Leicester
City Council

MINUTES OF THE MEETING OF THE
LEICESTER, LEICESTERSHIRE AND RUTLAND JOINT HEALTH SCRUTINY COMMITTEE

Held: MONDAY, 16 JUNE 2025 at 10.00am

P R E S E N T :

Cllr Agath
Cllr Haq
Cllr March
Cllr Sahu
Cllr Crook
Cllr Durrani
Cllr King
Cllr Poland
Cllr Stephenson
Cllr Harvey

* * *  * *  * * *

## 45. APOLOGIES FOR ABSENCE

Apologies were received from Cllr Singh Johal and Harsha Kotecha, who sent Kash Bayani as a substitute.

## 46. DECLARATIONS OF INTEREST

Councillor King declared his wife was involved for Stroke Association.

## 47. MINUTES OF THE PREVIOUS MEETING

The minutes of the meeting held on 17 March 2025 were agreed as a correct record.

## 48. COMMITTEE MEMBERSHIP 2025-26

The Membership of the Commission was agreed.

## 49. TERMS OF REFERENCE

The Commission noted the Scrutiny Terms of Reference.

## 50. DATES OF MEETINGS

The dates of the meetings for the Commission were confirmed as follows:

16th June 2025
27th November 2025
23rd February 2025

## 51. PETITIONS

It was noted that none were received.

## 52. QUESTIONS, REPRESENTATIONS AND STATEMENTS OF CASE

It was noted that none were received.

## 53. NHS TRANSFORMATION

The Executive Director for Integration and Transformation for Leicester, Leicestershire and Rutland (LLR) submitted two papers to outline where the NHS in LLR were at financially in terms of budget.

As part of the presentation, it was noted that:

- During the last financial year, the system worked together to deliver a challenging joint financial plan. Despite the difficulty, the system saved £150 million by improved efficiency of service delivery.
- Demand for health and care services continued to rise, increasing the pressure to deliver further savings. The total budget for LLR was £2 billion, with a further £190 million in savings required.
- National and local changes announced earlier this year had intensified pressures. These included organisational restructures that were impacting staff, with the ICB in LLR required to reduce its running costs by up to 33%. NHS Trusts had also been given targets to reduce workforce growth, particularly in non-clinical/non-patient-facing roles and there had been a pause on recruitment in these areas.
- Health and care partners across LLR were tackling these challenges head on. Everyone working in the system remained committed to delivering the high quality care our communities expected and deserved.

They were focused on making every pound count but the scale of the challenge meant they would need to make difficult choices about how services were delivered or potentially stopped.
- They would continue to work closely with partners, including councils, voluntary sector organisations, patients and the public to become more efficient and make the changes needed to meet financial targets.

The 3 key areas of focus were:

- **Recruitment and staffing** – Prioritising the most critical, patient-facing roles, and reducing bank and agency spend, whilst maintaining a strong focus on putting patient safety first.

- **Tackling inefficiencies** – including inefficient processes to delivering care that doesn't meet patients' needs. We can all help by improving how we work and making sure we are delivering the right care in the right way.

- **Redesigning services** – It was essential that budgets funded the services our population required most. That may mean changing or potentially stopping some established services and rethinking how to deliver better outcomes for patients.

As well as focusing on these areas, they were contributing to the development of the national 10-Year Health Plan, which aimed to transform healthcare delivery by emphasising prevention, enhancing community-based care, and embracing digital technologies. The local shorter-term operational plans would be developed alongside this to ensure we are aligned nationally while responding to local needs.

In discussions with members and officers, the following was noted:

- Assurance was given that, despite savings pressures, progress had been made on initiatives such as mental health cafés and health checks.
- It was acknowledged that system transformation was discussed each year, with questions raised around how savings targets were being met and measured.
- The potential to include year-end reporting on the work programme was suggested.
- Concern was raised regarding the impact of workforce reductions, particularly a 33% reduction in ICB staffing, and how staff morale and wellbeing were being supported.
- Support mechanisms such as weekly briefings, leadership visibility, and transparency with staff had been implemented.
- Recruitment was restricted to business-critical roles, emphasis was on avoiding duplication and sharing capacity across partner organisations.
- Concerns were raised about the impact of efficiency savings on patient care, especially within general practice, and the availability of GP

appointments.

