Meeting: **Health Overview and Scrutiny Committee**

Date/Time: **Wednesday, 14 January 2026 at 2.00 pm**

Location: **Sparkenhoe Committee Room, County Hall, Glenfield**

Contact: **Mr. E. Walters (0116 3052583)**

Email: **Euan.Walters@leics.gov.uk**

Membership

Dr. S. Hill CC (Chairman)

Mr. M. Bools CC	Mr. J. McDonald CC
Mr. N. Chapman CC	Mr. J. Miah CC
Mrs. L. Danks CC	Mr. P. Morris CC
Mr. M. Durrani CC	Mr. B. Piper CC
Mr. P. King CC	Mr J. Poland CC
Mrs. K. Knight CC	Mr. K. Robinson CC

AGENDA

Item		Report by	
1.	Minutes of the meeting held on 5 November 2025.		(Pages 3 - 14)
2.	Question Time.		
3.	Questions asked by members under Standing Order 7(3) and 7(5).		
4.	To advise of any other items which the Chairman has decided to take as urgent elsewhere on the agenda.		
5.	Declarations of interest in respect of items on the agenda.		
6.	Declarations of the Party Whip in accordance with Overview and Scrutiny Procedure Rule 16.		

7.	Presentation of Petitions under Standing Order 36.		
8.	Primary Care	Integrated Care Board	(Pages 15 - 34)
9.	Medium Term Financial Strategy 2026/27-2029/30	Director of Public Health and Director of Corporate Resources	(Pages 35 - 44)
10.	Pandemic Planning.	Director of Public Health	(Pages 45 - 58)
11.	Date of next meeting. The next meeting of the Committee is scheduled to take place on Wednesday 4 March 2026 at 2.00pm.		
12.	Any other items which the Chairman has decided to take as urgent.		

Minutes of a meeting of the Health Overview and Scrutiny Committee held at County Hall, Glenfield on Wednesday, 5 November 2025.

PRESENT

Dr. S. Hill CC (in the Chair)

Mr. M. Bools CC
Mr. N. Chapman CC
Mrs. L. Danks CC
Mr. P. King CC
Mrs. K. Knight CC
Mr J. Poland CC
Mr. K. Robinson CC

Apologies

Mr. M. Durrani CC and Mr. B. Piper CC

In attendance

Mr. J. Miah CC – joined via Microsoft Teams
Mr. J. McDonald CC – joined via Microsoft Teams
Fiona Barber – Healthwatch Leicester and Leicestershire
Mr. J. T. Orson CC (items 28 and 32 refer) - joined via Microsoft Teams.
David Williams, Group Director Strategy & Partnerships, Leicestershire Partnership NHS Trust (item 33 refers).
Susannah Ashton, Divisional Director, EMAS, Leicester, Leicestershire and Rutland (item 34 refers).

26. Minutes of the previous meeting.

The minutes of the meeting held on 3 September 2025 were taken as read, confirmed and signed.

27. Question Time.

The Chief Executive reported that no questions had been received under Standing Order 34.

28. Questions asked by members.

The Chief Executive reported that three questions had been received under Standing Order 7(3) and 7(5).

1. Question from Mr. A. Innes CC:

As has been widely publicised, the services at St Mary's Birth Centre have been suspended for an indeterminate period of time due to staff shortages. The community in Melton and the surrounding areas are rightly concerned that this closure may become permanent. There has been local representations made by residents, councillors and the MO for Melton and Syston.

I would like to know what are the current plans for the birthing centre, and how do the ICB intend to fulfil their statutory responsibility to provide adequate health services for the communities they serve?

Reply by the Chairman:

I have asked University Hospitals of Leicester NHS Trust (UHL) for an answer to your question and I have received the following response:

"Pausing births and inpatient care at the Centre from 7 July was a difficult but necessary step. We did this to ensure the safety of mums and babies - nothing is more important. We are currently working with colleagues at the Leicester, Leicestershire and Rutland Integrated Care Board to determine next steps for St Mary's Birth Centre. This includes discussion of the safety risks and mitigation. We anticipate an update from the ICB and UHL will happen before January 2026."

As soon as UHL and the ICB are ready to provide any further detail about their plans I intend to request that they attend a meeting of the Leicestershire County Council Health Overview and Scrutiny Committee to present a report, not just on St Mary's Birth Centre, but on the plans for maternity services in the whole of Leicestershire. Officers will ensure that you are made aware of when this meeting will take place and provide you with a copy of the report.

2. Question from Mr. A. Innes CC:

Melton Mowbray is serviced by a single GP practice, Latham House, and following a recent report that the project to site a second GP practice in the town has been suspended there is further upset in the community following this decision. The Melton community cannot continue to have a situation where appointments are pushed out to 6 weeks and even for simple tests, we have to wait weeks to have these done.
I would like to ask does the Chair of the Committee share my concerns and how is the ICB planning to meet their statutory requirement to ensure that there is adequate healthcare provision for the communities in their designated areas, and more specifically for Melton Mowbray?

Reply by the Chairman:
I share the concerns of residents and local members from Melton over this issue. Therefore, we will be examining this matter in more detail at a future meeting of the Leicestershire County Council Health Overview and Scrutiny Committee. I am aware of concerns elsewhere in the County over GP practices, so any report we have will cover not just Melton, but other areas as well. In addition, the issue of access to GP practices is going to be examined by the Leicester, Leicestershire and Rutland Joint Health Scrutiny Committee in the new year.

In the meantime, I have obtained the following statement from the Integrated Care Board:

"We are working closely with GP practices across Leicester, Leicestershire and Rutland (LLR), including in Melton, to ensure any available, additional funding and recruitment opportunities are taken up and used to meet the health needs of our diverse communities, equitably. Practices are supported to implement new ways of working to

improve access and care, including introducing new technology, integrating a wider range of health professionals, innovating how care is provided and improving premises.
We are working with Latham House specifically to increase the ways the practice can support local residents, including a new digital suite at the main site, an approved redevelopment of a property owned by the practice on Sherrard Street to extend clinical services and increasing recruitment including five GPs. We are committed to continuing to work with Melton Borough Council on the health services provided for residents and our Chief Executive and Chief Strategy Officer are due to meet over the coming weeks with the council leaders.

To ensure we use limited resources in the best way to meet the needs of all patients, we are also coordinating partners across the health and care system by matching them to the right level of care for their medical condition, with the right health professional, in the right part of the NHS, first time, and improving access to same-day care. We are currently engaging with local communities to raise awareness of a two-step process to help them get the right care.

Supporting information:

- The healthcare provided by GP practices is funded according to the national GP contract and the integrated care board receives limited other funding streams with which to increase investment in general practice.
- Recent examples include additional investment to ensure local practices receive equitable funding to provide core services and encouraging primary care networks (groups of practices) to recruit additional staff from a wide range of roles under the Additional Roles Reimbursement Scheme (ARRS) - 30 additional newly qualified GPs have been employed in practices in LLR under this scheme.
- ICBs do not routinely receive capital funding to develop new practices themselves. Any new premises therefore need to be funded by local authority S106 contributions, private/public investment and GP practice investment.
- This helps balance the needs of all patients across Leicester, Leicestershire and Rutland using limited NHS resources.
- Over recent years, GP practices have been working hard to evolve how they provide care to improve access and improve patients' health.
  - GP practices have a wider mix of specialist health professional who work together to care for patients. GPs look after the most seriously unwell patients and those with the most complex needs and people with less serious health conditions are supported by the wider practice team, appropriate for the condition.
  - GP practices also work more closely with community pharmacies. Now conditions that used to be seen in general practice are looked after in a pharmacy, for example under the Pharmacy First scheme.
  - Practices are using new technologies which are often more convenient for many people. Digital options won't be suitable for everyone, but they free up traditional methods for those who can't use online options.
  - Cloud based telephone systems, with a call-back function, and online forms for making requests.
- Through GP practices and NHS 111, same-day appointments can be arranged if a patient's condition means that they need to be seen quickly. This could be at their own practice, at a local pharmacy under the Pharmacy First scheme, at an urgent treatment centre or another GP practice or health centre (during evenings, weekends and bank holidays). Melton Urgent Care Centre provides these latter appointments. Melton also has a Minor Injury Unit.

- The ICB regularly seeks the views of local people about the services they experience, in order to make improvements. The ICB carried out an LLR-wide GP practice experience survey in 2024. Local residents currently have the opportunity to share their views of same-day appointments, such as general practice and pharmacy appointments, and a new two-step approach to getting care quickly. The questionnaire closes on 7 December 2025: https://leicesterleicestershireandrutland.icb.nhs.uk/be-involved/need-help-fast-engagement/"

3. Question from Mr. J. T. Orson CC

Melton residents were dismayed to learn that the ICB has deferred funding for a second GP practice until February 2027. This decision has understandably intensified concern about the adequacy of current provision.

Would you agree that the time is right for constructive scrutiny—particularly in relation to Latham House Medical Practice? Persistent concerns around staffing levels, patient engagement, waiting times, and care protocols suggest that Health Scrutiny might now play a vital role in clarifying both current practice and future need. A formal review could offer reassurance, transparency, and a pathway forward.

I also believe all four Melton LCC Members and MBC would welcome the opportunity to contribute a solutions-focused perspective. There are areas where modest adjustments could yield meaningful improvements, and I'm confident both Councils stand ready to support any ongoing efforts.

I hope this letter strikes the right balance between challenge and collaboration. Please let me know if further discussion or additional detail would be helpful.

Warm regards,
Joe Orson
Melton Wolds Division

Reply by the Chairman:

I agree that the time is right for constructive scrutiny of the issues relating to Latham House Medical Practice. Officers that support the Leicestershire County Council Health Overview and Scrutiny Committee have been liaising with the Integrated Care Board regarding which would be a suitable Committee meeting for representatives of the ICB to come and present a detailed report on access to GP Practices, not just in the Melton area but in the whole County of Leicestershire. It is hoped that the report would address many of the issues you raise such as staffing levels and waiting times. The members that represent divisions in the Melton area will be invited to the Committee meeting at which this issue is considered. However, the limitations in terms of the powers and time constraints of the Health Overview and Scrutiny Committee must be recognised. Whilst the Committee can request reports and ask questions at public meetings, a more in-depth formal review would have to be carried out by the ICB themselves. Please see the interim response from the ICB set out in the answer to the question from Mr. Innes CC above. Please be assured that the Committee will continue to scrutinise the ICB on this topic and will invite you to any Committee meeting relating to health issues in the Melton area.

29. Urgent items.

There were no urgent items for consideration.

30. 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 an interest in Agenda Item 3: Questions asked by members and Agenda Item 7: presentation of petitions as he worked for Edward Argar MP as a Senior Caseworker and had been involved in campaigning regarding St Mary's Birth Centre and access to GP Practices in the Melton area.

31. Declarations of the Party Whip.

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

32. Presentation of Petitions.

The Chief Executive reported that the following petition had been received from Mr. J. T. Orson CC under Standing Order 36 signed by over 2,000 Leicestershire residents (over 3000 signatures in total):

> "We are a growing community in Melton Mowbray, and it is crucial to protect all our health-related services. However, the impending closure of St Mary's Birth Centre is more than just a Melton issue - it's a significant concern for the entire University of Leicester Hospitals Trust. St Mary's Birth Centre has been an invaluable facility for expectant mothers not only in Melton but also from across Leicestershire and Rutland. Many choose it for its outstanding maternity and postnatal care, characterised by a nurturing environment and exceptional professional support.
>
> Despite the invaluable services provided by St Mary's Birth Centre, it suffers from a lack of promotion and insufficient staffing. These issues affect its ability to operate to its full potential and serve the needs of our community. Closing this centre would not only limit choice for expectant mothers across the Trust, but also place additional strain on alternative maternity services within the region, potentially compromising the quality of care, particularly postnatally.
>
> "Better Births" a 2016 report from the National Health Service, reveals that having more birthing options leads to better health outcomes for both mothers and babies. The centralisation of maternity services often overlooks the unique benefits provided by community-focused and midwife-led centres like St Mary's.
>
> Our goal is to urge the University Hospitals of Leicester NHS Trust to not only re-open St Mary's Birth Centre but to revisit the decision to remove our only freestanding midwife-led unit in Leicestershire, and secure its future with adequate staffing and through promoting its services. We need to ensure that it receives the recognition and resources deserved to remain a viable option for expectant mothers now and for future generations.

> Stand with us in the fight to safeguard women's choices and local services. Sign this petition now to protect and promote the exceptional care provided by St Mary's Birth Centre, ensuring it remains the gem that it is."

