Meeting: **Health Overview and Scrutiny Committee**

Date/Time: **Wednesday, 4 March 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. Miah CC
Mrs. L. Danks CC	Mr. P. Morris CC
Mr. M. Durrani CC	Mr. D. Page CC
Mr. P. King CC	Mr. B. Piper CC
Mrs. K. Knight CC	Mr J. Poland CC
Mr. J. McDonald CC	Mr. K. Robinson CC

Please note: this meeting will be filmed for live or subsequent broadcast via You Tube at https://www.youtube.com/@committeemeetingsatleicest9269/playlists

Item		Report by	
1.	Minutes of the meeting held on 14 January 2026.		(Pages 5 - 16)
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.	CQC Inspection Update: LPT Adults Community Mental Health Services	Leicestershire Partnership NHS Trust	(Pages 17 - 20)
9.	Elective Care, diagnostics and cancer performance.	University Hospitals of Leicester NHS Trust	(Pages 21 - 24)
10.	Issues arising from Health Performance report that merit more detailed scrutiny.		(Pages 25 - 56)

11. Date of next meeting.

    The next meeting of the Committee is scheduled to take place on Wednesday 3 June 2026 at 2.00pm.

12. Any other items which the Chairman has decided to take as urgent.

QUESTIONING BY MEMBERS OF OVERVIEW AND SCRUTINY

The ability to ask good, pertinent questions lies at the heart of successful and effective scrutiny. To support members with this, a range of resources, including guides to questioning, are available via the Centre for Governance and Scrutiny website www.cfgs.org.uk. The following questions have been agreed by Scrutiny members as a good starting point for developing questions:

- Who was consulted and what were they consulted on? What is the process for and quality of the consultation?
- How have the voices of local people and frontline staff been heard?
- What does success look like?
- What is the history of the service and what will be different this time?
- What happens once the money is spent?
- If the service model is changing, has the previous service model been evaluated?
- What evaluation arrangements are in place – will there be an annual review?

Members are reminded that, to ensure questioning during meetings remains appropriately focused that:

(a) they can use the officer contact details at the bottom of each report to ask questions of clarification or raise any related patch issues which might not be best addressed through the formal meeting;

(b) they must speak only as a County Councillor and not on behalf of any other local authority when considering matters which also affect district or parish/town councils (see Articles 2.03(b) of the Council's Constitution).

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Agenda Item 1

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

PRESENT

Dr. S. Hill CC (in the Chair)

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

In attendance

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

40. Minutes of the previous meeting.

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

41. Question Time.

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

1. Question from Cllr. Helen Cliff:

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

Reply by the Chairman:

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

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

Supplementary question from Cllr. Helen Cliff:

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

Reply by the Chairman:

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

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

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

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

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

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

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

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

I strongly dispute two statements in the ICB report.

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

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

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

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

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

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

Do you agree that.

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

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

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

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

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

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

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

Thank you for your consideration.

Reply by the Chairman:

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

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

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

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

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

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

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

Supplementary question from Cllr. Pip Allnatt:

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

Reply by the Chairman:

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

42. Questions asked by members.

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

43. Urgent items.

There were no urgent items for consideration.

44. Declarations of interest.

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

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

45. Declarations of the Party Whip.

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

46. Presentation of Petitions.

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

47. Primary Care

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

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

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

As part of discussions the following points were made:

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

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

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

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

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

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

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

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

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

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

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

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

Melton

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

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

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

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

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

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

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

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

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

RESOLVED:

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

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

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

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

Arising from discussions the following points were noted:

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

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

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

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

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

RESOLVED:

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

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

49. Pandemic Planning.

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

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

Arising from discussions the following points were noted:

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

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

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

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

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

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

RESOLVED:

That the contents of the update be noted.

50. Date of next meeting.

RESOLVED:

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

2.00 - 5.35 pm CHAIRMAN
14 January 2026

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Agenda Item 8

Leicestershire Partnership NHS Trust

HEALTH OVERVIEW AND SCRUTINY COMMITTEE: 4 MARCH 2026

REPORT OF LEICESTERSHIRE PARTNERSHIP NHS TRUST

CQC INSPECTION UPDATE: LPT ADULTS COMMUNITY MENTAL HEALTH SERVICES

Purpose of report

1. The purpose of this report is to provide assurance to the Health Overview Scrutiny Committee following the Care Quality Commission (CQC) inspection of the Trust's adult community mental health services. It summarises:

   a) the key findings;
   b) highlights areas of good and outstanding practice;
   c) outlines actions taken to address areas for improvement, and
   d) describes the Trust's response to the CQC Warning Notice.

2. The Committee is asked to note the findings, acknowledge the improvements made, and support the Trust's ongoing improvement programme. The Committee is also asked to encourage and support joint working between the Trust and the Local Authority to address mental health access and waiting times, and to ensure that Council-commissioned mental health services are prioritised, recognising that timely provision requires coordinated action across the local health and care system.

Background

3. The CQC has published its report following an inspection of the Trust's community mental health services for adults of working age, which took place in May 2025. This service is one of the Trust's 15 core services. The overall rating for the service is 'Requires Improvement'.

4. The inspection of the community mental health teams was part of a series of inspections of mental health services across England following publication of the Section 48 review into Nottinghamshire Healthcare NHS Trust after a fatal incident in Nottinghamshire.

5. The inspection identified clear progress since the previous CQC inspection. The service was rated 'Good' in three of the five CQC domains – Safe, Effective and Caring, compared with two domains rated 'Good' at the last inspection. This reflects sustained improvement and the impact of the Trust's ongoing quality improvement and transformation programmes. It also demonstrates the work actively being undertaken in partnership, overseen by the Mental Health Collaborative and through the neighbourhood mental health work.

6. The CQC highlighted a number of positive findings, including:

a) Staff treated patients with kindness, empathy and compassion, listened to them as partners in their care, and respected their privacy and dignity.
b) The service was effective at working across teams within the Trust and with partner agencies to meet patients' needs and keep them safe.
c) Staff wellbeing was well supported, with a culture that enabled staff to speak up if they had concerns.
d) The service was effective at learning lessons from safety incidents.
e) Staff undertook holistic assessments, empowering patients and supporting them to live healthier lives.
f) The service understood the needs of its diverse populations and was working to tackle health inequalities.

7. In addition, the CQC identified a number of areas of outstanding practice, including:
   a) Delivering evidence-based care and treatment;
   b) How staff, teams and services work together;
   c) Partnerships and communities.

8. The CQC also identified areas for further improvement, including:
   a) Patients sometimes waiting too long for outpatient appointments, with large caseloads in some teams;
   b) Unfilled vacancies, resulting in reliance on long-term temporary staffing;
   c) Care and risk management plans not always being fully up to date or sufficiently detailed.

9. The table below (fig.1) compares the CQC inspection of this service in 2017 with the most recent inspection, demonstrating improvement.

   fig.1

CQC ratings: LPT Community mental health services for adults

	Safe	Effective	Caring	Responsive	Well Led	Overall
2017	Requires Improvement	Requires Improvement	Good	Requires Improvement	Good	Requires Improvement
2025	Green	Green	Green	Requires Improvement	Requires Improvement	Requires Improvement

10. In relation to outpatient waiting times, the CQC issued a Warning Notice, requiring significant improvement and enabling the CQC to return to assess compliance. The CQC returned in January 2026 and the Trust is awaiting the outcome of this.

11. The Trust has responded promptly and robustly:
   a) A significant transformation plan was already in place which is fundamentally changing the model of delivery, based on public engagement, which is now positively impacting on waiting times.
   b) Waiting times have reduced across all locations and professions;
   c) Caseload management has been strengthened and workforce capacity continues to be addressed.

d) While consultant shortages remain a national challenge, the Trust has appointed two new substantive consultant psychiatrists and three acting consultants since the inspection, strengthening clinical leadership and continuity of care.

12. The Inspection Report changed the Well-Led domain rating from Good (which we achieved in 2017) to Requires Improvement. The report has identified that:
    a) Staff and senior leaders share a clear vision and strategy for improving community mental health services and understand how their roles contribute to better outcomes.
    b) Leadership is visible, capable, and inclusive, with structured professional development supporting staff career progression.
    c) There is a strong culture of openness and safety, with staff encouraged and supported to raise concerns through the Freedom to Speak Up process.
    d) Partnerships with local organisations, voluntary groups, and community services are well-established, enabling people to access joined-up care.
    e) Staff actively engage in quality improvement projects and research, including initiatives that have reduced inpatient admissions and improved patient pathways.

13. While we have these strengths, the CQC identified that further work is required to strengthen governance and risk management; this is being actively addressed by the Trust.

Conclusions

14. The CQC inspection provides constructive assurance on adult community mental health services and demonstrates clear progress, while also identifying areas for further improvement, particularly around access and waiting times.

15. The service is now rated ‘Good’ for Safety, Effectiveness and Caring, with inspectors highlighting examples of good and outstanding practice. Service users provided largely positive feedback, reporting that they felt:
    a) safe,
    b) supported,
    c) listened to, and
    d) had good relationships with staff.

16. The Trust has shown strong grip in addressing areas for improvement. Reductions in waiting times, progress with recruitment, strengthened caseload oversight, and robust governance provide assurance that risks are being actively managed.

17. The Trust remains focused on sustaining improvement through its mental health transformation programme to enhance access, experience, and outcomes for patients and service users.