- It was noted that there was no official GP-to-patient ratio, but partnership working with practices was ongoing. There remained a national shortage of GPs.
- Bank staff continued to be used due to flexibility, but efforts were being made to reduce agency reliance and improve rostering.
- The system executive group had submitted an operational and efficiency plan, and there was an intention to bring this forward for future scrutiny.
- Members requested access to efficiency plans and the metrics used to monitor progress. Clarification was provided on ICB running costs, noting the organisation remained in the lowest 10 out of 42 nationally. With an offer to circulate monthly public broadcasts detailing how financial targets were being addressed.
- A request was made for data on GP appointments, including the breakdown between GP-led and alternative staff-led consultations. It was reported that 60% of appointments in the city were with GPs and 40% with other practice staff, though this did not always align with patient feedback.
- GP services were supported by Primary Care Networks, with some offering additional hours in evenings and weekends, but this varied across locations.
- Concerns were raised about the accuracy of appointment data and whether patients understood the new models of care. Clarification was given that the 33% workforce reduction would not affect patient-facing roles but would impact functions supporting delivery and scrutiny.
- Questions were raised about whether reductions in emergency care demand were being reflected in statistics, particularly around urgent care usage. Urgent care centres saw significant daily attendance, many patients could have been seen elsewhere, and the system was working to stream patients appropriately.
- There was recognition that reducing pressure on one part of the system could lead to increased demand elsewhere.
- Reassurance was sought around the safe transfer of safeguarding responsibilities from the ICB to provider organisations. A transition committee had been established to oversee these changes, and it was confirmed that no service would be moved without assurance of safety.
- The timeframe for delivery of transfer plans was set for December 2025, although further national information was still awaited.
- Concerns were raised about public communication regarding service changes, particularly in rural areas and for older populations.
- National communications were in place to reassure the public that their existing services would not change.
- Discussion took place on the underuse of urgent care and minor injury services in rural districts, and the associated cost implications.
- It was noted that services must be better utilised and more equitably accessed across geographies.
- There was a brief discussion on potential local government reorganisation and its potential implications for health and care planning, but no confirmed proposals were in place.

- It was confirmed that no changes would be made to services without clear evidence and assurance that it would be safe and appropriate to do so.

AGREED:

1. That the reports were noted.
2. That an item on primary care access and general practice models be added to the work programme.
3. That an in-depth session on GP service provision across LLR, broken down by area, be added to the work programme or delivered via informal briefings.
4. That figures on patients who presented at primary care and whether this is due to the increase of available GP appointments to be circulated to members.
5. The Model ICB blueprint to be circulated to members.
6. That a further update on ICB changes be scheduled for the November meeting.

## 54. PILOT DIGITAL PROJECT

The East Midlands Ambulance Service Senior Manager for Quality presented the digital programme pilot for stroke recovery which is a collaboration with University Hospitals of Leicester.

As part of the presentation, key points noted were:

- The programme aimed to improve patient safety and equality. Stroke had been the 4th largest cause of death and was the biggest cause of gained disability.
- Stroke was hard to diagnose. A definitive diagnosis required a CT scan in hospital. The role of the paramedic was to recognise the symptoms and pre-alert the hospital. In 2022/23, data showed that 69% of cases were stroke mimics.
- The pilot was intended to allow pre-hospital video triage. All ambulance technicians were provided with an iPad which allowed a direct video call with a stroke consultant when the team suspected a stroke. This allowed better preparation on the stroke ward and reduced the time for definitive treatment.
- The technology allowed use of the shared care record allowing clearer signposting and pathways, reducing the burden on the Emergency Department.
- The streamlining of the service through the video triage allowed ambulances to be back in the community faster, improved service efficiency, provided strong staff satisfaction, whilst patients received optimum care and experiences.
- The pilot was launched in January 2024 and was intended to last 12 months. It was reviewed in January 2025 and funding was received to continue the project and launch it across further areas in the East Midlands.

- Half of paramedics and technicians had been trained to use the technology in Leicester, Leicestershire and Rutland so far.
- In September 2024 the pilot was moved to a 24/7 model, with 293 successful consultations completed.
- The technology had prevented 28% patients being needlessly conveyed to hospital.
- There was a higher occurrence of stroke in correlation with deprivation in Leicester. The pilot had therefore helped address health inequalities and offered an opportunity to improve health outcomes.
- The accuracy of the video triage raised no risk or safety concerns for patients.
- Barriers for the pilot included:
    - the challenge of linking 2 organisations on Microsoft Teams, particularly with consideration for data governance issues and information security.
    - Difficulty providing 8 different stroke consultants with access.
    - The support needed to be provided quickly for potential stroke patients. This had led to the development of a one touch button for the ambulance technicians. If this failed to be answered by a consultant, the crew would revert to the pre-alert method. High levels of unanswered calls were an issue and reduced motivation so staff training was provided for crews and consultants and incentives were put in place until the process was fully embedded into the system.
- A national move was now underway to embed this system in all ambulance services.

In response to questions and comments from members, it was noted that:

- The pilot was a fantastic initiative.
- The software used by the ambulance crews allowed roaming across different networks to maximise location use. There had been 3 cases where the signal could not be optimised, and in these instances the crew pre-alerted the hospital and made the call once the signal had improved.
- The Integrated Stroke Delivery Network (ISDN) provided oversight to stroke provision across healthcare and optimised treatment availability. The initial grant was £100,000 initially and this covered provision of training, staff to look at data and the equipment.
- Stroke services had been particularly challenged due to stroke mimics.
- A lot of work had been done into remote triage and NHS pathways which would allow seamless movement across systems. This technology provided the opportunity for lots of development and could be applied across other areas.
- There were issues initially in the pilot with Microsoft Teams and consultants not picking up calls. This reduced, with a small number of calls were going unanswered – around 3 or 4 calls per week. There were also cases where strokes would be attended by crews

who had not yet been trained.

