Leicester City Health and Wellbeing Board
1 October 2026

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

EXECUTIVE SUMMARY:

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

In response to the evolving health and care landscape, a development workshop has been held by the Group to review its role and priorities. Members reaffirmed the Group's role in supporting delivery of the Health & Wellbeing Board's priorities through system leadership, partnership working, oversight of the Joint Health, Care and Wellbeing Strategy, joint commissioning, neighbourhood development and Better Care Fund governance.

The Group have agreed to strengthen governance and oversight by ensuring closer alignment between strategic priorities, programmes such as Leading Better Lives and neighbourhood delivery, supporting joint commissioning activity across the city with the creation of a commissioning register to identify opportunities and improving oversight of system risks. Population health intelligence, commissioning decisions and service transformation will also be informed through inclusion of the JSNA Programme Board within the wider governance framework.

Following the workshop, the Group has updated its Terms of Reference to reflect its role and strengthen its ability to provide leadership, assurance and coordination on behalf of the Health & Wellbeing Board. The revised Terms of Reference are included at Appendix A for approval.

The Group has also considered the future development of neighbourhood models for health and care. While recognising that wider system changes and local government reorganisation may influence future arrangements, members agreed there remains a need to maintain momentum. Future work will focus on establishing governance arrangements for neighbourhood delivery and developing neighbourhood plans in partnership to meet local priorities and needs.

The recommissioning of the dementia support service has also been discussed and commended by the Group as a positive example of joint commissioning across health and

care partners. Following a review of service performance, population needs, engagement findings, best practice guidance and CQC feedback, the service has been redesigned to improve equity of access and better meet the needs of Leicester's diverse communities. Further information is provided at Appendix B.

The Group has also supported the development of the Leicester Rough Sleeping Partnership Plan, recognising that homelessness and rough sleeping require a coordinated, whole-system response. Members committed to supporting delivery of the plan through strong partnership working across health, housing, social care and wider stakeholders to improve outcomes for vulnerable residents in line with national objectives.

Updates on the Health & Wellbeing Board Delivery Plan have continued to be provided on a cyclical basis to the Group for monitoring performance and identifying opportunities for joint working. The latest updates have included hypertension case finding as well as mental health wellbeing related to social inclusion, and supportive networks – the full updates can be found below at Appendix C.

List of appendices:
Appendix A - Leicester Integrated Health & Care Group Terms of Reference
Appendix B – Dementia Support Service Briefing Note
Appendix C – Delivery Plan Updates

Appendix A

The Leicester Integrated Health and Care Group

Terms of Reference

Introduction

These Terms of Reference set out the membership, remit, responsibilities, and reporting arrangements of the Leicester Integrated Health and Care Group. This Group will ensure alignment and demonstration of the values and behaviours set out between the Leicester, Leicestershire and Rutland and Northampton ICB Cluster (LLR ICB) and Leicester City Council (LCC) and its partner organisations.

It will be responsible for leading a partnership approach to ensuring that people living in Leicester receive the right level of care in the right place and support the development of services that address unwarranted variation, tackle inequalities, and deliver improved health and wellbeing outcomes.

Commitment Statement

By confirming the terms of reference, Members agree to commit to attending the Leicester Integrated Health and Care Group meetings on a monthly basis. If unable to attend, Members will ensure that a designated deputy will attend in place to represent the team/group/organisation and provide feedback on any important discussions or decisions made during the meeting. Members understand the importance of active participation in meetings and will make every effort to fulfil this commitment.

1. Purpose

The Leicester Integrated Health and Care Group is established to support the Health and Wellbeing Board in providing leadership, direction, delivery and assurance in fulfilling its aim to '**Achieve better health, wellbeing and social care outcomes for Leicester's population and a better quality of care for children, young people and adults using health and social services.**'

The Group is the principal place-based partnership forum responsible for providing strategic oversight, assurance and system leadership for Leicester's Joint Health and Wellbeing Strategy, Joint Strategic Needs Assessment(s), Leading Better Lives Programme and Neighbourhood Health Framework on behalf of the Health and Wellbeing Board. The Group will ensure that these programmes are informed by population need to improve outcomes for Leicester residents by operating as a coherent system to provide a preventative offer and reduce inequalities.

2. Responsibilities

The responsibilities of the Leicester Integrated Health and Care Group, are as follows:

2.1. To drive forward the work of the Health and Wellbeing Board, in supporting the implementation of Leicester's Joint Health and Wellbeing

Strategy (JHWS), as well as any other identified workstreams requested by the Health & Wellbeing Board.

2.2. To oversee the delivery and alignment of the Leading Better Lives programme and Neighbourhood Health Framework on behalf of the Health and Wellbeing Board by identifying priorities and collaboration for a coherent preventative model to support people of Leicester in each of the agreed neighbourhoods.

2.3. To facilitate joint commissioning between the LLR ICB and LCC, maximising opportunities for joint working and integration of services and providing strategic co-ordination of commissioning across both organisations.

