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

DATE: **THURSDAY, 27 NOVEMBER 2025**
TIME: **10:00 am**
PLACE: **Meeting Rooms G.01 and G.02, Ground Floor, City Hall, 115 Charles Street, Leicester, LE1 1FZ**

Members of the Committee

Leicester City Council

Councillor Pickering (Chair of the Committee)
Councillor Agath
Councillor Haq
Councillor March
Councillor Sahu
Councillor Singh Johal
Councillor Westley

Leicestershire County Council

Councillor Hill (Vice-Chair of the Committee)
Councillor Morris
Councillor Durrani
Councillor King
Councillor Knight
Councillor McDonald
Councillor Poland

Rutland County Council

Councillor Harvey
Councillor Stephenson

Members of the Committee are invited to attend the above meeting to consider the items of business listed overleaf.

For Monitoring Officer

Officer contacts:
Katie Jordan (Senior Governance Support Officer) e-mail: katie.jordan@leicester.gov.uk
Oliver Harrison (Governance Support Officer) e-mail: Oliver.Harrison@leicester.gov.uk)
Leicester City Council, City Hall, 115 Charles Street, Leicester, LE1 1FZ

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If you have any queries about any of the above or the business to be discussed, please contact: katie.jordan@leicester.gov.uk or Oliver.Harrison@leicester.gov.uk of Governance Services. Alternatively, email governance@leicester.gov.uk, or call in at City Hall.

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USEFUL ACRONYMS RELATING TO
LEICESTERSHIRE LEICESTER AND RUTLAND JOINT HEALTH SCRUTINY COMMITTEE

Acronym	Meaning
ACO	Accountable Care Organisation
AEDB	Accident and Emergency Delivery Board
AMH	Adult Mental Health
AMHLD	Adult Mental Health and Learning Disabilities
BMHU	Bradgate Mental Health Unit
CAMHS	Children and Adolescents Mental Health Service
CHD	Coronary Heart Disease
CMHT	Community Mental Health Team
CVD	Cardiovascular Disease
CCG LCCCG ELCCG WLCCG	Clinical Commissioning Group Leicester City Clinical Commissioning Group East Leicestershire Clinical Commissioning Group West Leicestershire Clinical Commissioning Group
COPD	Chronic Obstructive Pulmonary Disease
CQC	Care Quality Commission
CTO	Community Treatment Order
DTOC	Delayed Transfers of Care
ECMO	Extra Corporeal Membrane Oxygenation
ECS	Engaging Staffordshire Communities (who were awarded the HWLL contract)
ED	Emergency Department
EHC	Emergency Hormonal Contraception
EIRF	Electronic, Reportable Incident Forum
EMAS	East Midlands Ambulance Service
EPR	Electronic Patient Record
FBC	Full Business Case
FYPC	Families, Young People and Children
GPAU	General Practitioner Assessment Unit
HALO	Hospital Ambulance Liaison Officer
HCSW	Health Care Support Workers
HWLL	Healthwatch Leicester and Leicestershire
IQPR	Integrated Quality and Performance Report

JSNA	Joint Strategic Needs Assessment
NHSE	NHS England
NHSI	NHS Institute for Innovation and Improvement
NQB	National Quality Board
NRT	Nicotine Replacement Therapy
OBC	Outline Business Case
PCEG	Patient, Carer and Experience Group
PCT	Primary Care Trust
PDSA	Plan, Do, Study, Act cycle
PEEP	Personal Emergency Evacuation Plan
PICU	Paediatric Intensive Care Unit
PHOF	Public Health Outcomes Framework
PSAU	Place of Safety Assessment Unit
QNIC	Quality Network for Inpatient CAHMS
RIO	Name of the electronic system used by the Trust
RN	Registered Nurse
RSE	Relationship and Sex Education
SOP	Standard Operating Procedure.
STP	Sustainability Transformation Partnership
TASL	Thames Ambulance Service Ltd
UHL	University Hospitals of Leicester
UEC	Urgent and Emergency Care

PUBLIC SESSION

AGENDA

NOTE:

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1. APOLOGIES FOR ABSENCE

2. DECLARATIONS OF INTEREST

Members are asked to declare any interests they may have in the business on the agenda.

3. MINUTES OF THE PREVIOUS MEETING **Appendix A (Pages 1 - 10)**

The minutes of the meeting held on 16th June 2025 have been circulated and the Committee is asked to confirm them as a correct record.

4. PETITIONS

The Monitoring Officer to report on the receipt of any petitions submitted in accordance with the Council's procedures

5. QUESTIONS, REPRESENTATIONS AND STATEMENTS OF CASE

Jean Burbridge asks:

1. Why is UHL closing down St Mary's midwife led birth centre? This birth centre is the stand-alone midwife led birth facility for the whole of Leicester, Leicestershire and Rutland. The Decision Making Business Case following public consultation for Building Better Hospital For the

Future promised a replacement stand-along midwife led birth centre would be created at Leicester General Hospital but this has not happened.

2. A stand-alone midwife led birth centre is supposed to be one of the four options made available to women for the births of their babies. However, St Mary's in Melton Mowbray seems to be closed down with little discussion. Has this been brought before the Joint LLR Health Overview and Scrutiny Committee for detailed scrutiny?

3. If not, can the chair give an assurance that no closure will take place before detailed scrutiny has taken place in this committee?

6. DIGITAL FOCUS

Appendix B (Pages 11 - 38)

The Integrated Care Board submit a report to update the Commission on digital tools for patients and those supporting them.

7. UPDATE ON WINTER PRESSURES

University Hospitals Leicester (UHL) will give the Commission a verbal update on the current position.

8. SYSTEM HEALTH EQUITY

A verbal presentation will be provided by Health Partners for the Commission on System Health Equity conducting a deep dive into longer waits at both the Emergency department and patients waiting for ambulances to assess the impact against protected characteristics.

9. 24/25 YEAR END REVIEWS

Please note this item is for information only.

Leicester, Leicestershire and Rutland (LLR), Integrated Care Board (ICB) - https://leicesterleicestershireandrutland.icb.nhs.uk/wp-content/uploads/2025/08/LLR-ICB-Annual-Report-and-Accounts-2024-25.pdf

University Hospitals Leicester (UHL) - https://www.uhleicester.nhs.uk/publications/annual-report-and-accounts-2024-25/

Leicester Partnership Trust (LPT) - https://www.leicspart.nhs.uk/wp-content/uploads/2025/09/LPT-Annual-Report-2024-25-FINAL.pdf

10. DENTAL PROGRESS REPORT **Appendix C (Pages 39 - 44)**

The Chief Medical Officer for the Integrated Care Board (ICB) submits a report to give the Commission an overview of NHS Dental Commissioning across Leicester, Leicestershire and Rutland (LLR).

11. MEMBERS QUESTIONS ON MATTERS NOT COVERED ELSEWHERE ON THE AGENDA

Members are invited to ask any questions that are not covered elsewhere on the agenda.

12. WORK PROGRAMME **Appendix D (Pages 45 - 48)**

Members will be asked to note the work programme and consider any future items for inclusion.

13. ANY OTHER URGENT BUSINESS

Appendix A

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 :
Councillor Pickering – Chair
Councillor Hill – Vice Chair

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

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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.

