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.