18. The Trust has shown strong grip in addressing areas for improvement. Reductions in waiting times, progress with recruitment, strengthened caseload oversight, and robust governance provide assurance that risks are being actively managed.

19. The Trust remains focused on sustaining improvement through its mental health transformation programme to enhance access, experience, and outcomes for patients and service users.

Background papers

CQC published report 13 January 2026
https://www.cqc.org.uk/provider/RT5/reports/AP10381/community-based-mental-health-services-for-adults-of-working-age

CQC published report of 30 April 2018
https://api.cqc.org.uk/public/v1/reports/9ffbdd36-11e3-4b4b-8d98-6f27a6eea56c?20210117194415

Equality Implications

N/A

Human Rights Implications

N/A

Appendices

N/A

Officer(s) to Contact

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Agenda Item 9

University Hospitals of Leicester NHS Trust

HEALTH OVERVIEW AND SCRUTINY COMMITTEE: 4 MARCH 2026

ELECTIVE CARE, DIAGNOSTICS AND CANCER PERFORMANCE

REPORT OF UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST

Purpose of report

1. The purpose of this report is to provide the Committee with an update on elective care, diagnostics and cancer operations at University Hospitals of Leicester NHS Trust (UHL). The report will provide an insight on the Trust's elective care recovery progress and cancer waits and the work being done to reduce waits for the patients of Leicester, Leicestershire and Rutland (LLR).

Background

2. Elective care and cancer performance across Leicester, Leicestershire and Rutland (LLR) continues to face significant pressures, primarily due to increasing demand, emergency activity, industrial action and workforce shortages. UHL is implementing a comprehensive programme of actions to improve waiting times and strengthen its services, as detailed in this report.

Elective recovery

3. Elective care covers a broad range of planned, non-emergency services, from diagnostic tests and scans to outpatient appointments, surgery and cancer treatments. Nationally and locally the drive has been to reduce the length of time patients are waiting for their treatment. We have seen significant improvement compared to 2022 when some patients were experiencing waits of more than two years.

4. In our most recent reported waiting list at the end of January, we had 90 patients waiting 65 weeks or more and no patients waiting longer than 78 weeks. All patients waiting within the 65-week wait cohort are regularly reviewed by the Director of Planned Care, to ensure that next steps are in place and all possible actions have been taken to conclude the patient's pathway as soon as possible.

5. At the end of January, UHL reported 2,715 patients (97 patients less than last month) waiting more than 52 weeks, this is 2.6% of the total waiting list size. Our aim is to deliver <1% of the total waiting list. The 52-week position has started to improve with additional activity being delivered as part of UHL's elective recovery plan.

18-week waits (Referral to Treatment performance)

6. NHS Referral to Treatment (RTT) performance measures the waiting times for elective (non-urgent) care in England from GP referral to the start of consultant-led treatment. RTT performance tracks both completed and ongoing pathways.

7. In terms of the 18-week RTT standard, performance for UHL at the end of January was just below 52%. We expect by the end of March to deliver 57% of patients waiting less than 18 weeks for their treatment.

Actions

8. Key actions to support elective recovery performance include (not a fully exhaustive list):
   - Additional 'super-clinics' to support General Surgery and Musculoskeletal.
   - Additional insourced clinics planned for February and March in Oral and Maxillofacial surgery.
   - Actions are being supported by 'sprint' funding from NHS England.
   - Action plans to maximise additional capacity (East Midlands Planned Care Centre, Hinckley Community Diagnostic Centre, and the newly opened Endoscopy Unit at the Leicester General Hospital).
   - Exploring AI solutions to support tasks like appointment booking, processing referrals and dictation.
   - Independent sector being used to support with long waits in Orthopaedics.
   - Advertising for a locum to support the Orthopaedic position.

Diagnostics

9. As of the end of January 2026, there were 5,008 patients waiting more than six weeks for a diagnostic test, of which 1,301 patients have been waiting over 13 weeks. This represents a performance of 78.1%, with 21.9% of patients over six weeks. The forecast year end position expects further improvements, and it is anticipated performance will improve to 85%.

Actions:

10. Key actions to support improvements in diagnostics include (not a fully exhaustive list):
    - Additional CT and MRI capacity.
    - Increasing Non-Obstetric Ultrasound (NOUS) capacity, including additional insourced staff to support.
    - Additional diagnostic capacity
        - Hinckley Community Diagnostics Centre opened in June 2025, which offers a range of tests such as CT, MRI, X-Ray, Ultrasound, Phlebotomy, Dermatology, Audiology and Endoscopy.
        - Endoscopy Unit at the Leicester General Hospital opened in November 2025, increasing the capacity across the Trust by an additional 300 patients per month.
    - A second DEXA (bone density) scanner is being installed in March 2026, which will support a reduction in waiting times.
    - Expanding direct access tests for primary care.

Cancer

11. UHL is the largest NHS trust in the East Midlands for cancer referrals and is a large tertiary centre, offering specialised services for patients with some of the most complex conditions across the region. Cancer referrals vary month on month with no specific trend. Referrals year to date have seen an increase of 3.8% compared to the previous year. Conversion rates year to date have reduced slightly to 6.3%.

12. The NHS Faster Diagnosis Standard (FDS) in England requires that patients with suspected cancer receive a definitive diagnosis or have cancer ruled out within 28 days of an urgent referral. December performance across the three cancer standards continues to show improvement. December Faster Diagnosis Standard (FDS) delivered 72% of patients being told they have cancer or have had a cancer ruled out within 28 days. Breast remains the main driver of variance due to an ongoing capacity gap, although improvements have been made in December. This remains a risk for the Trust and is reliant on additional capacity and insourcing.

13. This NHS 62-day Referral to Treatment standard dictates that there should be no more than 2 months (62 days) wait between the date the hospital receives an urgent suspected cancer referral and the start of treatment. 62-day performance in December saw a slight improvement of 0.3% to 56%. 31-day performance continues to improve and is expecting further gains in Q4 with Radiotherapy recovery on track and drug performance holding.

Key Actions:

14. Key actions to support improvements in cancer include (not a fully exhaustive list):
    - Additional capacity running at evenings and weekends.
    - Insourced and outsourced solutions to support workforce, including locums.
    - Additional surgical robotic capacity to support specific waits in Urology.
    - Use of East Midlands Combined Authority (EMCA)/NHS England (NHSe) E Cancer Recovery Funds to support additional activity and reduce pathway length.
    - Quality improvement project underway within Breast pathway.
    - Oncology improvement plan under development.
    - Pathway reviews identifying key areas for improvement by service.
    - Additional 5th radiotherapy linear accelerator (linac) in place, which uses external beam radiation to treat cancers.

Summary

15. A comprehensive programme of actions is underway to improve access and shorten waiting times. This includes increasing clinic activity, expanding diagnostic and theatre capacity, collaborating with system partners to review referral routes and optimise care settings, and working with clinical teams to implement digital solutions that enhance the efficiency of patient pathways.

16. We have also opened new facilities - including our second Community Diagnostic Centre in Hinckley and a new Endoscopy Unit at the Leicester General Hospital - both of which support faster diagnosis. We have made significant investments in

replacement radiotherapy machines over the last 3 years, purchasing a fifth LINAC radiotherapy machine to reduce waiting times.

17. We are working closely with NHS England and the East Midlands Cancer Alliance to support recovery, expand capacity, and ensure patients receive timely diagnosis and treatment. While progress has been made, we know there is more to do, and we remain fully committed to improving the experience and outcomes for our patients.

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Leicestershire County Council

HEALTH OVERVIEW AND SCRUTINY COMMITTEE: 4 MARCH 2026

REPORT OF THE DIRECTOR OF PUBLIC HEALTH, LAW AND GOVERNANCE AND THE ICS PERFORMANCE SERVICE

HEALTH PERFORMANCE UPDATE

Purpose of Report

1. The purpose of the report is to provide the Committee with an update on public health and health system performance in Leicestershire and Rutland based on the available data in late January 2026.

2. The report contains the latest available data for Leicestershire and Rutland and LLR on a number of key performance metrics (as available in January 2026) and provides the Committee with local actions in place.

Background

3. The Committee has, as of recent years, received a joint report on health performance from the County Council's Business Intelligence Service and the ICS Commissioning Support Unit Performance Service. The report aims to provide an overview of performance issues on which the Committee might wish to seek further reports and information, inform discussions and check against other reports coming forward.

Future Changes to Performance Reporting Framework

4. In March 2025 NHS England (NHSE) published its new NHS Performance Assessment Framework for 2025/26 setting out a revised approach to assessing how success and areas for health performance improvement will be identified and how organisations will be rated. The new framework replaced the NHS System Oversight Framework 2021/22. NHSE are testing new ICS operational plan submissions against the new framework. The framework data was published on 26 June 2025 in an interactive web-based public accountability tool.

5. The approach is based on assessing performance metrics across four domains of an integrated care system for ICBs and acute care, mental health, community and ambulance providers. The extensive set of metrics cover a wide range of areas including national operating objectives in the NHS planning guidance, finance and productivity metrics, public health and patient outcome metrics, quality and inequalities metrics, and priority system metrics.