Leicester City Council

Digital Focus

Joint Scrutiny Commission

Date of meeting: 27/11/2025

Lead director/officer: Peter Burnett/Laura Godtschalk

Useful information

■ Report author: Laura Godtschalk

1. Summary

Digital tools for patients and those supporting them are maturing at pace in LLR, with growing benefits for those using them. They help to simplify and streamline interactions with a care system that is often comprised of many moving parts, and give people greater control over their care. In parallel, vital work is scaling up around digital inclusion, both increasing the digital confidence and skills of members of the public and staff, and ensuring that services remain easily and equally accessible to those who, whether by choice or circumstances, are not users of online tools.

The NHS App continues to expand its functionality, offering patients improved access to both GP and hospital services. This includes features such as appointment management, prescription ordering, and access to medical records.

Integration with the University Hospitals of Leicester (Phase 1) has been completed, enabling patients to manage, cancel and rebook appointments through the app., Integration with the Leicestershire Partnership Trust is pending, awaiting the outcomes of national pilots for clinical system integration.

Digital inclusion initiatives are being scaled up across the region, with more than 60 digital hubs now operating within Leicester, Leicestershire, and Rutland (LLR). These hubs provide support with digital access, device recycling and digital skills training. In addition, both national and local efforts are ongoing to promote digital inclusion and ambassador programmes, ensuring equitable access and digital support for all communities.

2. Recommendation(s) to scrutiny:

Joint Scrutiny Commission are invited to:

- Note the progress and benefits of the NHS App rollout and integration.
- Support ongoing digital inclusion initiatives and ambassador programmes.
- Endorse further system integration and funding bids to expand app functionality.
- Encourage continued collaboration with local authorities and VCSE sector to maximise digital access and reduce inequalities.
- Support further development and adoption of digital information sharing tools that support the team around the patient and reduce the coordination burden on individuals and their carers.

3. Detailed report

NHS App Functionality

The NHS App offers a range of core functionalities for patients registered with GP surgeries, including access to detailed medical records, appointment management, prescription ordering, and other essential services. However, access to certain features such as viewing detailed medical records (aka accelerated access) depends on whether individual GP practices have enabled the functionality. This variation means that not all patients currently see the same information within the app. There are 8 practices in LLR who do not enable detailed medical records for all patients, due to the nature of the services they provide and concerns around safeguarding. Patients who do not have detailed medical access can contact their GP surgery to request.

Recent integrations to the NHS App have introduced new features, including the ability for patients to view and manage their acute hospital appointments. Future ambitions include enabling patient-initiated follow-ups, supporting digital care plan management, introducing two-way communication between patients and care teams, and achieving broader integration with clinical systems across health and care settings. The delivery of these developments remains dependent on national funding and the continued enhancement of the NHS App platform at national level.

Alongside additional access and visibility via the NHS App and other digital methods, it is important to note that non-digital methods are still supported. Enablement for c80% to access digitally means more time for the c20% who require non-digital interactions. Further, secure and proportionate information sharing between professionals, including via the LLR Care Record, reduces the reliance on patients memorising their care record to support them in accessing coordinated care that spans across multiple different providers.

Digital Inclusion

There are now more than 60 digital inclusion hubs across Leicester, Leicestershire, and Rutland (LLR), supported by the Good Things Foundation. These hubs provide free data, digital devices, and digital skills training to help individuals get online and build confidence in using digital tools.

Device recycling initiatives are also underway, aiming to repurpose retired digital equipment for community use and ensure that more people have access to suitable technology.

Community engagement initiatives include local ambassador programmes and public events that promote the NHS App and encourage digital health management. These efforts focus on supporting both digital-first patients and those who remain digitally excluded, ensuring equitable access to digital health services.

The Digital Inclusion Action Plan aligns closely with national strategies designed to reduce digital exclusion and promote digital wellbeing, ensuring that everyone can benefit from the growing range of digital health and care services.

With the NHS Medium Term Framework Plan’s specific focus on “digital as default”, we recognise the potential of equity impact and have raised this as a concern nationally.

LLR Care Record

The LLR Care Record is key digital infrastructure supporting coordinated and informed direct care, and an NHS 10 year plan enabler, securely providing a blended view of a

person’s recent health and care information. Users of LLR CR across health and social care report significant reductions in time spent seeking information, which frees up staff time for direct care. For example, social care and physiotherapy teams in Leicestershire County Council previously spent an average of 2 hours per day searching for information, while the Discharge Hub spent over an hour and a half daily. LLR CR users in social care report an average time saving of 30 minutes each time they log into the system relative to phoning and emailing. Perhaps more significantly, they are able to accelerate end-to-end processes such as assessment and confirm care needs much sooner as a result of having self-service access to required information.

The LLR Care Record enables holistic, integrated care, and reduces inequity, especially where a person may be less able to convey their own case history. By joining up key information from multiple organisations for direct care purposes, it provides a view of a person's health and care journey supporting better, safer decision-making and coordination, both along streamlined pathways and in the context of neighbourhood working.

LLR CR is designed to be inclusive, quick to learn and easy to use. It is usually accessed via existing systems, avoiding additional passwords and logins. Staff are trained, and there is an audit trail on all uses, ensuring confidentiality and security. Only staff involved in a person’s health and care can access the information.

Adult social care colleagues describe the LLR Care Record as a "game changer," highlighting:

- Time saved accessing information
- Reduced need for phone calls to GP practices
- Easier and quicker direction to appropriate support, including to avoid hospital readmission
- Improved understanding of where a person is on their care pathway.

The LLR CR programme has invested in multi-media publicity, including animated videos, radio adverts in multiple languages, Facebook campaigns, and accessible leaflets. This ensures widespread awareness and accessibility, especially among linguistically diverse populations.

The LLR CR has been developed through collaborative user centred design techniques where front-line users help to inform the interface and define and prioritise the datasets required by or available from their services. The programme team actively seeks feedback from users and partners, and shares and collaborates with other Integrated Care Systems to define best practice approaches and broaden impact.

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

4.1 Financial Implications

- NHS App appointment functionality is anticipated to deliver financial benefits arising from: reduced missed appointments (£120 per DNA avoided), call centre efficiencies, and reduced postage costs (£2/letter).
- Resource reallocation opportunities from operational efficiencies.

4.2 Equalities Implications

- Digital inclusion initiatives aim to reduce health inequalities by supporting those at risk of digital exclusion.
- Ongoing monitoring to ensure equitable access for all communities.
- Design with digitally excluded in mind.

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Integrated Care Board

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NHS App update

Appendix B

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GP functionality in NHS App

Standard NHS App Functionality

- Order repeat prescriptions and nominate a pharmacy where you would like to collect them
- Book and manage appointments
- View your GP health record to see information like your allergies and medicines
- View COVID-19 vaccinations
- Register your organ donation decision
- Choose how the NHS uses your data
- View your NHS number (find out what your NHS number is)
- Use NHS 111 online to answer questions and get instant advice or medical help near you
- Search trusted NHS information and advice on hundreds of conditions and treatments
- Find NHS services near you

