Leicester
City Council

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

Held: TUESDAY, 9 SEPTEMBER 2025 at 5:30 pm

P R E S E N T:

Councillor Pickering - Chair

Councillor Haq	Councillor March
Councillor Orton	Councillor Sahu

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150. WELCOME AND APOLOGIES FOR ABSENCE

The Chair welcomed everyone to the meeting and led on introductions. Apologies had been received from Councillor Singh Johal and Councillor Westley, with Councillor Orton attending as substitute for Councillor Westley.

151. DECLARATIONS OF INTERESTS

There were no declarations of interest made.

152. MINUTES OF THE PREVIOUS MEETING

The minutes of the Public Health and Health Integration Scrutiny Commission held 8th July 2025, were confirmed as a correct record.

153. CHAIRS ANNOUNCEMENTS

The Chair advised the Commission that Blood Centres across the East Midlands had issued an urgent appeal for more donors, due to missed and cancelled appointments over the summer holidays.

154. QUESTIONS, REPRESENTATIONS AND STATEMENTS OF CASE

It was noted that none had been received.

155. PETITIONS

It was noted that none had been received.

156. RESTRUCTURING UPDATES - ICB & NHS ENGLAND

The Chief Strategy officer for the Leicester, Leicestershire and Rutland Integrated Care Board submitted a report to update the commission on national reform of the NHS operating model across England which will involve the integration of the Department of Health and Social Care and NHS England, and a changed role for ICBs.

It was noted that:

- Dr Sanganee provided a brief update on the presentation slides and the reconfiguration process, including the clustering arrangements with Northamptonshire to form the LNR.
- LLR and Northamptonshire ICBs remain separate statutory bodies. Working in partnership, however over time they would work as one cluster with
  - Single Board Governance
  - Unified Leadership Team
  - Shared staffing structure
- Building a transformational cluster between NICB and LLR ICBs provided the opportunity to drive forward the Ten-Year Plan within communities and neighbourhoods, to continue improving health outcomes, while at the same time rising to the very real financial challenges faced
- It was reported that the 10-year health plan had been launched, alongside structural changes within NHS England, with ICBs required to reduce their running costs by 50%. This would have significant impacts nationally.
- The clustering process was explained as not being a merger, but separate bodies working in partnership under a single board governance structure. Progress was continuing at this stage.
- Nationally, chair arrangements had been announced. For the LNR cluster, Anu Singh (former chair in the Black Country) had been appointed, and Toby Sanders, Chief Executive, would be the Chief Executive across the cluster. Further national announcements were still awaited.
- Reference was made to the model ICB blueprint and running cost requirements, noting that Northamptonshire was already implementing these changes.
- The Leicester, Leicestershire and Rutland ICB replaced the Leicester City, East Leicestershire and Rutland and West Leicestershire clinical commissioning groups. The ICB manages the budget for the provision of NHS services in LLR
- The commission cycle was described as something already in practice, supporting stronger organisations through reductions in operational work.
- The focus remained on the health and wellbeing of the population, delivering high-quality care, reducing waiting times and improving patient experience.
- Partnership working with organisations and community leaders was

ongoing, and the role of local authority colleagues was highlighted as increasingly important.
- The cluster design and functions were outlined as a developing process, with an emphasis on keeping partners informed.

In discussions with Members and Youth Representatives, it was noted:

- Members raised concerns that documents presented to the commission in March had been out of date.
- It was confirmed that Paula Clark remained ICB Chair until 1 October when Anu Singh would take over a new Chair.
- Concerns were raised around the complexity of the new structure, the lack of visibility of leaders attending Scrutiny Commission Meetings and how accountability would be maintained across Leicester, Leicestershire and Northamptonshire.
- Concerns were expressed that the reports provided contained little information about Northamptonshire, and it was questioned how accountability would be ensured.
- Members acknowledged the challenges for staff and suggested it would be helpful for the new Chief Executive and Chair to attend scrutiny in future
- It was explained that both ICBs would remain statutory organisations with accountability through health overview and scrutiny, supported by a joint leadership team working across the LNR footprint.
- Job losses were expected to be around a third, though exact figures were still subject to national negotiations.
- Assurances were given that access and quality of care would remain the same, with further updates to follow as the national process developed.
- Discussion took place on who the new structure would ultimately be accountable to. It was confirmed that accountability would remain dual, with scrutiny continuing in both LLR and Northamptonshire.
- It was noted that under the national ICB blueprint, some functions would be transferred to providers, local authorities or other partners. This was still being worked through nationally and locally, with assurances that any transfers would be carried out safely, with engagement and without adverse impact on partners. Engagement with scrutiny would continue and updates would be provided.
- Concerns were expressed that some changes had already been identified without wider awareness, and members requested early sight of such developments. It was clarified that organisational functions and commissioning decisions were distinct. Commissioning decisions would continue to be taken in partnership and subject to equity and quality impact assessments, with input from public health colleagues.
- It was confirmed that preventing miscommunication between sectors was a high priority. Work was underway to improve interface working between GPs, hospitals and specialists, strengthen handovers, and integrate services around primary care and communities through the neighbourhood model. Communication with patients and the public was also being strengthened.

