



Leicester
City Council

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

Held: MONDAY, 23 FEBRUARY 2026 at 10.00am

P R E S E N T :

Councillor Pickering - Chair
Councillor Hill – Vice Chair

Cllr Agath
Cllr Dr Bloxham
Cllr Durrani
Cllr Haq
Cllr King
Cllr Poland
Cllr Sahu

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72. APOLOGIES FOR ABSENCE

Apologies were received from Cllr Harvey and Cllr Stephenson.

73. DECLARATIONS OF INTEREST

Cllr Poland declared he works for the MP for Melton and Syston who has been very active opposing the closure of the St Marys Birth Centre.

74. MINUTES OF THE PREVIOUS MEETING

The minutes of the previous meeting held on 27th November 2025, were confirmed as a correct record.

75. CHAIRS ANNOUNCEMENTS

The Chair noted that an additional meeting has been scheduled for 30th April 2026.

76. PETITIONS

It was noted that none had been received.

77. QUESTIONS, REPRESENTATIONS AND STATEMENTS OF CASE

The Monitoring Officer reported that sixteen questions had been received:

Godfrey Jennings asked:

1. What is the JHOSC's view of University Hospitals of Leicester NHS Trust's and Leicestershire Partnership NHS Trust's adoption of Palantir's Federated Data Platform, taking into consideration that international human rights proponents Amnesty International have urged all public bodies to end any contracts with Palantir?
2. Could I request the briefing in development for Trusts due to be released early March is published alongside the minutes for this meeting?
3. Does the committee agree that it is the responsibility of UHL and LPT to put in place a robust plan to consult the communities within LLR and to undertake a cost-effectiveness analysis, comparing Palantir's products with alternative products and providers, bearing in mind Trusts elsewhere have found their locally produced solutions to be far superior than what the Federated Data Platform is offering and have thus declined to adopt the FDP. Can the committee also confirm that these NHS trusts retain the discretion to act in accordance with the respective outcomes, irrespective of any supposed "mandate" from the Department of Health and Social Care, as confirmed by the FDP Regional Delivery Manager in FOI requests, and that the risk of proceeding without community trust would be catastrophic, considering around 50% of people have indicated in YouGov polling that, given the choice, they would opt out of such services, which would only entrench inequalities in health service planning?

Health Partners responded:

For guidance the following is NHS England statement on Palantir Data is a core part of how the NHS delivers care, it's at the heart of transforming services and improving outcomes for patients; using it well saves lives. The NHS Federated Data Platform will transform operational efficiency across local, regional and national NHS services, connecting critical data in real-time to accelerate diagnosis pathways, streamline discharge processes, and ensure faster, more coordinated care that reduces waiting times for all patients.

NHS England ran an independent and transparent procurement exercise in line with public contract regulations. The choice of preferred supplier was not made by a single person, it was the result of assessment by many different individuals. A consortium, led by Palantir, was awarded the

contract to deliver the NHS Federated Data Platform in November 2023.

NHS England has a duty to treat all suppliers the same regardless of the public perception of any organisation, or the opinions held by any of their shareholders. NHS England cannot exclude any supplier that is lawfully established and able to bid from participating in the procurement. We are confident that our procurement process did not enable any supplier that does not meet our strict standard selection criteria (which includes mandatory and discretionary exclusions relating to illegal activity, social and environmental breaches) and robust Information Governance requirements to continue through the process.

NHS England takes seriously its responsibility to handle health and care data lawfully, proportionately, ethically and in confidence. Privacy by design is a core principle of the NHS Federated Data Platform. We prioritise data protection from the outset and have implemented robust security measures to safeguard patient information. Access to data must have an explicit aim to benefit patients and/or the NHS in England.

Access to NHS health and social care data within the NHS Federated Data Platforms will be carefully controlled. Only authorised users will be granted access to data for approved purposes. The contract has strict stipulations about confidentiality, and there is governance in place to monitor delivery and usage of the NHS FDP. Palantir only operate under the instruction of the NHS when processing data on the platform. Palantir do not control the data in the platform, nor are they permitted to access, use or share it for their own purposes.

