



Leicester
City Council



Leicestershire
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Rutland
County Council

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

DATE: MONDAY, 28 SEPTEMBER 2026

TIME: 10:00 am

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

Members of the Committee

Leicester City Council

Councillor Halford (Chair of the Committee)

Councillor Singh Sangha

Councillor Bajaj

Councillor Clarke

Councillor March

Councillor Singh Patel

Councillor Sahu

Leicestershire County Council

Councillor Dr Hill (Vice-Chair of the Committee)

Councillor Durrani

Councillor Poland

Councillor Morris

Councillor McDonald

Councillor Knight

Councillor King

Rutland County Council

Councillor Stephenson

Councillor Ross

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

For Monitoring Officer

Officer contacts:

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Further information

If you have any queries about any of the above or the business to be discussed, please contact Katie Jordan, Governance Services: email Katie.Jordan@leicester.gov.uk or Julie Bryant Governance Services: email Julie.Bryant@leicester.gov.uk call in at City Hall, 115 Charles Street, Leicester, LE1 1FZ.

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

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

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

PUBLIC SESSION

AGENDA

NOTE:

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1. APOLOGIES FOR ABSENCE

2. DECLARATIONS OF INTEREST

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

3. CHAIRS ANNOUNCEMENTS

4. MINUTES OF THE PREVIOUS MEETING

**Appendix A
(Pages 1 - 14)**

The minutes of the meeting held on Thursday 30th April have been circulated and the Committee is asked to confirm them as a correct record.

5. MEMBERSHIP

Members are asked to note the membership of the committee for 2026-27 to note as follows:

City Council representatives
Cllr Elaine Halford (Chair)
Cllr Mohinder Singh Sangha
Cllr Deepak Bajaj
Cllr Adam Clarke
Cllr Melissa March
Cllr Devi Singh Patel
Cllr Liz Sahu

County Council representatives
Cllr Dr Sarah Hill (Vice Chair)
Cllr Moinuddin Durrani
Cllr Phil King
Cllr Kerry Knight
Cllr John McDonald
Cllr Peter Morris

Cllr James Poland

Rutland County Council representatives
Cllr Lucy Stephenson
Cllr Ramsey Ross

6. TERMS OF REFERENCE

Appendix B
(Pages 15 - 22)

The Committee are asked to note the Terms of Reference for 2026/27.

7. DATES OF MEETINGS

Members are asked to note the dates of meetings for 2026-27 as follows:

- Monday 28th September 2026, at 10am
- Thursday 26th November 2026, at 10am
- Monday 22nd February 2026, at 10am.

8. PETITIONS

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

9. QUESTIONS, REPRESENTATIONS AND STATEMENTS OF CASE

Cllr Ramsay Ross submitted the following questions to the Scrutiny Committee:

Palantir Systems – the Cost-Benefit of their adoption to UHL

Background Information to Questions:

1) Extracted from an investigation by **the Financial Times** published on 8th July 2026.

The key points that the FT report makes are:

- i) we do not know the true annual operational cost of the Palantir system vs the initial cost of the system
- ii) we do know that Palantir is being given access to individual patient data, although Palantir insists that the use of this data is controlled by the NHS
- iii) One third of hospitals have delivered fewer operations since introducing the system and major operational gains are limited to a few major hospitals
- iv) The NHS publishes its data available at: NHS organisations live with NHS Federated Data Platform

Supplemental information:

- *UHLeicester uses Palantir as does Northants General Hosp Trust (the two trusts now have the same Chair). Cambridge Univ. Hospitals Trust and Cambridge Community Trust also use the system. These trusts all report benefits.*
- *Whilst Lincolnshire Partnership NHS Foundation Trust uses the system, it has reported no benefits.*

- *Recently (July) the NHS has conceded that the cause-and-effect benefits of the FDP cannot be separated out, given the number of other variables and therefore the benefits cannot be estimated with a high degree of accuracy.*

2) The **Health Foundation** has established that the Palantir Optica tracking tool, used to reduce delayed hospital discharges has found "no noticeable improvement in discharge performance among trusts using Optica.....The gradual upward trend in performance observed in these trusts before they adopted the Optica toll continued at broadly the same rate after it was implemented".

Questions to the ICB:

- i) What are those specific and quantifiable Cost-Benefits that have been delivered to date from:
 - a. The FDP
 - b. The Optica tracking tool (if currently used)
- ii) What is the annual operation cost of each of these systems (split between the monies paid to Palantir and those of UHL) and what is the applicable contractual date upon which the Palantir contracts can be terminated?

10. PRIMARY CARE ACCESS IN LEICESTER, LEICESTERSHIRE AND RUTLAND GP ACCESS UPDATE AND PRIMARY CARE ACCESS RECOVERY PLAN - 2026/27

**Appendix C
(Pages 23 - 46)**

The Integrated Care Board (ICB) submit a report in response to the Leicester, Leicestershire's and Rutland Joint Health Scrutiny Committee's request for results, data, and progress from GP Patient Surveys, alongside a wider update on GP access performance and the actions being taken to improve access and patient experience across Leicester, Leicestershire, and Rutland.

11. IMPACT OF THE PROPOSED CLOSURE OF LOCAL HEALTHWATCH SERVICES ACROSS LEICESTER, LEICESTERSHIRE AND RUTLAND

**Appendix D
(Pages 47 - 68)**

The Chair of Healthwatch Leicester and the Chair of Healthwatch Rutland submit a report setting out the concerns of the three local Healthwatch organisations regarding Government proposals set out in the Health Bill 2026/27 that would result in the closure of Healthwatch services across Leicester, Leicestershire and Rutland (LLR). Healthwatch is the statutory, independent champion for people who use health and social care services.

The paper sets out its purpose, provides background and context on the Healthwatch role, outlines the risks associated with discontinuing Healthwatch provision, highlights the value Healthwatch delivers and presents recommendations for the Committee.

12. LEADERSHIP AND GOVERNANCE ARRANGEMENTS FOR UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST AND UNIVERSITY HOSPITALS OF NORTHAMPTONSHIRE (INFORMATION ONLY) **Appendix E
(Pages 69 - 70)**

The attached briefing from University Hospitals of Leicester NHS Trust (UHL) and University Hospitals of Northamptonshire (UHN) provides an update on leadership and governance arrangements and is submitted for information only.

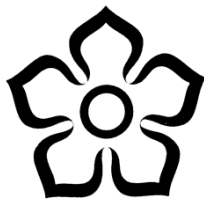
13. MEMBERS QUESTIONS ON MATTERS NOT COVERED ELSEWHERE ON THE AGENDA

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

14. WORK PROGRAMME **Appendix F
(Pages 71 - 74)**

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

15. ANY OTHER URGENT BUSINESS



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Appendix A

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

Held: THURSDAY, 30 APRIL 2026 at 10.00am

P R E S E N T :

Councillor Pickering - Chair
Councillor Hill – Vice Chair

Cllr Agath
Cllr Durrani
Cllr Haq
Cllr King
Cllr March
Cllr Morris
Cllr Ross
Cllr Sahu
Cllr Stephenson
Cllr Taylor

* * * * *

83. APOLOGIES FOR ABSENCE

Apologies were received from Cllr Harvey and Cllr Poland. Cllr Ramsey and Cllr Taylor were in attendance as substitutes.

84. DECLARATIONS OF INTEREST

No interests were declared.

85. MINUTES OF THE PREVIOUS MEETING

AGREED:

That the minutes of the previous meeting held on 23rd February 2026, were

confirmed as a correct record.

Councillor March noted that she had been marked as absent from the meeting, although apologies had been provided to the Chief Whip. The Governance Officer noted this and updated the record to reflect that apologies had been received.

86. CHAIRS ANNOUNCEMENTS

No announcements were made.

87. PETITIONS

A petition was submitted by District Councillor Butcher for information only to Members of the Commission before formally submitting the petition to the Integrated Care Board (ICB).

Cllr Butcher said:

The people in Melton Mowry are fed up of being overlooked in terms of essential health services. We are fed up of the 8am dash to get urgent care access, which is tricky for our more vulnerable and elderly residents to navigate and leaves those who are successful feeling more like they have won the lottery against all odds than simply accessing NHS services they fund through their taxes. We are fed up with being told by sorry, that the capacity by receptionists that are at capacity for the day, we should go to the walk-in in Loughborough instead. This simply is not an option for many and why we can have our own fit for purpose walk-in centre in another is another discussion.

We are fed up of waiting months, not days or weeks, at a time for routine appointments and the continual changes of our named GPs, meaning those with complex needs are repeatedly having to retell their stories and crossing their fingers that the new doctor will understand.

As these experiences show, the urgent need for a second GP practise cannot be overstated. As a town, we deserve better. We deserve robust health care infrastructure that meets our growing needs. GP services also play a vital role in protecting our NHS as fewer patients present to hospitals, if they can be seen more quickly in the community, this should be something that the ICB supports.

The current health care facilities are clearly struggling to meet the demand, leading to long waiting times and reduced access to timely medical care.

Many residents have expressed frustration and worry over the ability to see a general practitioner when needed. I have 3,268 signed the petition, formally urging the ICB to reconsider their decision to commit again to the immediate establishment of a second GP surgery practice, or at the very least to restart their previous expiration of the matter. No more excuses. It is time for the ICB to recognise the pressing health care needs of Milton Mowbray and for once listen to the views of our community. This is about patient choice and forward thinking, ready for the expansion of all the houses on the local plan.

Toby Sanders, Chief Executive of the Leicester, Leicestershire and Rutland Integrated Care Board (ICB), responded that an invitation would also be extended to Councillor Butcher to attend the next ICB Board meeting in public in June to raise the matter directly. It was acknowledged that the concerns outlined had also been recognised by the ICB Chair and Chief Executive.

88. QUESTIONS, REPRESENTATIONS AND STATEMENTS OF CASE

Cllr Ramsay Ross submitted the following questions to the Scrutiny Committee:

1. LRI-A&E

What progress has been made on the issues of Staffing and Alternative Provision of Services and what further steps are envisaged for 2026:
Staffing:

- What reduction has there been in the number of agency and bank nursing staff between January 2024 and December 2025?
- What increase has there been in the number of consultant, middle and junior level medical staff between January 2024 and December 2025?
- Staff sickness rates – what reduction has been achieved since 2024?

The following response was provided:

What reduction has there been in the number of agency and bank nursing staff in ED between January 2024 and December 2025?

There has been a 45% reduction in bank and agency usage in ED from January 2024 to December 2025.

What increase has there been in the number of consultant, middle and junior level medical staff in ED between January 2024 and December 2025.

University Hospitals of Leicester NHS Trust has appointed four additional consultants in the adult emergency department and two additional consultants in the children's emergency department. There has been no change in the number of middle-grade or junior doctors during this period.

Staff sickness rates in ED – what reduction has been achieved since 2024?

Staff sickness rates in the emergency department have reduced overall since January 2024, from 5.25% to 4.72%, representing a decrease of 0.53 percentage points.

2. Alternative Provision, Utilisation and the Management of Flows:

- The use of NHS111 – Market Harborough and Rutland MH Urgent Care Clinics now require appointments, with no walk in provision (and the Corby Health Centre proposes to introduce similar measures).
- Is this approach to patient access consistent with addressing the CQC findings highlighting those LRI-A&E patients who either could not gain access to, or had not attempted to get a GP appointment or

Out-of-Hours clinical appointment?

- Has the utilisation of facilities, such as the Merlyn Vaz Centre, increased since January 2024?
- What steps have been taken to address the level of demand for mental health provision?

The following response was provided:

On 1 April 2026, new same-day appointments were introduced in Leicestershire during evenings, weekends and bank holidays. Patients may be offered one of the new appointments, when they contact NHS 111 with an urgent health need. A small number of appointments are also available via GP practices and patients who go to the emergency department for minor health problems may also get an appointment booked for them. All appointments are with a GP, are 15 minutes long and take place at one of eight locations. It is an appointment-only service and replaces what were known as extended access appointments and taking place from urgent care centres in Enderby, Coalville, Hinckley, Lutterworth, Market Harborough and Melton Mowbray.

The minor injury units in Melton and Market Harborough and the urgent treatment centres at Loughborough, Oadby and Merlyn Vaz can all continue to be used on a walk-in basis.

Also on 1 April 2026, the Rutland Minor Illness and Injury service opened at Rutland Memorial Hospital, replacing the previous urgent care centre and minor injury unit. This is mainly an appointment-based service, with appointments available through NHS 111 and GP practice. Initially, a small number of walk-in appointments are available for minor injuries only.

Both of these new services are making it easier for people to get help quickly for urgent but non-life threatening health problems and support the NHS aim of matching each patient to the right level of care, from the right health professional, in the right part of the NHS, first time - known as Right Care, Right Place.

By asking people to contact NHS 111 or their GP practice when they have an urgent health problem helps ensure the NHS makes best use of all the available appointment options, including at GP practices, pharmacies under the Pharmacy First scheme, urgent treatment centres or the new same-day appointments described above. The approach reduces the number of places people need to contact and avoids unnecessary waits or trips to services that may not be suitable.

In addition, the NHS has increased the number of appointments overall:

- Since mid-2024, Pharmacy First referrals have more than doubled to over 4,000 per month and referral rates per 1,000 population have risen across most primary care networks (PCNs). The latest year statistics for 2025 show the growth of referrals per 100,000 patients is the best in England.
- Total number of General Practice appointments offered in LLR for Apr-Feb (latest month's data) was 7,328,852, representing a 1.68% increase from the same period in 24/25 and an additional 120,826 appointments.
- Over 35,000 of the new Leicestershire same-day appointments are available annually representing a 1.9% increase compared to the previous extended access/urgent care model

Recognising the right care, right place approach, demand for urgent treatment

centres has been relatively stable since January 2024, but with fluctuations though winter depending on the timing of the flu season. If demand exceeds capacity, the provider is able to flex their workforce to manage patient flow and avoid the need to pass patients onto further care pathways.

Mental health care follows a similar approach to ensure patients are treated in the right place for their needs. For urgent mental health matters, patients are encouraged to call NHS 111 and choose the mental health option. They will go through to the Central Access Point where a mental health call taker will triage their needs. They may arrange for a mental health professional to speak to them, advise them to go to the Mental Health Urgent Care Hub at the Bradgate Unit, or advise on more local support available such as a mental health Neighbourhood Café.

3. The Role of Councils: The CQC noted that demand in A&E was higher than planned due to the increased length of stay for patients who could not be transferred to other hospital Depts, in part due to discharge rates (bed-blocking). It further noted that discharge rates were impacted by problems with provision of community care, support for people living with deprivation, and homelessness.

- Is the ICB content with those steps that have been taken by Councils since 2024 to address patient discharge issues and what further steps are required in 2026?

The following response was provided:

The ICB works in close partnership with local authority colleagues and wider system partners across Leicester, Leicestershire and Rutland to support timely and effective discharge from hospital. We recognise that discharge is a shared system responsibility, requiring coordinated action across health, social care, housing, and voluntary sector partners.

Since the 2024 CQC report, there has been clear and evidenced progress across the system. This includes the strengthening of intermediate care services, with increased capacity to support discharge and admission avoidance, alongside more responsive pathways to support patients presenting through the Emergency Department. These improvements reflect a collective focus across partners to enhance patient flow and reduce delays.