6. A number of national and local priorities have been set for the health system for 2025/26 including: -

- Improving referral to treatment to 65% nationally by March 2026, with every trust expected to deliver a minimum 5% improvement. Improving performance against the cancer 62-day and 28-day Faster Diagnosis Standard to 75% and 80% respectively by March 2026.
- Improving Accident and Emergency waiting times with a minimum of 78% of patients seen within 4 hours in March 2026. Category 2 ambulance response times should average no more than 30 minutes across 2025/26.
- Improving patients access to general practice, improving patient experience, and improving access to urgent dental care, providing 700,000 additional dental appointments.
- Improving patient flow through mental health crisis and acute pathways, reducing average length of stay in adult acute beds, and improving access to children and young people's mental health services, to achieve the national ambition for 345,000 additional children and young people aged 0 to 25 compared to 2019.

7. Delivery of the national priorities will aim to be achieved by focusing on -
    - Reducing demand through developing Neighbourhood Service models;
    - Making full use of Digital Tools;
    - Addressing inequalities and shifting towards secondary prevention;
    - Living within budget, reducing waste and improving productivity; Providers will need to reduce their cost base by at least 1% and achieve 4% overall improvement in productivity.
    - Maintaining focus on the overall quality and safety of services.

8. The following 3 areas form the main basis of current reporting to this Committee, and they will continue to be revised as the new performance assessment approach develops further:

    a. ICB/ICS NHS System Priorities Performance Report – Appendix 1
    b. Leicestershire Public Health Strategy outcome metrics and performance – Appendix 2.
    c. Performance against metrics/targets set out in the Better Care Fund plan.

9. Performance reporting is also a key element of the LLR ICB Collaboratives, and many of these groups have Quality and Performance subgroups, which receive performance reports throughout the year.

NHS System Oversight Framework

10. The new NHS Oversight Framework 2025/26 describes a consistent and transparent approach to assessing Integrated Care Boards (ICBs) and NHS trusts and foundation trusts, ensuring public accountability for performance and providing a foundation for how NHS England works with systems and providers to support improvement. This is a 1-year framework and has been developed with the engagement and contributions from the NHS leadership and staff, representative bodies and think tanks, including through two public consultations.

11. NHSE will report ICB performance against the full suite of oversight metrics, but will not issue a comparative rating. ICBs will still be assessed through a statutory annual assessment, which reviews how well each ICB is performing its statutory duties. NHSE will introduce the segmentation approach for ICBs in 2026/27.

Summary of ICB/ICS Performance

12. The performance report attached as Appendix 1 aims to provide a high-level overview of the Leicester, Leicestershire and Rutland (LLR) achievement of the 2025/26 Plan Priorities. Slide 3 sets out a summary of performance issues against current plan targets, contained in the body of the report. The main issues are included below for ease of reference.

Alerts

13. The alerts are as follows:
    - Acute and Community Hospital **bed occupancy** remains maximised at above 90% occupancy. This is despite additional bed capacity being opened.
    - **Referral To Treatment (RTT) waits** for 65+ and 52+ weeks have improved but remain above plan. Trauma and orthopaedics, Gynaecology and Ear, Nose and Throat continue to be pressured with a high volume of referrals.
    - **Cancer 62-day performance** is behind plan with a risk to the delivery of the planned target of 63.2% - an improvement plan is place with improvements expected in Q4.

- Shift in **Length of Stay in in-patient Mental Health** provision – ongoing discharge delays due to social care capacity. Court of Protection, Prison repatriation and MoJ decisions causing extended delays.
- Number of **Learning Disability Adults and Autistic Adults** inpatients remains above plan. This is linked to the number of Learning Disability Adult inpatients that are under MoJ restrictions that risk meeting the end of year target.

Assure

- CATEGORY 2 EMAS **Ambulance response** (<30mins) remains red – Ambulance Handover delays remained challenged – Release to Respond has now been implemented. This has overall improved the performance of Ambulance Handovers thus impacting on the CAT 2 Mean Response.
- **Cancer** - FDS – improvement from previous month
- **Mental Health Talking Therapies** Reliable recovery is off plan in November although improved from October – Service working to deliver the target for Q4.
- **Long waits for CYP services** continue to increase as expected however the rate of increase has been less than anticipated with the October outturn c200 below plan.
- LLR remain in tiering for **Elective Care (52 weeks), Cancer (62 Day), Emergency Department (4 hours performance) and Ambulance Handover).**
- **GP Appointments delivered** in month for October were slightly below plan – the impact of the implementation of Online Consultation and new additional contractual obligations will have impacted on delivery. It is expected November will have returned to expected levels.

Update, Risk and Learning on Plans

- Operational pressures due to the **emergency demand** impacting upon elective activity.
- Rollout of PAS has impacted on overall productivity in 2025/26 in UHL impacting on total **waiting list size.**
- Impact of court of protection delays due to MoJ impact on timelines adversely impacting on Length of Stay.
- Learning Disability Adults - **annual health checks** at 56.1% currently and the local target is 80%. Practices continued to be supported by the PCLNs to meet the target in Q4.

Advise

- Continue to deliver to the system **4-hour performance** to target. Delivery of plans continue to maintain this with continued pressure on the Emergency Department.
- **18 week waits** remains static and below plan.
- **Mental Health** – reliable improvement performance continues to be strong at 67%
- **CYP access to Mental Health services** – more children and young people continue to be able to access services in LLR.

13. The ICB is forecasting to exceed its running cost allocation due to under delivery against the corporate staff costs target. Bank spend is above the system cap for the year to date and forecast to continue to be at year end, however this was planned at the start of the year.

Public Health Outcomes Performance – Appendix 2

14. Appendix 2 sets out current performance against a range of outcomes set in the performance framework for public health. The Framework contains 36 indicators related to public health priorities and delivery. The dashboard sets out, in relation to each indicator, the statistical significance compared to the overall England position or relevant service benchmark where appropriate. A rag rating of 'green' shows those that Leicestershire is performing better than the England value or benchmark and 'red' worse than the England value or benchmark.

15. Analysis shows that of the comparable indicators, 13 are green, 17 amber and 3 red. There are 3 indicators that are not suitable for comparison or have no national data.

16. Of the thirteen green indicators: cancer screening coverage – breast cancer and cancer screening coverage - bowel cancer, have both shown significant improvement over the last five years. Cervical cancer screening coverage (25-49 years old) and cervical cancer screening coverage (50-64 years old) have both shown a significant declining (worsening) performance over the last five years, whilst new STI diagnoses (excluding chlamydia aged 24 years and under) has shown a significant increasing (worsening) performance.

17. Of the seventeen indicators that are amber: smoking status at time of delivery has shown significant improvement over the last 5 time periods. Successful completion of drug treatment: non opiate users and admission episodes for alcohol-related conditions have both shown a significant worsening performance over the last five years.

18. Of the three red indicators: for HIV late diagnosis in 2022-24, Leicestershire ranked 15th out of 16 when compared to its nearest statistical neighbours. For the cumulative percentage of the eligible population aged 40 to 74 offered an NHS Health Check who received an NHS Health Check in 2020/21-2024/25, Leicestershire ranked 11th out of 16. For breastfeeding prevalence at 6 to 8

weeks in 2024/25, Leicestershire ranked 5th out of 8 when compared to its nearest statistical neighbours.

19. In 2022-24 life expectancy at birth increased in both males and females in Leicestershire. In 2021-23, inequality in life expectancy at birth for males in Leicestershire falls within the best quintile of the country, whilst for females in Leicestershire life expectancy at birth falls within the 2nd best quintile. Leicestershire and Rutland have combined values for the following two indicators - successful completion of drug treatment (opiate users) and successful completion of drug treatment (non-opiate users).

20. Further work is underway to progress improvement across the range of indicator areas. Further consideration will be given to actions to tackle these areas as part of the Health and Wellbeing Strategy implementation and the public health service plan development process.

Better Care Fund and Adult Care Health/Integration Performance

21. Nationally, the Better Care Fund (BCF) plan guidance for 2025/26 was published by NHS England (NHSE) in January 2025. Full Health and Wellbeing Board BCF Submissions were made by end of March 2025, with outcome letters in May 2025.

22. The BCF performance framework for 2025/26 is set out in the table below: -

Emergency Admissions	
Indicator	Emergency admissions to hospital for people aged 65+ per 100,000 pop.
Supporting Metric	Unplanned hospital admissions for chronic ambulatory care sensitive conditions per 100,000 pop.
Supporting Metric	Emergency hospital admissions due to falls in people aged 65 and over directly age standardised rate per 100,000.
Discharge Delays	
Indicator	Average length of discharge delay for all acute adult patients
Indicator	Proportion of adult patients discharged from acute hospitals on their discharge ready date
Indicator	For those adult patients discharged on DRD, average number of days DRD to discharge
Supporting Metric	Patients not discharged on their DRD, and discharged within 1 day, 2-3 days, 4-

	6 days, 7-13 days, 14-20 days and 21 days or more.
Supporting Metric	Local data on average length of delay by discharge pathway.
Residential Admissions	
Indicator	Long-term support needs of older people (age 65 and over) met by admissions to residential and nursing care homes, per 100,000 population.
Supporting Metric	Percentage of people, resident in the HWB, who are discharged from acute hospital to their normal place of residence.
Supporting Metric	The proportion of people who received reablement during the year, where no further request was made for ongoing support.

