and De Montfort University. The LARP programme was developed nationally to embed dedicated research expertise within local authority public health teams.
Since her arrival, our LARP, Annabelle Long, has established a research clinic - a practical, accessible resource through which colleagues can bring any and all research related questions. She provides advice and support for example, guidance on methodology and study design, exploring potential collaboration opportunities, and building confidence and competence in research. This clinic has initially focused within the Public Health team, but it is the team's ambition to extend it to colleagues across Leicester City Council. The potential value of this model extends beyond public health and potentially there are many council teams who are well placed to contribute to and benefit from this work.

The presence of the LARP role also strengthens Leicester's relationship with the NIHR and positions the council to engage more actively with nationally funded research programmes and funding opportunities, increasing our potential to attract external investment in locally relevant research. Furthermore, Annabelle is able to network with wider research stakeholders: for example, the Integrated Care Board, Leicester Partnership Trust, the East Midlands research Co-operative, local Health Determinants Research Collaborators, and the local civic university partnership, which provides opportunities for best practice sharing, collaboration and identification of novel, local research opportunities.

4. University Partnerships

Leicester benefits from two universities within the city — De Montfort University (DMU) and the University of Leicester (UoL) — both of which carry significant public health, health sciences, and social research expertise. The Public Health team has existing collaborative relationships with both institutions, as well as Loughborough University, and is taking deliberate steps to formalise and deepen these. For example, through our involvement in the civic university's partnership.

De Montfort University has recently established a new Masters in Public Health (MPH) programme, and Leicester City Council's Public Health team is an active collaborating partner. This includes staff involvement in teaching, curriculum development, and academic input that draws on the realities of public health practice in a complex urban local authority. The collaboration is mutually beneficial: it contributes to training the next generation of public health professionals while creating structured opportunities for council staff to engage with academic thinking, refresh their knowledge base, and strengthen their own skills.

The University of Leicester collaboration is also being developed and strengthened, with joint working on research and shared projects of direct relevance to the city's population, for example, members of the public health team have been involved in TB research within the city.

These partnerships are being developed on the basis of mutual benefit, clear expectations, and reciprocity. We want to ensure that they are not passive arrangements in which the universities lead and the council provides access to data or communities. If access to data or our communities is requested, Leicester City Council expects to be an active partner, and the research repository described below is one mechanism through which partner institutions will be held to account on their obligations to our population.

Additionally, work is underway for the very first Public Health research showcase conference (name to be finalised) where members of the public health team will be showing their work to local university partners. The idea is that this will be a space for local academic partners to understand and appreciate the work which is already going on at the local authority level and provide them with inspiration for how their academic output could be more aligned with the immediate and real-world issues which our local residents are facing.

5. Public Health Research Working Group and Research Strategy

The Public Health team has established a Public Health Research Working Group, bringing together colleagues with an interest in research activity. This group will provide internal governance of the team's research programme, coordinates activity across different workstreams, and ensures that research priorities remain aligned with the council's wider public health objectives and with the needs of Leicester's population.
The Working Group has developed and agreed a Public Health Research Strategy which is currently under-going internal sign-off, setting the direction for research activity over the coming years. The vision of the group is to embed a strong and inclusive research culture with the long-term ambition that this will translate into more effective and inclusive programmes which will improve health and reduce health inequalities across Leicester. Subject to sign-off, the priority areas are developing research culture and capacity; promoting and securing research funding; simplifying and strengthening research practice through robust governance and ethics processes; exchanging knowledge and research findings with our communities.
A central feature of the strategy is community involvement and collaboration at all stages of the research process. Research in Leicester will, wherever appropriate, be co-designed with local people — drawing on lived experience, building community trust, and ensuring that both the questions asked and the findings produced are accessible and meaningful to those they concern. This is both a point of principle and a point of practice: research shaped by the communities it affects is more likely to address the right questions, generate relevant findings, and ultimately influence decisions in ways that make a difference on the ground.

6. Research Governance and Ethics

For council employees to engage in research with confidence — and for that research to be trusted — robust governance and ethical frameworks are essential. At present, the pathway for staff wishing to conduct research is not always clear, and this can act as a practical barrier to engagement. We are working to strengthen Leicester City Council's research governance infrastructure, with the explicit aim of making it simpler and more accessible for staff to conduct research that is ethical, well-governed, and properly overseen.
We have undertaken a mapping exercise which has presented examples of broadly four local authority research ethics models. Some authorities have no process at all and saw research as an activity initiated outside of the local authority and only conducted by external researchers. Several authorities use an assurance model where they have a formal process to ensure projects have had an external ethics review, but projects were still conducted by external researchers with the local authority having oversight only. Other local authorities were seen to have an advice model and used a mixture of formal and informal advice on projects to ensure ethical acceptability. Both external researchers and local authority staff were seen as potential research creators. This is the model that best fits current practice within the Leicester City Council Public Health team.
Finally, a small number of local authorities were viewed as having a review model, having internally led ethics committees that were independent of external committees and tailored to specific local authority needs. This model allowed research to be conducted by internal staff without needing a university collaborator to gain access to a formal ethics committee.