The Chair stated that the issues raised in the petition were of interest to the Committee and liaison was taking place with NHS partners about which would be a suitable Committee meeting to have a report and presentation on this topic. Interested parties would be informed of the date of the meeting in due course.

33. New LPT Strategy - Together We Thrive.

The Committee considered a report of Leicestershire Partnership NHS Trust (LPT) which introduced their new strategy 'Together we thrive'. A copy of the report, marked 'Agenda Item 8', is filed with these minutes.

The Committee welcomed to the meeting for this item David Williams, Group Director Strategy & Partnerships, LPT.

Arising from discussions the following points were noted:

(i) One of the key elements of the strategy was a move from analogue to digital. It was hoped to automate admin processes, such as changing an appointment date, so that staff could focus on other tasks. This approach was welcomed in the main by members, but it was emphasised that it was important to ensure people that were not digitally enabled were not left out. In response reassurance was given that LPT aimed to help promote digital literacy. It was explained that if the majority of patients engaged with LPT digitally, this would leave more time for staff to engage with the patients that were less digitally enabled. Members raised concerns that the latter were the cohort that would need LPT services more and could therefore still be negatively affected by the move from analogue to digital.

(ii) Members raised concerns about vulnerable people with mental health issues having to engage with Artificial Intelligence rather than a human person.

(iii) In response to a question as to whether the commitment to building compassionate care and wellbeing for all needed to be contained within a strategy, as it should be business as usual, it was emphasised that it was important to re-enforce this aim. Examples of where the wellbeing work was effective was the community events taking place at Fearon Hall in Loughborough and the respiratory work taking place in West Leicestershire.

RESOLVED:

That the contents of the LPT strategy 'Together we thrive' be noted.

34. East Midlands Ambulance Service.

The Committee considered a report of East Midlands Ambulance Service (EMAS) which gave an overview of their work. A copy of the report, marked 'Agenda Item 9', is filed with these minutes.

The Committee welcomed to the meeting for this item Susannah Ashton, Divisional Director, EMAS, Leicester, Leicestershire and Rutland.

Arising from discussions the following points were noted:

(i) One of the advantages of EMAS being a regional organisation rather than solely for Leicestershire was that in periods of high demand in Leicestershire resources could be taken from elsewhere in the region to help out.

(ii) At times EMAS would take a patient picked up in Leicestershire across the border to a hospital in the West Midlands as it was closer, however EMAS would not pick patients up in the West Midlands.

(iii) Ambulances could take longer to reach patients in rural areas. The software used by EMAS gave advice on the best routes to take to avoid roadworks or other blockages. Although there were ambulance stations in rural areas this did not mean an ambulance would be at the station ready to go when a call came in for a rural area. The ambulance could be on a job in another area.

(iv) The table in the report demonstrated that the category 2 response times had lengthened significantly in December 2023 and again in December 2024. This was thought to be due to an increase in demand around that time of the year rather than being due to staff being on holiday. Reassurance was given that staffing levels did not fluctuate during the year and were kept consistent.

(v) In response to concerns raised, members were reassured that whilst patients were waiting for an ambulance or paramedic the control room would keep in touch with them. The number of call takers and clinicians available to provide the Hear and Treat service had been increased. NHS England had set a target of 20% of ambulance calls being managed by the Heart and Treat service; the latest figure for EMAS was 24%.

(vi) In response to a question about how ambulance handover times at the Emergency Department in Leicester compared with other areas of the country, it was explained that it varied. The National Standard was a 15 minute handover time but as this was not always realistic, in 2025 ICBs had been asked to aim for a 30 minute handover time. It was agreed that the exact comparison data would be provided to members after the meeting.

(vii) Members queried what percentage of people called for an ambulance when they did not need one and could have received treatment via another method. Some patients that were dealt with by EMAS had called 111 and some had called 999. Patients did not always call the correct number for their medical issue, but either way they would receive the same service because the same pathway system was used. Members indicated that they might wish to scrutinise these issues further at a future meeting.

(viii) Concerns were also raised that the call operators were allocating ambulances to calls when the patient could have been conveyed to hospital via other means. Members queried how good the call handlers were at triaging patients and deciding what treatment and assistance they required. In response it was explained that the accuracy was variable and it could be challenging for the call takers to make the right assessment as most patients did not have the medical training to describe their symptoms accurately. However, calls could be re-categorised very easily once EMAS had seen a patient face to face. Reassurance was given that the calls were reviewed and audited and further guidance was issued to call operators when necessary. It was not possible for EMAS to change the questions asked by call operators as the questions were set nationally. It was agreed that data regarding the accuracy of the triage process would be provided after the meeting.

(ix) It was explained that 39% of patients dealt with by EMAS were conveyed to hospital and the remaining 61% were conveyed to an alternative place of care. Members asked to receive further information regarding these statistics.

(x) In response to a query, it was explained that there were enough training places for paramedics. Locally Nottingham Trent University and Northampton University ran the courses. However, the problem was that there were not enough vacancies for newly qualified paramedics.

(xi) West Leicestershire had been named as one of 43 areas in England which would benefit from improved Neighbourhood Health Services as part of a government scheme. A decision had been made locally that this work would focus on respiratory issues and EMAS was linked in with this work. EMAS was also involved in other community schemes such as work taking place in Hinckley and Bosworth district to identify and address mould in homes.

RESOLVED:

(a) That the overview of the work of EMAS be noted:

(b) That officers be requested to provide regional comparison of ambulance handover times, data regarding the accuracy of the triage process and the percentage of calls to EMAS where the patient could have received appropriate treatment elsewhere.

35. Leicestershire HIV Late Diagnosis.

The Committee considered a report of the Director of Public Health regarding the latest HIV late diagnosis position, and actions underway to improve diagnosis across Leicestershire. A copy of the report, marked ‘Agenda Item 10’, is filed with these minutes.

Arising from discussions the following points were noted:

(i) Leicestershire was ranked 15th out of 16 when benchmarked against comparable authorities for the metric ‘HIV late diagnosis in people first diagnosed with HIV in the UK’. The data had to be considered with caution because not all authorities carried out the same amount of testing. Although Worcestershire was rag rated green for this metric, they carried out far less testing than Leicestershire. Leicestershire was ranked 3rd out of 16 for testing rates. The HIV late diagnosis indicator was based on the proportion of all those diagnosed with HIV who were diagnosed late and very few authorities were meeting the national target of <25%. The Cabinet Lead for Health stated that it was more important to increase testing numbers, and not be too concerned if this led to an increase in positive tests.

(ii) In response to a suggestion that the whole population of Leicestershire could be tested for HIV, it was explained that this would not be a proportionate and necessary approach, but increasing testing numbers was important.

(iii) The Public Health Department was analysing the HIV data to see what could be learnt. There were some difficulties as due to the small numbers, data was redacted. Demographic data was not available at district level but was available at Leicestershire level.

(iv) During the Covid-19 pandemic HIV testing at home had been introduced and this had continued after the pandemic. It had been proved to be popular and successful. The amount of tests taking place at home was increasing year on year. Members welcomed this.

(v) Nationally, work on HIV was directed through ‘Towards Zero – An action plan towards ending HIV transmission, AIDS and HIV related deaths in England’. Members welcomed this work and felt that the aim was realistic. However, concerns were raised about the possible impact of budget cuts on HIV work.

(vi) There were concerns that the public was not using barrier forms of contraception as much as they should be and were too reliant on taking Pre-Exposure Prophylaxis (PrEP). This was leading to an increase in other sexually transmitted infections such as syphilis and gonorrhea. Messages needed to be disseminated to the public to remind them to use condoms.

(vii) Peer support groups were available for people with HIV.

RESOLVED:

That the update regarding HIV diagnosis be noted and the actions underway to improve diagnosis across Leicestershire be welcomed.

36. Healthwatch Leicestershire Annual Report 2024/25.

The Committee considered a report of Healthwatch Leicester and Leicestershire which presented their Annual Report 2024-25. A copy of the report, marked ‘Agenda Item 11’, is filed with these minutes.

The report was presented by Fiona Barber, Healthwatch Leicestershire Board member.

Arising from discussions the following points were noted:

(i) Access to GP appointments was one of the main issues raised by the public with Healthwatch.

(ii) In response to concerns raised by a member about parking at Leicester Royal Infirmary, Fiona Barber agreed to raise this with University Hospitals of Leicester NHS Trust during her next meeting with them.

(iii) The Healthwatch Leicester and Leicestershire Contract was held by Leicester City Council and Leicestershire County Council under a formal joint working agreement. In response to concerns raised by a member that cuts could be made to Healthwatch funding as part of an efficiency review taking place at Leicestershire County Council, reassurance was given that the current contract was funded in total via a ring-fenced grant.

(iv) The government was proposing that Healthwatch functions related to healthcare be combined with the involvement and engagement functions of Integrated Care Boards and Healthwatch functions related to social care transfer to local authorities. Primary legislation was required to implement these changes as Healthwatch had been set up as a result of the Health and Social Care Act 2012. The legislation was currently being drafted but was not expected to pass through parliament until later in 2026. In the meantime Healthwatch was continuing business as usual.

RESOLVED:

That the contents of the Healthwatch Annual Report 2024-25 be noted.

37. Issues arising from Health Performance report that merit more detailed scrutiny.

The Committee considered a joint report of the Chief Executive and the ICS Performance Service which provided update on public health and health system performance in Leicestershire and Rutland based on the available data in October 2025. A copy of the report, marked ‘Agenda Item 12’ is filed with these minutes.

Members were asked whether there were any areas identified in the report that they felt required more detailed scrutiny at a future meeting. Secondary/elective care appointment waiting times was suggested and how the waiting lists were managed. In addition it was noted that the metric relating to suspected cancer patients starting treatment within 62 days of referral was rag rated red therefore members felt that it was worth a detailed look at the reasons behind this.

RESOLVED:

(a) That public health and health system performance in Leicestershire be noted;

(b) That officers be requested to provide a report for a future meeting regarding secondary care appointment waiting times and cancer referrals.

38. Noting the work programme of the Leicester, Leicestershire and Rutland Joint Health Scrutiny Committee.

The Committee considered the work programme of the Leicester, Leicestershire and Rutland Joint Health Scrutiny Committee, a copy of which marked ‘Agenda Item 13’, is filed with these minutes.

RESOLVED:

That the work programme be noted.

39. Dates of future meetings.

RESOLVED:

That future meetings of the Committee take place on the following days all at 2.00pm:

Wednesday 14 January 2026;
Wednesday 4 March 2026;

Wednesday 3 June 2026;
Wednesday 9 September 2026;
Wednesday 4 November 2026.

2.00 - 4.21 pm CHAIRMAN
05 November 2025

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NHS
Leicester, Leicestershire and Rutland

HEALTH OVERVIEW AND SCRUTINY COMMITTEE: 14 JANUARY 2026

PRIMARY CARE

REPORT OF THE INTEGRATED CARE BOARD

Purpose of report

1. The purpose of this report is to provide an oversight and summary on Primary Care services that are commissioned by the Integrated Care Board (ICB) and delivered by Primary Care providers (GP Practices) across Leicester, Leicestershire and Rutland (LLR).

2. This will include a focus on national contract and locally tailored commissioning arrangements to explain how this supports patients in LLR to improve clinical outcomes and increase the number of appointments available in Primary Care General Practice.

3. Details will also be given regarding the ongoing local processes to ensure continued improvement around quality and safety and contractual compliance.

4. In response to a request from the Committee, information is provided specific to the Melton Mowbray area with regards to the current and future delivery of Primary Care services.

Background

5. Nationally, it is recognised that pressures in Primary Care are increasing in all areas, including the availability of an appropriately trained and experienced workforce to achieve the capacity to meet demand of patients in a growing and more complex population. The ICB is committed to ensuring that the provision of General Practice and wider Primary Care in LLR is enabling patients to access services in a timely and effective way. This will improve the experience and clinical outcomes of patients navigating the health system and support wider system partners by:
   • Helping to mitigate exacerbated demand across the wider system, e.g. ED attendances;
   • Improving communication and transfer of care between Primary, Secondary and Community care;
   • Providing better oversight and coordination in the management of people with Long-Term Conditions.