Local authorities have contributed to this progress, including taking action to address housing-related barriers to discharge through the introduction of additional temporary accommodation for individuals who are medically fit but require short-term housing solutions. This has been supported by wider system changes to improve coordination and oversight of discharge pathways. Recent CQC inspections with local authorities has recognised improvements in discharge arrangements, reflecting a more coordinated and effective system-wide approach.

Looking ahead, discharge remains a priority across all partners. Local

authorities have set out plans for 2026/27 to continue strengthening community-based provision and support individuals, alongside ongoing work across the NHS and system partners to further improve discharge processes and patient flow.

The ICB is assured that appropriate steps have been taken since 2024, and that there is a clear and shared commitment across the system to continue building on this progress.

4. Ambulance Waiting Times and Utilisation of Services: East Midlands

service response times have worsened in the period from August to October 2025, having been stable earlier in the year. What are the top three reasons for the recent change in service provision to December 2025?

- Out of Area Patient Discharge - the CQC noted the under utilisation of the independent provider of patient transport services. Has this been addressed?

The following response was provided:

The CQC report states that the ICB-contracted patient transport service was not available for out of area patients.

Each ICB is responsible for arranging patient transport for its own patients. The responsibility for arranging repatriation for out of area patients is decided between ICBs on a case-by-case basis, depending on the hospital where the patient is currently located and where they need to go.

5. NHS Dentistry Provision Crises

In December 2024 there were c. 8000 foreign qualified dentists on the waiting list to take the two-part General Dental Council (GDC) overseas registration exam. In 2025 there were 350, or 4% of such dentists, who took the GDC exams. What specific written representations has the LLR-ICB made over the past 2 years, concerning the rapid accreditation of these dentists?

The following response was provided:

The ICB is not able to verify the specific figure cited regarding “8,000 foreign-qualified dentists on the waiting list” for the General Dental Council (GDC) Overseas Registration Examination, as this data is held nationally by the GDC and NHS England.

Over the past two years, NHS Leicester, Leicestershire and Rutland ICB has not made formal written representations directly to the GDC regarding the rapid accreditation of overseas-qualified dentists. Responsibility for professional regulation, examination capacity and accreditation processes sits nationally rather than with ICBs.

The ICB has, however, contributed to this issue through NHS England regional and national channels, including workforce and dental commissioning forums,

and by supporting national work led by the Office of the Chief Dental Officer for England and the British Dental Association with the GDC. Nationally, ORE examination capacity was increased in 2024, with a further expansion announced by NHS England in March 2026.

Locally, the ICB has focused on measures within its remit, including supporting streamlined supervised practice arrangements for overseas dentists entering NHS primary care and participating in the NHS England Dental Recruitment Incentive Scheme.

For further detail on accreditation processes or national correspondence, NHS England and the General Dental Council would be the appropriate bodies to approach.

Cllr Ramsey raised the following additional questions, that would be picked up outside of the meeting.

1. Alternative Provision, Utilisation and Management of Flows, Can utilisation data for Minor Injury (ideally) and Urgent Treatment Centres (certainly) be provided on a rolling monthly basis, alongside LRI A&E data, to support wider “public messaging” on the proper use of LRI A&E services and the understanding of Cllrs?
2. From the Integrated Care Journal of 14th April 26 Cheshire East have initiated an Early intervention programme for frail and vulnerable residents which has resulted in a sharp fall in emergency admissions for this patient group. Is there such a programme within LLR?
3. Noted that there are over 35000 new appointments via the new Leicestershire same day appointments, representing a 1.9% increase. What are the equivalent figures for the City and Rutland?
4. Independent provider of patient transport services confirmation that there is no issue with LLR utilisation of this service?
5. NHS Dentistry Provision confirmation that the LLR-ICB has made no such representations to NHS nationally/Govt on the issue raised in the question?

Cllr Haq submitted the following questions:

1. Please could we have an update on the creation of a Maggie’s Cancer Centre in Leicester, why is this taking so long ?

The following response was provided:

- Maggie’s are a national cancer charity whose aim it to bring people together in a calm and friendly spaces in new, modern, and well-furnished buildings that would help them to find comfort in the experiences of others.
- There are several centres across the UK, and recently one has opened

- in Northampton.
- Until late in 2025, there was no commitment to build a Maggie's centre in Leicester. However, Maggie's have confirmed their desire to build a centre in Leicester, and a Leicester scheme is included in their 5-year fund raising plan.
- UHL are meeting with Maggie's to plan this centre, although no date has yet been agreed for it to commence construction.

2. Why are the people of Leicester, Leicestershire and Rutland losing out on the world leading Cancer treatment and Support?

The following response was provided:

Cancer waiting times

- The average waiting time for cancer treatment continued to improve in 2025/26 with further improvements required against the 62-day Standard in 2026/27.
- Gynaecology, Head & Neck, Skin and Urology services have all demonstrated improvements, with fewer patients waiting over 62 days than in 2024/25.

What the LLR system is proud of in 2025/26

- Improved waiting times for patients with Prostate and Breast Cancer receiving hormone therapy prior to Radiotherapy.
- Secured funding to continue with the Non-Specific-Symptoms pathway. So far this has supported 158 patients receiving an earlier cancer diagnosis.
- FIT tests are now distributed and processed by UHL providing quicker results.
- The Liver surveillance programme has been extended secured for a further year to support earlier identification of cancer.
- Expanded our Robotic surgical programme in line with the National NHS and Cancer plans – this means offering patients less invasive surgery, reduced length of stay, reduced complications, less pain and faster return to normal activities.
- Continued to work collaboratively with University Hospitals of Northamptonshire to provide mutual aid support for Oncology patients across both counties.
- Reduced the time patients are waiting on the day for oncology treatments though improved scheduling.
- Upgraded our Brachytherapy equipment with state-of-the-art. The unit also received a visit from HRH Prince Edward.

89. UPDATE ON ST MARY'S BIRTH CENTRE

The Integrated Care Board (ICB) and University Hospitals of Leicester NHS Trust (UHL) provided the Committee with an update following the decision taken by the ICB Board on 19th March 2026 regarding St Mary's Birth Centre.

The following was noted:

- The decision followed a lengthy period of engagement, discussion and public debate, including a public meeting held in Melton to hear directly from residents and stakeholders.
- It was acknowledged that there continued to be differing views on the decision however, the Board was satisfied that due process had been followed and that the decision had not been taken lightly.
- Safety concerns relating to St Mary's had increased since 2021, with only 92 births recorded during 2024/25.
- Low activity levels and workforce pressures had created increasing clinical risks, including difficulties maintaining staffing resilience and clinical confidence.
- Approximately 30% of staff had been unavailable at points during the review period, further impacting sustainability of the service.
- The importance of maintaining safe oversight for mothers and babies and compliance with national maternity safety standards was highlighted as a key factor in the decision making process.
- National delays to the New Hospitals Programme had impacted the planned maternity developments across Leicester, including proposals linked to Leicester General Hospital (LGH).
- UHL remained committed to developing maternity and postnatal provision at LGH using existing facilities and creating a calmer postnatal environment for women and families.
- Work was underway to reconfigure postnatal wards at LGH within the next 3 months to provide more dedicated and supportive postnatal spaces.
- Feedback gathered through engagement activity demonstrated that families highly valued the calm environment, postnatal support and community feel previously offered at St Mary's.
- Concerns raised by local residents and families had included increased travel times, parking pressures and reduced local choice for mothers in rural areas.
- It was acknowledged that the closure process and temporary pause had been upsetting for staff working within the service.
- Transition arrangements were in place to support staff, including opportunities for midwives to work within services at LGH or continue working within Melton based provision where appropriate.
- Community based maternity support and home birth services would continue to form part of the wider maternity model across Leicester, Leicestershire and Rutland.
- Leicester was reported to have one of the higher home birth rates nationally at approximately 2% to 3%, although it was acknowledged that further work was required to improve awareness of available choices for women.
- Home births were subject to detailed safety assessments and delivered through a dedicated specialist team.
- National guidance required maternity services to continue offering a range of birth choices, including home birth, planned caesarean section

- and vaginal birth options.
- Community based perinatal mental health services remained available locally, whilst specialist inpatient provision continued to operate on a regional basis due to the small number of beds required across the East Midlands.
- Despite delays to the wider New Hospitals Programme, £39 million in enabling funding had been secured to support essential works across the Leicester Royal Infirmary, Leicester General Hospital and future children's and maternity hospital developments.

In discussion with Committee Members and Officers, the following was noted:

- Historically St Mary's may not have been consistently promoted and low activity levels may have reflected a lack of awareness amongst expectant mothers regarding available birth options. Questions were raised regarding how maternity choices, including home birth and midwife led care, would be communicated and promoted more effectively in future.
- Whilst birth choices were technically offered, women and families did not always feel fully informed regarding the full range of available options or settings, which could result in women feeling directed towards larger hospital sites by default.
- Many women had reported positive experiences at St Mary's, particularly in relation to the calm environment, postnatal support, breastfeeding support and continuity of care. Questions were raised regarding how similar "home from home" environments could be recreated within larger hospital settings.
- Work was underway to redesign postnatal spaces and strengthen postnatal care provision at Leicester General Hospital within the next 3 months to create a calmer and more supportive environment for women and families.
- Questions were raised regarding whether all postnatal services and support previously available at St Mary's would now be delivered in one location and whether women and families would be made fully aware of the services available to them.
- Community postnatal and breastfeeding support services remained in place, although inpatient postnatal provision at Melton was no longer available.
- Inpatient perinatal mental health provision continued to operate on a regional basis due to low patient numbers, although community based support remained available locally.
- Home births continued to operate safely within Leicester, Leicestershire and Rutland through dedicated teams and established safety assessments.
- Standalone midwife led units required minimum staffing levels, including at least 2 midwives on site, and the very low number of births at St Mary's had made the service increasingly difficult to sustain safely.
- Delays to the New Hospitals Programme could impact long term plans

for maternity services across Leicester General Hospital and Leicester Royal Infirmary, although enabling funding had been secured to continue essential development works across the sites.

- Travel times, parking and accessibility remained significant concerns for rural families travelling into Leicester for maternity care, including the impact of longer journeys on women experiencing stress and anxiety. Discussions were taking place with local councils to improve parking arrangements at both Leicester Royal Infirmary and Leicester General Hospital.
- Clarification was sought regarding whether future maternity provision at Leicester General Hospital would include all postnatal services within a single dedicated area for women and families.
- The length of the review process and delays between the original consultation and final decision had contributed to uncertainty for families, campaign groups and staff. Lessons had been learned regarding engagement, communication and the handling of long running service reviews.
- The significance of St Mary's to local families and communities may not always have been fully reflected through activity data and numerical measures alone.
- Ongoing scrutiny of maternity services, including birth choices, postnatal provision and support for women and families following the closure of St Mary's Birth Centre, was requested to ensure any gaps in provision or support were identified and addressed.

AGREED:

1. That the update be noted.
2. That further updates on maternity provision, birth choices and
3. postnatal services be included within the Committee's ongoing
4. maternity scrutiny work programme.

90. SPEECH AND LANGUAGE THERAPY SERVICE IN LEICESTER, LEICESTERSHIRE AND RUTLAND

The Leicester Partnership Trust (LPT) submitted a report to the Committee providing information about Speech and Language Therapy Services (SALTS) in Leicester, Leicestershire and Rutland.

The Group Director of Strategy and Partnerships provided an overview of the report. The following was noted:

- The report included parental feedback on Early Language Support for Every Child ELSEC, which had been a focus at the previous Scrutiny meeting.
- Performance information on SALTS waiting times were provided. 2024 had seen a drop in recorded performance for referral assessments, this had now recovered due to a balancing of resources.
- The target was to keep monthly follow-up support at or below 4,000 young people, figures were currently just within threshold.
- Schools were identified as a key source of support, and it was vital that

teachers were able to provide sufficient assistance within the school setting. Developing the Expert at Hand Offer was key.

- The focus was on developing ways to improve Family Empowerment.
- The ICB had 3 key priorities, one of which was to give children and young people the best start.

In discussion with Committee Members and Officers, the following was noted:

- The report included 5 years of performance data.
- The SALTS pathway was dependent on need. The first appointment included both assessment and commencement of treatment. Some children might require several appointments, with others requiring lifelong support with links to SEND. Further data could come back to Scrutiny, including on numbers referred for community support.
- Feedback demonstrated a high level of satisfaction for service users. Preferences were for intensive support, with early intervention.
- It was vital to utilise professionals to their maximum to manage caseloads, preferably within the school setting. There was an inbuilt capacity of knowledge within the city schools.
- The Expert at Hand offer was pending implementation. It was hoped that ELSEC could be rolled out as part of the offer.
- LLR was one of nine locations across the country receiving additional funding of £2.2m under the Changing People Programme (CPP). ELSEC had already performed well. Funding updates would come via Children, Young People and Education (CYPE) Scrutiny.
- The 18 week target referenced the national Referral To Treatment (RTT) target.
- The SEND Reform Plan had been established in a Central Government White Paper. Work was ongoing to embed the new policy.
- All referrals were triaged on need and risk. It was noted that whilst clinical cases were remaining stable, referrals relating to delay were doubling due to increased need. Research as to causation was ongoing. It was noted that poverty, screen time and modern family ways of living could all contribute to speech issues amongst children.
- GPs and Health Workers constituted the largest number of referrals.
- SALT was being embedded within the schools and long term case-loads would be reviewed.
- A key challenge for the NHS, education and the Local Authority was preventative work and the implementation of early support.
- Sufficient resilience was in place within the schools to enable the programme which would develop over time. NHS support would be provided to all schools.
- The NHS had been requested to become the delivery programme manager, reporting to the Director of Children's Services. Partnership working was key.
- Members raised concerns about capacity and 'burnout' for young people and their families. It was noted that NHS services were working with young people and their families in numerous ways which included forums and wider engagement methods. The NHS was working with the City Council on

Children's strategies. Members were urged to champion the services available

- Members recommended that the item return to Scrutiny as a joint item with Adult Education, CYPE Scrutiny and other relevant services such as CAHMS.

AGREED:

- 1) That the Committee note the report.
- 2) For figures to be circulated to members on community support referrals.
- 3) Funding updates would come via Children, Young People and Education (CYPE) Scrutiny.
- 4) The item would return to Scrutiny with relevant stakeholders invited.

91. MEMBERS QUESTIONS NOT COVERED ELSEWHERE ON THE AGENDA

No questions were raised.

92. WORK PROGRAMME

The Chair noted that this was the final meeting of the municipal year and thanked Members and Health Partners for their contributions and work throughout the year.

The Chair reminded Members that any suggested items for inclusion in the work programme should be shared with the Chair and the Senior Governance Officer

93. ANY OTHER URGENT BUSINESS

With there being no further business, the meeting closed at 11.50am.

Appendix B

Leicester, Leicestershire and Rutland Joint Health Scrutiny Committee

Working arrangements and Terms of Reference

1. Membership

The Membership of the Committee shall be made up of 16 voting members – 7 members nominated by the City Council, 7 by the County Council and 2 by Rutland Council. In view of the size of the Committee and the range of its responsibilities, it is considered that there should be no co-opted members.

Each Healthwatch body in Leicester, Leicestershire and Rutland will be invited to send a non-voting representative to the meeting.

Members of the Committee will be appointed by each relevant Local Authority in accordance with its procedures.

