

Leicester
City Council

Meeting of the Public Health and Health Integration Scrutiny Commission

Date: Tuesday, 3 November 2026

Time: 5:30 pm

Place: Meeting Room G.01, Ground Floor, City Hall, 115 Charles Street, Leicester, LE1 1FZ

Members of the Committee

Councillor Halford (Chair)

Councillor Westley (Vice-Chair)

Councillors Bajaj, Clarke, March, Sahu, Singh Patel and Singh Sangha

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

For Monitoring Officer

Officer contacts:

Julie Bryant (Governance Services), Katie Jordan (Governance Services) and Governance Services (Governance Services)

Tel: Leicester City Council, City Hall, 115 Charles Street, Leicester, LE1 1FZ

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If you have any queries about any of the above or the business to be discussed, please contact: **Julie Bryant (Governance Services), Katie Jordan (Governance Services) and Governance Services (Governance Services), Governance Services on .** Alternatively, email governance@leicester.gov.uk, or call in at City Hall.

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PUBLIC SESSION

AGENDA

NOTE:

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1. Welcome and Apologies for Absence

To issue a welcome to those present, and to confirm if there are any apologies for absence.

2. Declarations of Interests

Members will be asked to declare any interests they may have in the business to be discussed.

3. Minutes of the Previous Meeting

Appendix A

The minutes of the meeting of the Public Health and Health Integration Scrutiny Commission held on 1st September 2026 have been circulated, and Members will be asked to confirm them as a correct record.

4. Chairs Announcements

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

5. Questions, Representations and Statements of Case

Any questions, representations and statements of case submitted in accordance with the Council's procedures will be reported.

6. Petitions

Any petitions received in accordance with Council procedures will be reported.

7. Health Protection

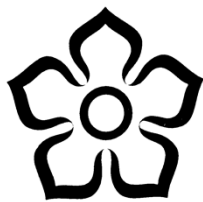
The Director of Public Health will provide the Commission with a verbal update.

8. Leicester, Leicestershire, Rutland & Northamptonshire ICB Cluster – Winter Plan 2026/27

Appendix B

The Integrated Care Board (ICB) submit their Winter Plan 2026/27 for Leicester, Leicestershire, Rutland and Northamptonshire to the Commission.

- | | | |
|-----|--|-------------------|
| 9. | Vaccination in Leicester City: Targeting Resource where need is Greatest | Appendix C |
| | The Integrated Care Board (ICB) Vaccinations, Immunisation & Screening Team submit a report to the Commission on Vaccination in Leicester City: targeting resource where need is greatest. | |
| 10. | Work Programme | Appendix D |
| | Members of the Commission will be asked to consider the work programme and make suggestions for additional items as it considers necessary. | |
| 11. | Any Other Urgent Business | |



Leicester
City Council

Appendix A

Minutes of the Meeting of the
PUBLIC HEALTH AND HEALTH INTEGRATION SCRUTINY COMMISSION

Held: Tuesday, 1 September 2026 at 5:30 pm

P R E S E N T :

Councillor Halford (Chair)
Councillor Westley (Vice Chair)

Councillor Clarke
Councillor March

Councillor Sahu
Councillor Singh Patel

Councillor Singh Sangha

In Attendance

Rob Howard

* * * * *

53 Welcome and Apologies for Absence

None were received.

54 Declarations of Interests

The Chair asked members to declare any interests in proceedings for which there were none.

55 Minutes of the Previous Meeting

The Chair highlighted that the minutes from the meeting held on 30th June 2026 were included in the agenda pack and asked Members to confirm whether they were an accurate record.

AGREED:

- It was agreed that the minutes for the meeting on 30th June 2026 were a correct record.

56 Chairs Announcements

No announcements were made.

The Chair advised a change of item order which was requested by officers and approved by the Chair.

57 Questions, Representations and Statements of Case

It was noted that none had been received.

58 Petitions

It was noted that none had been received.

59 Health Protection

The Director of Public Health provided an update on health protection activity since the previous meeting. It was noted that:

- There had been no reported cases of salmonella in Leicester. Members heard that there had been 259 reported cases nationally, including one death.
- Investigations suggested that a number of cases may be linked to imported eggs and residents were encouraged to purchase eggs carrying the British Lion quality mark where possible.
- An increase in cases of viral meningitis had been reported and continued to be monitored through health protection arrangements.
- Work continued to promote vaccination uptake across different age groups.
- A local communications campaign was being developed to help parents, carers and schools better understand the childhood vaccination schedule and the ages at which vaccinations should be administered.
- National surveillance arrangements remained in place for seasonal flu and Respiratory Syncytial Virus (RSV).
- Whilst the RSV vaccination programme had demonstrated positive benefits, uptake remained below desired levels.
- Current RSV vaccination uptake amongst pregnant women in Leicester was approximately 48%, compared with a national average of 62%.
- Uptake amongst older people was approximately 48%, compared with a national average of 68%.
- No new cases of measles had been reported since the previous update.
- Tuberculosis rates in Leicester remained amongst the highest in the country, however a decline in cases had been recorded during the first half of 2026.

In response to Members' questions, it was noted that:

- Members discussed the accessibility of vaccination records through the NHS App and highlighted the benefits of enabling parents, carers and young people to easily access and monitor vaccination histories.
- It was noted that access to vaccination information through the NHS App was dependent on arrangements within individual GP practices.
- Members considered that improved access to vaccination records could help remove barriers to vaccination uptake by making it easier for residents to identify missed vaccinations and access reliable information.
- Officers acknowledged the value of a consistent approach and agreed that improved digital access to vaccination records would support wider vaccination promotion efforts.

AGREED:

1. The update on health protection activity be noted.
2. The Governance Officer be requested to write to the Leicester, Leicestershire and Rutland Integrated Care Board, on behalf of the Chair and Lead Member, seeking support for improved access to vaccination records through the NHS App.

60 Healthwatch Annual Report

Healthwatch Leicester and Leicestershire submitted their Annual Report, “Speaking up for Better Care” to the Commission.

The Chair of Healthwatch Leicester and Leicestershire provided an overview of the report. Key points to note were as follows:

- Healthwatch Leicester and Leicestershire was an independent structured consumer champion for Health and Social Care. The experiences, views and concerns of patients, residents, service users and the local community were heard and used to influence the planning, commissioning and delivery of health and care services across the city and county.
- During 2025, Healthwatch had engaged with over 46,000 people, receiving information on health experiences, also providing information and signposting.
- 38 enter and views had taken place, and a number of reports had been published.
- 8 GP practices within the Willow Group had been visited as requested by the ICB. Inconsistencies had been identified which resulted in commitments to improve.
- A survey review was planned to identify any underrepresented groups and encourage wider participation.
- 24 neighbourhood mental cafes had been visited, and referral pathways were being improved.
- Women’s health focus had included access to specialist support, continuity of care, better information and joined-up pathways.
- A review had been undertaken on supported living. Issues included communication, inclusion, health instability, social isolation and support and planning.

- A further significant area of focus was hospital discharge, experiences were gathered and issues identified around decision making, medication, follow up support, planning and communication.
- Work around access to healthcare for the deaf and hard of hearing community was revisited, significant barriers were found to remain around booking appointments, interpreters and receiving accessible information.
- For 2027, the three main areas of focus would include:
 - Pharmacy First. A survey had gone live in July 2026 and there would be an inclusivity drive.
 - Digital access to NHS services, particularly within Primary Care.
 - Tackling health inequalities whilst strengthening partnerships.
- Young people's experiences around healthy weight and lifestyles would be explored.
- 20 enter and views were planned throughout the year, to include same day access.

In response to Member questions and comments, the following was noted:

- Survey findings were shared with relevant bodies, including the ICB, with follow-up reviews undertaken to assess progress. Where improvements were not evident, matters would be escalated.
- Regarding patient feedback for The Willows, an improvement had been seen through the quality group, it was important to capture patient voices alongside metrics.
- Concerns about GP practices were triangulated with the CQC and ICB, with findings reported to stakeholders and follow-up undertaken to monitor recommendations and escalate unresolved issues where necessary. Safeguarding issues were raised immediately.
- A wider report could come back to the scrutiny commission in the future on wider practice issues.
- Further communications were planned to promote the Mental Health Cafes. It was noted that utilisation had increased.
- Conversations were ongoing with UHL and the ICB regarding digital access barriers, with a refresh of the digital strategy.
- Addition support had come from the Local Authority to fund work on women's health and a research project. Further information could be provided to the commission on additional funding.

AGREED:

- 1) That the report be noted.
- 2) For further information on additional funding to be provided to members.

61 **Winter Pressures Update**

The Chief Medical Officer for the LLR Integrated Care Board introduced the item and presented an update on winter planning and system preparedness across Leicester City for winter 2026/27.

It was noted that:

- Winter planning formed part of a year-round approach to managing system pressures, with increasing challenges also being experienced during periods of extreme weather during the summer months.
- Learning from previous years had resulted in improved resilience across the system, strengthened partnership working and clearer escalation arrangements when pressures arose.
- The NHS 10-Year Plan emphasised a shift towards neighbourhood and community-based care, with a focus on prevention and reducing avoidable hospital admissions.
- Pre-transfer clinical assessment services enabled patients to be assessed by UHL and LPT services where appropriate, helping to avoid unnecessary admissions.
- Partnership working with local authorities, adult social care and home care providers remained a key component of winter planning arrangements.
- Pathways such as Same Day Emergency Care, Pharmacy First and community response services continued to provide alternatives to Accident and Emergency attendance and hospital admission.
- A single point of access remained an important element of the urgent care offer, helping patients access the most appropriate service first time.
- Vaccination programmes remained a key priority, including flu and RSV vaccinations, with targeted outreach activity planned to support uptake, particularly within the city and amongst priority groups.
- Additional investment had been made to support vaccination delivery and improve protection against respiratory illness during the winter period.
- Improving access to mental health support and maintaining workforce resilience across the system remained priorities.
- Community hospital beds, virtual wards and enhanced community services would continue to support patient flow and reduce pressure on acute services.
- Demand and capacity modelling had been undertaken to assess likely activity levels and identify additional capacity requirements during the winter period.
- Public communications activity would focus on improving awareness of available healthcare services and promoting vaccination uptake.

The Commission heard that system-wide planning arrangements had involved all health and care partners, including local authorities, to ensure organisational plans complemented one another and formed part of a single LLR winter plan.

It was further noted that:

- Governance and escalation arrangements had been reviewed in preparation for winter.
- Local and regional winter planning exercises would be undertaken to stress test arrangements and identify any remaining risks.
- Surge and escalation plans had been modelled against a range of scenarios, including levels of demand beyond those experienced during a typical winter period.
- No significant risks had been identified at the present time, although planning assumptions and resilience arrangements would continue to be tested through the forthcoming exercises.
- Additional capacity had been identified across acute, community and primary care services to support anticipated demand.

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

- Members acknowledged that summer pressures were becoming increasingly significant and expressed disappointment that previous reporting had not included sufficient performance information and assurance measures.
- The Pharmacy First service was recognised as a positive development which had improved patient access to care and reduced pressure on other parts of the system.
- Workforce pressures remained a concern, particularly given the increasing impact of extreme weather conditions throughout the year.
- UHL intended to undertake a review of lessons learnt from summer pressures to inform future planning.
- Staff across the health and care system were commended for their work in responding to sustained demand pressures.
- Improvements had been achieved in ambulance handover performance, although challenges remained on periods of exceptionally high demand.
- Demand modelling was informed by historical activity levels, seasonal demand patterns and current growth trends.
- Historically, the first two weeks of January represented the most challenging period of the winter, with Mondays and Tuesdays continuing to experience the highest levels of demand.
- Activity during the winter period was currently forecast to range between approximately 950 and 1,050 attendances per day, with the highest recorded day during the previous winter having exceeded 1,050 attendances.
- Current modelling identified an approximate shortfall of 40 beds and this would continue to be tested through scenario planning exercises.
- Members sought assurances regarding the impact of access to GP appointments on Accident and Emergency attendances.
- It was acknowledged that supporting residents to access the most appropriate healthcare service remained a key priority across the system and that public communications would play an important role in achieving this.

AGREED:

1. The Commission noted the update on Winter Pressures planning and preparedness across the Leicester, Leicestershire and Rutland health and care system.
2. Members support the promotion of vaccination programmes and public awareness campaigns encouraging residents to access the most appropriate healthcare services.
3. A further update on winter pressures, demand and system resilience be brought to the Commission at an appropriate point during the winter period.

62 **Leicester Neighbourhood Approach**

The Integrated Care Board (ICB) provided the Commission with an update on the development of the Leicester City Neighbourhood Programme, including progress on neighbourhood footprint development, stakeholder engagement, and plans for the next phase of work. The report also highlighted the potential implications of Local Government Reorganisation (LGR). The Commission was asked to note the progress made to date. The report was taken as read, with an overview provided. Key points to note were as follows:

- The landscape was continuing to evolve towards greater provision of community-based care and preventative support.
- From the ICB perspective, progress had been slower in recent months due to organisational restructuring.
- Services would need to be transitioned safely, supported by workforce collaboration, community engagement and partnership working with the LA's and the VCSE sector, alongside developments in care delivery, digital methods and vaccination programmes.
- It was noted that Local Government Reorganisation was likely to have an impact on outcomes.
- 4 delegated workshops had taken place with elected members attending.
- Key strategies included coordination of services, clear and simple pathways and digital focus.
- The 3 main focuses were: frailty, children and young people and wider premature mortality.
- Clinical assessment days had been piloted with a wider team of health care professionals available at Physiotherapy sessions.

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

- Work was ongoing to strengthen data sharing between the partner organisations.
- Benefits of the neighbourhood strategy included the LUCID programme for chronic kidney disease, which would enable more patients to receive care closer to home and reduce the need to travel to hospital.
- Other areas which would benefit included mental health services. £8m of funding had been provided to develop weight management strategies.
- Further details on strategies for premature mortality and weight issues could come back to the scrutiny commission.
- The engagement events had been beneficial and had identified a number of key themes, which would be reflected in future commissioning arrangements.
- Opportunities to learn from other areas in the South-West on Frailty were noted.
- Planning would focus on a transference of care services, rather than a duplication of delivery.
- The strategy was not linked to a specific budget but was based on a pathway approach. Greater investment in prevention was needed, funding for new services could be shared across providers where appropriate.

AGREED:

1. That the report on the Leicester Neighbourhood Approach be noted.

63 **Work Programme**

The Chair reminded Members that should there be any items they wish to be considered for the work programme then to share these with her and the senior governance officer.

64 **Any Other Urgent Business**

There being no further business, the meeting closed at 7.20pm

System Winter Plan

Public Health and Health Integration Scrutiny Commission

Date of meeting: 3rd November 2026

Lead Director/Officer: ICB

Useful information

- Ward(s) affected: All
- Report author:
- Author contact details:
- Report version number:

1. Summary

Partners across Leicester, Leicestershire, Rutland and Northamptonshire have developed a single, system-wide Winter Plan to support the continued delivery of safe, timely and effective care over the winter period.

The plan builds on year-round urgent and emergency care work and brings together NHS organisations, local authorities, primary care, VCSE organisations and other partners around a shared approach. It focuses on prevention and proactive care, helping people access the right care in the right place, supporting effective patient flow and discharge, and ensuring services have the capacity and resilience to respond to additional winter pressures.

2. Recommended actions/decision

- **NOTE** the anticipated pressures facing health and care services during Winter 2026/27 and learning incorporated from Winter 2025/26.
- **CONSIDER AND COMMENT** on the system-wide actions being taken to mitigate these pressures, particularly those relating to urgent and emergency care, discharge, community capacity and interface with adult social care.
- **RECEIVE ASSURANCE** regarding the governance, escalation and clinical oversight arrangements that will operate during periods of significant operational pressure.
- **NOTE** the risks that remain where demand, workforce pressures or seasonal illness explain planning assumptions.

3. Scrutiny / stakeholder engagement

The winter plan report is being taken to scrutiny committees across the area and where appropriate health and wellbeing boards for discussion and scrutiny.