6. The LLR ICB Primary Care Transformation Board (PCTB) 2025/26 operational priorities continue to focus on maximising and expanding capacity to improve access and optimise health outcomes at neighbourhood level, address health inequalities and continue to deliver the ambitions set out in the NHS Long-term Plan. These priorities are:

a. Priority 1 - Reducing Unwarranted Variation and Improving Access for Patients
b. Priority 2 - Managing Winter Pressures
c. Priority 3 - Ongoing Quality Assurance and Safety
d. Priority 4 - Ensuring Value for Money and Contractual Compliance

7. The ICB oversees delivery of nationally agreed contracts with Primary Care providers, including Primary Care Network (PCN) Directed Enhanced Service (DES) which is designed to encourage GP practices to work together as Primary Care Networks (PCNs) to improve local patient care in specific areas in exchange for additional financial remuneration. During 2025/26, PCNs have worked in collaboration with member practices, ICB and wider system partners to support the delivery and implementation of national PCN DES as outlined in the table below:

PCN DES Delivery 2025-26	
Requirement	**Delivery in LLR**
Improving health outcomes and reducing health inequalities	All 26 PCNs submitted their Population Health Inequality plans outlining their aim to improve health outcomes for its population using a data-driven approach and population health management (PHM) techniques. The themes include Long-term diseases management, prevention, mental health, children and young people, women's health, early cancer screening, etc. PCNs will be invited to submit an outcome plan in May 2026 outlining the delivery of the plan and benefit to patient outcomes.
CVD	Overall, there has been an increase in early intervention and preventive care, particularly cardiovascular disease (CVD), reflecting the NHS's priority to reduce avoidable illness and early mortality. • Hypertension: Improvement in Hypertension identification by 19% • Atrial Fibrillation: Increase in AF identification by 2.5% • Lipid management: Increase in the Lipid management by 70%
Structured Medication Reviews	The Structured Medication Review (SMR) is a national, long-standing requirement for PCNs to work closely with their Clinical Pharmacist to increase the number of SMRs for the following cohort of patients: • Residents in care homes • People with learning disabilities • Those with severe frailty (housebound, isolated, recent admissions or falls) • Patients with complex polypharmacy (10+ medicines) • Patients on medicines associated with medication errors or harm • Patients on medicines linked to dependence or withdrawal These SMRs are vital for preventing avoidable harm, improving medicines optimisation, and supporting system priorities around frailty, safety, and reducing unplanned hospital activity. Across all indicators, activity has improved between October and November 2025, representing a positive shift in momentum: Many PCNs fall into the 1–24% engagement band, with a smaller proportion achieving ≥50%. As SMRs are annual reviews, majority of these are completed in the new year whereby patients are invited for health checks and medication reviews undertaken at the same time.
Early Cancer Diagnosis	LLR PCNs continue to increase cancer referrals in collaboration with partners and are working to improve early diagnosis. In addition, PCNs collaborate with Cancer Alliance to improve screening uptake, inclusive of breast, bowel and cervical cancer.

Local Approach to Commissioning

8. Alongside the nationally mandated elements of contractual and quality assurance expected to be carried out by ICBs, LLR have developed a tailored approach to the commissioning of specific services within Primary Care.

The Community Based Services

9. The Community Based Services (CBS) are a suite of locally commissioned services developed in 2023 and launched to coordinate practice payment for Locally Enhanced Services (LES) during 2024/25.

10. This local approach encourages what is traditionally thought of as the 'left shift' of suitable hospital activity that can be carried out in the community or by General Practice, closer to the homes of patients and with a transparent and fair remuneration process for practices that is directly linked to the activity.

11. The following table outlines the elements contained within the CBS offer in LLR:

Community Based Services (CBS) Offer in Primary Care	
Service Element	**Description**
Phlebotomy - Adults Phlebotomy - Children	Primary and Secondary initiated bloods service in general practice for adults and children.
Wound Care, Dressings, Suture & clip removal - Primary and Secondary	Provision of wound management in a local care setting, reducing the demand on acute and urgent care services.
Minor Injuries	Provision of evidence based minor injury care that optimises health and wellbeing and reduces the impact of minor injury, whilst reducing pressure on both emergency and primary care services.
Complex Care: Proactive care of patients with multimorbidity and/or complex needs	Provision of additional support and care for a specific sub-cohort of patients in LLR who are known to have complex / End of Life (EoL) health and / or care needs and would benefit from a structured care and medical review.
Nursing and Residential Care Homes Patients	Provision of additional services for patients in Nursing or Residential Homes, reducing the demand on acute and urgent care services.
Annual surveillance of at-risk individuals from Prostate Cancer	Patients who need active surveillance (those that do not have a cancer diagnosis but have a persistently elevated (Prostate Specific Antigen) PSA which requires monitoring).
Glucose Tolerance Testing in pregnancy	Oral glucose tolerance test (OGTT) in pregnancy between 24 and 28 weeks of pregnancy to diagnose gestational diabetes (GDM) or earlier than 24 weeks where a pregnant woman has had GDM during a previous pregnancy.
Urine Beta hCG Testing	Provision of an accurate and rapid pregnancy test result for patients who are identified as more appropriate for GP practice testing than self-testing including advice

	and signposting to support services as determined by the result of the test.
Vaginal Ring Pessaries	Provision of a service for all ambulatory female patients aged 18 years and over, registered with an LLR GP practice presenting with symptoms or incidental findings of vaginal prolapse or currently have a ring pessary fitted by another provider to have access to high quality vaginal ring pessary service delivered in primary care. The service will encompass the insertion of new, renewal or removal of pessaries and includes the reasons for a vaginal pessary, the benefits and any side effects.
Ear Irrigation	Provision of a service to patients with an identified need following a clinical consultation requiring an ear irrigation intervention.
Medicines Optimisation Framework (MOF) PQS)	Quality improvement focussing on: − Medicine safety − Antimicrobial Stewardship − Evidence based choice of medicines − Medicines Optimisation as part of routine practice − Understand patient experience
Monitoring Shared Care Medication (Including Lithium)	Monitoring of Shared Care Medicines as defined by the LLR Traffic Light system and Shared Care Agreements.
Supply and Administration of Defined Injectable Medicines	Supply and administration of defined Injectable Medicines.
Administration of depot Antipsychotics	Supply and administration of depot antipsychotic injections in line with normal best practice for the conditions being treated and in accordance with Leicester, Leicestershire & Rutland Area Prescribing Committee (LLR APC) Traffic Light classification requirements.

Table 2 - CBS Offer in Primary Care

Specialised Services

12. Due to the especially diverse cohort of communities that reside within LLR compared to other areas of the country, the ICB commission a small number of Specialised Primary Care providers to ensure equity within specific cohorts with regards to access to and effectiveness of services, to improve the health outcomes for recognised vulnerable groups. Following a recent procurement exercise, the ICB has issued long-term contracts for:
    - LLR-wide Primary Care services for asylum seekers awaiting a decision from the home office who are being accommodated in short-term ‘Contingency’ accommodation;
    - LLR-wide Primary Care services for the Homeless;
    - LLR-wide ‘Violent Patient Service’ (statutory responsibility of ICBs).

Same Day Access (SDA)

13. The vision for Leicester, Leicestershire and Rutland (LLR) as part of the Same Day Access services is to offer an integrated, coherent, and intelligible “same day” care service whereby patients can access the right service through an enhanced navigation and triage process to be seen by a GP for their care.

14. The primary aim of the Same Day Access is to ensure our Leicester, Leicestershire and Rutland patient population receive the “Right Care, Right Place, First Time” which we trust will reduce demand for acute emergency care and increasingly meet people’s needs in the most appropriate primary care setting closer to home.

15. The Same Day Access service is designed to ensure all patients, regardless of ethnicity, age, disability, sex, gender reassignment, religion/belief, or sexual orientation, can receive same day access care in a General Practice setting, because their needs cannot safely wait for the next day or a routine appointment at their registered General Practice. In addition, the service aims to ensure that patients, carers, and parents of young children are supported to access the right same day treatment and where necessary, be referred to the appropriate health care service for ongoing management.

16. The Same Day Access service provides additional primary care capacity, outside of core hours to support the balance of same day need and continuity of care. This is to ensure that patients have a seamless transition into and out of the service and that it promotes appropriate sharing of information to optimise the outcomes of care.

17. The principle of Same Day Access is to provide a service that is integrated operationally and strategically with other urgent care services in the wider health economy and thereby, reduce the number of patients having an avoidable attendance in an acute hospital.

18. Same Day Access appointments have/are being commissioned across LLR to:
    - Support the provision of on-the-day appointments for patients with conditions that can be managed in Primary Care.
    - Help to mitigate the burden of increased activity in Urgent and Emergency Care (UEC) services, such as walk-in centres and ED.

19. These services have been commissioned separately across the different ‘Places’ in LLR to meet the specific needs of local populations:

Leicestershire Same Day Access

20. Leicestershire Same Day Access is scheduled to commence on 1 April 2026, following the Most Suitable Provider (MSP) process under the Provider Selection Regime (PSR).

21. The SDA model is a key component of the LLR urgent care strategy and aligns with the national SDA hub approach, supporting integrated, neighbourhood-based care and improved access for local populations.

22. SDA will be delivered as part of the wider urgent care framework, closely aligned with NHS 111, the Clinical Navigation Hub, and Emergency Departments, and delivered through federations aligned to Primary Care Networks (PCNs).

23. From 1 April 2026, the Leicestershire population will have access to Same Day Access appointments Monday to Friday from 6:30pm to 8:00pm, Saturday 9:00am to 5:00pm and Sunday 10:00am to 2:00pm.

24. Same Day Access appointments will be available to all patients registered with a county GP and access at eight different locations across the county:
    1. Market Harborough
    2. Melton Mowbray
    3. Lutterworth
    4. North Blaby
    5. Hinckley
    6. Northwest Leics
    7. Charnwood
    8. Oadby Wigston (Additional Site)

25. On average there will be over 35,000 Same Day Access appointments available throughout the year offered Monday to Sunday.

26. Overall, this programme links with the ICB direction of travel for Neighbourhood based models of care with an aim to reduce avoidable acute activity and improving patient experience.

Priority 1 - Reducing Unwarranted Variation and Improving Access for Patients

27. The variation between general practice providers regarding how appointments are made available can result in patients becoming confused about how and where to access care when they feel they need it and ultimately may contribute to a default approach of patients opting for established UEC pathways to be seen on-the-day instead.

28. There is a rolling programme to address unwarranted variation in the availability and accessibility of general practice appointments across all practices in LLR. The General Practice Assurance and Improvement Group (GPAIG) comes together monthly to review data and intelligence at practice level and identify occurrences of unwarranted variation. This includes representatives from all Primary Care teams at the ICB; Transformation, Contracts, Quality, Estates and IMT.

29. Looking at LLR-wide data from the current financial year, we can see:

The total number of General Practice appointments offered within LLR for this period was 4,692,092.

This is a **2.2% Increase** from the same period in 24/25 (additional 99,223 appointments)

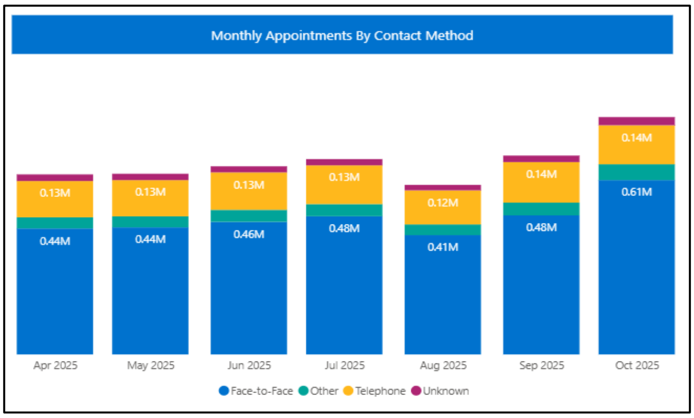


Table 4 – Data Source - National GPAD Portal – General Practice appointments across all staff types in LLR

The average appointment rate per 1000 patients for this period was 543.

