Minutes of a meeting of the Health Overview and Scrutiny Committee held at County Hall, Glenfield on Wednesday, 14 January 2026.

PRESENT

Dr. S. Hill CC (in the Chair)

Mrs. L. Danks CC	Mr. J. Miah CC
Mr. M. Durrani CC	Mr. D. Page CC
Mr. P. King CC	Mr J. Poland CC
Mrs. K. Knight CC	Mr. K. Robinson CC

In attendance

Mr. A. Innes CC (item 47 refers).
Mr. B. Lovegrove CC (item 47 refers).
Mr. J. T. Orson CC (item 47 refers).
Toby Sanders, Chief Executive, Integrated Care Board (item 47 refers).
Yasmin Sidyot, Deputy Chief Operating Officer – Integration and Transformation, ICB (item 47 refers).
Mayur Patel, Head of Integration & Transformation (Primary Care), ICB (item 47 refers).
Amita Chudasama, Head of Emergency preparedness, resilience and response, ICB (item 49 refers).

40. Minutes of the previous meeting.

The minutes of the meeting held on 5 November 2025 were taken as read, confirmed and signed.

41. Question Time.

The Chief Executive reported that two questions had been received under Standing Order 35.

1. Question from Cllr. Helen Cliff:

Given the stakeholder's briefing dated 5th January 2026, it now appears that the six-month "temporary pause" in services at St. Mary's Birth Centre in Melton Mowbray was a rather disingenuous step towards a decision that had clearly already been taken. So, can the Chair confirm the continued support of this committee to retain birthing and postnatal services at St. Mary's Birth Centre and the desire to apply scrutiny to the ICB and UHL Trust over the decisions they have arrived at to reduce service provision across the Trust, and how they have gone about making these decisions – particularly with reference to equitable access for rural communities and maintaining choice for women?

Reply by the Chairman:

I can confirm that the Committee is aware of the public concerns regarding St Mary's Birth Centre and will scrutinise the ICB and UHL on the topic. We have been liaising with the ICB regarding which would be a suitable Committee meeting for the ICB to present a report regarding this issue and answer questions from Committee members. The date has not yet been confirmed but discussions on the date are ongoing.

At the present time, the Committee is not yet in a position to set out its views and state what it supports in relation to St Mary's Birth Centre. A more detailed understanding of the facts and options will be required before the Committee can come to a view. We will let you know at which Committee meeting the topic will be discussed. In addition, the Leicester, Leicestershire and Rutland Joint Health Scrutiny Committee is also intending to consider a report on this topic in the coming months. The next meeting of that Committee is on Monday 23 February 2026.

Supplementary question from Cllr. Helen Cliff:

Could the Chair provide assurance that the Committee will try and ensure that people in rural communities have equality of access to healthcare services? Would the Chair be agreeable to having a meeting with me to discuss the matter further?

Reply by the Chairman:

I am happy to meet with you. Please be assured that the Committee will scrutinise this matter. It has also been confirmed that the Leicester, Leicestershire and Rutland Joint Health Scrutiny Committee will have an agenda item relating to maternity services at its meeting on Monday 23 February 2026.

2. <u>Question from Cllr. Pip Allnatt:</u>

I am a resident of Melton, a patient at the Latham House Medical Practice (LHMP), where I attend the patient panel, and also the Leader of Melton Borough Council (MBC). Thank you for the opportunity to table a question.

LHMP, established in 1931 now has circa 36,000 registered patients, covering Melton Town and 66 parishes and villages is one of the largest group GP practises in the country. In 2022 the ICB identified our area as a "high priority in the Primary Care Estate Strategy (PCES) due to housing growth".

County Councillor Joe Orson, my predecessor at MBC, can attest to the fact that he initiated direct working with the ICB to create a second GP practice for the town of Melton Mowbray in 2022.

In fact, MBC support health and wellbeing generally. For example, funding mental health advice to the farming community, facilitating specialist equipment for those with physical and other disabilities at our swimming pool, and movement and recreation sessions for older residents. We have provided additional car parking for LHMP to create greater capacity and safety for female clinicians; we are planning similar in Bottesford.

We are increasingly frustrated by Melton being sidelined. An ill-disguised permanent closure of St Mary's Birthing Centre on spurious criteria, on support for dementia care,

the late reopening of our hospital Gilespie ward and now the abrupt halt to progressing a second GP practice.

I strongly dispute two statements in the ICB report.

