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

**DATE: MONDAY, 23 FEBRUARY 2026**

**TIME: 10:00 am**

**PLACE: Meeting Room G.01, 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 Singh Johal

Councillor Haq

Councillor Westley

Councillor March

Councillor Sahu

#### **Leicestershire County Council**

Councillor Hill (Vice-Chair of the Committee)

Councillor Crook

Councillor Knight

Councillor Durrani

Councillor McDonald

Councillor King

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:**

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Oliver Harrison (Governance Support Officer) e-mail: [Oliver.Harrison@leicester.gov.uk](mailto:Oliver.Harrison@leicester.gov.uk)

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

<b>Acronym</b>	<b>Meaning</b>
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	Clinical Commissioning Group
LCCCG	Leicester City Clinical Commissioning Group
ELCCG	East Leicestershire Clinical Commissioning Group
WLCCG	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**

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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 - 14)**

The minutes of the meeting held on 27<sup>th</sup> November 2025 have been circulated and the Committee is asked to confirm them as a correct record.

### **4. CHAIRS ANNOUNCEMENTS**

The Chair is invited to make any announcements as they see fit.

### **5. PETITIONS**

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

### **6. QUESTIONS, REPRESENTATIONS AND STATEMENTS OF CASE**

The Monitoring Officer reported that sixteen questions had been received:

1. Godfrey Jennings to ask - What is the JHOSC's view of University Hospitals of Leicester NHS Trust's and Leicestershire Partnership NHS Trust's adoption of Palantir's Federated Data Platform, taking into consideration that international human rights proponents Amnesty International have urged all public bodies to end any contracts with Palantir?
2. Godfrey Jennings to ask - Could I request the briefing in development for Trusts due to be released early March is published alongside the minutes for this meeting?
3. Godfrey Jennings to ask - Does the committee agree that it is the responsibility of UHL and LPT to put in place a robust plan to consult the communities within LLR and to undertake a cost-effectiveness analysis,

comparing Palantir's products with alternative products and providers, bearing in mind Trusts elsewhere have found their locally produced solutions to be far superior than what the Federated Data Platform is offering and have thus declined to adopt the FDP. Can the committee also confirm that these NHS trusts retain the discretion to act in accordance with the respective outcomes, irrespective of any supposed "mandate" from the Department of Health and Social Care, as confirmed by the FDP Regional Delivery Manager in FOI requests, and that the risk of proceeding without community trust would be catastrophic, considering around 50% of people have indicated in YouGov polling that, given the choice, they would opt out of such services, which would only entrench inequalities in health service planning?

4. District Councillor Bob Waterton to ask - At the March 2025 meeting of the Leicester, Leicestershire and Rutland Joint Health Scrutiny, the spokesman for University Hospitals of Leicester stated that a review into the clinical safety implications of the delay in funding for Our Future Hospitals was being undertaken by UHL. He promised that the review would be completed within three months and that the review would be available to the public. The minutes of the March 2025 meeting state that it would be "made available via the Trust Board minutes". There is an item on the review in UHL's recently published Our Future Hospitals and Transformation Committee minutes for December 2025. However, it is not possible to find out from these minutes what the content of the review is because the associated papers are not made available to the public. Has the review now been made available to the public and, if so, how? What were its findings?

Questions relating to St Marys and Maternity Services across Leicester, Leicestershire and Rutland.

5. Anna Pollard to ask - The case for the closure of St. Mary's seems to be predicated in part on low birth numbers. Can you confirm why you have not taken into consideration the numbers using the postnatal ward which are much higher, with many women transferring in for excellent postnatal care from around the Trust area, and what exploration has been done into the possibility of retaining the postnatal ward in the event the birthing services are permanently removed?
6. Jean Burbridge to ask - Why has a staffing challenge, which appeared to arise from temporary rather than permanent circumstances, resulted in a decision for permanent closure? We saw in the newspapers earlier this month that many cancer units are being prevented from hiring more doctors for cost-cutting reasons. Is it the case that UHL is not able, for reasons of policy or finance, to hire enough midwives to staff maternity services?
7. Jean Burbridge to ask - The decision to close St Mary's Birth centre without replacement breaches a promise made in 2021 that a stand-alone midwife led unit would be trialled at the LGH for "at least three

years” (Azhar Farooqi, then CCG chair, at the CCG meeting on the Building Better Hospitals for the Future Decision Making Business Case, June 2021). This is not the first time a consultation in Leicester, Leicestershire and Rutland has led the public to believe that the closure of one service would be replaced by another, only to find later that the closure occurs but not the replacement. The public are left losing their service and receiving no replacement and often feel duped and let down. Does the ICB accept that another decision not to honour the replacement service is likely to undermine further public confidence in the integrity of local NHS consultation exercises?

8. Godfrey Jennings to ask - Is the plan to site all maternity services in the city centre, on the site of the Royal Infirmary, major incident and pandemic proof and if so, how?
9. Borough Cllr Helen Cliff to ask - Regarding safety, recently, a Melton resident who lives walking distance from St. Mary's Birth Centre, had an unattended birth due to the home birth team being too far away to get to her in time, which resulted in an ambulance being needed to transfer them both to hospital afterwards. Another resident, who feared not getting to a Leicester hospital in time from Melton, chose to relocate to her parents' house to be closer to the city when the time came. Had she not done so, her baby would have been born in the car on the way as her labour was as quick as she feared it might be. Can you explain how shutting the doors of St. Mary's made either of these women and their babies more safe, than had they been able to be cared for by midwives at the birth centre in Melton Mowbray, and can you confirm what recruitment plans you have to expand the home birth team in light of the withdrawal of services at St. Mary's, to cater for those who still wish to avoid a hospital birth in the city moving forwards.
10. Brenda Worrall to ask - The most recent CQC inspections gave maternity care at the Royal Infirmary and Leicester General Hospital a rating of 'Requires Improvement' but a rating of 'Good' for maternity care at St Mary's. Does UHL have confidence in the CQC ratings? What are the views of midwives who work at St Mary's – do they feel that the quality of the care they give has been questioned by local NHS leaders? Do the midwives who work at St Mary's continue to have faith in the safety and value of St Mary's?
11. Brenda Worrall - Has Councillor Helen Cliff's updated briefing paper on St Mary's birth centre been considered by the Committee?
12. Borough Cllr Allen Thwaites - In the Decision-Making Business Case, following the public consultation in 2020, to establish a standalone midwife led unit at the Leicester General Hospital, you made a promise to local residents, that closing the doors of St. Mary's signified a relocation of standalone midwife-led services, not an outright withdrawal across the Trust?

13. Borough Cllr Allen Thwaites - Can you confirm when the ICB and/or the Trust first sought legal advice on your proposal to renege on that promise?
14. District Councillor Bob Waterton to ask - Closure of St Mary's - It is very difficult for the public to get any sense of what is happening with the Our Future Hospitals reconfiguration from UHL's public Board papers. Why is this and what alternative communication channels has UHL used to keep the public updated on a regular basis? Why are UHL Board papers from previous meetings no longer in the public domain and must now be requested instead in writing?
15. Sally Ruane to ask - Research has shown that, for low risk pregnancies, stand-alone midwife led birth centres have as good outcomes for babies and better outcomes for mothers (in terms of less intervention and more "normal" births) than other types of birth units. It is not surprising therefore that the National Institute for Health and Care Excellence (NICE), which establishes the quality guidelines in the NHS, states that stand-alone midwife led birth centres should be made available. How does removing the stand-alone midwife led birth centre safeguard patient choice for low risk women and meet the NICE quality standard?
16. Sally Ruane to ask - As well as a place for giving birth, St Mary's also provides invaluable inpatient postnatal care (with 8 beds in 2020). This care is taken up by a far wider group of mothers than those who choose to give birth at St Mary's. The CQC singled this care out as of particular benefit for mothers with complex needs such as women with physical disabilities or mental health conditions. Why is no explicit mention of postnatal care made in the pause and proposed closure statements? Is it true that UHL does not collate the numbers of women who use this postnatal care? If we included these service users, the balance of benefits to costs would alter but they have been excluded from the calculation.

## **7. UPDATE ON ST MARY'S BIRTH CENTRE**

**Appendix B  
(Pages 15 - 22)**

The Chief Nursing Officer for Leicester, Leicestershire and Rutland and Northamptonshire Integrated Care Boards submits a report to update the commission on the decision to pause births and postnatal inpatient services at St Mary's Birth Centre (SMBC) in July 2025 consultation and engagement process.

## **8. LLR SEND & INCLUSION ALLIANCE UPDATE**

**Appendix C  
(Pages 23 - 54)**

The Director of Leicester, Leicestershire and Rutland (LLR) SEND and Inclusion Alliance Team submit a report to provide the Commission with information about the work of the LLR SEND and Inclusion Alliance including:

- LLR SIA approach to co-production
- LLR SEND Change Programme Partnership (CPP)

- › SEND Aligned Commissioning Programme
- › Shaping SEND Futures – local community inclusion model
- › Operational Plan for 2026/27

**9. MEMBERS QUESTIONS NOT COVERED ELSEWHERE ON THE AGENDA**

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

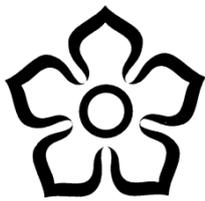
**10. WORK PROGRAMME**

**Appendix D  
(Pages 55 - 58)**

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

**11. ANY OTHER URGENT BUSINESS**





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# Appendix A

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

Held: THURSDAY, 27 NOVEMBER 2025 at 10.00am

### P R E S E N T :

Councillor Pickering - Chair

Councillor Hill – Vice Chair

Cllr Agath  
Cllr Dr Bloxam  
Cllr Durrani  
Cllr Haq  
Cllr Macdonald  
Cllr March  
Cllr Polan  
Cllr Sahu  
Cllr Smith

\* \* \* \* \*

### **59. APOLOGIES FOR ABSENCE**

Apologies were received from Cllr Harvey, Stephenson, Knight and King and Helen Mather, Gemma Barrow, Rob Howard, Harsha Kotecha, Damian Roland and Sarah Smith.

### **60. DECLARATIONS OF INTEREST**

Cllr Poland declared he works for Edward Argar, the MP for Melton and Syston. Mr Argar had been particularly active in stopping the closure of the St Mary's Birth Centre.

Cllr Westley declared he is Chair of the patient panel at a local GP Surgery.

### **61. MINUTES OF THE PREVIOUS MEETING**

The minutes of the previous meeting held on 16<sup>th</sup> June 2025, were confirmed as a correct record.

## **62. PETITIONS**

It was noted that none were received.

## **63. QUESTIONS, REPRESENTATIONS AND STATEMENTS OF CASE**

The following questions were asked:

Jean Burbridge asked:

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-alone 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?

The Chair allowed a supplementary question:

So when you say temporary closed for safety reasons, what are those safety reasons?

Godfrey Jennings asked:

1. Do the commitments in the 2021 Decision Making Business Case regarding Building Better Hospitals For the Future (now renamed Our Future Hospital) still stand? Several times, UHL has reaffirmed those commitments, although it is accepted that the Treatment Centre at the Glenfield Hospital will be different from that originally envisaged following the establishment of the separately funded East Midlands Planned Care Centre. The UHL webpage on Our Future Hospitals is vague and UHL has now stated its plan to close St Mary's Birth Centre in Melton Mowbray.
2. Will UHL give an assurance that the promised midwife led stand-alone birth centre at the General Hospital will be in place before any closure of St Mary's?

The Chair allowed a supplementary question:

Commitments in the 2021 business case, Building Better Hospitals for the Future confirmed the commitments at Glenfield Hospital and East Midlands Care Centre. The Future Hospitals website stated plans to pause St Marys in Melton. Will NHS University Hospitals Leicester (UHL) give a promise that Health Centre at the General Hospital will be in place before the closure of St Mary's?