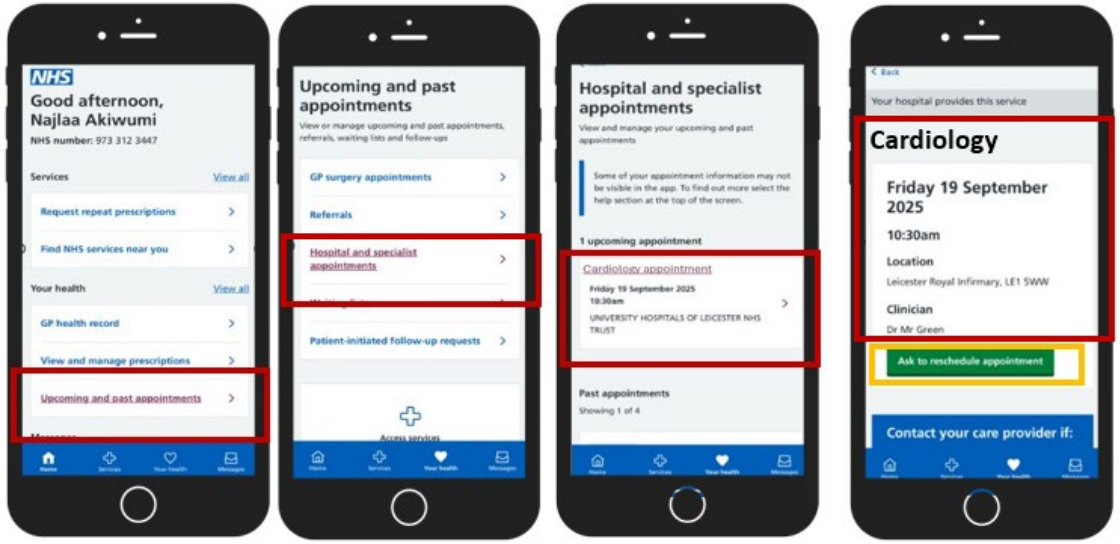
Depending on you GP surgery's system and the access provided, the NHS app may also offer:

- Message your GP surgery or a health professional online.
- Detailed medical record access (test results, letters etc).
- Contact your GP surgery using an online form and get a reply.
- Access health services on behalf of someone you care for.
- View useful links your doctor or health professional has shared with you.

Acute -Phase 1- Complete

1. Core features: Complete

- View referrals and appointments in one place
- See a single point of contact for appointments
- Get supporting information for appointments
- View past appointments
- Cancel Appointments
- Reschedule Appointments



Acute -Phase 2- Next steps

2. Additional features: Bids submitted for funding, awaiting outcome.

- Leicestershire Partnership Trust system integration for Mental Health and Community appointment management, plus other functionality.
- University Hospitals of Leicester further integration to provide more access to patients.
- Receive notifications and messaging
- See documents
- Complete pre-appointment questionnaires
- Manage documents and questionnaires
- Paperless preference

Acute -Phase 3- Future Ambition

3. New and First of Type

NHS app has been initially connected to LLR's Interweave digital Infrastructure, alongside ambition to integrate clinical systems direct and with NHS app uplift this could enable people to:

- Patient initiated follow up action (PIFU)
- View and contribute to care plans
- View and amend appointments from other providers
- Two- way communication with care team
- Manage consent

Benefits

- **Better access and control for patients**
- **Faster, easier prescription management**
- **Digital Maturity and operational efficiency:** As of April 2025, 114 NHS trusts are live with the service. Wayfinder is now the second most-used service in the NHS App, contributing to reduced waiting times, missed appointments, and carbon emissions.
- **Fewer missed appointments** – estimated saving £120 per DNA avoided.
  1k DNAs avoided = £120k resource to reallocate for care.
- **Fewer basic information seeking calls** – estimated staff saving 59p per 3 minute call avoided.
  1k calls avoided = 50 hours or £590 of call centre or ward capacity freed to repurpose.
- **Patient preference - Digital or written letters** – estimated saving £2 per physical letter avoided.
  10k letters avoided = £20k cashable efficiency.
- **Carbon reduction at scale:** Full implementation of Wayfinder features is forecast to reduce carbon emissions by over 1,100 tonnes CO2e per annum, equivalent to the footprint of more than 262,000 outpatient attendances.
  Digital communications via NHS App offer a 97.8% reduction in carbon emissions per appointment letter compared to traditional paper-based correspondence.
- **Low carbon system architecture:** The Patient Care Aggregator (PCA), which enables information sharing between trusts and the NHS App, has been architected using sustainable design principles. This includes minimising computer use, adopting serverless technologies, and leveraging renewable-powered cloud hosting. The PCA's operational carbon impact is less than 0.1 tCO2e.

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Digital Inclusion Initiatives Update

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Digital Inclusion Hubs supported by Good Things Foundation (GTF)

- The National Digital Inclusion Network is supported by GTF
- Member organisations support their local communities with free digital inclusion services and Digital Hub services are provided as part of their local offer
- Digital Hubs are safe spaces that offer free mobile data (National Databank), devices (National Device Bank) and beginner digital skills training (LearnMyWay)
- Each hub can provide whatever services they choose, tailoring the offer to match their means
- Community access points and organisations delivering help and support services to the public
- GTF provide organisations with grant opportunities, drop-ins from network ambassadors and regular online training
- LLR has 60+ Hubs hosted by the VCSE sector and local authorities (see map)
  https://www.goodthingsfoundation.org/find-support/map
- The LLR ICB are identifying new potential hubs opportunities, using Core20PLUS5 and Census 2021 information

Good Things Foundation

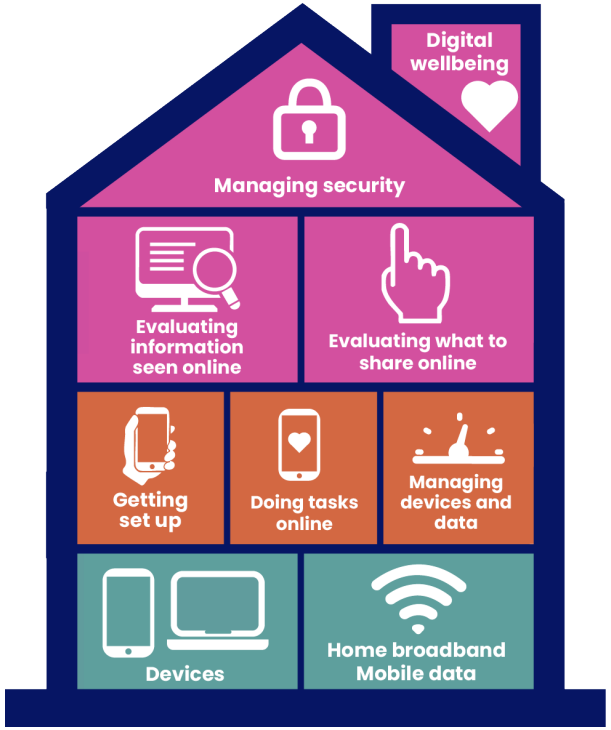
Recycling LLR's digital devices

- LLR Digital Inclusion lead assessing what ICS organisations are doing with their retired digital devices and working with them to reroute these devices to Good Things Foundation's national device repository
- Working with our local hubs to apply for devices to distribute when Good Things Foundation sends out invitations to do so
- Work with hubs to encourage their local communities to directly donate to them

Good Things Foundation

Digital Inclusion Action Plan

- UK government's strategy to ensure everyone can access and use digital technologies confidently and safely, aiming to reduce digital exclusion and improve life chances across society
- Built from the Minimum Digital Living Standard (MDLS) definition
- Exploring potential LA involvement in:
  - Repurposing of government laptops
  - GOV.UK App as a digital front door
- Supporting applications to the Digital Inclusion Innovation Fund



NHS App Ambassadors National Programme

- Promoting the NHS App benefits for the public and colleagues
- Supporting the enrolment of digital leaders within practices into the national programme

- Creating and supporting a local community of ambassadors, sharing good practice and solutions to the public's digital problems
- Supporting public events and PPG meetings to promote the app
- Championing a digital first approach for patients:
  - Ability to digitally self-serve their health management
  - Relieve pressure on phone and face-to-face access, so that those digitally excluded have easier access to practices via phone and face-to-face
  - Improving the lived experience of the public and our front-line staff

Leicester Communities Together Event

- Promoting the NHS App and demonstrating key functionality available to the public
- Advising on appropriate routes for engaging with urgent care
- Signposting the public on how to register and improve their access to services digitally

NHS
Leicester, Leicestershire and Rutland
Integrated Care Board

LLR Care Record

A proud partner in the:

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Health and Wellbeing Partnership

Leicester, Leicestershire and Rutland Care Record*

1.2m LLR patients of all ages able to benefit from information sharing for direct care

30 minutes Average time saved per login by adult social care staff

12,670 Logins per month. Plus huge growth potential.