- Members highlighted the importance of community leadership in shaping services. It was reported that strong relationships already existed with community teams and leaders, and more work would be undertaken to allow services to develop locally. Patient and citizen voices were identified as central to future service design.
- Concerns were raised about the role of GPs as coordinators of services given reliance on locums and high staff turnover. It was confirmed that primary care networks would be fundamental building blocks of neighbourhood teams. In some areas GPs would lead, while in others community services would do so. Mapping work was being carried out to align GP, community, local authority and voluntary sector services.
- Clarification was sought on the appointment of a new Chief Executive. It was explained that national guidance was being followed and the update was the most accurate available. Once confirmation was received, positions would be announced and new leaders would engage directly with scrutiny. Interim arrangements remained complex, with leadership currently working across two patches.
- Members questioned how prevention, neighbourhood working and high-quality care could be delivered with reduced budgets and frozen posts. It was explained that the changes reflected the national agenda and the 10-year health plan. While impacts would not be immediate, the intention was to reduce duplication, particularly between NHS England and ICBs, and to streamline governance. The principles of accessible, local and high-quality care remained central, though commissioning and governance processes would evolve.
- The NHS acute trust league table was discussed following the publication of a new national oversight framework. It was reported that the local trust had been placed in segment 3, reflecting its financial deficit but also recognising improvements in patient experience, quality and financial governance. The trust had exited the recovery support programme, showing progress compared to three or four years ago, though further improvement was required. The framework was acknowledged as complex, but the results reflected both challenges and areas of positive progress.

AGREED:

1. That the report be noted.
2. That acute trust performance would be brought back to a future meeting for further scrutiny
3. For the new Chief Executive and the new Chair of the LNR to attend the next meeting.
4. The structure of the LNR be added to the work programme.

157. WINTER PROTECTION

The Chief Medical Officer introduced the item. It was noted that:

- The winter plan was developed annually.

- There were urgent emergency care challenges throughout the year, with increased challenges over winter, due to respiratory viruses and seasonal pressures.

The LLR ICB Head of Emergency Care gave an overview of the planning process and detailed the steps in place to ensure correct intervention levels were in established. Key points to note were as follows:

- NHS England had adopted a different approach when asking ICB's to develop their winter plans, with an increased emphasis on detail and mandated content.
- All ICB's develop Winter Plans, which were tailored to meet their particular area requirements.
- Plans must include the Health and Care position on surge and super surge. (Suge being increased activity owing to flu, COVID or RSV and Super Surge pertaining to a combination of respiratory challenges.)
- Workforce deficit planning was vital to allow for winter illness and infection outbreaks.
- NHS England mandated planning timelines.
- Regional stress testing events enabled further planning consideration.
- The NHS currently developed its own plans. The LPT plan had been to board that week, while the UHL plan was scheduled at their board at the end of the week.
- Engagement was ongoing with a variety of working groups.
- The vaccination plan was a key focus for the upcoming winter, covering Covid 19, Flu & respiratory vaccines, targets were in place.
- Key prioritised groups included pregnant women, young children, school age children, older adults, those with existing health issues and staff.
- The approach consisted of two key components:
    - Ensuring accessible access to vaccination services.
    - Increasing awareness among key groups.
- GPs surgeries would continue to provide the core offer, with community pharmacies also providing the service. Mobile vaccination units would be in place 3 days a week throughout the winter.
- This year the vaccine offer would be extended to children aged two to three years.
- A community sites pilot had been initiated to address the low vaccine uptake in pregnant women.
- Every care home across LLR would be included in the vaccine programme.
- Those discharged from Care Homes would be eligible for vaccination, through agreed arrangements with LPT and UHL acute providers.
- The parental consent process was to be made more accessible to increase children's vaccine uptake during the course of the school day.
- Vaccine awareness promotions would include national invites, GP recall, voluntary sector work with key groups and promotion of the vaccine hub website.