Due to the questions relating to the same item of business, the Chief Medical Officer of the Integrated Care Board, chose to respond to the questions all at once. The following was noted:

- The decision for closure was taken on 7<sup>th</sup> July 2025.
- The reason for the closure was due to low numbers of patients and limited staffing for the unit.
- Pausing births and inpatient care at the centre from 7th July was a difficult but necessary decision. University Hospitals Leicester took this step to ensure the safety of women, mothers and babies using the service, and that safety must remain the highest priority.
- The Integrated Care Board is currently working with University Hospitals Leicester to determine the next steps for Saint Mary's Birth Centre and, as has been said, this is a pause at this point in time. This work includes consideration of all safety issues and any mitigations in place, and an update is expected to be provided in the new year.
- It was confirmed that this was a pause of the current facility, and that work was ongoing to consider the next steps and the options that had been outlined. Any future decisions would be assessed from both a safety and an equity perspective to ensure that the appropriate decision was made. Members were advised that a further update would be provided with clarity early in the new year.
- In response to the question regarding safety concerns, it was explained that the reasons for the pause had been set out in July and were reiterated. These related primarily to the low number of births taking place at the centre and the resulting challenges in safely staffing the unit. It was emphasised that ensuring patient safety and adequate staffing levels remained paramount. Members were advised that a full review of the service was ongoing, including consideration of mitigations currently in place and the future position of the unit. It was confirmed that a more detailed report would be brought back to scrutiny, setting out the outcomes of this work, and that this would take place within the agreed timescales. It was also stated that scrutiny would receive this information before any formal decision was made.
- It was clarified that the pause was not driven by financial pressures and that funding was available. It was acknowledged that staffing was available, including midwives completing training who were seeking employment within Leicester and Leicestershire. However, it was explained that the work underway focused on ensuring the service could be delivered safely, was sustainable, and represented value for money in the context of the very low number of births at the centre. Consideration was also being given to equity of access. Members were advised that this work was ongoing and subject to both Integrated Care

Board and University Hospitals Leicester governance processes, and that a detailed report would be brought back to scrutiny once this work had been completed.

AGREED:

That an update would be provided to the commission in the New Year.

## 64. DIGITAL FOCUS

A representative from the ICB presented a report to update the Commission on the Digital Tools available for patients and the NHS app:

- The core functionality of the NHS app was increased. Patients were given full digital access to their GP records on the app. In Leicester, Leicestershire & Rutland (LLR) only 8 GP practices do not have this feature, this was due to the nature of their services, but further access can be requested by registered patients.
- Phase 1 of the integration brought University Hospitals of Leicester (UHL) services to the app so that patients can now manage, cancel and request bookings. It was noted that there was an average of over 250,000 views on the app per month.
- Leicestershire Partnership Trust (LPT) integration to the NHS app was pending and was dependent on the outcome of a national pilot scheme into the connectivity of the app into extended clinical systems, such as mental health and community space.
- Future ambitions for the service were detailed including patient initiated follow up, digital care plan management and two-way communication between patients and care teams. All of which was subject to national funding and the NHS app uplift which was being worked on. This was with the aim of making the app into a multi-faceted gateway tool for patients.
- It was stressed that non digital methods were to remain supported so that nobody was left behind. The initiative pushed the two goals of maximizing online access for the 80% who are digitally enabled while continuing offline support for the 20%. There were over 60 digital inclusion hubs across LLR which are supported by the Good Things Foundation. The hubs were providing digital access, support and device recycling as part of their services. There was also an ambassador programme and public engagement events to promote digital services and support digitally excluded individuals.
- It was highlighted that LPT was recently selected for the Vodafone digital inclusion programme. They received 40 sim cards with contracts and data to assist homeless families, enabling them to keep in contact with support networks and NHS services.
- The care record system, which was mentioned in a previous scrutiny meeting, allows for information sharing across health, social care and connected organisation. Some of the benefits of this system have been the accurate and timely sharing of information. There was also notable

time savings in some areas, in social care there were some assessments that were completed 2 weeks earlier than before. Whilst surveys amongst staff have recorded up to a 30-minute reduction in time per log in, per person which was freeing up more time in the working week.

Comments:

- Members raised concerns about the impact of digitisation and fears that elements of the public will be digitally excluded from GP access. It was further suggested that this may result in a two-tier system of patient access to NHS services. The scarcity of digital inclusion hubs in rural areas of Leicestershire compared to the city was raised in support of this by members. It was highlighted that Harborough which makes up a quarter of the County only has 4 hubs while Melton has only 1. This is from a total of over 60 in the Leicestershire area. There was an openness from representatives of the LLR for further expansion of the hubs to provide coverage to more areas and they welcomed input and collaboration from local authorities.
- The ad-hoc nature of GP digitisation was also touched on by members. The fact that GP practices have had to procure their own software has led to an inconsistent role out of digitisation across the board. In response, it was detailed that there was some shared learning, pilot schemes and talk of group procurement between some GP practices, facilitated by the ICB. However, it was noted that it is down to individual GP practices to get involved in these forums and projects, as they are their own individual businesses and the ICB cannot compel them to do so.
- The functionality and user interface of the app was commented on by members. Members who had examined their medical records on the app detailed that there was no search function, meaning they had to manually sift through their medical records to find certain information. It was also noted that there were inconsistencies when it came to receiving notifications about appointments and test results. While elements of the app were praised it was suggested that over selling the app before it's ready could discourage people from using it. In response it was stressed that the app is an ongoing national project and a logical step as more things in society were shifting to digital. There was recognition that the app was not as polished as it could be, but this was due to it not yet being the finished product.
- The members were keen to find out about the usage of the app and if there was any recording of this data. It was advised that data was collected nationally and could be accessed locally as required. The NHS representatives stated that they were unsure if there was tracked frequency of usage, but they would be happy to investigate this. Regarding a subsequent question about the percentage of the LLR population who use the app it was advised that LLR has one of the highest usage rates.
- The topic of data security was touched on, and questions were raised regarding what safeguards are in place to protect the information from bad actors. It was stated that LLR have a robust cyber security system

in place and that work has been constantly done to ensure it is improved and developed. LLR also have had links with the Cyber Security Operations Centre (C-SOC) It was acknowledged that in these situations a hacker must only be lucky once and there would undoubtedly be disruptions. In such an event that were business continuity plans in place and constant training was taking place, with lessons learned during the Leicester City cyber incident being incorporated.

- In response to questions about greater communication between patients and practices, the Chief Medical Officer for the ICB, flagged the new 'You and Your GP' system which was now implemented. There was now a link on every GP practice website where any patient could give feedback on the services provided by their local practice. It was encouraged that all members should help to promote this new service amongst their constituents.

Agreed:

The report was noted by the Commission.

## **65. UPDATE ON WINTER PRESSURES**

The Chief Medical Officer and Deputy Chief Operating Officers gave a verbal update to the Commission on the current winter pressures. The following was noted:

- An early surge in flu had been identified which had not been anticipated nationally and had taken trusts by surprise. Partners across acute, primary care and EMAS had worked together to identify additional actions and ensure plans remained effective.
- The focus included improving ambulance response times, quicker handovers and ensuring ambulances arriving at the Leicester Royal Infirmary could transfer patients safely and promptly to release vehicles back into the community.
- Work continued to improve A&E performance with an emphasis on increasing the number of patients seen within 4 hours and improving care for children. A paediatric surge had been experienced and a paediatric hub had opened at Groby Road Medical Practice for all children across LLR to be directed appropriately. This had begun operating during the week.
- A first respiratory surge had also been highlighted, alongside the ongoing challenges with long A&E wait times, including waits of over 12 hours for patients needing a mental health bed. Work continued to reduce these times and improve patient flow through the hospital. Ensuring timely discharge for patients who were ready to leave was identified as essential to maintaining capacity and protecting staff and patients.
- Work undertaken since the Emergency Care Action Plan and the winter plan was outlined. This included reviewing how to reduce demand, improve flow through services and strengthen discharge processes.

- Same day emergency care services had been expanded, including direct access to surgical and medical reviews and clinics. Productivity within existing services was being improved, particularly for patients needing diagnostics.
- Patients continued to be redirected to the most appropriate setting including hubs and urgent care centres. Improvements to discharge processes were being monitored against specific criteria and timeframes.
- Additional capacity had come online for winter, including LOROS beds and new wards at the General Hospital and Preston Lodge community setting. The first floor had opened and the second floor was due to open in January.
- It was noted that 6th January was historically the busiest day for health services and preparations were underway to manage expected pressures. Work also continued on supporting and deploying the workforce during the Christmas period, recognising limited staffing flexibility.
- An update on primary care and pharmacy was provided, confirming that additional practice activity was underway to ensure patients were directed to the most appropriate services rather than attending A&E unnecessarily.

In discussions with members, the following was noted:

- Questions were raised about the KPIs shown in the winter planning slides, with a request for these to be shared in more detail at a future meeting to show performance against them. A progress update on the indicators was also requested, including how they were being monitored over winter.
- Clarification was sought on the additional LOROS beds supporting discharge and whether these were funded by the NHS. It was confirmed that four additional beds had been identified, with two now operational and two more due to go live next month.
- Concerns were expressed about flu and Covid vaccination uptake. One member reported that some GP practices had told patients they could not book vaccinations in person, which was contributing to lower uptake. This had been raised with the ICB, as the information was not correct.
- Work was taking place to address variation across practices, including weekly discussions on redirection at the door policies and the impact of national contract changes introduced on 1st October. Data was being reviewed weekly and trends were emerging in particular practices. Further support was being provided to practices and PCNs, including GP webinars to promote more effective referral routes.
- A query was raised regarding how many practices were experiencing access issues of this kind. It was reported that eight practices were currently being worked with closely out of a total of one hundred and twenty. Broader concerns were also shared about the ability to access out of hours care after 10pm and the recurring pattern of winter pressures. Members questioned why improvements were not more visible given the level of planning undertaken each year.

- There was support for receiving a post winter comparison to understand what improvements had occurred and what gaps remained. It was acknowledged that some improvements had been made, although these were not always evident during peak pressure periods. Percentage improvements in waiting times had been observed, although ambulance delays continued to pose a significant challenge and demand across the system had increased.
- The importance of accessible primary care was highlighted, noting that eight practices experiencing difficulties could equate to approximately one hundred and twenty thousand affected patients.
- Public concerns were shared about ambulance and A&E waiting times, with some reports of patients waiting up to fourteen or sixteen hours and not being seen within four hours. Questions were raised about what constituted an acceptable waiting time for ambulances and for patients in waiting rooms, as well as when meaningful improvement could realistically be expected. It was noted that public confidence in NHS services was being impacted, particularly during winter when delays were greatest.
- It was reported that demand continued to grow due to an ageing population and rising numbers of patients with multiple long term conditions. Attendances at A&E were reaching record highs, with up to one thousand patients presenting in a single day. National standards remained four hours for A and E waits and forty five minutes for ambulance handovers, although the preferred ambition was fifteen minutes.
- Continued pressures across primary care, pharmacy and community services were also noted. The system was operating at the highest escalation levels more frequently and remained focused on ensuring patients were redirected appropriately while prioritisation was maintained. Capacity had increased although workforce challenges persisted. Productivity improvements continued to be required across the system, with benchmarking showing some progress against regional and national performance.
- Further questions were raised about why some new wards would not open until January despite high demand. It was explained that the Leicester General ward was opening in phases due to building work only recently being completed and workforce for the first stage now in place. Additional capacity had been introduced for paediatrics, including the paediatric hub at Groby Road, although demand remained extremely high. Leicester continued to be one of the busiest areas in the UK for paediatric attendances. Additional support was being provided for families and young people during the respiratory surge period, which typically ran from mid-November to January, with capacity planned to remain in place until the end of March.
- Clarification was sought again about the LOROS beds and whether four additional beds were available. It was confirmed that these were bespoke winter beds intended to support system pressure differently. If successful, the initiative could potentially continue longer term, which would also support LOROS financially given the wider range of community services they provided.