The NHS exists to provide healthcare that is free at the point of use for everyone who needs it. This mission transcends politics, geography, and ideology. We will continue to make procurement decisions based on what best serves patients and the NHS mission, guided by professional expertise and proper process. This approach has served the NHS well throughout its history and will continue to guide us as we work to build an NHS fit for the future.

Nationally, the Federated Data Platform is helping to join-up patient care, increase hospital productivity, speed up cancer diagnosis and ensure thousands of additional patients can be treated each month. The platform is now being used by over 150 NHS organisations across England, with another 57 signed up to implement it in the next few months.

Information from UHL

Our commitment to equality, diversity and inclusion remains unwavering. These aren't just words in our strategies - they're fundamental to how we serve our diverse communities across Leicester, Leicestershire and Rutland. We recognise the critical importance of maintaining trust with all our communities, particularly those who face the greatest health inequalities.

The selection of Palantir as the technology partner for the FDP was a decision taken at national level by NHS England, following a robust procurement process. This wasn't a local decision by UHL. Given NHS England's commitment to this contract and the mandate for all trusts to implement the FDP, UHL will be working within this framework whilst ensuring we maintain the highest standards of information governance, data protection and ethical practice in how we use the platform locally. We will continue to be transparent about how patient data is used and protected and ensure all uses align with our values and commitment to our communities.

Anna Pollard asked:

1. The case for the closure of St. Mary's seems to be predicated in part on low birth numbers. Can you confirm why you have not taken into consideration the numbers using the postnatal ward which are much higher, with many women transferring in for excellent postnatal care from around the Trust area, and what exploration has been done into the possibility of retaining the postnatal ward in the event the birthing services are permanently removed?

Health partners responded:

Sustained low birth numbers are indeed a key concern with regard to St Mary's being far below clinical safety recommendations and being one of the key reasons behind the ongoing discussions regarding the centre's future.

The subject of postnatal care has been one raised throughout the engagement period and we thank everyone for their observations and points made in this regard. Engagement sessions with mothers and staff have been attended by senior leaders within the ICB including the Chief Nursing Officer so these points can be considered and taken into account.

All of these comments and opinions will be part of the final recommendations to be made to the ICB Board meeting so please be reassured that they will be fully taken into account.

Cllr Helen Cliff asked:

1. Regarding safety, recently, a Melton resident who lives walking distance from St. Mary's Birth Centre, had an unattended birth due to the home birth team being too far away to get to her in time, which resulted in an ambulance being needed to transfer them both to hospital afterwards. Another resident, who feared not getting to a Leicester hospital in time from Melton, chose to relocate to her parents' house to be closer to the city when the time came. Had she not done so, her baby would have been born in the car on the way as her labour was as quick as she feared it might be. Can you explain how shutting the doors of St. Mary's made either of these women and their babies more safe, than had they been able to be cared for by midwives at the birth centre in Melton Mowbray, and can you confirm what recruitment plans you have to

expand the home birth team in light of the withdrawal of services at St. Mary's, to cater for those who still wish to avoid a hospital birth in the city moving forwards.

Health partners responded:

We fully acknowledge the experiences described, and the anxiety and distress that situations such as these can cause for women and families. Hearing these stories matters. Each individual experience provides important insight into how service changes affect people's lives, particularly in communities where geography, transport availability and distance from larger hospital sites create additional pressures. These accounts are directly informing the wider engagement and review process.

The key safety concern centres on the staffing fragility at the unit, which affects our ability to maintain a safe and stable workforce. This is then compounded by the very low number of births, reducing the clinical exposure staff need to keep competencies current. This combination led to the present pause in services, and the challenge is even greater in rural or geographically spread communities, where sustaining safe staffing across several small sites is inherently more difficult.