This is an **Increase of 9** from the same period in 24/25 and is **above the national average**

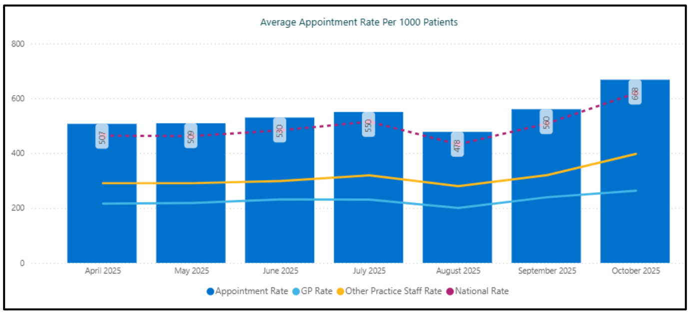


Table 5 – Data Source - National GPAD Portal – General Practice appointments across all staff types in LLR

70.9% of appointments were face-to-face

This is a **Decrease of 1%** from the same period in 24/25 (acknowledging a national push towards virtual/tel)

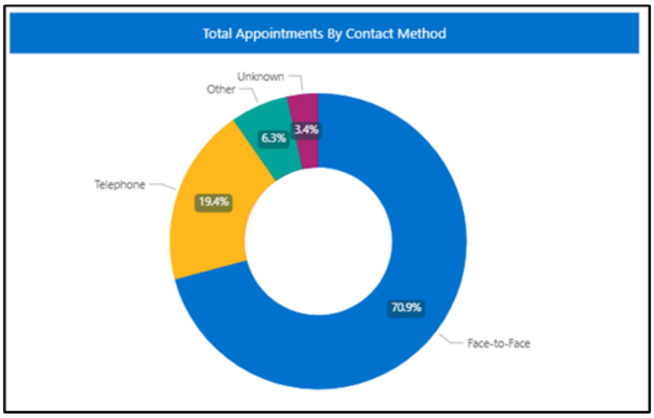


Table 6 – Data Source - National GPAD Portal – General Practice appointments across all staff types in LLR

39.8% of appointments took place on the day of contact.

37.5% of appointments took place within +1 to +14 days.

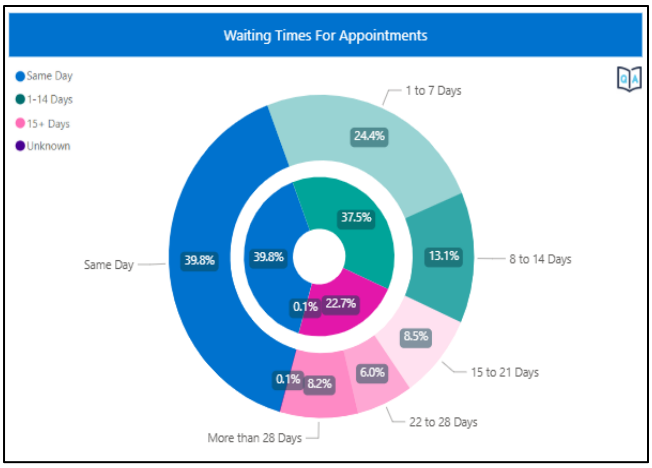


Table 7 – Data Source - National GPAD Portal – General Practice appointments across all staff types in LLR

30. This data shows that our practices are delivering more appointments whilst also transforming the way they work to implement changes that meet new mandates, e.g. increasing virtual consultations, whilst still fulfilling their traditional role of the management of chronic illnesses for patients with long-term conditions.

Digital

31. All practices in LLR are now utilising Cloud-Based Telephony technology, which means that calls can be digitally managed and coordinated between sites - even across practices in the same PCN for Business Continuity Management scenarios, such as emergency practice closures. This also means most practices are using a live call-back system that holds callers' place in the queue without them having to wait on the phone.

32. Every practice has now also implemented new Online Consultation (OLC) solutions for implementation, alongside telephone and traditional face-to-face appointments where clinically appropriate and/or preferred by patients.

33. Practices are also encouraged to promote the use of the NHS app for prescription requests and access to personal health records.

Reducing Did Not Attends (DNAs)

34. DNA rates within General Practice have risen significantly across LLR within the last 3 years.
    - 265,288 appointment DNA in 22 / 23 - 15% repeat patients;
    - 282,321 appointment DNA in 23 / 24 - 16% repeat patients;
    - 288,933 appointment DNA in 24 / 25 - 32% repeat patients.

35. This equates to 139,000+ hours of lost clinical time, assuming that all appointments were 10 minutes in duration. The impact of patient DNAs on capacity and access across the system is significant: patients will experience longer wait times to be seen and patients may utilise other alternative pathways (for example - NHS 111, A & E and Urgent Care Centres).

36. The project was launched in Leicester City initially, where best practice was shared, and has subsequently been launched in Leicestershire and Rutland following positive results. The project aims to actively promote the following messaging:
- If you have an appointment that you cannot attend, you must cancel it.
- If you need to cancel an appointment, it's really easy to do so.

37. Reducing DNA rates across LLR aims to ensure that patients receive the right care at the right time, to reduce ED attendances and avoidable hospital admissions.

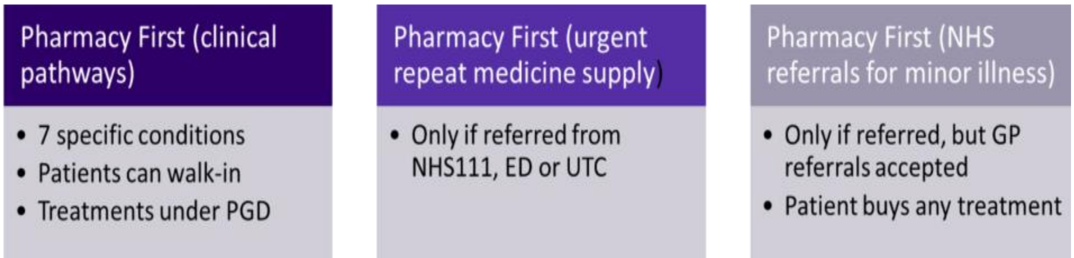
38. Quarter 1 & Quarter 2 has seen a reduction of DNA rates within Leicester City of 1.77%. This will be closely monitored going forwards for Quarter 3 & Quarter 4 across LLR, whilst processes are given time to embed.

Community Pharmacy

39. The NHS Long Term Plan published in January 2019 highlighted the need to boost out-of-hospital care and to reduce pressure on urgent and emergency care (UEC). It also committed the NHS to make greater use of community pharmacists’ skills and opportunities to engage patients. The NHS Community Pharmacist Consultation Service (CPCS) was commissioned by NHS England as an advanced service from October 2019. A patient referred into the service had a confidential consultation with a community pharmacist to assess their need for an urgent repeat medication or to assess acuity of minor illness symptoms and provide advice to support next steps.

40. In May 2023, NHS England and the Department of Health and Social Care (DHSC) published the Delivery Plan for Recovering Access to Primary Care and committed to expanding the role of community pharmacy. One of the ways this was delivered was by the evolution of the previous CPCS service into the new Pharmacy First with the addition of the option for pharmacists to treat seven common conditions by supplying NHS funded medicines.

41. The full service therefore consists of three elements:



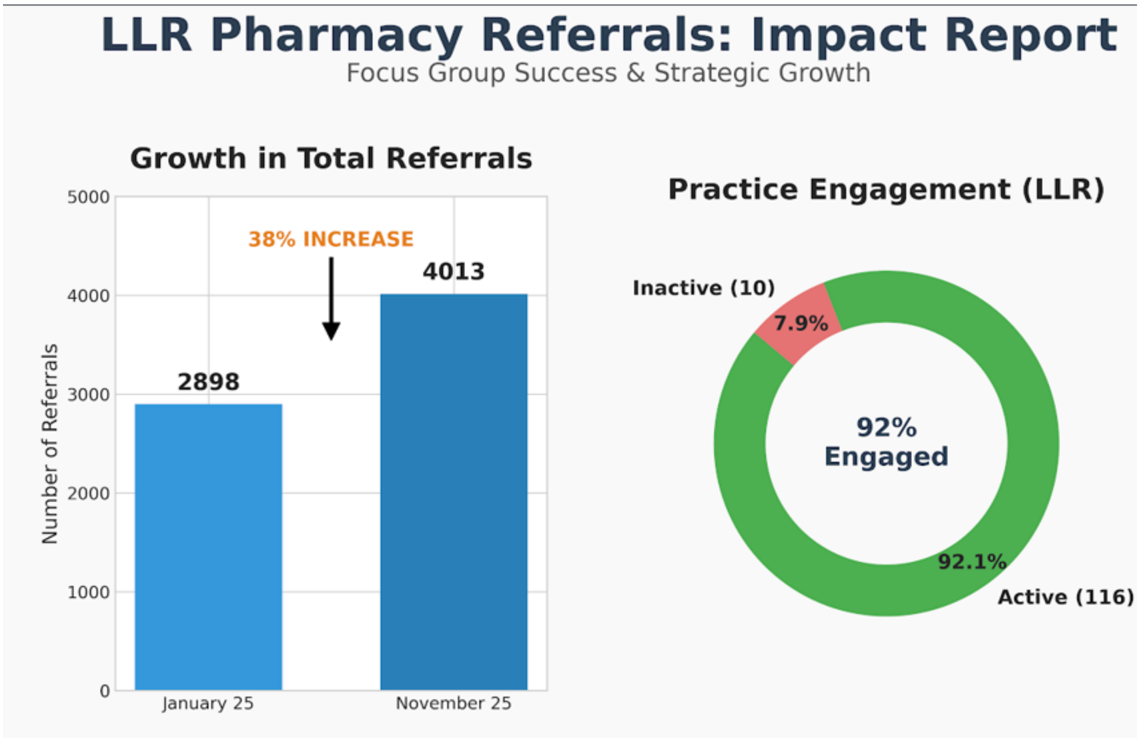
42. As an advanced service, pharmacies can choose to opt in to the service or not, but if opted in must provide the full service (exceptions for distance selling pharmacies). As of November 2025, only two pharmacies in LLR had not signed up to provide the service. The main reason for this is the physical space in those 2 pharmacies does not enable to offer the full range of service required.

43. The strategic aims of the service are to:

- Provide access to appropriate urgent care services in a convenient and easily accessible setting.
- Free up clinician capacity in the above settings, for the treatment of patients with higher acuity conditions
- To promote community pharmacy supported self-management of health as a first-choice option for patients and therefore prevent inappropriate use of UEC services in the future.
- To provide urgent access to patients who are not registered with a GP for treatment of low acuity minor illnesses.
- To further utilise the clinical skills of community pharmacy teams to complete
- episodes of care for patients and improve access.

44. The current activity levels for Pharmacy First within LLR have grown dramatically over the year. We have implemented a bi-monthly Pharmacy First Focus group with the PCN managers to offer support and guidance around all areas of community pharmacy.

45. Since starting Focus Groups, we have seen an increase in practice referrals to pharmacies of 38% increase across LLR.



46. Looking at the above graphic, it shows that in January 2025 we recorded 2,898 referrals and the most recent data in November 2025 shows that number at 4,013. Moving from sub-3,000 to over 4,000 referrals indicates that the infrastructure and pharmacy capacity are successfully scaling to meet increased demand. We have also been working individually with PCN's offering a 1-2-1 service to look into details of current issues so we can assist with any support they require. The engagement from our 126 practices within LLR is now at 92% with only 10 practices in the latest data not offering a referral, this has been consistent for 3 months. So once again we have seen great developments within LLR. Our current referral rate per 1000 patients makes us the leading ICB within the Midlands region.

Metric	Value	Insight
Growth	+38.5%	High momentum; successful adoption of Focus Group feedback.
Active Practices	116 / 126	High system-wide buy-in; low "leakage" of potential referrals.
Sustainability	3 Months	The engagement levels are a "new normal," not a temporary spike.
Market Position	#1 in Midlands	Demonstrates "Best in Class" status for the referral per 1000 metric.

47. Looking at the past 3 months of data recorded (September, October and November) and using the calculations according to the British Medical Association that around 13 appointments being a safe number of patients that a GP can manage in a half-day session and that a full time GP works 9 sessions a week. In terms of approximate GP sessions saved within practices (understanding that these sessions can be taken up by patients with more serious illnesses) the approximate GP sessions saved by utilising Pharmacy First can be seen below.

Month	Approx GP sessions
September	230.9
October	314.3
November	308.7

Priority 2 – Managing Winter Pressures

48. As part of wider system Winter Planning processes, a detailed plan has been submitted to identify how Primary Care can continue to contribute to mitigating increased pressure across all sectors.

49. As part of this, further additional capacity has been commissioned within Primary Care to mitigate pressure associated with regular winter surges being felt by wider system partners:

Acute Respiratory Infections & Response hub

50. The hub enables children to access medical care for respiratory illnesses that may cause fever, laboured breathing, lethargy and poor feeding or fluid intake. The hub will provide additional access to medical care for children and young people with non-life-threatening respiratory illnesses such as coughs, colds and wheezing caused by winter viruses

51. To help the Children's Emergency Department focus their resources on life and limb threatening emergencies, children that require respiratory or other related support can now be referred to the hub by either their GP practice or by triage staff at the Children's Emergency Department. The hub, which is based in Leicester, will offer appointments to patients between 2:00pm and 9:00pm Monday to Friday. An extra 2,470 appointments will be provided from December 2025 until March 2026.