AGREED:

1. That the verbal update be noted.
2. That a special meeting would take place with all health partners for the City in January and an update to follow at the next Joint Health Meeting in February.

## 66. SYSTEM HEALTH EQUITY

The Director of Health Equality and Inclusion for UHL, gave a verbal presentation update on the Accident and Emergency Department's waiting times:

- The update was requested following a question relating to ambulance hand over times and the potential impact based on protected characteristics for patients waiting for ambulances at a previous meeting. To assess this question, data was examined from October 2025 which analysed sex, ethnicity, frailty and deprivation status of 1,800 patients and how these factors affected people waiting for ambulances. The findings were that there was no significant difference based on a protected characteristic and that clinical need and acuity of illness being the driving factor.
- Further work was done to examine the experiences of patients and how different groups of people might experience waiting as well as how they might attend the Emergency Department. UHL Emergency Department (ED) data between 2022 and 2024 was investigated for the research, with wait times and frequency of attendance being examined. The Director hoped that this extra information would further add to conversation around the previous item on winter pressures.
- Between July 2022 to November 2024 there was an 11% increase in ED attendance. This was fuelled by a 21% increase in Paediatrics and 7% increase in adults. While there was a noted increase in children's attendance, adult attendance outnumbered children by nearly a factor of 3.
- There was an overall goal of simplifying the data so interventions can be had with specific groups and populations as well as what service changes need to be made to support this. There are different needs for different population groups with a clear need around deprivations status and age. The data showed that the most prominent groups in the Emergency Department were older patients of a white ethnicity, Black and Asian individuals and deprived groups. Black and Asian individual as well as deprived groups were all overrepresented in the Emergency Department, but their average patient acuity was lower. Older patients who are of a white ethnicity tend to wait longer but this was due to the complexity of their needs.
- Emergency Department usage was becoming less concentrated amongst traditional high use groups. A broader, more complex patient mix was emerging across the population.
- The data was collated on to maps, so the areas of LLR with particularly

high Emergency department attendance can be identified. This was with the aim of passing this information on to primary care and community partners, so they can engage with the identified communities and develop interventions. Thus, driving down Emergency Department attendance in the future.

In response to Members comments:

- The utility of the slides in relation to the previous topic was echoed by members and that it was stated that it would have been useful to see the slides before the meeting. It was commented how factors such as vaccinations and GP access in deprived and rural communities, ultimately accumulates in the Emergency department
- The GP to patient ratio in the City and its subsequent impacts on the Emergency Department was notably raised by members. It was stated that until the issue of the high GP to patient ratio is tackled, then it will continue to contribute to the high Emergency Department numbers. The fact that high levels of complex health cases in the City, were monopolising GP's resources was also highlighted. In response, the Chief Medical Officer for the ICB acknowledged that the lower levels of GPs in the City was an issue which they were working to improve. The ICB was also offering extra support and funding to GP practices in the City to help tackle the health inequality issues.
- The topic of longer wait times for older white patients was commented on and further details were requested about what the underlying causes of this difference were. It was suggested by members that it would perhaps be better if the data focused on more subdivided sections such as the City and County separately to provide more accurate information on the factors that were assessed. In answer to this, it was explained that the wait times for elderly white patients was due the complexity of their needs and not how sick they were.

Agreed:

1. The presentation was noted.

## **67. 24/25 YEAR END REVIEWS**

The item was for information only and the reports were noted.

## **68. DENTAL PROGRESS REPORT**

The Leicester, Leicestershire and Rutland (LLR) Integrated Care Board (ICB) submitted a report to update the Commission on NHS dentistry which continued to operate under a national contract, limiting the extent of local decision making despite efforts to focus activity on health needs and inequalities. The following was noted:

- It was reported that progress had been made although national contractual

constraints continued to pose challenges. Some areas of delivery were mandated nationally, including the requirement to provide seven hundred thousand urgent dental appointments nationally. Locally, an allocation of just over ten thousand appointments had been received. However, the ICB commissioned just under fourteen thousand appointments. Performance in this area had not been as strong as expected, and further targeted communications and awareness activity was planned to improve access for people with specific needs.

- General dental activity across LLR was reported to be relatively positive compared to other areas. Activity was at forty nine percent which was slightly higher than previous levels and on track to meet its year-end target. Providers had been invited to participate in an over performance scheme to deliver an additional ten percent of activity, equating to around thirty thousand appointments. Work was also taking place with providers who were underperforming to establish whether additional session time could be offered.
- Where practices continued to under deliver activity, contract values could be reduced and reinvested into other areas where need was greater. The ICB has commissioned additional funding to the Community Dental Service CIC for patients with learning disabilities, dental phobias or other complex needs who could not be treated in standard dental settings.
- The Commission also received an update on oral cancer, with Leicester previously recorded as having the highest prevalence and mortality rates nationally. Partnership work with Turning Point was underway to identify at risk patient groups. Individuals engaged with relevant charities would be able to be referred directly into participating dental practices. A similar pilot had run successfully in the West Midlands. In addition a care homes had been trialled in Charnwood, Hinckley and Bosworth. Training for early detection of oral cancer continued, with identified patients referred for appropriate treatment.
- The overall programme was described as being aligned to the local targeted needs assessment with the intention of narrowing health inequalities.

In discussions with Members, the following was noted:

- Reference was made to previous reports highlighting Leicester's high rates of oral cancer and poor dental health outcomes for children. Concern was expressed that up to two thirds of children did not have access to an NHS dentist.
- Members asked how the measures outlined would move the system from its current position to improved outcomes and what additional actions could be implemented. Further clarification was sought on contract rebasing, how it would apply to underperforming providers, and how a Unit of Dental Activity operated within the contract structure.
- It was explained that children were included within the ten percent over performance scheme and that specific criteria were used when allocating additional units of dental activity.
- Concerns were raised that contract rebasing could destabilise an already sensitive service. The contract was described as complex, with approximately eight hundred thousand units allocated across

LLR. If a provider was unable to deliver its allocation, the expectation was that the units would be redistributed so they could still be used. Examples were provided including one unit for a check-up, three for a filling and twelve for a bridge. Further work was taking place on the rebasing process.

- Questions were raised about whether there was sufficient UDA capacity to meet local population needs and what the estimated level of required provision might be. It was noted that demand exceeded availability and that some children were receiving hospital based treatment for multiple dental extractions.
- Unlike general practice, NHS dental practices did not hold a registered patient list and were not obliged to operate in the same way as GP practices. Dentistry operated within an independent sector market and recruitment pressures remained significant, although work was underway with universities to support the future workforce pipeline.
- Further discussion took place on whether additional units could be delivered if the government provided them. Members asked who the responsible minister was, and whether lobbying might lead to increased allocation.
- Oral cancer prevention was revisited, with members asking whether activity was being funded locally to target risks associated with shisha use in Leicester. It was confirmed that additional capacity could be delivered and that work with providers was ongoing. The responsible minister was identified for future lobbying, and public awareness work relating to oral cancer risks remained part of ongoing programmes.
- A query was raised about the ability of residents across LLR to obtain an NHS dentist. It was confirmed that recall lists existed within practices, although wider registration data was not held. Members highlighted the difficulty of accessing services and commented on the complexity of the forms patients were required to complete.
- Questions were also asked about how many people across LLR were registered with NHS dentists compared to private providers. It was confirmed that no comprehensive list existed and that this was a national issue being considered as part of the ten-year plan for dentistry. Work continued with the local dental committee to explore the business model for NHS dentistry and the challenges practices faced.
- Concerns were raised about the position in Rutland where 82% of adults were not accessing NHS dental care. Members asked what mitigations were available to address this. It was noted that a procurement for ten thousand UDAs was underway, although legal considerations had delayed progress. An update on the outcome was expected soon. Providers across LLR were eligible to participate in these schemes, although if providers in Rutland did not come forward it indicated a lack of interest in offering NHS provision.
- The discussion concluded with an acknowledgment that the situation was not ideal and that delays in the procurement process carried risks. There was concern that if progress was not achieved soon, the

market would continue to shift further towards private provision. The Commission supported revisiting the issue at a future meeting.

AGREED:

That the report be noted

**69. MEMBERS QUESTIONS ON MATTERS NOT COVERED ELSEWHERE ON THE AGENDA**

It was asked how the additional 2.5M hospital appointments were being allocated?

In response it was noted that Each Integrated Care Board were given an allocation and they would work through and see how much could be used.

It was raised that East Midland Ambulance Services were using private ambulances. What the cost per day and year was for the use of these?

It response it was noted that the figures would be shared with the Commission at the next meeting.

**70. WORK PROGRAMME**

The Chair highlighted the work programme and invited Members to make suggestions.

**71. ANY OTHER URGENT BUSINESS**

With there being no further business, the meeting closed at 12.25pm.





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# Update on St Mary's Birth Centre

Joint Leicester, Leicestershire and Rutland  
Scrutiny Commission

23/02/2026

Maria Laffan  
Chief Nursing Officer  
Leicester, Leicestershire and Rutland and  
Northamptonshire Integrated Care Boards

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## Useful information

- Ward(s) affected: Leicester, Leicestershire and Rutland
- Report author: Ket Chudasama, Deputy Chief Strategy and Planning Officer
- Author contact details: [ket.chudasama@nhs.net](mailto:ket.chudasama@nhs.net) 07760 990396
- Report version number: 1

### 1. Summary

University Hospitals of Leicester NHS Trust (UHL) took the difficult decision to pause births and postnatal inpatient services at St Mary's Birth Centre (SMBC) in July 2025 due to concerns over safe staffing and declining birth numbers. To understand the impact of the pause, the Leicester, Leicestershire and Rutland Integrated Care Board (LLR ICB) commenced a period of engagement on 5 January 2026, running to 15 February 2026. The engagement seeks experiences from affected patients, families and staff to inform next steps.

The intended direction, consistent as far as is possible with the findings of the 2021 public consultation and supported by legal advice, is to relocate births to the existing midwifery led unit at Leicester General Hospital while maintaining community maternity services in Melton. A full report will be considered by the LLR ICB Board on 19 March 2026.

### 2. Recommendation(s) to scrutiny:

Joint Leicester, Leicestershire and Rutland Scrutiny Commission are invited to:

- **Note** the progress of the engagement and emerging themes.
- **Note** the changes made to strengthen the engagement approach in response to feedback received
- **Receive** the outcome of the engagement and the ICB's final decision following the LLR ICB Board meeting on 19 March 2026.

### 3. Detailed report

#### 3. Background

##### 3.1 Temporary Pause of Services

In July 2025, University Hospitals of Leicester NHS Trust (UHL) took the difficult decision, following discussion with ICB, to pause births and postnatal inpatient services at St Mary's Birth Centre. There are several longstanding challenges at St Mary's, where less than 1% of Leicester, Leicestershire and Rutland's births take place, that worsened in the months prior to the pause. This included safe staffing - around 30% of the community team were unavailable due to maternity leave, sickness, or planned absences. Birth numbers at the centre were also in decline, with just 92 births taking place in the year prior to the pause. More women are presenting with complex needs that require closer obstetric or neonatal support, meaning fewer are eligible to use standalone midwifery units like St Mary's. The low number of births makes it harder for staff to maintain clinical experience and for the centre to operate safely.

The following maternity services continue as normal:

- Community antenatal and postnatal clinics
- Access to midwifery-led care through the Trust's home birth team and at the Leicester Royal Infirmary and the Leicester General Hospital midwifery led units
- Births in obstetric-led maternity units at the Leicester Royal Infirmary and Leicester General Hospital

### **3.2 2021 Public Consultation and Current Context**

The 2021 *Building Better Hospitals for the Future* public consultation set out a plan for births at St Mary's to move to a new standalone midwifery led unit (MLU) at LGH. Key contextual changes now affecting delivery include:

- National changes have delayed construction of the new maternity hospital at LRI.
- There is no available capital funding for a new standalone MLU at this time.
- Birth numbers at St Mary's have continued to fall, and staffing pressures have worsened.