- Consultant Connect, a previous project had been embedded into the system.
- High levels of staff turnover had caused difficulties, but new staff are trained in this as standard practise now. More work is required to embed it as there had been instances where staff reverted to previous methods.
- It was hoped the initiative would become regional which could allow access to more consultants. However, it was important to be mindful of centres not becoming overwhelmed as well as the importance of local knowledge of bed and wards, as well as the consultant who had been alerted to be on hand on arrival.
- EMAS used 2 sub-contracts for private ambulance providers. It was being considered how to provide these with access to the triage system. The training for the staff was ready to go, it was the digital aspect that required finalising.
- There was a national challenge around availability of ambulances. This had led to a lot of work to ensure that signposting was optimised for appropriate pathways which would reduce unnecessary demand on Emergency Departments.
- Consideration was ongoing for how triage could be used to reduce the need for ambulances or to ensure priority was met appropriately when they were dispatched.
- Concerns were raised that the support and care following a stroke was a postcode lottery.
- There was a quandary of where the limited resources should be invested, whether it was in preventative work, emergency departments or rehabilitation.
- It was hoped that the technology could soon be applied to other emergencies.
- Concerns were raised around the resilience of the system in emergency situations. Members were reassured that lots of work was done around responses in emergency planning.
- The equitability of the initiative was questioned, particularly as ambulance call out response rates for EMAS were lowest in Rutland. EMAS was working with Health Watch Rutland on this.

AGREED:

1) Information to be provided by EMAS on how many private crews and ambulances were being used.
2) Slides to be shared with Members.
3) Report was noted.

## 55. SHARED CARE RECORD

The Leicester Partnership Trust (LPT) gave a verbal presentation on the Shared Care Records.

It was noted that:

- The Shared Care Record covered different patient groups and local authorities.
- The system brought together various data sets into one place, this offered a more holistic view of a person's care, including any social care provision.
- Historically, social care teams had to wait for information before picking up cases, but this system aimed to reduce those delays.
- Around 1,100 social care users and professionals across the three local authorities had access to the record.
- The system also showed who was providing care across different organisations.
- GPs were in the process of being rolled out onto the system.
- Other services such as Pharmacy First, LOROS, EMAS, Rainbows, and patient care local terms were also being connected.
- Onboarding continued for new use cases and in alignment with national directions, while also focusing on local user needs.
- A pilot had started with Children's Social Care groups, including Looked After Children, working on a data set to support direct care for individual children.

In discussions with Members, the following was noted:

- It was noted that Adult Social Care (ASC) had often been overlooked compared to health services. Questions were raised about who the 1,100 users accessing the shared care record were, as this only represented a small portion of the ASC workforce in the city. Concerns were expressed about whether frontline staff were benefiting from the system.
- Officers clarified that teams granted access had been prioritised by local authorities, such as front door, mental health workers, learning disability workers, social care workers and review teams and rapid response teams. The system was designed to link into existing platforms like Liquid Logic, avoiding the need for additional logins. Care homes also currently had access to SystmOne, with potential for integration with the care records.
- Members welcomed the progress and asked about the timeframe for enabling access to records during a person's hospital stay and how early in their care journey this could happen.
- Officers explained that timelines were dependent on work by system suppliers and aligned with financial year planning. While there were internal targets, no national deadlines had been set.
- Questions were raised on how the rollout would be paced and how different IT systems used by domiciliary care providers could be affected by the process. It was noted that many local authorities use Liquid Logic, which could help speed up national implementation. Careful management of consent, especially from families and informal carers was emphasised.
- Concerns were raised about data security, particularly regarding children. Members questioned safeguards in place to prevent full access

to sensitive information stored in systems like Liquid Logic.

- Officers reassured that access was strictly for direct care and based on a need to know basis. Not all users had access to full records, and data visibility was limited to specific patients and relevant information only.
- Queries were made about the financial cost of the programme, especially in light of past failed attempts by the government to implement similar systems. It was also raised about GDPR compliance, consent pathways, and the lack of supporting information in the report.
- Officers responded that every interaction with the care record was tracked and accessible only to authorised healthcare professionals. The programme aimed to speed up discharge and improve direct care delivery.
- The significant difference made by integrated systems like SystmOne was noted and highlighted past issues where paper notes were physically carried across hospital departments.
- Clarification was sought on whether the system would be accessible to lower-level care workers, such as visiting carers. Officers explained that access currently extended to more official or clinical roles, such as pharmacists and hospice staff, but not to domiciliary carers visiting people in their homes.

AGREED:

1. The presentation was noted.
2. Further information would be circulated to members.
3. The pathways diagram to be shared with members.

## 56. MEMBERS QUESTIONS ON MATTERS NOT COVERED ELSEWHERE ON THE AGENDA.

Members raised concerns about dentistry across the LLR. Members were advised to contact the ICB and an item on dentistry would be added to the work programme.

## 57. WORK PROGRAMME

The chair highlighted the work programme and items noted during the meeting would be added to the work programme.

## 58. ANY OTHER URGENT BUSINESS

With there being no further business, the meeting closed at 12.30.