2. Chair and Vice-Chair

The position of Chair will rotate between the City Council and the County Council on a two-year cycle. The Vice Chair will be from the Authority not holding the Chair. The City Council will nominate the Chair for the period May 2025 to May 2027, and the County Council and City Council will then rotate the position of Chair and Vice-Chair in each two-year cycle afterwards.

3. Secretariat

The Secretariat will be provided by the Authority nominating the Chair. The Secretariat will liaise with all three authorities in drawing up the agenda. The Constitution/Standing Orders of the Authority providing the Secretariat will apply to the Joint Committee.

4. Policy Support

Both the City Council and the County Council will each provide an officer to assist the Health Scrutiny Process.

Both officers will liaise with and assist the Secretariat in drawing up the agenda and undertaking or commissioning research from within their respective Councils on behalf of the Joint Committee. Liaison will take place with the nominated officer(s) from Rutland Council.

5. Agenda Planning and Briefing

The Chair and Vice Chair will be consulted on the agenda. Arrangements will be made for providing information on agenda items to Rutland at an early stage. An agenda setting meeting will be held prior to the main meeting with the Chair and Vice Chair to which the lead Rutland member will be invited to attend. These meetings may be held virtually.

Any member of the Joint Committee will be entitled to ask for an issue to be placed on the agenda. Any such request should be in writing and accompanied by the reason for raising the item. If appropriate, the Secretariat may discuss with the member whether other means of

addressing the issue have been explored and the outcome of this (e.g. has it been raised with the relevant Trust and what response was received). The Secretariat may report on such other means and outcomes to the Joint Committee.

In planning agendas, members will bear in mind the purpose of the Joint Committee, namely, to achieve a co-ordinated response from the three authorities on key issues of common interest within the health agenda and to avoid duplication whilst recognizing that authorities may wish to carry out separate scrutiny exercises in the light of the particular circumstances of their areas and priorities of their authority.

A joint briefing arrangement will be provided for the Chair and Vice-Chair with officer support. The briefing meeting will be held on the same day as the meeting, one hour before the meeting is due to start.

There will be provision to include as a general item on the agenda for Member Questions on matters that are not covered elsewhere in the same agenda.

These arrangements will be reviewed periodically.

6. Scope of the Joint Committee

- i) The Joint Committee is the appropriate body to be consulted by NHS England on any proposals in accordance with Regulation 30 of the Local Authority (Public Health and Wellbeing Boards and Health Scrutiny) Regulations 2013 (as amended by The

Local Authority (Public Health, Health and Wellbeing Boards and Health Scrutiny) (Amendment and Saving Provision) Regulations 2024). The Regulations provide that where the appropriate person (NHS England) has any proposals for a substantial development or variation of a health service in an area they must consult the local authority. Where the consultation affects more than one local authority in an area, the local authorities are required to appoint a Joint Committee to comment upon the proposal and to require a member or employee of the responsible person to attend its meeting and respond to questions in connection with the consultation.

The Regulation does not prevent constituent Councils of the Joint Committee considering the issues separately; but it is the responsibility of the Joint Committee to formally respond to the consultation process.

- ii) The Committee may write to request (via a call-in request form) that the Secretary of State consider calling in a proposal. The Department for Health and Social Care expects this only to be used in exceptional situations where local resolution has not been reached.

All written requests should state clearly how the request meets one of the following criteria:

- a) there are concerns with the process that has been followed by the NHS commissioning body or NHS provider (for example, the adequacy of

the content of consultation with the public or the time allowed for consultation with the public; how options have been developed);

- b) a decision has been made and there are concerns that a proposal is not in the best interests of the health service in the area.
- iii) To scrutinise and comment on the exercise by all other NHS bodies of functions or proposals on a strategic basis which affect the areas of all three authorities.
- iv) To scrutinise the activities of Health Trusts with responsibility for health service functions across the area of the three authorities (i.e. UHL Trust, Leicestershire Partnership Trust, East Midlands Ambulance Service, and the NHS England etc.).
- v) To respond to any consultations by the Health bodies referred to in (i) above, including those which involve a substantial variation in provision of such service.
- vi) To respond to other consultations issued by all the NHS bodies which affect the areas of the three authorities.

7. Frequency of Meetings

Meetings of the Committee will generally take place three times a year, but extra meetings may be convened with the agreement of the Chair.

8. Quorum

The quorum of the Committee shall be at least one quarter of the whole number of the Committee. (4)

9. Voting

All decisions will be made by a majority vote of Members present at the Committee. In the event of an equality of votes, the chair will have a second and casting vote. Where a casting vote is exercised this will be recorded in the minutes.

A minority report may be prepared and submitted to the relevant NHS body (or Secretary of State) along with the majority report in the following circumstances: -

- (i) when a majority of members of a particular Authority disagree with the findings; and
- (ii) when at least one quarter of the members of the joint committee disagree.

10. Referrals

Referrals to the Joint Committee from individual health scrutiny committees should be carefully monitored and the reasons for the referral should be included in any report.

Referrals from Healthwatch should be considered carefully in line with the purpose of the committee to

avoid overloading the Joint Committee. The City and County Councils have protocols in place to ensure that referrals are not used as a substitute for other processes.

11. Media/Publicity Protocol

Where possible any press releases or publicity on behalf of the Committee should be undertaken after consulting all Spokespersons. Where this is not possible the Chair and Vice Chair of the Joint Committee will be authorised to issue press releases on the basis that these will be copied/e-mailed to all Group Spokespersons.

Responsibility for public and media relations on behalf of the Committee lies with the Authority responsible for the Secretariat.

12. Access to Information

The Access to Information Procedure Rules laid down by the Host Authority will apply with any necessary modifications. Link to Leicester City Council Constitution: <https://www.leicester.gov.uk/sites/default/files/2026-04/Our%20constitution.pdf>

13. Interpretation of Rules of Procedure

Subject to the provisions outlined in these working arrangements the Scrutiny Procedure Rules laid down by the Host Authority will apply with any necessary modifications.

**Primary Care Access in
Leicester, Leicestershire
and Rutland
GP Access Update and
Primary Care Access
Recovery Plan - 2026/27**

Public Health and Health Integration Scrutiny Commission

Date of meeting: Monday 28th September 2026

Lead Director/Officer: Integrated Care Board

Useful information

- Ward(s) affected: Leicester, Leicestershire, and Rutland (LLR)
- Report author: Mayur Patel
- Author contact details: mayur.patel@nhs.net / 07788338758
- Report version number: V1

1. Summary

- This report responds to the Joint Health Overview and Scrutiny Committee's request for results, data, and progress from GP Patient Surveys, alongside a wider update on GP access performance and the actions being taken to improve access and patient experience across Leicester, Leicestershire, and Rutland.
- Provides an overview of GP access across LLR, including appointment activity, locally commissioned access arrangements, and patient experience.
- It describes the range of access routes available to patients, including practice-based appointments, Same-Day Access, Enhanced Access, digital routes, and community pharmacy.
- It also sets out the ICB's approach to monitoring access, addressing unwarranted variation, and delivering the Primary Care Access Recovery Plan during 2026/27.

2. Recommended actions/decision

Scrutiny Commission is asked to note:

- Note the summary on 2025/26 GP access across Leicester, Leicestershire, and Rutland.
- Note the Q1 and Q2 2026/27 performance and the emerging trends in access and patient experience.
- Note access and service delivery across Leicester City, Leicestershire, and Rutland.
- Note the development and implementation of the LLR Primary Care Access Recovery Plan.
- Note the actions being taken to improve access and reduce unwarranted variation.

1. Purpose of the Report

This report provides the Joint Health Overview and Scrutiny Committee (HOSC) with an update on access to General Practice across Leicester, Leicestershire, and Rutland (LLR). It responds to the Committee's request for results, data, and progress from GP Patient Surveys, alongside information on GP access performance and improvement activity.

The report builds on the previous HOSC consideration of primary care access and provides an update on the position during the first half of 2026/27. It also sets out the approach being taken through the LLR Primary Care Access Recovery Plan to improve access, patient experience, and consistency of service.

The report covers:

- the current position on GP access across LLR.
- performance during Q1 and Q2 2026/27.
- the position across Leicester City, Leicestershire, and Rutland, including areas of local variation.
- progress in the development and implementation of the Access Recovery Plan.
- the main challenges affecting access and patient experience; and
- priorities for the remainder of 2026/27.

The report focuses specifically on GP access and related patient experience rather than the wider primary care transformation programme.

2. Recommendations

The Joint HOSC is asked to:

- **Note** the summary on 2025/26 GP access across Leicester, Leicestershire, and Rutland.
- **Note** the Q1 and Q2 2026/27 performance and the emerging trends in access and patient experience.
- **Note** access and service delivery across Leicester City, Leicestershire, and Rutland.
- **Note** the development and implementation of the LLR Primary Care Access Recovery Plan.
- **Note** the actions being taken to improve access and reduce unwarranted variation.

3. Executive Summary

Access to General Practice remains an important issue for patients and local communities across Leicester, Leicestershire, and Rutland (LLR).

General Practice continues to manage high levels of demand alongside increasing levels of clinical complexity and need. Across LLR, practices continue to provide substantial levels of appointment capacity, with activity during 2025/26 and into 2026/27 meeting or exceeding planned levels.

Over recent years, the Integrated Care Board (ICB) has also invested in a range of access arrangements, including same-day access, enhanced access, digital access, cloud-based telephony, multidisciplinary workforce expansion, and community pharmacy pathways. These arrangements provide patients with a range of routes into primary care and support practices to manage demand appropriately.

However, appointment activity and capacity do not on their own determine how patients experience access. Patient feedback continues to identify access and ease of contacting general practice as

areas for improvement, and there remains variation in access and patient experience between practices, PCNs and localities.

The 2026 GP Patient Survey demonstrates that patients continue to report high levels of confidence and trust in healthcare professionals and positive experiences of care once they access services. However, the survey also highlights ongoing challenges relating to access, ease of contact and variation in patient experience between practices and localities. The actions set out within this report are intended to address these issues and improve future patient-reported experience.

The focus during 2026/27 is therefore increasingly on making best use of the capacity already available and ensuring that this translates into timely, appropriate, and consistent access for patients. This includes improving care navigation, making effective use of alternative access routes, reducing unwarranted variation, and ensuring that access improvements are equitable.

The development of cluster wide LLR Primary Care Access Recovery Plan provides the framework for this next phase of improvement. It brings together existing access arrangements within a single improvement approach focused on:

- improving timely access.
- improving patient experience and reducing unwarranted variation.
- strengthening primary care through workforce, digital and neighbourhood approaches.
- strengthening governance and continuous improvement; and
- improving equity of access.

The remainder of this report provides an overview of current performance, patient experience, local variation, and the actions being taken through the Recovery Plan during 2026/27.

4. Summary of GP Access across Leicester City, Leicestershire, and Rutland (2025/26)

During 2025/26 the ICB worked in collaboration with general practice to improve access in primary care through the following schemes and initiatives:

SCHEMES TO IMPROVE ACCESS	PERFORMANCE
GP Appointments Categorisation The GP Appointment Dashboard (GPAD) provides information on appointment activity and timing across general practice and shows that LLR practices continued to provide substantial levels of appointment activity during 2025/26.	Across LLR, the GP Appointment Dashboard for 2025/26 indicated practices were providing appointments above the planned at an average of 100.9%. • Planned appointments: 7,960,199. • Actual appointments: 8,030,860 • Difference of 70,661 appointments For 25/26, LLR delivered 8.03 million GP appointments, exceeding the planned level by 70,661 appointments (100.9%). Performance exceeded plan in eight of the twelve months, with the highest volume delivered in October (826,329 appointments) Same Day Clinically Urgent (England average 70%) • Leicester performed above at 72% • Leicestershire was below at 68% • Rutland achieved at 75%

SCHEMES TO IMPROVE ACCESS	PERFORMANCE
	- Across LLR the average was aligned to national at 70% Same-Day Appointments (England average 44%) - Leicester performed at 44% - Leicestershire achieved at 38% - Rutland achieved at 33% - Across LLR, 40% of appointments were delivered on the same day, slightly below the national benchmark of 44%. Routine Appointments (England average 70%) - Leicester achieved above at 83% - Rutland achieved above at 81% - Leicestershire achieved above at 75% - LLR overall delivered 78% of routine appointments within two weeks, significantly above the national average. Face to Face Appointments (England average 70%) - Leicester achieved above average at 72% - Leicestershire at national average of 70% - Rutland delivered below at 60% - LLR overall delivered at national average of 70% of appointments face-to-face. During 2025/26, recorded GP appointment activity exceeded planned activity in the majority of months.
NHS App offered to all patients to check access care, book appointments, review their medical records, etc.	During 25/26 NHS App Registrations has increased by 9.6% (70,287 new registrations)
Online Consultation available in general practice via the practice website.	100% of eligible practices across LLR offer their patients the option to request prescriptions, make query via the online consultation option.
Cloud-Based Telephony installed in all practices to enable ease of access	100% of practices are on cloud-based telephony which enables patients to have better telephone access and offered a call back option to reduce waiting time.
Paediatric Acute Respiratory and Response (ARI) Hub The service offered Same-day, face-to-face primary care assessment service for children with an acute respiratory illness or febrile illness complaint to support during the winter pressures and ran from November 2025 to March 2026.	November 25 - March 26 ARI Clinics offered across LLR: 2,314 - Appointment offered 1,728 (75%) - Appointments Booked 1,498 (86.7%) - Patients Attended 25 referred to UHL The aim of this service was to; - Support patients with urgent clinical needs by enhancing same-day access to assessment and specialist advice as needed.

SCHEMES TO IMPROVE ACCESS	PERFORMANCE
	• Seek to reduce ambulance callouts, A&E attendances and hospital admissions for patients who could be appropriately managed in the community. • Reduce the burden of acute respiratory and other febrile illness on primary care and provide more time for practice teams to support patients where continuity of care is most important.
Same-Day Access - Locally commissioned service (outside core hours) The SDA service commenced in Leicester City from 1st October 2025, offering City patients access to Same-Day Appointments out of core GP practice hours to access appointments across ten sites from Monday to Friday 6:30pm to 8:00pm, Saturday 9:00am to 5:00pm and Sunday 10:00am to 2:00pm.	From October 25 to March 26 a total of 10,551 appointments has been offered, with an average of 1,758 appointments a month. Through clinical triage the Same-Day appointments are booked via NHS 111, Clinical Navigation Hub, Emergency Department and General practice offering a patient with a 15-minute GP appointment.
Enhanced Access (ES) Enhanced Access enables patients to access routine primary care appointments during evenings and weekends through Primary Care Networks (PCNs). The service supports improved access to general practice and a broader range of primary care services outside core practice opening hours.	LLR During 2025/26, LLR delivered 5,715 hours per month against a contractual requirement of approximately 4,900 hours per month, providing an average of 815 hours. • Total contracted (minimum) hours 58,798 • Total hours delivered 68,580 • Above contracted hours by 9,782 (16.6%) Leicester (2025/26) • Contractual requirement: 21,615 • Actual activity: 25,725 • Leicester City delivered 19.0% more hours than required, accounting for approximately 37.5% of all Enhanced Access activity across LLR. Leicestershire • Contractual requirement: 35,113 • Actual activity: 39,648 • Leicestershire delivered 12.9% above contract, representing approximately 57.8% of all Enhanced Access activity delivered across LLR. Rutland • Contractual requirements: 2,070 • Actual activity: 3,207 • Rutland delivered 54.9% above the contractual minimum, making it the highest performing place in proportional terms. During 2025/26, Enhanced Access (EA) services LLR delivered 68,580 hours of activity against a

SCHEMES TO IMPROVE ACCESS	PERFORMANCE
	contractual requirement of 58,798 hours, exceeding the minimum requirement by 9,782 hours (16.6%). All three places delivered above their contracted levels. The highest delivery recorded of EA activity was during October. This demonstrates strong system-wide provision of additional primary care appointments and good utilisation of Enhanced Access capacity across LLR.