2.4. To ensure that strategic priorities, commissioning intentions, neighbourhood plans, transformation programmes and joint commissioning activities across partner organisations are aligned, evidence-based and responsive to the current and future needs of Leicester's population using evidence from joint strategic needs assessments.

2.5. To identify and develop opportunities across both adults and children's services in relation to the transformation agenda to improve outcomes for Leicester City specific challenges through partner organisations, boards, and partnerships/collaboratives.

2.6. Recommend to the HWB how the agreed Better Care Fund at Place level should be allocated.

2.7. Offer support, guidance, and challenge to collaboratives/partnerships and system groups on developing an approach on delivering services/programme initiatives for Leicester's population.

2.8. Empower Leicester residents and ensure that their voices are heard and considered through lived experiences, case studies and the Engagement Insights Hub.

2.9. Strengthen community involvement in decision-making processes by harnessing the reach and trust VCSE's have within local communities.

2.10. Drive action on key the priorities and outcomes from the local NHS, Adult Social Care and Public Health through a Leicester City lens.

Key Principles:

- Ensuring that all partner organisations collaborate in order to bring together appropriate joint arrangements for planning and commissioning.
- Ensuring the needs of the population, patients, service users and carers, are central to the Group's work.
- Developing joint commissioning in priority areas where the Group can add value in terms of improved outcomes and promotion of greater efficiencies.
- Approaching the agenda and work of the HWB board in an open and transparent way, ensuring equity is at the heart of decisions made.

The Group will achieve this by:

3. Leicester's JHWS/Delivery Plan

3.1. Ensuring the delivery of the Health and Wellbeing Boards Strategy, to include:
- Identifying the needs and drivers behind the priorities and activities in the HWBS through population health management intelligence,
- Monitoring delivery and impact of the activity in support of the priorities,
- Action planning to drive improvement; and
- Assurance to the Health and Wellbeing Board on delivery of its priorities and activities.

3.2. Each Priority area will deliver a review of progress, challenges and 'deep dive' where appropriate.

3.3. Identifying, resolving and where necessary escalating barriers and obstacles to delivery.

3.4. Ensuring the work of system level partnership/collaboratives are fully aligned to the needs of the Leicester City Place.

3.5. Leicester Integrated Health and Care Group will establish time limited Task and Finish groups when appropriate.

4. Strategic and Commissioning

4.1. Overseeing the review, development and implementation of any joint strategies and joint strategic needs assessments, between LCC and LLR ICB, including the operational and transformational priorities of the LLR ICB.

4.2. Maintaining an overview of the delivery of joint strategies, joint strategic needs assessments and its role of joint commissioning.

4.3. To horizon scan for emerging issues such as new policy or legislation, new needs or problems within joint systems, working through an understanding of these and agreeing actions to address them.

4.4. To identify opportunities for joint commissioning of services and/or service integration and providing leadership around joint working practice.

4.5. Formulating solutions to complex problems faced by both organisations and identifying, assessing and addressing joint risks.

5. Leading Better Lives & Neighbourhoods

5.1. To provide strategic oversight and assurance for the delivery of the Leading Better Lives Programme and Neighbourhood Health Framework ensuring both programmes are delivered as a coherent preventative model for the people of Leicester.

5.2. Provide leadership and coordination across partners to ensure neighbourhood plans are aligned with agreed strategic priorities, population need and the principles of prevention, early action and reducing inequalities in line with the JHWS, JSNA's and Leading Better Lives programme.

5.3. Promote collaboration between statutory services, the voluntary, community and social enterprise sector, local communities and wider partners to build community capacity and improve outcomes and address inequalities for residents in Leicester.

5.4. To oversee delivery against agreed outcomes, milestones, performance indicators, risks and benefits associated with the Leading Better Lives Programme and Neighbourhood Health Framework ensuring priorities are shaped by population health intelligence, community insight and Joint Strategic Needs Assessment evidence.

5.5. To receive regular reports from programme boards, neighbourhood structures and delivery groups for providing assurance and/or escalate issues requiring system-wide action to the Health and Wellbeing Board.

5.6. Champion co-production by ensuring that the voices of residents, communities, carers and people with lived experience inform the design, delivery and evaluation of both the Leading Better Lives programme and neighbourhood approaches.

Better Care Fund (BCF)/Resources

5.7. To support development of the Leicester BCF Plan and associated metrics and expenditure plan for approval by the HWB and funding partners, and to lead its effective delivery.

5.8. Management of pooled and/or aligned budgets including receiving regular financial and performance reports and ensuring funding and evaluation processes are in place.

5.9. Recommending the allocation of resources to enable to meet the delivery and its strategic objectives at Place level.

5.10. Clearly identifying financial requirements to ensure any affordability risks are exposed and can be tested for viability, and potential for scalability.

5.11. The Group may choose to establish a task and finish group to undertake detailed work if it feels necessary and appropriate for the planning and monitoring of the BCF.