The Trust routinely assesses workforce requirements across all elements of the maternity pathway, including community midwifery, continuity models, and home birth provision to ensure services are aligned with local demand, demographics, travel times and the realities of providing care across rural and semi-rural areas.

Decisions about the long-term future of St Mary's will be taken by the ICB Board in March. As part of that process, feedback such as this including concerns around access, travel distance, emergency response times, local choice, and the impact of service centralisation on families is being fully considered.

Jean Burbidge asked:

1. Why has a staffing challenge, which appeared to arise from temporary rather than permanent circumstances, resulted in a decision for permanent closure? We saw in the newspapers earlier this month that many cancer units are being prevented from hiring more doctors for cost-cutting reasons. Is it the case that UHL is not able, for reasons of policy or finance, to hire enough midwives to staff maternity services?
2. The decision to close St Mary's Birth centre without replacement breaches a promise made in 2021 that a stand-alone midwife led unit would be trialled at the LGH for "at least three years" (Azhar Farooqi, then CCG chair, at the CCG meeting on the Building Better Hospitals for the Future Decision Making Business Case, June 2021). This is not the first time a consultation in Leicester, Leicestershire and Rutland has led the public to believe that the closure of one service would be replaced

by another, only to find later that the closure occurs but not the replacement. The public are left losing their service and receiving no replacement and often feel duped and let down. Does the ICB accept that another decision not to honour the replacement service is likely to undermine further public confidence in the integrity of local NHS consultation exercises?

Health partners responded:

1. Recommendations about the long-term future of St Mary's will be considered by the ICB Board in March. The staffing challenges at St Mary's are longstanding and cannot be resolved through short-term recruitment.

These pressures were further compounded by very low birth numbers, often only one or two a week, which meant midwives could not maintain the level of regular clinical exposure needed to safely run a standalone midwife-led unit. National guidance, including NICE NG4 on safe midwifery staffing, Birthrate Plus workforce methodology, NHS England maternity safety standards, and RCM/RCOG guidance, is clear that birth volume must be sufficient to maintain safe staffing and ongoing competence in standalone settings.

This is not a cost-cutting decision. Nor is the Trust prevented from recruiting midwives. The challenge is structural: in a unit with consistently low activity, even additional staffing cannot overcome the lack of continuous clinical exposure or the unsustainable pressure created by trying to maintain 24/7 cover through temporary staffing and goodwill.

2. We understand the concerns raised and recognise that public confidence in NHS consultation and engagement processes is essential. The 2021 decision, following the Building Better Hospitals for the Future consultation, set out an intention to relocate births from St Mary's to a new standalone midwife-led unit at Leicester General Hospital, with the expectation that this model would be established and tested over time.

However, that expectation was based on the circumstances that existed in 2021: service activity, workforce stability and the national New Hospitals Programme plans at that time. Since then, the situation has changed significantly. Birth numbers at St Mary's have fallen to very low levels, and at the same time the unit has faced persistent challenges to maintain 24/7 cover. At the time of the pause decision the model was seen as no longer safe or sustainable.

Alongside this, changes to the national New Hospitals Programme mean that the planned new facility at Leicester General Hospital can no longer be delivered as originally envisaged. Together, these developments mean that the assumptions underpinning a three-year trial of a standalone midwife-led unit are no longer in place.

The ICB and UHL therefore have a responsibility to base decisions on current safety, workforce and infrastructure realities, rather than plans that reflected a very different context. These matters, including the views raised through engagement, the pressures on the workforce, and the implications for women and families will be fully considered in the decision-making process.

Brenda Worrell asked:

1. The most recent CQC inspections gave maternity care at the Royal Infirmary and Leicester General Hospital a rating of 'Requires Improvement' but a rating of 'Good' for maternity care at St Mary's. Does UHL have confidence in the CQC ratings?
What are the views of midwives who work at St Mary's – do they feel that the quality of the care they give has been questioned by local NHS leaders? Do the midwives who work at St Mary's continue to have faith in the safety and value of St Mary's?
2. Has Councillor Helen Cliff's updated briefing paper on St Mary's birth centre been considered by the Committee?