On the day support for General Practice

52. The ICB provides on the day support to practices to identify solutions to operational and systemic issues as they are encountered. Practices are encouraged to regularly report their operational capacity with regards to the availability of general access appointments as part of a local Operational Pressures Escalation Level (OPEL) framework for Primary Care which feeds into wider system coordination of daily pressure.

Priority 3 - Ongoing Quality Assurance and Safety

53. LLR ICB has embedded a comprehensive assurance and improvement framework that goes beyond compliance to actively address unwarranted variation and promote equity in patient care. The approach combines quantitative data with qualitative insights to create a holistic understanding of practice performance. While dashboards and metrics provide a starting point, they are never viewed in isolation. Instead, they are contextualised with local intelligence, patient feedback, and practice-level engagement to ensure that variation is understood, whether warranted or unwarranted, and acted upon appropriately.

54. The General Practice Quality Dashboard is central to this work. It maps variation across clinical outcomes, patient experience, and medicines safety indicators, enabling commissioners to identify patterns that may signal inequity or risk. This intelligence informs monthly discussions at the General Practice Assurance and Improvement Group (GPAIG), where data is translated into practical actions. For practices with significant variation, tailored Desktop Reviews are produced, highlighting improvement priorities and sharing best practice examples. These reviews are not punitive; they are collaborative tools designed to empower practices to make meaningful changes.

55. The Quality Assurance and Improvement Toolkit (QAIT) further strengthen this approach. It provides practices with a structured self-assessment against national standards while offering guidance on improvement strategies. By integrating Local Authority assurance requirements, QAIT has streamlined reporting and reduced duplication, freeing practices to focus on quality rather than bureaucracy.

56. Governance is underpinned by a risk-based, multi-level framework aligned to National Quality Board guidance. Routine assurance occurs at GPAIG, while enhanced oversight and rapid intervention are triggered for higher-risk scenarios. This graduated model ensures proportionate responses and fosters a culture of continuous improvement rather than reactive compliance.

57. Our commitment to reducing unwarranted variation is reflected in tangible outcomes. Appointment availability has increased by 2.2% between April and October 2025, with LLR practices delivering an average of 543 appointments per 1,000 patients, exceeding national benchmarks. This improvement is not uniform, however, and the dashboard continues to highlight areas where access remains constrained. These insights have informed targeted interventions, such as workflow redesign and resilience planning, to ensure sustainable gains.

58. 96% of LLR practices are rated Good by the CQC, and patient experience scores, while only slightly below national averages (FFT England = 75%, FFT LLR = 72%), show positive trends. Importantly, QAIT submissions reveal a shift in the types of support requested towards complex areas such as Learning Disabilities, Medicines Safety, and Patient Experience indicating that previous interventions have enabled practices to progress beyond foundational compliance.

59. System-level projects, such as the Transgender Screening Quality Improvement initiative and improvements in care home interfaces and the management of Freedom to Speak Up concerns further demonstrate the application of tackling variation at scale. These projects are designed not only to resolve immediate issues but to embed processes that prevent recurrence, ensuring long-term sustainability.

60. The GP Tracker provides visibility of assurance levels and planned interventions. Of the 126 practices:
    - 85 require no further action, reflecting sustained improvements and resilience.
    - Others are engaged in varying levels of support, from desktop reviews, onsite visits and a range of supportive interventions based on risk stratification.

61. This dynamic approach ensures resources are directed where they are most needed, reducing unwarranted variation and safeguarding patient safety.

62. The intervention model is deliberately flexible, allowing us to tailor support to the unique context of each practice. Options range from Quality Improvement Forums, which foster peer learning and spread best practice, to specialist input from IPC, safeguarding, and medicines safety teams. Clinician-to-clinician conversations provide a safe space for discussing sensitive issues, while external programs such as the NHS Support Level Framework and GP Improvement Programme offer additional capacity.

63. Crucially, these interventions are not one-off fixes. They are designed to build capability within practices, enabling them to sustain improvements independently.

Priority 4 - Ensuring Value for Money and Contractual Compliance

Ongoing contract management

64. LLR ICB continues to maintain strong oversight of GP contracts to ensure that public funds are used appropriately and that patients receive safe, effective care. The approach is structured, transparent and aligned with statutory responsibilities.

65. How the ICB manages contracts day-to-day:

- Active oversight of all GP contracts (GMS, PMS, APMS), including monitoring performance, identifying concerns early, and putting recovery actions in place where needed.
- Quality and Contract Visits, undertaken jointly with Nursing & Quality colleagues, ensure that practices meet required standards and that risks are managed proactively.
- Regular analysis of activity, demand, capacity, finance and performance data, enabling the ICB to confirm that services are being delivered as commissioned and within budget.
- Monitoring data quality to ensure that reporting is accurate and reliable, supporting fair funding and robust assurance.
- Providing contractual advice and responding to practice queries, helping practices understand and meet their obligations.
- Coordinating the Contract Assurance Template process, which provides additional scrutiny for practices requiring enhanced assurance.
- Handling complaints, MP enquiries and FOI requests, ensuring transparency and accountability in how primary care services are commissioned and overseen.
- Supporting service reviews and pathway redesign, ensuring that any changes deliver value for money and comply with the NHS Provider Selection Regime.
- Overall, the ICB's ongoing contract management aims to secure value for money, maintain high-quality care, and ensure that practices meet their contractual responsibilities.

Recent contract changes

66. The ICB has implemented national and local changes linked to the 2025/26 GP contract. These changes support improved access, digital transformation, and workforce sustainability.

National changes implemented locally

67. The changes implemented locally are:

- 4% uplift to the global sum, increasing core practice funding.
- Expanded locum reimbursement, supporting workforce resilience and continuity of care.
- Enhancements to Additional Roles Reimbursement Scheme (ARRS) and System Development Fund (SDF) funding, enabling practices and PCNs to strengthen multidisciplinary teams and develop services in line with national priorities.

Local implementation priorities

68. The priorities are:
    - Phased introduction of mandatory online consultation tools, ensuring practices can offer modern, accessible contact routes while maintaining non-digital options for those who need them.
    - Rollout of GP Connect functionality, improving interoperability and enabling better information sharing across the system.
    - Support for improved patient-facing resources, helping practices meet expectations around digital engagement and access.

69. These changes are designed to improve patient experience, strengthen workforce capacity, and ensure that primary care services remain sustainable and responsive.

70. In January 2026, we will contact the practice to highlight areas of non-compliance and set out the actions required to achieve contractual compliance. We will also liaise with the Local Medical Committee (LMC) to support the commissioner in ensuring a consistent approach to contractual compliance and messaging.

<u>Looking Forward - 26/27 and beyond</u>

71. The future of primary care is defined by a shift from reactive "sickness" management to proactive, community-based wellness. By supporting the growth and development of place and system-based primary care organisations, we can move from a volume-focused access model to an outcomes-focused approach. Place and system-level providers are well-situated to take greater responsibility for patient cohorts, working across the primary care family, community services and VSCE partners to deliver personalised neighbourhood-level care while providing expert analysis and integration support.

72. With this in mind, as part of the Strategic Commissioning Framework for Integrated Care Boards ICBs will need to review and adapt the way we commission services from Primary Care in line with all other providers of Health services. https://www.england.nhs.uk/long-read/strategic-commissioning-framework/

73. This will include moving toward a strategic, neighbourhood-based approach to work alongside new statutory organisations that will assume oversight for operational delivery alongside financial responsibility through national contracting and procurement structures; overseen by ICBs.

A Neighbourhood Focus – Melton Mowbray

74. The ICB has been asked by the Committee to provide information in relation to access to GP Practices in the Melton area as a result of concerns raised by members and the public about a lack of provision.

75. Data taken from the Melton, Syston and Vale (MSV) Primary Care Network (PCN) during the current financial year (April-October 2025) shows the following:

76. Locally, the ICB has worked with partners to address a desire for additional Primary Care provider contracts to be implemented in Melton. Two options have been explored with Melton Borough Council (MBC), but neither were financially viable; even when accounting for the Section 106 developer contributions of c.£1m. Co-location was explored both as part of a new-build leisure centre and also in MBC's offices in Parkside, where office accommodation was to be repurposed to meet clinical standards and a new surgery created on the first floor.

77. In August 2025, the ICB took the decision to pause the consideration of a new GP Practice in Melton Mowbray but remains committed to continuing to work with MBC to explore options when guaranteed funding and suitable, affordable premises are identified.

78. The reasons for the pause are:

- The ICB does not receive capital funding to develop new practices itself. Any new premises therefore need to be funded by local authority Section 106 contributions, private/public investment and GP practice investment. Section 106 funding is awarded by local authorities to support new housing developments and is used to invest in roads and schools, as well as healthcare premises.
- Published data from NHS Digital (from 2020 to August 2025) showed only a 3.19% increase in patient registrations at the current Melton practice.

- 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. Perceived decrease in availability of general practice appointments is a national issue, although data suggests that more appointments are available and being delivered now per registered patient than ever before.
- All ICBs are going through a process of clustering with other ICBs to reduce management costs by 50%. At the time there was uncertainty around staffing availability to support the process of exploring further options.

79. The pause is until February 2027, but should anything change before then, particularly regarding available funding, the ICB will re-visit an options appraisal.

Questions submitted to Committee meeting on 5 November 2025 (added to the report as background information)

80. The following questions and answers were read into the record at the Health Overview and Scrutiny Committee meeting on 5 November 2025:

1. <u>Question from Mr. A. Innes CC:</u>

Melton Mowbray is serviced by a single GP practice, Latham House, and following a recent report that the project to site a second GP practice in the town has been suspended there is further upset in the community following this decision. The Melton community cannot continue to have a situation where appointments are pushed out to 6 weeks and even for simple tests, we have to wait weeks to have these done.
I would like to ask does the Chair of the Committee share my concerns and how is the ICB planning to meet their statutory requirement to ensure that there is adequate healthcare provision for the communities in their designated areas, and more specifically for Melton Mowbray?

Reply by the Chairman:

I share the concerns of residents and local members from Melton over this issue. Therefore, we will be examining this matter in more detail at a future meeting of the Leicestershire County Council Health Overview and Scrutiny Committee. I am aware of concerns elsewhere in the County over GP practices, so any report we have will cover not just Melton, but other areas as well. In addition, the issue of access to GP practices is going to be examined by the Leicester, Leicestershire and Rutland Joint Health Scrutiny Committee in the new year.

In the meantime, I have obtained the following statement from the Integrated Care Board:

“We are working closely with GP practices across Leicester, Leicestershire and Rutland (LLR), including in Melton, to ensure any available, additional funding and recruitment opportunities are taken up and used to meet the health needs of our diverse communities, equitably. Practices are supported to implement

new ways of working to improve access and care, including introducing new technology, integrating a wider range of health professionals, innovating how care is provided and improving premises.
We are working with Latham House specifically to increase the ways the practice can support local residents, including a new digital suite at the main site, an approved redevelopment of a property owned by the practice on Sherrard Street to extend clinical services and increasing recruitment including five GPs. We are committed to continuing to work with Melton Borough Council on the health services provided for residents and our Chief Executive and Chief Strategy Officer are due to meet over the coming weeks with the council leaders.

To ensure we use limited resources in the best way to meet the needs of all patients, we are also coordinating partners across the health and care system by matching them to the right level of care for their medical condition, with the right health professional, in the right part of the NHS, first time, and improving access to same-day care. We are currently engaging with local communities to raise awareness of a two-step process to help them get the right care.

Supporting information:

- The healthcare provided by GP practices is funded according to the national GP contract and the integrated care board receives limited other funding streams with which to increase investment in general practice.
- Recent examples include additional investment to ensure local practices receive equitable funding to provide core services and encouraging primary care networks (groups of practices) to recruit additional staff from a wide range of roles under the Additional Roles Reimbursement Scheme (ARRS) - 30 additional newly qualified GPs have been employed in practices in LLR under this scheme.
- ICBs do not routinely receive capital funding to develop new practices themselves. Any new premises therefore need to be funded by local authority S106 contributions, private/public investment and GP practice investment.
- This helps balance the needs of all patients across Leicester, Leicestershire and Rutland using limited NHS resources.
- Over recent years, GP practices have been working hard to evolve how they provide care to improve access and improve patients' health.
  - GP practices have a wider mix of specialist health professional who work together to care for patients. GPs look after the most seriously unwell patients and those with the most complex needs and people with less serious health conditions are supported by the wider practice team, appropriate for the condition.
  - GP practices also work more closely with community pharmacies. Now conditions that used to be seen in general practice are looked after in a pharmacy, for example under the Pharmacy First scheme.
  - Practices are using new technologies which are often more convenient for many people. Digital options won't be suitable for everyone, but they free up traditional methods for those who can't use online options.
  - Cloud based telephone systems, with a call-back function, and online forms for making requests.
- Through GP practices and NHS 111, same-day appointments can be arranged if a patient's condition means that they need to be seen quickly. This could be

at their own practice, at a local pharmacy under the Pharmacy First scheme, at an urgent treatment centre or another GP practice or health centre (during evenings, weekends and bank holidays). Melton Urgent Care Centre provides these latter appointments. Melton also has a Minor Injury Unit.