23. The table below shows the latest BCF metrics for the 2025/26 financial year, the targets and outturns for Q2 where available:

Metric	Target Q3	Actual	Commentary
Indirectly standardised rate (ISR) of emergency hospital admissions per 100,000 population	1581	1430 Oct/Nov only.	Quarter 3 data so far shows improved performance against the plan. Year to date (YTD) shows that the average rate of admissions is 1,432 per month against a plan of 1,653.
Average length of discharge delay for all acute adult patients, derived from a combination of:	0.41	0.60	Data for Quarter 3 so far shows that off target by 2.4% against planned performance. YTD, 1.6% off target. However, data shows Leics HWB performing better against both the England and East Midlands average. Data is currently only available until November 25.
proportion of adult patients discharged from acute hospitals on their discharge ready date (DRD)	86.5%	84.9%	
for those adult patients not discharged on DRD, average number of days from DRD to discharge.	3.22 days	4.6 days	

Long-term support needs of older people (age 65 and over) met by admission to residential and nursing care homes, per 100,000 population	217	213	The plan for Q3 was 217 admissions and actual data shows this to be 213 up until Quarter 2. YTD performance is 421 against a target of 434.

List of Appendices

Appendix 1 – LLR NHS System Priorities Performance Report
Appendix 2 – Public Health Outcomes – Key Metrics

Background papers

University Hospitals Leicester Trust Board meetings can be found at the following link:
http://www.leicestershospitals.nhs.uk/aboutus/our-structure-and-people/board-of-directors/board-meeting-dates/

LLR Integrated Care Board meetings can be found at the link below
https://leicesterleicestershireandrutland.icb.nhs.uk/about/board-meetings/

NHS Performance Assessment Framework for 2025/26.

Officers to Contact

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Andy Brown – BI Team Leader, Andy.Brown@leics.gov.uk

Leicester, Leicestershire and Rutland
Working in partnership with
Northamptonshire Integrated Care Board

Quality Performance and Outcomes Committee
Leicestershire & Rutland ICB Performance Report

January 2026

Prepared by:
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A proud partner in the:
Leicester, Leicestershire and Rutland
Health and Wellbeing Partnership

Making Meetings Matter use of 3 As – Good Governance

Adopting best practice from the Good Governance Institute
The 3 As – what is this and what does this mean?

- The 3As report format provides a simple way for groups and committees to report to their parent group/committee or indeed to the executive group or board of directors.
- It provides a succinct way in which to report and highlight particular areas of a programme of work that require action/escalation

What are the 3 A's

- **Alert** – what are the 3-4 key issues/risks that you need to alert the Board/meeting on? These are issues/risks that require action/escalation in order to aid or support decision/actions to mitigate or manage
- **Assurance** – what are the key areas that require and you need to provide assurance on where progress is being made but may not yet have achieved the trajectories set or met the milestones anticipated
- **Advise** – what are the key areas/items you want to advise the board/meeting on where key achievements have been made that have had an impact – benefits/outcomes

Not everything will be covered with the above and therefore the box on update, risks and learning should support leads to include into the report any sharing of learning, brief updates and review of any risk

Performance Report – LLR Executive Summary

Alert

- Acute and Community Hospital bed occupancy remains maximised at above 90% occupancy. This is despite the additional bed capacity opened.
- Referral To Treatment (RTT) 65+ and 52+ weeks improved but remain above plan. Trauma and orthopaedics, Gynaecology and ENT continue to be pressured with high volume of referrals.
- Cancer 62-day performance is behind plan with a risk to the delivery of the planned target of 63.2% - improvement plan is place with improvements expected in Q4.
- Shift in LOS in in-patient MH – Ongoing discharge delays due to social care capacity. Court of Protection, Prison repatriation and MoJ decisions causing extended delays.
- Number of LDA and Autistic Adults inpatients remains above plan. This is linked to the number of LDA inpatients that are under MoJ restrictions that risks meeting the end of year target.

Update, risk and learning on Plans

- Operational pressures due to the emergency demand impacting upon elective activity
- Rollout of PAS has impacted on overall productivity in 25/26 in UHL impacting on total waiting list size.
- Impact of court of protection delays due to MoJ impact on timelines adversely impacting on LOS
- LDA Annual health checks at 56.1% currently and the local target is 80% practices continued to be supported by the PCLNs to meet the target in Q4

Assure

- CAT 2 EMAS Ambulance response (<30mins) remains red – Ambulance Handover delays remained challenged – Release to Respond (W45) has now been implemented. This has overall improved the performance of Ambulance Handovers thus impact on the CAT 2 Mean Response.
- Cancer - FDS – improvement from previous month
- MH Talking Therapies Reliable recovery is off plan in November although improved from October – Service working to deliver the target for Q4.
- Long waits for CYP services continue to increase as expected however the rate of increase has been less than anticipated with the October outturn c200 below plan.
- LLR remain in tiering for Elective (52 weeks), Cancer (62 Day), ED (4 hours performance and Ambulance Handover).
- GP Appointments delivered in month for October were slight below plan – the impact of the implementation of Online Consultation and new additional contractual obligations will have impacted on delivery. It is expected November will return to expected levels.

Advise

- Continue to deliver to the system 4-hour performance to target. Delivery of plans continue to maintain this with continued pressure on ED.
- 18 WW remains static and below plan.
- MH – TT reliable improvement performance continues to be strong at 67%
- MH – CYP access to MH services – more CYP continue to be able to access MH services in LLR.

Reports Content

Performance against Plan

Notes for Performance tables

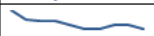
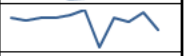
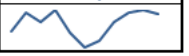
- Actual figures are RAG rated (shaded) on the basis of the extent to which the plan is currently being achieved. Where the metric is being achieved, it is green. Failure to achieve is shaded red, however there is an **amber status which is within 5% of achieving.**

- Depending on the metric, “good” might mean being below the target or above the target.

    - There is one anomaly within this ruling: the primary requirement for the 18-week RTT metric (shown on the table on Slide 6) **is the percentage, not the absolute figure.** The plan expects the actual number of patients waiting less than 18 weeks to be high, but as a proportion of a total waiting list which needs to decrease. Therefore, whether this figure is good or bad depends on another metric rather than on itself. The colour-coding on these lines **(on slide 6)** are therefore based on whether the percentage figure, the metric below it, is achieving or failing.

- Where there is only a quarterly plan for a metric, the assumption is that this is evenly split across the months of the quarter.

Performance against Plan – UEC Summary

Measure	ICB Plan Mar-26	Current Month	ICB Plan	ICB Actual	UHL Plan	UHL Actual	12 month (ICB)
% of A&E attendances within 4 hours (all types)	78.20%	Dec-25	76.1%	78.9%	61.0%	65.7%	
% of Type 1 and 2 A&E attendances within 4 hours	61.00%	Dec-25	61.00%	65.7%	61.0%	65.7%	
% of A&E attendances over 12 hours Type 1	-	Dec-25	-	7.5%	-	7.5%	
Ambulance handover monthly average time	00:15:00	Nov-25	00:15:00	00:47:14	00:15:00	00:52:44	
Ave bed occupancy (inc escalation)	93.0%	Nov-25	-	-	92.0%	89.0%	
Ave discharged on discharge ready date	88.3%	Nov-25	NA	NA	87.4%	86.5%	
Ave discharge delay	3.9%	Nov-25	NA	NA	3.9%	4.4%	

Updates since previous month:

- UHL GIRFT red lines from December 2025
- ED from 10/12/2025 where no patients spends >24hrs in ED.
- Agreed escalation process for Clinical Operational Standards.
- SDEC never to be used as a bedded escalation space.
- Equity of access to diagnostics in all acute assessment areas.
- Streamlined discharge process to decrease overall length of stay.
- EMAS - Introduction of Ambulance 45 mins Release to Respond SOP from 10/12/2025.

Current issues:

- Acute and CoHo bed occupancy is maximised following the early January 2026 surge demand.
- Ambulance handover performance was very challenged in early January but recovering from w/c 19/01/2026.
- Community-based UTCs demand continues to exceed commissioned capacity.
- The Winter Additionality ARI Hub has seen a reduction in respiratory demand so has flexed to receive all age patients for a broader range of clinical presentations.

Risks:

- Challenges in consistently delivering the Ambulance 45 mins Release to Respond SOP.
- High levels of ED and UTC attendances, non-elective admissions and wider system surge impact.
- Ability to deliver our Winter Plan with the anticipated positive impacts.

Dependencies:

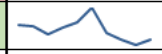
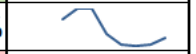
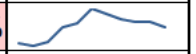
- Delivery and impacts of the wider system schemes via Primary Care, Community Care, Long Term Care, and Children & Young People.

Future actions & mitigations:

- Recovery from the Resident Doctors Industrial Action and the Christmas / New Year demand variability in December 2025.
- The remaining Winter Additionality schemes have gone live in January 2026.
- Embedding of learning from Ambulance 45 mins Release to Respond SOP (live from 10/12/2025) and the agreed Pause SOP.