Health partners responded:

UHL welcomes and values the CQC's independent assessments across all three maternity sites. NHS leaders have been clear throughout that the professionalism, compassion and quality of care provided by individual midwives are not in question. The concerns raised relate instead to structural and service-level pressures, not the capability or commitment of staff.

The core issues are the persistent staffing challenges. These pressures were then compounded by a declining number of births, making it increasingly difficult to maintain the continuous exposure and stability required for a safe standalone unit. It is these system-wide pressures not staff performance that drove the safety concerns.

Supporting colleagues through this period remains a priority. Senior leaders continue to maintain regular, open and honest conversations with staff who were working at St Mary's at the time of the pause, creating space for them to raise questions, share their experiences and contribute to planning. Enhanced wellbeing, pastoral and professional support has also been put in place. Their expertise and insight are central to shaping the future of maternity services, and UHL remains fully committed to supporting, valuing and listening to these colleagues throughout the transition and beyond.

Cllr Allen Thwaites asked:

1. In the Decision-Making Business Case, following the public consultation in 2020, to establish a standalone midwife led unit at the Leicester General Hospital, you made a promise to local residents, that closing the

doors of St. Mary's signified a relocation of standalone midwife-led services, not an outright withdrawal across the Trust?

2. Can you confirm when the ICB and/or the Trust first sought legal advice on your proposal to renege on that promise?

Health partners responded:

1. The 2021 decision, following the Building Better Hospitals for the Future consultation, set out an intention to relocate births from St Mary's to a new standalone midwife-led unit at Leicester General Hospital, with an expectation that this model would be established and tested over time. That expectation was based on the service activity, staffing position and national New Hospitals Programme plans that existed in 2021. Since then, the situation has changed significantly. Birth numbers at St Mary's have fallen to very low levels, leading to significant challenges in maintaining safe staffing, as colleagues were not getting exposure and competencies required for a safe standalone unit. Staffing pressures have increased, and changes to the national programme mean the planned new facility at Leicester General Hospital can no longer be delivered as originally envisaged.

These changes mean the assumptions that supported a three-year trial are no longer in place. The ICB and UHL therefore have a responsibility to base decisions on the current safety, workforce and infrastructure realities, even when these differ from earlier plans. These matters will be taken into consideration in the decision-making process.

2. The ICB has received extensive legal advice around the original consultation process, decision making and next steps now required. This legal advice forms the basis of all the activity now taking place.

Bob Waterton asked:

1. Closure of St Mary's - It is very difficult for the public to get any sense of what is happening with the Our Future Hospitals reconfiguration from UHL's public Board papers. Why is this and what alternative communication channels has UHL used to keep the public updated on a regular basis? Why are UHL Board papers from previous meetings no longer in the public domain and must now be requested instead in writing?
2. At the March 2025 meeting of the Leicester, Leicestershire and Rutland Joint Health Scrutiny, the spokesman for University Hospitals of Leicester stated that a review into the clinical safety implications of the delay in funding for Our Future Hospitals was being undertaken by UHL. He promised that the review would be completed within three months and that the review would be available to the public. The minutes of March 2025 meeting state that it would be "made available via the Trust Board minutes". There is an item on the review in UHL's recently published Our Future

Hospitals and Transformation Committee minutes for December 2025. However, it is not possible to find out from these minutes what the content of the review is because the associated papers are not made available to the public. Has the review now been made available to the public and, if so, how? What were its findings?

Health partners responded:

1. UHL has proactively shared information with the public through its website, social media channels, stakeholder updates and press releases. This has included announcements about changes to the programme timeline in 2025, the opening of new buildings and services, as well as more recent news confirming the release of £39m of funding from the national New Hospitals Programme. This funding is enabling UHL to begin essential enabling works across its three hospital sites during 2026, expected to complete in 2028, ahead of the main construction phase, which is planned to commence in 2032. Information about the programme has also been included in UHL's Annual Reports, and key developments are reported to the Trust Board via the Our Future Hospitals and Transformation Committee. Board papers from the two most recent Trust Board meetings are available on UHL's website. Previous Trust Board papers are available on request and will soon be published online as part of further website development.