4. Detailed report

Full report can be found within appendix a

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

5.1 Financial implications

N/A

Signed:

Dated:

5.2 Legal implications

There are no direct legal implications arising from this report.

Signed:

Dated:

5.3 Equalities implications

N/A

Signed:

Dated:

5.4 Climate Emergency implications

N/A

Signed:

Dated:

5.5 Other implications (You will need to have considered other implications in preparing this report. Please indicate which ones apply?)

6. Background information and other papers:

N/A

7. Summary of appendices:

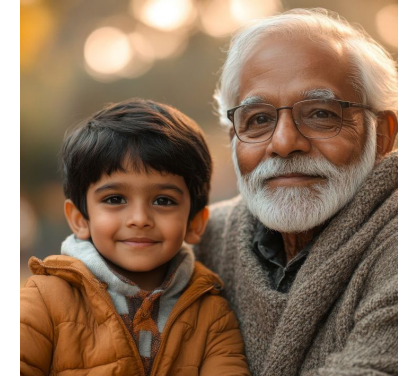
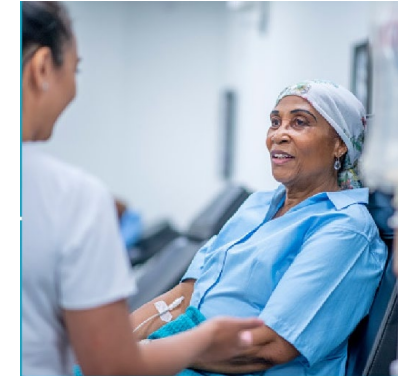
Appendix A: Full report

8. Is this a private report (If so, please indicate the reasons and state why it is not in the public interest to be dealt with publicly)?

9. Is this a “key decision”? If so, why?

Leicester, Leicestershire, Rutland & Northamptonshire ICB Cluster – Winter Plan 2026/27 -FINAL

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Exec Summary

System intent

To maintain safe, timely and effective care through winter by reducing avoidable demand, strengthening alternatives to hospital, improving flow and discharge, protecting quality and dignity, supporting the workforce, and maintaining system grip through clear governance and escalation

- A whole-system approach focused on prevention, neighbourhood care, urgent community response, frailty, same day emergency care, mental health crisis alternatives, discharge, infection prevention, vaccination, communications and escalation.
- 15 • UHL and UHN modelling identifies a material acute capacity gap, with mitigations focused on additional winter capacity, decision-maker capacity, SDEC optimisation, length of stay reduction, virtual wards, discharge lounge capacity, transport, pharmacy and imaging support.
- LPT & NHFT plans focus on children and young people, vulnerable adults, community health services and mental health, including UCR, virtual frailty ward, direct admissions, improved inpatient discharge, crisis alternatives and co-streaming at the ED front door.
- Local Authority Plans provides a place-based plan for prevention, Home First, reablement, adult social care market resilience, vaccination, urban and rural severe weather resilience, mental health escalation routes and local winter reporting.
- System oversight will be through the System Coordination Centre, SHREWD, daily System Flow Calls, established UEC governance, provider governance and clear escalation to executive forums.

• Northants

• Overall Assurance Position: Amber

- The Northamptonshire submission demonstrates a clear strategic direction supported by established governance arrangements, strong system leadership and mature operational oversight through the System Coordination Centre. The submission describes a broad range of initiatives focused on admission avoidance, neighbourhood delivery, discharge improvement, mental health support and winter resilience, with evidence of collaborative working across acute, community, mental health, primary care and ambulance partners.
- Strengths are evident within the Quality, Neighbourhoods, Discharge and CYP sections, with good evidence of proactive schemes supporting frailty, admission avoidance, community-based care and patient safety. The system also demonstrates strong operational grip through established escalation processes, daily coordination arrangements and clear governance structures.
- Whilst the submission provides a reasonable level of assurance, several areas would benefit from further detail regarding workforce resilience, delivery timescales, measurable outcomes, winter-specific enhancements and how existing schemes will be adapted to manage sustained winter pressures. Additional assurance is also required in relation to IPC arrangements, mental health flow and crisis enhancements, and how operational intelligence is translated into coordinated system action

• LLR

• Overall Assurance Position: Green/Amber

- The Leicester, Leicestershire and Rutland submission presents a well-developed and mature approach to winter planning, demonstrating strong system leadership, established governance arrangements and evidence of collaborative working across health and care partners. The plan highlights a broad range of initiatives focused on admission avoidance, discharge improvement, neighbourhood delivery, mental health support and CYP services, underpinned by established operational oversight through the System Coordination Centre and system escalation processes.
- The submission provides confidence that appropriate governance, escalation and partnership arrangements are in place to manage winter pressures. There is clear evidence of integrated working across acute, community, primary care, mental health, local authority and ambulance partners, alongside a strong focus on prevention and supporting people closer to home. Mental Health, CYP, Primary Care and Community Care arrangements are particularly well developed.
- Whilst the overall submission provides a good level of assurance, further confidence could be gained through greater quantification of planned benefits, clearer workforce resilience arrangements during sustained periods of pressure, and further evidence demonstrating how key schemes will be monitored, evaluated and adapted throughout winter. Additional assurance is also required in relation to IPC arrangements and the ongoing management of corridor care and system capacity pressures.

Planning Principles

- Evidence-based and realistic, with quantified capacity, workforce and financial assumptions where available.
- System first, with shared risk, mutual aid, clear escalation, and a single view of demand, capacity and risk.
- Home First and prevention-first, with proactive care for high-risk cohorts and escalation into appropriate community alternatives.
- Quality and dignity, with a focus on mitigating harm associated with long waits, ambulance handover delays and non-standard environments.
- Clear accountability, with named organisational and system governance routes for delivery, adaptation and escalation.

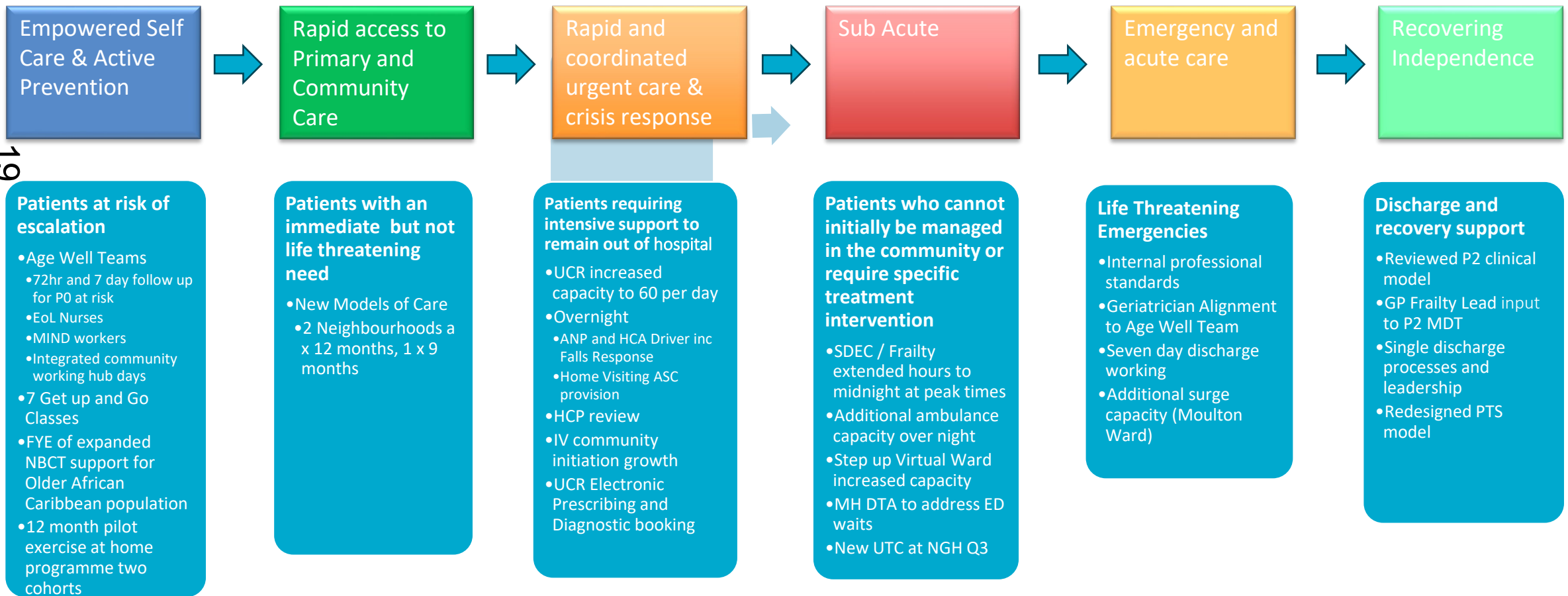
Learning from Winter 25/26 LLR and Northants

What should be retained	What should be strengthened
Clear escalation plans, system coordination, teamwork and shared awareness.	Earlier contingency triggers and clearer activation thresholds across acute, community and social care.
Admission avoidance through PTCDA, UCR, SDEC, Ageing Well and neighbourhood support.	More consistent discharge pathways, weekend responsiveness and social care alignment.
Discharge coordination, MDT working and homecare capacity management.	Workforce resilience, communication, and reducing staff burnout and sickness.
Adverse weather preparedness and operational resilience.	Earlier surge capacity decisions, particularly where mobilisation affects patient experience and staff pressure.
Use of direct access SDEC pathways, CDU pull from ED, escalation spaces and extended pharmacy access.	Capacity planning for cardiology demand, infection prevention constraints, pharmacy delays, transport and patient moves across sites.
	Implement the actions and take the learning to improve long ambulance waits at NGH

Northants UEC New 26/27 Elements

Right Care, Right Time, Right Place

An Integrated Multi Partner Approach to Mitigating and Responding to Urgent and Emergency Care Demand



System Mitigations to Reduce Acute Demand and Improve Flow 26/27 - Northants



Scheme	Timeline	Impact on Attends
Age Well Teams Expansion – Full year effect of new starters in March for NBCT, End of Life Nurses from September, MIND workers from October and additional local group programmes	Phased with completion in Q3	Medium
Primary Care New Models of Care – Provision of additional same day capacity in two of the nine neighbourhoods using hub and spoke approach, ensuring same day access for complex patients can be delivered in own practice and releasing GP capacity to better support LTC patient care planning	First site Q1 launch, Q3 phased impact, Second site Q2 launch, Q4 phased impact	High
Urgent Community Response – Additional core hour provision 4 patients per day with further overnight capacity for 6 persons per day including night falls response. Additional night response vehicle and crew for winter	25% in Q1, 60% by Q3 and 100% in Q4	Medium
Reduce Admissions – Continued expansion of SDEC including Frailty SDEC with access to overnight sitting services, greater use of virtual ward capacity as step up and use of neighbourhood P2 capacity for step up as alternative to hospital admission. These are alongside the go-live for NGH UTC	Q3	Low
Pathway 2 Transformation – Improved outcomes from revised skill mix and staffing models for confusional bed pathways and increased specialist therapy for stroke, spinal, FND etc. Increased through put supporting decreased lost acute days and timely flow but also to decrease entries to permanent 24 hour care settings	Q3	Low
Reduced Readmission Rates – Improved discharge arrangements with new integrated discharge hub. Alignment of Hospital Geriatricians with Neighbourhood Teams for pathway zero concern follow up and future joint working, actions to tackle deconditioning during hospital stays to increase persons returning to home successfully. Redesign of patient transport model to better meet requirements of safe and effective UEC system	By the end of Q2	Medium

Our UEC Strategic Priorities

10-Year Plan

Focusing on preventing sickness, not just treating it

Moving more care from hospitals to communities

Better use of technology in health and care

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Priority A:

Prevention and proactive, personalised care (including LTC management); People are supported and empowered to avoid the need for emergency services wherever possible

Priority B:

When people need **same day or urgent care**, they can easily and rapidly access the **right care at the right place at the right time**

Priority C:

Effective and efficient urgent and emergency care pathways for:
children & young people;
frailty;
mental health crisis;
learning disability & autism;
palliative & end of life care

Priority D:

Partners work together to ensure joined up and **coordinated care, including improved flow and early supported and safe step-down from services**

Priority E:

Be **data & intelligence led**; understand and predict our population needs in order to support those at greatest risk, tackle **health inequalities** and deliver tailored population-based approaches

Health Inequalities and Neighbourhood Health

All Priorities have an all-age approach

System Mitigations to Reduce Acute Demand and Improve Flow 26/27 - LLR



Scheme	Timeline	Impact on Attends
Merlyn Vaz Streaming Model – Optimise and expand walk-in capacity through UTC front-door triage and revised appointment lengths, improving access to same-day care and reducing avoidable ED attendances	By the end of Q2	High
Proactive Care Planning for People with Complex Needs – Support delivery of personalised care plans to improve anticipatory care, reduce crisis presentations and support patients to remain well at home.	Commenced in April 2026- 70% completed by Q3, 30% by the end of Q4	Medium
CRM Model – Transition from LUCID and Enhanced Diabetes Management programmes to a targeted CRM approach, focusing proactive interventions on high-risk patient cohorts within Primary Care.	July 2026	Low
Population Cluster Approach – Expand the City INT outreach model to targeted population cohorts, improving health literacy, promoting self-management and shifting activity from ED and urgent care settings into Primary Care and Community Pharmacy	By the end of Q2	Medium
Neighbourhood Frailty Management – Introduce community frailty management through Integrated Neighbourhood Teams, with three neighbourhood footprints , supporting earlier intervention and admission avoidance.	4 neighbourhoods by October 2026, remaining 7 neighbourhoods by the end of Q4	Medium
Integrated Single Point of Access – Deliver a single access route into community urgent care services, improving navigation, reducing duplication and enabling timely access to the most appropriate community response.	October 2026	Medium
Single Integrated Frailty Service (Hospital at Home) – Develop a coordinated frailty service that strengthens admission avoidance, supports earlier discharge and provides acute-level care within community settings.	September 2026	Medium
48-Hour Post-Discharge Follow-Up – Provide proactive follow-up for high-risk patients following discharge to reduce avoidable readmissions and improve recovery outcomes	August 2026	Medium

System Winter Priorities 2026/27



1. Prevention and admission avoidance

Proactive care, neighbourhood working, primary care, community pharmacy, social prescribing, voluntary sector support, PTCDA, UCR, frailty and falls pathways.

2. Alternatives to ED and ambulance conveyance

SPoA, clinical navigation, UTC optimisation, SDEC with direct access, virtual wards, Hospital at Home principles, mental health crisis alternatives and co-streaming.

3. Flow through hospital and community services

23 Acute capacity schemes, SDEC expansion, direct admissions, community hospital flow, transfer improvements, AMU/CDU/ward processes and operational grip. Co-streaming by MH clinicians in ED to identify MH service users earlier for alternative place to assess.

4. Discharge, Home First and reablement

Integrated discharge hubs, discharge to assess, P0 to P3 pathway targets, Rutland Home First, reablement, MADE events, discharge lounges and transport optimisation.

5. Infection prevention, vaccination and health protection

IPC advice, cohorting, isolation, respiratory virus screening, care home outbreak management, staff and patient vaccination, targeted outreach and communications.

6. Mental health and crisis pathway resilience

Assessment Hub, Central Access Point, CAP 111 Mental Health Line, Crisis Cafes, CRHT prioritisation, inpatient discharge planning from day one and partnership working.

7. CYP resilience

Paediatric SDEC, under-5s advice, school-aged flu programme, CAMHS day hospital pilot, CAMHS Crisis Plus, vaccination outreach and Paediatric virtual ward/OPAT optimisation.

8. Workforce wellbeing and resilience

Workforce risk identification, safe staffing review, agency oversight, staff vaccination access, wellbeing support and clear operational communications.

9. Communications and public confidence

Right care, right place, winter wellness, targeted public and colleague communications, local clinician-led content and community channels.

10. System grip, governance and escalation

SCC, SHREWD, System Flow Calls, OPEL, surge and escalation plans, provider governance, UEC Collaborative and executive escalation.