7,900 Individuals' records accessed per month

£1.3m/yr Working time freed up for care

9 minutes Average time saving per Leics Partnership Trust login – the average duration of a GP appointment

13 Health and Care IT systems interacting with the LLR Care Record

149 Weeks of effort freed up per month asking and responding.

21,000+ LLR and EMAS health and care staff with access to LLR Care Record for direct care

* Based on Oct 2025 usage rates, excluding EMAS activity

Starting from specific information needs to deliver value

GP practice diabetes nurse
- What happened when my patient was in hospital because of their diabetes?
- Have their medications or care advice changed?

Local Authority social care
- What are the discharge support needs?
- Do they have assistive equipment?
- How much social care help will they need?
- Are there special requirements eg. help with meds?
- Post stroke, are speech therapy involved?

LPT or social care occupational therapy
- Is there anything I need to be aware of if I'm doing a home visit?
- Who else is involved in this person's care?

UHL urgent and emergency care
- What health conditions or allergies does this emergency patient have?
- Do they have additional communications needs eg. needing a translator?
- Are they already in the care of a virtual ward?

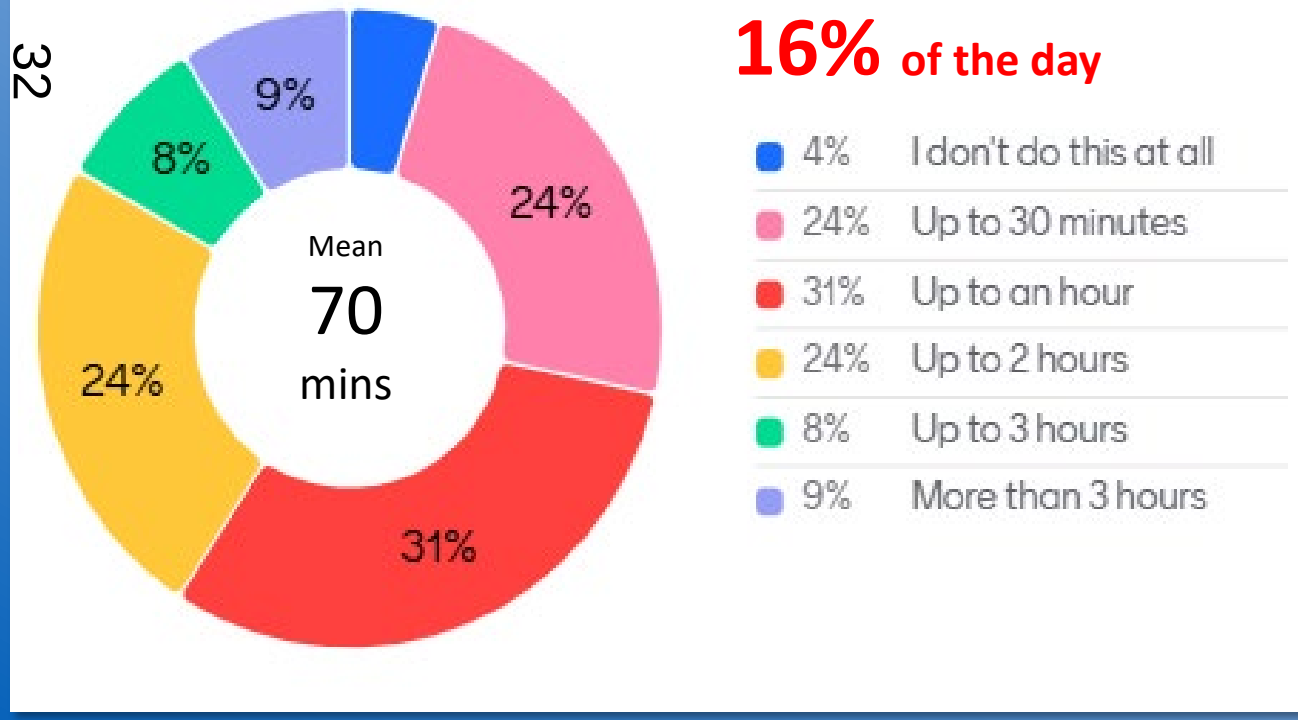
Paramedic on a mental health callout
- What mental health condition(s) is this person living with?
- Do they have a crisis plan that we can activate?

LOROS/LPT/UHL end of life care
- What are this person's care preferences?
- Who else is involved?

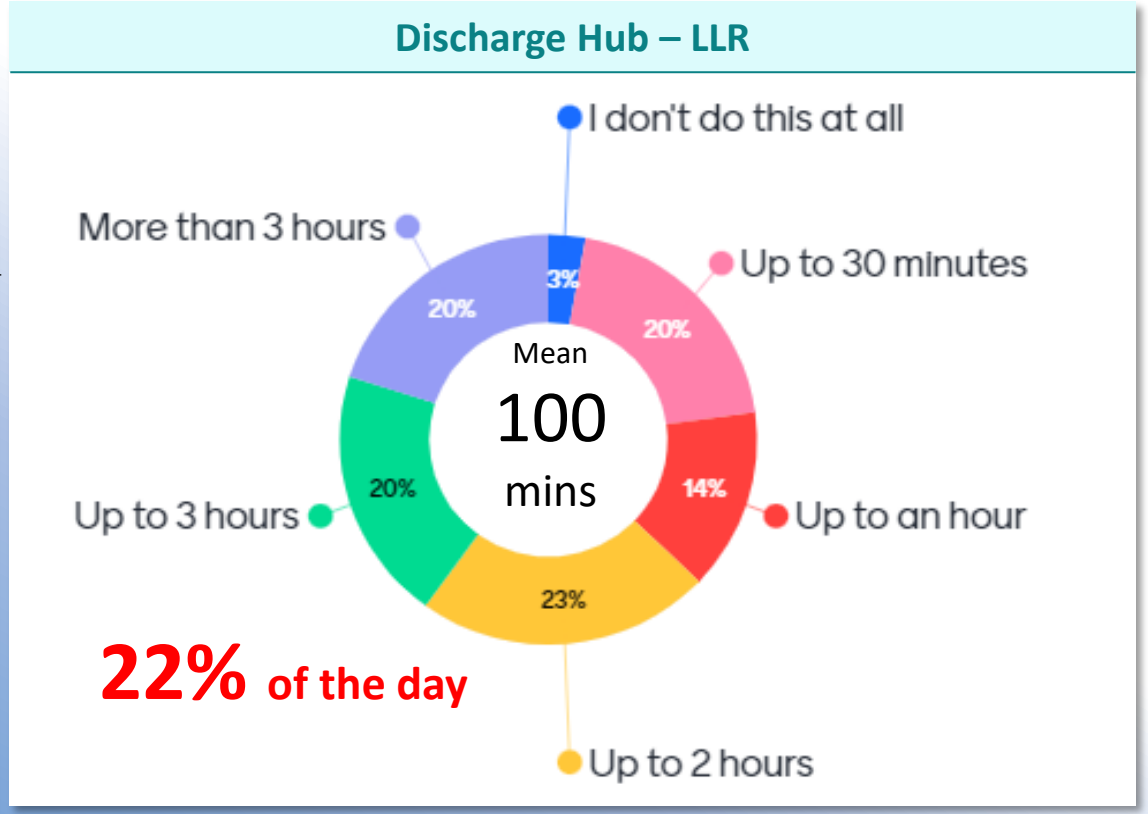
Social Care: Productivity and care impacted by information-seeking burden