5. GP Access 2026/27 (Q1 and Q2)

Patients can access General Practice through a number of routes. These include routine and urgent appointments within practices, same-day access, enhanced access, online and digital routes, community pharmacy services and multidisciplinary teams working within practices and primary care networks.

The availability and use of these routes vary according to local circumstances. The aim is to ensure that patients are able to access the most appropriate professional or service for their needs, while maintaining access to a GP where clinically required.

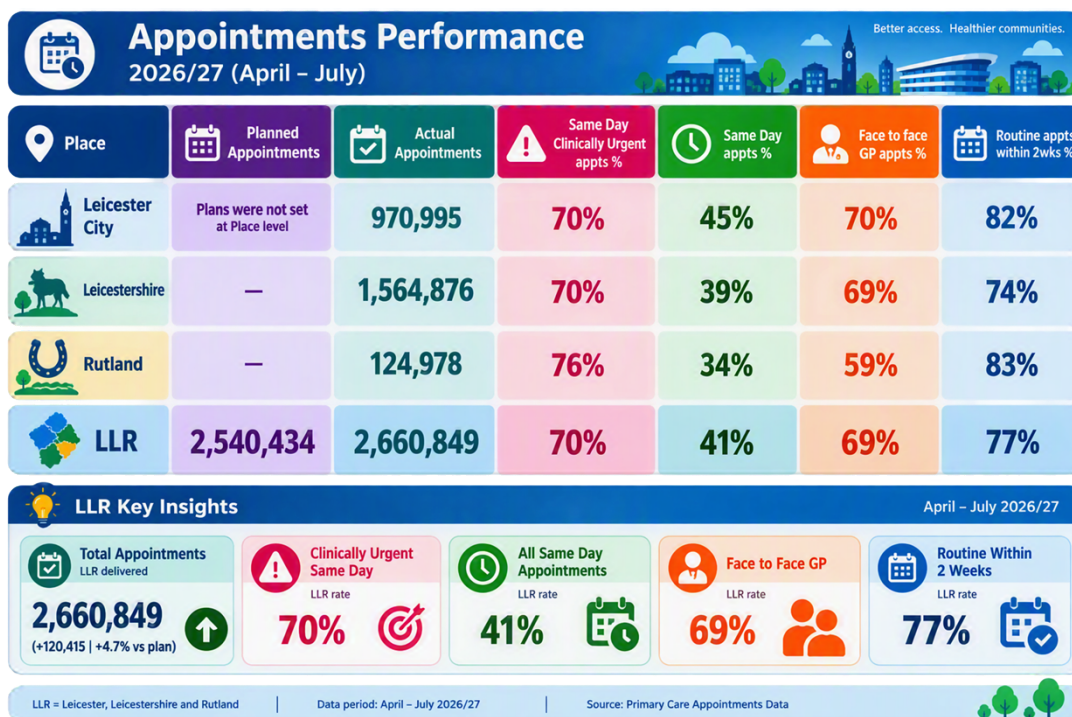
5.1 GP Appointments Access & Delivery across Leicester, Leicestershire & Rutland (Q1 & Q2)

NHS England publishes the GP Appointment Dashboard based on the appointment categorisation which demonstrates that primary care services across LLR continue to deliver high levels of access, with appointment volumes consistently meeting or exceeding the planned activity.

2026/27 (April - July)						
Place	Planned Appointments	Actual Appointments	Same Day Clinically Urgent appts %	Same Day appts %	Face to face GP appts %	Routine appts within 2wks %
Leicester City	Plans were not set at Place level	970995	70%	45%	70%	82%
Leicestershire		1564876	70%	39%	69%	74%
Rutland		124978	76%	34%	59%	83%
LLR	2540434	2660849	70%	41%	69%	77%

LLR delivered **2,660,849 GP appointments** from April to July 2026 against a planned requirement of **2,540,434 appointments**, equating to **105%** exceeding planned capacity by more than 120,415 appointments. This continues a sustained trend of strong performance, with LLR delivering above plan in the majority of months during the year.

LLR GP Appointments Summary (April - July 2026)



Same Day Clinical Urgent Appointments

Same Day Clinically Urgent Appointments are appointments for patients whose condition has been assessed as requiring a clinical response on the same day because waiting longer could result in deterioration or increased risk.

Across LLR, Leicester City, Leicestershire and Rutland were at or above the national average of 70%, with Leicester City and Rutland at 70% and Leicestershire at 76% with an average LLR performance of 70%. For the LLR system:

- **2025/26:** 70% of clinically urgent appointments were provided on the same day.
- **2026/27 (April to July):** 70% of clinically urgent appointments were provided on the same day.

This means that around **7 in every 10 patients assessed as needing same-day urgent care received an appointment on the day they contacted their practice**, demonstrating consistent performance year-on-year.

Same-Day Appointments

Same Day Appointments are any appointments where the patient is seen, contacted, or consulted on the **same calendar day that the appointment was booked or requested**.

Unlike **Same Day Clinically Urgent Appointments**, a same-day appointment does **not necessarily mean the patient's condition was clinically urgent**. A same-day appointment could be:

- A clinically urgent problem needing immediate assessment.
- A patient preference for a same-day consultation.
- An administrative or follow-up review arranged on the day.

- A minor illness or issue that happened to be accommodated on the same day.

Across England, **44% of appointments are delivered on the same-day, Leicester met the national average benchmark at 45%**, whilst the overall LLR position remains close to the national figure at 41% with **Leicestershire at 39% and Rutland 34%** which continues to provide significant same-day access opportunities for patients.

Routine Appointments Delivered Within Two Weeks

Routine appointments are appointments for health issues that are **not clinically urgent** and can safely wait for a planned appointment at a later date.

Across LLR, **77% of routine appointments** are delivered within 2 weeks, with **Leicester at 82% and Rutland at 83%** close to the **National average of 85%** and **Leicestershire at 74%**. The data indicates that the majority of recorded routine appointments were provided within two weeks, although there remains variation between places. Leicester and Rutland continue to perform particularly strongly against this measure.

Face-to-Face Appointments

Face-to-face appointments accounted for **69% of recorded appointments across LLR from April to July 26**, broadly in line with the **national position of 70%**. The proportion varied between places, with **Rutland at 59%, Leicestershire at 69%** and **Leicester City above national average at 70%**.

The GP Appointment Dashboard (GPAD) demonstrates that GP Practices across Leicester, Leicestershire and Rutland are performing strongly against key national access measures:

Overall, the data indicates that GP practices across LLR continue to provide accessible, timely and responsive services, whilst delivering activity above planned levels and maintaining strong performance across key patient access indicators.

5.2 Same-Day Access - Locally commissioned service (outside core hours)

The Same-Day Access service provides additional urgent primary care capacity and an alternative route for patients requiring same-day assessment. It is intended to support appropriate use of urgent and emergency care services by providing an additional community-based option where clinically appropriate.

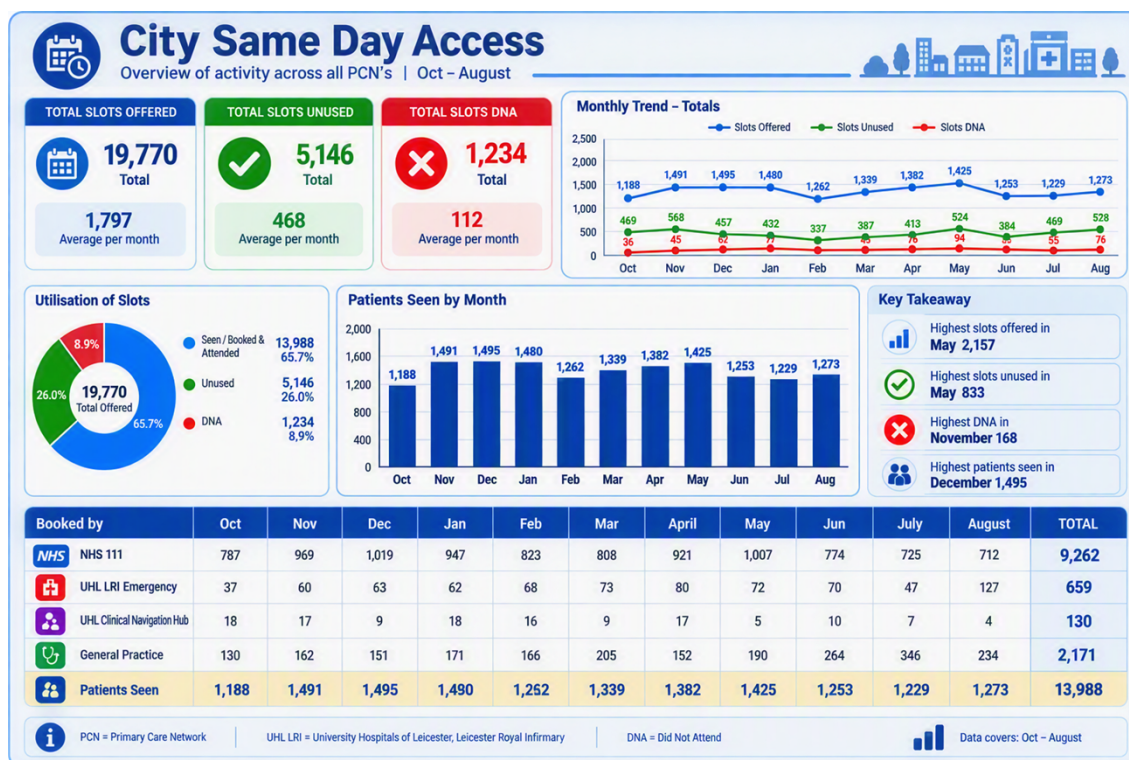
The service contributes to wider system objectives by:

- Improving patient access to same-day appointments during out of hours Monday to Sunday
- Providing alternatives to Emergency Department attendance.
- Supporting NHS 111 clinical disposition pathways.
- Increasing resilience within general practice.

Leicester City Same-Day Access

Same-Day Access commenced in Leicester City on 1st October 2025 and continues to play an important role in improving access to urgent primary care appointments for Leicester City residents to access care from 10 sites across the city. The service provides additional clinical capacity that can be booked directly by NHS 111, General Practice, the Clinical Navigation Hub, and Urgent Care services, helping patients receive timely care in the most appropriate setting and reducing pressure on both general practice and emergency departments.

Same-Day Access Activity (October 2025 and August 2026):



Based on the summary data, around **74% of all available appointments were successfully used by patients** for same-day access.

The Same-Day Access Service has become an important component of Leicester City's urgent and primary care offer. The service has provided over **18,500 additional appointment opportunities**, supported thousands of patients through NHS 111 and General Practice, and contributed to reducing demand on urgent and emergency care services.

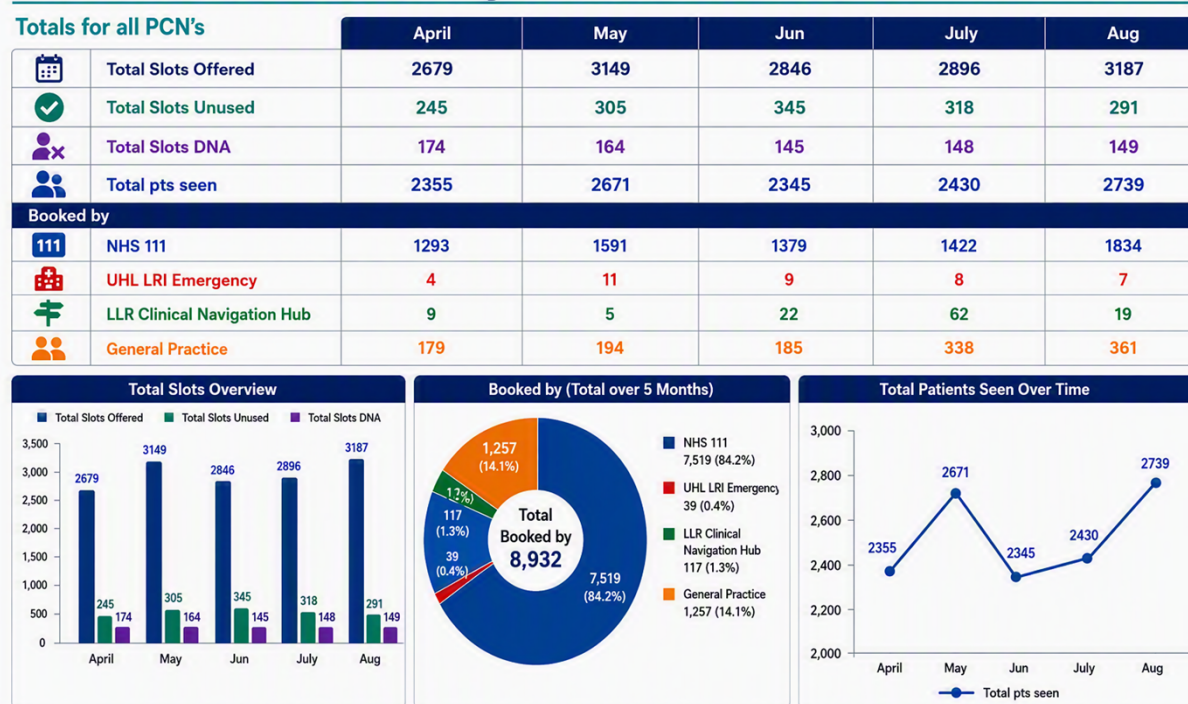
The increasing number of referrals from General Practice, alongside strong utilisation from NHS 111 and emergency care pathways, demonstrates that the service is becoming increasingly embedded within the Leicester healthcare system and is improving timely access to care for Leicester City residents.

Leicestershire Same-Day Access

Same-Day Access launched on 1 April 2026, providing an average of 3,000 appointments per month. Between April and August 2026, a total of 14,757 appointments were made available, achieving an 84% utilisation rate.

Based on the 84% utilisation, this trend suggests growing awareness and confidence amongst practices in using SDA capacity to support patients who need urgent assessment when demand exceeds practice capacity.