Demand, Capacity and Bed Modelling

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Operational plan summary

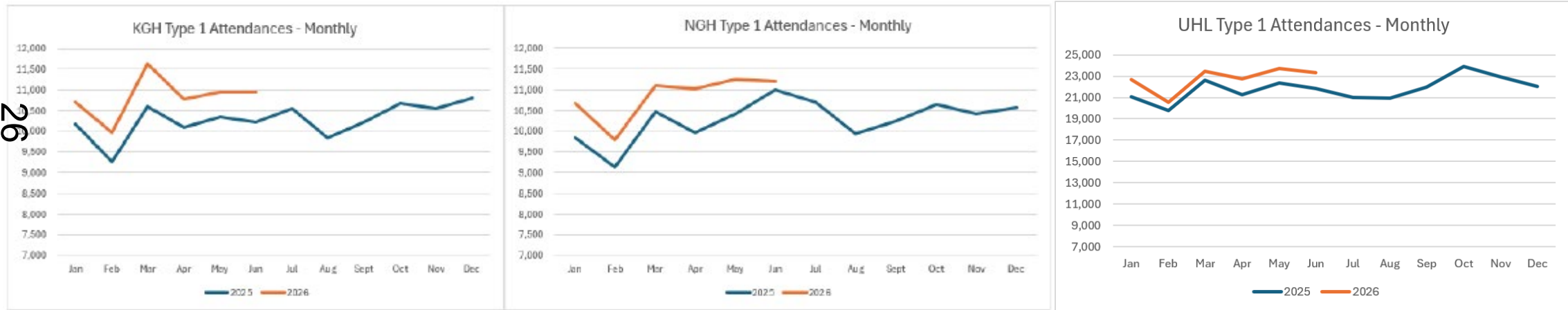
The operational plan was set to take into account Winter pressures and the impact of the mitigation schemes:

- The planned number of **primary care appointments** is 8m for LLR and 5m for Northamptonshire
- The **ambulance handover time** for UHL is planned to come down to 30 minutes by March 2027 from a planned high of 37 minutes in both October and January. For both KGH and NGH this is planned to be 25 minutes by March 2027 from a planned high of 32 minutes for KGH and 40 minutes for NGH in April 2026
- The planned number of **Type 1 attendances** is based on 25/26 outturn with 0 growth plan across the three providers. This breaks down as 265k for UHL, 124k for KGH and 113k for NGH
- The **Non-Elective** admissions UHL has 120k planned with KGH 43k and NGH 36k. The percentage planned to be 0 length of stay is 46% in UHL, 48% in KGH and 21% in NGH
- The total number of discharges for **non-elective admissions** is planned to be 65k for UHL, 22k for KGH and 29k for NGH
- The **overnight general and acute bed occupancy** ranges from 86% in May for UHL to 94% in January and March. For KGH it remains at 97%+ for the year apart from August. For NGH it is 95% for most of the year with a peak of 98% in December
- Activity plans submitted in the operational plan are included at the end of the pack.

ED Type 1 Attends & Emergency

The system's operational plans for 26/27 was based on 25/26 outturn with no growth in Emergency Department (ED) attendances, factoring in work as part of Neighbourhoods, primary care access and alternatives to ED (At-ED). YTD position as of M3 demonstrates a 6% increase in Type 1 ED attendances for KGH and NGH as well as for UHL

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The reasons from the growth are multi-factorial. There is a combination effect of long-standing growth (which has been running at 5-7% and likely represents inability to address chronic issues such as inequality, preventative interventions and altering public expectations) but also includes primary care contract changes and altering seasonal presentation patterns. To address this there has already been a meeting of the Health Partners Executive to create a bespoke action plan. Whilst ED attends have increased this is **not** translating into additional admissions in several key cohorts

Bed Modelling - UHL

The Trust has used the PWC bed model to assess the expected capacity required, whilst the model does not give detailed monthly analysis assuming the maximum requirement in the model is representative of Winter this is demonstrating a gap of -123 beds the majority of which are in ESM and RRCV.

The assumptions in the PWC model are:

- 92% occupancy – raising the occupancy to 95% would reduce the beds needed to 1841 and therefore reducing the gap by 62 beds. This would create challenges with flow and would therefore create a risk to the achievement of ambulance handovers, 24 hr in ED or 12 hr performance metrics.
- 27 • The activity plan submitted as part of planning – in Q1 we have admitted 2282 (5%) more patients and using the current activity level this would increase the gap by 18 beds.
- The projected gap is like that forecast last year (181 v's 178) which is representative of the progress being made as the plan is set higher in 26/27 (outturn of 25/26) and the gap was based on plan for 25/26.
- When added Bad Beds (waits in ED, Corridor Care, CDU) are included this gives a gap of 215 beds.

26/27 Bed Requirements based on PWC bed model
Max - Winter

CMG	Need	Got	Gap	Bad Beds	Gap
ESM	759	674	-85	-50	-135
CHUGGS	354	327	-27	-5	-32
MSS	143	162	19	-2	17
RRCV	509	465	-44	-35	-79
W&C	138	152	14	0	14
Total	1903	1780	-123	-92	-215

Bed Modelling - UHL



To mitigate the gap, we have developed various schemes that are detailed below. These schemes include additional capacity and efficiency schemes such as optimisation of SDEC and reduced LOS.

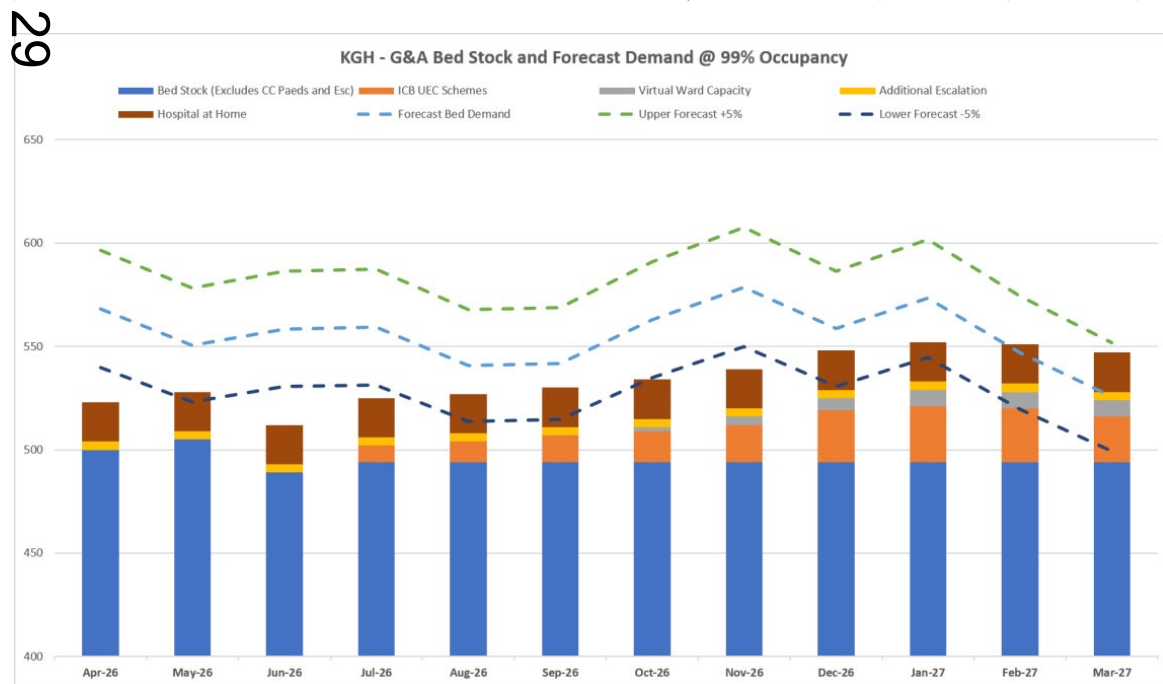
These mitigations if fully delivered reduce the bed gap from -215 to -109, however with our current mitigations we do not have sufficient plans to reduce this risk any further. We continue to review all options. In planning the mitigations, we have reviewed the gap at a CMG level as detailed below, therefore our plan is weighted to ESM and RRCV.

Mitigations	Total	CMG IMPACT				
Gap pre mitigations	215	ESM	RRCV	MSS	CHUGGS	W&C
Ward 19 LGH	20	20				
Ward 11 LGH	13	13				
Ward 16 GH	5		5			
Ward 17 GH	5		5			
Ward 23 Annex	5		5			
Reduced LoS	25	10	6	2	5	2
Paediatric SDEC	5					5
Acute VW	12	12				
Adults SDEC's	11	5	3		3	
MeMed	5		5			
Total	106	60	29	2	8	7
Remaining Gap	-109					

	Gap	Mitigation	Gap
ESM	-135	60	-75
CHUGGS	-32	8	-24
MSS	17	2	19
RRCV	-79	29	-50
W&C	14	7	21
Total	-215	106	-109

Bed Modelling - KGH

Metric	Assumptions	Apr-26	May-26	Jun-26	Jul-26	Aug-26	Sep-26	Oct-26	Nov-26	Dec-26	Jan-27	Feb-27	Mar-27
Forecast Beds required (99% bed occupancy)	99%	537	519	526	528	509	509	530	546	526	541	515	493
Forecast Beds required (95% bed occupancy)	95%	559	541	548	550	530	531	553	569	548	564	537	514
Additional Escalation		4	4	4	4	4	4	4	4	4	4	4	4
Bed Stock (Excludes Paeds & CC)		500	505	489	494	494	494	494	494	494	494	494	494
DTA Backlog within the ED (demand impacting beds required)		40	40	40	40	40	40	40	40	40	40	40	40
Cardiology Virtual Ward								2	4	6	8	8	8
Impact of ICB UEC Schemes					8	10	13	15	18	25	27	26	22
Hospital at Home		19	19	19	19	19	19	19	19	19	19	19	19
UHN LoS bed reduction as per IBP (1.5% reduction)		8	8	8	8	8	7	8	8	8	8	8	7
Surplus / Deficit at 99% Occupancy		-62	-39	-62	-51	-30	-27	-44	-55	-26	-37	-12	7
Surplus / Deficit at 95% Occupancy		-85	-61	-85	-73	-51	-49	-67	-79	-49	-60	-34	-14



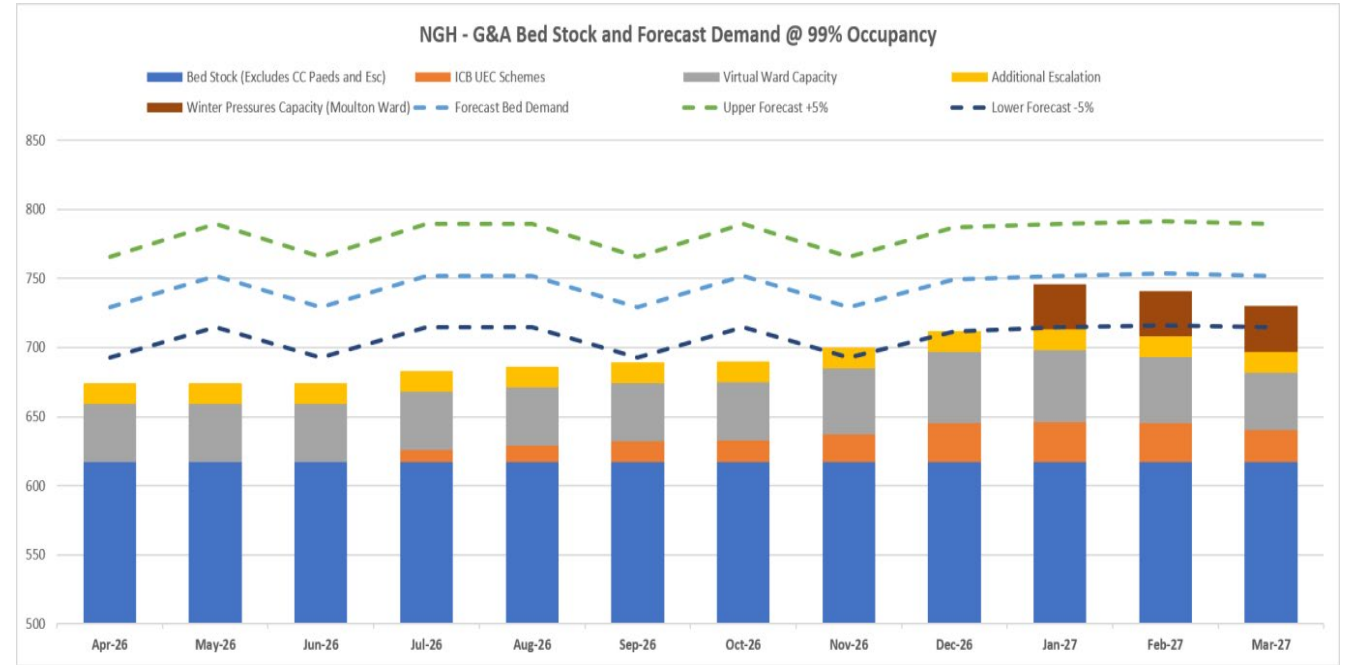
KGH Bed Model Forecast

- There is a mitigated bed deficit of -62 beds in April as the worst month which improves to 7 in March, based on actual and forecast beds at 99% bed occupancy. This includes
- There is a 9 bed reduction in KGH core bed stock comparing 25/26 to 26/27 through expansion of planned care unit and short stay unit with associated a LOS reduction (4.4 to 2.2 days) with this new model of care.
- Delivery of system schemes being delivered up to capacity of 27 beds, as per Appendix Two.
- Delivery of KGH reduction in non-elective length of stay as per plan.
- Hospital at home capacity is planned throughout the year to be maintained at existing levels with 19 bed capacity for patients who otherwise would meet criteria to reside.
- Planned expansion of cardiology virtual ward

Bed Modelling - NGH

NGH Bed Model Forecast

- There is a mitigated bed deficit of -78 beds in May as the worst month which improves to -6 in January, based on actual and forecast beds at 99% bed occupancy. This includes
- Delivery of system schemes being delivered up to capacity of 29 beds, as per Appendix Two.
- Escalation bed capacity including discharge lounge (6), day rooms (6) and on average 3 escalation beds in New Heart Centre without impacting elective TCIs.
- Operational go live of Moulton Ward is planned to open late December (21st) providing a full 3 month escalation capacity of 33 beds during Q4, mitigating the bed deficit to -6 beds in January 2027.
- Delivery of NGH reduction in non-elective length of stay as per plan.
- A UHN Virtual Ward steering group supports oversight and governance in utilising virtual ward capacity for patients who otherwise would meet criteria to reside and therefore, freeing up physical capacity within the acute bed base, a key mitigation of the bed deficit during Q3/4. Bed capacity plan for 26/27 is detailed below with maximum capacity of 52 beds across acute medicine, stroke and respiratory. Additional capacity for cardiology heart failure virtual ward is now in place at NGH with up to 8 beds, expanding to KGH from October 2026.