Considerable time per day seeking information:

Social Care and Physiotherapy – Leicestershire



Discharge Hub – LLR



Time savings enhancing social care

Surveys show, average **30 minutes per login saved** obtaining information in social care

20 minutes' less information chasing per day = **2 working weeks** /person /year for other tasks

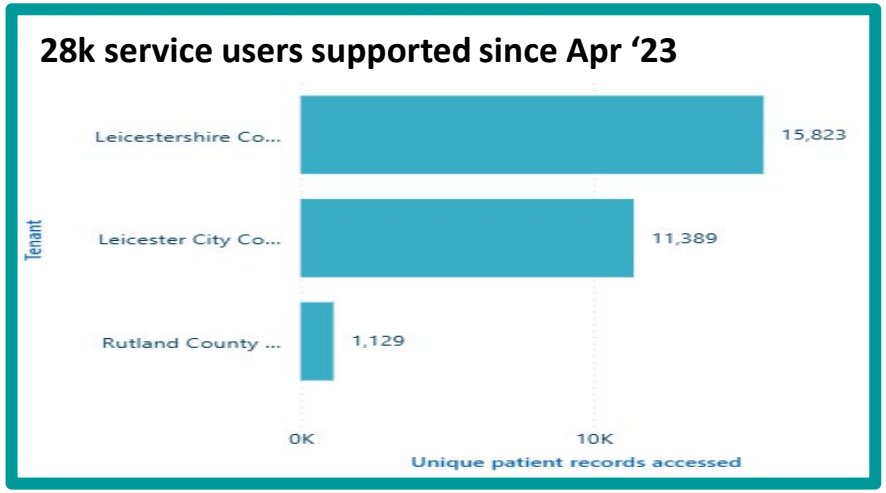
Adult Social Care: More time to care

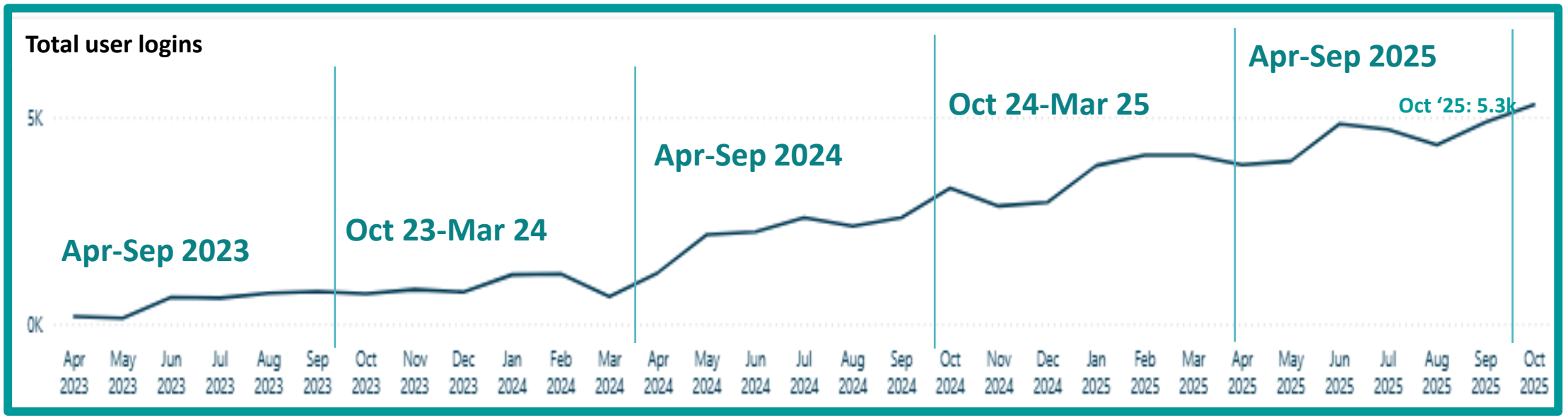
"Throughout my experience in health and social care, what the service user is missing is time to talk with us."

"LLR Care Record frees your time up to allow you to do the problem-solving. It frees your mind a little bit more to allow you to actually think about it. The person you are working with gets a much better outcome."

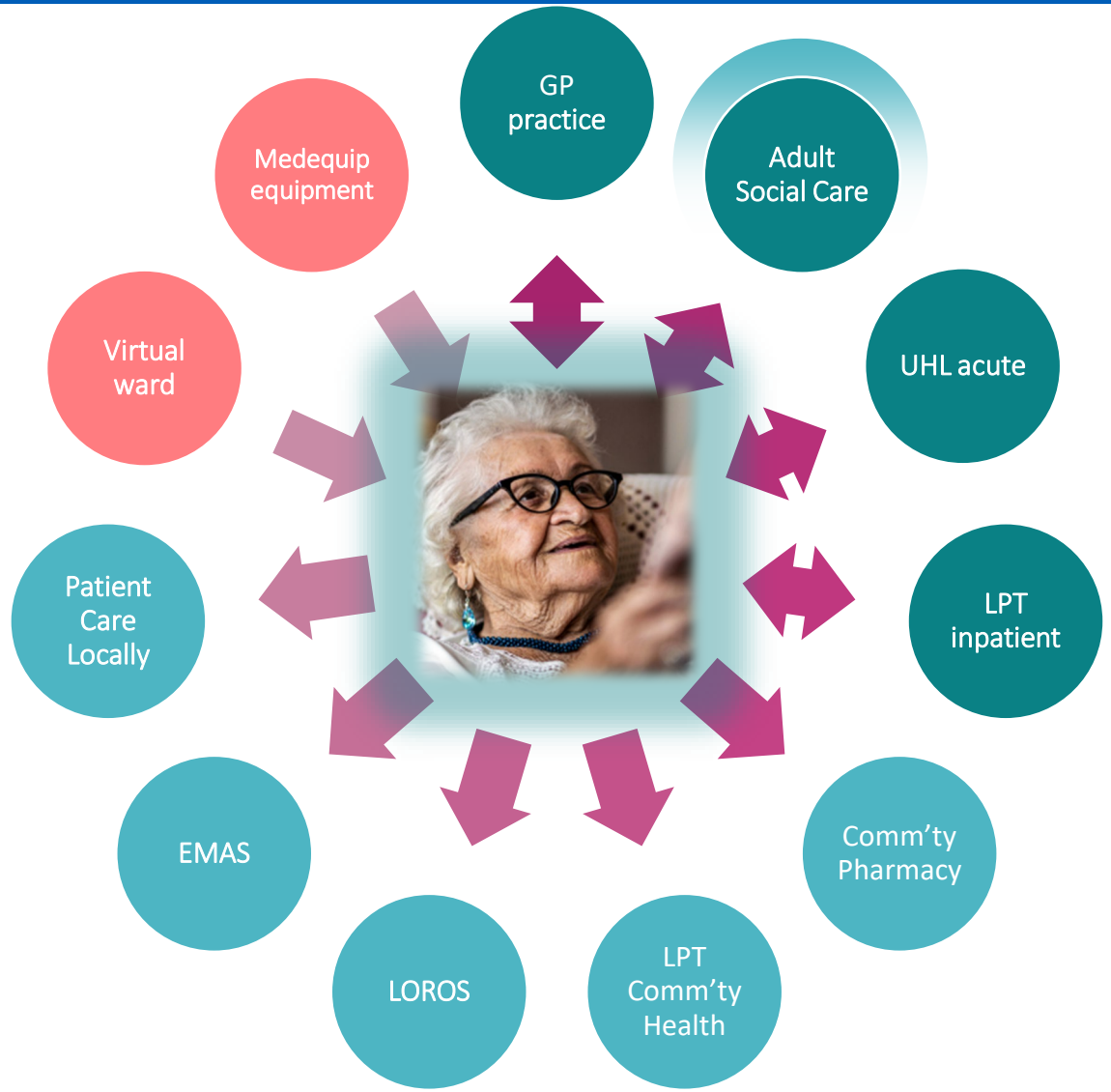
Local Authority: usage of the LLR Care Record