We have developed an options appraisal discussing the pros and cons of each approach and will be presenting to DMT with a suggestion that Leicester City Council aims for a review model with an internal ethics committee. We would undertake a risk-based approach, with an initial registration and screening process to ensure that only projects that require a formal ethics process would follow this route to strike a balance between facilitation and robustness.
Strong governance protects the organisation and, most importantly, our population. Ensuring that research conducted in Leicester — whether led internally or in partnership with external organisations — is properly consented, ethically reviewed, and subject to appropriate oversight is a prerequisite for the model of community partnership and public trust that our strategy depends upon.

7. Research Repository

Leicester City Council is developing a research repository — a systematic record of all formal research collaborations between the Public Health team (and, in time, the wider council) and external partners, including universities, NHS bodies, and other organisations.
The repository serves two key functions. First, it provides oversight: the council will maintain a clear, consolidated picture of what research is being conducted in Leicester, with whom, on what terms, and with what data. This enables proper governance and reduces the risk of activity occurring without appropriate knowledge or accountability. It also reduces the risk of organisations and teams working in silos, potentially repeating work and reducing community trust. Second, it is a mechanism for accountability with external partners: organisations collaborating with the council will be expected — as a condition of partnership — to share completed data, findings, and outputs with Leicester City Council and with the population their research concerns. The repository creates a formal record against which this expectation can be tracked and, where necessary, enforced.
This matters particularly in Leicester. Our population is a valuable resource for researchers, and there is a risk that research conducted here — particularly by external bodies — extracts data and generates outputs that never return to the communities that made the research possible. The repository is a practical mechanism for ensuring that benefit flows back to Leicester, and that our population is not simply a convenient sample for others' academic advancement.

8. Individual Research Projects

In addition to the structural and strategic work described above, a number of individual research projects are in early stages of development. These reflect both the research interests and expertise of team members, and the priority public health challenges facing Leicester's population. Some examples include, Annabelle working with public health team colleagues in developing a participatory action research project looking at Shisha messaging, a particular issue in Leicester which will require a bespoke solution. Therefore, effort is being made to involve those most effected in our community. Members of the team are working to influence a DMU-led British Heart Foundation grant application looking into targeted hypertension case-finding within the city, especially

trying to target those who would not normally see a GP. We are working with University of Leicester to investigate the feasibility of delivering NHS health checks in the community, also in areas of greatest need. We are working with colleagues to help develop robust data collection methods for Leicester City Football Club in their community project work. A Research Working Group subgroup are working on writing up data on in-hospital smoking cessation work, in collaboration with UHL, for publication. Annabelle has been working closely with public health colleagues to help disseminate previous work on urinary incontinence in care homes through an academic journal.

9. Conclusion

Leicester's demographic uniqueness is both a challenge and an opportunity. A city whose population does not mirror national norms cannot simply import evidence from elsewhere and expect it to fit. But if we as a city invest in generating and interpreting our own evidence - in partnership with our communities, our universities, and national research bodies – we can become a leader in this area and champion our communities at the same time. We can contribute to national knowledge as well as draw upon it, as we aim to practice community-centred, population-responsive public health practice. The work described in this report represents early progress. Scrutiny is asked to note, and if in agreement also, support, and engage with this work as it continues to develop.

4. Background information and other papers:

5. Summary of appendices:

Research Knowledge and Skills Audit

Introduction

The term research can often mean different things to different people, and people within the council may be doing research without calling it that.
The Specialist Centre for Public Health (SCPH) collaborated on a consensus exercise with 60 participants from local authorities who came from a range of different job roles, directorates and geographical areas to develop a definition of research for local authorities (National Institute for Health Research (NIHR) SCPH, 2025)

> *"Local Authority research supports decision making about practice, policies and interventions at a local, regional or national level and/or helps us understand how people are impacted by the context in which they live, work and go about their daily lives"*

Part of my role as the local authority research practitioner within Leicester City Council is to increase research capacity and capability. To understand what skills and capability were already present with the team, with the help of the new Public Health Research Group, we undertook a brief survey.
The survey drew on this definition to include a broad scope of research which would include using any form of information, insight or data to increase understanding of a topic.

Methods

A brief ten question survey was developed using questions from the individual level of the validated research capacity in context tool developed by Queensland Health and Griffith University (Holden *et al.,* 2011).
The survey was online and delivered via Microsoft Forms. An all-staff email with the survey link was sent to all public health staff with a reminder sent a week later.
Data from MS Forms was downloaded onto an Excel sheet. MS forms also provided basic descriptive statistics for the completed survey responses.

Results

Response Rate

There were 47 responses to the survey (response rate of 41%). There was an even spread of responses from the three public health teams with 39% of respondents coming from the IMPACT team, 33% from the Prevention team and 28% from the EPIC team [Fig 1].