Metric	Assumptions	Apr-26	May-26	Jun-26	Jul-26	Aug-26	Sep-26	Oct-26	Nov-26	Dec-26	Jan-27	Feb-27	Mar-27
Forecast Beds required (99% bed occupancy)	99%	689	712	689	712	712	689	712	689	709	712	714	712
Forecast Beds required (95% bed occupancy)	95%	718	742	718	742	742	718	742	718	739	742	744	742
Additional Escalation		15	15	15	15	15	15	15	15	15	15	15	15
Bed Stock (Excludes CC Paeds and Esc)		617	617	617	617	617	617	617	617	617	617	617	617
DTA Backlog within the ED (demand impacting beds required)		40	40	40	40	40	40	40	40	40	40	40	40
Virtual Ward Capacity		42	42	42	42	42	42	42	48	52	52	48	42
Impact of ICB UEC Schemes					9	12	15	16	20	28	29	28	23
Winter Pressure Capacity (Moulton Ward)											33	33	33
UHN LoS bed reduction as per IBP (1.5% reduction)		10	11	10	11	11	10	11	10	11	11	11	11
Surplus / Deficit at 99% Occupancy		-55	-78	-55	-69	-66	-40	-62	-29	-37	-6	-13	-22
Surplus / Deficit at 95% Occupancy		-84	-108	-84	-99	-96	-69	-92	-58	-67	-36	-43	-52

Prevention and Vulnerable Cohorts

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Vaccinations - 2026/27 Ambitions

Vaccine	Cohort	ICB	2025/26 Outturn	2026/27 Plan	Notes
Flu 32	Pregnant Women	LLR	42.9%	44.0%	Uplift of 1.1%
		Northants	49.3%	53.8%	Uplift of 4.5%
	Children 2-3 Years	LLR	44.6%	46.4%	Uplift of 1.8%
		Northants	41.5%	44.3%	Uplift of 2.8%
	Children -Primary School	LLR	52.3%	56.5%	Uplift of 4.2%
		Northants	46.0%	52.3%	Uplift of 6.3%
	Children - Secondary School	LLR	46.2%	49.1%	Uplift of 2.9%
		Northants	40.2%	45.1%	Uplift of 4.9%
	Adults 18-64 at risk	LLR	40.3%	41.5%	Uplift of 1.2%
		Northants	39.7%	42.2%	Uplift of 2.5%
	Adults 65+	LLR	74.9%	75.0%	Uplift of 0.1%
		Northants	75.1%	75.0%	Maintain
	Adults 16+ who are homeless	LLR Northants			New cohort

Vaccine	Cohort	ICB	2025/26 Outturn	2026/27 Plan	Notes
COVID	All cohorts	LLR Northants	56.3% 58.8%	56.3% 58.8%	Maintain Maintain
	Care homes	LLR Northants	71.0% 65.2%	71.0% 65.2%	Maintain Maintain
RSV	Catch up cohort	LLR Northants	68.6% 69.9%	70.0% 70.0%	Uplift of 1.4% Uplift of 0.1%
		LLR Northants	46.3% 42.5%	60.0% 60.0%	Uplift of 13.7% Uplift of 17.5%
	Pregnant women	LLR Northants	40.5%	50.0% 50.0%	Uplift of 9.5% No baseline
		LLR Northants			New cohort
	65-74 years	LLR Northants			New cohort
	75-79 years	LLR Northants			New cohort
	80+ years	LLR Northants			New cohort

- Additional plans to be set around pneumococcal vaccines when NHSE regional team share baselines
- Frontline staff are local targets and will be updated if NHSE set these centrally
- As part of the additional actions for Winter a LNR RSV vaccination campaign through General Practice to deliver the 50%

Improving Uptake in Underserved Communities

LNR commissioning approach:

Commission resources at an LNR level and manage their distribution using population health data to target key communities and co-design interventions; this involves:

- Taking a proportionate universalism approach
- Gaining insights and understanding by listening to communities and working with VCSE organisations
- Taking a system-wide approach in collaboration with public health teams and providers
- Monitoring and evaluating uptake and impact of interventions

Family Hubs

Piloting vaccination clinics inside Family Hubs, to be delivered alongside antenatal classes and other family services.

Super Vaccinators

Team of healthcare professionals can offer all vaccines
Flexible resource, targeted at low uptake practices
Provides workforce resilience

Communications and Engagement Resources

Vaccine Hub website, materials tailored to local communities, geo-location mapping

Central Booking Team

Inbound patient phone-line
GP Lists - call and text priority groups
Immunosuppressed, Care home and housebound patients



Supervaccinator, Alex, working on the RHU with its driver, Justin

Roving Healthcare Unit

Target: low uptake, high deprivation, diverse communities
Vaccination offer: COVID-19, flu, MMR, pertussis and RSV
Plus: Blood pressure checks and MECC
Collaboration with other services i.e. AAA, fibro scanning, cancer

Training and Development

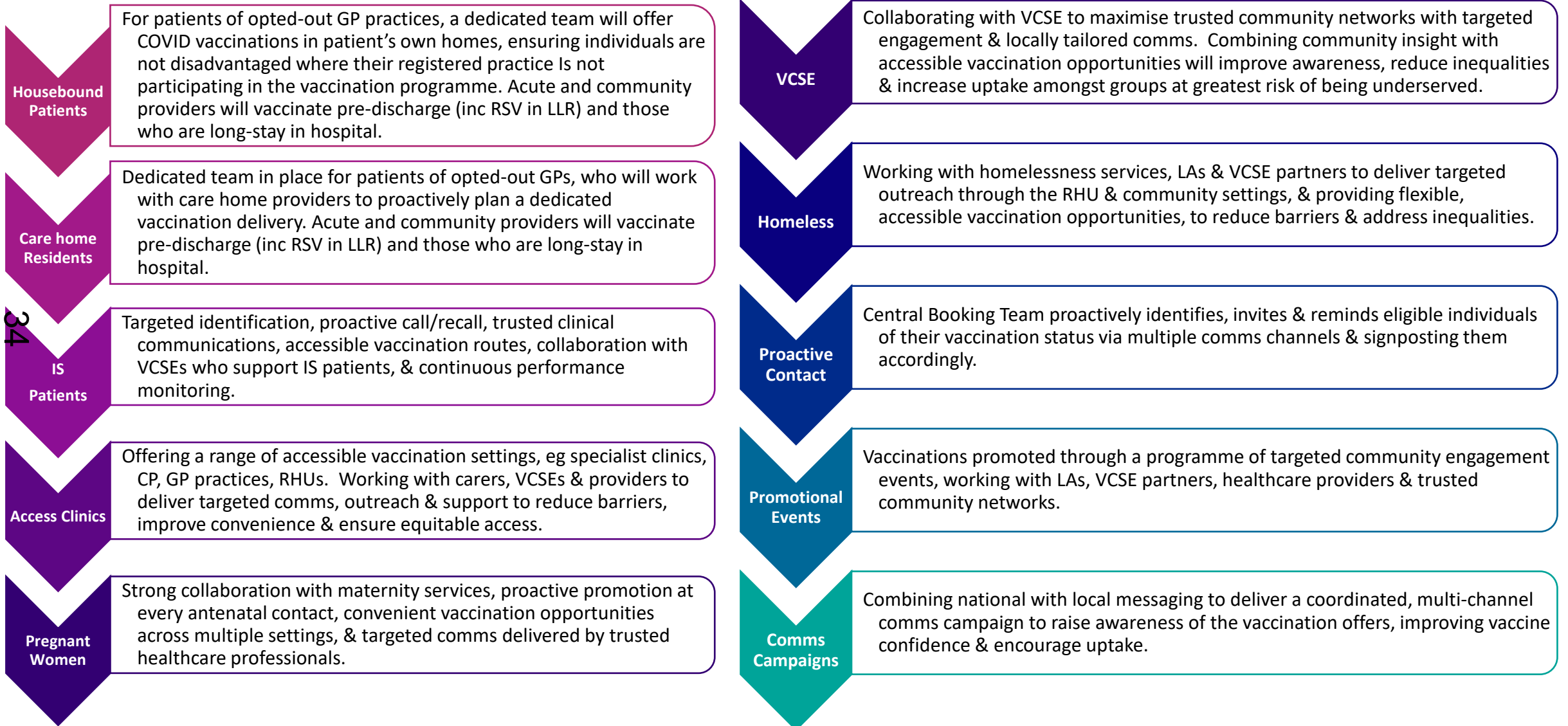
Culture & Faith in LLR training
Meetings with local cultural and faith leaders
Visits to community settings and faith centres

Working with Voluntary and Community Sector Enterprises

To gain insights and understand barriers
Collaborative projects commissioned through VCSE to improve uptake i.e.
Local Immunisation Street Team
Health & wellbeing fairs and events



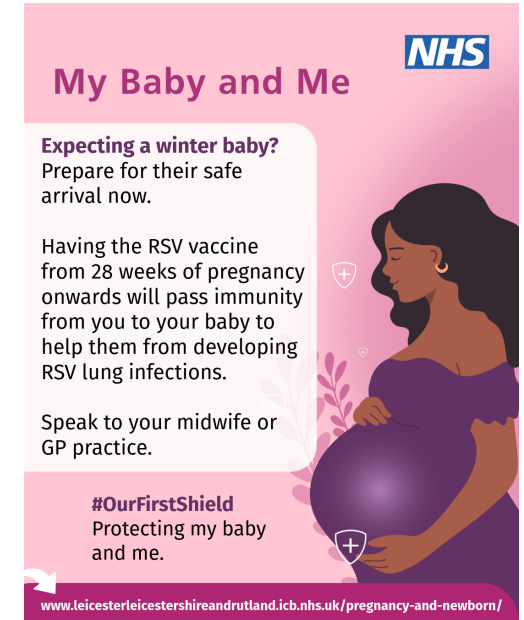
Priority Cohorts: Vulnerable and Underserved Groups



Winter Vaccination Programme Assurance

- Robust governance in place through the LNR Vaccination & Immunisation Board, with CMO oversight as SRO.
- Delivery plans developed following winter 2025 review, with provider trajectories, performance monitoring and regular reporting established.
- System plans aligned to national requirements for Flu, COVID-19, RSV and Pneumococcal vaccination programmes.
- Risk-stratified approach targeting older adults, care home residents, pregnant women, children, frontline staff and clinically vulnerable groups.
- Targeted programme in place to improve uptake and reduce unwarranted variation across LNR.
- Population health data used to identify and prioritise communities with lower uptake and higher risk.
- Outreach delivery through roving healthcare units, community pharmacies, Family Hubs and community settings.
- Strengthened communications, call/recall and VCSE partnerships to support underserved and vulnerable populations, including housebound patients, care home residents and people experiencing homelessness.

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NHS

My Baby and Me

Expecting a winter baby?
Prepare for their safe arrival now.

Having the RSV vaccine from 28 weeks of pregnancy onwards will pass immunity from you to your baby to help them from developing RSV lung infections.

Speak to your midwife or GP practice.

#OurFirstShield
Protecting my baby and me.

www.leicesterleicestershireandrutland.icb.nhs.uk/pregnancy-and-newborn/

The poster features a pregnant woman in a purple dress holding her belly, with a shield icon on her arm. The background is pink with floral patterns.

Risk Stratification and pro-active care planning - complex LTC

Risk stratification is used at both practice and Place level to identify high need patients and patient cohorts with contractual incentives in place to support practice to work with their highest need patients. Additionally the ICB has a number of specific workstreams to respond to the highest areas of need identified in our recent Integrated Needs Assessment (INA.)

Cardiovascular Kidney Metabolic (CVKM) disorders. CKM represents the largest cause of avoidable morbidity and health inequalities for the ICB. We are developing a twin track approach to identify undiagnosed patients and maximise best practice care practice and neighbourhood level and to establish MDT care models targeted at our higher need patients. These models used proven care models and emerging treatments which have been shown to have in year impact. Our initial focus is in two areas of CKM

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- *Chronic Kidney Disease (CKD)* – The LUCID model covers most of LLR PCNs and is being progressively rolled out. A virtual MDT supports patients to access treatments such as Finerenone which has been shown to reduce risk of emergency admissions and delay progression to dialysis and other high cost treatments.
- *Heart Failure (HF)* – Developing the proven LUCID focus on HF will be the use of SGLT2i treatments which are shown to reduce exacerbations and admissions. This will initially be targeted to high risk patients and those with recent HF admissions.

Care Planning

Work in LLR ICB has demonstrated that patients with complex health needs who have a care plan in place are significantly less likely to be admitted as an emergency than those who don't. This is supported by a LES in LLR and this learning is being applied in Northamptonshire through the Neighbourhood based New Care Models programme.

Neighbourhood-led coordination

Integrated Neighbourhood Teams support same-day care, rapid assessment and navigation — ensuring people are directed to the right service first time

- Agreement of core neighbourhood team membership for the high-risk cohorts
- Agreement of extended neighbourhood team membership
- Mapping of current position and timeline to achieve extended provision for each neighbourhood
- Alignment of key hospitals medics to neighbourhoods
- Completion of a maturity matrix, mapped against neighbourhood framework to determine gaps and opportunities
- Design delivery model for proactive upstream approach (LLR)
- Reduce progression into higher frailty and complexity cohorts
- Neighbourhood in reach via ACP and Consultant to support EoL and palliative care. Increase completion of RESPECT planning, reduction in 'crisis episodes' and increase in patients dying in their preferred place of death.
- Multi-agency drop-in sessions at community venues across LLR
- Increase use of neighbourhood mental health cafes for same day support from primary care
- Increased signposting / referrals to 'Getting Help in Neighbourhoods' projects to meet individual needs.

Neighbourhood Teams at the centre of delivery

Integrated Neighbourhood Teams bring together primary care, community services, mental health, social care, hospices and VCSE partners to provide coordinated, wrap-around support for people with complex needs,

- Agreement of core neighbourhood team membership and extended neighbourhood team
- Mapping of current position and timeline to achieve extended provision for each neighbourhood
- Alignment of key hospitals medics to neighbourhoods
- Completion of a maturity matrix, mapped against neighbourhood framework to determine gaps and opportunities
- Design delivery model for proactive upstream approach (LLR)
- Additional nonclinical content visible in-patient record
- Released time for extended reviews for persons with complex LTC
- Identification of digital opportunity to enable self-care and prevention
- Accurate recording of baseline frailty index within primary care record
- Additional End of Life Nurses as part of integrated neighbourhood MDTs to reduce frequent admissions in last year of life

Primary Care & Admission Avoidance

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PC PLANS FOR SURGE AND ESCALATION

- Maintain oversight of General Practice capacity and operational pressures through GPAD, GPES, General Practice OPEL and system intelligence, enabling early identification of risks and timely escalation through the System Control Centre.
- Prioritise same-day urgent care through effective triage, care navigation, online consultations and Pharmacy First, supporting delivery of **Right Care, Right Place, First Time**.
- Proactively manage vulnerable patients through population health management, personalised care planning and Enhanced Health in Care Homes, helping reduce avoidable admissions and support care closer to home.
- Continue to expand digital access by increasing:
 - **NHS App logins increasing by 44%,**
 - **online consultations by 154%**
- **Northamptonshire continues to be one of the top users of online consultations in the country.**
- **100% of LLR practices are enabled for GP Connect with 97% in Northants**, improving patient access and supporting integrated care.
- Strengthen multidisciplinary primary care capacity through the **Additional Roles Reimbursement Scheme (ARRS)**, with workforce increasing by **20% during 2025/26** and a further **3% in Q1 2026/27**, supporting improved access and winter resilience.

URGENT DENTAL CARE

- Deliver the national requirement for **8.2% of NHS dental contractual activity** to be allocated to urgent dental care appointments across the LNR Cluster.
- Monitor provider compliance, service utilisation and Directory of Services availability to maintain timely access and reduce pressure on General Practice, NHS 111 and Emergency Departments.

Primary Care Access and Recovery

SAME DAY ACCESS (SDA) AND ENHANCED ACCESS	• Deliver additional winter capacity through a coordinated seven-day Same Day Access model across the LNR Cluster, including 64,901 commissioned urgent appointments annually across LLR and approximately 1,450 additional same-day urgent appointments each week through the Northamptonshire SDA pilot. • Delivery of Acute Respiratory Infection hubs for 120 persons per day including direct booking for acute, 111, EMAS • Support delivery of the ambition for 90% of clinically urgent requests to be managed on the same day, reducing demand on Emergency Departments, NHS 111 and other urgent care services. • Maintain Enhanced Access services to protect core General Practice capacity, with LLR consistently delivering between 8% and 24% above commissioned capacity while Northamptonshire has delivered between 15% and 30% above commissioned hours over the last three years, demonstrating provider flexibility and resilience during periods of peak demand.
CONTRACTUAL COMPLIANCE	• Maintain oversight of 2026/27 GP Contract delivery through GPAD, the General Practice Dashboard and local intelligence, providing targeted improvement support where required. • Ensure practices maintain compliant access arrangements, including core opening hours, online consultation availability and patient communications, supported by 100% GP Connect enablement across LLR practices. • Continue to promote digital access and quality improvement to enhance patient experience and reduce unwarranted variation.