6. Governance

See Appendix 1 for the position of the Leicester Integrated Health and Care Group in wider system and Place governance.

Membership of the Leicester Integrated Health and Care Group

Organisation	Name	Role
Leicester City Council	Laurence Jones / (Co-Chair)	Strategic Director, Social Care and Education
LLR ICB	Yasmin Sidyot (Co-Chair)	Director of Integration (Neighbourhoods & UEC) and Leicester Place Lead

Leicester City Council	Kate Galoppi	Director of Adult Social Care and Commissioning
Leicester City Council	Ruth Lake	Director, Adult Social Care and Safeguarding
Leicester City Council	Damian Elcock	Director Social Care and Early Help
Leicester City Council	Rob Howard	Director of Public Health
Leicester City Council	Katherine Packham	Public Health Consultant
Leicester City Council	Sharon Mann	Programme Manager - Health and Wellbeing Board
Leicester City Council	Georgia Humby	Leicester Integrated Health and Care Group Lead Officer
LLR ICB	Nisha Patel	Head of Integrated Commissioning
LLR ICB	Mayur Patel	Head of Primary Care Commissioning
LLR ICB	Joanna Clinton	Head of Strategy and Planning
LLR Primary Care	TBC	Primary Care Network Lead
ICB	Joanne Ryder	Head of Engagement and Insights
UHL	Simon Pizzey	Associate Director, Strategy and Partnerships
UHL	Muhammed Kathrada	Head of Partnerships
LPT	Vicki Quinn	Head of Business and Transformation
LPT	Abbie Woodhouse	CHS Head of Service
Leicester and Leicestershire Healthwatch	Harsha Kotecha	Chair of Healthwach Leicester and Leicestershire
VCSE	Hardip Chouhan	Head of Operations & Services, Voluntary Action Leicester (VAL)

Attendance from the system Collaboratives/Partnership will be required as and when it is deemed necessary to present and bring to the meeting the system level plan/model. Priority leads will also be required to attend to brief the Group on updates on a periodic basis.
Members commit to fully participating in the Group by highlighting relevant issues from their sector, taking responsibility for taking the work of the Group back into their organisation and holding each other to account.

Chair

The Chair of the Group will alternate between the Strategic Director, Social Care and Education at Leicester City Council and the Director of Integration (Neighbourhoods and UEC) at the LLR ICB.

Meetings

Meetings will be held monthly via MS Teams. Face-to-face or hybrid meetings, when required, will be held at a mutually convenient venue.
The Leicester Integrated Health and Care Group has a Lead Officer responsible for coordinating reports, managing the action log and risk register and supporting agenda setting with the Chairs to ensure work of the group is aligned and targeted to the purpose and responsibilities outlined above.
Meetings will be administered alternatively in accordance with the relevant chair by either the Social Care & Education Directorate or Integration Directorate.
The agenda and papers will be issued at least 4 working days in advance of the meeting unless there are exceptional circumstances for delayed circulation that must be authorised by the Chair.

Declarations of Interest

Members are required to state for the record any interest relating to any matter to be considered at each meeting. These declarations will be recorded in the minutes and where necessary an individual may be asked to withdraw from the meeting for that part of the agenda.

Meeting Quoracy and Decisions

Quorate will be Chair or nominated deputy plus:

- One representative from LCC - Social Care & Education
- One representative from LCC – Public Health
- One representative from LLR ICB
- One representative from UHL
- One representative from LPT

Organisations are asked to take responsibility for ensuring attendance from appropriate officers according to the items on the agenda for each meeting. Where a deputy is sent to attend a meeting, they should not be used as a regular replacement to the main member of the Group due to the importance of having the posts listed involved wherever possible.
Where a meeting is inquorate, the Group may continue to discuss matters and take decisions. Any organisation that is not in attendance will be notified of proceedings for ratification but seizes the opportunity to contest decision-making.
It may become necessary for decision-making to occur outside of scheduled meetings virtually via email. However, it is imperative that these are logged and included in minutes for audit purposes.

Accountability and Reporting

The Group will provide a regular update to the HWB at every meeting which will include:

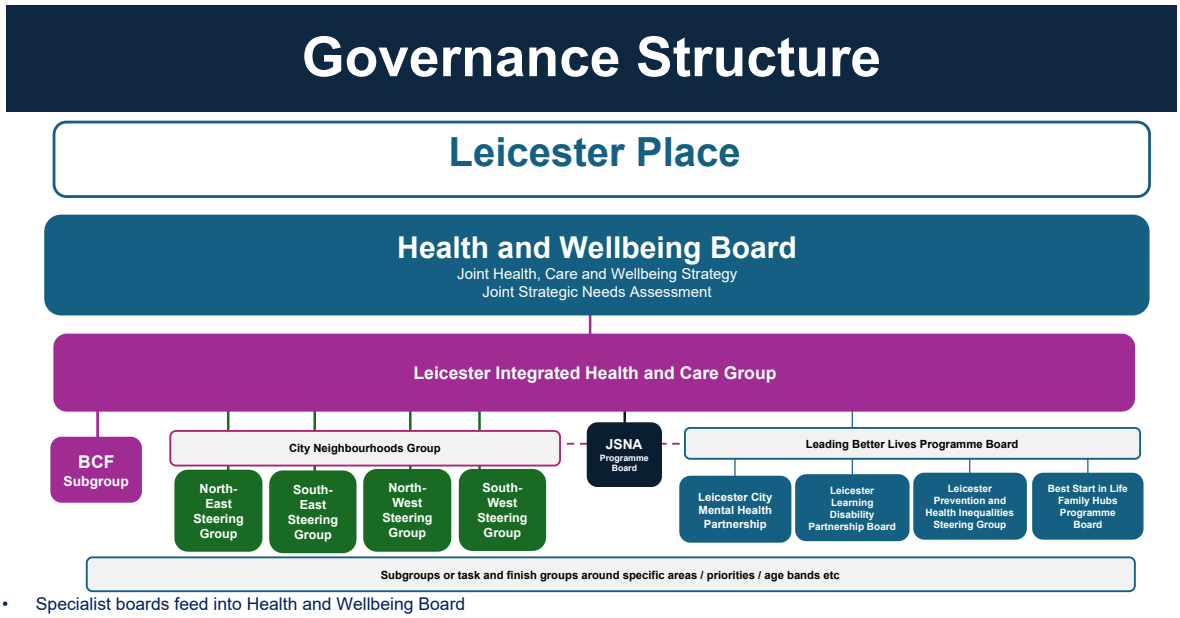
- Reports on performance of health and care programmes, notably the delivery of Leicester's JHWS, Leading Better Lives programme, neighbourhood updates and the BCF.

- An annual report on the use of resources in support of the BCF.
- Reports or updates on specific work commissioned by the HWB, as and when requested.

Terms of Reference Review

There will be a review of the scope, conduct, membership and effectiveness of the Group annually unless circumstances require a more frequent review. The Group will be responsible for agreeing any suggested amendments prior to being approved by the HWB.
Date of approval: August 2026
Date of review: August 2027

Appendix 1



- Specialist boards feed into Health and Wellbeing Board
- Most subgroups attend Health and Wellbeing by request
- **The Leicester City Integrated Health and Care Group reports at each meeting and can escalate points from other boards**

Appendix B

Health and Wellbeing Board Briefing Note

Dementia Support Service Recommissioning

Report Author: Nicky Seneschall-Jones, Business Change Commissioning Manager

Purpose - To provide an overview of the work undertaken to commission a redesigned Dementia Support Service (DSS) for Leicester to better meet current and future local needs.

Background

The Dementia Support Service is a non-statutory service jointly funded by Leicester City Council, Leicestershire County Council and the Leicester, Leicestershire and Rutland Integrated Care Board with the aim of supporting people with dementia to maintain their independence. Delivered by Age UK since April 2021, the outgoing service supports people living with dementia, individuals awaiting diagnosis, and their families and carers through:

- information and advice
- personalised support
- social groups
- carer learning

The outgoing service has supported a significant number of residents. During 2025/26, 943 people with dementia and 1,544 carers accessed support, with annual referrals ranging from approximately 2,200 to 2,800, with increasing proportions of these coming from people who are pre-diagnosis (16%)

Drivers for Change

Data Analysis – Analysis of current service activity showed that Leicester City residents were not accessing the service proportionately to the city's demographic profile. Future population projections show an increase in the number of Leicester residents living with dementia, with the city's ageing population also becoming increasingly more diverse.

Research and best Practice - NICE guidance and the Midlands and Lancashire Dementia 100 Toolkit highlighted identified opportunities to strengthen the preventative and therapeutic support offer.

CQC Feedback – This identified the need to improve access to IAG and services for under-represented groups and address language, digital and cultural barriers.

Engagement and Co-production - The redesign was informed by engagement with people living with dementia, carers, professionals and VCSE organisations and included surveys, focus groups, co-production events and targeted discussions with South Asian communities.

Feedback from existing service users consistently emphasised the value of one-to-one support, information and advice, social groups, peer support and carer learning. These elements have therefore been retained in the new model.

Communities not accessing support highlighted a need for greater awareness of dementia, more culturally appropriate services, localised support groups and interventions that help delay cognitive decline. These priorities informed the revised specification.

New Service Model

In line with local need and the requirements of the Procurement Act 2023 to consider Lotting, the new service has been commissioned through separate City and County contracts. Both retain the existing Core Offer while allowing for further targeted place-based delivery.