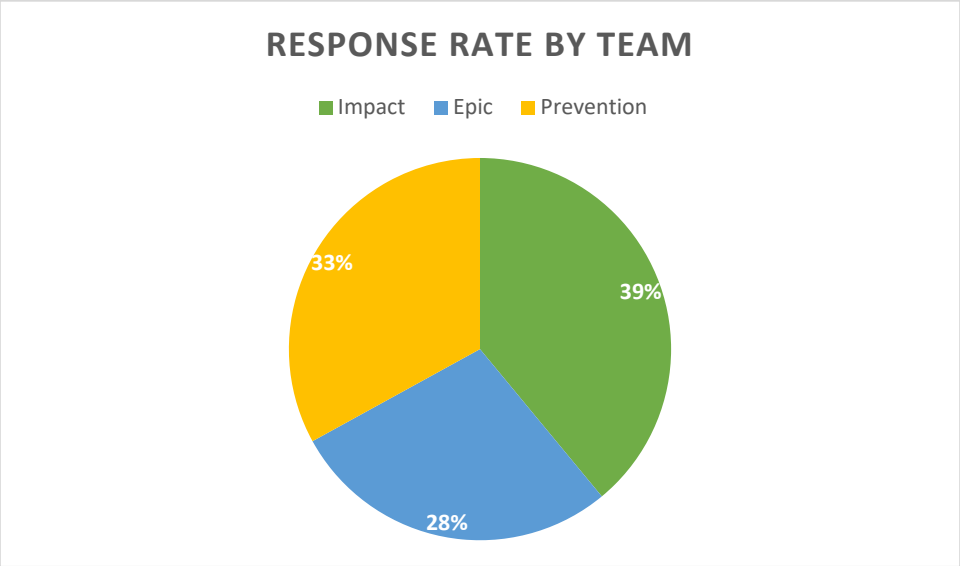

Figure 1: Survey response rate by team

Research Involvement and Experience

Two thirds of respondents reported having an undergraduate degree (66%) with a third having a master's degree (34%). A further 15% of respondents reported having other post graduate qualifications. However, it is likely that up to 83% of respondents had an undergraduate degree as some people reported post graduate qualifications but not undergraduate qualifications. Just under half the respondents (43%) reported having current involvement in research with 45% having no current involvement; 47% reported being involved in research in the last 12 months with 47% not being involved. When exploring research activity by team, over half of the respondents from EPIC (54%) and Prevention (53%), reported current involvement in research with 28% of IMPACT team members reporting current involvement [Fig 2].

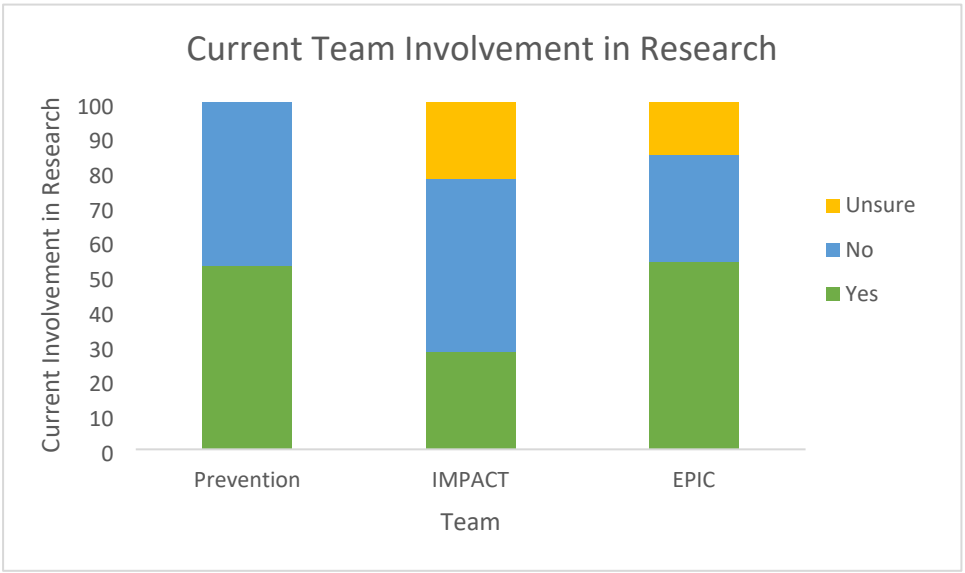

Figure 2: Current research involvement by team

Service evaluations were the most common research activity taking place across the department with eight respondents reporting involvement. Surveys and focus groups were the most used data collection methods across the three teams. There was also a wide range of areas that were using research activities including healthy weight, oral health, vaping, women's health and health inequalities.

The EPIC team reported taking part in the most service evaluations (four respondents involved in six evaluations) and were also more likely to report qualitative type data collection including focus groups, engagement activity and gathering insights. The IMPACT team reported more quantitative types of research activity including surveys, data analysis and report writing. The Prevention team had the most widespread range of research related activities, reporting using both quantitative and qualitative methods.

There was a wide spread of different research experiences with 91% of respondents reporting they had experience of collecting data to 4% of respondents reporting they had experience of securing research funding [Fig 3].