- "Published data from NHS Digital (from 2020 to August 2025) showed only a 3.19% increase in patient registrations at the current Melton practice", and
- "There is no evidence, according to local and nationally published appointment data, that Melton should be prioritised above other areas across LLR for investment in additional Primary Care service provision."

Registrations are modest because of high turnover of medical staff, a declining reputation of LHMP and residents going elsewhere, privately or less local. “Appointment data” is very soft statistically because, as many patients will confirm, it is just so difficult to get an appointment, so they visit a hospital or just give up.

During 2024 and 2025 the ICB was content to work with MBC to successfully establish the technical feasibility of a second GP practise at one of two buildings owned by MBC and only withdrew because of financial viability. Now they choose to use partly historic data on registrations to suggest that there is now no need for a second surgery at this time.

I respectfully suggest they are not just moving the goal posts but changing the game.

I attach further analysis to demonstrate that housing growth will continue to support the ICB’s policy from 2022 when Melton was considered a “high priority in the Primary Care Estate Strategy (PCES) due to housing growth”.

So, my question to you today focuses on the second GP practice and through you to the ICB.

Do you agree that.

(a) The decision by the ICB to suspend work on a second GP practice until 2027 is unsatisfactory given its “high priority” of 2022?

(b) While increasing primary care capacity at LHMP is welcome a new second GP practice will support the established principle that patients should have an element of choice within the NHS?

(c) The ICB is incorrect to pray in aid “uncertainty about funding from s106 agreements” because.

1. Section 106 revenue is only ever a “contribution”.
2. Section 106 allocations obviously compete with other essential infrastructure priorities.
3. Section 106 revenue is paid gradually as new homes are built and sold.

4. Any new GP practise will have a gradual take up of new registrations and therefore its NHS revenue funding is gradual.

Therefore, wherever and whenever a new GP Practise is created it is for the NHS to front load the capital required.

(d) The reasons given by the ICB, quoted above, to de-prioritise Melton are unsound?

Thank you for your consideration.

Reply by the Chairman:

I thank Cllr Allnatt for all the information he has provided.

Cllr Allnatt will be aware that later on the agenda for this meeting the Committee will be considering a report relating to GP Practices (agenda item 8). It was requested by the Committee that the report provide detailed information regarding access to GP Practices in Leicestershire and particularly the Melton area. I am disappointed that the report does not contain the depth of information that I was hoping for. Nevertheless, the Committee intends to thoroughly question the ICB regarding GP access in Melton during agenda item 8. Until that discussion has taken place with the whole Committee, I am not able to answer all of Cllr Allnatt's questions. I can however offer the following brief comments:

I agree that a new second GP practice in Melton would support the established principle that patients should have an element of choice within the NHS.

It appears from the report the ICB provided for the meeting on 14 January 2026 that there is some confusion amongst the NHS regarding how Section 106 contributions for health matters are agreed and collected. The Committee may wish to discuss this in detail during agenda item 8 and ensure all parties have clarity regarding the process.

I cannot comment on the decision by the ICB to suspend work on a second GP Practice in Melton until I understand how the ICB made that decision and what factors they took into account.

I do not have enough information to give a view on whether the decision to de-prioritise Melton was unsound.

Please be assured that I will be seeking answers to all these questions from the ICB.

Supplementary question from Cllr. Pip Allnatt:

I note that there is no national guidance on the number of GP practices per geographical area or set ratio of practices per population size. What is a reasonable number of GPs per GP Practice? Does the Committee agree that being able to choose between individual GPs within one practice is not the same as being able to choose between different GP Practices? Given that the ICB was originally of the view that a second GP Practice in Melton was required, what has changed to cause them to now come to the view that a second practice is not required?

Reply by the Chairman:

The answers to these questions will be covered later in the meeting as part of agenda item 8: Primary Care.

42. Questions asked by members.

The Chief Executive reported that no questions had been received under Standing Order 7(3) and 7(5).

43. Urgent items.

There were no urgent items for consideration.

44. Declarations of interest.

The Chairman invited members who wished to do so to declare any interest in respect of items on the agenda for the meeting.

Mr. J. Poland CC declared a Non-Registerable Interest in agenda item 8: Primary Care as he worked for the Rt Hon Edward Argar MP who was campaigning regarding GP Practices in the Melton area.

45. Declarations of the Party Whip.

There were no declarations of the party whip in accordance with Overview and Scrutiny Procedure Rule 16.

46. Presentation of Petitions.

The Chief Executive reported that no petitions had been received under Standing Order 36.