Leicestershire Same Day Access

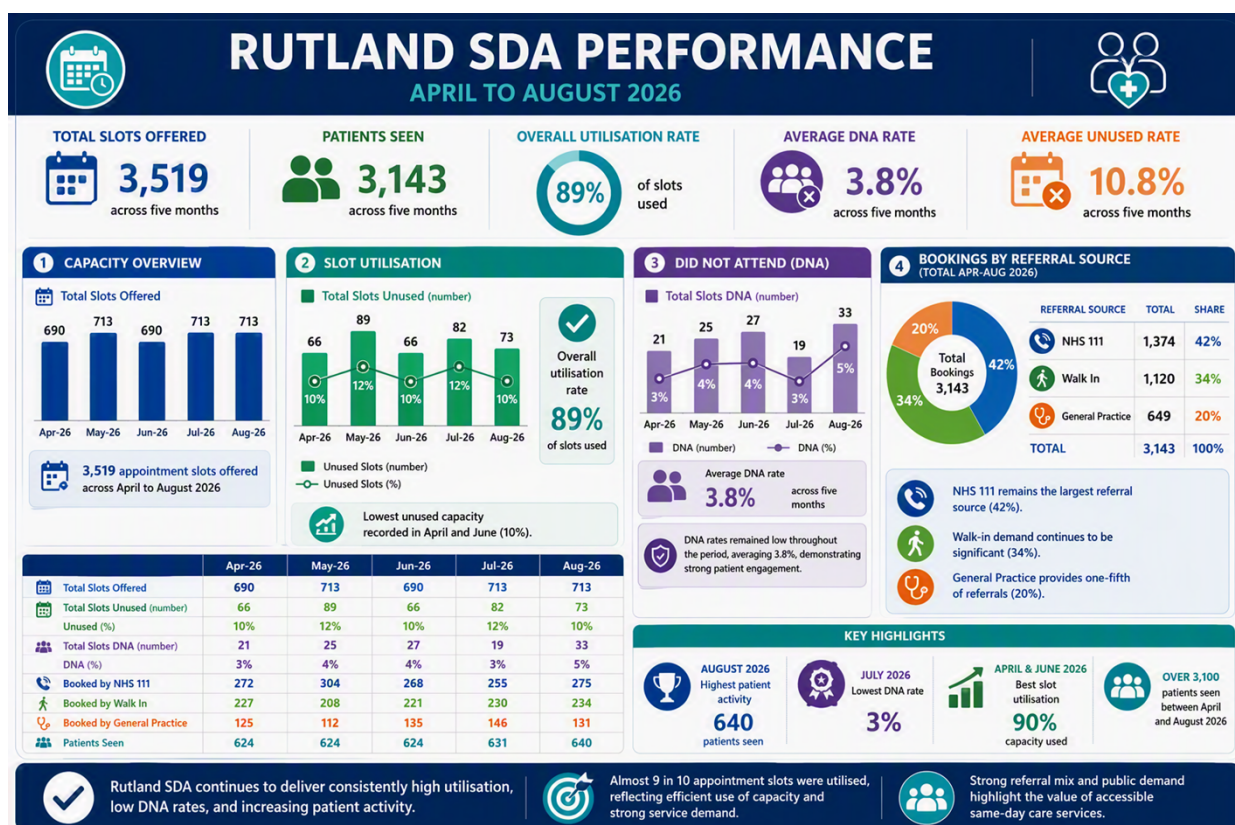


The Leicestershire Same-Day Access Service is making a significant contribution to improving access to urgent primary care. The service has provided almost **14,000 additional appointments** in five months, delivered high utilisation rates, and supported thousands of patients to receive timely care without needing to access emergency services.

Rutland - Same-Day Access

Since its launch, the Rutland Same-Day Access (SDA) Service has become an important component of local urgent primary care provision, providing residents with rapid access to assessment and treatment whilst reducing pressure on routine general practice appointments and wider urgent care services.

Between **April and August**, the service provided an additional 3,143 **same-day appointment slots**, ensuring patients requiring urgent care were able to access timely support closer to home.



The service provides an additional route to same-day primary care assessment for Rutland residents and is an important part of the local urgent primary care offer.

The SDA service across LLR is helping improve access by:



Providing an additional 64K same-day appointment a year across LLR during out of hours evening and weekends, including Bank Holidays.



Through an effective clinical triage process, patients meeting the same day criteria are offered rapid access to same day appts closer to home which are booked via NHS 111, Clinical Navigation Hub, Emergency Department and general practice.



SDA appts support system partners during periods of high demand to ensure patients are directed to the right clinician for the right care convenient to their location.



Providing an alternative to attendance at urgent and emergency care services.



Ensuring patient choice to receive care closer to home and at the earliest opportunity.

5.3. LLR Enhanced Access - 26/27 Primary Care Network Directed Enhanced Service (DES)

For 2026/27, PCNs across Leicester, Leicestershire and Rutland continues to successfully deliver on the PCN DES Enhanced Access. Through Enhanced Access, PCNs deliver additional primary care appointments from Monday to Friday's 6:30pm to 8:00pm and Saturday 9:00am to 5:00pm as per the PCN DES service requirements.

Enhanced Access is designed to improve access in general practice by ensuring those patients can be offered an appointment outside practice core hours and convenient to patient needs and helps to reduce pressure on urgent and emergency services.

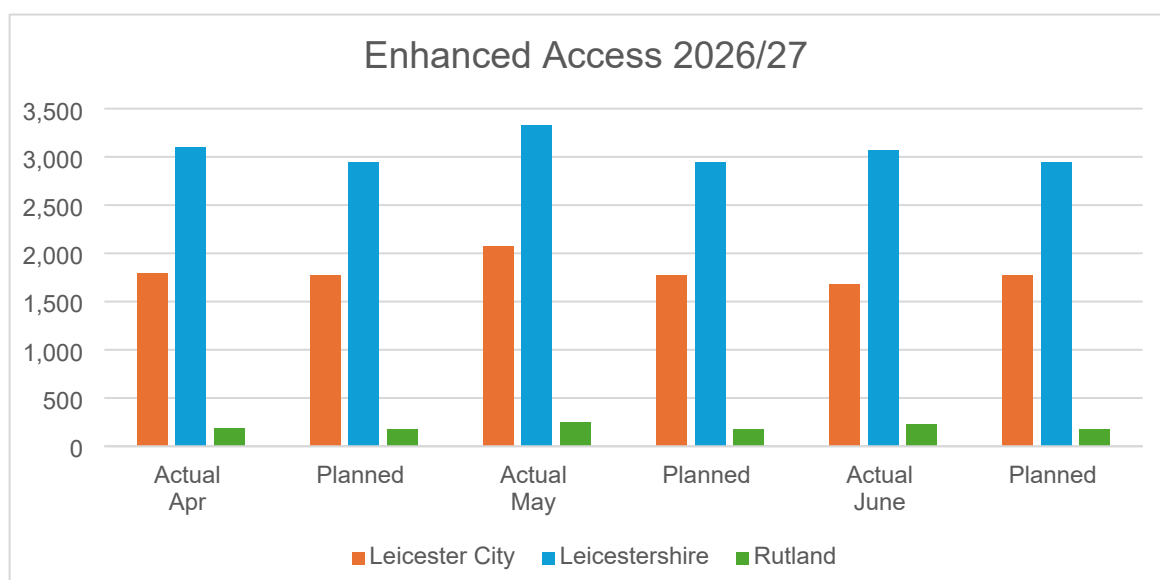
Across Leicester, Leicestershire, and Rutland for the first quarter (April - June), LLR delivered **15,701 Enhanced Access hours** against a contracted minimum of **14,688 hours**, thus exceeding the contractual requirement for that quarter by **1,012 (6.9%)** overall.

LLR Enhanced Access Activity (April - June 2026)

Month	Hours Delivered	Minimum Requirement	Variance
April	5,081	4,896	+185
May	5,654	4,896	+757
June	4,966	4,896	+70
Total	15,701	14,688	+1,013

Outlined below is a summary of Enhanced Access delivered by Place:

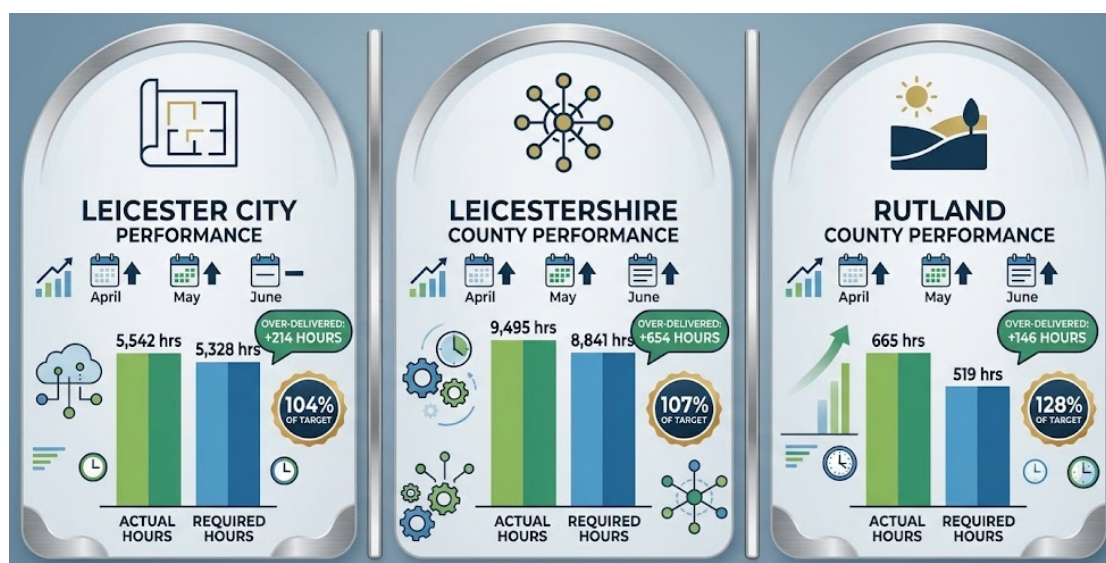
	April			May			June		
	Actual	Planned	Variance	Actual	Planned	Variance	Actual	Planned	Variance
Leicester City	1,789	1,776	12	2,074	1,776	298	1,679	1,776	-97
Leicestershire	3,102	2,947	155	3,329	2,947	382	3,064	2,947	117
Rutland	191	173	18	251	173	77	223	173	49
Grand Total	5,081	4,896	185	5,654	4,896	757	4,966	4,896	70



Leicester City delivered above its contractual requirement in April and May and only marginally below target in June. Across the quarter, Leicester City delivered **5,542 hours** against a requirement of **5,328 hours**, exceeding the target by **213 hours**.

Leicestershire consistently exceeded contractual requirements each month, delivering **9,495 hours** against a requirement of **8,841 hours**, representing an additional **654 hours** of capacity.

Rutland exceeded its contracted requirement in all three months, delivering **665 hours** compared to a requirement of **519 hours**, an over-delivery of **144 hours**.



5.4 GP Access through NHS App and Online Consultation

NHS APP

The NHS App continues to play an increasingly important role in supporting patient self-service and digital access across LLR primary care, which is demonstrated in the activity tables below.

LLR NHS App Utilisation:

2025/26: April 25 - March 26

	New Registrations	Logins	Repeat prescriptions	Appt Bookings	Appt Cancellations
NHS App LLR	70,287	12,660,396	1,424,794	60,530	44,148
NHS App City	29,458	3,136,765	278,790	16,698	10,123
NHS App Leicestershire	39,490	9,067,702	1,080,307	41,827	32,533
NHS App Rutland	2,032	455,292	65,697	2,005	1,512

2026 /27: April 26 - July 26

	New Registrations	Logins	Repeat prescriptions	Appt Bookings	Appt Cancellations
NHS App LLR	21,150	5,241,840	558,552	17,875	16,142
NHS App City	9,218	1,278,724	110,066	3,312	3,475
NHS App Leicestershire	11,380	3,763,468	420,529	13,503	12,113
NHS App Rutland	605	199,348	27,958	975	554

NHS App usage maintains a strong growth across LLR, with over 12.6 million logins recorded during 2025/26 and more than 5.2 million logins already recorded during the first four months of

2026/27. Prescription ordering remains one of the most popular features, with over 1.4 million prescriptions requested in 2025/26, rising further during 2026/27. Registration numbers remain strong, demonstrating continued patient adoption of digital services. The data demonstrates increasing use of digital routes alongside existing telephone and face-to-face access arrangements.

One particularly positive finding is that monthly logins increased from 865,495 in April 2025 to 1,297,346 by March 2026, representing an increase of almost 50% over the year. Prescription requests also rose from 104,007 to 140,810 over the same period, demonstrating growing patient trend on the NHS App for routine healthcare interactions.

Online Consultation:

Online Consultations (OLC) continue to be a key component of digital access across LLR, providing patients with a convenient route to contact their practice and access support online.

LLR OLC Activity

2025/26: April 25 - March 26

	Total Submission	Clinical Submissions	Admin Submissions
OLC LLR	1,108,320	769,423	337,507
OLC City	438,919	308,449	130,470
OLC Leicestershire	624,977	427,196	196,391
OLC Rutland	44,424	33,778	10,646

From October 2025, OLC monthly submissions more than doubled, with activity significantly increasing from September 2025. The major contributing factor for this upwards trend was the introduction of the GMS OLC requirement from 1st October; however it should also be noted that from October 2025, national reporting also included data from Rapid Health, which is not available prior to this date.

In March 2026, LLR recorded the highest monthly activity, with over 143,000 submissions.

2026/27: April 26 - July 26

	Total Submission	Clinical Submissions	Admin Submissions
OLC LLR	582,465	409,302	173,137
OLC City	225,810	157,271	65,539
OLC Leicestershire	337,215	237,380	99,809
OLC Rutland	18,440	14,651	3,789

For 2026/27, June 2026 saw the highest monthly activity with 159,962 submissions.

Online Consultation usage has shown substantial growth across LLR. During 2025/26, practices received over 1.1 million Online Consultations, with activity rising steadily throughout the year and peaking at 143,524 submissions in March 2026. This momentum has continued into 2026/27, with 582,465 submissions recorded between April and July, representing a 161% increase compared to the same period in the previous year.

Overall Patient Access via Digital Channels Continues to Scale Across LLR Primary Care, and these figures clearly demonstrate increasing digital adoption and patient engagement.

This growth reflects the success of ongoing digital transformation initiatives and highlights the increasing importance of self-service tools in supporting patient access, improving convenience, and helping primary care manage demand efficiently.

5.5 Pharmacy First

Community pharmacy continues to play an increasingly important role in improving access to urgent same-day care and reducing pressure on both General Practice and Emergency Departments.

Following the national expansion of the Pharmacy First service, community pharmacies across Leicester, Leicestershire and Rutland (LLR) have significantly increased referral activity, supporting the management of low-acuity urgent conditions throughout 2025/26.

Pharmacy First enables community pharmacists to assess and treat a range of common conditions through the provision of NHS-funded medicines and clinical advice. The service improves timely patient access to care, promotes self-management where appropriate, and releases valuable General Practice capacity for patients with more complex clinical needs.

Performance throughout 2025/26 reached record levels across LLR, with activity increasing by 24.3% compared with the previous year. This growth resulted in LLR being recognised nationally as the fastest-growing Integrated Care Board (ICB) for Pharmacy First referrals per 100,000 population during 2025/26.

This positive trajectory has continued into 2026/27. During Quarter 1, referrals increased by 45% compared with the same period in 2025/26, with 11,930 referrals compared to 8,227 during Q1 of the previous year.

To support continued service growth, internal referral targets were introduced for 2026/27 based on previous-year activity levels. Monthly targets were set at approximately 900 additional referrals above the equivalent period in 2025/26. Despite these being stretch targets, performance has exceeded target in every month of 2026/27 to date.