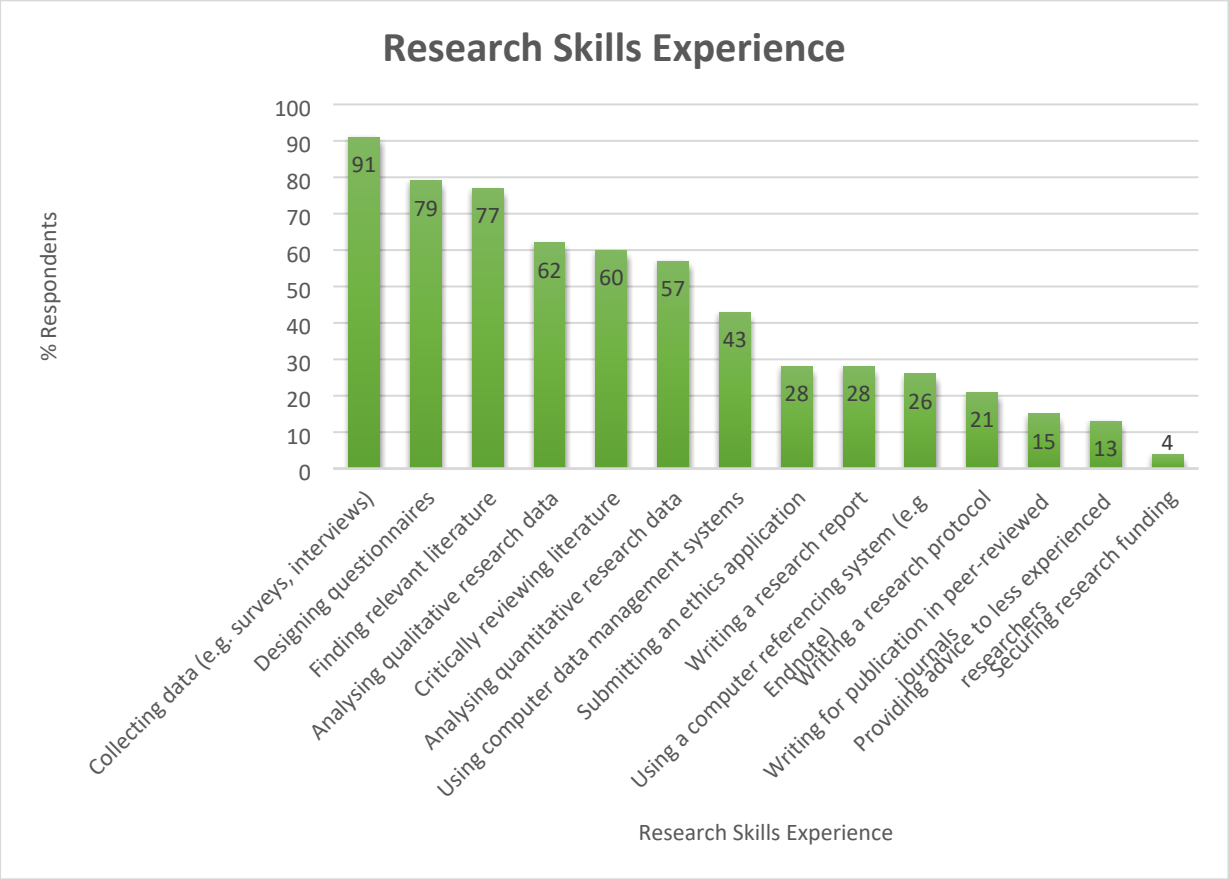

Figure 3: Current research skills experience

Research Skills: Interest and Confidence

There was even coverage of the skills people wanted to learn that ranged from 28% wanting to be able to provide advice to less experienced researchers to 62% wanting to learning how to analysis qualitative data [Fig 4].

Figure 4: Interest in learning research skills

The top five research skills that people wanted to learn were analysing qualitative research data (40%), securing research funding (38%), analysing quantitative data (34%), critically reviewing literature (32%); using computer data management systems and submitting an ethics application were both 30% [Fig 5].