For Leicester City, the new specification also includes:

- Targeted education and outreach to under-represented communities
- Greater collaboration with local VCSE organisations to broaden the support offer
- Culturally appropriate information, advice and support
- Delivery of Cognitive Stimulation Therapy
- Preventative outreach focused on reducing dementia risk factors

To support these additional requirements, Leicester City have increased their annual contributions from £116,382 to £195,382. The ICB continue to contribute towards both contracts with their original contribution split across the two lots proportionate to dementia population data.

Following procurement, Alzheimer's Society was awarded both contracts for an initial three-year term with potential extensions to 5 years. Although City and County services will be delivered separately to account for local requirements, there will be consistent referral pathways and a single point of entry through a joint phone and email contact, with people triaged to the appropriate local service.

Performance Monitoring

A strengthened performance framework has been introduced, including:

- Monitoring of uptake and outcomes by demographic group and neighbourhood
- Ongoing responsive action where service uptake does not reflect local population needs
- Alignment with wider system measures such as dementia diagnosis rates, avoidable crises, hospital admissions and demand for formal care packages

Appendix C

Delivery Plan Updates:

Date: May 2026

Title of workstream: Hypertension prevention and case finding
Objective: *To increase detection of hypertension in Leicester through primary and secondary preventative measures and optimisation of treatment.*

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

Reporting Project	Project KPIs and Targets	Update	Next steps	PLUS Groups - SMI - LD - Homelessness - Care experience young people	Risks and mitigations	RAG for period (please include an explanation for rating)	Outcomes Contributing to RAG Rating
Advanced Pharmacy Meds op design group	• Increase proportion of blood pressure service consultations that are ABPM to 10%	The proportion of blood pressure service consultations that were ABPM has risen through 25-26 reaching 9.5%	EMPCT taking actions around low ABPM performers	None	BP checks inappropriately targeted drives low quality perception of service. EMPCT quality work to mitigate.	Amber Overall growth strong,	

	• Grow total annual blood pressure check service consultations by 15% from 2024 baseline.	in March 26 (6.6% for 25-26 as a whole) The total number of BP checks performed in 25-26 rose to 93257 (17.4% up on 24-25). 180 – 190 LLR pharmacies consistently deliver BP checks each month, with 110 – 115 performing ABPM checks	Service specification updates anticipated in Q2 25-26 to reduce inappropriate clinic checks		Low GP practice engagement in referrals, but uncertainty on future specification contents has delayed GP engagement work	ABPM struggling	
NHS Health Checks Meds op design group	• N screened • N diagnosed within 12 months of check date • N receiving health check as part of QRISK score >10% recorded	• N screened: 2024-25: Q1= 2802 Q2= 2670 Q3= 2898 Q4= 3652	Work is progressing to identify potential new models of delivery and have been working with the two universities in the city to identify	This will be largely dependent on eligible population defined within NHS Health Check inclusion criteria, although work will continue to target specific areas of Leicester where uptake is known to be lower, combined with hypertension case finding work and	The re-commissioning of the NHS Health Check service is nearly complete, with just a couple of GP Practices left to sign their contract. The new contracts will be for a maximum of 7 years.	Green- overall performance of NHS Health Check programme is performing strongly and line with anticipated target	NHS Health Check - Data | Fingertips | Department of Health and Social Care Current overall uptake for NHS Health Checks in Leicester is

		2025-26: Q1= 2682 Q2= 2502 Q3= 2265 Q4= 2634 • N diagnosed within 12 months: 2023-24: 573 2024-25: 504 • N receiving health check (part 2) 2024-25: Q1= 352 Q2= 224 Q3= 327 Q4= 295	possible ways to develop health check offer via this route. In addition, working to support the hypertension case finding programme to ensure patients are being re-directed and signposted to have their NHS Health Check where appropriate and if deemed eligible.	looking to target higher risk groups.		figures for 2024-25 and 2025-26. More detail can be found below: NHS Health Check - Data | Fingertips | Department of Health and Social Care	55.9% compared to national average of 34.4%.

		2025-26: Q1= 295 Q2= 293 Q3= 242 Q4= 363					
Support case finding and optimisation of Hypertension City Place monthly meetings Long terms conditions partnership board	**Outcomes** • Increase in knowledge of risk factors for hypertension and behaviour change amongst target population • Increase in number of people a) accessing a BP test, b) being diagnosed with hypertension, c) being optimised • Increase in number of people receiving risk reduction advice and making appropriate behaviour change to manage risk	• Task and finish group in process of transitioning to a longer-term working group to continue work started through PHISG. • RHU continue to deliver BP checks in addition to vaccination activity. • Opportunistic BP checks being carried out within higher risk populations,	• Continued opportunistic BP health promotion (to form a calendar of events for the year ahead). • Offsite pharmacy delivery model – to continue to share opportunities suited to pharmacy support as	Early discussions with LDA Collaborative Health Equity Lead, and SMI & Social isolation task and finish group to support consideration of accessibility and other needs of these groups within hypertension work.	Key notable risks: 1. No designated resource attached to this work – intervention options have been developed to maximise on existing capacity/resources. 2. Requires 'buy in' from all key stakeholders – lack of this from any single area could limit reach and effectiveness of project.	Green – on track with no areas for escalation at this time.	Since initiation of the T&F group: • At least 176 BP checks carried out on the Roving Health Unit (N.B. data covers period up to 31/01/26 when vaccination campaign period ended) • 153 BP checks carried