Q1 Performance

Month	April 2026	May 2026	June 2026
Actual Referrals	4,092	3,701	4,137
Daily Average	205	185	207
2025/26 Referrals	3,069	2,544	2,614
Increase vs Previous Year	1,023	1,157	1,523

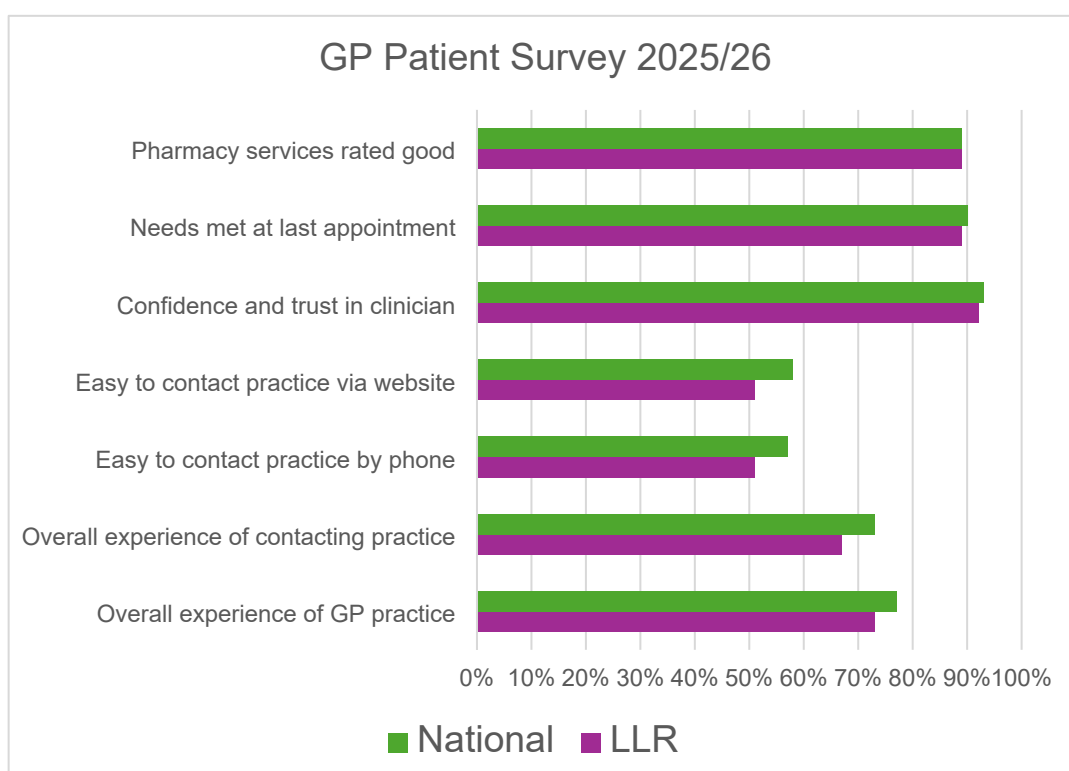
Target Referrals	3,969	3,444	3,514
Variance to Target	+123	+257	+623

The data demonstrates sustained growth in Pharmacy First utilisation across LLR, with referral volumes exceeding both previous-year performance and locally agreed targets. This reflects continued engagement from referring services, increasing public awareness of the service, and the valuable contribution community pharmacy makes to improving access to urgent care across the system.

6. GP Patient Experience

The 2026 GP Patient Survey shows that patients across LLR continue to report high levels of confidence and trust in healthcare professionals and positive experiences once they have accessed care. However, the survey also highlights continuing challenges relating to access and contacting practices, together with variation in patient experience across localities. These findings have informed the focus of the LLR Primary Care Access Recovery Plan, including improvements to telephone access, digital access, same-day access arrangements and targeted support where variation is identified.

Summary Findings

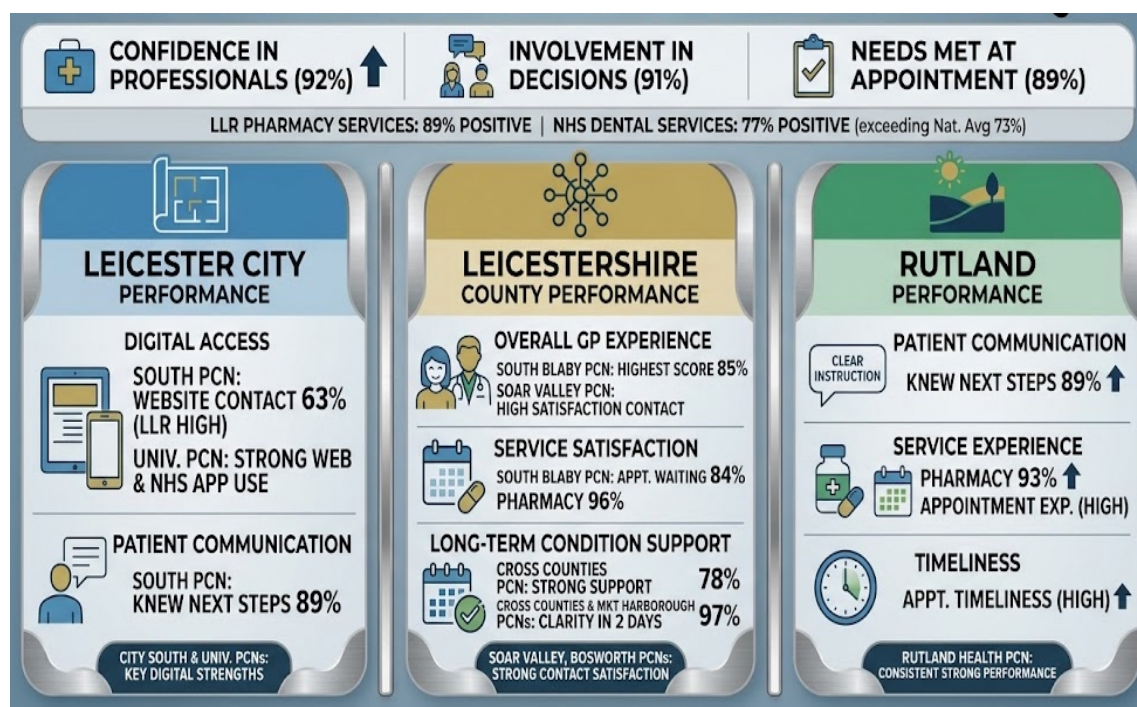


LLR Summary of GP Survey Results

Across LLR, patients reported high levels of confidence and trust in healthcare professionals (92%), involvement in decisions about their care and treatment (91%), and having their needs met during their last appointment (89%).

Additionally, 89% of respondents reported a positive experience of pharmacy services and 77% reported a positive experience of NHS dental services, exceeding the national average of 73%.

GP Patient Survey Results by Place:



Priorities for 2026/27 to improve patient experience.

The survey results point towards key priorities for the coming year:

- **Improve Access Across All Channels:** Focus on reducing barriers to telephone, website, and NHS App access, with particular attention to high-volume practices and areas with the greatest performance gaps.
- **Reduce Variation Between PCNs:** Develop targeted support for lower-performing areas while establishing mechanisms to spread learning from consistently high-performing PCNs.
- **Protect and Sustain High-Quality Clinical Experience:** Ensure work to improve access does not adversely affect consultation quality, patient confidence, or personalised care.
- **Strengthen System-Wide Learning:** Establish a structured approach to identifying, sharing, and implementing effective practice across PCNs, supported by peer learning, benchmarking, and continuous improvement methodology.

The 2026 GP Patient Survey presents a clear message for LLR. Patients continue to value the quality of care they receive from healthcare professionals, but difficulties accessing services continue to influence overall perceptions of general practice. The findings reinforce the importance of improving access and ease of contact as part of the wider work to improve patient experience.

The variation observed between PCNs presents both a challenge and an opportunity. By understanding the factors underpinning success in high-performing areas, providing targeted support to areas facing the greatest challenges, and maintaining the strong clinical experience already reported by patients, LLR can drive more consistent outcomes and narrow the gap with national performance during 2026/27.

7. Progress made During 2026/27

The ICB's approach to primary care access is moving from a focus on individual access initiatives towards a more structured and coordinated recovery approach.

The **Primary Care Access Recovery Plan 2026/27** brings together the actions being taken across primary care to improve timely access, patient experience, and consistency, while making best use of existing capacity.

The Recovery Plan recognises that access is not measured by appointment volumes alone. The ICB will therefore consider appointment activity alongside patient experience, timeliness of access, use of alternative access routes, workforce and digital capacity, quality and safety, and variation between practices, PCNs and places.

The approach for 2026/27 is focused on:

- improving timely access to appropriate primary care.
- making best use of existing appointment and workforce capacity.
- improving patient experience, including the ease of contacting practices and obtaining an appropriate appointment.
- reducing unwarranted variation in access and service delivery.
- strengthening care navigation and the use of appropriate alternative routes, including community pharmacy and multidisciplinary teams.
- maintaining access through both digital and non-digital routes, recognising that not all patients can or want to access services digitally; and
- identifying and addressing inequalities in access where local data and intelligence indicate a particular need.

The Recovery Plan therefore provides a framework for bringing these areas together, with progress monitored through a combination of activity, access, experience, quality, and variation measures. This will allow the ICB to identify where further support or action is required and to focus improvement activity proportionately.

8. Variation

There is variation in access and patient experience across practices, PCNs and localities.

Not all variation is necessarily a concern. Differences can reflect population need, geography, deprivation, workforce arrangements, and the way services have been configured locally.

The ICB's focus is on identifying **unwarranted variation** – where differences in access or patient experience cannot reasonably be explained by local circumstances and where improvement may therefore be possible.

Measure	Leicester City	Leicestershire	Rutland	LLR
Same-day appointments	44%	39%	34%	41%
Routine within 2 weeks	83%	75%	83%	78%
Face-to-face	72%	72%	61%	71%

Access improvement will continue to be considered alongside quality and safety. The ICB will use contractual information, quality intelligence, patient feedback, and local performance information to identify areas requiring further review. Where concerns are identified, the response will be proportionate and may include supportive improvement activity, peer learning, targeted review, or formal contractual processes where appropriate.

9. The ICB's Plan

The development of the **LNR Access Recovery Plan 2026-28** recognises that some groups may experience additional barriers to accessing General Practice. These can include barriers

associated with deprivation, rurality, disability, language, digital exclusion, and other population characteristics.

The ICB will use available data, patient insight, and local intelligence to identify where access may be poorer for particular communities and to inform targeted improvement activity.

The cluster-wide LNR Access Recovery Plan will provide a coordinated and consistent approach to improving access across the system. This plan will set out shared priorities, improvement trajectories, and opportunities for collaborative working across Primary Care, whilst recognising the differing needs of local populations. The cluster-wide plan is currently in development and will be shared with partners at a later date once finalised.

The intention is not to create separate access systems for different groups, but to ensure that access improvement takes account of local need and that additional support and resources are directed where barriers are greatest, helping to reduce inequalities and improve patient experience and outcomes across LNR.

10. LNR Access Recovery Plan 2026-28

The ICB Primary Care Access Recovery Plan provides the framework for the next phase of improvement.

Its overall aim is to ensure that patients receive the right care, from the right professional, at the right time and through the most appropriate route.

The Plan is organised around five strategic objectives:

- **Improve timely access.**
- **Improve patient experience and reduce unwarranted variation.**
- **Strengthen primary care through workforce, digital innovation and neighbourhood working.**
- **Strengthen governance, accountability, and continuous improvement.**
- **Improve access equity.**

For HOSC purposes, the main areas of practical delivery can be summarised as follows:

Area of focus	What this means in practice
Access and capacity	Making best use of Same-Day Access, Enhanced Access and practice capacity; improving demand and capacity management and care navigation.
Patient experience and variation	Using performance intelligence and patient feedback to identify variation and provide targeted improvement support.
Workforce and digital	Making effective use of the multidisciplinary workforce, digital access, and community pharmacy pathways.
Governance and assurance	Strengthening monitoring, contractual oversight and improvement processes.
Equity	Understanding barriers to access and ensuring improvement activity considers different population needs.

The Recovery Plan is intended to support improvement across the system while allowing individual areas and practices to respond to their own local circumstances.

A key principle of the Recovery Plan is that appointment activity should be considered alongside a broader range of access, experience, equity, and quality measures:

- patient experience and ease of access.
- timeliness of access.
- Same-Day Access utilisation.
- Enhanced Access utilisation.
- appropriate use of digital access.
- use of community pharmacy pathways.
- workforce indicators.
- continuity of care where clinically appropriate.
- variation between practices and PCNs; and inequalities in access.

Where possible, future reporting will show both the overall LLR position and relevant variation between Leicester City, Leicestershire, and Rutland.

This will enable the ICB to assess not only whether overall performance is improving, but whether improvements are being experienced consistently across local communities.

In implementing this plan, ICB will exercise its commissioning and contractual responsibilities where applicable.

11. Governance and Assurance

Delivery of the Access Recovery Plan will be overseen through established Primary Care Commissioning and Transformation governance arrangements.

Performance will be considered alongside:

- patient experience and ease of access.
- practice performance and activity information.
- contractual and quality information; and
- local intelligence and feedback.

Where concerns are identified, the ICB will seek to understand the underlying causes and determine the appropriate response. This may include benchmarking, peer learning, sharing of good practice, targeted improvement support and, where necessary, formal contractual or performance management processes.

The approach is intended to provide proportionate assurance that access is being actively monitored and that improvement action is targeted appropriately, while recognising that sustainable improvement needs to be delivered through practices, PCNs and local service arrangements.

12. Priorities for the Remainder of 2026/27

The focus for the remainder of 2026/27 will be to build on the access infrastructure already in place and demonstrate measurable improvement in how patients experience access.

The main priorities are:

- improving consistency of access across LLR.

- making effective use of Same-Day Access and Enhanced Access capacity.
- improving care navigation and the use of alternative access routes.
- reducing unwarranted variation between practices and PCNs.
- improving ease of contact and patient experience.
- supporting appropriate use of community pharmacy and the wider multidisciplinary workforce.
- developing digital access while maintaining suitable non-digital routes.
- identifying and addressing inequalities in access; and
- using performance information to target support and demonstrate improvement.

The next phase of the programme will therefore be focused on **improvement, consistency, and measurable improvement**, rather than simply creating additional access capacity.

13. Conclusion

LLR has developed a substantial range of primary care access arrangements and delivered significant levels of appointment activity during 2025/26 and the first part of 2026/27.

However, activity and capacity alone do not fully reflect patients' experience of accessing care. Patient feedback and variation between practices and localities demonstrate that further improvement is required.

The Primary Care Access Recovery Plan provides the framework for the next phase of improvement, with a focus on timely access, patient experience, unwarranted variation, equity, workforce, and effective use of existing capacity.

The GP Patient Survey demonstrates that while patients continue to value the quality of care provided by general practice, access and ease of contact remain areas where improvement is required. The actions described within this report are intended to respond directly to these findings and improve both operational performance and patient experience over time.

The ICB will continue to monitor activity, access, patient experience, quality, and local variation and use this intelligence to target improvement activity and provide assurance to partners and local communities.

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

5.1 Financial implications

Signed:
Dated:

5.2 Legal implications

There are no direct legal implications arising from this report.
Signed:
Dated:

5.3 Equalities implications

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Signed:
Dated:

5.4 Climate Emergency implications

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:

7. Summary of appendices:

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?