Urgent Care

- Across LNR there are four Urgent Treatment Centres open 7 days a week (inc BH);
 - Loughborough – 24 hours
 - Oadby – 8am – 9pm
 - Merlyn Vaz (Leicester City) - 8am – 8pm
 - Corby – 8am – 8pm
- 41 • These services will run as planned and winter comms plan will continue to encourage our population to contact NHS111/NHS111 online to be directed/booked to the most appropriate service for their needs.
- Northampton General Hospital will open their onsite UTC at the end of August and extend the hours to overnight late September. This will improve patient experience and outcomes and decompression on main ED to allow higher risk patients to be better managed.
- Corby UTC will also expand their bookable appointment slots to Primary Care to reduce redirection to ED for urgent on the day needs.

Urgent Care

Merlyn Vaz UTC

- To support winter (and longer term) the ICB are proposing to make changes to the Merlyn Vaz service to maximise the UTCs contribution to the Urgent and Emergency Care pathway. This includes:
 - Increase UTC appointments from 15 minutes to 20 minutes.
 - Introduce Point of Care Testing and Healthcare Assistant support to improve clinical decision-making and reduce onward referrals to ED.
 - Enable acceptance of ED dispositions via the DoS to reduce avoidable Emergency Department attendances and improve patient flow.
 - Introduce a clinical triage function with a new Advanced Practitioner role to support early pathway intervention, redirection to alternative services, and to maximise ED avoidance for Walk-in patients.
- The proposed change will take effect from September 2026 – March 2027, with the plan to fund recurrently following review of change and evaluation.
- The service change is expected to avoid 50 ED attends a day, with further improvements anticipated as the model becomes established.

Community Pharmacy

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- The system will continue to maximise Community Pharmacy's contribution to winter resilience through Pharmacy First, Hypertension Case Finding, the Pharmacy Contraception Service and the Discharge Medicines Service, supporting delivery of **approximately 70,000 Pharmacy First** and **26,400 contraception consultations** during 2026/27 for LLR and around **110,000** Pharmacy First referrals in Northamptonshire (including contraception consultations).
- Demand and utilisation of Community Pharmacy has doubled through 25/26- 26/27, where we are seeing record numbers in LLR for referrals.
- Pharmacy First activity has more than doubled since 2025/26, with LLR achieving one of the highest growth rates nationally per 100,000 population supported by continued referral optimisation from General Practice, NHS111 and UTCs.
- Explore the opportunity to use independent prescribing in community pharmacy to widen the scope of patients that can be seen in Pharmacy First via an additional winter pressures service.
- Community Pharmacy capacity remains sufficient to meet demand, providing confidence that referrals can continue to divert activity safely from General Practice and Emergency Departments throughout winter. This will be monitored to ensure mitigations are in place in case this does become a challenge.
- We will work to maximise participation in the expanded Pharmacy First Service by increasing the number of pharmacies signed up to deliver additional prescribing-only clinical pathways and prescription management services.

Community Services

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Subtitle goes here



Rapid response and alternatives to admission

Urgent Community Response & Admission Avoidance

- **Increase Urgent Community Response (UCR) capacity**, including extended core hours and overnight provision, delivering a **25% increase in NHS 111 and EMAS transfers** across Northamptonshire
- **Increase LLR UCR activity by 10%**, supporting an additional **2,050 people** to receive urgent care in the community.
- **Introduce seven-day IV therapy pathways within Urgent Community Response**, supported by point of care testing.
- **Expand overnight sitting services**, supported by ambulatory follow-up, reducing short-stay admissions and enabling more people to remain at home.
- **Develop step-up capacity within Community Hospitals**, initially providing **five step-up beds across LLR** to support admission avoidance

Frailty, Virtual Wards & Remote Monitoring

- **Implement a single integrated frailty service**, operating **7 days a week (08:00–20:00 minimum)**, supporting an additional **546 people**.
- **Increase access to specialist community support across the cluster**, including greater use of step-up Virtual Wards to safely manage people at home.
- **Increase the number of people supported through remote health monitoring**, enabling earlier identification of deterioration and proactive intervention.
- **Expand the Falls Response service**, including point of care testing, increasing the proportion of people remaining at home from **80% to 90%**.

Urgent Access, Diagnostics & Clinical Decision Making

- **Expand community diagnostics and point of care testing**, enabling earlier clinical decision-making and reducing unnecessary hospital attendance.
- **Increase alternatives to Emergency Department attendance** through new Urgent Treatment Centres, same-day community hubs and direct access pathways.
- **Increase use of direct access to SDEC** and expand Frailty SDEC capacity and operating hours in line with GIRFT recommendations.
- **Mobilise the LLR Single Point of Access (October 2026)**, providing health and care professionals with a single route into urgent community services and avoiding an estimated **2,400 ED attendances**.

Specialist Community Support

- **Expand the PTCDA service**, supporting an additional **500 people** and avoiding **400 Emergency Department attendances** (2025/26 baseline: **4,102 people supported and 2,560 admissions avoided**).
- **Expand rapid specialist palliative and end of life care assessment and intervention**, including consultant and ACP in-reach, supporting an additional **115 people** and reducing Emergency Department attendances and hospital admissions.

Faster recovery and reduced length of stay

Stronger post-hospital support, reablement and neighbourhood-based follow-up help people regain independence sooner and avoid readmission

Discharge Flow & Reducing Length of Stay

- **Strengthen seven-day working** across partner organisations and enabling services (including diagnostics) to reduce delays and minimise patients with no reason to reside.
- **Further transform Pathway 2 services**, reducing demand for Pathway 3 and improving the timeliness of discharge.
- **Implement an Acute Medicine Hospital at Home pilot**, supporting selected patients with acute medical conditions to receive hospital-level care at home, with capacity for 20 virtual ward beds, supporting approximately 180 patients during the pilot period

Recovery, Rehabilitation & Reablement

- **Optimise reablement, rehabilitation and recovery services**, maximising short-term support to help people regain independence following illness or crisis.
- **Strengthen frailty and falls prevention**, through proactive identification, rapid therapy input, strength and balance programmes, home safety interventions, care home falls reviews, intermediate care and targeted prevention.

Post-Discharge Support & Preventing Readmission

- **Strengthen Pathway 0 (simple discharge) pathways**, including joint community MDT follow-up to support people recovering at home.
- **Implement an enhanced 48-hour post-discharge offer**, supporting recovery closer to home and targeting a reduction in readmissions from the current **22% baseline to 20%**

Surge and Super Surge conditions and actions

Surge and Super surge actions linked into OPEL Triggers linked to following key risks:

- Workforce resilience and availability (increased sickness/industrial action) across health and care sector incl. Vol Sector
- Surges in service demand linked to peaks in illness (respiratory) with same day urgent referrals peaking
- Extreme weather events (flooding, snow, freezing temperatures)
- IT/digital infrastructure impacts

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Key system Actions to support during surge and super surge in Community:

- Twice weekly staffing reviews to support forward planning
- Delivery of staff vaccination plan
- Additional recruitment to staff bank
- Triage and prioritisation of visits based on urgency and capacity v demand
- Redeployment of staff to support key areas
- Robust business continuity plan to support adverse weather and IT outage
- Use of 4x4 services
- Strengthen lone worker support
- Discharge Co-ordinators to work closely with Adult Social Teams regarding timely discharges.
- Clear escalation and system support for escalation

Flow, Occupancy & Discharge

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Subtitle goes here



Managing Flow and Occupancy - LLR



The LLR System Discharge Operational Group supports overarching governance, system performance and escalations across discharge pathways and aims to reduce delays, with membership from: UHL, LPT, ASC, ICB, Care Home Sectors, EMAS and Non-Emergency Patient Transport. LLR health and social care partners have agreed to deliver the following:

- **Transfer of Care (Acute to Community Hospitals/Care homes)** Achieve 80% of transfers by 17:00 each day.
- **Timely Discharge of P0 patients** Achieve 66% of discharge by 17:00 each day.
- **7-day Discharge Model** Consistent discharge plans in place for 50 patients Monday-Friday, 30 patients Saturday-Sunday.
- **Early submission of RDS forms** To support early discharge planning.
- **Pathway 3** To secure discharge plans within 7 days.

UHL Surge Actions

- 49 UHL are in the process of introducing the SHOP model that will enable early flow from wards.
- Use of MADE at UHL for ED and Front door wards.
- Reviewing alternative pathway to support patient discharge.
- Continue MDTs with partners to progress early discharge planning and unblock challenges with complex cases.

LPT Surge Actions

- Additional escalations calls with extra board rounds with ANP, use of boarding beds to increase capacity and matrons on board rounds to escalate challenges
- In-reach review by VIR Frailty ACPs, and silver meetings with senior colleagues during super-surge

LLR ASC Actions:

- ASC will continue to source packages of care and placements in-line with demand, supported by ICRS/CRS where necessary. However, challenges remain for patients requiring two carers, larger packages, and the availability of placements in the care home market.

Partners to utilise SCC as a point of escalation, particularly for external/OOA support.

Discharge Plan - LLR

- LLR Discharge Hub transferring to UHL to provide greater system working.
- New System Discharge Co-Ordinator for LLR Discharge Hub to be in post to support with discharge planning.
- UHL are progressing a series of MADE events during peak periods of pressure in UHL, focused on improving ED flow by reducing bed waits and enabling safe discharge for patients not requiring acute admission.
- Increase use of UHL's Intermediate Care beds for ED patients who do not require acute care but are also unable to return to usual residence due to housing, safeguarding, social breakdown.
- UHL target of <11% G&A beds occupied by patients no longer meeting the criteria to reside.
- Local Authority to support during times of pressure in-line with key metrics and BAU, surge and super-surge actions, acknowledging the limitations of the care home market.
- Community Hospitals are piloting a new model of enhanced staffing that will reduce deconditioning and support a reduction in LOS.
- All available High Dependency beds to be utilised, including accepting step-up referrals from ED.
- All available community hospital beds to be pre-allocated daily, with a focus on discharge before noon.
- Improved flow through LPT Community Hospital to support system, including flexing of beds, boarding SOP, LOS reduction, and system pathway transformation e.g., Stroke.
- Improve the timely discharge from community and MH beds into community setting facilitated with support from LA partners

Managing Flow and Occupancy - Northants

- Integrated Discharge Hub fully operational seven days in October
- EMAS PTS Transformation lead as part of Hub in September
- Partners use of OPTICA to improve pre discharge tracking and planning
- Revised delivery arrangements West Northants to reduce P1 delayed days to 3 days average from Q3 and 2 days Q4
- Increased flow through P2 capacity for additional 20 patients per month
- 51 AQP Framework appointed provider for 'at home transition' for people moving through confusional beds pathway
 - Decrease NRTR patients from 150 to 100 (system count)
 - Improve intensive support for persons entering care homes to increase take and reduce readmission failure
 - Internal transformation programmes within NGH and KGH to reduce deconditioning
 - Refresh of training to ensure that 4AT are correctly completed on admission for all patients to generate early flags for engagement of Dementia & Delirium Team
 - Clinical Senate set trigger point actions in escalation to ensure safe management of flow and balanced risk sharing across partners
 - Moulton Ward escalation beds Dec – March to support step-down at UHN

Managing surge and escalation – LNR

Whole System response to deliver sufficient patient flow to meet demand at times of surge and super surge:

- Provider Winter Plans outline their respective actions to safely manage flow with specific actions:
 - Additional escalation bed capacity
 - Utilisation of all available escalation capacity across the hospitals including boarding
 - Review of cancelling non-cancer/non urgent elective inpatient surgery and outpatient clinical to free up medical and nursing staff and support capacity
 - Review of urgent electives (not cancer)
- Establishment of Clinical Senate at system level to:
 - Agree system triggers for critical incident
 - Dynamic risk assessment – clinical and patient safety in relation pressure, surge and critical incident
 - Agree short term system actions at organisation level beyond OPEL 4 measures that support de-escalation and enable patient flow as safely as is possible

Governance, Command and Escalation

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Subtitle goes here



Leadership and Governance –Command & Escalation

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Level	Mechanism	Purpose
System	System Coordination Centre, SHREWD, daily System Flow Calls, SCC SOPs and escalation action cards.	Maintain shared view of demand, capacity, flow and operational risk; coordinate mitigating actions and mutual aid.
Executive	COO meetings, UEC Delivery Board, UEC Collaborative, Transformation Boards, ICB Committees and Board.	Maintain senior accountability, assurance and escalation where delivery is off track or system risks materialise.
Clinical	Clinical Executive, Clinical Responsibility Group, System Quality Group and clinical escalation routes. Establishment of Clinical Senate	Ensure clinical leadership, oversight of risk and consistency of patient safety response.-
Provider	UHL/UHN UEC Transformation Group, Trust Leadership Team, tactical command, LPT/NHFT operational governance, LA local reporting.	Track organisational actions and escalate risks to system governance.
Regional	Daily SCC connectivity with Regional Operations Centre when operational pressure escalates.	Articulate system pressures, actions and support needs to regional teams.

Quality, Safety, Risk Management, IPC, Workforce Wellbeing and Assurance

55



Subtitle goes here



Quality, Safety, IPC and Workforce Wellbeing

Quality and dignity

- Mitigate harm from long waits, delayed handover and non-standard care through daily safety review, rapid flow, escalation huddles and clear clinical responsibility.
- Review patient experience, incidents, falls, pressure damage and other quality indicators through provider and system governance.
- Apply explicit quality safeguards to ASC super-surge derogations and monitor impact during and after their use.
- Monitor intended and unintended consequences of SPoA and home visiting pathway changes.

• Infection prevention and outbreak response

- Use symptom-based screening across telephone and face-to-face care, separating symptomatic patients promptly and applying appropriate PPE.

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- Maintain enhanced cleaning, ventilation checks, PPE stock assurance and outbreak escalation arrangements.
- DHU plan specifies a minimum six-week PPE stock at sites, staff exclusion while symptomatic and rapid response to linked cases; local IPC leads should confirm alignment with current national and system guidance before final issue.
- Maintain UHL screening, cohorting, isolation, IPC advice and health protection support; protect ambulance handover areas from inappropriate cohorting.
- Formalise independent sector care provider contingency for respiratory and norovirus outbreaks, staffing shortages and weekend decision-making.

• Workforce Wellbeing

- Provide convenient staff vaccination routes, peer or local champions, outreach to care sector staff and regular uptake reporting.
- Target eligible residents, care home residents, vulnerable groups, unpaid carers, pregnant women and CYP, with action to reduce inequalities in uptake.

Integrated Risk Register

Risk	Impact	Mitigation	Escalation
Residual acute capacity gap	Long waits, occupancy and quality risk.	Deliver UHL/UHN mitigations; maximise SDEC, virtual ward, discharge and support services.	UHL/UHN governance, TLT, SCC and UEC governance.
SPoA mobilisation or demand mismatch LLR Only	Unintended demand shift to ambulance, ED or community services.	Readiness assurance, live demand/capacity monitoring, MDT governance, early warning and corrective action.	DHU, commissioners, SCC and UEC governance.
Home visiting pathway transition LLR Only	Reduced responsiveness or increased conveyance after 1 October change.	Pathway clarity, Primary Care readiness, workforce stability, monitoring and contingency.	DHU, Primary Care, ICB and SCC.
Primary care access pressure	Higher 111, UTC and ED demand.	OPEL oversight, same-day access, enhanced access, digital routes, ARRS and Pharmacy First.	Primary Care and ICB escalation to SCC.
ASC capacity or market instability	Delayed discharge, unmet need and carer breakdown.	Market monitoring, provider contingency, brokerage, reablement flow, seven-day capacity and mutual aid.	Local authority, ICB and SCC.
Super-surge quality risk	Poorer experience or outcomes and higher long-term care use.	Senior authorisation, individual risk review, time-limited derogation, monitoring and recovery plan.	ASC senior leadership and system quality governance.
Care home / service outbreaks	Closures, delayed discharge and staff shortage.	Vaccination, IPC, outbreak response, PPE, provider contingency and health protection support.	Public Health, UKHSA, provider IPC and SCC.
Workforce sickness and burnout	Reduced capacity and resilience.	Recruitment, backfill, rotas, redeployment, vaccination, wellbeing and mutual aid.	Provider and system workforce escalation.
Severe weather	Disrupted travel, visits, homecare and transport.	4x4 access, weather alerts, emergency planning, prioritisation and local resilience.	Local authority emergency planning, DHU and SCC.
Data or trajectory not validated	False assurance or misdirected capacity.	Confirm LLR-only baselines, owners, reporting frequency and data definitions before approval.	ICB programme governance and system executive.

