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.