Members of the public are welcome to ask questions at the end of Public Trust Board meetings or submit questions in advance by emailing: uhl-tr.corporatemeetingsmailbox@nhs.net

Alternatively, individuals may submit a Freedom of Information request by contacting:
uhl-tr.foi-freedomofinformation@nhs.net

Requests made under the Freedom of Information Act must be submitted in writing and include the requester's name and a contact address (either email or postal).

2. The New Hospitals Programme (NHP) announcement in 2025 led to delay of approximately three years in the forecast completion date of the NHP programme at UHL. It did not create additional clinical risk and means that any clinical risks that would be mitigated by the programme would need to be held for longer. NHS Trusts constantly manage and mitigate risk as part of their normal oversight of hospital care.

The risk report was completed on 25 June and went through the Trust's governance. It is not in the public domain. UHL has a robust process for management of its risks, and these risks sit within that process and the mitigations of risk. There were several mitigations agreed as part of the report that will continue to mitigate the risks as the NHP programme progresses.

The UHL NHP programme has begun in Leicester following the release of an initial £39m of funding from the national New Hospitals Programme. This funding is enabling UHL to begin essential enabling works across its three hospital sites during 2026, expected to be completed in 2028, ahead of the main construction phase, which is planned to commence in 2032.

The investment is a major milestone in UHL's journey to create modern, state of the art facilities that will further improve patient care and experience. It builds on the work to expand our offering, including the East Midlands Planned Care Centre and Endoscopy Unit at the Leicester General Hospital, the Preston Lodge rehabilitation unit in North Evington, and the Hinckley Community Diagnostic Centre. All are helping UHL to deliver world class

Sally Ruane asked:

1. Research has shown that, for low risk pregnancies, stand-alone midwife led birth centres have as good outcomes for babies and better outcomes for mothers (in terms of less intervention and more "normal" births) than other types of birth units. It is not surprising therefore that the National Institute for Health and Care Excellence (NICE), which establishes the quality guidelines in the NHS, states that stand-alone midwife led birth centres should be made available. How does removing the stand-alone midwife led birth centre safeguard patient choice for low risk women and meet the NICE quality standard?
2. As well as a place for giving birth, St Mary's also provides invaluable inpatient postnatal care (with 8 beds in 2020). This care is taken up by a far wider group of mothers than those who choose to give birth at St Mary's. The CQC singled this care out as of particular benefit for mothers with complex needs such as women with physical disabilities or mental health conditions. Why is no explicit mention of postnatal care made in the pause and proposed closure statements? Is it true that UHL does not collate the numbers of women who use this postnatal care? If we included these service users, the balance of benefits to costs would alter but they have been excluded from the calculation.

Health partners responded:

1. NICE guidance and wider national evidence show that midwife-led care is a safe and positive option for many women with low-risk pregnancies. It is associated with fewer interventions and often a more personalised birth experience. Both the ICB and UHL fully support this approach, and midwife-led care will continue to be an important part of the maternity offer across Leicester, Leicestershire and Rutland.

At the same time, it is important to recognise that the safety of any midwife-led service depends on the local circumstances in which it

operates. The challenges at St Mary's are not about the principle or value of midwife-led care, nor about the dedication of the staff. They relate to sustained low birth numbers and ongoing staffing pressures, which have made it increasingly difficult to run the unit safely on a 24/7 basis.

National guidelines emphasise that maternity services must be safe, accessible and equitable, and decisions about how midwife-led care is delivered need to reflect the realities of the local population, workforce and geography.

In Leicester, Leicestershire and Rutland, women will continue to have access to midwife-led birth options, including at Leicester General Hospital, Leicester Royal Infirmary and through the Home Birth Team, ensuring that choice remains available within settings that can be staffed and supported safely.