LLR Care Record Usage Apr 2023-Sep 2025	Adult Social Care	Health partners	Total
Total user logins	69.5k	72.5k	142.0k
Time released for care (working weeks)	924	356	1,200





A key part of the local team around the person



Social care assessments completed

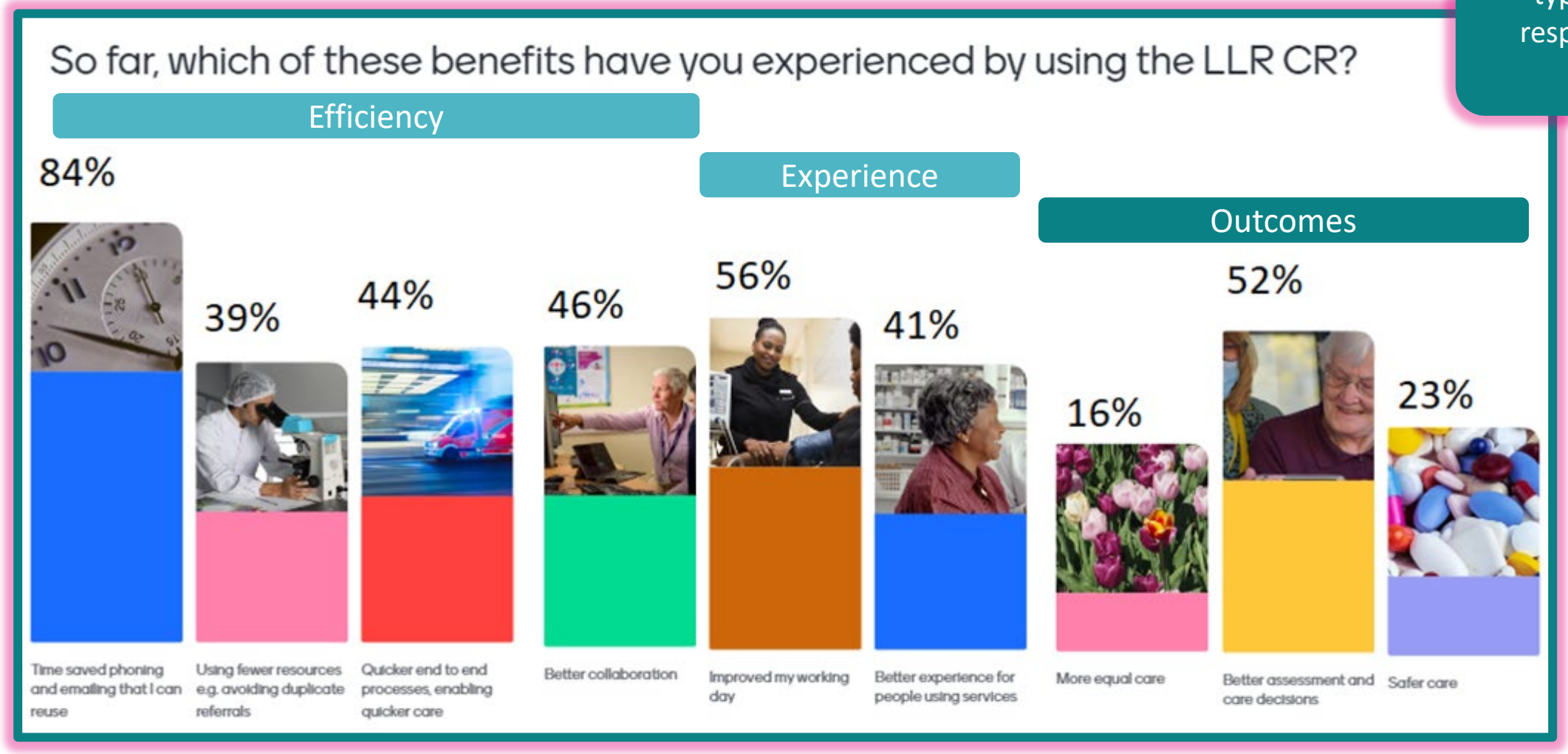
two weeks sooner

- supports long term plan
- faster decisions
- effective local care
- escalation and deterioration avoided

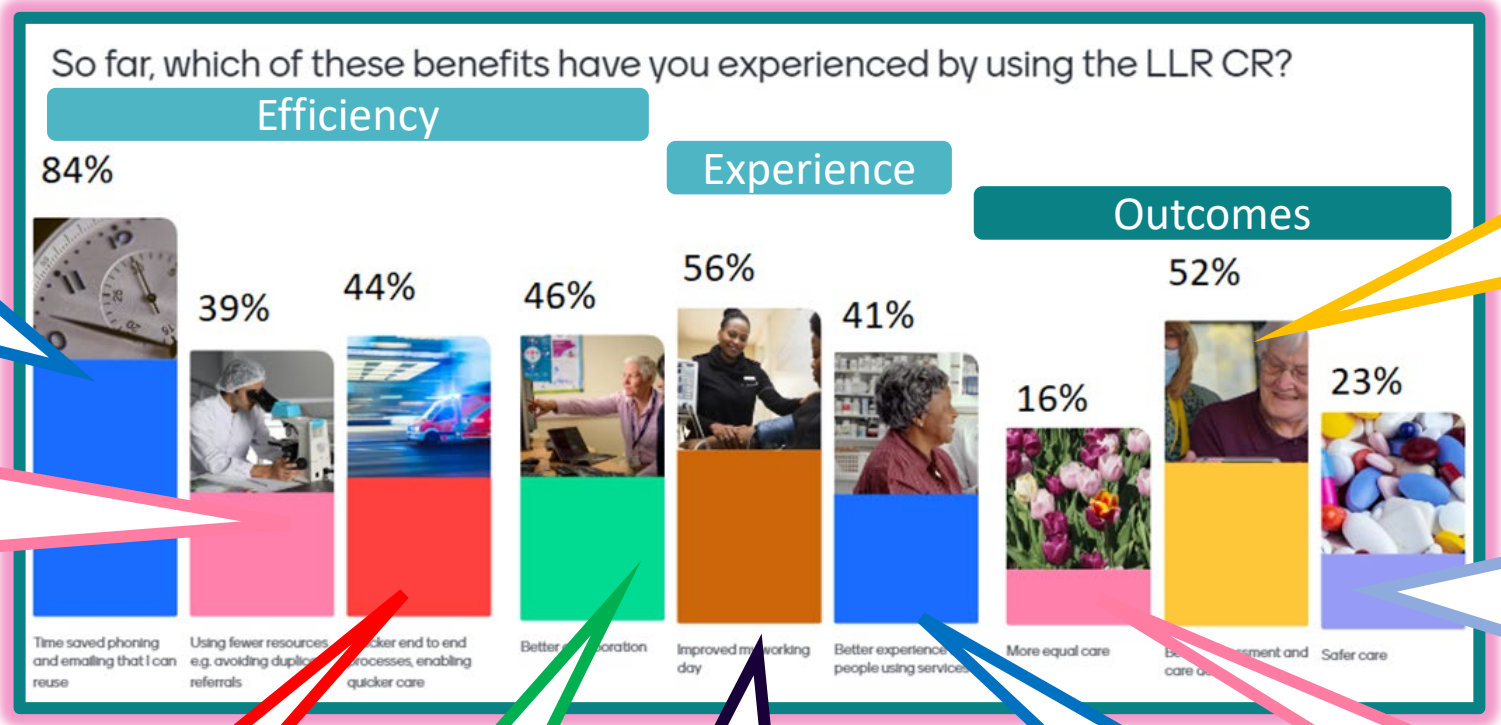
Staff confirm much more than time savings – Leics Social Care