Delivery Dashboard and Assurance



Domain	Core measures	Oversight
Demand and access	111 demand and response; GP OPEL; same-day access; UTC activity; ED attendances.	SCC, Primary Care, DHU, UHL, UHN, EMAS
Ambulance and front door	Conveyance, Category 3 deflection, handover, first assessment, 4/12/24-hour waits.	SCC, EMAS, UHL, UHN, DHU.
SPoA and community alternatives	SPoA activity, referral source/outcome, deflection, UCR, home visiting, falls, night nursing, virtual wards.	DHU, NHFT, LPT, ICB, UEC governance.
Acute capacity and flow	Open beds, occupancy, escalation spaces, SDEC, LOS, long stays, bed gap mitigations.	UHL/UHN tactical command and SCC.
Discharge and ASC	MOFD/CRFD, pathways 0-3, reablement dwell, brokerage, P2/P3 capacity, transport, readmission.	Discharge governance, local authorities, SCC.
Care market	Domiciliary capacity, care home vacancies, provider risk, outbreaks and staffing.	Local authorities, ICB and SCC.
Primary care and pharmacy	Capacity, access, urgent same-day handling, Pharmacy First referrals/activity, GP Connect and urgent dental access.	Primary Care and ICB governance.
Mental health and CYP	Crisis activity, ED co-streaming, inpatient LOS/CRFD, paediatric SDEC and CYP navigation.	NHFT, LPT, UHL, UHN, DHU and SCC.
Quality and IPC	Harm reviews, incidents, falls, pressure damage, outbreaks, side-room demand, PPE and vaccination.	System Quality Group and provider quality.
Workforce	Sickness, vacancies, agency, rota fill, additional capacity fill and wellbeing signals.	Provider and system workforce governance.
Communications	Reach, engagement, service navigation feedback, stakeholder issues and staff understanding.	System and partner communications leads.

Readiness Actions and Recommendations

No.	Action	Owner	Timing
1	Confirm accountable executive and operational leads for every priority, provider/place contribution and risk.	System / organisations	Before final approval
2	Validate all LLR and Northants Primary Care baselines, trajectories and activity commitments;	ICB Primary Care	Before final approval
3	Complete SPoA and home visiting transition readiness assurance for 1 October 2026, including demand, workforce, pathways, communications and fallback. LLR Only	DHU / ICB / Primary Care	Before 1 October 2026
4	Confirm NHS 111 winter plan after completion of the regional plan and incorporate material changes.	DHU / ICB	When regional plan available
5	Complete ASC desktop stress test across operational and social work teams.	LA ASC	September 2026
6	Test independent sector contingency and ASC surge/super-surge decision-making, including quality safeguards and recovery.	Local authorities / ICB	Before winter escalation
7	Confirm financial approvals, mobilisation dates, workforce and benefits for UHL/UHN/NHFT/LPT and system schemes.	UHL/UHN /NHFT/LPT ICB	Before winter escalation
8	Agree final dashboard, data definitions, trigger thresholds and reporting cadence across SCC and governance.	System UEC leadership	Before final approval
9	Validate escalation action cards across provider, Primary Care, local authority, place, SCC and regional routes.	All partners	Before winter escalation
10	Complete an integrated system readiness review and evidence closure of critical dependencies.	UEC governance / executives	Before winter escalation

Operational plan detail

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Primary Care, Ambulance handover and ED attendances

Operational Plan

Appointments in General Practice

	Apr-26	May-26	Jun-26	Jul-26	Aug-26	Sep-26	Oct-26	Nov-26	Dec-26	Jan-27	Feb-27	Mar-27
Leicester, Leicestershire and Rutland	599,811	657,550	644,947	638,127	644,952	695,141	778,858	721,258	620,450	718,437	664,326	704,655
Northamptonshire	404,819	404,819	354,216	455,421	354,216	404,819	506,203	455,421	404,819	455,421	404,819	455,421

Operational Plan

Average handover time (Total Handover time (ED and non ED) / No of handovers (ED and non-ED))

	Apr-26	May-26	Jun-26	Jul-26	Aug-26	Sep-26	Oct-26	Nov-26	Dec-26	Jan-27	Feb-27	Mar-27
UHL	00:33:19	00:37:14	00:31:52	00:29:57	00:35:32	00:31:59	00:37:06	00:31:51	00:30:09	00:37:15	00:30:11	00:30:12
KGH	00:32:56	00:31:10	00:31:06	00:29:55	00:29:37	00:28:29	00:28:31	00:27:36	00:26:46	00:26:19	00:25:40	00:25:00
NGH	00:40:00	00:38:00	00:36:00	00:35:00	00:34:00	00:33:00	00:32:00	00:31:00	00:30:00	00:27:00	00:26:00	00:25:00

Operational Plan

Number of attendances at type 1 A&E departments

	Apr-26	May-26	Jun-26	Jul-26	Aug-26	Sep-26	Oct-26	Nov-26	Dec-26	Jan-27	Feb-27	Mar-27
UHL	21,296	23,100	22,341	20,966	20,666	22,016	23,119	23,741	22,958	21,759	20,763	22,819
KGH	10,110	10,406	10,324	10,598	9,940	10,280	10,511	10,710	10,964	10,182	9,604	10,988
NGH	9,964	10,430	11,008	10,692	9,943	9,442	9,875	9,264	8,861	8,118	7,551	8,690

NEL admissions

Operational Plan

Number of specific acute non-elective spells in the period with a length of stay of zero days

	Apr-26	May-26	Jun-26	Jul-26	Aug-26	Sep-26	Oct-26	Nov-26	Dec-26	Jan-27	Feb-27	Mar-27
UHL	4,445	4,525	4,505	4,487	4,428	4,496	4,674	4,633	4,757	4,845	4,570	4,829
KGH	1,339	1,503	1,521	1,786	1,624	1,749	1,727	1,669	1,774	2,013	2,055	2,248
NGH	969	844	684	498	500	611	726	569	662	601	554	638

Operational Plan

Number of specific acute non-elective spells in the period with a length of stay of one or more days

	Apr-26	May-26	Jun-26	Jul-26	Aug-26	Sep-26	Oct-26	Nov-26	Dec-26	Jan-27	Feb-27	Mar-27
UHL	5,235	5,329	5,305	5,284	5,215	5,295	5,505	5,456	5,602	5,705	5,382	5,688
KGH	1,885	1,988	1,866	1,886	1,798	1,846	1,875	1,889	1,921	1,957	1,774	1,848
NGH	2,445	2,454	2,320	2,336	2,224	2,287	2,432	2,352	2,703	2,419	2,376	2,745

Operational Plan

Number of specific acute non-elective spells in the period

	Apr-26	May-26	Jun-26	Jul-26	Aug-26	Sep-26	Oct-26	Nov-26	Dec-26	Jan-27	Feb-27	Mar-27
UHL	9,680	9,854	9,810	9,771	9,643	9,791	10,179	10,089	10,359	10,550	9,952	10,517
KGH	3,224	3,491	3,387	3,672	3,422	3,595	3,602	3,558	3,695	3,970	3,829	4,096
NGH	3,414	3,298	3,004	2,834	2,724	2,898	3,158	2,921	3,365	3,020	2,930	3,383

Discharge and Bed Occupancy



Operational Plan

Overnight total general and acute bed occupancy %

	Apr-26	May-26	Jun-26	Jul-26	Aug-26	Sep-26	Oct-26	Nov-26	Dec-26	Jan-27	Feb-27	Mar-27
UHL	90%	86%	89%	91%	88%	89%	93%	90%	91%	94%	93%	94%
KGH	97%	97%	97%	97%	94%	97%	97%	97%	98%	98%	97%	97%
NGH	95%	95%	95%	95%	94%	95%	95%	95%	98%	95%	95%	94%

Operational Plan

Total number of discharges for non-elective admissions

3

	Apr-26	May-26	Jun-26	Jul-26	Aug-26	Sep-26	Oct-26	Nov-26	Dec-26	Jan-27	Feb-27	Mar-27
UHL	5,235	5,329	5,305	5,284	5,215	5,295	5,505	5,456	5,602	5,705	5,382	5,688
KGH	1,885	1,988	1,866	1,886	1,798	1,846	1,875	1,889	1,921	1,957	1,774	1,848
NGH	2,445	2,454	2,320	2,336	2,224	2,287	2,432	2,352	2,703	2,419	2,376	2,745

Bed Modelling

UHL Acute Capacity Modelling

CMG	Need	Got	Initial gap	Bad beds	Gap including bad beds
ESM	759	674	-85	-50	-135
CHUGGS	354	327	-27	-5	-32
MSS	143	162	19	-2	17
RRCV	509	465	-44	-35	-79
W&C	138	152	14	0	14
Total	1903	1780	-123	-92	-215

UHL Mitigated Position

CMG	Gap	Mitigation	Residual gap
ESM	-135	60	-75
CHUGGS	-32	8	-24
MSS	17	2	19
RRCV	-79	29	-50
W&C	14	7	21
Total	-215	106	-109

Vaccination in Leicester City: targeting resource where need is greatest

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Dr Naomi Caldwell
Deputy Chief Medical Officer
ICB Vaccinations, Immunisation & Screening Team

3 November 2026



Appendix C

Vaccination in Leicester City

Targeting resources to areas of need

Use local uptake data to identify gaps, then take vaccination and trusted conversations into the places where people already are.

66

See the gap

Using published City uptake, practice-level intelligence and cohort insight to identify where access and follow-up are weakest.

Move the offer

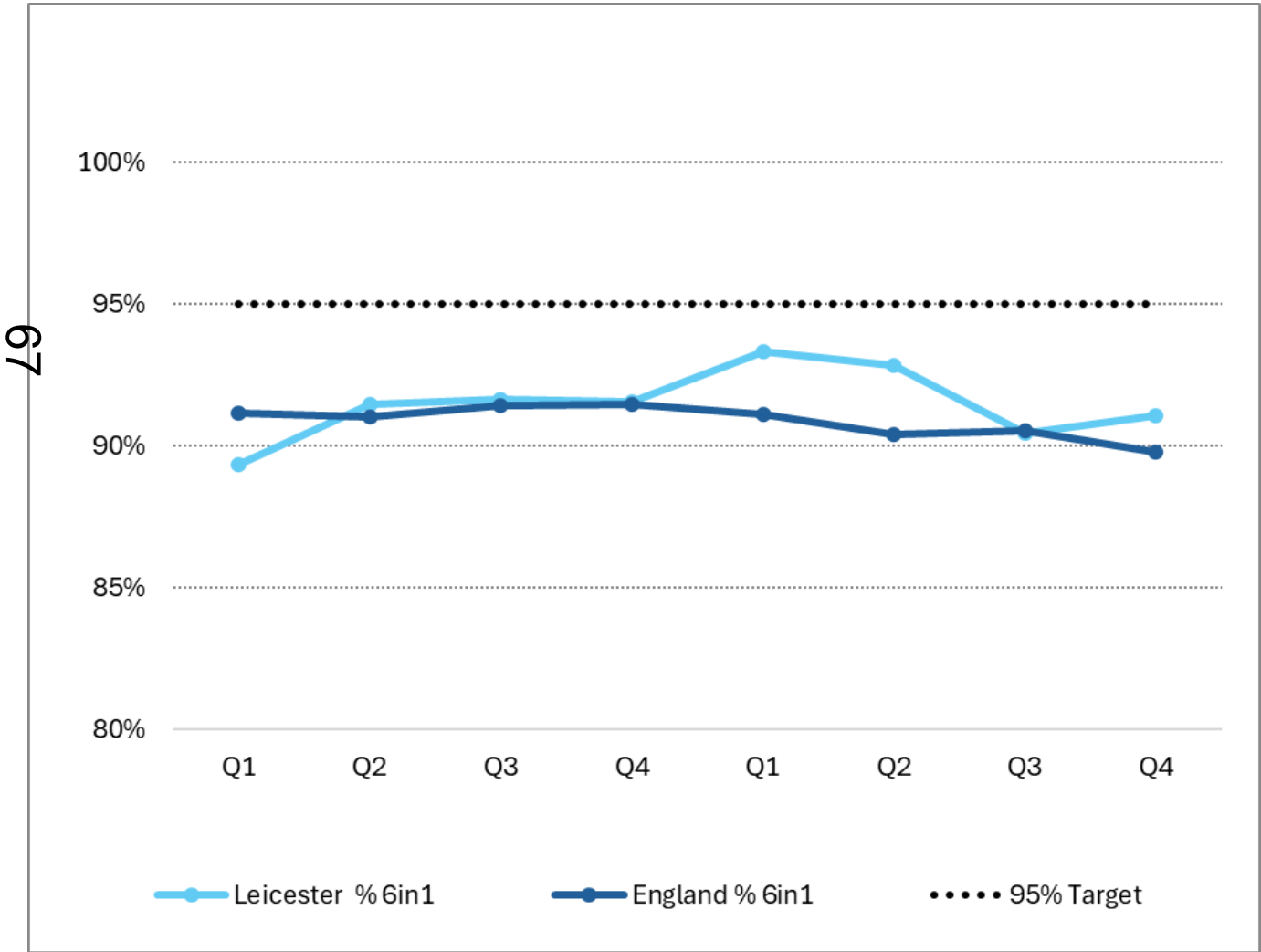
Deploying roving healthcare units (RHUs), community pharmacies (CPs) and supervaccinators in schools, on education campuses, trusted venues and in priority neighbourhoods.

Build trust

Co-designing with schools, universities, Public Health, faith networks and VCSE partners, then adapt delivery to what communities tell us.

6-in-1: Leicester remains below the 95% national target

Quarterly place level coverage, 2024/25 to 2025/26



6-in-1 % Coverage

6-in-1 is a single combined injection that protects babies against 6 potentially life-threatening diseases: diphtheria, tetanus, pertussis, polio, haemophilus influenzae type b (Hib), and hepatitis B.

The primary course is offered at 8,12 & 16 weeks. An additional 6-in-1 dose at 18 months applies under the revised routine schedule introduced from July 2025.