- The ICB regularly seeks the views of local people about the services they experience, in order to make improvements. The ICB carried out an LLR-wide GP practice experience survey in 2024. Local residents currently have the opportunity to share their views of same-day appointments, such as general practice and pharmacy appointments, and a new two-step approach to getting care quickly. The questionnaire closes on 7 December 2025: https://leicesterleicestershireandrutland.icb.nhs.uk/be-involved/need-help-fast-engagement/"

2. Question from Mr. J. T. Orson CC

Melton residents were dismayed to learn that the ICB has deferred funding for a second GP practice until February 2027. This decision has understandably intensified concern about the adequacy of current provision.

Would you agree that the time is right for constructive scrutiny—particularly in relation to Latham House Medical Practice? Persistent concerns around staffing levels, patient engagement, waiting times, and care protocols suggest that Health Scrutiny might now play a vital role in clarifying both current practice and future need. A formal review could offer reassurance, transparency, and a pathway forward.

I also believe all four Melton LCC Members and MBC would welcome the opportunity to contribute a solutions-focused perspective. There are areas where modest adjustments could yield meaningful improvements, and I'm confident both Councils stand ready to support any ongoing efforts.

I hope this letter strikes the right balance between challenge and collaboration. Please let me know if further discussion or additional detail would be helpful.

Warm regards,
Joe Orson
Melton Wolds Division

Reply by the Chairman:

I agree that the time is right for constructive scrutiny of the issues relating to Latham House Medical Practice. Officers that support the Leicestershire County Council Health Overview and Scrutiny Committee have been liaising with the Integrated Care Board regarding which would be a suitable Committee meeting for representatives of the ICB to come and present a detailed report on access to GP Practices, not just in the Melton area but in the whole County of Leicestershire. It is hoped that the report would address many of the issues you raise such as staffing levels and waiting times. The members that represent divisions in the Melton area will be invited to the Committee meeting at which this issue is considered. However, the limitations in terms of the powers and time constraints of the Health Overview and Scrutiny Committee must be recognised. Whilst the Committee can request reports and ask questions at public meetings, a more in-depth formal review would have to be carried out by the ICB themselves. Please see the interim response from the ICB set out in the answer to the question from Mr. Innes CC above. Please be assured that the Committee will continue to scrutinise the ICB on this topic and will invite you to any Committee meeting relating to health issues in the Melton area.

Background papers

Report considered by Leicester, Leicestershire and Rutland Health Scrutiny Committee on 17 July 2024: https://democracy.leics.gov.uk/documents/s184224/GP%20Practices.pdf

Circulation under the Local Issues Alert Procedure

Mr. A. Innes CC
Mrs. K. Knight CC
Mr. B. Lovegrove CC
Mr. J. T. Orson CC

Officer(s) to Contact

Report authors: Mayur Patel, James Hickman, Seema Gaj, Lorna Simpson, Fayaaz Hussain, Amy Walker, Charlotte Dickens, Dane Bull, Jonathan Gardiner, Glenn Halliday

■ Author contact details: Mayur.patel@nhs.net/ 07788338758

Leicestershire County Council

HEALTH OVERVIEW AND SCRUTINY COMMITTEE

14 JANUARY 2026

MEDIUM TERM FINANCIAL STRATEGY 2026/27 – 2029/30

JOINT REPORT OF THE DIRECTOR OF PUBLIC HEALTH AND THE DIRECTOR OF CORPORATE RESOURCES

Purpose of Report

1. The purpose of this report is to:

   a) provide information on the proposed 2026/27 to 2029/30 Medium Term Financial Strategy (MTFS) as it relates to Public Health; and

   b) ask the Committee to consider any issues as part of the consultation process and make any recommendations to the Scrutiny Commission and the Cabinet accordingly.

Policy Framework and Previous Decisions

2. The County Council agreed the current MTFS in February 2025. This has been the subject of a comprehensive review and revision in light of the current economic circumstances. The draft MTFS proposed for 2026/27 to 2029/30 was considered by the Cabinet on 16 December 2025.

Background

3. The MTFS is set out in the report to the Cabinet on 16 December 2025, a copy of which has been circulated to all members of the County Council. This report highlights the implications for the Public Health Department.

4. The revised MTFS for 2026-30 projects a gap of £23m in the first year that (subject to changes from later information such as the Local Government Finance Settlement) will need to be balanced by the use of earmarked reserves. There is then a gap of £49m in year two rising to £106m in year four, based on a 2.99% Council Tax increase, although no decision has yet been made on the level of increase to be approved.

5. Reports such as this one are being presented to the relevant Overview and Scrutiny Committees. The views of this Committee will be reported to the Scrutiny Commission on 26 January 2026. The Cabinet will consider the results of the scrutiny process on the 3 February 2026 before recommending an MTFS,

including a budget and capital programme for 2026/27, to the County Council on the 18 February 2026.

Service Transformation

6. Funding for Public Health activities comes from the Public Health grant, to be spent only on specific public health activity in line with national grant conditions.

7. Provisional allocations for the next three years, 2026/2027 to 2028/2029 were announced by the Department of Health and Social Care (DHSC) on 17th December. The announcement consolidated four, currently separate, funding streams into the Public Health Grant. These are the:

   - Drug and Alcohol Treatment and Recovery Improvement Grant (DATRIG);
   - Individual Placement and Support Grant (IPSG);
   - Local Stop Smoking Services and Support Grant (LSSSSG);
   - Swap to Stop scheme.

8. The Public Health Grant for 2026/27, including the consolidated funding streams, is £33.11m, rising to £34.39m in 2027/28 and £35.33m in 2028/29. Within the 2026/2027 provisional allocation the ‘core grant’, stripping out the consolidated aspects, is £30.84m. For planning purposes, the Department assumed it would be circa £30.7m, which represents approximately a 1.9% increase on the 2025/26 grant.

9. The DHSC has now specified ‘ring fences within the ring fence’, stipulating a minimum amount that must be spent on drugs and alcohol treatment, recovery and prevention, and smoking cessation. For 2026/27, within the overall grant of £33.11m, £6.67m must be spent on tackling drugs and alcohol and £1.46m on smoking cessation. In later years these figures rise, for drugs and alcohol expenditure, to £7.43m in 2027/28 and £7.87m in 2028/29 and, for smoking cessation, £1.47m in 2027/28 and £1.48m in 2028/29.

10. The impact of what is effectively a direction to increase expenditure on the prevention, treatment and recovery from drugs and alcohol misuse of 105 year on year, will be to restrict the increase available in the rest of the grant to an approximate rise of 2.4% between 2026/27 to 2027/28 and 1.6% between 2027/28 to 2028/29.

11. The Department, and the services it commissions and delivers, continue to be structured in line with statutory duties and the Public Health Strategy. The Department will consider the in-house provision of services as a preferred option, where appropriate, recognising that specialised health improvement treatment services will continue to be externally commissioned through the NHS and third sector markets.

Proposed Revenue Budget

12. Table 1 below summarises the proposed 2026/27 revenue budget and provisional budgets for the next three years thereafter. The proposed 2026/27 revenue budget is shown in detail in Appendix A.

Table 1 – Revenue Budget 2026/27 to 2029/30

	2026/27 £000	2027/28 £000	2028/29 £000	2029/30 £000
Original prior year budget	-2,746	-2,086	-2,086	-2,086
Budget transfers and adjustments	660	0	0	0
Add proposed growth (Appendix B)	0	0	0	0
Less proposed savings (Appendix B)	0	0	0	0
Proposed/Provisional budget	**-2,086**	**-2,086**	**-2,086**	**-2,086**

13. The Public Health department is required to meet increased provider costs as well as internal staff pay awards which are not funded by the Council's central pay contingency.

14. The total gross proposed budget for 2026/27 is £35.8m with contributions from health, transfers and various other income sources totalling £4.8m. The ring-fenced grant allocation for 2026/27 £33.1m.

15. The proposed net budget for 2026/27 is distributed as shown in Table 2 below:

Table 2 - Net Budget 2026/27

	£000	%
Public Health Leadership	4,026	12.98
Community Delivery	1,703	5.49
Quit Ready	1,172	3.78
First Contact Plus	209	0.67
Other Public Health Services	171	0.55
Health Improvement	653	2.10
Weight Management Service	328	1.06
Mental Health	128	0.41
Workplace Health	96	0.31
Children's Public Health 0-19	9,647	31.08
Domestic Violence	386	1.25
Sexual Health	4,202	13.55
NHS Health Check Programme	520	1.68
Substance Misuse	5,745	18.52
Physical Activity	896	2.89
Obesity Programmes	10	0.03
Health Protection	401	1.29
Tobacco Control	70	0.23
Active Together (fully grant funded)	0	0.00
VCSE/Communities	661	2.13
Total	**31,024**	**100.0**
Public Health Ring Fenced Grant	**-33,110**	
Total Net Budgeted Spend	**-2,086**	

Budget Changes and Adjustments

GROWTH

16. There is no growth proposed for the department, the ring fenced grant means the department makes no call on the Council's General Fund. However, the following areas have been identified as key issues.

17. The Health Check programme is a prescribed service that is currently delivered by general practice. Health checks should be offered to eligible individuals aged 40-74 every 5 years. The initial £1m budget for this had been reduced through savings targets over recent years by 60% to a revised budget of £0.4m. Although the new service has been re-procured with a more targeted funding mechanism, there is still a risk that the programme could exceed the budget. Activity has increased to pre pandemic levels and, due to an ongoing backlog of eligible people in addition to a growing population of eligible people, the revised budget for 2026/27 is £520,000 which is £120,000 above the original budget prior to the pandemic.

18. An in-year cost pressure for 2024/25 onwards was created by the change in the way the NHS contribution to the Agenda for Change (A4C) pay award for NHS staff within services commissioned by Public Health was processed. In previous years the national agreement was that the NHS would pay for the year the increase was due in full and then in the following year the Public Health grant would fund the cost. This is actioned by adding the cost to the contract value through a contract variation, creating a new baseline. The Council has two providers currently where this arrangement is in place. The uplift amount for the contracts changes each year but has previously been in the region of £220k per annum.

SAVINGS

19. There are no savings proposed for the department, however, the department is continuously working to maximise grant efficiency.

Savings under Development

20. To help bridge the gap several initiatives are being investigated within the County Council to generate further savings. This work was already underway as part of the Council's strategy to address the MTFS gap and does not include any of the findings from the Efficiency Review, which is discussed in more detail later in the report. Outlines of the proposals were included as Appendix D, Savings under Development to the 16 December Cabinet report. Once business cases have been completed and appropriate consultation and assessment processes undertaken, savings will be confirmed and included in a

future MTFS. This is not a definitive list of all potential savings over the next four years, just the current ideas and is expected to be shaped significantly as the Efficiency Review progresses.

21. There are no savings under development for the Public Health department.

Future Financial Sustainability

22. Despite delivery of extensive savings already, a significant gap remains, emphasising the need to accelerate and expand the Council's ambitions and explore new, innovative options. A step-change in approach is required.

23. The Efficiency Review was initiated by the new Administration in response to a then-projected £90m budget gap by 2028/29, alongside mounting pressures on capital funding and special educational needs budgets. To address these financial challenges, the Council commissioned a comprehensive, evidence-led review of all services and spending, aiming to identify ways to accelerate existing initiatives and identify new opportunities. The review will identify opportunities to redesign services, optimise resources, and embed a performance-driven culture across the organisation.

24. Key elements of the review include:

- Reviewing all Council activities for cost reduction, service redesign, and income generation (excluding commercial ventures).
- Assessing existing MTFS projects and savings ideas to prioritise or redesign them, identify where savings targets could be stretched or accelerated.
- Strengthening governance, data management and resource mobilisation within the current Transformation Strategy.
- Reviewing the County Council's approach to delivering change to ensure well placed to support implementation and future Council change initiatives.