Average benefit types per respondent

4



Backed up by users' stories: Leics Social Care



Time saving

"Speed has improved where we used to wait for GP contact we can now check for ourselves."

Better care

"I am able to **confirm diagnosis** and **make appropriate recommendations** to meet long term needs."

Safety

"I was unable to contact a [person] regarding a **concern for welfare**...By using the care record, I was able to **obtain a more recent number and speak with the [person].**"

Resource efficiency

"Realised **already referred to a service** I was going to make a referral to but they hadn't mentioned."

Faster progress

"Enabled me to **get accurate information** to support continuing health care checklists, **without the lengthy time required to access via phone calls to** health professionals."

Coordination

"Once diagnosis identified I was able to **ensure the right Team progressed the request**."

Better working day

"...you get accurate information quickly, and reduce time spent sourcing, so will **protect our stress levels."**

Patient experience

"Assisted me in making the most **appropriate recommendations**. this **increased Service User independence**, whilst maintaining **privacy** and **dignity** and increased their **mental wellbeing**."

Equity

"With people with **cognitive impairments and no family** - useful to get health information, so this can make **decisions around care quicker**."

Appendix C

LLR ICB – Dental Progress Report

LLR Joint Scrutiny Commission

Date of meeting: 27/11/2025

Lead director/officer: Dr Nil Sanganee, Chief Medical Officer

Useful information

■ Ward(s) affected: All

■ Report author: Jo Grizzell, Senior Planning Manager, Leicester, Leicestershire and Rutland ICB

Lewis Parker, Commissioning Manager, East Midlands Primary Car Team

■ Author contact details: jo.grizzell@nhs.net

■ Report version number: Version 1.0

1. Summary

NHS dental commissioning in the East Midlands transferred from NHS England to local Integrated Care Boards (ICBs) in April 2023, enabling more responsive, locally driven planning supported by a central operational team. In Leicester, Leicestershire, and Rutland (LLR), mid-year activity for 2025/26 shows improved performance, with nearly half of commissioned Units of Dental Activity (UDA) already delivered. Significant expansion in urgent care has been achieved, exceeding national targets and supported by financial incentives to increase capacity further. A three-year dental plan is now in place to improve access and reduce inequalities, featuring a new procurement for oral surgery (Intermediate Minor Oral Surgery [IMOS), schemes enabling providers to deliver additional activity, contract rebasing to reinvest underused funding, expanded General Anaesthetic capacity for paediatrics, and targeted pilots for high-needs patients and care home staff.

2. Recommendation(s) to scrutiny:

The Leicester, Leicestershire and Rutland (LLR) Joint Health Overview and Scrutiny Committee (HOSC) are invited to note the contents of the report, providing information on current dental service provision and the future plans to improve dental access

3. Detailed report

A. Commissioning Responsibility and Governance

Members are advised that NHS England was responsible for the commissioning of NHS dental services until 31 March 2023. Effective 1 April 2023, responsibility for commissioning NHS dental services including primary, community, and secondary dental care was formally delegated to the East Midlands Integrated Care Boards (ICBs). This transition empowers the ICBs to address local population needs through localised commissioning which are aligned to its Oral Health Needs Assessment (OHNA).

A robust governance structure has been established to delineate responsibilities. This structure enables the ICB to determine its annual plan and strategic direction for the dental function and make appropriate local decisions. Concurrently, the operational dental commissioning team, which is hosted by the Nottingham and Nottinghamshire ICB on behalf of the five East Midlands ICBs, is responsible for the day-to-day delivery of contracting and commissioning functions. This dual-level approach has been designed to ensure minimal disruption and a smooth transition to support both service providers and patients.

B. Patient Access and Prioritisation

It is important to acknowledge that the concept of patient registration with an NHS dentist has been superseded since 2006. While many practices maintain a list of NHS patients for recall purposes, patients are unable to register with an NHS dentist in the same manner as with a General Practitioner (GP). Dentists are commissioned to deliver a defined level of dental activity (e.g., Units of Dental Activity - UDAs) rather than to provide care for a specific cohort of registered patients.

In the context of service demand, dentists may need to prioritise patients presenting with acute dental problems over routine check-ups. Furthermore, it should be noted that a six-monthly review is not routinely required. Clinical guidance recommends that adult patients with good oral health be reviewed less frequently, typically on an annual or biennial basis, while the recommended interval for children is between three and twelve months.

C. Current Provision and Performance (LLR)

Within Leicester, Leicestershire, and Rutland (LLR), there are currently 133 general dental contracts in place. This total comprises:

- 6 Specialist Orthodontic Practices
- 13 General Dental Service (GDS) Practices providing orthodontics
- 7 Specialist Orthodontic Pathway Providers

1. Activity Delivery (2025/26)

Performance data for the 2025/26 financial year indicates a delivery of 802,791 Units of Dental Activity (UDAs) to date across LLR. This represents 49.82% of the total activity commissioned for the region.

- Comparative Performance: For the same period in 2024/25, 47.63% of commissioned activity was delivered, demonstrating a marginal improvement in delivery figures for 2025/26. This improvement has been achieved despite the cessation of the National New Patient Premium scheme which was introduced as part of the Government’s National Dental Reform.
- Annual Projection: In 2024/25, the total commissioned activity delivered was 88.05%. Current in-year performance trajectory suggests that the overall UDA delivery for 2025/26 will exceed the previous year's figure.

D. Urgent Care Provision

Following the Government's announcement in February 2025 to increase urgent appointments nationally by 700,000, each ICB received a specific target for provision.

The East Midlands Primary Care Team acted with significant expediency to procure this additional capacity. The target set for LLR was 10,137 appointments. However, procurement exceeded this, resulting in 13,968 additional urgent care appointments being made available.

- Service Delivery: Five providers were commissioned to deliver the additional appointments across LLR. Patients can access these services either by contacting

NHS 111 for signposting to the nearest available urgent care site or by liaising directly with a participating practice.
- Existing Capacity: LLR also benefits from five additional urgent care services operating between 8am and 8pm, 365 days per year. Practices delivering urgent care are able to provide subsequent treatment for patients following an urgent appointment.