What the gap shows

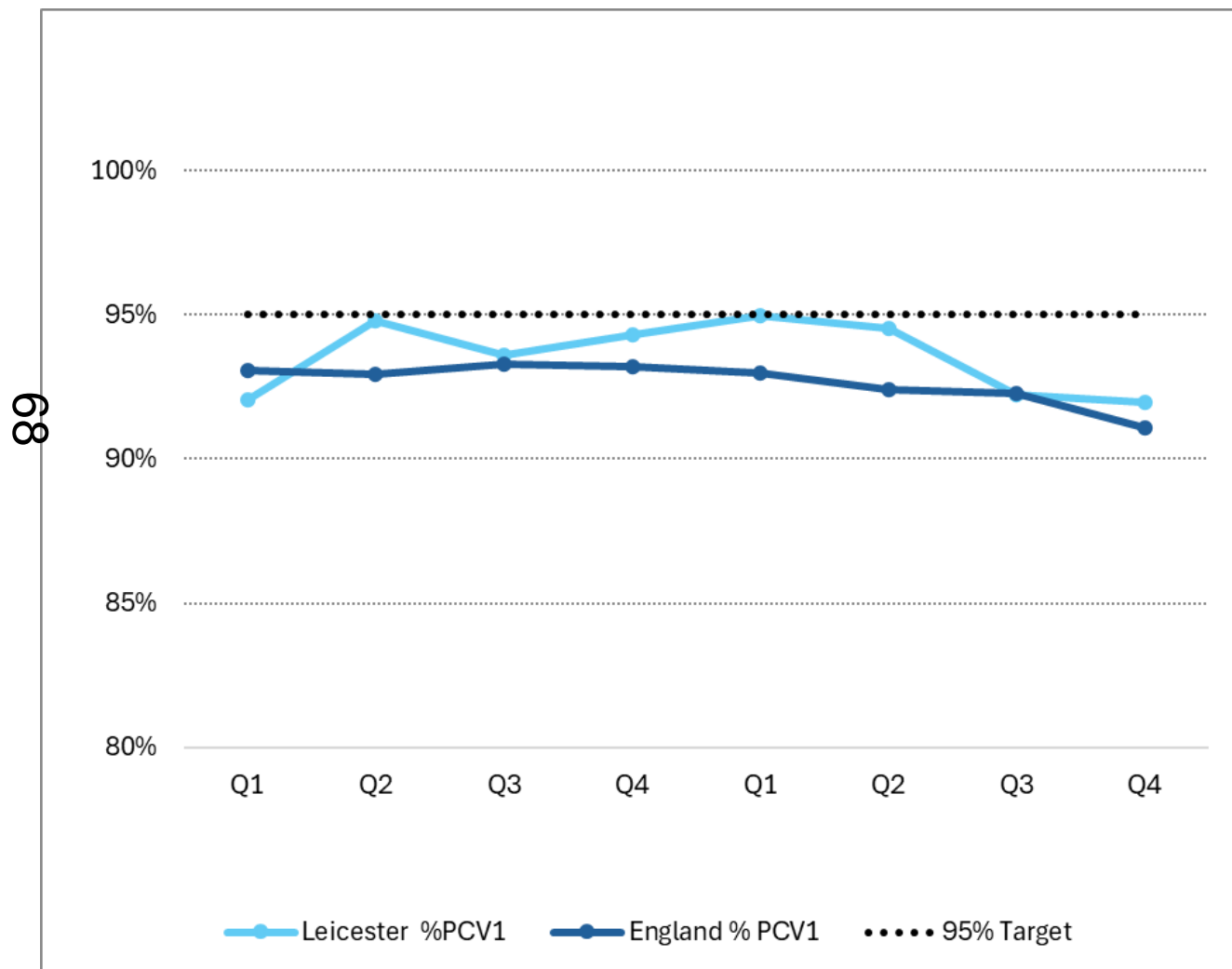
Leicester City remains below the 95% coverage ambition. Improvement is not yet consistently sustained across the period shown.

Priority response

Strengthening GP practice call/recall and focusing on additional access where opportunities are greatest.

PCV1: Improvement is not yet consistently sustained

Quarterly place level coverage, 2024/25 to 2025/26



PCV1 % Coverage

Pneumococcal conjugate vaccine (PCV1) protects babies against serious bacterial infections pneumonia, meningitis, and sepsis.

Offered at 12 weeks of age, followed by a booster on or shortly after the first birthday.

What the gap shows

Leicester City remains below the 95% coverage ambition.

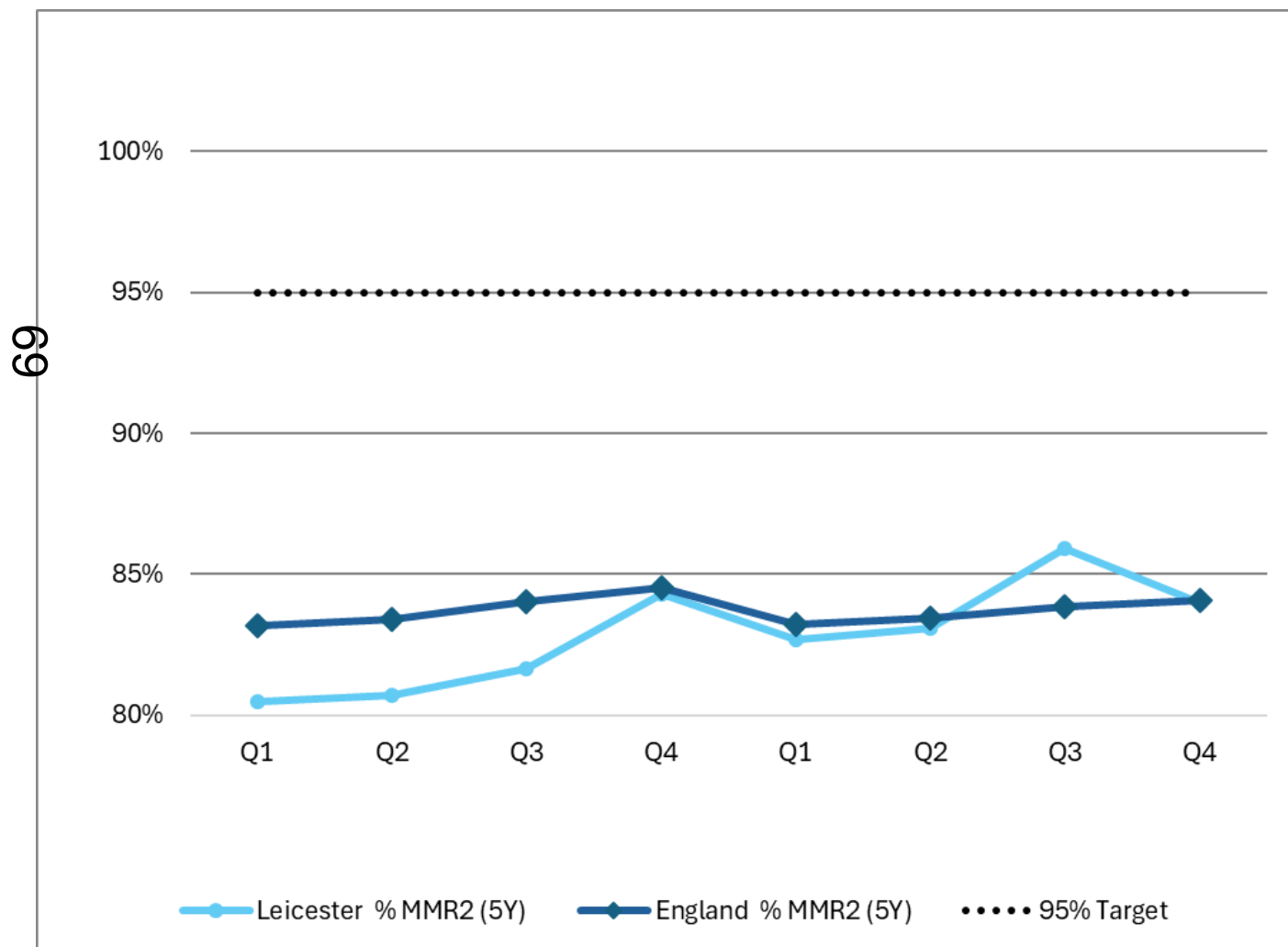
Recent quarterly movement should be interpreted cautiously: PCV1 coverage also fell nationally in the latest quarter, and quarterly estimates can be affected by cohort and population changes. Local practice-level intelligence is being used to identify persistent gaps requiring action.

Priority response

Using GP practice-level intelligence to target call/recall and provide additional outreach access where coverage remains lowest.

MMR2 at 5 years: Improvement but the City gap remains material

Quarterly place level coverage, 2024/25 to 2025/26



MMR2 (5 years) % Coverage

Historically, the second dose was offered at around 3 years and 4 months. Under the revised schedule, it is offered at 18 months for eligible cohorts, with catch-up available at any later age.

Two doses provide around 99% protection against measles, compared with around 93% after one dose.

What the gap shows

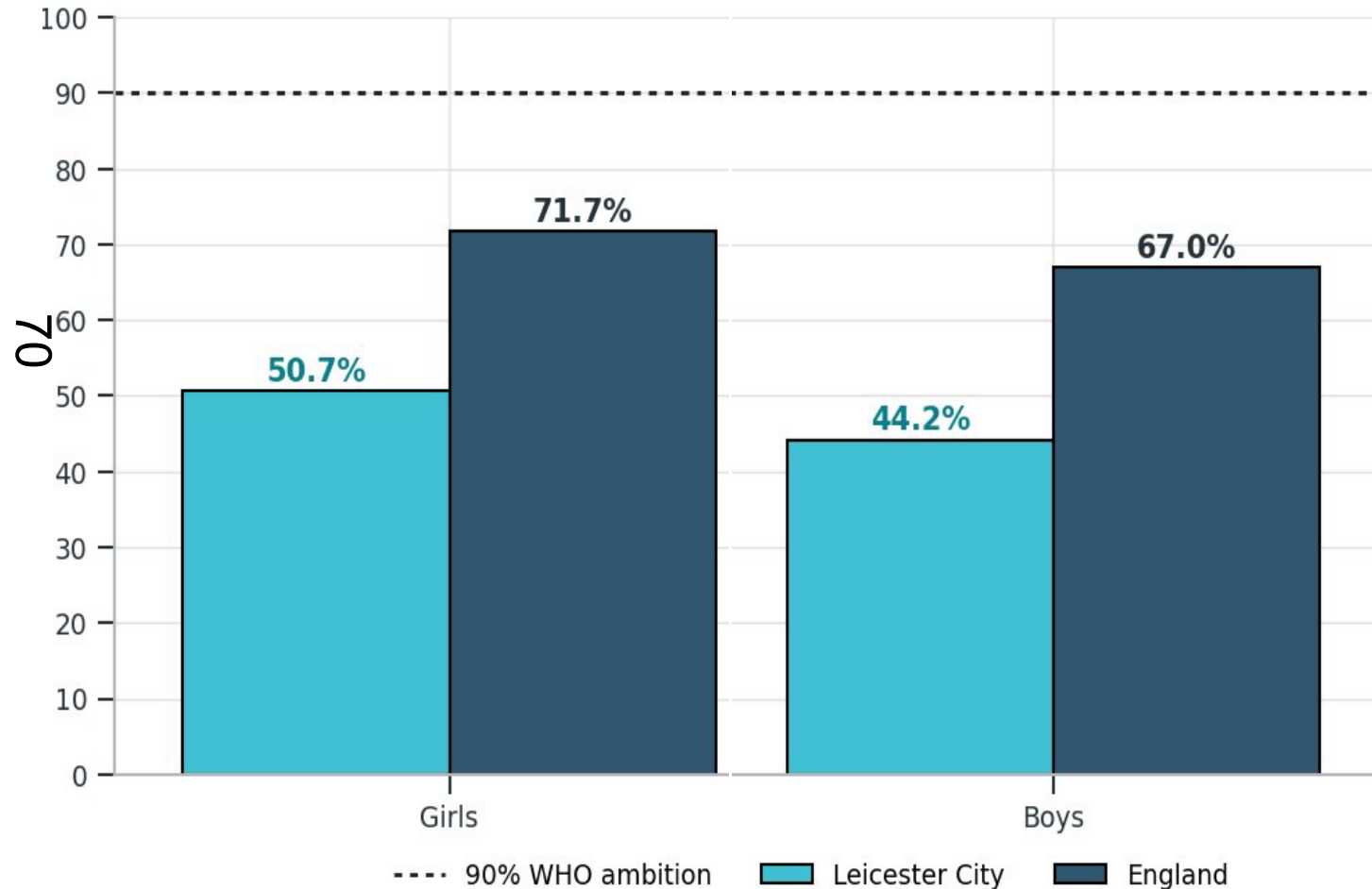
Leicester City remains below the England average and the 95% national coverage target. Improvement is evident, supporting continued focus on identification and catch-up of missed second doses.

Priority response

Using GP practice level intelligence to identify missed second doses and provide repeat catch-up opportunities in school and through outreach activities in the community.

HPV Year 8: Leicester remains well below England uptake

Published Year 8 coverage, academic year 2024/25



HPV Year 8 % Coverage

HPV vaccine is routinely offered to girls and boys in school Year 8. Since September 2023, most eligible young people need one dose.

NHS England ambition: eliminate cervical cancer by 2040.

What the gap shows

Leicester City is 21.0% below England for girls, and 22.8% below England for boys. Both are also well below the World Health Organisation 90% ambition for girls to be vaccinated by age 15.

Priority response

Using school-level uptake and consent intelligence to target follow-up, repeat offers and accessible catch-up routes in the lowest uptake schools and communities and via GP call/recall.

Winter flu vaccination in people aged 65+: the City gap remains

Final published end-of-season uptake, 2025/26

71

Leicester City
64.3%

Midlands
74.7%

England
74.5%

WHO target
75.0%

What the gap shows

Leicester City is 10.2% below England and 10.7% below the 75% WHO target. The local gap remains material despite a broadly stable national position.

Priority response

Core offer: GPs and CPs remain the core vaccination routes.

Targeted follow-up: Strengthened invitation, call/recall and follow-up of missed opportunities.

Additional access: Using RHUs, supervaccinators and trusted community venues where routine vaccination offers are insufficient.

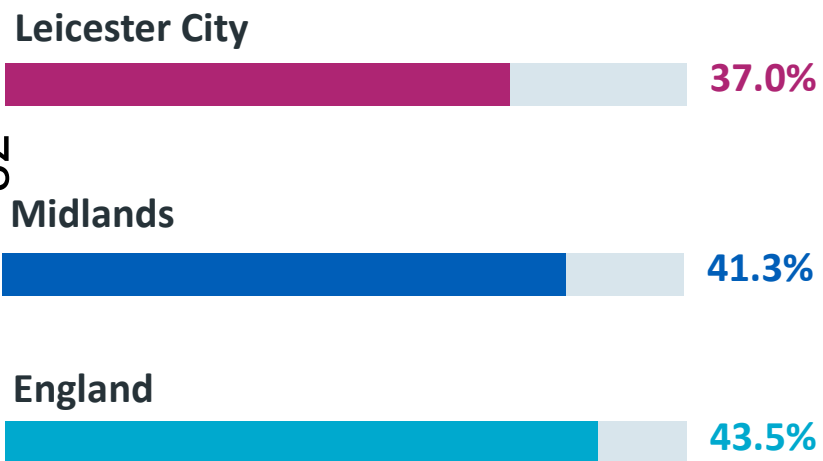
Assurance focus: Tracking completed vaccinations to keep pace with the England campaign average vaccination uptake.

Flu vaccine is routinely offered to people aged over 65 years; people aged under 65 years in a clinical risk group, pregnant women, 2 & 3-year-olds, and school-aged children and frontline health and social care workers. Eligibility has been extended to people experiencing homelessness for the first time this autumn/winter.

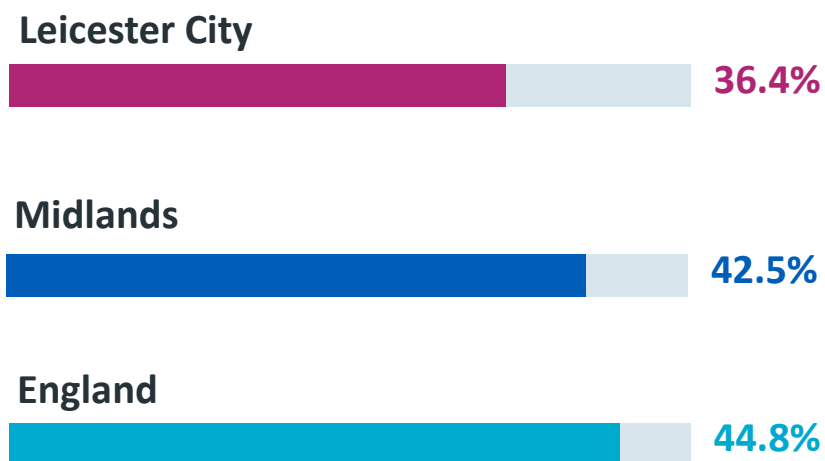
Winter flu vaccination in 2- and 3-year-olds: Leicester remains below England

Final published end-of-season uptake, 2025/26

2-year-olds



3-year-olds



What the gap shows

Leicester City is 6.5% below England for 2-year-olds and 8.4% below for 3-year-olds. The wider gap in 3-year-olds suggests a need for repeated offers, not a single invitation.