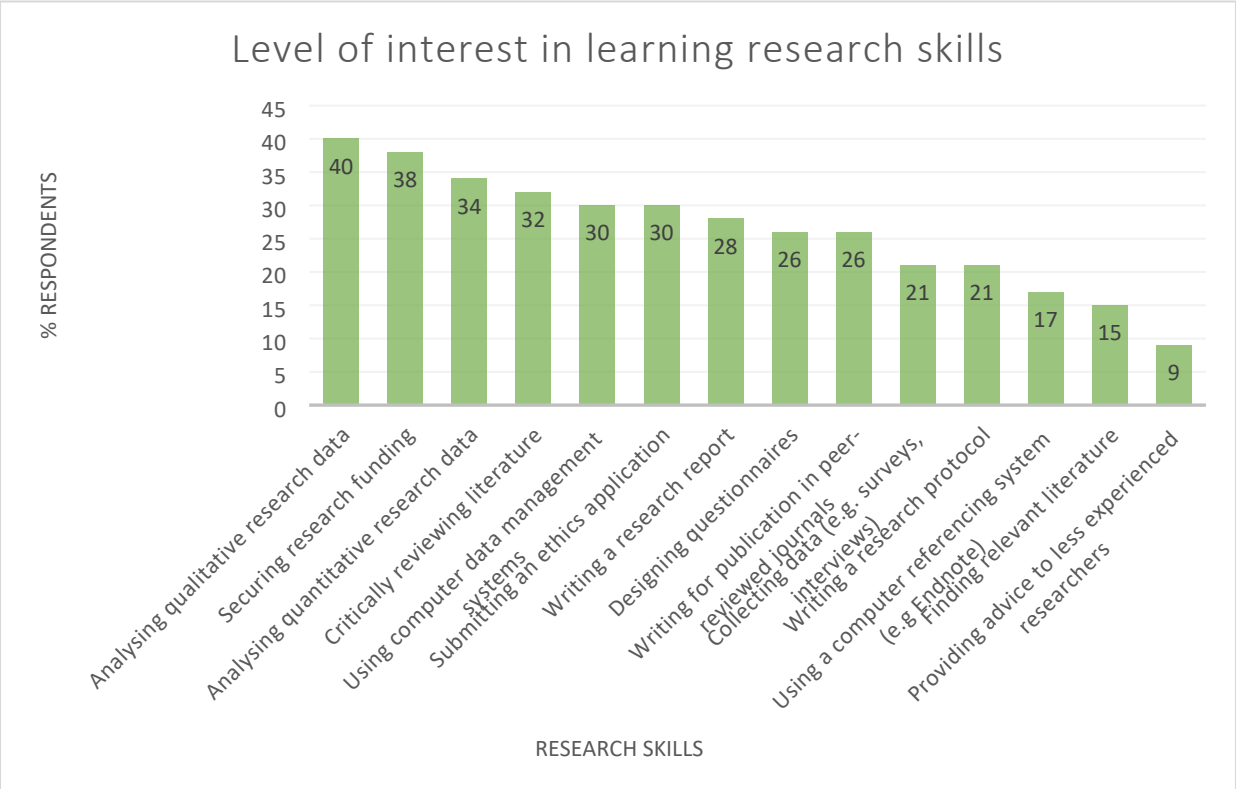

Figure 5: Level of interest in learning research skills

The levels of confidence that respondents showed in research skills varied widely from high levels of confidence in skills that are being regularly used for usual council work such as finding relevant literature (81% confident), designing questionnaires (74% confident) and collecting data (83% confident). There was less confidence in skills that may be seen as more academic such as securing research funding (11% confident), submitting an ethics application (15% confident), writing for publication in peer-reviewed journals (17% confident) and providing advice to less experienced researchers (17% confident) [Fig 6].