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

- Leicester childhood vaccine uptake was below half the national average. Improvement efforts were ongoing, particularly in identified concerning areas.
- Engagement work included the school age immunisation link nurses.
- Improvements to the childhood vaccine consent process would enable better liaison with parents. An HPV vaccine pilot had shown early evidence of improved consent rates.
- The school age immunisation service provider was Leicestershire Partnership Trust.
- Member support and promotion within the communities was welcomed.
- The National Covid Fund enabled the vaccine buses. There had been a 69% funding reduction, and numbers of clinics would be halved. Targeted resourcing continued.
- Funding of Super Vaccinators continued for areas with notably low uptake.
- Services currently remained commissioned by NHS England, but it was hoped that when delegation occurred there could be more efficient use of funding.
- There was a clear emphasis on working with local communities to raise vaccine awareness.
- Vaccine uptake improvement targets included the:
    - 5% improvement for staff Flu vaccine.
    - 3% improvement for 2-3 year olds.
- Childhood immunisation statistics could be shared which showed an improvement for the city.
- Numbers would be shared on website traffic, success with vaccine site was noted and a QR code was available.
- Funding for outreach services was designed for short-term purposes and it was not yet known how much would be allocated in the next financial period. There had been a 69% reduction in outreach funding, which was created in response to COVID. Bidding was in place to secure short term-funding.
- The majority of the funding was long-term and in budget.
- Historically health data had been analysed across LLR but was now more focused on local priorities.
- Services remained stretched and risk of critical incidents remained, due to increased hospital admissions and primary care. Patient waiting times were still excessive and a hard winter could take a toll.
- Community engagement was vital to mitigate public vaccination concerns.
- A communications toolkit was distributed widely and could be issued to the committee.
- Paediatric staff worked solely with children and children's KPI's were in place to enable priority.
- Vaccinations didn't always require a pre-booking and there was a roving health care unit.
- Primary Care Networks received funding for enhanced access.
- Injectable antibiotics could be administered by community teams and pharmacies to reduce the strain on GPs and hospitals.
- A range of consultation options were available and could be tailored to patient's needs, these included telephone, online and AI contact.

- Campaigns were in place to promote mental health support and signpost to help.
- There were an increased number of dental appointments available. Dental practices self-managed triaging.
- Winter planning had not reduced but there was a tougher financial environment. Funding from NHS England for Primary Care was less likely to be available this year. Resource management was a key focus.
- New initiatives had come in to reduce ambulance waiting times.
- There was a focus on access points for early intervention to ease the strain on hospital admissions.
- There was not a freeze in place in hospital bank staff.
- LLR had one of the highest utilisations of pharmacies and work was ongoing to meet with capacity. LLR had around 200 community pharmacies, around 100 of these were within Leicester. All but 2 of the Leicester pharmacies were signed up to the Pharmacy First Scheme.
- There were around 88k planned Pharmacy First consultations with around 86k being delivered across LLR last year. Data showed a delivery of 8-10k for the first quarter of this year which was in line with targets.

AGREED:

1. The Commission notes the report.
2. Childhood immunisation statistics would be shared with the committee.
3. Statistics on website traffic would be shared with the committee.
4. The Communications Toolkit would be distributed to the committee.

158. GP ACCESS

Leicester, Leicestershire and Rutland ICB Deputy Chief Operating Officer for Integration and Transformation presented the report.

The LLR ICB wanted to create a service that was easier to use, fairer for everyone, and made the best use of NHS resources. That meant:

- A simpler system where people would only need to remember two main contact points: their GP practice and NHS 111
- A consistent offer across the city, including evening and weekend GP appointments
- Reducing unnecessary steps so people would spend less time navigating the system and more time getting the care they need

It was noted that:

- The main focus moving into 2026/27 would be on meaningful engagement rather than lengthy discussions.
- Access to care could be simplified into two steps. The first step encouraged residents to consider self-care options such as the NHS App, the NHS website, 111 online or local pharmacies before seeking

appointments. The second step involved contacting GP practices or calling NHS 111 to ensure the right care was accessed in the right place.

- It was highlighted that traditional literature was often ineffective as many residents did not read leaflets. Instead, investment had been made to commission VCSE organisations to deliver targeted engagement work. Surveys were planned across the city, county and Rutland, with the Leicester survey including questions on same day access appointments. Messaging would be targeted at specific groups including families with children under 10, young professionals, homeless people, refugees, and other groups facing barriers to healthcare.
- The programme in Leicester was funded to provide practical support through VCSE groups, with materials such as business cards and reference guides designed to be accessible in community settings. The approach would focus on real-life options, self-care, and engagement by people already embedded in communities. Work was also underway with PCNs and local authorities to ensure consistent messaging. The same day access model was due to go live in October 2025.
- Further detail was provided on the commissioning of approximately 20 VCSE organisations to deliver services. These groups represented the diversity of the city and had received training to tailor messages to their own communities. The emphasis was on teaching people to support others and raising awareness of what the NHS is, beyond hospitals, in multiple languages.
- Outreach activity was being delivered across areas such as Belgrave, Spinney Hills and Braunstone, and through collaboration with GPs, pharmacies, community groups and local initiatives including sports clubs, gospel groups and neighbourhood hubs. Work was also taking place with LPT mental health neighbourhood leads to support access to NHS services, including mental health care.
- Partnerships extended to Leicester City Council, housing, adult education and ESOL teams, with basic first aid training delivered jointly. Engagement also included universities, schools, wardens in halls of residence, supermarkets and shopping centres. Translation services were available to reduce language barriers.
- Feedback was being gathered through community channels, with findings independently evaluated to ensure accurate reflection of community needs and experiences.