Link to reports content

Performance against Plan – RTT Summary

Elective RTT Measures	ICB Plan Mar-26	Current Month	ICB Plan	ICB Actual	UHL Plan	UHL Actual	12 month (ICB)
Total incomplete pathways	119,942	Dec-25	121,743	123,213	106,849	107,775	
65 week waits	NA	Dec-25	0	107	0	92	
52 week waits	1,083	Dec-25	1,396	2,540	1,226	2,812	
52ww %	1.2%	Dec-25	-	2.1%	1.1%	2.6%	-
18 week waits	74,746	Dec-25	72,540	69,811	63,479	56,059	
18ww %	-	Dec-25	-	56.7%	-	55.8%	
First appointment 18ww %	69.8%	Dec-25	66.8%	59.0%	64.9%	60.4%	
Total <18 years	-	Dec-25	-	11,429	-	9,959	
52 ww <18 years	-	Dec-25	-	187	-	166	-
18 ww <18 years	6,582	Dec-25	6,358	7,055	-	6,210	
18ww % <18 years	-	Dec-25	-	61.7%	-	62.4%	-

Updates since previous month:

- TWL- reduced by approx. 2k
- 65+ - Improved on previous month but above plan.
- 52+ - Improved on previous month but above plan
- Time to wait for treatment or a decision that no treatment is required continues to reduce for patients waiting 52+ weeks
- 18ww – static and below plan.
- 18ww<18 years – Static and above plan

Current issues:

- Trauma and orthopaedics, Gynaecology and ENT continue to be pressured specialities with high volume referrals
- Paediatrics remains challenged due to increased demand for beds resulting in elective cancellations

Risks:

- Operational pressures due to the emergency demand impacting upon elective activity
- PAS issues continue impact on productivity

Dependencies:

- IS capacity and utilisation
- Workforce (admin)
- Financial resource availability

Future actions & mitigations:

- On going PAS fixes continue to support recovery and timely data capture
- Q4 National sprint finance incentive available to support over delivery against plan
- Weekly escalation calls in place for 65+ww with COO oversight
- Route to zero in place expected compliance by end of Feb 26.
- 52 week wait (1% total waiting list size), actions in place to support delivery by end of Mar 26, including elimination of non admitted 52 week waits (without next appointment)
- Mutual aid in place for orthopaedics

Link to reports content

Performance against Plan – Diagnostics Activity & Performance

Diagnostic Activity Measures	ICB Plan Mar-26	Current Month	ICB Plan	ICB Actual	UHL Plan	UHL Actual	12 month (ICB)
YTD Activity - MRI scans	7,283	Nov-25	7,189	6,151	6,535	6,454	
YTD Activity - CT scans	11,981	Nov-25	11,817	3,841	10,780	10,177	
YTD Activity - Non-obstetric Ultrasound	12,332	Nov-25	12,048	12,612	9,475	8,662	
YTD Activity - Colonoscopy	1,031	Nov-25	1,175	1,258	1,116	916	
YTD Activity - Flexi-sigmoidoscopy	394	Nov-25	405	452	372	307	
YTD Activity - Gastroscopy	837	Nov-25	1,020	1,344	964	943	
YTD Activity - Echocardiology	3,614	Nov-25	3,418	1,219	2,393	2,262	
YTD Activity - DEXA scans	1,128	Nov-25	1,018	1,335	920	583	
YTD Activity - Audiology assessments	1,658	Nov-25	2,065	2,393	1,463	1,583	
YTD Activity TOTAL	40,258	Nov-25	40,155	30,605	34,018	31,887	

Updates since previous month:

UHL DM01 Performance (Dec)
- 6+ week: 4,208 (Static)
- 13+ week: 1,105 (Static)
- TWL – 23,720 (Improved)
- Performance 82.3% (9.8% behind plan)
- Overall static position at the end of December. Improvements continue to be observed in NOUS, Audiology, MRI. Endoscopy and DEXA recovery at risk.

Current issues:

- Reduction in uptake of WLI/Additional sessions
- Staffing pressures (administrative) across modalities affecting booking
- PAS implementation, DQ and validation reporting errors (mainly affected Endoscopy)

Risks:

- Endoscopy – reliant on WLIs to backfill some of the new unit capacity until full recruitment in place to support return to plan.
- Dexa – 2nd scanner due March.
- RTT long wait pressures

Dependencies:

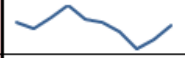
- Demand inc Planned pts
- Capacity inc complex & GA lists
- ERF funding in place

Future actions & mitigations:

- NOUS –recovery continues with ERF – return to plan end of Q4.
- Audiology – additional capacity ERF – recovery planned Q4 .
- Endoscopy - new unit opened 5/11, recovery commenced, ongoing DQ issues. Expected improvements Q4, weekly PTL meetings in place to drive improvements.
- DEXA recovery by Q4, additional equipment planned March & Van as backup being explored (ERF).
- Imaging – MRI and CT complex patients >13wks, escalation meetings in place.

Link to reports content

Performance against Plan – Cancer Summary

Cancer Measures	ICB Plan Mar-26	Current Month	ICB Plan	ICB Actual	UHL Plan	UHL Actual	12 month (ICB)
% starting treatment within 62 days	70.3%	Nov-25	64.1%	58.7%	66.2%	55.7%	
% starting treatment within 31 days	90.0%	Nov-25	78.5%	77.8%	79.3%	75.0%	
% receiving diagnosis / confirmation within 28 days	80.0%	Nov-25	77.0%	69.5%	78.0%	69.0%	

Updates since previous month:

- FDS – improvement from previous month.
- Breast driving variance from plan (without this would be 80%) performance.
- 62 – improvement from previous month. Largest variance from plan being driven by Breast, LOGI and Urology.
- 31 – Improvements in radiotherapy continue with 5th linac in place, with 0 breast waits, prostate on track for end of Q4.
- EMCA / NHSE CRF funds supporting

Current issues:

- Increased demand continues since peak post pandemic
- Capacity constraints across pathways
- Specific capacity constraints for 1st appointment waits in Breast (triple assessment clinics with challenges with radiology cover).
- Increased diagnostic investigations required
- Theatre constraints (mainly in Urology, Gynae, Lung pathways)
- Delays to 1st appt in Oncology

Risks:

- Capacity
- Workforce
- Breast time to 1st appt
- Increasing demand

Dependencies:

- Demand
- Capacity including across radiology, pathology
- EMCA / CRF funding to support recovery actions

Future actions & mitigations:

- Clinical prioritisation of patients, weekly PTLs and RAPs in place
- EMCA & NHSE CRF / Tier funding to support
- Oncology regional review of mutual aid and workforce opportunities (EMPA/EMCA) inc collaborative working with UHN for fragile services
- Radiotherapy 5th Linac in place – recovery end of Q4.
- Breast QI project & insourcing for radiology underway
- LOGI changes to MDT and PTL commenced Jan – expect to see impact Q4.
- Days Matter EMCA to support FDS commenced in Breast, LOGI, Gynae, Urology
- 2nd Urology & Gynae robot to support long waits

Link to reports content

Performance against Plan – Mental Health/Learning Disabilities & Autism

Mental Health & Learning Disabilities Measures	ICB Plan Mar-26	Current Month	ICB Plan	ICB Actual	12 month (ICB)
Talking Therapies - Reliable Recovery	48.00%	Nov-25	48.00%	45.00%	
Talking Therapies - Reliable Improvement	67.00%	Nov-25	67.00%	67.00%	
Inappropriate Out of Area Placements	-	Nov-25	-		
Patients accessing Perinatal Mental Health services	1,259	Nov-25	1,259	1,160	
Children's & Young People's access to Mental Health services	17,745	Nov-25	17,745	18,800	
Individual Placement and Support	825	Nov-25	798	780	
Mental Health beds - ALOS	51.9	Nov-25	53.9	67.0	

Updates since previous month:

- **NHSTT** There was a slight increase in RR in November (45%) from October
- Reliable Improvement continues to be strong at 67%
- Remedial Actions are continuing (enhanced supervision, targeted outcome reviews, and performance improvement plans)
- Wait for Step 2 reduced from over 75 day to less than 31, long waiters reduced by 83%
- **ALOS** - Acute adult readmission rates remain low across PICU & MHSOP demonstrating effective partnership working to support discharge
- 10 high impact actions evidence improved discharge planning , reduced delays and enhanced patient outcomes
- System wide collaboration through MADE events and joint action plans

Current issues:

NHSTT – Impact of high deprivation on recovery across the city.
Non engagement between referral and first session remains high.
Circa 800 people per month discharged after only 1 session.
High number of referrals deemed to be unsuitable.

ALOS – Ongoing discharge delays due to social care capacity, market provision gaps and social care staffing shortages.
Court of Protection, prison repatriation and MoJ approvals causing extended stays.
Workforce contracted patterns and pressures impacting sustainability of 7 day working
Deficit in medical leadership with no Clinical Director for Adult, PICU and Step Down so escalation of key medical barriers challenged
Differing clinical/professional opinions delaying discharge destination decisions

Significant bed days accrued by a small number of complex cases impacting the average, mean average evidences that extracting outliers shows lower than national average.

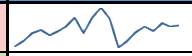
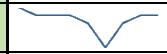
Risks/ Dependencies:
National expectation to increase the **NHSTT** workforce with no additional funding identified
Planning numbers deemed non-compliant for 26/27
Longer term negative impact on future commissioning

ALOS -AHP workload pressures result in delays for assessments particularly in MHSOP
Single occupancy housing / accommodation shortages remain a significant barrier.
Complexity of cases continues to increase demand on inpatient services.

Future actions & mitigations:
Targeted marketing and engagement to attract the right people at the right time.
Optimised clinical productivity and caseload management.
Evidence based training programme
Engaged in 'unsuitable referrals' study at regional level.
Clawback clause 26/27 to be renegotiated, and additional Network activity to be utilised.

ALOS - Daily PTL reviews with focused tracking and prioritisation
Weekly multi agency CRFD escalation meetings
Sustained focus on workforce resilience, housing solutions and system wide collaboration.