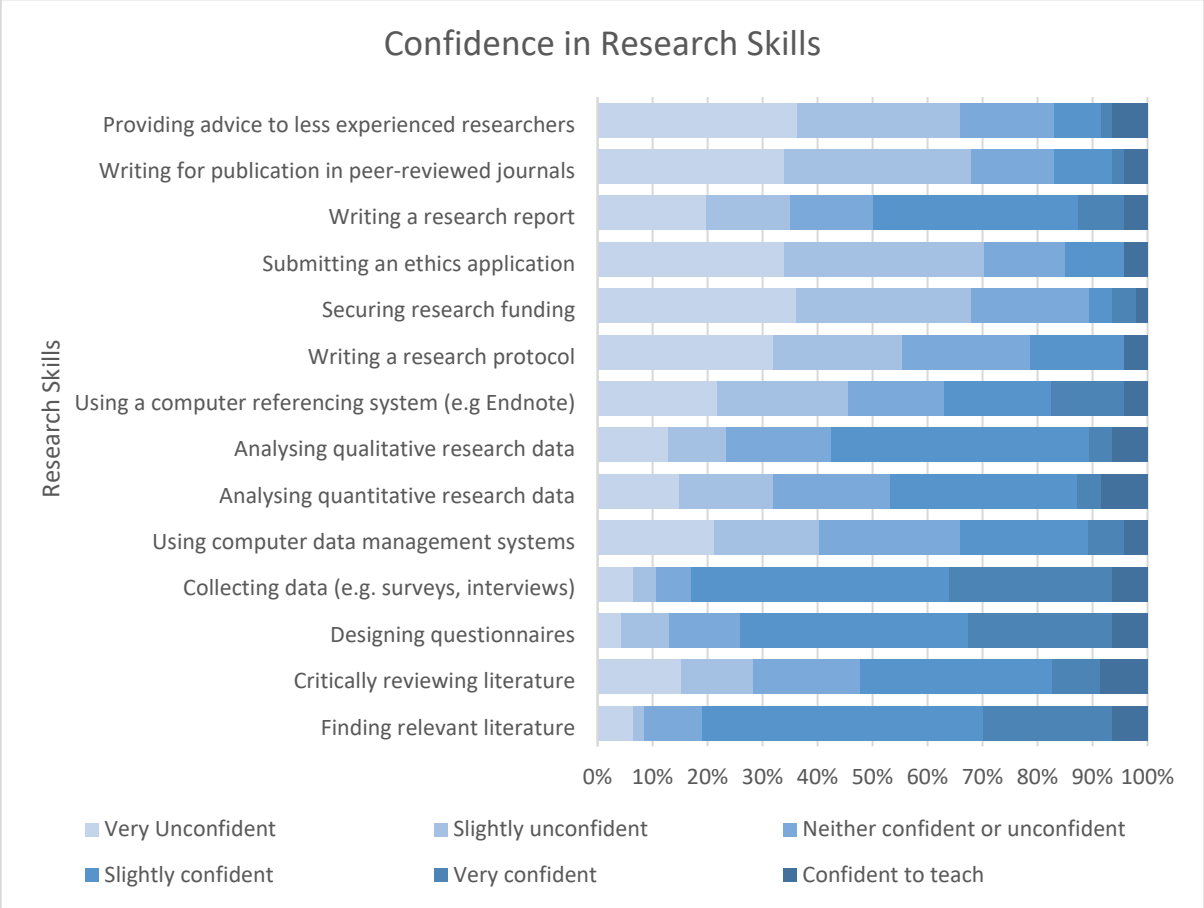

Figure 6: Confidence levels in research skills

Discussion

Summary of Findings

This survey aimed to provide a baseline assessment of the research knowledge and skills in the Leicester City Council Public Health team.
Findings indicated that there was a high level of experience in research skills that may be seen as day-to-day council business such as finding relevant literature, designing questionnaires and collecting data. There was a much lower level of experience in research skills that may be seen as more academic such as securing research funding, submitting an ethics application and writing for publication in peer-reviewed journals.
Just under half the respondents had been involved in research in the last 12 months with just over 40% currently involved.
There was widespread interest in learning new research skills with over half the respondents keen to gain knowledge about analysing data, securing research funding and writing research reports.

Comparison with other Research

This survey used questions from the individual level of the validated research capacity in context tool which has been used by other local authorities to look at research capacity.

Coventry Health Determinants Research Council (HDRC) looked at research capacity and culture in the early part of their second year of funding. Their survey was completed across the whole of the council and had a 7% response rate. They found 23% of those who responded had been involved in research in the last 12 months, whilst 27% reported using research evidence to inform their work in the last 12 months (Bell, Chapman and Taylor, 2025). The findings for Leicester City may well be higher as the survey was completed by public health staff only, which is often a more research active part of a council. In their findings Coventry reported that both the public health and education departments were overrepresented in the survey sample which would add further weight to this argument.

They had similar findings for research experience, having higher levels of experience in finding relevant literature, collecting data and analysing research data, with lower levels of experience in writing research protocols, writing for publication in peer-reviewed journals, submitting ethics applications and securing research funding (Bell, Chapman and Taylor, 2025).

Seven additional HDRC's from the first wave of NIHR funding completed baseline assessments of research capacity, capability and culture through online surveys also using the research capacity in context tool. These were again completed across the whole council workforce and had a response rate that varied from 2 – 10%. Levels of experience in research skills were similar across these local authorities which corresponded to the findings from both Coventry and Leicester (Bell *et al*., 2025).

Many of these local authorities also found that respondents had 'hidden' research skills gained through undergraduate or postgraduate degree training with research methods modules (Bell *et al*., 2025). There were similar findings in Leicester with just under half the respondents reporting postgraduate qualifications which were likely to have included some research methods training. These research skills appear to be underutilised in the local authority setting and efforts should be made to both recognise their existence and harness them for the benefit of the council as a whole.,

Conclusion

This work has provided a baseline assessment of the research knowledge and skills in the Leicester City Council Public Health team. There are examples of research knowledge, skills and experience across the breadth of the Public Health team that can be built upon as we look to develop the research capacity and capability within Leicester City Council.

References

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Specialist Centre for Public Health, National Institute for Health and Care Research, 2025. *Definition of research study*. Available at: https://sites.google.com/view/nihrrssscph/research-governance-and-ethics/definition-of-research-study (Accessed:7th October 2025).

Appendix C

Leicester City Council

Mental Health and Suicide Prevention

Public Health and Health Integration Scrutiny Commission

Date of meeting: 24/03/2026

Lead director/officer: Rob Howard

Useful information

- Ward(s) affected: All
- Report author: Amy Jones, Mark Wheatley
- Author contact details: amy.jones@leicester.gov.uk mark.wheatley@leicester.gov.uk
- Report version number: 1.0

1. Summary

1.1 This report is to update the Public Health and Health Integration Scrutiny Commission about the latest work on Suicide Prevention and to promote mental wellbeing in Leicester. It builds on recent papers to inform the Commission about the Leicester, Leicestershire, and Rutland (LLR) Suicide Prevention Strategy 2024-2029.[1] In addition to oversight by local authorities, actions on suicide prevention are reported to the LLR Mental Health Collaborative.

1.2 Suicide prevention is a local and national priority. The suicide prevention strategy and action plan for LLR have been developed by local authority Public Health teams to reflect the work of a multi-agency partnership. It was developed through engagement with stakeholders, partners and people with lived experience with the aim of addressing local needs and aligning with the national strategy.

1.3 This work is underpinned by Real Time Suspected Suicide Surveillance Data (RTSSS). This is collected by police first responders and is a way of tracking potential death by suicide. The data is labelled suspected suicide because it is not coroner confirmed. Using RTSSS is a way of identifying, monitoring, and responding to emerging trends and risks. It helps the local partnership to support people who've been bereaved or affected by someone dying unexpectedly and to improve local intelligence about those people who are most vulnerable to death by suspected suicide.

1.4 The Commission was previously briefed on the local strategy. This emphasises that "suicide is everyone's business." It focuses on early intervention, reducing stigma, and providing targeted support to high-risk groups. Some key areas of concern include

- Targeting support for people in high-risk demographics.
- Implementing "Mental Health Friendly" places and clubs to upskill the community in having conversations about mental health.
- Using RTSSS to focus support on identified locations and groups.
- Enhancing support services for those affected by suicide.

1.5 Regarding local data, while the rate of death by suicide in Leicester has fluctuated it is not significantly higher than the national average. According to RTSSS, in 2025 26 people from Leicester were reported to have died by suspected suicide.