Given this position, the ICB's approach, informed by legal advice, is to enact the 2021 consultation outcome as far as possible by:

- Relocating births to the existing midwifery led unit at LGH.
- Maintaining community maternity services in Melton Mowbray.

## **4. Engagement Approach**

This section explains how the engagement approach has been designed and the principles guiding it.

### **4.1 Principles and Legal Framework**

The approach is grounded in:

- Cabinet Office public engagement principles
- Equality Act 2010
- Brown Principles
- Gunning Consultation Principles
- Health and Social Care Act 2012

The accountable organisation is LLR ICB, with affected services delivered by UHL. Legal advice confirms that continuing engagement is appropriate and remains in line with our public involvement duties, without the need to move to formal consultation.

### **4.2 Target Audiences**

The engagement is seeking views from:

- Those who were planning or considering giving birth at St Mary's between July 2025–September 2026
- Those who used St Mary's (births and postnatal care) between January 2021– July 2025 (extended eligibility following current engagement feedback)
- Staff who worked at St Mary's Birth Centre before the pause in service
- Staff and students working in the maternity services at LLR

- Partners, carers, and family members of these people

## 5. Engagement Methods

This section describes the tools and routes used to engage with stakeholders.

### 5.1 Materials

- Online and paper impact questionnaire (with equality monitoring) written in clear and accessible language: [www.bit.ly/smbc-impact](http://www.bit.ly/smbc-impact)
- Translated and accessible versions available on request
- Dedicated webpage on ICB website [www.bit.ly/smbc-impact](http://www.bit.ly/smbc-impact)
- Support is available via the ICBs Engagement and Insights Team to help people complete the questionnaire via:
  - Emailing [llricb-llr.beinvolved@nhs.net](mailto:llricb-llr.beinvolved@nhs.net)
  - Calling 0116 295 7532
  - Writing to: Freepost Plus RUEE–ZAUY–BXEG, SMBC Engagement, Leicestershire and Rutland Integrated Care Board, Room G30, Pen Lloyd Building, Leicestershire County Council, Leicester Road, Glenfield, Leicester LE3 8TB

### 5.2 Mechanisms and Channels

- UHL patient lists
- Maternity, Neonatal and Voices Partnership (MNVP) (via emails, WhatsApp and Facebook)
- Healthwatch Leicester & Leicestershire
- Leicester Mammias
- SMBC campaign group
- Local councillors, MPs, and Health & Wellbeing Boards
- Social media – ICB website, ICB Facebook page and Facebook ‘Spotted’ pages across Leicester, Leicestershire and Rutland
- Local media – Two press releases sent to media contacts and channels across Leicester, Leicestershire and Rutland.
- GP newsletters and networks
- Voluntary sector engagement – reached via the LLR VCSE Alliance through email and the forum covering all protected characteristics, areas and varying levels of interest.
- A wide range of stakeholders from across Leicester, Leicestershire and Rutland covering all audiences identified through the ICBs comprehensive stakeholder database.

### 5.3 Focus Groups

Four cohorts:

1. SMBC staff
2. People due to give birth at SMBC before the pause
3. People considering giving birth at SMBC between July 2025–September 2026

4. People who have used SMBC between January 2021 and July 2025 (extended eligibility following current engagement feedback)

Two additional online sessions were added due to low uptake at initial sessions. One-to-ones are offered to those who would prefer to give feedback outside of a focus group. So far, one session of this kind has taken place.

## **6. Engagement Update (as at 5/02/26)**

### **6.1 Participation so far**

- Staff online focus group (19.01.26)
- Staff face to face focus group (Melton, 20.01.26)
- Patient face to face focus group (Melton, 20.01.26)
- Patient face to face focus group (Leicester, 27.01.26)
- Patient online focus group (05.02.26)
- All correspondence received via email is responded to in a timely manner.
- Meetings held with councillors/MPs on request and as identified by interest.

### **6.2 Early emerging themes**

Early engagement feedback has highlighted a range of initial reflections from patients and staff, with emerging themes centred on access and practicalities, people's experience of care and support, the importance of clear communication about the pause, and varied workforce perspectives during a period of change. Feedback also indicated that women value having easy access to supportive postnatal care at St Mary's, including breastfeeding support, continuity, and care that feels personal to their individual needs. These early themes are provisional and will continue to develop as more feedback is gathered.

## **7. Changes Made to Engagement Approach**

Given the volume of feedback relating to the quality and importance of postnatal care at SMBC, it is both appropriate and necessary for the ICB to amend its engagement approach to ensure that these concerns are fully examined, proportionately reflected in the evidence base, and used to strengthen the robustness and credibility of subsequent decision making. The specific changes we are making are:

- Eligibility widened to include users of SMBC (births and postnatal care services) from 2021–2025
- Deadline extended to 15 February 2026
- Additional online focus groups added (05.02.2026 and two planned for 11.02.2026)
- Communications broadened to improve reach

## **8. Next Steps**

The engagement process will continue until 15 February 2026, during which time the ICB will actively gather experiences, feedback and views from patients, staff, partners and stakeholders to fully understand the impact of the proposed changes to services at St Mary's Birth Centre.

Following the close of the engagement window, all responses will undergo an independent evaluation and thematic analysis to ensure that the findings are robust, impartial and accurately reflect the views of those affected.

The outcome of this analysis will be incorporated into a comprehensive final report, which will be presented to the LLR ICB Board on 19 March 2026 to support informed decision-making regarding these services. Should the Joint Health Overview and Scrutiny Committee request further assurance or clarification, the ICB will return to JHOSC for additional scrutiny.

Subject to the Board's approval of the recommended way forward, the programme will then move into an implementation phase, ensuring that any agreed changes are enacted in a safe, timely and carefully managed manner.

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

##### **4.1 Financial Implications**

The implications are currently being assessed and will be provided in the next iteration of this report for the Committee's consideration.

Signed: Ket Chudasama

Dated:12.02.2026

##### **4.2 Legal Implications**

The implications are currently being assessed and will be provided in the next iteration of this report for the Committee's consideration.

Signed: Ket Chudasama

Dated:12.02.2026

##### **4.3 Equalities Implications**

The implications are currently being assessed and will be provided in the next iteration of this report for the Committee's consideration.

Signed: Ket Chudasama

Dated:12.02.2026

##### **4.4 Climate Emergency Implications**

The implications are currently being assessed and will be provided in the next iteration of this report for the Committee's consideration.

Signed: Ket Chudasama

Dated:12.02.2026

##### **4.5 Other Implications**

The implications are currently being assessed and will be provided in the next iteration of this report for the Committee's consideration.

Signed: Ket Chudasama

Dated:12.02.2026

## **5. Background information and other papers:**

## **6. Summary of appendices:**

### **Appendix A: St Mary's questionnaire**



St Marys  
Questionnaire 29.01.2





## **HEALTH OVERVIEW AND SCRUTINY COMMITTEE: 23<sup>rd</sup> February 2026**

### **LLR SEND & Inclusion Alliance Update**

#### **REPORT OF THE DIRECTOR OF LLR SEND & INCLUSION ALLIANCE**

##### **Purpose of report**

1. This report provides the Committee with information about the work of the Leicester, Leicestershire and Rutland SEND & Inclusion Alliance (SIA) including:
  - LLR SIA approach to co-production
  - LLR SEND Change Programme Partnership (CPP)
  - SEND Aligned Commissioning Programme
  - Shaping SEND Futures – local community inclusion model
  - Operational Plan for 2026/27
2. This report also sets out the central role that this collaborative arrangement across LLR will play in responding to the SEND Reforms that will be set out in the anticipated Schools White Paper and associated publications.
3. Finally, this report notes that the Alliance is currently resourced to July 27 and that proposals for funding from commissioning bodies to sustain the arrangements have been drafted.

##### **Policy Framework and Previous Decisions**

4. SEND (Special Educational Needs and Disability) legislation in England is primarily governed by the Children and Families Act 2014 (Part 3), which mandates support for children and young people (0-25) through SEN Support and Education, Health, and Care (EHC) plans.
5. This is supported by the Equality Act 2010 which protects children with disabilities from discrimination and the SEND Code of Practice 2015 which is statutory guidance that local authorities, schools and health bodies must follow.
6. The government's SEND and Alternative Provision green paper "Right Support, Right Place, Right Time" alongside a Schools White paper, was published in March 2022. In March 2023, the government published the SEND and Alternative Provision Improvement plan.
7. Note: The government is expected to publish a further Schools White Paper before the end of the current financial year.

## **Background**

8. The national SEND and Alternative Provision Change Partnership Programme (CPP) is a Department for Education (DfE)-funded initiative launched in September 2023, to test and refine proposed policy reforms for children in England with Special Educational Needs and Disabilities. LLR is one of nine regional partnerships working across 32 local areas that was selected to test proposed changes.
9. Over these past two phases of the programme, more than 11 areas of reform have been tested across LLR; helping to create a stronger co-production and co-design ethos, shaping a more inclusive system and providing valuable evidence to the government to inform the SEND reform plans, and the soon to be published Schools White Paper.
10. In anticipation of the CPP concluding in June 2026 local partners created the LLR SEND & Inclusion Alliance (SIA) to sustain the impactful and cohesive programmatic approach used in the CPP; ensuring systemwide improvements in commissioning and delivery of services can continue to be effectively led. Endorsed by the DfE and NHSE, local organisations are collaborating within the Alliance to benefit local people and placing LLR as a target for innovation and investment.
11. The LLR SIA Operational Plan for 2026/27 was approved by the SIA Board in January. Commitments in the Plan include the delivery of the first-year priorities in the LLR SEND Joint Commissioning Strategy; delivery of the Local Integrated Service Offer (phase three of the national Change Programme); and roll-out of Shaping SEND Futures, the SIA's Community Inclusion Programme.
12. The LLR SIA is underpinned by a formal Memorandum of Understanding (appendix 2). It is accountable to the LLR Directors of Children's Services (DCSs) via the Children's and Young People's Executive Group. The DCSs set the strategic direction of the SIA, and delivery is achieved in partnership with the local NHS.

## **SIA Strategic Aims and Progress**

13. The five strategic aims of the LLR SIA are:
  - I. to co-produce our goals and delivery plans.
  - II. to ensure all children and young people with SEND, who don't need specialist provision, have their needs met in mainstream education.
  - III. to ensure all children and young people with SEND feel that they belong in their local communities
  - IV. to facilitate aligned commissioning as a health, care and education system, to ensure that our children and young people with SEND, and their families, receive the support that they need when they need it.
  - V. to collectively own the challenges and opportunities of our local SEND system to ensure we provide a high-quality standard of integrated support for children and young people with SEND, and their families.

14. Co-production:

The LLR SIA has established a Co-production Group, appointed a Co-production Lead for children and young people (CYP) with lived experience of the SEND system who is supervised by academic colleagues at the University of Derby. Co-production with parent carers is achieved via the three LLR Parent Carer Forums Chairs.

15. The CYP Co-production lead and PCF Chairs are PCF Chairs are partners on the SIA Board. The SIA has created a Co-production Charter (appendix 1 - slide 4) which underpins all activities of the SEND and Inclusion Alliance.

16. Inclusive mainstream education:

Phase three of the CPP has focused on the creation and establishment of a Local Integrated Service Offer (LISO) to support children and young people to remain in local mainstream education (appendix 1– slide 5).

17. Several projects have been tested that increase capacity to support CYP with SEND in mainstream education settings. Two of these have been jointly funded by DfE and NHSE; PINS (Partnership for Inclusion of Neurodiversity in schools) and ELSEC (Early Language Support for Every Child).