As part of the current review, the ICB is looking carefully at the full range of feedback from women, families, staff and local communities. Concerns about travel time, equity, rural access, continuity of care and the impact of service change are all being considered alongside the clinical evidence.

The priority is to ensure that women can make informed, supported choices within a maternity service that is safe, sustainable and designed around their needs, now and into the future.

2. St Mary's has provided both births and dedicated inpatient postnatal care, and we fully recognise how valued that care has been by local families. When the standalone facility first opened, it was important to ensure that women choosing to give birth there had access to ongoing postnatal support on site, reflecting best practice at the time and the commitment to providing a safe, continuous and community-centred model of care.

The decision to pause services was not taken lightly. The underlying issues including very low birth activity over a sustained period and persistent staffing pressures that made it impossible to maintain safe 24/7 cover, affect both birth activity and the ability to provide inpatient postnatal care safely.

Although families have used the postnatal beds without giving birth at St Mary's, overall activity has reduced in line with the declining number of births. Including this limited activity does not change the overall safety assessment. The key issue is whether a service can be staffed consistently, safely and sustainably, and in the current context, this is not something that can be reliably achieved at St Mary's.

78. UPDATE ON ST MARY'S BIRTH CENTRE

The Integrated Care Board (ICB) provided the Committee with an update

outlining engagement activity, background context and next steps in relation to St Mary's Birth Centre. The following was noted:

- The full report would be considered by the ICB Board on 19th March, ahead of the final decision.
- The findings of the 2021 consultation regarding maternity configuration at Leicester General Hospital and Melton were referenced.
- Long standing challenges relating to St Mary's were highlighted, including low activity levels, workforce pressures and compliance with national maternity safety standards.
- Fewer than 1% of births across Leicester, Leicestershire and Rutland had taken place at St Mary's, with 92 births recorded in the year prior to closure.
- Challenges in safely staffing the unit were outlined, including the need to meet national guidance and maintain an appropriate skill mix.
- National changes and delays to the New Hospital Programme had impacted delivery of the planned new maternity hospital at Leicester Royal Infirmary, and overall birth numbers had continued to decline.
- The option to relocate services to Leicester General Hospital was referenced, alongside the continued availability of local antenatal and postnatal provision in Melton Mowbray.
- Engagement activity had taken place with women who were pregnant or considering birth between July 2025 and September 2026.
- Engagement had been extended between January 2021 and July 2025 and had included online focus groups, direct discussions and engagement with student midwives.
- Feedback received had covered themes including geography, communication, personal experience of care and understanding of maternity pathways.
- Feedback would be used to inform the Board report ahead of the decision in March.

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

- Members sought clarification on the number of responses received as part of the engagement process, particularly given the questionnaire closing date, and were advised that this would be reflected within the full Board report.
- It was suggested that historically St Mary's may not have been promoted consistently, and questions were raised regarding how birth options were presented to expectant mothers and whether engagement methods, including social media, had effectively reached younger women. It was explained that midwives were encouraged to promote appropriate birth settings and that discussions with women formed part of individualised maternity pathways.
- Clarification was requested regarding the geographical distribution of women who had given birth at St Mary's. It was reported that approximately 31.5% were from LE13 or LE14 postcodes, with others choosing alternative units or home birth.
- Concern was expressed that the Committee had not received the full

Board report ahead of the ICB decision date and that a number of detailed questions remained outstanding, including matters relating to workforce and previous clinical ratings. In response, it was stated that staffing requirements were linked to national maternity guidance, that birth complexity had increased across the system, and that compliance with safe staffing standards remained a key consideration.