Performance against Plan – Mental Health/Learning Disabilities & Autism

Mental Health & Learning Disabilities Measures	ICB Plan Mar-26	Current Month	ICB Plan	ICB Actual	12 month (ICB)
Physical Health Checks - Learning Disabilities	4,009	Nov-25	1,069	408	
LD Inpatients - Adult	9	Dec-25	9	13	
Autistic Inpatients - Adult	13	Dec-25	13	16	
LD/A Inpatients - CYP	3	Dec-25	3	1	

Updates since previous month:

- The latest local LD Annual Health Checks (AHC) data (from 6 January 26) confirms that a total of 3026 checks had been completed (56.1% of LD Register). Confirmed local target: 80%. Practices continuing to be supported by PCLNs to meet target during Q4.
- Number of LD adult inpatients remains at 13
- Number of autistic adult inpatients remains at 16
- The number of CYP inpatients has increased to 2 – so now just 1 below trajectory. 1 CYP inpatient now meets the long stay criteria of 9 months (as outlined in the planning guidance for 26/27)

Current issues:

- The number of Autistic adults admitted into a mental health inpatient beds is impacting our ability to meet year end inpatient targets for both autistic adults and those with a learning disability who may also be autistic
- Lack of commissioned response for autistic people in the community, but who do not have a mental health condition, is one of the main reasons for the increasing number of inpatients – Clinical Summits held in LPT to review options (see future actions and mitigations)

Risks/Dependencies

- The number of LDA inpatients that are under MoJ restrictions remains a risk in meeting end of year target. Sourcing appropriate providers to manage ongoing risks in the community can cause delays in discharge. This does cause a pressure on inpatient services and failing to meet end of year target
- Mental Health Act 2025: Development of appropriate community ingredients to prevent admission for those with LD/Autism but without a confirmed MH diagnosis – initial baseline scoping exercise undertaken across health and social care

Future actions & mitigations:

- Update presented to Leicester Partnership Trust Executive Management Board (LPT EMB) in January 26 following a series of clinical summits at the end of the year – confirmed greater Directorate of Mental Health (DMH) support to be made available to the Specialist Autism Team (SAT), including DMH medical staff sessions
- Dynamic Support Pathway Project now well established including a review of referral criteria and establishment of Dynamic Support register (DSR) Panels to ensure appropriate oversight from senior leaders

Link to reports content

Performance against Plan – Community Services

Community Services Measures	ICB Plan Mar-26	Current Month	In Month ICB Plan	In Month ICB Actual
Community Care Contacts	1,126,352	Oct-25	93,060	113,720
Community Service waiting list over 52 weeks (CYP)	7,527	Oct-25	6,587	6,380
Community Service waiting list over 52 weeks (Adult	-	Oct-25	-	-

Updates since previous month:

- Community Care contacts continue to be above trajectory and have increased following a dip over the summer months due to schools returning. We anticipate remaining at or above plan for the remainder of 2025/26.
- Long waits for CYP services continue to increase as expected however the rate of increase has been less than anticipated with the October outturn c200 below plan.
- Adult services continue to have no waits in excess of 52 weeks, and this is expected to be maintained for the remainder of the year.

Current issues:

- All over 52 week waits for CYP community services are attributed to referrals for Neurodevelopmental Disorders (ND) (ADHD/ASD). Referrals for core community paediatrics are working towards an 18 week wait by February 2026 and are on plan to meet this.
- Referrals for CYP with ND continue to be above historic volumes and exceed capacity to manage within 18-week timeframe. Continued growth in long waits is expected to continue albeit with some impact from internal and system-wide SEND transformation.

Risks:

- Diagnostic delay affects long term outcomes.
- Increase in complaints and concerns
- Negative impact on families as a result of greater prevalence of mental health and behaviour management issues.
- Substantive recruitment to Educational Psychology posts unsuccessful.
- Numbers waiting continue to increase with continuing high volume of referrals.
- Impact of reduced local voluntary, community and sector (VCS) capacity to support CYP / families whilst waiting.
- Increased demand to meet statutory timeframes for Looked After Children (LAC) requires reallocation of resources leading to reduced capacity to manage long waits

Future actions & mitigations:

- Attention deficit hyperactivity disorder (ADHD) nurses release consultant capacity for new referrals.
- Advanced Nurse Practitioners support nursing capacity and oversight enabling throughput to be maximised.
- Resources in place to support timely responses to complaints and concerns.
- Demand and capacity reviews will maximise nurse caseload with training and supervision structure to support enhanced skills.
- ADHD Annual Review Primary Care pilot enabling improved flow to be rolled out.
- Productivity work to increase capacity within existing resources.
- Robust Did Not Attend / Was Not Brought measures minimise lost capacity.

Link to reports content

Performance against Plan – Primary Care

Primary Care Measures	ICB Plan Mar-26	Current Month	In Month	
			ICB Plan	ICB Actual
Appointments in General Practice	693,477	Oct-25	709,816	657,793
Units of dental activity delivered (rolling 12 months)	356,049	Q2	356,049	365,959
Unique patients seen - adult (rolling 12 months)	398,059	Q2	389,213	385,204
Unique patients seen - child (rolling 12 months)	164,777	Q2	162,423	164,112
Pharmacy First consultations	12,545	Oct-25	12,841	17,333

Updates since previous month:

Primary Care- All 126 LLR practices have been reviewed and allocated either No Further Action (NFA) required or a 'next steps' with regards to improving Quality and Performance during 25/26:
NFA-83, Contracts and Quality Visit-5, additional Desk Top Review-21, Contract Assurance Template to be completed-13, escalated to QIG-4 (Quality Improvement Group).

Dental- Several non-recurrent schemes were launched in November 2025. Through an Expression of Interest process, the 110% Over Performance Scheme allocated an additional 54,023 UDAs for LLR residents for the remainder of 2025/26.

The Flexible Commissioning Scheme also commissioned LLR providers to protect capacity for priority groups, including new patients and adults with valid charge exemptions.

Current issues:
Primary Care:

- Although we can identify outliers and understand the challenges regarding unwarranted variation, there are few levers available to enforce changes in access and patient triage models at individual practice level due to the limitations in the national GMS contract.
- NHS App National data, currently being cleansed and updated. Data may not be correct
- ICB continue to monitor Online consultations (OC) via the monthly data and update national report on activity via the monitoring taking place at regional national level. Though all LLR practices are contractually required to offer OC, the ICB continue to review practices websites to monitor how OC information is shared with patients.

Dental:

- Workforce challenges within dentistry remain an issue
- Following the national urgent care schemes launched at the beginning of 2025, the target number of commissioned appointments set, remain higher than demand leading to underutilised urgent care sessions across the LLR ICB
- Issues amongst the dental profession with the current national dental contract, particularly around lower UDA rates.

Risks:
Primary Care: OC Contractual implementation – Ongoing review of implementation and delivery of OC.

Dental: The under delivery of dental targets due to the issues outlined

Unutilised clinical time in relation to urgent dental care

Dependencies:
Primary Care:
ICB holds webinars to support practices with implementation
ICB undertakes reviews of practice websites to ensure information is available to pts on OC access.

Dental:
Further national dental contractual reform, with announcements due ahead of the 26/27 financial year.

Future actions & mitigations:
Primary Care: Continued implementation of Primary Care and Urgent Emergency Care (UEC) Access Group to identify special variation at practice level, how this may be impacting UEC pathways such as ED attendance and put in place interventions to mitigate.

- ICB will continue to monitor the national online consultation activity, and work with practices where there is low uptake. Work continues to support to achieving full compliance. A governance group is being established to review compliance elements.

Dental: Further dental reinvestment in 26/27, with two planned procurements set to take place to increase dental appointment availability

- The continuation of the rebasing contracts with additional contracts to be reduced ahead of the 26/27 financial year. To date, 19,039 UDAs have been rebased, effective from 1 April 2026, generating savings of £631,064, which will be reinvested to improve dental access through higher-performing contracts.
- Further focus on enhancing communications to increase awareness of commissioned urgent dental care sessions available

Link to reports content

Performance against Plan – Maternity

Maternity Care Measures	ICB Plan Mar-26	Current Month	In Month ICB Actual	
National safety ambition to reduce stillbirth (rate per 1000)	Reduction 2023 4	Sep-25	4	
Neonatal mortality (per 1,000 births)	Reduce 2021 2.4	2023	2.4	
Maternal mortality	Reduce 21/22 *	2023/24	0	

Updates since previous month:

Good News: An LLR infant / perinatal mortality working group set up working in partnership with ICB / Public Health / UHL to help address our perinatal mortality rates.

Patient Outcome: Interim provider now in place and commenced delivery. Running in parallel - procurement process in place to secure longer term provider with contract that can be extended for up to 3 years from 1 April 2026.
*The Maternity and Neonatal Voices Partnership (MNVP) supports women to have their voices heard and support improvements in services.

Current issues:

- Increasing infant mortality rate in Leicester City – currently at 7.9 per 1000 births from 2024 data
- In 2024 there was a decrease in neonatal deaths but increase in stillbirth and extended perinatal deaths
- Increase in infant mortality where IVF overseas was identified as a modifiable factor
- Increased Necrotising Enterocolitis (NEC) rates alert notification of outlier status generated as result of NEC rates being 13.2% compared to national average of 6.4%

Risks:

- 57.6% of neonatal deaths more than 24 weeks were due to congenital abnormalities. There may be demographic and cultural reasons that influence this trend as more people are choosing to continue with pregnancy when it is known the baby has conditions not compatible with life

Future actions & mitigations:

- Working with Office for Health and Improvement and Disparities (OHID) and NHSE on deep dive review and development of system wide action plan.
- Focused task and finish group around IVF overseas established with key actions identified.
- NEC being addressed by UHL with host of inter-related interventions including optimising periprem, early breastmilk, ultra gentle stabilisation and microbial stewardship.
- Ongoing review of counselling for congenital abnormality and discussed in regional forums.
- Local Maternity Neonatal Services (LMNS) attends Perinatal Mortality Review Tool (PMRT) meetings so review trends and support system wide SMART actions where appropriate.