1. Urgent Care Incentive Scheme

For the remainder of the 2025/26 financial year, ICBs across England have been instructed to invite contractors to deliver an increase of 25% in urgent care Courses of Treatment (CoTs), benchmarked against their estimated baseline delivery from the first four months of the financial year (as calculated by NHS England).

- Incentive Payment: Contractors who achieve this target will be eligible to receive an incentive payment of £50 per additional CoT. A partial incentive payment is available for contractors who achieve 70% of the required additional activity. These payments are *in addition* to the agreed contract value.
- Capacity Requirement: Contractors must have sufficient capacity within their annual contracted UDAs. Where a contractor is projected to fully deliver their contract, the ICB may agree to a non-recurrent uplift, allowing the total annual contract activity to reach up to 110% of the regular contract amount, subject to feasibility and funding availability. This offer has been extended to providers across Leicester, Leicestershire and Rutland and 42 expressions of interest (EOIs) have been received. EOIs are currently being assessed with the outcome communicated to providers in November 2025 allowing providers to begin delivering the additional activity.

E. Dental Commissioning Plans

The ICB has developed a three-year dental plan which is aligned with the recommendations outlined in the LLR Oral Health Needs Assessment. The plan focuses on enhancing access for areas identified as having the greatest need. Key initiatives for 2025/26 and beyond include:

- IMOS Procurement (Integrated Minor Oral Surgery): Following the resolution of legal challenges related to the abandoned procurement in February 2025, the IMOS procurement was relaunched on 16 June 2025. New services are scheduled to commence on 1 May 2026 under a Personal Dental Service (PDS) agreement, with a seven-year contract term and an option for a three-year extension. Existing provider contracts have been extended to ensure service continuity during the live procurement process.
- 110% Over-Performance Scheme: All LLR providers have been invited to express an interest in delivering an additional 10% above their current NHS contract volume. The previous year's scheme resulted in an additional 33,394 UDAs being made available to LLR residents.
- Flexible Commissioning Scheme: The Expression of Interest process concluded on 24 October 2025, offering underperforming providers the opportunity to ring-fence protected time for specific target groups, including new patients and adults eligible for charge exemptions. Two successful applications based in Leicester City and Market Bosworth were approved, with the scheme commencing on 10 November 2025.

- Contract Rebasing: The East Midlands Primary Care team has formally notified dental providers who have consistently underperformed over the past three financial years of the ICB's intention to reduce their contract value unless performance demonstrates a sustained improvement. The rebasing process is currently in progress, with funding released from reduced contracts slated for reinvestment into the dental workstream.
- Additional General Anaesthetic Sessions: To address access issues for high-needs patients (e.g., those with learning difficulties, severe dental phobia, or very young children), who cannot be treated via other modalities, two additional General Anaesthetic (GA) sessions per week will be made available recurrently from 2026/27. This expansion is projected to treat 336 additional patients per year (8 patients per week / 84 sessions per annum).
- High Needs Patient Pilot: The LLR ICB has secured approval for a High Needs Patient Pilot. This initiative is designed to provide dental access to patients from high-needs groups who have not attended a dentist in over two years. In collaboration with local support services and charities, referred patients will be offered dental appointments for themselves and their family members. The scheme is expected to launch in early 2026, making 12,000 UDAs available.
- Care Home Staff Oral Health Improvement Pilot: This pilot aims to enhance the skills of care home workers to better support residents' oral health, including the identification of dental and oral disease symptoms. Where required a referral can be made to a designated practice. Following successful initial phases in Charnwood, Hinckley, and Bosworth and Rutland, plans are underway to extend the pilot to other areas within LLR.

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

4.1 Financial Implications

- All costs related to the initiatives set out within this report are funded through the ICBs allocated budget
- Recurrent costs (e.g., GA expansion, future IMOS contracts)
- Non-recurrent investments (urgent care uplift, pilots, contract uplifts)
- Recurrent savings (contract rebasing)
- Targeted reinvestment aimed at improving access in high-need areas

These implications are typical for a dental commissioning programme undergoing expansion and redesign.

Signed: Dr Nil Sanganee, Chief Medical Officer

Dated: 19th November 2025

4.2 Legal Implications

There are no legal implications

Signed: Dr Nil Sanganee, Chief Medical Officer

Dated: 19th November 2025

4.3 Equalities Implications

Several groups experience disproportionate challenges accessing NHS dental care, including:

- People with learning disabilities or autism

- People with severe dental phobia
- Children and very young families
- Older residents, particularly those in care homes
- People living in deprived areas
- Groups with language or cultural barriers
- Individuals who have not accessed dental care for over two years

The commissioning plans specifically target these groups through:

- Additional General Anaesthetic (GA) sessions
- The High Needs Patient Pilot
- Care Home Staff Oral Health Improvement Pilot
- Flexible commissioning aimed at new and charge-exempt patients

The LLR Oral Health Needs Assessment identifies significant variation in oral health outcomes across Leicester, Leicestershire and Rutland.

Targeted schemes, particularly flexible commissioning and contract rebasing will support reinvestment into areas with the highest levels of need.

This approach aligns with equality duties to reduce health inequalities for deprived and marginalised communities.

These initiatives are expected to reduce inequalities in access and outcomes.

- Urgent care expansion (13,968 additional appointments) improves access for people who struggle to obtain routine dental care

The ICB continues to meet its statutory obligations under:

- The Equality Act 2010, including the Public Sector Equality Duty (PSED)
- The Health and Care Act 2022, which requires action on health inequalities
  An Equality Impact Assessment (EIA) will be completed or updated for major procurements such as IMOS and the High Needs Patient Pilot.

Signed: Dr Nil Sanganee, Chief Medical Officer

Dated: 19th November 2025

4.4 Climate Emergency Implications

There are no climate emergency implications.

Signed: Dr Nil Sanganee, Chief Medical Officer

Dated: 19th November 2025

4.5 Other Implications

None identified

Signed: Dr Nil Sanganee, Chief Medical Officer

Dated: 19th November 2025

Leicester, Leicestershire and Rutland Joint Health Scrutiny

Work Programme 2025-26

Date of Meeting	Agenda Items	Organisation Responsible	Notes
Monday 16 June 2025	Introduction to NHS, changes (structural) difference between 50% reduction and 50% growth (briefing) and the policies Pilot Digital Project (EMAS) Shared care record	**UHL/ ICB/ LPT**	1. Admin processes, bureaucracy and IT issues getting in the way of patients being seen by the right person. 2. LA/ NHS working together
Thursday 27 November 2025	System Health Equity Committee request to conduct a 'deep dive' into longer waits at both the Emergency department and patients waiting for ambulances to assess the impact against protected characteristics. Digital Focus (Presentation)	**EMAS / UHL/ ICB** **UHL/ ICB**	

	24/25 year-end review – info circulated Dentistry	**ICB/LPT** **ICB**	
Monday 23 February 2026	In depth session on GP specifics across LLR broken down by each area (Possible informal briefing) CAMHS and SALTS		

Topic	Detail	Date
Dentistry		**November 2025**
ICB Highlight sheet of data	Members requested more data to be scrutinised focusing on the ICB and statistics.	
Ambulance Service and wait times		
GP Access		**March 2026**
Out of hours access		
LLR out of hours and emergency care		
System approach to stroke		
CAHMS		

NHS work to tackle isolation – i.e. the social prescribing model across LLR and its effectiveness in directing patients/public to services. Access to healthcare.		