- Members questioned how the 2021 consultation had informed the current position and whether circumstances had materially changed since that time. It was acknowledged that delays to the New Hospital Programme and wider national developments had impacted delivery of the original proposals, and that financial constraints meant previously anticipated capital funding was no longer available.
- Concerns were raised regarding travel times from Melton to Leicester hospitals, ambulance access routes and the potential impact on families without private transport, alongside wider pressures within primary care and housing growth in the Melton area. It was confirmed that equality and quality impact assessments had been undertaken and that issues relating to access and travel had been considered as part of the decision making process.
- Members asked what alternative recruitment options had been explored to sustain the service and whether more experienced staff could have been appointed. It was reported that recruitment campaigns had been undertaken without sufficient response, that newly qualified midwives required further experience before working in standalone units, and that strengthening home birth services and community support formed part of the wider maternity model.
- Discussion took place regarding patient choice for low risk women and the proportion currently classified as category 1 and 2 risk, which was reported as approximately 25%. It was noted that not all counties operated standalone birth centres and that home birth remained an available option within Leicester, Leicestershire and Rutland.
- Members emphasised the importance of equity across the wider birthing population of approximately 9,500 births per year and the need to balance resource allocation across the system. It was acknowledged that the issue was deeply emotional for families and communities.
- Members requested clarification regarding public involvement arrangements for the March ICB meeting and suggested that scrutiny may wish to consider further examination of the decision and timeline. The Chair acknowledged the strength of feeling expressed and confirmed that where genuine concerns regarding access, safety or service provision were identified, it would be appropriate for the Committee to consider how these could be incorporated into the ongoing maternity scrutiny work programme in a structured and evidence led manner.

The Chair responded directly to Brenda Worrals question:

“Has Councillor Helen Cliff’s updated briefing paper on St Mary’s birth centre been considered by the Committee?”

The Chair responded to a public question regarding whether Councillor Helen

Cliff's updated briefing paper on St Mary's Birth Centre had been considered by the Committee. The Chair confirmed that the paper had not yet been formally considered, as items must be submitted and scheduled through the agreed work programme. The Chair further confirmed that where there were genuine concerns regarding access, safety or service provision, it would be appropriate for the Committee to examine these, and officers would review the paper to advise how it may be incorporated into the maternity scrutiny work in a structured and evidence led way.

RECOMMENDATION:

Councillor Haq, seconded by Councillor Sahu, moved that the Integrated Care Board defer the decision scheduled for 19th March 2026 to allow further time to consider the decision, the proposed timeline, and the options for maternity care for women across Leicester, Leicestershire and Rutland, including provision at Leicester General Hospital and women's choice of care.

The ICB was asked to note this recommendation.

AGREED:

1. That the Committee note the report.
2. The Committee asks the ICB to consider the above recommendation.
3. That an update on the current position is brought to the next meeting on 30th April 2026.

79. LLR SEND & INCLUSION ALLIANCE UPDATE

The Leicester, Leicestershire and Rutland SEND and Inclusion Alliance gave a presentation to the Committee on the purpose and activities of the Alliance.

The following was noted:

- The LLR SEND and Inclusion Alliance had been funded by the Department for Education having evolved from the national SEND and Alternative Provision Change Programme Partnership.
- The programme was Department for Education led and overseen locally by the Director of Children's Services, with input from NHS partners.
- The Alliance aimed to connect and bring together different areas of the system to develop new and more integrated ways of working.
- The first 2 years had focused on developing Local Area Inclusion Plans and testing 11 elements of proposed SEND reform. The final year concludes in Summer 2026 and is concentrating on the development of a Local Integrated Service Offer.
- A key objective was to support more children and young people with additional needs to remain in mainstream education wherever appropriate.
- The ELSEC (Early language Support for Every Child) programme had operated as a pathfinder and, due to its success, there was an ambition to continue the work through to 2027.