Impact of the proposed closure of local Healthwatch services across Leicester, Leicestershire and Rutland

Leicester, Leicestershire and Rutland Joint Health
Scrutiny Committee

Date of meeting: 28th September 2026

Lead Director/Officer: Harsha Kotecha Chair of
Healthwatch Leicester & Leicestershire
Alan Walters Chair of Healthwatch Rutland,

Useful information

■ Ward(s) affected: All

■ Report author: Tracey Allan-Jones Healthwatch Rutland Team Manager, Gemma Barrow Healthwatch Leicester & Leicestershire Team Manager

■ Author contact details: tracey.allanjones@healthwatchrutland.co.uk
gemma.b@healthwatchll.com

■ Report version number: version 1.0

1. Summary

1. This paper sets out the concerns of the three local Healthwatch organisations regarding Government proposals set out in the Health Bill 2026/27 that would result in the closure of Healthwatch services across Leicester, Leicestershire and Rutland (LLR). Healthwatch is the statutory, independent champion for people who use health and social care services. The proposed changes would remove the independent mechanism for gathering, representing and escalating the health and care experiences of patients, carers and communities.
2. The paper sets out its purpose, provides background and context on the Healthwatch role, outlines the risks associated with discontinuing Healthwatch provision, highlights the value Healthwatch delivers and presents recommendations for the Committee.

2. Recommended actions/decision

1. To note the statutory duties that would be compromised or lost.
2. To note the current operating model.
3. To note the national picture, including the current progress of Government proposals in the Health Bill 2026/27.
4. To note the implications of the proposed closure of Healthwatch services across Leicester, Leicestershire and Rutland.
5. To note the outline of the risks to patients, the public and the wider health and care system.
6. To note the evidence of the value and impact of Healthwatch in improving services and safeguarding patient voice.
7. Seek assurance that the Government will provide genuine opportunities for public engagement and coproduction in designing the new post-Healthwatch arrangements and the Patient Experience Directorate, including clarity on how independent scrutiny will be protected within any future framework.
8. Request clear and robust transition plans from the Integrated Care Board (ICB) and local authorities to safeguard the continued collection of independent patient voice and lived experience.
9. Recommend that the LLR ICB and local authorities collaboratively design and commission jointly funded Independent Patient Voice Services to replace statutory Healthwatch. A single, trusted and independent source of public insight, aligned

with Neighbourhood Models and accessible to all communities, will be essential to maintaining independence, reach and credibility.

10. Recognise that Healthwatch Leicester, Healthwatch Leicestershire and Healthwatch Rutland stand ready to work constructively with partners to help shape the new post-Healthwatch system. Our organisations bring deep expertise in patient voice, community engagement and independent scrutiny and we are committed to ensuring that any future model is genuinely accessible, inclusive and trusted by local people.

3. Scrutiny / stakeholder engagement

Healthwatch was established under the Health and Social Care Act 2012 to act as the independent consumer champion for health and social care.

Its statutory duties include:

- Gathering and representing the views of patients, carers and the public.
- Visiting services to observe care and speak with service users (“Enter and View”).
- Providing evidence-based recommendations to commissioners and providers.
- Escalating concerns to regulators, including CQC and NHS England.
- Supporting people to obtain clear information about services and to navigate them effectively.
- Ensuring diverse communities have a voice in shaping services.

Healthwatch is required to be independent, publicly accountable and accessible to all communities.

Between the 3 Healthwatch organisations in Leicester, Leicestershire and Rutland Healthwatch:

- Engages thousands of residents each year through surveys, outreach and community events.
- Provides insight reports that influence commissioning and service redesign.
- Works closely with Integrated Care System partners, local authorities, VCSE organisations and providers to bring patient experiences into decision-making.
- Provides a trusted route for people to raise concerns safely, anonymously if they wish and independently of service providers.
- Supports system transformation with patient experience insights at Health & Wellbeing Boards and subgroups, Primary Care Transformation Board, Mental Health Collaborative, System Quality Group, Safeguarding Board, Transferring Care Safely Group, Adults & Communities Overview & Scrutiny and Health Overview and Scrutiny committees.

Context

4. Detailed report

Proposed Changes

- At a national level, Healthwatch England functions will transfer to a new Directorate of Patient Experience within the Department of Health and Social Care.
- Local Healthwatch services across all local authority areas of England will close. The
- current statutory duties of Healthwatch in LLR will be transferred to the Integrated Care Board and local authorities. In practice, this would strip away the current independent mechanism for representing patient and public views.
- So far there is no clarity on how independent patient voice will be safeguarded during these major service changes.

Progress of the Health Bill through Parliament and next steps

1. The Bill was introduced on 14 May 2026, passed its Second Reading in June with the detailed Committee Stage concluding on 16 July 2026. In spite of repeated concerns raised by MPs about the loss of independent patient voice if Healthwatch is abolished, no Government amendments were tabled during the transit through the Commons.
2. During Commons consideration of the Bill at Report Stage on 7th & 8th September, the Minister for Secondary Care, Karin Smyth, stated that in passing the Bill into the House of Lords, the Government would 'review these provisions [on the abolition of Healthwatch] and ensure that our approach sufficiently empowers and devolves to local populations'.
3. The Bill was introduced in the Lords on 9th September and is scheduled for Second Reading on 13th October 2026, after which it will progress to Committee Stage for detailed scrutiny.

Parliament has not published an expected date for Royal Assent to bring the final Bill into law. However, the Department of Health and Social Care has indicated to local Healthwatch that it expects Royal Assent to be achieved in Spring 2027.

Healthwatch Engagement on proposals

- During 2025, the Local Healthwatch Working Together Group collaborated to challenge the Governments proposals with a national petition of 10,000+ signatures and an [open letter](#) to the then Secretary of State.
- During 2026 the group raised the issues in a letter to the new Prime Minister, Andy Burnham. This was followed up by a Parliamentary Briefing by local Healthwatch leaders on 7th September, the day before the final stage in the Commons.

Locally, Healthwatch has raised these matters with MPs, who have in turn shared our concerns with the Secretary of State for Health and Social Care to seek clarity on the planned changes and make the case to preserve independent patient voice.

Risks to patients and the public

The closure of local Healthwatch services would have several implications for patients, carers and communities across Leicester, Leicestershire and Rutland:

- The current independent route for people to share their experiences of health and social care would no longer exist.
- Opportunities for patient voice to inform decision-making may be reduced, particularly for people who are less likely to engage directly with statutory bodies.
- Vulnerable and marginalised groups, including older people, carers, disabled people and those experiencing health inequalities, may face additional barriers to being heard.
- People who are not digitally enabled may find it harder to provide feedback as systems move towards “digital-first” approaches as required by the [NHS 10 Year Health Plan](#)
- Many patients and service users are less likely to report concerns directly to the organisation providing their care. These risks reducing the visibility of issues that would otherwise be raised independently.

Risks to system accountability and quality

The removal of local Healthwatch would also affect how the Integrated Care System (ICS) identifies and responds to issues:

- The ICS and local authorities would lose an independent source of intelligence on patient experience, quality and access.
- Routine scrutiny currently provided through Healthwatch participation in system meetings and partnerships would no longer be available.
- Emerging safety or quality concerns identified through Healthwatch community engagement may be harder to detect at an early stage.
- The division of feedback mechanisms between NHS and local authority social care bodies may make it more difficult to understand experiences across whole care pathways, such as hospital discharge into community and home-based care.

Long-term insight and organisational memory held by Healthwatch on patient experience trends in LLR communities would be lost.

Loss of social Value

The closure of local Healthwatch will also result in a significant loss of social value currently generated across LLR including:

- Healthwatch has established trusted connections with communities and grassroots organisations that enable people to speak openly about their experiences in a way they may not feel able to with statutory bodies in the future.
- Healthwatch volunteers play a key role in engagement, Enter and View activity and reaching seldom-heard groups, contributions that would not be replicated within statutory structures.
- Loss of reach into marginalised communities. Healthwatch’s independence and community-based approach enables engagement with people who are

less likely to participate in formal consultations or engage directly with statutory services.

- The insight generated through Healthwatch continuous community engagement helps identify emerging issues early and supports preventative approaches. Without this independent intelligence, opportunities for early action may be reduced.

The Value of Local Healthwatch

The value of local Healthwatch organisations as a body are set out in detail in Appendix A which further describes the duties and funding mechanisms whilst highlighting the social value, community reach and system benefits that will be lost without local Healthwatch provision.

A recent, [nationally compiled report](#) highlights the collective impact and full breadth of the work of the Healthwatch network.

Closer to home, the value of Healthwatch achievements in LLR are demonstrated in our annual reports each year:

2023-24 The value of listening:

[Rutland](#)

[Leicester and Leicestershire](#)

2024-25 Unlocking the power of people driven care:

[Rutland](#)

[Leicester and Leicestershire](#)

2025-26 Speaking up for better care:

[Rutland](#)

[Leicester and Leicestershire](#)

Examples of the Impact of Local Healthwatch (Leicester, Leicestershire and Rutland)

Improving access to hospital care

Following our joint Enter & View visits to the Leicester Royal Infirmary Ophthalmology department, the hospital has made several improvements. These include increasing ophthalmology capacity, using SMS reminders and telephone calls to improve communication, reviewing signage for visually impaired patients, progressing an electronic calling system and improving patient comfort through refreshments, water provision, volunteer support and help with navigation while waiting.

Every woman's health matters

With support from the Women's Health Team, we have engaged more than 2,700 women and girls across LLR to understand their health priorities. Their experiences are helping shape local plans, including access to services, community-based clinics, specialist training and greater awareness of women's health issues. This work feeds into the LLR ICB Women and Girls' Health Programme, ensuring local insight informs future service development.

Strengthening support for people living in temporary accommodation

Healthwatch Leicester and Leicestershire (HWLL) gathered insight from people living in temporary accommodation in Leicester City and those experiencing homelessness, focusing on access to services and continuity of care. Our findings informed system discussions on safe discharge, GP registration and continuity of care. This group is now better reflected in local planning and service design conversations.

Shaping the local Dementia Strategy

HWLL and HWR together engaged people living with dementia and their carers to understand their experiences and priorities for support.

Our insight directly informed the Leicester, Leicestershire and Rutland Living Well with Dementia Strategy (2024–2028).

The strategy now better reflects real experiences of diagnosis, support and caring responsibilities. There is stronger emphasis on equitable and person-centred dementia care, including underserved communities.

Influencing suicide prevention and male mental health work

HWLL explored barriers to men accessing mental health support, including stigma and cultural factors, through community engagement.

- Our findings contributed to local suicide prevention priorities and partnership discussions.
- Partners have strengthened their focus on engaging men earlier and reducing stigma.

Improving information and guidance for self-funders of social care

Healthwatch Rutland (HWR) highlighted that self-funders of social care in Rutland often face their care journey feeling unprepared, unsupported and overwhelmed, with many describing confusion, emotional strain and a lack of clear, accessible guidance.

- The challenges faced by self-funders are now recognised and reflected in quality improvement planning and development of social care.
- Clearer information about choices and guidance on care and funding has been incorporated in the new, co-produced social care website.

Strengthening NHS communication and administration processes between services and with patients

HWR's exploration of Rutland residents' experiences of NHS communication and administration showed that poor coordination between services leaves people anxious, frustrated and, at times, unsafe. Many participants pointed to confusing appointment systems, delayed test results and unclear medication updates, demonstrating the urgent need for better joined-up working and clearer, more accessible information across the NHS in LLR.

- Digital systems development at UHL has brought in a new Patient Administration System to support the coordination of care and reduce duplication and error,

- The ICB and local GP practices have actively worked to increase awareness and use of the newer communication methods including call back functionality, online consultations and online prescription management.

Reaching and representing seldom-heard communities

Healthwatch in Leicester, Leicestershire and Rutland engage widely with communities less likely to be heard, including ethnic minority groups, LGBTQ+ people, members and families of the Armed Forces, people with disabilities, carers and those facing social exclusion.

- Thousands of experiences have been shared directly with decision makers, strengthening the local evidence base on health inequalities.
- Commissioners and providers are using our insight to inform service improvements and reduce inequalities.
- Our work continues to ensure that services are shaped by the people who use them, especially those most at risk of being overlooked.

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

5.1 Financial implications

Local Healthwatch is funded through local authorities.

The grant is funded through the Ministry of Housing, Communities and Local Government to local authorities to support the delivery of the local Healthwatch functions. The grant is provided for this purpose and is not discretionary general funding for local authorities. The funding therefore must be used to secure provision of local Healthwatch services in line with the County Council's statutory duties under the Health and Social Care Act 2012.

The current grant is funded until March 2027.

Signed: Tracey Allan-Jones

Dated: 15th August 2026

5.2 Legal implications

There are no direct legal implications arising from this report.

Signed: Tracey Allan-Jones

Dated: 15th August 2026

5.3 Equalities implications

There are no equality implications arising from the recommendations in this report.

Local Healthwatch work actively supports inclusion, community cohesion and reducing health inequalities across diverse communities.

Local Healthwatch is committed to promoting equality and welcomes diversity in all aspects of its service delivery. We operate in a diverse community, and our aim is to harness the talent within the community to help improve our service provision further. We understand

that our services have to be delivered in a different way to meet the legitimate needs of different communities. We operate an Equality and Diversity Policy in service delivery and employment.

Signed: Tracey Allan-Jones

Dated: 15th August 2026

5.4 Climate Emergency implications

None

Signed: Tracey Allan-Jones

Dated: 15th August 2026

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

None

6. Background information and other papers: Healthwatch Leicester and Leicestershire Annual Report 2025-26, Healthwatch Rutland Annual report 2-25-26

7. Summary of appendices: Appendix A – The Value of Local Healthwatch. This appendix demonstrates the value of local Healthwatch in representing independent community views. Influencing service improvement and promoting accountability across local health and care systems. The appendix outlines Healthwatch standards in maintaining independence whilst fulfilling statutory duties.

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)? No

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

Appendix A

The value of Local Healthwatch



healthwatch

About Local Healthwatch

Who We Are:

Local Healthwatch are champions for people using health and social care services. There are over 150 local Healthwatch across the country. We make sure NHS leaders and other decision makers listen to what people say and use that feedback to improve care. We also help the public find clear, reliable information and advice about health and care. Our goal is simple —to make health and care better for everyone.

What We Do:

- Support the public through advice and signposting.
- Gather real time insight into public needs, experiences, and concerns.
- Share public feedback and evidence based insights to improve planning, commissioning, and services.

Why We're Unique:

- **Community led:** We listen directly to local people and make sure their experiences shape the way services are designed and delivered.
- **Partnership Working:** We work closely with the NHS, local councils, and voluntary organisations to make joined up care a reality.
- **Insight driven:** Our recommendations are based on real stories and data from our community engagement and research.
- **Rooted in the community:** Local Healthwatch are locally informed, so we understand the unique challenges and strengths of our areas.
- **Voice for all:** We make sure everyone, especially those who are seldom heard, have a say in shaping health and care.
- **Connected and consistent:** We're part of a national Healthwatch network, giving local voices influence at both local and national levels.

Our Impact

- We identify inequalities in health and social care and highlight how to address them.
- We provide the Integrated Care System (ICS) with meaningful public feedback to shape better services.
- We strengthen accountability and transparency across health and care organisations.
- We help partners meet their statutory duties around public engagement and consultation.

Legislative Background

NHS Reorganisation Act

1974

- Created Community Health Councils (CHCs).
- Marked the beginning of independent statutory services.
- Set a 51-year precedent for public involvement.

1

Health & Social Care Act Changes

2001

- Introduced Patient and Public Independent Forums (PPIFs).
- Established Commission for Patient & Public Involvement in Health (CPPIH).
- Separated independent complaints services from PPI structure.