18. The LLR ELSEC pathfinder programme is a joint initiative launched in September 2023 by DfE and NHSE. The ELSEC programme is designed to identify and support children's speech, language, and communication needs through early intervention and innovative workforce models. ELSEC is delivered in Early Years settings, schools, families' own homes and Family Hubs. Together with many partners across LLR, we have made significant progress in strengthening a more balanced, responsive and effective system to meet children's speech, language and communication needs for the 0-11 age range. To date, almost 1000 children across LLR with universal or targeted SLCN, have received much timelier and evidence-based support, and have been diverted away from NHS waiting lists for specialist Speech and Language Therapy. Parents and schools report strong satisfaction with the service.

19. PINS has been equally successful in LLR and was uniquely led by LLR Parent Carer Forums. Mainstream primary schools involved in PINS have positively evaluated the programme in terms of increasing knowledge and skills related to supporting CYP with SEND, and PCFs report stronger inter-sector relationships and support for parents. DfE and NHSE have committed to further funding ELSEC and PINS in 2026/27.

20. The LLR SIA are also developing a neurodevelopmental profiling tool which will support schools, parents and children and young people with suspected neurodevelopmental challenges to better understand and respond to their needs, regardless of diagnosis. This is due to be tested later this year.

21. When the CPP concludes in July 2026, the LISO workstream will evolve into supporting the implementation of the anticipated Schools White Paper. A summary of key impacts from the CPP can be found in appendix 1 – slide 2.

## 22. Community Inclusion: Shaping SEND Futures

Shaping SEND Futures is the LLR SIA's approach to holistic community-based inclusion acknowledging that CYP spend only a proportion of their time in schools. School leaders report that many young people attend school with additional needs, not directly relating to SEND, but instead as a consequence of socio-economic factors such as poverty, addiction and in some cases, domestic violence.

23. The LLR SIA is working closely with LLR Family First Partnership Programme Leads to ensure initiatives are complementary rather than duplicative. Pilots under the Shaping SEND Futures workstream have resulted in closer working relationships between primary care, schools and family hub; testing innovative new roles to support older school age children, and closer working with the voluntary and community sector to support CYP with SEND in their local communities.

## 24. Case study: Social Prescribing in Hinckley and Bosworth

*Our Hinckley and Bosworth Shaping SEND Futures (SSF) Team piloted a new Social Prescriber (SP) post which aimed to work specifically with children, young people and their families / carers; a first in England for this cohort. Evaluation for the full pilot is currently underway with 6 month findings demonstrating:*

- *889 consultations / contacts with CYP and families*
- *157 appointments diverted from the GP practice*
- *121 referrals directly from CYP and families attending drop-in sessions that had been arranged across the Hinckley and Bosworth area.*
- *100% satisfaction rating from all patients / clients*
- *Wellbeing assessments increasing from 30% at first meeting to 70% on discharge.*

*This scalable model has now been implemented in other SSF footprints with adaptations including SPs being based in schools and providing more targeted support to SENCOs. With LD /SEND SPs embedded in schools, this will provide an alternative route for education to access links to non-clinical local service support for children and young people e.g. mental health support links without having to go through a GP.*

## 25. Aligned Commissioning

Local evidence has been triangulated across the CPP-developed Local Area Inclusion Plans, our locally produced Young Researchers, Young Voices report, and analysis of our newly established LLR SEND Data dashboard which collates quantitative intelligence across LLR's health, social care and education sectors.

26. Seven clear priorities for aligned commissioning have been identified (attached – slide 6) and work is underway to scope the three we are prioritising for 2026/2027:

- I. Social and Emotional Mental Health
- II. Co-ordination of information, advice and support
- III. Preparation for adulthood – post-16 support.

27. Whilst the LLR SIA cannot commission services on behalf of the four LLR commissioning organisations, we have a key role in identifying and articulating need across the health, care and education system, coordinating activities and making recommendations to accountable bodies.
28. The LLR SIA deliberately uses the language of aligned commissioning in acknowledgment that new funding to commission additional services is unlikely, so it is incumbent on us to ensure that services we do commission as a system meet need, are cohesive, and provide value for money.
29. Collective Ownership and Accountability  
The LLR SIA is accountable to the LLR System Executive and the LLR CYP Executive. The full governance structure can be seen in appendix 1 – slide 7.
30. It is anticipated that through the embedding of our co-production charter, the delivery of our aligned commissioning priorities, Shaping SEND Futures programmes and local integrated service offer, the LLR SIA will significantly contribute to an effective and more affordable SEND system that delivers improved experiences and outcomes for children and young people with SEND and their families.

### **Resource Implications**

31. The LLR SIA is currently resourced to July 2027. Proposals for funding from commissioning bodies to sustain the SIA arrangements have been drafted.

### **Background Papers**

32. SEND and Alternative Provision Improvement Plan (2023)

Publisher: Department for Education

Publication date: 2 March 2023

### **Circulation under the Local Issues Alert Procedure**

33. None

### **Equality Implications**

34. Children and young people with Special Educational Needs and Disabilities (SEND) are statistically more likely to experience poor physical and mental health, barriers to accessing services, and worse long-term outcomes. Although SEND policy is rooted in education law, the SEND system plays a critical role in reducing health inequalities—largely through joint working with health partners, early identification, targeted support, and statutory duties placed on Integrated Care Boards (ICBs).

## **Human Rights Implications**

35. SEND law requires reasonable adjustments and appropriate provision to ensure pupils with disabilities can participate fully, supporting their right to non-discrimination and accessible schooling.

## **Other Relevant Impact Assessments**

NA.

## **Appendices**

Appendix 1 – SIA overview slides



SIA Overview

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Appendix 2 – SIA Memorandum of Understanding



SIA MOU

## **Officer(s) to Contact**

Name and Job Title: Fay Bayliss, Director, LLR SEND & Inclusion Alliance  
Telephone: 07717 346584  
Email: fay.bayliss@nhs.net

Name and Job Title: Mark Roberts, Director, LLR SEND & Inclusion Alliance  
Telephone: 07902 852735  
Email: mark.roberts31@nhs.net

# LLR SEND & Inclusion Alliance

formerly SEND & AP Change Programme Partnership (CPP)

29

Fay Bayliss – Co-Director  
Mark Roberts Co-Director

Leicester, Leicestershire and Rutland Joint  
Health Scrutiny  
February 2026



# Ambitions beyond the SEND & AP CPP

## Change Programme Partnership workstreams across phases



### Phase 1 testing

- Developing Local Area Inclusion Partnerships
- Standardised Digitised EHCP template
- Tailored Advisory Lists
- Local Area Inclusion Plan
- Mediation at earlier stage
- 3 tier Alternative Provision (AP)
- Early Language Support for Every Child (ELSEC)
- Alternative Provision Strategic Taskforce APST (City)

### Phase 2

- Advice & Information
- Coproduction Charter
- Alternative Provision (AP)
- APST (City, County, Rutland)
- ELSEC
- Partnership for Neurodiversity in Schools (PINS)

### Phase 3

- Local Integrated Service Offer (LISO)
- APST (County & Rutland)
- Alternative Provision (AP)
- ND Inclusion
  - ELSEC
  - PINS
- SEN Units/Resourced Provision
- Assistive Technology lending libraries
- Local Inclusion Plan, Maturity Assessment tool (feedback on templates/guidance)
- SEND & Inclusion Alliance

### Key Impacts:

**Advice & Information:** MDT approach to EHC Assessment – improved KPIs and backlog clearance

**ELSEC:** c.1000 children's needs met with universal & targeted approaches – 100% parental satisfaction. Focus on reducing HI

**PINS:** Increased capacity to support need in mainstream education; improved relationships between LAs, Schools and PCFs

**ATLL:** System efficiencies for equipment costs (scoping scalability)

**LAIPS:** informing joint/aligned commissioning priorities and underpin LLR Community Inclusion Programme

**Formation of the LLR SEND & Inclusion Alliance (endorsed by DfE)**



# LLR SEND & Inclusion Alliance: 5 Strategic aims



- Co-production is the golden thread that weaves through everything we do, and our work is underpinned by our locally developed Co-Production Charter. **We aim to co-produce our goals and delivery plans.**
- The Local Integrated Service Offer (LISO) is a multi-disciplinary approach to bridge the gap between specialist and mainstream provision. **We aim to ensure all children and young people with SEND, who don't need specialist provision, have their needs met in mainstream education.**
- Our community inclusion programme works with LLR communities to support local cyp with SEND to thrive. **We aim to ensure all children and young people with SEND feel that they belong in their local communities.**
- Our Joint Commissioning Strategy. **We aim to facilitate commissioning as a health, care and education system, to ensure that our children and young people with SEND, and their families, receive the support that they need when they need it.**

Having these building blocks in place will facilitate collective ownership and strengthen accountability. **We aim to collectively own the challenges and opportunities of our local SEND system to ensure we provide a high-quality standard of integrated support for children and young people with SEND, and their families.**

**System commitment to these aims are formalised within the LLR SIA MOU**

# LLR Co-production Charter

Coproduction involves individual and community voices working together in respectful partnership to improve lives.



## We respect and trust everyone in the process

We support and enable everyone to be heard

We are clear on the way forward and act on what has been agreed

We are honest, respect confidentiality and try to understand everyone's circumstances and point of view



## We work in partnership

We welcome and value everyone's views

We seek honest and transparent feedback

We understand that our different roles, responsibilities and perspectives are the key to good coproduction



## We communicate well

We listen to everyone's views

We feed back to everyone about what we have heard and what we have done

We make sure all communication is simple, accurate and easy to understand

We give everyone the information and support they need to participate



## We are inclusive

We make everyone feel welcome, comfortable and that they belong

We give everyone the time and space to be heard

We make sure that everyone can participate – for example meeting venues are accessible, we meet at suitable times, we provide interpreters where we can

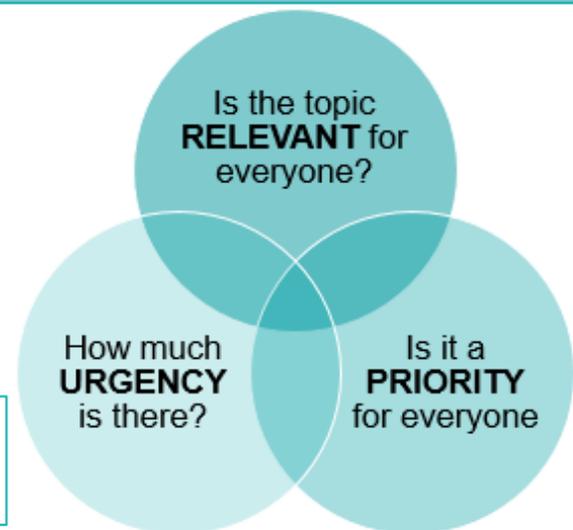
## Coproduction should happen at all levels:

- Individual
- Operational
- Strategic

## Coproduction should cover all relationships:

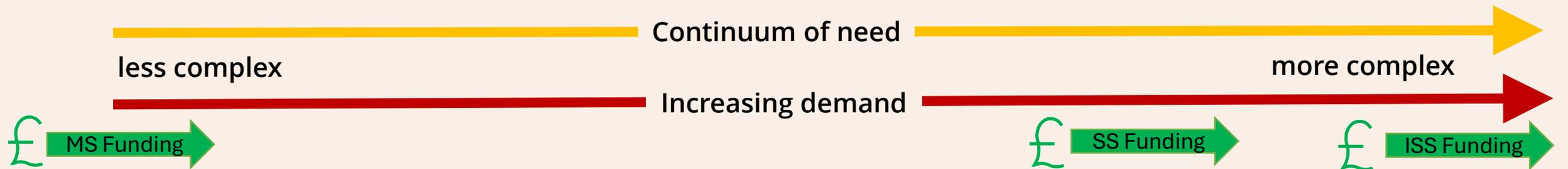
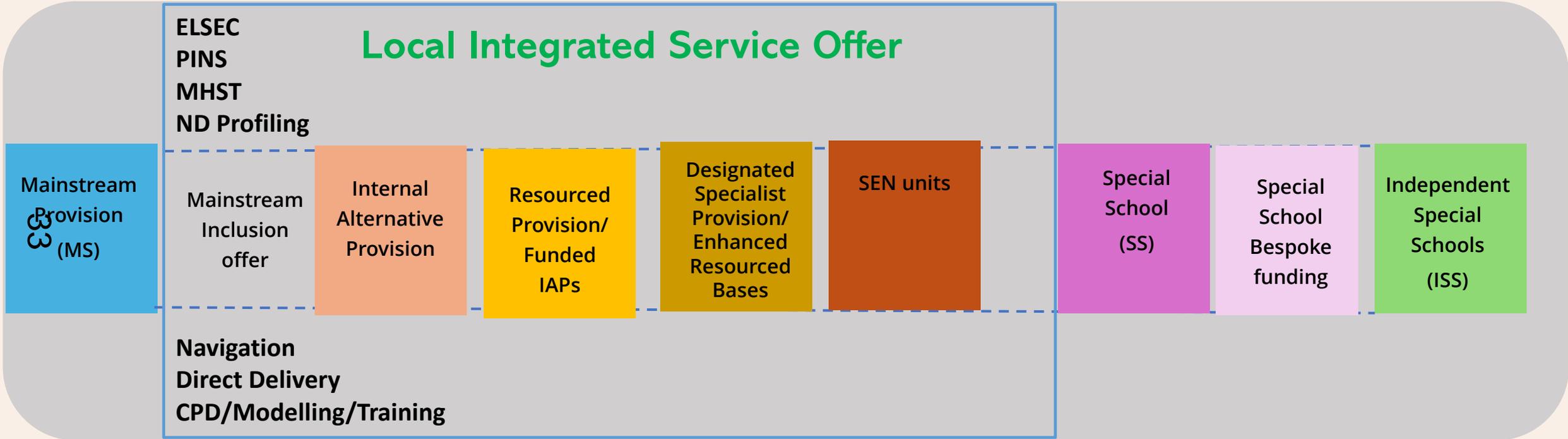
- Practitioners (inc schools) to parents and CYP
- Commissioners to parents and CYP
- Commissioners to practitioners
- Providers to other practitioners
- Parents and CYP with other parents and CYP

We seek to coproduce as much as possible but need to consider:



Bad planning is no excuse!

# Continuum of SEND Provision

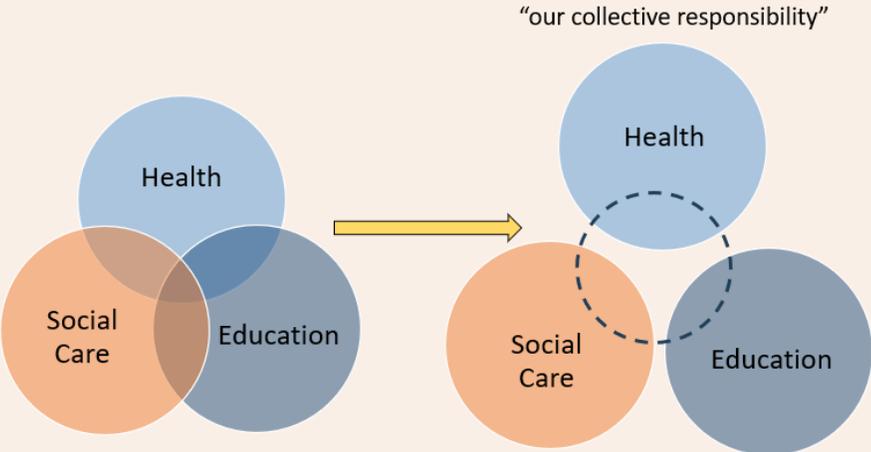


# Aligned Commissioning Priorities:



Evidence base:

- Triangulation of the 3 LLR Local Area Inclusion Plans (LAIPS – CPP phase 1)
- Findings from local ‘Young researchers, Young Voices’ report
- Analysis of locally developed SEND data dashboard



Prioritise in 2026/27

Action following evaluation

**2025/26      2026/27      2027/28      2028/29      2029/30**

1 MH (moderate) /trauma/attachment



2 Information, Advice and Support



3 Preparation for adulthood (Post-16)



4 Coordination and navigation



5 Integrated support while waiting offer



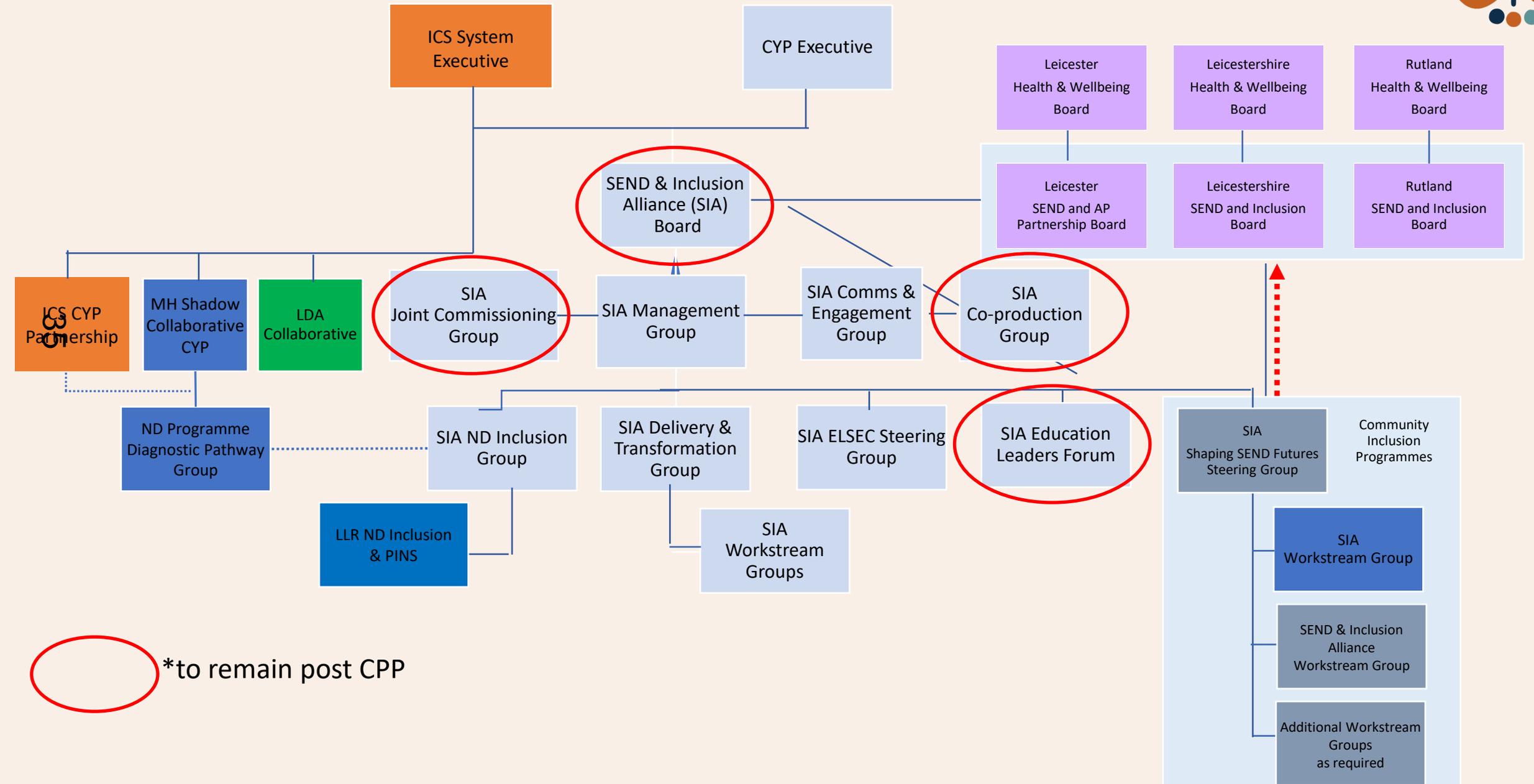
6 Speech, language and communication



7 SEND Transport



# SEND and Inclusion Alliance 2025/26





# Beyond the CPP...

## **The LLR SEND & Inclusion Alliance will:**

- Streamline our Central Delivery Team hosted by SDSA
- Focus on facilitating joint/aligned commissioning priorities
- Support scale and adoption of LLR Shaping SEND Futures (Community Inclusion Programme)
- Deliver commitments identified within our Operational Plan
- Strengthening collaboration with RIIA and regional PCFs
- Be a RIIA SEND Leadership Programme delivery partner and peer challenge facilitator
- Continue to inform the development of the RIIA data dashboard
- Seek to secure ongoing funding (beyond July 2027)

Please visit our website: <https://www.llrsia.com/>

## **MEMORANDUM OF UNDERSTANDING**

Leicester, Leicestershire and Rutland SEND & Inclusion Alliance

v1.1 - 29<sup>th</sup> July 2025

Review date: 31<sup>st</sup> March 2027

# CONTENTS

<b>1</b>	<b>PARTIES TO THE MEMORANDUM OF UNDERSTANDING</b> .....	<b>3</b>
<b>2</b>	<b>STATUS</b> .....	<b>3</b>
<b>3</b>	<b>PURPOSE OF THIS DOCUMENT</b> .....	<b>4</b>
<b>4</b>	<b>PURPOSE OF THE ALLIANCE</b> .....	<b>4</b>
<b>5</b>	<b>PRINCIPLES</b> .....	<b>5</b>
<b>6</b>	<b>ROLES AND RESPONSIBILITIES</b> .....	<b>7</b>
<b>7</b>	<b>DURATION AND REVIEW OF MOU</b> .....	<b>8</b>
<b>8</b>	<b>GOVERNANCE ARRANGEMENTS</b> .....	<b>9</b>
<b>9</b>	<b>ACCOUNTABILITY AND MONITORING</b> .....	<b>9</b>
<b>10</b>	<b>DISPUTE RESOLUTION</b> .....	<b>10</b>
	<b>Appendix 1 - LLR SEND &amp; Inclusion Governance Structure</b> .....	<b>11</b>
	<b>Appendix 2 - Dispute Resolution</b> .....	<b>12</b>
	<b>Appendix 3 - Signatories</b> .....	<b>15</b>

## 1 PARTIES TO THE MEMORANDUM OF UNDERSTANDING

1.1 This Memorandum of Understanding (“**MoU**”) is made on 1<sup>st</sup> September 2025 to formalise the LLR SEND & Inclusion Alliance (The Alliance) between:

LEICESTER CITY COUNCIL

LEICESTERSHIRE COUNTY COUNCIL

RUTLAND COUNTY COUNCIL

LLR INTEGRATED CARE BOARD

LEICESTERSHIRE PARTNERSHIP NHS TRUST

THE SCHOOL DEVELOPMENT AND SUPPORT AGENCY (SDSA)

LEICESTER CITY PARENT CARER FORUM

LEICESTERSHIRE PARENT CARER FORUM (LEICESTERSHIRE SEND HUB)

RUTLAND PARENT CARER VOICE

together the “**Parties**” and each a “**Party**”

## 2 STATUS

2.1 The Alliance is not a legal entity in its own right and it is acknowledged that this MOU is not a legally binding agreement. It does not change the statutory roles, responsibilities and accountabilities of any NHS, local authority or other body covered by this MOU.

2.2 During 2025 and 2026 the Alliance’s primary role will be to co-ordinate:

2.2.1 the delivery of the Change Programme Partnership

- 2.2.2 the delivery of the LLR SEND Joint Commissioning Strategy
  - 2.2.3 programmes of work assigned by the parties to it to improve the commissioning and delivery of services
  - 2.2.4 the roll-out of the LLR community inclusion program to deliver the Local Inclusion Support Offer
  - 2.2.5 integrated partnership working to improve quality of outcomes and lived experience for children and young people with SEND
- 2.3 It is expected that the Alliance will evolve and mature, over time, as will its relationship with each of the local organisations that form it in section 1.1 above. On an annual basis the Alliance will review its accountabilities and document these and this MOU will be superseded by an updated accountability agreement when required.