47. Primary Care

The Committee considered a report of the Integrated Care Board (ICB) which provided an oversight and summary on Primary Care services that were commissioned by the ICB and delivered by Primary Care providers (GP Practices) across Leicester, Leicestershire and Rutland (LLR). The report also provided specific information on the Melton area with regards to the current and future delivery of Primary Care services. A copy of the report, marked 'Agenda Item 8', is filed with these minutes, along with a separate document containing answers provided by the ICB in response to questions from the Committee about ratios of GPs to patients.

The report was presented by Yasmin Sidyot, Deputy Chief Operating Officer – Integration and Transformation, ICB, and Mayur Patel, Head of Integration & Transformation (Primary Care), ICB. Toby Sanders, Chief Executive, ICB was also present to answer questions.

The Committee welcomed to the meeting for this item Mr. A. Innes CC (Melton East division), Mr. B. Lovegrove CC (Belvoir division), and Mr. J. T. Orson CC (Melton Wolds division).

As part of discussions the following points were made:

(i) Members expressed disappointment that the report focused on the whole of LLR and did not give sufficient detail regarding GP provision in Leicestershire, which made it difficult to scrutinise the topic. Members requested the information be broken down to electoral division or individual GP Practice level. In response the ICB stated that they would provide more detailed data to the Committee after the meeting but explained that there were limitations on what could be provided as they were reliant on how the data was collected nationally. There were also data protection concerns as patients might be identifiable if data was provided at individual GP Practice level.

(ii) In response to further questions from members about the ratio of GPs to patients, it was explained that there was no national guidance on the number of GP practices per geographical area or per population size. Locally the ICB used a benchmark of 75 primary care appointments per thousand population, but this was not part of the formal contract with GP Practices. This figure was used by the ICB to identify where there was significant variation in levels of provision across LLR. A member raised concerns that focusing on an average across a large area could mask serious access problems in some (rural) areas. The ICB agreed to provide data on GP to patient ratios in Leicestershire after the meeting.

(iii) The ICB submitted that the level of access to GP Practices in Leicestershire compared well with the national and regional picture, though acknowledged that improvements could still be made locally and recognised that the public were raising complaints with elected members about access.

(iv) Concerns were raised by members that because patients were not able to get appointments at GP Practices this was displacing demand elsewhere and putting pressure on other services such as the Emergency Department. It was questioned whether the capacity of primary care was genuinely being increased or whether capacity issues were being masked by displacement. In response the ICB said that the numbers of patients attending the Emergency Department was not greater than had been planned and no peaks had been seen, but work would continue to ensure that patients attended the most appropriate place for the treatment they required.

(v) Members welcome the use of the NHS 111 telephone line and the increased use of digital tools by the NHS such as the NHS app and other online services. However, it was questioned how effective these services were at directing patients to the right service and whether demand was being incorrectly displaced elsewhere. In response it was explained that the NHS 111 call handlers used an algorithm set nationally and whilst they did not always provide the right advice to a patient, reviews of the calls took place to see what could be learnt and what improvements needed to be made to the process.

(vi) Members raised concerns that there was unwarranted variation between GP Practices and in particular that different GP Practices were using different technology which caused confusion for patients. In response reassurance was given that there were only two booking systems being used by GP Practices in LLR. The ICB explained that although GP Practices had a large degree of independence, the ICB was sending clear messages to GP Practices about using standard procedures. The contract with GP Practices specified that patients should be able to contact the Practice by phone if their issue was urgent or episodic, and if it was non-

urgent they should be able to communicate with the practice online. Therefore, these requirements should be implemented consistently across LLR.

(vii) Whilst the national contract with GP Practices covered same day access, it did not specify the number of same day appointments that were required. Therefore, the ICB had commissioned the Same Day Access service. This service used an enhanced navigation and triage process to enable patients to receive same day access care in a General Practice setting, where their needs could not safely wait for the next day or a routine appointment at their registered General Practice. On average there were over 35,000 Same Day Access appointments available throughout the year offered Monday to Sunday. A member stated that patients should always be able to get a same day appointment as standard, and also submitted that whilst 35,000 sounded a large number of additional appointments, per GP Practice it was not many. The member again questioned whether capacity had genuinely increased. In response the ICB confirmed that the Same Day access appointments were in addition to the routine appointments and emphasised that this was a significant improvement on the number of appointments that had been available previously.

