Leicester
City Council

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

Held: THURSDAY, 27 NOVEMBER 2025 at 10.00am

P R E S E N T :
Councillor Pickering - Chair
Councillor Hill – Vice Chair

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

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59. APOLOGIES FOR ABSENCE

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

60. DECLARATIONS OF INTEREST

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

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

61. MINUTES OF THE PREVIOUS MEETING

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

62. PETITIONS

It was noted that none were received.

63. QUESTIONS, REPRESENTATIONS AND STATEMENTS OF CASE

The following questions were asked:

Jean Burbridge asked:

1. Why is UHL closing down St Mary's midwife led birth centre? This birth centre is the stand-alone midwife led birth facility for the whole of Leicester, Leicestershire and Rutland. The Decision Making Business Case following public consultation for Building Better Hospital For the Future promised a replacement stand-along midwife led birth centre would be created at Leicester General Hospital but this has not happened.

2. A stand-alone midwife led birth centre is supposed to be one of the four options made available to women for the births of their babies. However, St Mary's in Melton Mowbray seems to be closed down with little discussion. Has this been brought before the Joint LLR Health Overview and Scrutiny Committee for detailed scrutiny?

3. If not, can the chair give an assurance that no closure will take place before detailed scrutiny has taken place in this committee?

The Chair allowed a supplementary question:

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

Godfrey Jennings asked:

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

2. Will UHL give an assurance that the promised midwife led stand-alone birth centre at the General Hospital will be in place before any closure of St Mary's?

The Chair allowed a supplementary question:

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

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

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

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

AGREED:

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

64. DIGITAL FOCUS

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

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

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

Comments:

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

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

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

Agreed:

The report was noted by the Commission.

65. UPDATE ON WINTER PRESSURES

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

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

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

In discussions with members, the following was noted:

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

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

AGREED:

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

66. SYSTEM HEALTH EQUITY

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

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

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

In response to Members comments:

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

Agreed:

1. The presentation was noted.

67. 24/25 YEAR END REVIEWS

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

68. DENTAL PROGRESS REPORT

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

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

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

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

In discussions with Members, the following was noted:

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

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

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

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

AGREED:

That the report be noted

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

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

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

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

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

70. WORK PROGRAMME

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

71. ANY OTHER URGENT BUSINESS

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