Priority response

Strengthening GP call/recall and follow-up after non-response

Making full use of CP access alongside GP vaccination clinic opportunities.

Linking Family Hubs, nurseries and trusted community routes to a confirmed vaccination offer.

New initiative: Family Hubs walk-in vaccination clinics opening across the city; first one opens at New Parks Family Hub every Tuesday throughout Nov, from 10am to 4pm.

Flu vaccine is routinely offered to people aged over 65 years; people aged under 65 years in a clinical risk group, pregnant women, 2 & 3-year-olds, and school-aged children and frontline health and social care workers. Eligibility has been extended to people experiencing homelessness for the first time this autumn/winter.

Targeted vaccination support is being directed into Leicester City

RHUs, supervaccinators and commissioned outreach supplement routine GP practice and CP provision where local intelligence identifies additional need

How additional support is deployed

Data-led targeting

Published uptake, GP practice and cohort intelligence, school-level information and community insight are used to identify where routine provision may need to be supplemented.

Roving Healthcare Units (RHU)

Mobile, walk-in vaccination sessions in agreed community locations, including homelessness services, education settings, community events and priority neighbourhoods.

Supervaccinators

A flexible clinical workforce used for smaller or shorter clinics where a full RHU is not proportionate, including support for priority GP practices and community venues.

Community pharmacy (CP) outreach

Commissioned outreach activity in education, care and community settings, alongside the established fixed-site CP offer.

Real example: taking prevention to The Bridge

Multi-partner outreach for people experiencing homelessness

86

TB chest X-rays

32

Flu vaccinations

Wider support

Sputum samples taken where needed and conversations about wider health needs.

Why this model matters

Trusted venue

Delivered where people already access support.

Multiple partners

System-wide partner/provider collaboration to meet community needs.

Practical access

Walk-in delivery reduced dependence on appointments and GP registration.

Targeted support supplements routine provision by bringing flexible clinical delivery into settings and communities where additional access is needed.

Need → resource → local access

RHU & Supervaccinator support in Leicester City

From 1 April to 19 October 2026

1,640

Vaccinations given:
RHU 358 +
Supervaccinators 1,282

60

RHU sessions at 38
different City venues

1,281

Childhood
immunisations given at
4 City GP practices

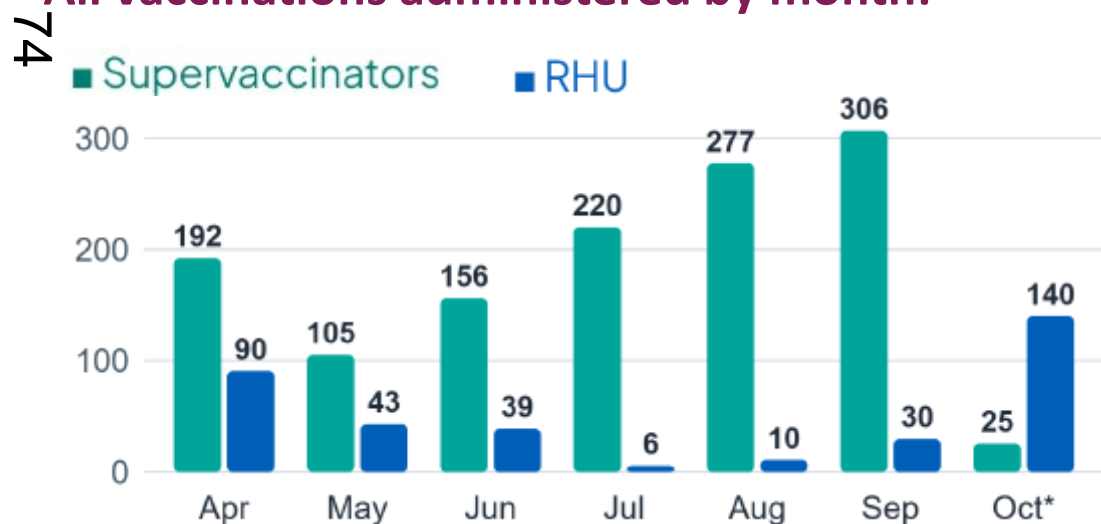
390

Blood pressure checks,
with high readings
referred onwards

766

MECC health and
wellbeing
conversations

All vaccinations administered by month:



Some of the overall numbers of vaccines delivered by RHU & supervaccinators include:
Flu 123, COVID 78, HPV 43, MenACWY 38, RSV 22, 6-in-1 415, MenB 311, PCV 201, Rota 180.

Flu for the homeless

The Bridge – 6 Oct

32 flu vaccinations in 1 day, working side-by-side with TB screening and other partner services. Repeat visits already arranged.

Braunstone: additional local access provided

A none AW25 vaccination venue. Since April: 6 sessions and 46 vaccines delivered, including 35 COVID/flu on 6 Oct assessment day.

Finding hidden risk

School A-level results-day visit uncovered a student's heart arrhythmia, also 40 BP checks at Winners Chapel found 10 abnormal readings requiring onward referral.

Young people protected

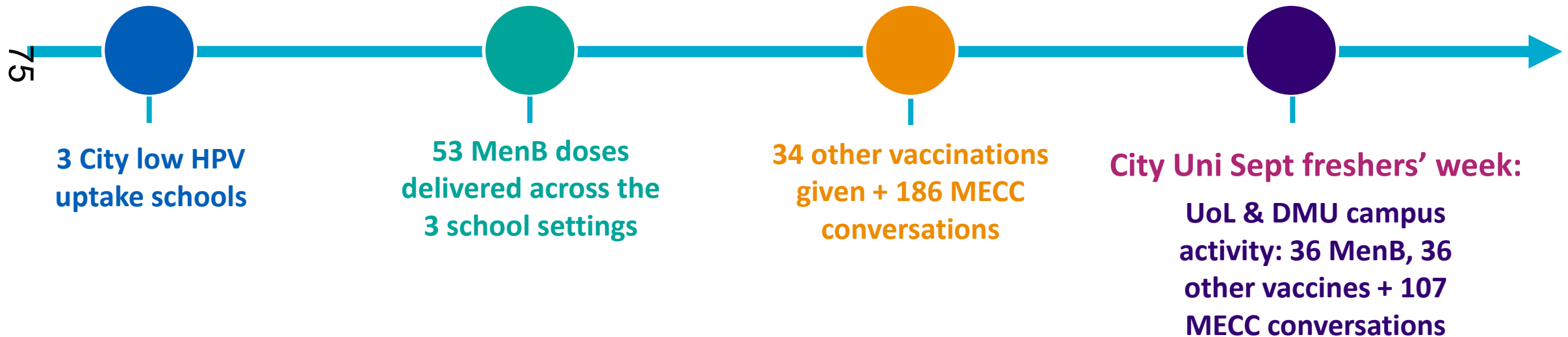
Gateway College: 5 visits and 66 vaccines

Uni freshers' week: 43 HPV and 38 MenACWY vaccinations.

New MenB: Reaching young people at key transition points

Taking the offer to A-level results day and university freshers' week; not relying on young people to find it themselves

3-Week multi partner mobilisation led to A-level results day, 13 August: providing MenB and other catch-up vaccinations & MECC interventions:



Building on this: repeat campus and transition point offers; link comms to confirmed clinic dates; use learning from school and university delivery to plan future catch-up vaccination activity; report doses and reach separately from population uptake.

School-aged vaccination: targeted & bespoke improvements

A clearer pathway from invitation and consent to vaccination and catch-up

School Age Immunisation Services

Flu: offered in primary and secondary schools from Sept to Dec

HPV: offered in secondary schools from Jan to March

MenACWY & Td/IPV: offered in secondary schools to Year 9s from April.

Catch-up vaccine opportunities, including MMR offered all year round.

What is underway

- **Priority-school micro-plans:** school-specific action based on uptake and local barriers
- **Consent improvement:** MAVIS enables parents to respond digitally and receive reminders; paper and supported routes remain available where needed.
- **Follow-up:** separate refusals from no response, absence and consent where vaccination was not completed, then make a repeat offer.

More ways to access

- In-school vaccination sessions and GP catch-up clinics
- Repeat offers available through RHUs, Specialist Sexual Health Services and community settings
- FE, 6th form and university routes, including opportunities for young people who change their minds.

MenACWY: protects against 4 strains of meningococcal bacteria that cause life-threatening meningitis and sepsis. **Td/IPV:** a 3-in-1 booster injection that protects against tetanus, diphtheria, and polio.

City approach: convert consent into completed vaccination by tracking non-response, absence and missed vaccination separately, then providing repeat and alternative offers.

Partnership

Targeted support

Repeat opportunities

Long-term change

Community investment: what partners delivered and what we learned

Trusted organisations turned information into conversations, booking support, referrals and vaccination access

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GATE

Used outreach and trusted community champions to improve access and health engagement with Gypsy, Roma and Traveller communities.

Wesley Hall

Used familiar community routes to support diverse families, migrants and refugees with awareness and signposting.

PEARL Initiative CIC

Linked four community locations to the RHU, providing eligibility advice, referrals and vaccination.

St Philip's Centre

Fatih-based discussions explored concerns and misinformation and identified trusted ways to communicate.

MamaDoc

Delivered 14 midwife-led drop-ins, with culturally sensitive advice, myth-busting information, booking support and follow-up.

Communities & Wellbeing Hub

Used schools and community networks to reach families, support tailor-made Q&A and strengthen volunteer health literacy.

Next step: connect community engagement more consistently to a confirmed bookable or walk-in vaccination offer.

Winter vaccination: protect those at greatest risk & reduce inequalities

Integrated flu and COVID-19 delivery, supported by targeted outreach where routine vaccination routes are insufficient

Protect vulnerable cohorts

Older people; care-home residents; people with long-term conditions or weakened immunity; pregnant women; eligible children; carers; frontline health and care staff; and people experiencing homelessness.

Maintain priority pathways

Dedicated assurance for care homes, housebound people, targeted routes for immunosuppressed patients; and mitigation where a usual provider has opted out or cannot deliver.

Target lower uptake

Use practice, cohort, deprivation and community insight to focus communication and access on neighbourhoods and ethnic communities where uptake is consistently lower.

What this means in Leicester City

Mixed access

GP practices and community pharmacies remain the core vaccination routes, supported by RHUs, supervaccinators and trusted and recommended community venues.

Trusted communication

Using ICB, Local Authority, GP practices, education providers, CPs, care homes, faith groups and VCSE comms channels, to provide vaccine information, eligibility, clinic information, booking routes, etc. Formats and language are adapted for the audience.

Active follow-up

Cohort-level identification, invitation and recall; care home assurance; and rapid follow-up where geographic or cohort gaps emerge.

Assurance focus: strong universal offer, with additional resource directed to the cohorts and communities least likely to be reached through routine delivery alone.

Going forward: build on what is working

Continue targeted access, strengthen follow-up and connect engagement directly to vaccination

More targeted access

Continued working with Public Health and VCSEs to agree RHU, supervaccinator and community pharmacy outreach, with venue choices informed by lower uptake neighbourhoods, communities and groups to improve access and community intelligence.

Winter protection

Maintaining tailored flu and COVID-19 pathways for the eligible groups with particular assurance for older adult care home residents, housebound people, immunosuppressed patients and people less likely to access routine services.

Better follow-up

Strengthened GP practice call/recall, MAVIS reminders, repeat school offers and alternatives after absence or non-response. Linking comms to confirmed dates and locations.

How councillors can help

- Champion vaccination messages through trusted local networks
- Identify and suggest neighbourhood venues and underserved groups we may be missing
- Join and shape the Vaccination and Screening Forum with VCSE partners
- Reinforce accurate and accessible messages and share feedback on barriers and gaps.

Future community funding is not yet confirmed. If available, the proposal is to connect funded engagement to a bookable or a walk-in vaccination offer and agree measures for reach, completed vaccinations and learning

Key risks and assurance for Leicester City

Transparent about the constraints, with clear mitigations and partnerships

Coverage remains below ambition

Risk: persistent gaps may leave some children and vulnerable adults under protected.

Assurance: City-level published trend, practice/cohort intelligence, call/recall and repeat access.

Access and consent barriers

Risk: digital-only consent, language, trust, mobility and provider capacity can reduce completion.

Assurance: paper alternatives where needed, translated information, trusted partners and accessible catch-up routes.

Activity does not equal uptake

Risk: outreach counts can show reach but not population coverage where no denominator exists.

Assurance: label sources and measures clearly; report delivery, reach and uptake separately.

Resource must follow need

Risk: additional activity may not reach the neighbourhoods and communities with the greatest barriers.

Assurance: document how locations are selected and use councillor/VCSE intelligence to challenge gaps.

Partnership ask: tell us where current routes are not working, which trusted venues should be used, and which communities need a different approach.

ICB resources, governance and risks: preparing for April 2027

Resources, clear ownership and specialist support must be maintained through transition

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1 Resources in place

Vaccination, immunisation and screening leadership; programme and inequalities capacity; Public Health expertise; data, comms and provider support across GP practices, CPs and outreach routes.

2 Local commissioning focus

Commissioning will focus on outcomes, inequalities and the needs of local communities, using published data for assurance and operational intelligence for action.

3 Commissioning transfer

Strategic commissioning of immunisation and screening programmes transfers on 1 April 2027.

4 Specialist support

The Office for Pan ICBs (OPIC), comprising former NHS England teams, will provide specialist commissioning and public health expertise.

5 Key risks and assurance

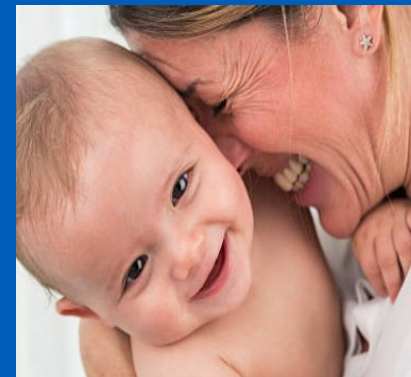
Risks: unequal uptake; short-term funding; workforce capacity; fragmented data; complex schedule changes; inconsistent access; and transition of responsibilities.

Assurance: clear ownership, multiple access routes, targeted resource, consent follow-up and programme governance.

Governance aim: a safe transition that protects delivery while strengthening local focus on uptake and inequalities.

Thank You

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Public Health & Health Integration Scrutiny Committee
Work Programme 2026-2027

Meeting Date	Item	Recommendations / Actions	Progress
30 June 2026	Introduction to Health Scrutiny Health Protection NHS Dentistry Leicester Neighbourhood Approach		

Meeting Date	Item	Recommendations / Actions	Progress
1 September 2026	Winter Pressures planning UHL/PH/ICB Health Watch Annual Report Leicester Neighbourhood Approach (adjourned from last meeting)	.	

Meeting Date	Item	Recommendations / Actions	Progress
3 November 2026	<i>Vaccinations update Mary/Annie</i> <i>Winter Pressures</i>		
1 February 2027	<i>Revenue Budget 27-28</i> <i>Rheumatology</i>		
8 March 2027			

Forward plan suggestions 2026/27:

Prevention and Health Inequalities	To include work done on Bowel Cancer.	
Palliative Care	To include information on Loros.	
Structure of the LNR	A report had been requested for the full structure of the LNR to come to scrutiny once available.	

Rheumatology	An update on recruitment and progress to come to the commission once available.	February 2027
Men's Mental Health		
Sexual Health Services		
Healthy babies s		
LLR Child Death Overview Panel Annual Report 2024/25	That a further update be brought back to the Commission on progress, including delivery against the action plan and any measurable impact on outcomes.	
Summer Pressures	Lessons and plans for summer 27	
Pharmacy First	Good news story	
UHL/ICB/LPT Work force	Summer/Winter Pressures respite	
Neighbourhood Data	Premature Mortality, access to obesity treatment and primary prevention	
ADHD and Autism Assessment Pathway	A report on the wait times for assessments in Leicester.	