1.6 Mental Health Friendly Places and Mental Health Friendly Clubs are part of the LLR response to promote better mental wellbeing and support people in adversity, who may be experiencing suicidal thoughts. They are mental health-friendly, safe, and supportive spaces which have received training and are part of a network of organisations which share information and good

[1] See Leicester, Leicestershire and Rutland (LLR) Suicide Prevention Strategy 2024-2029

practice. More about these initiatives can be found on Start a Conversation, the LLR Suicide Prevention website.[2]

1.7 There are 97 organisations signed up as MHFPs and clubs. These are situated in areas where the need is greatest, such as Beaumont Leys, Braunstone, Evington, Eyres Monsell, New Parks and St Matthews. 516 people have accessed the MHFPs training offer.

2. **Recommendation(s) to scrutiny:**

Public Health and Health Integration Scrutiny Commission is invited to note

- The LLR Suicide Prevention Strategy prioritises evidence-based, cross-sector action to target support for people in high-risk groups.
- Strategic action is owned by the LLR Suicide Audit and Prevention Group and is in line with the LLR Mental Health Collaborative.
- Death by suicide reflects wider inequalities, with those living in the most deprived areas likely to be worst affected.
- Initiatives linked to Mental Health Friendly Places are being developed across Leicester communities, especially in areas of greatest need, to promote safe, sensitive communication for people experiencing adversity in their everyday lives.

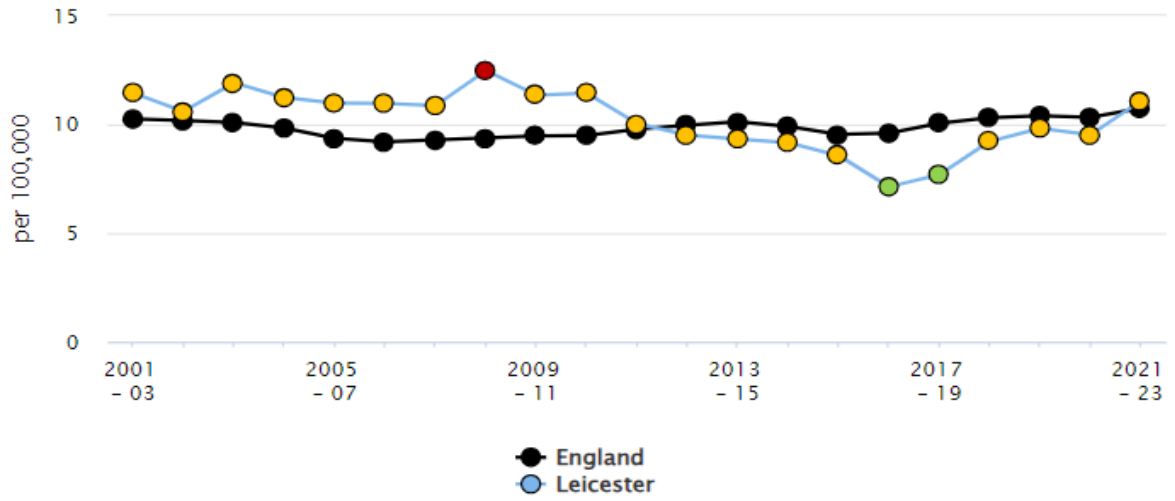
3. Detailed report

3.1 Risk of death by suicide reflects wider inequalities. There are differences in suicide rates according to people's social and economic circumstances with those in poorer communities more likely to be affected.

3.2 Official data for the rate of death by suicide is based on coronial verdicts. It is collected by the Office for National Statistics (ONS) and collated as a 3-year rolling average. Figure 1 below shows the trend in the rate of death by suicide for Leicester since 2001. The suicide rate for all persons in Leicester was 11.1 per 100,000 population for 2021-23. This rate is not significantly different to the national average suicide rate of 10.7 per 100,000 population. The suicide rate in Leicester has not been significantly different to the national average since 2001-3, other than in 2008-10 when it was higher and 2016-18 when it was lower.

Figure 1: Suicide rate (Persons) Leicester Source: ONS

[2] See https://www.startaconversation.co.uk/



3.3 As reported above, local initiatives are informed by RTSSS data. There were 26 people who were recorded as having died by suspected suicide in 2025. This was slightly less than the average annual figure for Leicester since RTSSS started in 2018.

3.4 RTSSS data allow for in-depth investigation of risks. In the period 2018-2025, 251 Leicester residents were recorded to have died by suspected suicide of whom 61.5% were resident in the most deprived, and 23.8% in the next most deprived, quartiles.

3.5 In Leicester, the median (the middle number in an ordered list of numbers) age of people dying by suspected suicide is 42 years for men and 38 for women. About 75% of people who die by suicide are men.

3.6 Public health approaches in Leicester focus on working with local communities to protect those who are most vulnerable, for example supporting people and families in debt, those living in poverty, people who are homeless, unemployed and those experiencing loneliness and isolation is vital to reducing risk.

3.7 MHFPs are the main community response for mental wellbeing and suicide prevention. Organisations which sign up to become a MHFP access free training including Mental Health First Aid, Samaritans Listening Skills, suicide prevention e-learning, healthy conversation skills, real talk suicide prevention, supporting others to develop a safety plan). As of March 2026, there are 97 MHFPs in Leicester and 516 people had accessed the training offer. As reported above, MHFPs are in some of the places of greatest need across Leicester.