- The Alliance was described as a coalition of the willing across partners, as it has no statutory functions, but it has 5 strategic aims including aligned commissioning and a community inclusion programme
- Leicester City Council hosted the LLR SEND Joint Commissioning Strategy, which has an initial focus area around moderate mental health needs; specifically for children with emotionally based school avoidance (EBSA)
- The Community Inclusion Programme, shaping SEND Futures, is linking with the Family First programme to ensure holistic support is provided for children with additional needs and their families.
- Engagement with headteachers had identified that SEND itself was not always viewed as the primary issue, but that adult mental health, domestic abuse and wider family pressures were having significant impact on children and young people.
- Pilot engagement events had been held in Hinckley and Bosworth and Northwest Leicestershire

In discussion with Members, the following:

- Clarification was sought regarding children not supported by CAMHS, including whether this referred to those without a diagnosis or those on waiting lists, and the age range of children supported. It was explained that not every young person required CAMHS level intervention and that the project was seeking innovative approaches to meet needs earlier and at a lower threshold. The programme aimed to provide an additional layer of support, including social prescribing, improving listening and engagement, and delivering in reach mental health practitioner support within schools, even where a formal diagnosis had not been made.
- Concern was raised as to whether expanding mainstream provision could risk reducing specialist support. It was clarified that the focus was on early help and early intervention, with the intention that timely support may reduce escalation and the need for later diagnosis. It was also emphasised that specialist SEND schools remained essential for children requiring higher levels of care, and that one aim of the project was to reduce pressure on those settings where appropriate.
- Members sought further information regarding the number of children supported, and the use of performance data, the measurable impact of the programme and any associated financial savings. It was reported that funding of 5.7 million pounds had been provided by the Department for Education to support 11 projects across LLR, ending the Summer 2026. Whilst sustainability was a concern, there was hope that demonstrable progress would support continuation through alternative funding routes. It was noted that demand for EHCPs had increased significantly, with around 150 percent rise referenced. It was suggested that clearer and more detailed data be included within future reports to assist Members in assessing impact
- The importance of family voice was highlighted, with concern expressed that parents could at times feel blamed within the wider system. It was acknowledged that capturing parent voice had not always been consistent and that perceptions of blame were a national issue. The Alliance was seeking to identify system gaps and improve practice. It

was reported that 3 Chairs of the Parent Carer Board were engaged with the programme and had a standing agenda item each month at the Alliance Board. Questions were raised regarding how disengaged parents were being reached and whether funding could support parent groups within schools and strengthen post 16 to 18 provision. It was confirmed that Parent Carer Forums were established and that work had taken place with local businesses to support young people into employment.

- Clarification was sought regarding how the Alliance promoted its work. It was reported that a communications and engagement strategy was in place, that the Alliance had formally existed since August 2025 and that an established website was now available. It was also noted that in some inner city schools a significant proportion of pupils had SEND needs.

AGREED:

1. The Committee noted the report.
2. A link to the LLR SEND and Inclusion Alliance website would be included within the minutes.

80. MEMBERS QUESTIONS NOT COVERED ELSEWHERE ON THE AGENDA

The following matters were raised in discussion and were linked to the next agenda item, the work programme:

- It was noted that GP access was scheduled as a future work programme item. Concern was raised regarding ongoing difficulties experienced by residents in securing GP appointments, with examples provided of delayed access leading to potential impacts on diagnosis and treatment.
- A query was raised regarding what sanctions were in place for GP practices not adhering to access requirements. It was suggested that this be considered as part of the forthcoming GP access item.
- Further concern was expressed regarding digital access requirements, particularly for elderly residents without access to computers or mobile phones. It was suggested that practices may be operating inconsistently and that there was a risk of a 2 tier system emerging.
- It was proposed that additional checks be undertaken across practices to better understand current access arrangements and patient experience in advance of the meeting scheduled for 30th April.
- The Chair confirmed that the matter would be noted and considered within the work programme.

AGREED:

1. LLR ICB to confirm to the next Joint Health Scrutiny Committee that all GP practices across Leicester, Leicestershire and Rutland accept telephone appointment bookings. This should include evidence of contact with all practices, with consideration given to undertaking a “secret shopper” exercise using existing ICB staff to test telephone access to appointments.

81. WORK PROGRAMME

The Chair noted the work programme which was discussed in Item 80.

82. ANY OTHER URGENT BUSINESS

With there being no further business, the meeting closed at 12:09pm