(viii) Not all appointments at GP Practices were with a GP. There was a mixture of staff roles within GP Practices that could be utilised depending on the patient's needs.

(ix) The report set out the approximate number of GP sessions 'saved' by utilising Pharmacy First. In response to a question from a member as to what 'saved' actually meant, it was explained that the GP was not free during the time saved, they were instead carrying out other appointments. The terminology just referred to the number of extra hours that the GP would have had to work had the Pharmacy First service not been in place. The member asked if the Committee could be provided with the throughput relating to hours saved, i.e. how many more patients were then seen, that would not otherwise have been, and the ICB agreed to provide this data.

(x) Did Not Attend (DNA) rates within General Practice had risen significantly across LLR within the previous 3 years. Members raised strong concerns regarding this and questioned what the reasons for the DNAs were. The ICB explained that they were investigating the causes of DNAs and would be carrying out a full analysis and the results would be available by the end of March 2026. It was known that the reasons could vary between different GP Practices and the majority of DNAs related to appointments on the same day that they had been booked. Members emphasised that the NHS needed to be firm with patients that did not attend appointments. The ICB agreed with this but clarified that the penalties for patients that missed appointments were limited. Work was taking place to make it easier for patients to cancel appointments. The role of the ICB was to give the GP Practices the tools to tackle the issue, but the ICB could not specify exactly how the GP Practices approached it. In response to a question regarding the cost to the NHS of people not attending appointments, the ICB agreed to provide this information after the meeting.

(xi) In response to a question on whether GPs working part time had an impact on patients being able to obtain appointments, it was explained that the ICB did not have the data for part time working, they only had the data for full time equivalents. However, the ICB agreed to look into this query and provide a response to the Committee after the meeting.

Melton

(xii) Latham House Medical Practice was the largest in LLR and the only Practice in the Melton area. It was part of the Melton, Syston and Vale Primary Care Network. The next largest GP Practice in LLR was Market Harborough Medical Centre. There were only 63 practices larger than Latham House in the whole country; some of these were single-site and some were multi-group. The ICB submitted that there were advantages to having large practices such as being able to provide a greater skill mix amongst staff. The size of the Practice was not a trigger for a new Practice being required, therefore members queried what would trigger the ICB to consider the need for a new Practice.

(xiii) The data in the report related to the Melton, Syston and Vale Primary Care Network but Syston was not in the Melton area. Members asked for the data to be disaggregated so it just related to Melton.

(xiv) Published data from NHS Digital (from 2020 to August 2025) showed only a 3.19% increase in patient registrations at Latham House Medical Practice. In response Melton members submitted that the additional need was there and the public had a negative impression of Latham House Medical Practice which was why they were not registering. The ICB re-iterated that in their view there was no evidence, according to local and nationally published appointment data, that Melton should be prioritised above other areas across LLR for investment in additional Primary Care service provision. It had been concluded by the ICB that Latham house did not stand out in terms of level of access, or appointments available. Members therefore queried which localities in Leicestershire had a greater need than Melton.

(xv) The Melton members felt let down by the ICB and pointed out that in 2022 the ICB had acknowledged that there was a need for an additional GP Practice in Melton and at that time had agreed to put together a business case, so members therefore questioned what had changed in the intervening period. It was noted that there was a different Chief Executive of the ICB in place in 2022. Members felt that the current position of the ICB was particularly surprising given the amount of new housing that was now planned in Melton. Members emphasised that conversations about demand caused by new housing needed to take place well in advance of the housing being built.

(xvi) According to the ICB no issues had been raised in terms of the quality of the services provided by Latham House Medical Practice. In response Committee members pointed out that whilst the latest inspection report of Latham House Medical Practice from the Care Quality Commission (CQC) gave a ‘Good’ overall rating, the CQC had not reviewed Latham House since March 2020 therefore their assessment could be out of date. Members had received anecdotal reports regarding poor quality service at Latham House, though acknowledged the situation might be improving.

(xvii) The ICB did not receive capital funding to develop new practices itself. GP Practices were funded on a per registered patient basis therefore if there were no patients there was no income stream. It was uncommon for new GP Practices to be started with no previous infrastructure. Section 106 contributions could be used for capital projects such as GP Practices, but they were unlikely to be enough for a whole new

Practice. They were usually used for smaller projects such as new consulting rooms in an existing practice.

(xviii) A decision on a second GP Practice in Melton had been paused until 2027 and in the meantime the ICB was working with Latham House Medical Practice to improve the patient experience including the telephone and booking procedures.