In response to member discussions, it was noted that:

- It was confirmed that feedback from patients and clinicians had shown some required longer than the standard ten-minute appointment. Same day access would therefore include GP-led appointments, with PCNs linked across ten hubs. Pharmacy First had supported longer appointments, particularly in evenings and weekends. It was explained that same day appointments after 6pm would be with a GP if required.
- Members queried the targeting of specific population groups and raised concerns about whether white men over 40, who are at high risk of suicide, and elderly residents were sufficiently included. It was explained

that the targeted groups were identified from A&E attendances and reflected those most likely to face barriers to care, while the whole population would still be included. Elderly people and those with long-term conditions would move directly into step two of the model, with step one designed for generally healthy individuals. It was noted that suicide prevention work could also be incorporated.

- Members highlighted that engagement of this kind could be very effective and asked what metrics would be used to measure success. It was explained that behaviour change took time, but metrics would include GP attendances and A&E activity. Success would be demonstrated by reductions in inappropriate A&E attendances, with the programme starting in September to provide early impact ahead of winter pressures.
- Clarification was sought on the use of terms such as “GP led,” “GP access” and “GP appointments.” It was explained that general practice had changed significantly since 2017, with PCNs expanding the workforce to include advanced nurse practitioners, mental health practitioners and other professionals. Access would depend on patient need, with GP input provided for cases where other healthcare staff could not meet the requirement.
- Members requested data on the overall number of GP appointments for 2024/25 and 2025/26. It was confirmed that historically hubs had been commissioned to provide same day appointments and that data would be brought to the next meeting, including the impact of longer GP-led appointments during evenings and weekends.
- Members welcomed the focus on simplicity and online access. It was noted that national work was ongoing to ensure NHS sources appeared first in search results, with further community education to be provided.
- It was confirmed that five-minute extensions to appointments would be treated separately from GP appointments. Patients contacting their practice during the day would be triaged and offered a same day evening appointment where necessary. Standard ten-minute appointments with other healthcare professionals would continue, with GP appointments available for those unable to wait. Training would include the importance of recording additional information.
- Members asked when the changes would begin. It was confirmed that a questionnaire would be launched on 10 September with supporting engagement events, and changes to GP access in the city would commence on 1 October. Feedback would be collated and used to refine the model.
- Members welcomed the increased promotion of the NHS App and asked whether doctors would use its features. It was confirmed that training was being provided to encourage this and that many patients were unaware of how to enable notifications.

Agreed:

1. That the Commission note the report.
2. That GP appointments would be an agenda item at the nest meeting.

159. NHS APP AND DIGITAL INCLUSION

The Group Director of Strategy and Partnerships gave an overview and presentation on the NHS App and Digital Inclusion initiatives. Key points to note were as follows:

- Some surgeries currently had more functions available, this was dependent on capacity and IT capability.
- Referrals and hospital appointments could now be viewed on the app, but dialogue functionality was not present.
- The app sourced information from multiple systems.
- Additional features enabling collaborative efforts were upcoming, pending national funding outcome.
- Connecting the app to the LLR care record opened up more options for patient care, such as patient follow ups.
- The plan was to introduce a two-way interaction, with patients contributing to their care plans.
- Benefits to the environment where anticipated due to the app reducing travel requirements.
- The more efficient ways of working would improve productivity.
- There was a focus on building digital inclusion amongst the 60 LLR hubs.

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

- The App would help to reduce missed appointments with notification reminders and rescheduling functionality.
- The aim was for the app to become the ‘front door’ for all NHS services for those wanting electronic access.
- Functions for carers were upcoming.
- Two-way messaging would feature on the app in the future. Current services having text-based chat included school nurses, health care visitors and mental health crises services. Sexual Health chat health was in trial.
- Other areas had received development funding but there were no indications that LLR was disadvantaged in the roll out of funding.
- GP appointment capacity would need to be managed efficiently.
- Digital literacy support could be built into the programme.
- The General GP contract was expected for implementation in 2026 and would establish national standards.
- Work was ongoing in the area of patient initiated follow up.
- Members surmised that the digital offer freed up resources for those not utilising digital services.
- Prescription control would improve with the app.

AGREED:

The Commission notes the report.

160. WORK PROGRAMME

The Chair invited Members to make suggestions. The following were noted:

- A visit to the A&E department
- Ambulance wait times
- NHS England Vaccination data

161. ANY OTHER URGENT BUSINESS

With there being no further business, the meeting closed at 8.33pm.