	• Reduction in number of strokes/myocardial infarctions in Leicester City **Proposed success measures** • Significant increase amongst no. of people in target population to have a BP test over a 6-month period (actual number TBC) • Significant increase in the number of newly diagnosed cases of hypertension (actual number TBC, % of estimated 24,000 undiagnosed cases in Leicester) • Increase in use of pharmacy services for measurement of BP (baseline to be established) • 100% of individuals attending a BP check to be	predominantly via: - GP registrars on placement with PH - Community Pharmacy via offsite testing model • SOP developed and approved to enable public health team staff to conduct BP checks as part of wider health promotion activity. • Proposal for BP monitor loan schemes via libraries agreed (April 2026)	and when they arise. • RHU to continue offering BP testing as part of routine vaccinations work • PH staff to be trained (aiming for May 2026) to carry out non-diagnostic BP checks. • Library BP monitor loan scheme to be progressed – aiming to launch August 2026.		- ICB restructure has affected consistency of clinical support for the group. 3. Possible impact on NHS Health checks (less people attending as a result of additional BP testing interventions) - Signposting to NHS HC to be embedded within intervention pathway. 4. Participation from target audience is essential. - Engagement with target		out using off-site Community Pharmacy model • 84 BP checks carried out by GP registrars on placement with public health. • Health promotion (without BP checks) carried out at two mosques, the Caribbean Carnival, Leading Better Lives event, Sri Lankan Tamil language school, annual public health conference, Haymarket health and wellbeing fair.

	assessed for risk factors and offered prevention advice/signposting/referral to support services • 100% of individuals with BP considered within 'dangerous' range referred for immediate management as per NICE guidance/local guidelines • Individuals with a high BP reading via pharmacy outreach testing to be advised to be offered ABPM as per NICE guidance/local guidelines. - Individuals identified with high BP to be referred to GP for medicines optimisation as per NICE guidance/local guidelines				audience ahead of development of intervention to support co-design/co-production. - Stakeholders include CWC representation. Full risk log to be reviewed as a standing agenda item at working group.		• Approximately 30% of checks indicated higher than normal range BP. • Approximately 10% of checks were with people who had never received a BP check previously. • All checks accompanied with lifestyle advice and signposting to appropriate services for further checks and follow up.

Case study/ qualitative examples of progress:

Project	Example

Point for escalation relating to any of the projects:

Bibliography of Projects

Project	Description
Advanced Pharmacy	Most pharmacies in Leicester are signed up to the NHSE hypertension case-finding programme. This involved blood pressure checks.
NHS Health Checks	The programme is a preventative check to assess overall health status for those aged 40-74 years and don't have a pre-existing medical condition, one of the key areas the NHS Health Check measures for is hypertension and risk of cardiovascular disease (QRISK score).

Support case finding and optimisation of Hypertension	i) Place based targeted work to support practices to identify pts , and link to neighbourhood plans (Community Health and Wellbeing plans) ii) a communication plans to support medication adherence (iii) using business intelligence analysis to understand the detection and optimisation gaps. iv) T&F group work to focus on reducing health inequalities in hypertension detection.

Date 17 06 2025

Title of workstream: Mental health and wellbeing related to social inclusion, and supportive networks
Objective: *Improving the mental health of our local population by promoting and facilitating community-based offers that support inclusion, connectedness and wellbeing*

Governance arrangements:

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

Reporting Project (*governance*)	**Project KPIs and Targets**	**Update**	**Next steps**	**PLUS Groups** - **SMI** - **LD** - **Homelessness** - **Care experienced young people**	**Risks and mitigations**	**RAG for period**	**Outcomes Contributing to RAG Rating**
Neighbourhood Mental Health Cafés *LLR Mental Health Collaborative*	All café providers have provided case studies for Q1. All NMHC's have been reviewed independently (i.e. by NL's but not	**Q1 26/27 data highlights** 209 new individual visitors. 1159 repeat contacts. (283 more contacts compared to same period in 25/26) **Top 5 providers (by number of contacts)** 1. New Parks (243)	Complete review of cafes by November 2026, which will be carried out by NL's for their geographic area. Continue co-production and partnership working	n/a	Risk that individual cafes do not embed into existing pathways		**Urgent Mental Health Hub** The Hub was contacted 8 times with three individuals attending for an assessment

	for their specified geographic area).	2. Beaumont Leys (196) 3. Highfields (164) 4. Thurnby Lodge (154) 5. Belgrave (143) **<u>Top 5 presenting issues (by number of contacts)</u>** 1. Anxiety (425) 2. Depression (387) 3. Isolation/Loneliness (203) 4. Needing someone to talk to (179) 5. Family issues (156) 82.8% of individuals reported feeling a little better or much better, mostly or very safe after support received from their café visit	with providers to strengthen the model				**Central Access Point** 4 referrals were to made to the Central Access Point **Safeguarding** 3 safeguarding referrals were made
Leading Better Lives	Metrics to be developed in co-production as part of the project	Programme has been agreed as corporate approach for early action – including the creation of a Programme Board.	To commission an external organisation to support with the development of the local area co-ordinator service. To complete an extensive mapping		Capacity and resource implications but to be explored now that agreement has been given for programme to be		Positive progress has been made this quarter with the leading better lives programme.