(xix) The ICB offered to organise a meeting between the Melton Councillors and Latham House and this offer was accepted by the Melton Councillors.

RESOLVED:

(a) That the update on Primary Care services in Leicestershire be noted with concern;

(b) That the Integrated Care Board be requested to provide a further update to a future meeting of the Committee regarding the plans for Latham House Medical Practice and primary care services in the Melton area.

48. Medium Term Financial Strategy 2026/27-2029/30

The Committee considered a joint report of the Director of Public Health and the Director of Corporate Resources which provided information on the proposed 2026/27 to 2029/30 Medium Term Financial Strategy (MTFS) as it related to Public Health. A copy of the report, marked 'Agenda Item 9', is filed with these minutes.

Arising from discussions the following points were noted:

(i) There was a typographical error at paragraph 10 of the report which should have said "The impact of what is effectively a direction to increase expenditure on the prevention, treatment and recovery from drugs and alcohol misuse of 10**%** year on year…"

(ii) Members welcomed that this time the Department of Health and Social Care (DHSC) had given provisional Public Health Grant allocations for the next three years rather than the usual one-year settlement.

(iii) The DHSC had specified ring fences within the ring-fenced Public Health Grant to be spent on drugs and alcohol treatment, recovery and prevention, and smoking cessation. These figures were included in the report at Table 2 - Net Budget 2026/27. The exact spending on those ring-fenced areas was largely prescribed nationally and had to be used to meet Key Performance Indicators. In response to a query from members as to what would happen if this money was not spent and whether it could be transferred to a different Public Health budget stream within the Council, it was explained that there was a risk that DHSC could ask for the money to be returned or they could reduce the amount given to the County Council in future allocations. This had happened to local authorities elsewhere in the country with regards to smoking cessation funding.

(iv) An amount of approximately £2 million of the Public Health grant was used to commission, by way of service level agreements, health improving elements of services in other departments that fulfilled the public health grant requirements and

the priorities of those departments. Newton Impact was carrying out an Efficiency Review of all the County Council's services and spending to identify savings to help meet the budget gap. Positive conversations had taken place between the Public Health department and Newton Impact regarding how Public Health could contribute to the County Council's savings. It was not expected that Public Health would transfer funding directly from its budget into the budgets of other County Council departments. However, it was hoped that the work of the Public Health department would help reduce the demand on services provided by other departments within the County Council. For example, the Public Health work regarding frailty and falls prevention could help reduce the demand on adult social care.

RESOLVED:

(a) That the report and information now provided be noted;

(b) That the comments now made be forwarded to the Scrutiny Commission for consideration at its meeting on 28 January 2026.

49. Pandemic Planning.

The Committee considered a joint report of the Integrated Care Board (ICB) and the Director of Public Health which provided an update on pandemic preparedness across Leicester, Leicestershire and Rutland (LLR). A copy of the report, marked 'Agenda Item 10', is filed with these minutes.

The Committee welcomed to the meeting for this item Amita Chudasama, Head of Emergency preparedness, resilience and response, ICB.

Arising from discussions the following points were noted:

(i) Exercise Pegasus had taken place in September, October and November 2025 which was a national Tier 1 pandemic preparedness exercise. There were concerns that this Exercise had not been as useful as it could have been and it did not have the right kind of input from central government. All the learning from the Covid-19 pandemic had not been implemented by central government and incorrect assumptions had been made about local capacity.

(ii) There was still an issue with the availability of Personal Protective Equipment and it was not stockpiled locally.

(iii) It was difficult to prepare for a pandemic in advance without knowing the exact nature of the pandemic. Detailed plans were not able to be written without knowing how infectious it was and how it was transmitted etc. Therefore, planning focused on broader strategic issues, local resilience structures and channels of communication. More specific Command and Control documents would have to be written at the time of the pandemic.

(iv) Concerns were raised that during the Covid-19 pandemic briefings with district councillors had been infrequent and information had been poorly communicated. Whilst there had been debriefs with NHS staff and top tier local authorities, district

councillors had not been asked for their feedback and learning from the Covid-19 pandemic.

(v) Other countries had managed the Covid-19 pandemic in a different and sometimes more successful way and learning should be gained from those countries.

RESOLVED:

That the contents of the update be noted.

50. Date of next meeting.

RESOLVED:

It was noted that the next meeting of the Committee would be held on Wednesday 4 March 2026 at 2.00 pm.

2.00 - 5.35 pm CHAIRMAN
14 January 2026