25. The review is being undertaken by Newton Impact and commenced in early November, with detailed recommendations due early 2026 to inform future financial planning and Cabinet decisions.

26. The first stage of work was focused on any immediate opportunity to accelerate existing MTFS savings. The first of these, included in the draft MTFS position, is reablement in Adult Social Care. The initial saving included in the MTFS is £1m, building on an existing saving in this area of £1.9m.

27. The further initiatives that will be developed over the next few months are expected to be a combination of i) ideas that had not progressed due to resource availability, ii) existing initiatives that can be expanded due to greater insight, iii) new initiatives to the Council.

28. The review is still in its early stages and is progressing as expected. If further initiatives can be developed to a satisfactory level of confidence they will be included in the MTFS report to the Cabinet in February.

29. The County Council is taking decisive action to close the budget gap and build a financially resilient organisation. The Efficiency Review will result in a revised Transformation Programme underpinned by strong governance and innovation to accelerate delivery and embed new ways of working. With significant uncertainty and change linked to Local Government Reorganisation, the coming year will be critical in driving high-impact change, engaging stakeholders, and preparing the organisation for future challenges.

30. There will need to be a renewed focus on these programmes during the next few months to ensure that savings are identified and delivered to support the 2026/27 budget gap. Given the scale of the financial challenge, focus will be needed to prioritise resources on the change initiatives that will have the greatest impact, and work is already underway to do this.

External Influences

31. Demand Led Activity

Sexual Health services are required to be provided on an open access basis and therefore there is a risk to the achievement of the MTFS if activity is higher than predicted. Health Checks are also demand driven and there was an increase in activity in 2023/24 above the level anticipated which led to an increase in the budget allocations for 2024/25 and 2025/26.

32. Inflation

The department continues to be at risk of inflationary pressures. Although there has been an increase to the Public Health Grant in 2026/27, there is an ongoing requirement for the Department to meet increased provider costs as well as internal staff pay awards which are not funded by the Council's central inflation contingency.

Other Funding Sources

33. There are several funding sources that contribute to the overall budget for Public Health.

Funding Source	**Description**	**Value £000**	**RISK RAG**
Public Health Grant	Public Health Grant Allocation 2026/27.	33,109	G
Sport England Grant	Active Together receive funding to deliver a number of programmes. Funding varies each year, according to the programmes supported.	1,004	G
Better Care Fund	Funding allocation for First Contact Plus.	207	G

Rutland County Council	The provision of Public Health support to the authority and a section 113 agreement for Mike Sandys as the DPH.	339	G
Office of the Police and Crime Commissioner	This funding is a contribution to the (drugs) treatment contract.	145	G
Integrated Care Board	To meet the costs of contraceptive devices which are fitted to treat an existing medical condition.	75	G

Background Papers

Cabinet 16 December 2025 - Medium Term Financial Strategy 2026/27 to 2029/30
https://democracy.leics.gov.uk/ieListDocuments.aspx?CId=135&MId=7882&Ver=4

Circulation under Local Issues Alert Procedure

None.

Officers to Contact

Mike Sandys, Director of Public Health
Tel: 0116 305 4239
E-mail: **mike.sandys@leics.gov.uk**

Declan Keegan, Director of Corporate Resources, Corporate Resources Department
Tel: 0116 305 7668
E-mail: **declan.keegan@leics.gov.uk**

List of Appendices

Appendix A – Revenue Budget 2026/27

Equality implications

34. Public authorities are required by law to have due regard to the need to:

- Eliminate unlawful discrimination, harassment and victimisation;
- Advance equality of opportunity between people who share protected characteristics and those who do not; and

- Foster good relations between people who share protected characteristics and those who do not.

35. Many aspects of the County Council's MTFS may affect service users who have a protected characteristic under equalities legislation. An assessment of the impact of the proposals on the protected groups must be undertaken at a formative stage prior to any final decisions being made. Such assessments will be undertaken in light of the potential impact of proposals and the timing of any proposed changes. Those assessments will be revised as the proposals are developed to ensure decision makers have information to understand the effect of any service change, policy or practice on people who have a protected characteristic.

36. Proposals in relation to savings arising out of a reduction in posts will be subject to the County Council Organisational Change policy which requires an Equality Impact Assessment to be undertaken as part of the action plan.

Human Rights Implications

37. There are no human rights implications arising from the recommendations in this report.

APPENDIX A

PUBLIC HEALTH DEPARTMENT

REVENUE BUDGET 2026/27

Net Budget 2025/26 £		*	Employees £	Running Expenses £	Internal Income £	Gross Budget	External Income £	Net Budget £
-30,088,436	**Public Health Ring-Fenced Grant**		0	0	0	0	-33,109,798	-33,109,798
	Department							
3,300,580	Public Health Leadership	B	3,322,273	1,039,057	-70,889	4,290,441	-265,000	4,025,441
1,781,989	Community Delivery	B	1,965,614	813,289	-150,000	2,628,903	-925,779	1,703,124
499,847	Quit Ready	B	839,638	392,556	0	1,232,194	-60,205	1,171,989
218,563	First Contact Plus	B	416,416	0	0	416,416	-207,718	208,698
161,250	Other Public Health Services	B	0	171,250	0	171,250	0	171,250
721,918	Health Improvement	B	536,660	361,100	-245,000	652,760	0	652,760
0	Public Health Advice	B	0	0	0	0	0	0
340,735	Weight Management Service	B	320,655	17,500	0	338,155	-10,000	328,155
42,824	Mental Health	B	55,909	672,617	-433,876	294,650	-167,150	127,500
105,293	Workplace Health	D	104,154	66,900	-40,000	131,054	-34,785	96,269
7,172,999	**Total**		**7,561,319**	**3,534,269**	**-939,765**	**10,155,823**	**-1,670,637**	**8,485,186**
9,521,223	**0-19 Children's Public Health**	**S**	0	9,646,459	0	9,646,459	0	9,646,459
	Health Related Harms							
386,945	Domestic Violence	S	0	386,492	0	386,492	0	386,492
4,048,145	Sexual Health	S	0	4,277,145	0	4,277,145	-75,000	4,202,145
547,500	NHS Health Check programme	S	0	645,481	-125,000	520,481	0	520,481
4,078,806	Substance Misuse	S	0	6,583,968	-371,000	6,212,968	-468,070	5,744,898
9,061,396	**Total**		**0**	**11,893,086**	**-496,000**	**11,397,086**	**-543,070**	**10,854,016**
	Physical Activity and Obesity							
895,951	Physical Activity	B	0	895,951	0	895,951	0	895,951

10,000	Obesity Programmes	B	0	80,000	-70,000	10,000	0	10,000
905,951	**Total**		**0**	**975,951**	**-70,000**	**905,951**	**0**	**905,951**
610,757	**Health Protection**	**B**	401,140	29,600	0	430,740	-29,571	401,169
70,000	**Tobacco Control**	**B**	0	70,000	0	70,000	0	70,000
0	**Active Together**	**B**	1,578,766	1,243,260	-707,308	2,114,718	-2,114,718	0
659,641	**VCSE/Communities**		566,587	1,066,200	-522,800	1,109,987	-449,439	660,548
-2,086,469	**PUBLIC HEALTH DEPARTMENT** **		**10,107,812**	**28,458,825**	**-2,735,873**	**35,830,764**	**-37,917,233**	**-2,086,469**

*** S/D/B** : indicates that the service is **S**tatutory, **D**iscretionary or a combination of **B**oth

** preventative expenditure within other Departments' budgets to be identified and absorbed into the ring fenced budget

NHS
Leicester, Leicestershire and Rutland
Integrated Care Board

HEALTH OVERVIEW AND SCRUTINY COMMITTEE:

14th JANUARY 2026

REPORT OF LEICESTER, LEICESTERSHIRE AND RUTLAND INTEGRATED CARE BOARD

PANDEMIC PLANNING

Purpose of report

1. The purpose of the report is to provide an update to the Committee on pandemic preparedness across Leicester, Leicestershire and Rutland (LLR), summarising current planning activity, key learning from recent national and local exercises, and proposed next steps to strengthen multi-agency resilience ahead of future pandemic threats.

Policy Framework and Previous Decision

2. The Health and Social Care Act 2012 places duties on local authorities and Directors of Public Health to protect the health of their populations. Pandemic preparedness is delivered through multi-agency arrangements under the Civil Contingencies Act 2004 (CCA), with local authorities and NHS bodies as Category 1 Responders and LRFs providing coordination.

3. Relevant national frameworks and guidance are included in the appendix.

Background

4. A pandemic is defined as the spread of disease across whole countries, international boundaries or continents at the same time, usually driven by a novel pathogen (virus, bacteria, fungi or other organism) to which there is little or no population immunity[1].

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[1] Framework for managing the response to pandemic diseases https://www.england.nhs.uk/long-read/framework-for-managing-the-response-to-pandemic-diseases/

5. The national risk register [2] outlines the most serious risks to the UK and identifies pandemics as an acute risk within the 'human, animal and plant health' theme. The most significant risk to materialise in the UK in recent years has been the COVID-19 pandemic. The most likely future pandemic is expected to be respiratory, but planning covers multiple transmission routes (respiratory, blood and body fluids, contact, ingestion and vectors) to cover a range of emerging infectious disease scenarios.

6. Each pandemic, by definition, is unique. Novel pathogens present different challenges to existing circulating biological agents, even where they closely resemble them. This may include extended duration of a pandemic (many months, even years), multiple waves of infection, vaccinations or specific treatments not currently or readily available, and wider or atypical population groups being at risk and affected.

7. The unequal risk and impact of a future pandemic will undoubtedly exacerbate existing health inequalities and cause new disparities for communities across the county.

8. Following detection of a pathogen with pandemic potential, the health system will need to respond to significant challenges, and will be required to:
   - Identify and isolate suspected cases;
   - Implement appropriate arrangements (such as scalable contact tracing, diagnostics, pharmaceutical and non-pharmaceutical countermeasures, management of excess deaths);
   - Recovery management;
   - Arrangements for effective national and global coordination.

9. Pandemic influenza remains one of the most well-characterised and historically recurring pandemic threats, offering a valuable framework for multi-agency preparedness planning. Pandemics such as the 2009 H1N1 outbreak have provided critical insights into surge capacity, planning, vaccine deployment logistics and the importance of timely public health communication. These lessons continue to shape our strategic approach across LLR.

10. Pandemic influenza emerges when a new flu virus is markedly different from recently circulating strains. Few - if any - people will have any immunity to this new virus thus allowing it to spread easily and to cause more serious illness. The conditions that allow a new virus to develop and spread continue to exist, and some features of modern society, such as air travel, could accelerate the rate of spread. Experts therefore agree that there is a high probability of a pandemic occurring, although the timing and impact are impossible to predict. The H1N1(2009) pandemic does not lessen the probability of a further

[2] National Risk Register 2025 - https://assets.publishing.service.gov.uk/media/67b5f85732b2aab18314bbe4/National_Risk_Register_2025.pdf

pandemic in the near future and should not be seen as representative of future pandemics.

11. The COVID-19 pandemic, caused by a novel coronavirus, began in 2019 and was an unprecedented global health crisis, affecting every aspect of life in Leicestershire as well as the wider UK and world. The pandemic required rapid, coordinated responses from health and care organisations, local authorities and communities, highlighting the importance of preparedness, resilience and learning for future threats.

12. COVID-19 is no longer classed as a global emergency, however, remains a notifiable infectious disease and continues to circulate at low levels in the community. Surveillance systems are in place locally and nationally to monitor for any increases in cases or the emergence of new variants. The NHS and public health partners remain vigilant with ongoing testing, vaccination and outbreak management protocols ready to be activated if required.

13. The UK Covid Inquiry was set up to examine the UK's response to and impact of the pandemic. Its first report was published on Resilience and Preparedness, noting the UK was not adequately prepared for a pandemic. The findings and recommendations are being incorporated locally to ensure future pandemic planning is robust, inclusive and informed by the lessons learned.

Current Position

Preparedness:

14. LLR partners have participated in major exercises (Tangra, Solaris, Pegasus) to test and improve pandemic response. These have led to better coordination, refined protocols, and stronger relationships. Plans are regularly reviewed and updated, with roles and responsibilities embedded in Local Resilience Forum structures. The exercises are detailed below:

    - Exercise Tangra, April 2025 – ICB led exercise aimed to test and improve the preparedness and response capabilities of organisations in the event of a pandemic. This was a mainly health focussed exercise mandated by NHS England (NHSE) and the Department of Health and Social Care (DHSC).