		Monthly community drop-ins are operating with a range of services to support, signpost and refer people in the community. Agreement has been given to proceed with four local area co-ordinators to align with neighbourhood models of care.	exercise to align workstreams to the agreed framework for early action and identify opportunities for collaborative working: 1. Community Offer 2. Partnerships 3. Digital Offer 4. Ways of Working To explore governance routes for other forums required to support the Programme Board.		a corporate approach.		Almost 300 people have attended community drop-ins. Information and advice zone was incorporated at Leicester Riverside Festival. Progress is being made with local area coordinators. Programme has been as corporate approach and has co-sponsors.

Joy app rollout *LLR Mental Health Collaborative*	Quality Review of the impact of Joy including data, case studies and partner testimonies.	Work ongoing with social prescribers to collate data, case studies and testimonies.	New software – Joyconnect – installed across primary care late 2025. Engagement ongoing. Case study attached from VCS partners getting referrals from Joy, MyChoice database project ended and we contacted those not in Joy – very few replied to invitations. Installation into LPT of JoyConnect is taking place early autumn 2026. Four staff engagement sessions already taken place. Focus now on the new Joy contract which is a shared one with neighbourhood working at the new Workwell scheme in	n/a			This section is rated green as the JOY Connect software rollout is taking place in primary care and fully planned for Q3 in LPT. Another rationale for the green RAG rating is the updated software will improve the functionality for practitioners using JOY, improved marketplace optimisation and streamlined referral functionality.

			primary care. This will help us to engage our GP partners in social prescribing as we embed the Workwelll processes. Due to start this autumn				
Mental Health Friendly Places *Leicester City Council - Public Health*	Measurement of training numbers. Measurement of Sign up's to the programme.	105 organisations signed up to the programme: 87 Mental Health Friendly Places (47 City only orgs and 37 LLR orgs) 20 Mental Health Friendly Clubs (11 City only clubs and 9 LLR clubs) 1 Mental Health Friendly Business (City) 237 people trained in MHFA Aware in City and LLR organisations.	Opening up for more clubs to join the programme and offer my space my game sessions in Nov 26. Mental Health Friendly Businesses launching imminently, training has been changed in to video format to meet the needs of businesses. Continuing to offer men's mental health training though the programme. Currently working with key	n/a	Organisational capacity to enable training requires flexible offers.		The programme is continuing to expand with new organisations signing up and the mental health friendly businesses initiative. The ongoing development of training as well as community engagement and events are also evidencing the success of the programme.

		209 MH First Aiders trained in City and LLR organisations. 39 people trained in Samaritans Listening Skills in City and LLR organisations. 30 people trained in Healthy Conversation Skills in City and LLR organisations. 58 people trained in Real Talk Grassroots Suicide Prevention in City and LLR organisations. 2025/ 2026 Survey currently open. Webinar being hosted on 8th October to coincide with World Mental Health Day-	organisations representing diverse groups to gather insight and feedback into men's mental health in different communities. This feedback will be incorporated into the training offer. Work to engage with faith leaders and trusted community leaders for awareness raising of mental health and suicide prevention as well as training for diverse communities. Procure training for those topics identified through MHFP survey Working with Vita Health to produce neurodiversity and mental health training to be ran through the				

		Updated version of Bridging Barriers with Men with Ryan Parke. Real Talk suicide prevention training being procured to be rolled out through the programme for World Suicide Prevention Day. 4 sessions of this training have been hosted and procuring further sessions for 2026/2027 Mental Health Friendly Places Celebration Event held in February 2025 in conjunction with Time To Talk day. Talks given by local mental health and suicide prevention services aswell as domestic violence, drugs and alcohol, autism	programme. Liaising with ND organisations and those with lived experience to inform the training. Collate responses from 2025/2026 MHFP survey and respond to further training needs identified. Hosting 2nd 'Together for Men 2026' conference on Thursday 19th November to coincide with international men's day. The day will be split into 2 parts, the afternoon session will be open to professionals, vcse organisations and sports clubs with guest speakers and stalls showcasing support for men's mental health. The				

		space and gambling harms. (Update) Hosted the 'Together For Men' Conference 2025 at Leicestershire Count Cricket Ground on 18th November. 100+ professionals, VCSE organisations and sports clubs attended the evening. Guest speakers and stalls showcasing the support for men and their wellbeing in LLR. 5 Mental Health Friendly Clubs are trained across LLR (1 in Leicester AFC Andrews) 5 more clubs to be signed up for next football season. AFC Andrews withdrew from the	evening session of the conference will be a marketplace of stalls of those services and organisations supporting men's mental health and will be open to members of the public to attend. Work with LPT to launch version 2 of the men's mental health booklet with updated services of support.				