Link to reports content

Performance against Plan – CVD/Hypertension

Area	NHS PRIORITIES 2025/26	Actual	Plan
CVDP002HYP: Percentage of patients aged 18 to 79 years with GP recorded hypertension, in whom the last blood pressure reading within the preceding 12 months is equal to 140/90 mmHg or less	Q2 25/26	65.96%	N/A
CVDP003HYP: Percentage of patients aged 80 years or over with GP recorded hypertension, in whom the last blood pressure reading within the preceding 12 months is 150/90 mmHg or less	Q2 25/26	80.82%	N/A
CVDP007HYP - Percentage of patients aged 18 and over, with GP recorded hypertension, in whom the last blood pressure reading (measured in the preceding 12 months) is below the age appropriate treatment threshold	Q2 25/26	68.95%	N/A
CVDP003CHOL - Increase the percentage of patients aged between 25 and 84 years with a CVD risk score greater than 20 percent on lipid lowering therapies to 60%	Q2 25/26	66.82%	N/A

Updates since previous month:

- **CVD003CHOL:** local data reached 70% in October 2025
- **Delivery against hypertension and lipid goals** are supported by more than one LTC programme: for example, Lucid, the Diabetes Enhanced Service and the launch of the Tirzepatide service in primary care.
- **Related outcomes** (Oct 25 LHIS data) :76% of CKD pts. on lipid management therapies; lipid management thresholds for Type 2 diabetics reached 95%

Current issues:

Hybrid closed loop implementation: LLR cannot meet the NICE TA without additional need for investment (HCL reduces risk of CVD related disease progression).

Diabetes Enhanced Service: the current funding envelope means we cannot reach 100% practice rollout which is mitigated by continued support from Diabetic Specialist Nurses. (Enhanced diabetes care results in increased volume of Hypertension and Lipid treatment goals reached).

Reduced availability of diabetes type 2 remission services: Rutland PCN not participating in T2DR, resulting in inequitable access. (T2DR results in weight loss, reduced Hba1c and lowered BP).

Risks:

- Hybrid Closed loop costs
- Not fully utilising the LLR Tirzepatide allocation

Dependencies:

- UHL staffing to delivery HCL
- Primary prevention services provide by Local Authority e.g. NHS Health Checks

Future actions & mitigations:

- HCL: Joint LNR proposal to JET to highlight risks and options
- Monitor Tirzepatide referrals and develop plan to ensure all referrals are made by March 26.
- T2DR mitigation planned with NHSE regional leads, meeting with PCN and ICB to discuss resolution
- Implementation of Cardio Renal Metabolic model PDSA to move from single disease management to multimorbidity
- Implementation of LUCID as business as usual

Link to reports content

Use Of Resources (Finance M8)

System KPI Dashboard	YTD £m			M1-12 £m		
	Target	Actual	Rating	Target	FOT	Rating
System Delivery of planned deficit (gross of deficit support funding)	68.81	85.65		80.00	80.00	
System Revenue expenditure not to exceed income (net of deficit support funding)	2,385.70	2,413.69		5,185.03	5,185.03	
System Capital expenditure not to exceed allocations	52.50	37.11		105.21	104.59	
System Operates within Cash Reserves	19.03	58.26		38.96	38.96	
System CIP delivery	96.03	92.49		190.47	184.98	
CIP delivery as a % of FOT	50.42%	50.00%				
System Agency spend within ceiling	15.58	9.70		23.37	17.35	
System Bank spend within ceiling	39.58	62.08		59.37	75.36	
Provider total pay costs	989.70	993.54		1,465.89	1,468.11	

Finance

2025/26- System Delivery of planned deficit (gross of deficit support funding)

- The ICB is forecasting to exceed its running cost allocation due to under delivery against the corporate staff costs target
- Bank spend is above the system cap YTD and forecast to continue to be at year end, however this was planned at the start of the year.

Link to reports content

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Public Health and Prevention Indicators in Leicestershire

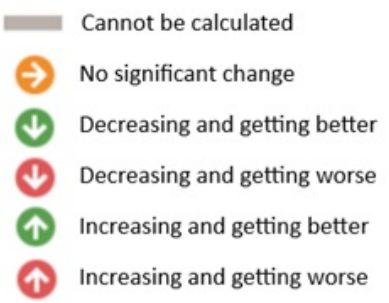
This dashboard presents performance data for Leicestershire on a range of Public Health and prevention indicators. The indicators included cover life expectancy, health improvement, health protection and healthcare and mortality.

Nearest Neighbour Rank (NN Rank): 1 is calculated as the best (or lowest when no polarity is applied).
Direction of Travel (DoT): Trend based on most recent five time periods.
RAG: Statistical significance compared to England or Benchmark.
Trendline: The scale and range of the vertical axis of each line graph changes in line with the values presented, where charts have a small axis range this can result in small differences between values appearing more considerable.

Notes:
-Indicators 'Successful completion of drug treatment: opiate users' and 'Successful completion of drug treatment: non opiate users' present figures for Leicestershire and Rutland combined.

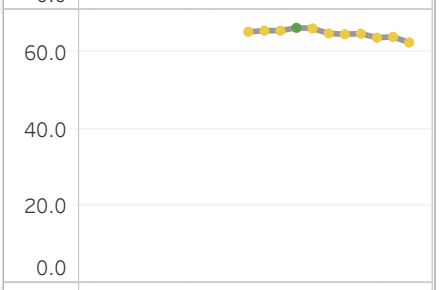
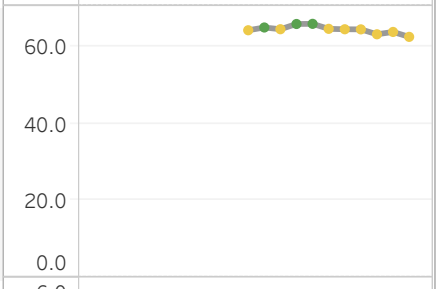
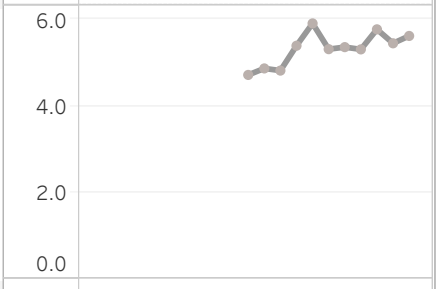
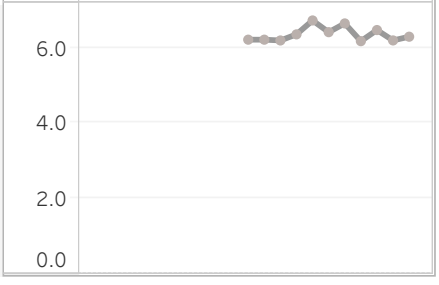
Statistical significance compared to England or Benchmark:

Direction of travel:

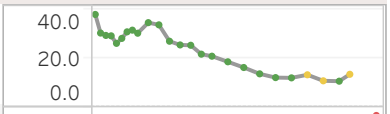
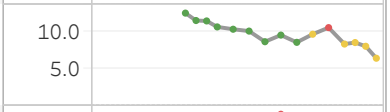
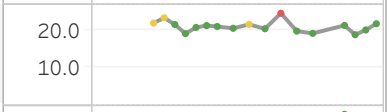
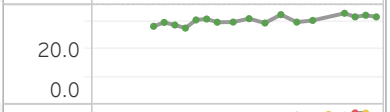
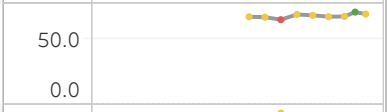
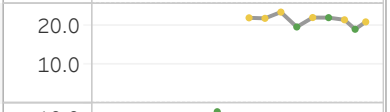
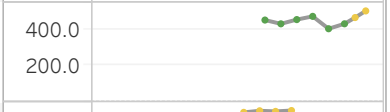
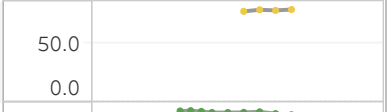
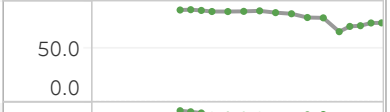
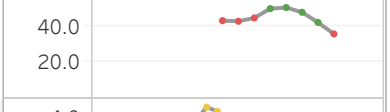