2

Local Government & Public Involvement in Health Act

2007

- Created Local Involvement Networks (LINKs).
- LINKs gathered views, influenced commissioning, and reported feedback.
- NHS complaints support outsourced to Carers Federation – costly and ineffective.

3

Health & Social Care Act

2012

- Replaced LINKs with Healthwatch.
- Healthwatch became the independent consumer champion for health and social care.
- Established Healthwatch England under the Care Quality Commission (CQC).
- Expanded statutory functions: enter and view services, represent local views, make recommendations, and support Independent NHS Complaints Advocacy

4

Organisational Background

Structure of Local Healthwatch

There are currently 153 local Healthwatch (LHW) in every area of England. They were introduced as part of the 2012 Health and Social Care Act.

Although some Healthwatch organisations are required to be social enterprises, there is no nationally mandated model for Local Healthwatch — creating a flexibility in terms of organisational arrangements.

Some local Healthwatch are jointly commissioned, with contracts and grants to deliver across two or more local authority areas.

- **Around 50% of LHW are individual 'free - standing' organisations** that solely or primarily deliver their Healthwatch contract. The other approximately 50% are what referred to as 'hosted' Healthwatch, where the contract is held by another named organisation that also delivers other things.
- **Of that 50% that are hosted**, around a third are hosted by an organisation that only holds that single Healthwatch contract. The other two - thirds of contracts are held by organisations that hold two or more Healthwatch contracts to deliver in different areas. A few examples of organisations that hold a larger number of contracts are The Advocacy People, People First Cumbria, or The Care Forum. Some local Healthwatch organisations have transitioned from being 'free - standing' organisations to establishing themselves as CICs, allowing them to deliver other work in their area.
- **Around 85% of local Healthwatch organisations receive additional funding** from Local Authorities, Integrated Care Boards (ICBs), Public Health, and third - party bodies to support activities beyond their statutory duties. However, the proportion of this additional funding varies widely. For many, it represents a relatively small share of their overall budget, while for a few, it exceeds 50% of their total funding.

The functional scope of each local Healthwatch is shaped by the specific demands of its area. According to King's College London's 2022 ethnographic study of local Healthwatch:

- **56.3%** of LHW engage with only one Clinical Commissioning Group.
- **82.3%** of LHW engage with only one Mental Health Trust.
- **62.5%** of LHW engage with only one Community Health Trust.
- **59.4%** of LHW engage with more than one Hospital Trust.

Funding Overview

Funding Sources

- 1. Local Reform and Community Voices Grant:** Department of Health & Social Care
- 2. Local Government Finance Settlement:** Ministry of Housing, Communities & Local Government

(Neither funding source is ringfenced, allocation is determined by local authorities)

- 3. Additional Funding Opportunities:** Local Healthwatch can also secure funding through commissioned work from Integrated Care Boards, Public Health, local authorities, and other third - party organisations.

(This funding can support work beyond statutory duties, provided it aligns with Healthwatch's remit and functions)

Funding Mechanism

Funding is distributed via the Adult Social Care Relative Needs Formula which supports local authorities in delivering the statutory functions of local Healthwatch, NHS Complaints Advocacy, and Deprivation of Liberty Safeguards.

Since 2014–15, Healthwatch England has tracked funding through annual surveys. Real-terms funding has declined by over £10 million since 2013 – 14.

- Healthwatch England is part of the Care Quality Commission (CQC), but local Healthwatch are independent.
- Local Healthwatch funding flows directly from the Department of Health & Social Care to local authorities.

Local Reform and Community Voices Grant Breakdown

- Deprivation of Liberty Safeguards in hospitals: £5.15 million
- Local Healthwatch funding: £14.15 million
- Independent complaints advisory services: £15.11 million

Key Considerations



Funding for local Healthwatch is small for the scope of its functions and support across England.



Healthwatch's extensive volunteer network enables outreach, data collection, public engagement, visits, and representation at no cost to taxpayer, all the while inputting a diverse range of perspectives.



Without local Healthwatch structures, thousands of hours of unpaid labour would be lost. This would increase the financial burden on other organisations that would need to replicate this work.

Core Duties of Local Healthwatch

The following duties are carried out by all local Healthwatch, either as part of their remit, or as part of their statutory functions as written in the Health and Social Care Act 2012.

Support the Public

- Help people find and access local services.
- Provide clear advice and information for informed care decisions.
- Offer accessibility support for people accessing GPs, dentists and appointments.
- Operate physical hubs and drop-in sessions for advice and support.

Listening & Engagement

- Community engagement in everyday spaces, such as foodbanks, churches, and community groups.
- Provide online and in-person feedback channels regarding health and social care.
- Attend community projects and forums.
- Co-produce services with the public and professionals.
- Liaise with voluntary organisations, local council boards (e.g. Health and Wellbeing Board), and other relevant groups regarding referrals, safeguarding, tackling health inequalities, and supporting individuals.

Advocacy & Complaints

- Support people and provide advice for individuals making complaints about health or care services.

Service Evaluation & Improvement

- 'Enter and View' visits are carried out in health and care settings such as care homes, GP practices, and hospitals. During these visits, Healthwatch staff and volunteers observe the quality of services and gather feedback from service users, their relatives, and carers about their experiences. The findings, along with any recommendations, are shared with service providers, regulators, and sometimes local authorities to improve these services.
- Publish reports by gathering public feedback themes and sharing them with commissioners and providers of care services and people responsible for managing or scrutinising local care services.
- Provide Healthwatch England with intelligence and insight, in order for it to run effectively.

Outreach & Awareness

- Run outreach and social media campaigns to gather feedback and local insight about health and care services.
- Inform and share through various platforms to the public about local health and social care information.

Additional Duties of Local Healthwatch

The following duties are not essential to the core delivery of local Healthwatch services. They are undertaken either due to specific local demands, variations in organisational structures, or differences in funding sources.

Advocacy & Complaints

- Provide independent NHS complaints advocacy (role is statutory, but provider of this service are determined by local authorities).
- Provide advocacy for people who may find it difficult to navigate services, e.g. due to a mental health condition (IMHA).

Service Evaluation & Improvement

- Independent service reviews for local public health or third - party organisations.
- Bespoke training for health and social care professionals.

Outreach & Awareness

- Create and share easy - to - understand public information guides.
- Host forums and multi - disciplinary teams, connecting and educating professionals across health and social care sector.

Examples of Commissioned Projects delivered across the Local Healthwatch Network

- Delivered non - clinical support to improve care and reduce attendances of high intensity users of emergency departments, as part of a cost - avoidance programme.
- Designed and implemented licensing frameworks enabling individuals in prison to access community dentistry services, improving health equity and continuity of care.
- Delivered system programmes to tackle health inequalities by gathering the lived - experience of young parents facing mental health challenges.
- Designed and delivered smoke - free campaigns in collaboration with public health and other organisations.
- Designed and delivered a hospital discharge project which informed resources like Pam's Story, the Move to Improve sheet, and the Working Together guide, helping patients stay active and involved in their care.
- Established Community Health Ambassador programmes which reach under - represented communities to share vital information, support innovative projects such as Safe Surgeries audit, and recruit a wide network of ambassadors.

The Value of Healthwatch



Advocacy & Support

- Mitigate concerns and reduce complaints by facilitating resolution meetings.
- Provide independent advocacy (not part of the Trust or commissioning bodies, like PALS).
- Support those unable to advocate for themselves or others.
- Offer exemplary success in NHS complaints advocacy.



Statutory Powers & Responsiveness

- Can request NHS responses within 20 days (often faster due to strong relationships) and can rapidly respond to identified issues.
- Use statutory powers to Enter & View health and care providers.



Navigation & Signposting

- Help people access the right care at the right time and place.
- Follow up to ensure successful referrals and outcomes.
- Focus on prevention by identifying unmet needs early and promoting timely access to care, improving public safety.



Community Engagement

- Deep engagement across communities to hear diverse voices.
- Outreach days in local areas to share knowledge and learn from services.
- Attend forums and events to strengthen collaboration.
- Meet social value standards by supporting vulnerable people, promoting sustainability, and helping providers deliver equitable, person - centred care across our communities.



Presence & Accessibility

- Weekly presence and drop - in support in public places across the community to support and signposts individuals.
- Work with Patient Participation Groups in GP practices.



Strategic Influence

- Represent public voice at: Health & Wellbeing Boards, Place Boards, Primary Care Boards, Mental Health Crisis Care Concordats, Quality Boards (Trusts & Local Authority), Safeguarding Boards, Transforming Care Boards, health overview groups and scrutiny committees.



Partnerships & Inclusion

- Strong relationships with health and care leaders, frontline staff, and groups within VCFSE.
- Champion the voice of unpaid carers.

Summary

Local Healthwatch supports all people.

Navigating health and social care is difficult; people sometimes need a little extra help. We are accessible with in - person, online, on the phone support, and we will go the extra mile to ensure that everyone gets help in the right place at the right time. Without our help and guidance, a large section of the community will be without their first point of contact in terms of finding the care that suits them.

Local Healthwatch are responsive and make changes happen.

Through our deep local knowledge, we deliver public feedback to better influence the planning, commissioning, and delivery of services. We take on new challenges, and our independence allows us to quickly pivot and be able to flex to local need.

We seek information and challenge assumptions.

It is vital that the voice of the public remains independent. Given our statutory roles, we have the unique ability to challenge bias, question decisions, and hold services accountable. Without local Healthwatch, decision makers might miss the real impact of their choices, and the health and care system could close lose vital transparency and accountability. - world

We bring services and community groups together.

We work service - to - service to ensure that professionals are informed about changes and support available. We offer training, host forums, attend community events, and directly engage with other services to help bridge the gap between services.

Powered by people who live, work and use services in their areas

Local Healthwatch staff teams and volunteers live, work and use local health and care services and the organisation buys local resources to support the local economy, as well as connecting and creating relationships with local groups.

Focus on prevention

Through signposting and support, we help connect individuals to the right care, at the right time, in the right place, improving access, safety, and wellbeing and addressing inequalities across our communities: all helping to relieve the burden on stretched services. Our goal is to empower people's choices today to prevent problems in the future.

Appendix B National Healthwatch Guidance (TAJ note AI sourced, not verified yet)

National expectations for local Healthwatch are set out by **Healthwatch England**, the **Department of Health and Social Care**, and the **Care Quality Commission**.

1. Independence

Local Healthwatch must be free from undue influence from commissioners or providers.

Source: Healthwatch England – Quality Framework (2020), Domain 1: Leadership & Governance

2. Accessibility and Inclusion

Healthwatch must engage with all communities, including seldom-heard groups, and ensure accessible routes for sharing experiences.

Source: Healthwatch England – “What We Do” and statutory guidance for local Healthwatch (2013)

3. Quality Framework

Healthwatch England's Quality Framework outlines standards for:

- Leadership and governance
- People and culture
- Insight and evidence
- Influencing and impact
- Sustainability

Source: Healthwatch England – Quality Framework (2020)

4. Statutory Compliance

Local authorities must commission a Healthwatch that can fulfil all statutory duties.

Source: Department of Health and Social Care – Local Healthwatch Regulations and Guidance (2012–2013)

5. Partnership Working

Healthwatch is expected to work collaboratively with ICSs, local authorities, VCSE partners, and regulators.

Source: Healthwatch England – “Working with Your ICS” guidance (2022)

6. Transparency

Healthwatch must publish reports, decisions, and financial information.

Source: Healthwatch England – Governance and Transparency Guidance (2018)

LLR JOINT HEALTH SCRUTINY COMMITTEE: 28 September 2026

Briefing note: Leadership and governance arrangements for University Hospitals of Leicester NHS Trust and University Hospitals of Northamptonshire

Purpose of report

This report provides an update for members on changes to the leadership and governance arrangements of University Hospitals of Leicester NHS Trust (UHL) and University Hospitals of Northamptonshire (UHN), which took effect from 14 August 2026.

Changes to governance and leadership arrangements

After two and a half years of working together under Group leadership arrangements, the UHL and UHN Boards agreed that our organisations need dedicated leadership and stronger local focus to accelerate improvements in patient care and meet the needs of the communities we serve.

This means UHL and UHN are no longer operating through a shared Group leadership and governance structure. Instead, each organisation will have its own Board, Chair, Chief Executive and executive team.

Members can be assured there are no changes to the services patients receive or where they receive their care. Day-to-day services and patient pathways will continue as normal.

As a result of the changes, some leadership roles changed at UHL from 14 August:

- Dr Andy Haynes, former UHL Vice Chair, is now the Acting Chair of UHL.
- Richard Mitchell, currently Group Chief Executive, will remain Chief Executive of UHL. Richard will continue as Chief Executive and Accountable Officer for UHN until 27 September, after which he returns to UHL full-time.
- Julie Hogg, Group Chief Nurse, and Will Monaghan, Group Chief Digital Information Officer, will shortly be returning full-time to UHL.
- Andrew Moore, former Group Chair, is now the Chair of UHN.

We are engaging with a small number of colleagues who were working in Group roles to agree next steps for them individually. The majority of staff at UHL and UHN are unaffected by the changes.

Ongoing partnership working

UHL and UHN have worked closely together to address shared challenges, strengthen services and support improvement. This collaboration has delivered benefits in areas

including digital transformation, research, education and clinical leadership, and has strengthened relationships between teams across both organisations.

UHL and UHN will continue to work together where collaboration supports better care, stronger services, shared learning and improved outcomes for local people. The areas for shared working are being overseen by a transition steering group and more information on the areas for continued collaboration will be confirmed in due course.

UHL remains committed to working closely with local partners, colleagues and communities in Leicester, Leicestershire and Rutland to improve care, tackle health inequalities and deliver sustainable services that meet the needs of local people now and in the future.

Further information

Should members have questions, feedback or require any further information, we would be happy to arrange a conversation or more detailed briefing. Please contact Emma Casteleijn, Director of Communications and Engagement in the first instance:

emma.casteleijn@nhs.net

Richard Mitchell

Chief Executive

University Hospitals of Leicester NHS Trust

richard.mitchell2@nhs.net

Leicester, Leicestershire and Rutland Joint Health Scrutiny
Work Programme 2026-27

Date of Meeting	Agenda Items	Organisation Responsible	Notes
Monday 28 September 2026	GP Access Healthwatch Risk update LLR/LNR written update (information only)	ICB	Results, data and progress from GP Patient Surveys
Thursday 26 November 2026	CAMHS Maternity Provision	LPT ICB/UHL	Update on progress since St Marys Closure/National update
Monday 22 February 2027	Winter pressures update	ICB/UHL	

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Topic	Detail	Date
ICB Highlight sheet of data	Members requested more data to be scrutinised focusing on the ICB and statistics.	
GP Access		June 2026
System approach to stroke		
CAHMS		
NHS work to tackle isolation – i.e. the social prescribing model across LLR and its effectiveness in directing patients/public to services. Access to healthcare.		
Over Seas Doctors Training Scheme	Are there are any similar contracts within LLR and what they are doing to check all similar contractual arrangements within LLR	
Maternity Provision	Members requested further updates on maternity provision, birth choices and postnatal services Young new mums support	

Speech and Language Therapy Service in Leicester, Leicestershire and Rutland	The item would return to Scrutiny with relevant stakeholders invited	
Fertility		
Men's mental health		