### **3 PURPOSE OF THIS DOCUMENT**

- 3.1 This document outlines and formalises the relationship in place between the parties and the Alliance for:
- 3.1.1 Co-ordinating the system approach to SEND service transformation and addressing challenges
  - 3.1.2 Overseeing the design, commissioning and deployment of programmes and work and new service developments generated by the Alliance with regard to co-production, commissioning, delivery and impact assessment
  - 3.1.3 The evolution of the maturity of the Alliance using an approach to be agreed by the Alliance Board

### **4 PURPOSE OF THE ALLIANCE**

- 4.1 The SEND Alliance has been established to ensure children, young people and young adults with special educational needs and disabilities and their families and carers can enjoy fulfilling lives and achieve their full potential, and to ensure that they can access impactful support from the right people at the right time.
- 4.2 The Alliance provides the opportunity for education, health, social care and voluntary and community sector organisations to come together to embrace difference, solve challenges such as unwarranted variation and inequality, as well as to improve resilience. It is expected that all parties will play a full part through commitment and the allocation of resources. The Alliance, along with place-based partnerships, will be a key component of the Integrated Care Systems (ICS), enabling the local system to deliver better health, education, care and efficient use of resources.

## 5 PRINCIPLES

5.1 The Seven Principles of Public Life (aka the Nolan Principles) underpin the Parties common purpose, relationships and behaviours.

5.1.1 Selflessness

5.1.2 Integrity

5.1.3 Objectivity

5.1.4 Accountability

5.1.5 Openness

5.1.6 Honesty

5.1.7 Leadership

(Ref: [The Seven Principles of Public Life - GOV.UK](#) )

5.2 The guiding principles by which the Parties to this MoU will abide are:

5.2.1 Adopting a clear and agreed vision and purpose that supports the priorities for the Parties and National NHS and DfE priorities

5.2.2 Ensuring co-production remains central to all work undertaken in the Alliance

5.2.3 The Alliance will be inclusive, evolutionary and purpose driven. In addition to the Parties, it must draw from the insights, experience and resources of those individuals and organisations necessary to fulfil its vision and purpose, for example: schools, social care; NHS providers; independent sector; primary care; the VCSE sector; carers; service users, etc.;

5.2.4 Operating in the spirit of inclusion, collaboration and partnership, demonstrating positive behaviours and mutual respect;

- 5.2.5 Including Place leaders and local government to ensure services are designed to meet the needs of the different communities across LLR;
- 5.2.6 Adopting an approach that delivers the Population Health Management five aims of; Enhanced Experience of Care, Improved Health and Wellbeing of the Population, Addressing and health and care inequalities, Increasing the well-being and engagement of the workforce, reducing costs and improving productivity.
- 5.2.7 Addressing education, health and care equity/inequalities as a core component of strategic planning and transformational activities.
- 5.2.8 Takes a whole pathway approach to transformation (including specialised and direct commissioning) and considers the life course approach to ensure services are fit from conception to 25 years;
- 5.2.9 Ensuring Partners are of equal status and standing;
- 5.2.10 Making decisions that are focused on the interests and outcomes of Service Users and people in LLR rather than organisational interests;
- 5.2.11 Supporting each other in achieving the Alliance Objectives;
- 5.2.12 Is accountable. Takes on, manages and accounts to each other for performance of the respective roles and responsibilities set out in this MoU and consider the wider impact across the LLR ICS;
- 5.2.13 Improve resilience across providers, particularly in relation to the workforce – with the expectation that the Alliance’s work will support workforce development and workforce planning;
- 5.2.14 Consider where specialisation and consolidation would provide better outcomes and value
- 5.2.15 Is open, honest and transparent by communicating concerns, issues or opportunities relating to this MoU, subject always to appropriate treatment of Commercially Sensitive Information and Competition Law;
- 5.2.16 Adhering to statutory requirements and Good Practice. Complies with applicable Law and standards including EU procurement rules, Competition Law, data protection and freedom of information legislation;

- 5.2.17 Acting in a timely manner. Recognises the time-critical nature of the MoU and respond accordingly to requests;
- 5.2.18 Making available sufficient and appropriately qualified resources to fulfil the responsibilities set out in this MoU, including its Schedules;
- 5.2.19 Looking to adopt a collective ownership of risk and reward, including identifying, managing and mitigating all risks in respect of their performance of the obligations under this MoU;
- 5.2.20 Maintaining flexibility in working together to meet the Alliance Objectives; and
- 5.2.21 Co-ordinating with and contributing to the development of other local partnerships.

## **6 ROLES AND RESPONSIBILITIES**

- 6.1 In view of the current maturity level of Alliance, the Parties agree the following roles and responsibilities for the period up to March 2027. Beyond this point, roles and responsibilities will be revised in an updated accountability agreement, to reflect the increased maturity of the Alliance.
- 6.2 All Alliance Parties will:
  - 6.2.1 Ensure delivery of the Change Programme Partnership and subsequent associated DfE and NHSE funded programmes of work as agreed by the Board
  - 6.2.2 Ensure delivery of the LLR SEND Joint Commissioning Strategy
  - 6.2.3 Deliver an agreed programme of work assigned by the Parties to improve the commissioning and delivery of services; overseeing the design, commissioning and deployment of programmes and work and new service developments generated by the Alliance with due regard to co-production, commissioning, delivery and impact assessment
  - 6.2.4 Co-ordinate wherever possible on a systemwide basis SEND service transformation and the addressing of challenges
  - 6.2.5 Ensure that the maturity of the collaborative is monitored and progressed using an approach agreed by the Alliance Board

- 6.2.6 Effectively engage with all other Partners and Stakeholders within and outside of the Alliance
- 6.2.7 Track and monitor the mobilisation and implementation of SEND developments, as well as any remedial/corrective action plans required
- 6.2.8 Manage the gathering and analysis of key data sets in conjunction with other Alliance Partners.
- 6.2.9 Ensure communications and engagement activities increase staff awareness and involvement in improvement activity
- 6.2.10 Ensure sufficient resources are made available to enact the requirements of the Alliance as set out in this MOU.

### 6.3 The Alliance Board

6.3.1 In addition Alliance Board will have the additional roles, as follows:

- 6.3.1.1 Assurance that the Alliance is delivering its transformation agenda and addressing the key SEND challenges;
- 6.3.1.2 Ensuring oversight of financial management, performance, quality and impact of the Alliance's activities
- 6.3.1.3 Act as the interface between the Alliance and NHS England, the Department for Education and the LLR NHS and Local Authority Executive Teams, ensuring robust lines of communication in both directions
- 6.3.1.4 Act as the strategic interface between the LD&A Alliance and other LLR partnerships and Boards

## 7 DURATION AND REVIEW OF MOU

- 7.1 The MOU will commence on 1 September 2025 and will continue until 31 March 2027. Either party can request that the end date be reviewed and/or amended, with the agreement of both parties.
- 7.2 During the period of this MoU, all Parties will work together to implement an agreed Maturity Plan. By so doing, a revised accountability agreement will be agreed, for 2027/28 and beyond, to reflect the expected increase in maturity.

- 7.3 In recognition that 2025/26 is the first year of operation, the Parties will conduct an initial review of the arrangements as set out in the MOU by the 31 March 2026.

## **8 GOVERNANCE ARRANGEMENTS**

- 8.1 Decision making will be undertaken within the governance arrangements outlined in Appendix 1. It is accepted that the governance arrangements will themselves mature and all Parties will work together to refine the meeting structures, reflecting these in the revised accountability agreement for March 2027 and beyond.
- 8.2 The Parties recognise that, as an overarching principle during 2025/26, flexibility will be required and they will seek to agree any additional oversight and interaction required to manage key risks and fulfil Alliance functions.
- 8.3 The Parties recognise the duties in terms of conflicts of interest and have agreed to manage conflicts of interest in line with the ICS's Conflict of Interest Policy, which will include establishing a conflicts of interest register, declaring and effectively managing conflicts of interest as they arise.

## **9 ACCOUNTABILITY AND MONITORING**

- 9.1 The Alliance Management Team is accountable to the Alliance Board that will be chaired by an Independent Chair supported by lead officers assigned by the Parties' organisations. The Alliance Management team will be led by a Director who will be accountable to the Board for the delivery of the Alliance's functions and responsibilities. In practice, the Director will set out an annual plan and report on progress against this on a quarterly basis.
- 9.2 The Board will be led by an Independent Chair appointed by the members of the LLR CYP Executive Group.
- 9.3 Through the work of the Independent Chair and the Board the Alliance will regulate its own performance and development. Providing annual reports to the CYP Executive and the ICs System Executive setting out commissioning and operational progress and plans.

9.4 In recognition that 2025/26 is the first year of operation, the Parties will conduct an initial review of the arrangements as set out in the MOU by the 31 March 2026.

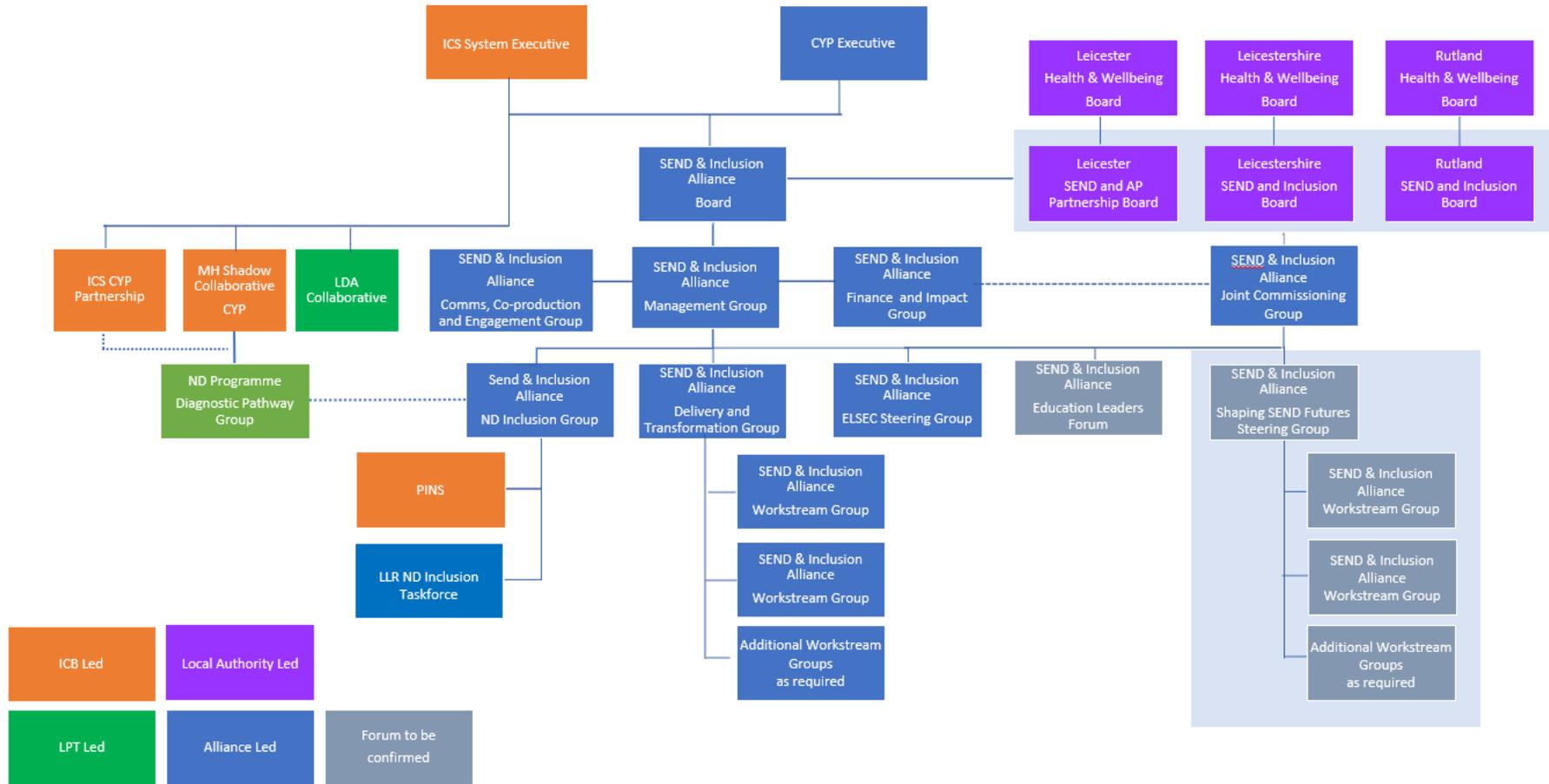
## **10 DISPUTE RESOLUTION**

10.1 In the event of disagreement about the oversight arrangements, or any other matter as set out in the MoU, the aggrieved Party shall notify the other Parties and the Parties will seek to resolve the matter with reference to the Dispute Resolution procedures (See appendix 2).