3.8 MHFPs contribute to the LLR suicide prevention strategy by raising awareness about mental wellbeing, promoting resilience to mental illness, improving access to wellbeing support in Leicester neighbourhoods, developing supportive networks and evaluating impact.

3.9 One MHFP offers this case study:

'we have had someone visit us a few times over the last few months, and on one visit to us, our staff who have done the e-learning and the Mental Health Aware training, started noticing some of the signs that he may be experiencing a very difficult time, and that

things might be more serious than he was letting on. Our staff were able to navigate a chat with him, asking him direct questions whilst also listening to him, being able to offer direct support in simply being available to chat, and ready to signpost him to other support and help.

Just under a week later, he came back in and seemed a lot better in himself. He told us that, whilst he hadn't at that point been feeling like he was thinking about "doing anything", he said "I have done before though", and that on his last visit, he had been "very low". He thanked the staff member for listening and making him 'feel welcome', and said he appreciated that we didn't make him feel embarrassed or judged when he had started crying a bit. He stated that it made him realise that coming to our project was something he really looked forward to, and that "lots of places just don't make the time to get to know people".

He now comes to our project nearly every week and is training to be a Buddy Team Mentor to welcome new people who come to the project, showing them around the site and where the tea and coffee is etc, and always lets other people know if they have anything they want to talk about, they should find one of the team for a chat.'

3.10 The ethos underpinning MHFPs is in line with NICE Guidance on Community Engagement. This provides advice on ways to draw on local knowledge, to bring together people in communities to plan, design, develop, deliver, and evaluate action to protect health.[3] This community development approach aligns with emerging integrated care programme in which the LLR Mental Health Collaborative prioritises placed based approaches. It also supports delivery of the local and national suicide prevention strategies and the need to tackle health inequalities.

3.11 There is increasing focus on supporting men to access support. This reflects the higher risk of suicide in men and is in line with the new national government strategy on men's health.[4] Helping men to access mental health support involves overcoming stigma, encouraging action through direct conversation, working with community groups which focus on supporting men, male role models, and reducing barriers to support by highlighting the strengths to be drawn from seeking help.

3.12 IN November 2025 the Together for Men Conference[5] was held at the Leicestershire County Cricket Ground on Grace Road. It was an opportunity to showcase, connect and strengthen the range of support, services and community initiatives available for men across LLR. It focused on the importance of mental and physical wellbeing and social connection. It was an opportunity for members of the public with an interest in men's mental health to network with key partners and highlighted the ongoing efforts to support men in MHFPs, Mental Health Friendly Clubs and organisations such as Active Together and the Leicestershire and Rutland County Football Association. More than 100 people attended on the night.

3.13 Since the conference MHFP and Vita Health have started to co-produce a men's mental health training for professionals and community organisations with an interest in supporting men. MHFPs are also working with LPT to produce a men's support booklet

[3] Overview | Community engagement: improving health and wellbeing and reducing health inequalities | Guidance | NICE

[4] Men's health: a strategic vision for England | CP 1432)

[5] Mens Mental Health Agenda.docx

with details of local services that support men with their health and wellbeing that can be passed to patients when they are discharged from hospital as well for people in more general need of support.

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

4.1 Financial Implications

Signed:

Dated:

4.2 Legal Implications

There are no direct legal implications arising from this report. The programme and strategy detailed aligns with the authority's statutory duties to identify and safeguard vulnerable adults and children and supports its obligations under the Human Rights Act in particular, that within Article 2 Right to life

Signed:S Holmes

Dated:16th March 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, to advance equality of opportunity between people who share a protected characteristic and those who don't and to foster good relations between people who share a protected characteristic and those who don't.

Protected Characteristics under the Equality Act 2010 are age, disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion or belief, sex, sexual orientation.

This report updates the Commission on progress with the Leicester, Leicestershire, and Rutland (LLR) Suicide Prevention Strategy 2024-2029. Suicide risk reflects wider inequalities, with higher rates among those in the most deprived areas, men (75% of cases, median age 42), and groups facing poverty, homelessness, unemployment, debt,

loneliness or isolation. Local data shows Leicester's suicide rate (11.1 per 100,000 for 2021-23) aligns with the national average. Targeted action focused in high-need wards like Beaumont Leys and New Parks and men's initiatives embed equality by prioritising high-risk demographics, reducing stigma, and promoting accessible support. Having a continued coordinated response to deliver support for those affected by suicide will have a positive impact on people from across all protected characteristics.
Signed: Equalities Officer, Surinder Singh, Ext 37 4148
Dated:16 March 2026

4.4 Climate Emergency Implications
Whilst there are limited climate emergency implications associated directly with this report, working to improve access to mental wellbeing support, particularly in deprived communities, can have the co-benefit of increasing the resilience of these communities to future changes and impacts. It is also worth noting that because 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: 16th March 2026

4.5 Other Implications
Signed:
Dated:

5. Background information and other papers:

6. Summary of appendices:

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. Loros update		
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	Public mental health and suicide prevention Research – building skills		
28 April 2026	*Items TBC:* *Rheumatology* *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.	