    - Exercise Solaris, May 2025 – LRF led exercise to gain insights into how different sectors, especially local authorities, and voluntary and community sectors would coordinate a pandemic response. This was also a pre-exercise for Exercise Pegasus.

    - Exercise Pegasus, Sept, Oct, Nov 2025 – a national Tier 1 pandemic preparedness exercise. The UK Government committed to a National Exercising Programme to deliver annual national exercises on a range of risks to test real-world resilience. The aim is to test the UK's ability to respond to a pandemic arising from a novel infectious disease, involving all regions, bringing together the Cabinet and every UK government department. This is a multi-agency simulation involving NHS, local authority, emergency services and voluntary sector partners to test pandemic response protocols.

15. Pandemic planning is one element of wider LLR preparedness and links to a suite of plans that would be activated in a pandemic, listed in Appendix B. Roles and responsibilities are embedded within the Local Resilience Forum (LRF) structures and are defined in Appendix C.

Resources:

16. Pandemic response requires coordinated action across different organisations within and beyond the health and social care sector. Key elements of resource planning include:

   - Review of PPE stock levels and supply chains, and fit testing capacity, coordinated across health, social care and local authority partners.
   - Testing and vaccination capacity is exercised, with flexible plans to permit surge testing and vaccination delivery as necessary, adapting protocols based on risk assessments in line with national frameworks.

Workforce:

17. The workforce actions taking place are:

- Surge staffing protocols agreed with NHS and social care partners, including bank and agency staff, volunteers, redeployment and mutual aid options.
- IPC training is developed and shared with partners across the health and social care sector with national escalation as required.
- Staff wellbeing and resilience during periods of increased demand was considered within the planning

Communications:

18. Core communication principles have already been agreed across all LRF organisations:

   - Use of trusted voices and spokespersons to deliver messages.
   - Multi-channel engagement (e.g. websites, social media, newsletters, and community networks).
   - Transparent updates aligned with national guidance.

- Proactive response to misinformation
- Consistency across agencies to avoid mixed messages.
- Accessibility and inclusion in all communications.
- Scenario planning and pre-prepared messaging.
- Community engagement and feedback mechanisms to adapt messaging.

19. The LRF Warning and Informing Cell would be stood up and have representation from all relevant agencies and a strategy in place to include:

- Reassurance through trusted platforms.
- Signposting to official websites and national messaging.
- Engagement with religious and community leaders.
- Outreach to local media contacts to promote accurate messaging from trusted spokespeople
- Coordination with national and regional campaigns.
- Sharing of local insights with national teams.

Command and Control

20. The LRF's command structures are utilised regularly across incidents and are embedded into emergency planning preparedness. There are clear triggers and thresholds in place to convene Tactical and Strategic Coordination Groups and all LRF organisations understand the process to convene these. During the initial stages of a pandemic, multiple command cells are activated as required (see appendix D), operating in line with Joint Emergency Services Interoperability Programme (JESIP) principles, and the Civil Contingencies Act 2004, ensuring key decisions and rationale is logged. Minutes, action logs, recordings and transcripts are created and stored. Multi-agency partnership working remains central to all emergency responses.

<u>Risks and Challenges</u>

21. A number of risks persist with pandemic planning:
    - Funding mechanisms for PPE, isolation support, accommodation support for homeless people, additional staffing and equipment.
    - Sustaining readiness during inter-pandemic periods to avoid capability erosion.
    - Workforce fatigue and retention in health and care sectors.
    - Building and sustaining public trust, particularly around vaccination
    - Addressing health inequalities and protecting vulnerable groups.
    - Food, medication and PPE supplies.
    - Legal requirements to support some interventions.

Key Developments Since Covid-19

22. Learning from COVID-19 has been incorporated into current pandemic planning leading to greater agility, better protection for staff and vulnerable groups, enhanced coordination, efficient use of resources, quicker response times and greater organisational resilience and ability to maintain critical services during disruption.

LRF:

- Adoption of virtual meetings enables quicker decision-making, and reduced travel demands on key personnel, whilst minimising transmission risk and protecting vulnerable groups.
- Specific operational cells (e.g. community support, care homes, pharmacy, education) were established and will be reactivated as needed.
- Flexible leadership for coordination groups.
- Strengthened data sharing, community engagement and scenario-based exercises.

Health:

- Single Points of Contact (SPOCs) with generic inboxes ensure resilience and consistency in operational response.
- Establishment of a Workforce Cell to support rapid set-up of testing and vaccination centres.
- Development of local escalation frameworks to manage surges in demand and prioritise essential services.
- Increased use of technology (e.g. MS Teams) for efficient, resilient meetings and rapid mobilisation.
- Implementation of Virtual Wards and virtual primary care appointments to support clinical practice.

Local Authority:

- Strengthened business continuity arrangements.
- Improved IT infrastructure to support remote and flexible working.
- Regular reviews and updates of LRF and organisational incident plans.

Proposals/Options

23. LRF organisations have identified actions to further enhance pandemic planning as part of the 3 exercises carried out this year. These include:
    - Strengthening data-sharing agreements and real-time surveillance capabilities.
    - Enhancing community resilience through targeted engagement with vulnerable populations and VCSE partners.

- Proactively planning command and control and ensuring cell structures are maintained.
- Continuation of multi-agency TCG and SCG immersive training to support and build on relationships with partners.
- Ensure all organisations maintain and refresh plans regularly.
- Review of current risk assessments and SOPs.
- Ensuring all staff have access to secure IT and reliable internet that would allow them to work from home if required in a future pandemic.
- Review IPC training and guidance.
- Confirming availability and how to operationalise the PPE hub.

Consultation/Patient and Public Involvement

24. Input has been gathered from NHS partners, local authority emergency planners, and community representatives through operational delivery groups and planning exercises.

Resource Implications

25. Existing resources from partners involved in planning will support the initial development and implementation. Additional funding may be required for enhanced responses in the event of a pandemic.

Timetable for Decisions

26. There are no decisions to be made by the Health and Wellbeing Board, however, regular pandemic updates will be provided following receipt of the Pegasus post exercise report from UKHSA.

Conclusion

27. LLR partners have robust foundations for pandemic preparedness and clear proposals to strengthen system resilience further in 2025/26. Board endorsement will support continued collaboration and focus on equity, agility and whole-system readiness.

Background papers

• National Risk Register 2025: https://www.gov.uk/government/publications/national-risk-register-2025

• NHS England – Framework for managing the response to pandemic diseases (July 2024): https://www.england.nhs.uk/publication/framework-for-managing-the-response-to-pandemic-diseases/

• UKHSA – Communicable disease outbreak management guidance and toolkits (2025): https://www.gov.uk/government/publications/communicable-disease-outbreak-management-guidance

• NHS England – EPRR: Core Standards and 2025/26 Annual Assurance: https://www.england.nhs.uk/publication/emergency-preparedness-resilience-and-response-core-standards/

• Cabinet Office – UK Government Resilience Action Plan (2025): https://www.gov.uk/government/publications/uk-government-resilience-action-plan/uk-government-resilience-action-plan-html

• Civil Contingencies Act 2004 – duties of Category 1 Responders: https://www.gov.uk/guidance/preparation-and-planning-for-emergencies-responsibilities-of-responder-agencies-and-others

• Role of Local Resilience Forums – reference document: https://www.gov.uk/government/publications/the-role-of-local-resilience-forums-a-reference-document

• Exercise Pegasus – national Tier 1 pandemic preparedness exercise (2025): https://www.gov.uk/government/news/largest-ever-national-pandemic-response-exercise-to-strengthen-against-future-threats

• NHS England Board update – Pandemic preparedness & Exercise Pegasus (July 2025): https://www.england.nhs.uk/long-read/pandemic-preparedness-exercise-pegasus/

• WHO – Pandemic Influenza Risk Management (2017): https://www.who.int/publications/i/item/WHO-WHE-IHM-GIP-2017.1

• WHO – Clinical practice guidelines for influenza (2024): https://www.who.int/publications/i/item/9789240097759

Circulation under the Local Issues Alert Procedure

28. Not Applicable

Appendices

Appendix A: Roles and Responsibilities
Appendix B: Plans
Appendix C: Pandemic Roles and responsibilities

Appendix D: Command structures

Officer(s) to contact

Amita Chudasama, Head of EPRR, LLR Integrated Care Board
Telephone: 0777 554 1930

Email: amita.chudasama@nhs.net

Anuj Patel, Strategic Lead – Health Protection, Leicestershire County Council

Email: Anuj.Patel@leics.gov.uk

Relevant Impact Assessments

Equality Implications

29. Pandemics disproportionately affect some groups (e.g., older people, clinically vulnerable, people with disabilities, certain ethnic groups, and inclusion health populations). Due consideration has been given to the needs of diverse communities and groups of staff. This is borne in mind when considering roles and responsibilities of all agencies and staff involved, promoting fairness, equality and diversity in the delivery of the service

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

Human Rights Implications

31. There are no human rights implications arising from the recommendations in this report.

Partnership Working and associated issues

32. Pandemic preparedness is inherently multi-agency. This report and associated plans have been developed with partners across the system.

Appendix A:

National frameworks and guidance:

- Civil Contingencies Act 2004
- NHS EPRR Framework & Core Standards
- WHO Pandemic Influenza Risk Management Guidance
- UK Influenza Preparedness Strategy 2011
- UKHSA Outbreak Management Plan

Relevant local guidance and plans include:

- LRF CONOPS for the Management of Pandemics
- LRF Mass Treatment Plan
- LRF Communication Cell Emergency Plan
- LRF Major Incident Framework
- LLR Outbreak Management Framework
- Individual agency Pandemic Plans

Appendix B:

Plans that may be activated during a pandemic

LLR ICB Incident Response
Business Continuity
High Consequence Infectious Disease (HCID)
Media and Communications
Mass Treatment
Multi-agency Incident Response Framework

Appendix C- Pandemic Roles and responsibilities

Organisation / Role	Key responsibilities
NHS England	• Strategic leadership of NHS response • Convene and chair regional calls with ICBs • Oversee local management of Antiviral Collection Points (ACPs) • Oversee PPE storage/distribution • Manage pandemic vaccination campaigns • Collate situation reports (SitReps) • Coordinate communications to NHS, partners, public, media • Convene recovery team for return to normal business
LLR Integrated Care Board (ICB)	• Convene Local Pandemic Influenza Incident Response Team (L-PIIRT) • Chair/attend Strategic Coordination Group (SCG) meetings • Lead local coordination and surge capacity arrangements • Chair Health Economy Tactical Coordination Group (HETCG) • Maintain 24/7 on-call arrangements • Share communications with local providers • Enact business continuity arrangements • Maintain local data collection and reporting • Participate in multi-agency response
UKHSA	• Support Chief Medical Officer and SAGE • Provide expert clinical/scientific advice • Liaise with SCG and NHS • Detect and respond to outbreaks in schools, care homes, community • Advise on use of antivirals • Disseminate public health information • Reinforce hygiene and social distancing messages
Directors of Public Health	• Review population health, surveillance, prevention, control • Provide visible local leadership • Advise on activation of wider pandemic response • Ensure public health presence on SCG, TCG, Excess Death Cell, Info/Intelligence Cell • Advise on vulnerability/resilience of local community • Mobilise local public health resources
East Midlands Ambulance Service (EMAS)	• Gateway for patient access to healthcare • Emphasise initial assessment/treatment at home • Ensure business continuity and expand workforce • Attend SCG and response meetings
UHL	• Provide emergency / secondary care • Implement infection prevention/control • Cohort / isolate patients • Increase critical care capacity • Maintain essential services • Organise / distribute antivirals and PPE • Communicate with staff, patients, public • Provide vaccination to staff/patients

Appendix D

Command structures that may be stood up during a pandemic:

LRF
- Strategic Coordinating Group (SCG)
- Tactical Coordinating Group (TCG)
- Media and Communications Cell
- Voluntary Sector Support Cell
- Humanitarian Assistance Cell
- Multi-Agency Information Cell (MAIC)
- Science and Technical Advisory Cell (STAC)
- PPE Cell (initial scoping stage)

Local Authority
- Support the recommendations of the LRF.
- Establish internal response groups to begin planning and coordination

Health
- Health Tactical Coordinating Groups (TCGs) to deliver the strategy set by the Health SCG.
- Activate related cells as required.
- Individual agencies hold their own organisational command meetings.
- Establish a health “battle rhythm” led by the Integrated Care Board (ICB)

Police
- Stand up a Gold Group to coordinate police response.