# Appendix 1

47

## SEND and Inclusion Alliance 2025/26 v8.3



## Appendix 2– DISPUTE RESOLUTION

- 1 Avoiding and Solving Disputes
  - 1.1 The Parties commit to working co-operatively to identify and resolve issues to mutual satisfaction to avoid, so far as is possible, dispute or conflict in performing their obligations under this MoU.
  - 1.2 For the avoidance of doubt, disputes relating to operational matters are to be resolved via individual party organisation’s dispute resolution procedures.
  - 1.3 The Parties believe that:
    - 1.3.1 by focusing on the LLR SEND Alliance Principles (Clause 5);
    - 1.3.2 taking decisions to tackle health inequalities, collective prioritisation of population needs, and service transformation; and
    - 1.3.3 maximising strategic planning opportunities through a shared decision-making framework;they will reinforce their commitment to avoiding disputes and conflicts arising out of or in connection with the services they provide.
  - 1.4 The Parties shall promptly notify the Board of any dispute or claim or any potential dispute or claim in relation to this MoU or the operation of the Services (each a “**Dispute**”) when it arises.
  - 1.5 The Board shall seek to resolve any Dispute to the mutual satisfaction of each of the Parties.
  - 1.6 The Board shall deal proactively with any Dispute in accordance with this MoU to seek to reach a unanimous decision. If the Board reaches a decision that resolves, or otherwise concludes a Dispute, it will advise the Parties of its decision by written notice.
  - 1.7 The Parties agree that the Board may determine whatever action it believes is necessary including the following:
    - 1.7.1 if the Board cannot resolve a Dispute, it may select an independent facilitator to assist with resolving the Dispute; and
    - 1.7.2 the independent facilitator shall:
      - (i) subject to the provisions of this MoU, be provided with any information they request about the Dispute;
      - (ii) assist the Board to work towards a consensus decision in respect of the Dispute;
      - (iii) regulate their own procedure and, subject to the terms of this MoU, the procedures of the Parties at such discussions;

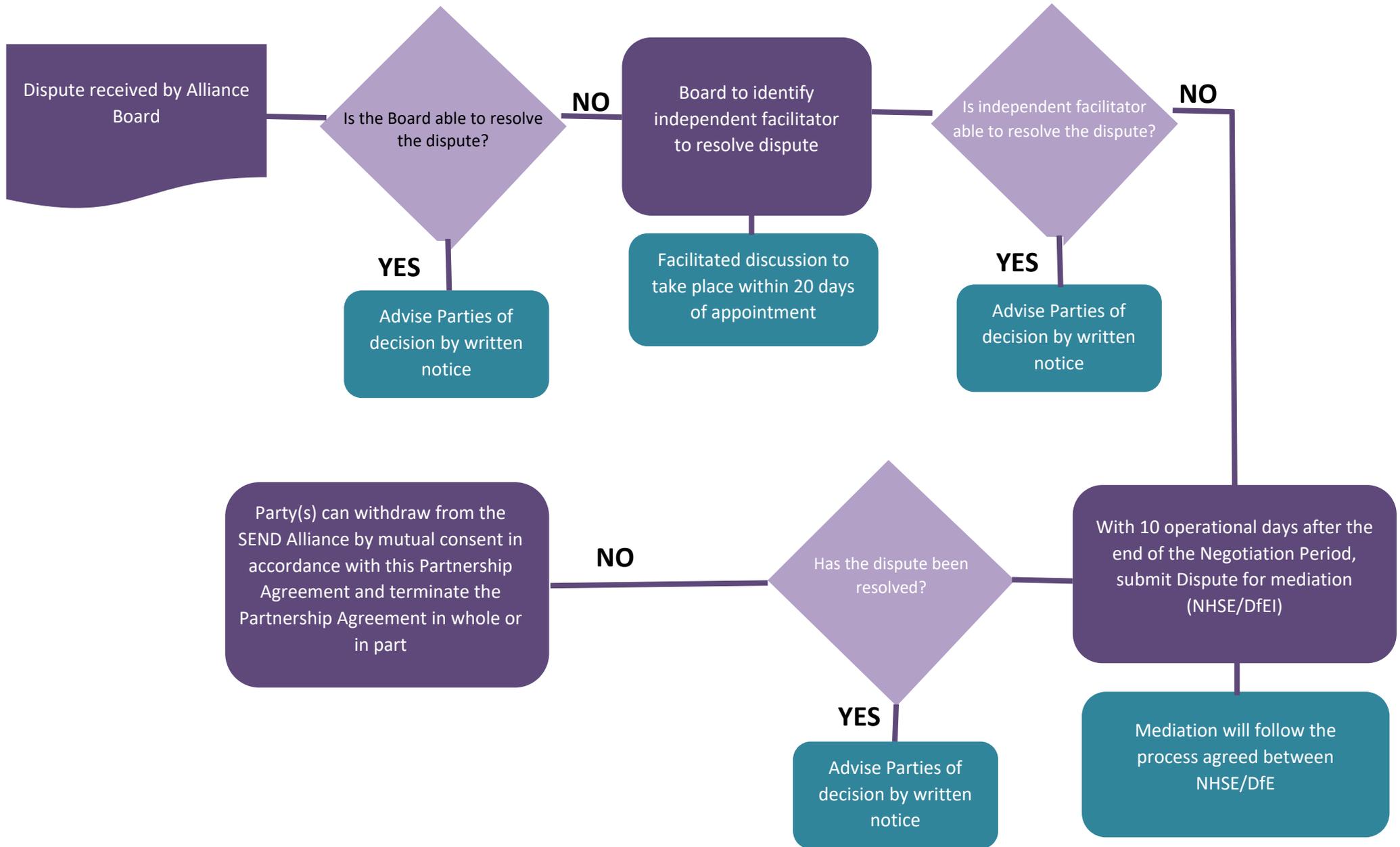
- (iv) determine the number of facilitated discussions, provided that there will be not less than three and not more than six facilitated discussions, which must take place within 20 Operational Days of the independent facilitator being appointed; and
- (v) have its costs and disbursements met by the Parties involved in the Dispute equally or in such other proportions as the independent facilitator shall direct.

1.7.3 If the independent facilitator cannot resolve the Dispute, the Parties must, within 10 Operational Days after the end of the Negotiation Period, submit the Dispute to mediation arranged jointly with NHSE/DfE.

1.7.4 If, after taking the steps in this procedure the Dispute cannot be resolved, the Parties may agree:

- (i) that the Party(s) involved in the dispute can withdraw from the LLR SEND Alliance by mutual consent in accordance with this Partnership Agreement.
- (ii) to terminate the Partnership Agreement in whole or in part.

## DISPUTE RESOLUTION PROCESS FLOW



50

## Appendix 3 – Signatories

### Disclaimer

It should be noted that by signing this document or by participating in the LLR SEND & Inclusion Alliance, the partners are not committing to legally binding obligations. It is intended that the partners remain independent of each other and that their collaboration and use of the term 'partner' does not constitute the creation of a legal entity, nor authorise the entry into a commitment for or on behalf of each other.

### Signed on behalf of Leicester City Council

Name: Sophie Maltby

Position: Director of SEND and Education

Signature: Sophie Maltby

Date: 16/9/2025

### Signed on behalf of Leicestershire County Council

Name: Tim Browne

Position: Assistant Director - Education

Signature: 

Date: 31/10/25

**Signed on behalf of Rutland County Council**

Name: Gill Curtis

Position: Head of SEND, Inclusion and Learning

Signature: *Gill Curtis*

Date: 05-01-2026

**Signed on behalf of LLR Integrated Care Board**

Name: .....Toby Sanders.....

Position: .....Chief Executive .....

Signature: *Toby Sanders*

Date: .....14<sup>th</sup> November 2025.....

**Signed on behalf of Leicestershire Partnership NHS Trust**

Name: ANGELA HILLERY

Position: Chief Executive

Signature: *A Hillery*

Date: 17/09/2025

52

**Signed on behalf of The School Development and Support Agency (SDSA)**

Name: **Mark Lambell**

Position: **CEO**

Signature: **M.Lambell**

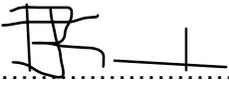
Date: **1/10/25**

53

**Signed on behalf of Leicester City Parent Carer Forum**

Name:.....Richard Jaramba.....

Position:.....Chair.....

Signature:..........

Date: 20-01-2026.....

**Signed on behalf of Leicestershire Parent Carer Forum (Leicestershire SEND Hub)**

Name: Hayley Dilks

Position C.E.O

Signature:H.Dilks

Date: 20.11.25

Signed on behalf of Rutland Parent Carer Voice

Name: Dionne Roundhill

Position: CO - Chairwoman

Signature: *Dionne*

Date: 6th Oct 2025

Leicester, Leicestershire and Rutland Joint Health Scrutiny

Work Programme 2025-26

Date of Meeting	Agenda Items	Organisation Responsible	Notes
Monday 16 June 2025	<p>Introduction to NHS, changes (structural) difference between 50% reduction and 50% growth (briefing) and the policies                      Pilot Digital Project (EMAS)                      Shared care record</p>	UHL/ ICB/ LPT	<ol style="list-style-type: none"> <li>1. Admin processes, bureaucracy and IT issues getting in the way of patients being seen by the right person.</li> <li>2. LA/ NHS working together</li> </ol>
Thursday 27 November 2025	<p>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.</p> <p>Winter Pressures verbal update</p> <p>Digital Focus (Presentation)</p>	<p>EMAS / UHL/ ICB</p> <p>UHL/ ICB</p>	

	<p>24/25 year-end review – info circulated</p> <p>Dentistry</p>	<p><b>ICB/LPT</b></p> <p><b>ICB</b></p>	
<p><b>Monday 23 February 2026</b></p>	<p>St Marys – Process and Engagement – 19<sup>th</sup> March update on decision – questions and points raised</p> <p>LLR SEND &amp; Inclusion Alliance update</p>	<p><b>update in March on decision/no conclusions in Feb</b></p>	
<p><b>Thursday 30<sup>th</sup> April 2026</b></p>	<p>Update on decision on St Marys</p> <p>Children and Young People Mental Health &amp; Speech and Language</p> <p>GP Access - In depth session on GP specifics across LLR broken down by each area (Possible informal briefing)</p>		

<b>Topic</b>	<b>Detail</b>	<b>Date</b>
ICB Highlight sheet of data	Members requested more data to be scrutinised focusing on the ICB and statistics.	
<b>Ambulance Service and wait times</b>		<b>November 2025</b>
GP Access		<b>April 2026</b>
Out of hours access		
LLR out of hours and emergency care		
System approach to stroke		
CAHMS		<b>April 2026</b>
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.		
Over Seas Doctors Training Scheme	Are there are any similar contracts within LLR and what they are doing to check all similar contractual arrangements within LLR	
<b>CAMHS and SALTS Children and Young People Mental Health &amp; Speech and language</b>		<b>March 2026</b>