		programme due to a change in committee members 2 further clubs signed up in the City this year: GNG FC Friar Lane & Epworth FC (Update) Mental Health Friendly Clubs successfully launched- currently 11 City clubs and 9 LLR clubs signed up to the programme. Mental Health Friendly Businesses being launched imminently with a target on barbers, hairdressers, local cafes, tattooists. Launch of the men's mental health booklet in					

		collaboration with LPT. Working in partnership with Vita minds. Have co-produced further training which is being rolled out through the programme including mental health awareness and fitness, looking after your own wellbeing and men's mental health training. These sessions have helped to engage mental health friendly clubs due to the shorter time frame of training. These training sessions have also been made into a video format to better reach mental health friendly businesses.					

		Mental Health Friendly Places are Hosting an event at Haymarket Shopping Centre on 10th September for World Suicide Prevention Day. We will be hosting a wall of hope to engage with members of the public asking them to leave uplifting and inspiring messages. We will be joined by Samaritans and Tomorrow Project on the day and will be handing out resources to local support as well as leaflets signposting the public to the 20 min suicide prevention training on SAC. MHFP's are also joining in to mark the day and hosting their own walls of hope at					

		their venues and handing out the training leaflets and other SAC resources. The Cenotaph at Victoria Park and City Hall will be lit up in yellow and orange from the 7th-11th Sept to mark WSPD. If successful will look to make this an annual event.					
Getting Help in Neighbourhoods Projects *LLR Mental Health Collaborative*	Quarterly case study theming takes place to demonstrate the impacts and outcomes of the GHiN projects.	Number of first time (new attendees) 2,601 Number of total attendees to sessions / activities 16,622 Attendees receiving 1-1 support 4,989	All GHiN projects have been reviewed within Q1. All Providers were found to be delivering a good standard of support to individuals, with some exceptional projects offered by Leicester Combat Academy, New Futures, Somali	Groups supported include: - Homeless - Vulnerable women (sex workers, sex trafficked, domestic dbuse) Asylum Seekers	At present no risks identified.		The rationale for the green RAG rating is that all projects have been reviewed and met the expectations of the scheme.

			Development Service.				

Case study/ qualitative examples of progress:

Project	Example
Neighbourhood Mental Health Cafés	**Saff Caff – June 2026 Case Study** Service User (SU) demographic: White, Female, 30-49, unemployed SU attended Saff Caff following self-harm and suicidal thoughts. Initially reluctant to engage, she accepted support to contact the Crisis Line and agreed to follow-up welfare checks. In subsequent sessions, the SU shared that family difficulties had led to increased gambling, self-injury, and a deterioration in her eating disorder. Staff supported her to access Gambling Harms, signposted her for debt advice, and provided information on eating disorder support services. Over time, the SU attended regularly, engaged with the GHiN programme, and became more open about her challenges. Despite delays in accessing the Crisis House, she remained engaged with support and accepted ongoing welfare checks.

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

Point for escalation relating to any of the projects:
NA

Bibliography of Projects

Project	Description
Neighbourhood Mental Health Cafés	Drop-in sessions delivered by voluntary sector providers and located in areas with highest levels of mental health need where people can get mental health support and advice – no appointment needed.

Mental Health Wellbeing & Recovery Support Service	Preventative mental health service enabling people to improve and maintain their mental health & wellbeing, or recover from mental illness, through better use of community assets & resources.
Bringing People Together Programme	Free activity sessions at community centres and libraries encouraging people to learn new skills, get more active and get together with others. Projects include: • Let's Get Together (LGT) • Let's Get Growing (LGG) • Let's Get Digital (LGD) • Let's Get Walking LGW) • Let's Get Creative (LGC) • Warm Welcome
Leading Better Lives	Developing a coproduced council-wide approach to prevention and community wellbeing, including monthly community drop ins and a local are co-ordinator service.
Prevention Concordat for Better Mental Health	Underpinned by a prevention-focused approach to improve mental health, which in turn contributes to a fairer and more equitable society.
Joy app rollout	Roll out of the Joy social prescribing app which promotes activities and support and allows people and professionals to make referrals
Mental Health Friendly Places	Encouraging local businesses & community organisations to take up training offer & accreditation to equip them with skills and knowledge to support people with mental health
Getting Help in Neighbourhoods Projects	Grant-funded projects allowing voluntary sector organisations to expand or enhance their existing offer in order to support mental health & wellbeing through activities and support.