Source: OHID, https://fingertips.phe.org.uk/ - February 2026

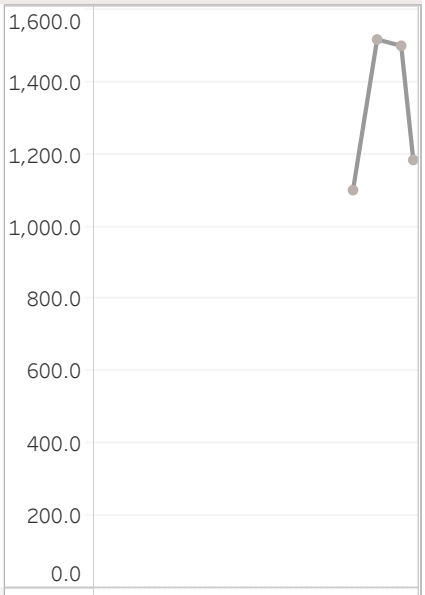
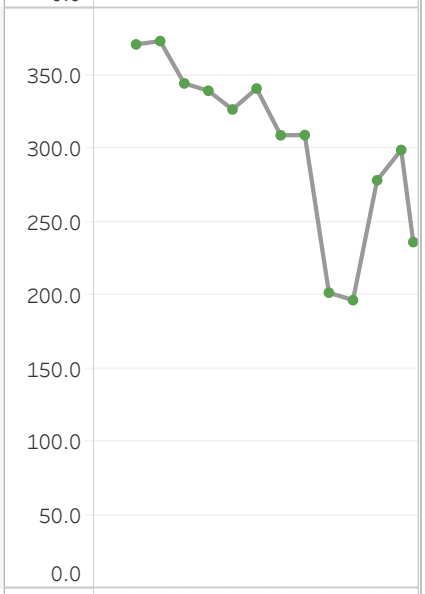
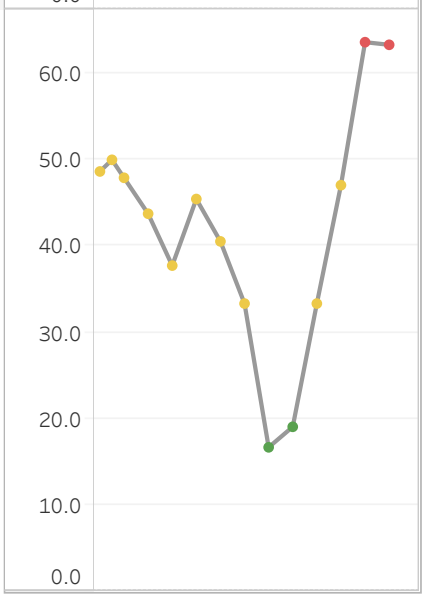
Public Health and Prevention Indicators in Leicestershire - Life Expectancy

Indicator	Latest Value	Latest Period	Prev. Value	DoT	Polarity	RAG	NN Rank	England Value	Trendline
Life expectancy at birth, years - Females	**84.0**	2022 - 24	83.7		High		8/16	83.3	
Life expectancy at birth, years - Males	**80.5**	2022 - 24	80.2		High		7/16	79.5	
Healthy life expectancy at birth, years - Females	**62.6**	2021 - 23	64.1		High		12/16	61.9	
Healthy life expectancy at birth, years - Males	**62.7**	2021 - 23	64.0		High		10/16	61.5	
Inequality in life expectancy at birth, years - Females	**5.6**	2021 - 23	5.5		Low		3/16	8.3	
Inequality in life expectancy at birth, years - Males	**6.3**	2021 - 23	6.2		Low		3/16	10.5	

Public Health and Prevention Indicators in Leicestershire - Health Improvement

Indicator	Latest Value	Latest Period	Prev. Value	DoT	Polarity	RAG	NN Rank	England Value	Trendline
Under 18s conception rate, per 1,000 - Females	**13.5**	2022	10.7	→	Low		10/16	13.9	
Breastfeeding prevalence at 6 to 8 weeks, % - Persons	**54.3**	2024/25	51.9	–	High		5/8	55.6	
Smoking status at time of delivery, % - Females	**6.4**	2024/25	8.0	↓	Low		10/16	6.1	
Reception prevalence of overweight (including obesity), % - Persons	**21.5**	2024/25	19.9	–	Low		8/16	23.5	
Year 6 prevalence of overweight (including obesity), % - Persons	**31.9**	2024/25	32.5	–	Low		6/16	36.2	
Overweight (including obesity) prevalence in adults, % - Persons	**65.8**	2023/24	65.9	–	Low		8/16	64.5	
Percentage of physically active adults, % - Persons	**68.6**	2023/24	70.1	–	High		9/16	67.4	
Percentage of physically inactive adults, % - Persons	**20.8**	2023/24	18.9	–	Low		11/16	22.0	
Successful completion of drug treatment: opiate users, % - Persons	**7.9**	2024/25	6.4	→	High		3/16	5.3	
Successful completion of drug treatment: non opiate users, % - Persons	**30.1**	2024/25	28.7	↓	High		9/16	29.1	
Admission episodes for alcohol-related conditions (Narrow), per 100,000 - Pers..	**503.4**	2023/24	466.8	↑	Low		10/16	504.1	
Estimated diabetes diagnosis rate, % - Persons	**79.4**	2018	78.6	–	High		6/14	78.0	
Cancer screening coverage: breast cancer, % - Females	**73.0**	2025	72.9	↑	High		11/16	71.7	
Cancer screening coverage: cervical cancer (aged 25 to 49 years old), % - Females	**72.6**	2024	72.1	↓	High		5/16	66.1	
Cancer screening coverage: cervical cancer (aged 50 to 64 years old), % - Females	**77.9**	2024	78.0	↓	High		4/16	74.3	
Cancer screening coverage: bowel cancer, % - Persons	**76.7**	2025	75.0	↑	High		4/16	72.9	
Cumulative percentage of the eligible population aged 40 to 74 offered an NHS Health Ch..	**35.8**	2020/21 - 24/25	42.2	–	High		11/16	38.9	
Self reported wellbeing: people with a low worthwhile score, % - Persons	**3.3**	2022/23	2.2	–	Low		4/16	4.4	

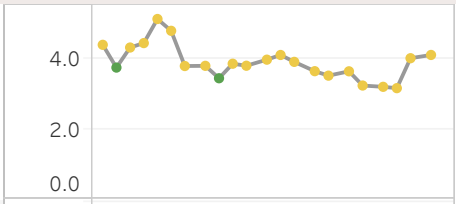
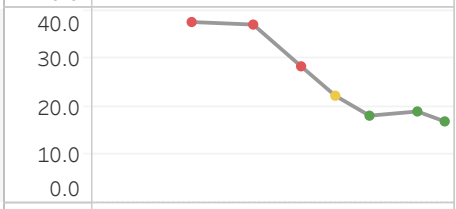
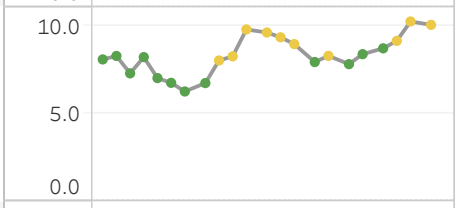
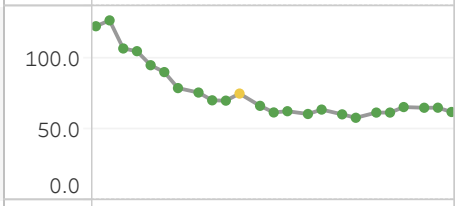
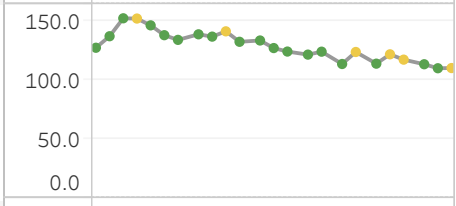
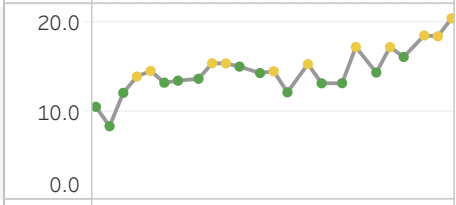
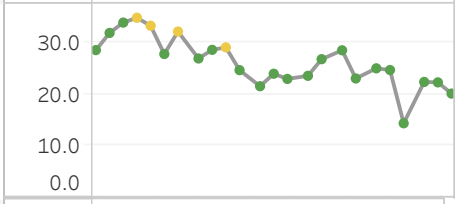
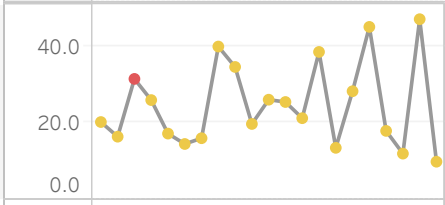
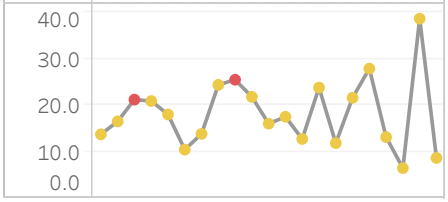
Public Health and Prevention Indicators in Leicestershire - Health Protection

Indicator	Latest Value	Latest Period	Prev. Value	DoT	Polarity	RAG	NN Rank	England Value	Trendline
Chlamydia detection rate per 100,000 aged 15 to 24 years - Persons	**1,184.8**	2024	1,500.5		N/a		16/16	1,249.8	
New STI diagnoses (excluding chlamydia aged 24 years and under) per 100,000 - Persons	**236.5**	2024	299.4	↑	Low		4/16	482.3	
HIV late diagnosis, % - Persons	**63.3**	2022 - 24	63.6		Low		15/16	43.3	

Note: On the trendline for 'HIV late diagnosis', the statistical significance compared to the benchmark in 2010 - 12 should be red/worse.

Public Health and Prevention Indicators in Leicestershire

- Healthcare & Premature Mortality

Indicator	Latest Value	Latest Period	Prev. Value	DoT	Polarity	RAG	NN Rank	England Value	Trendline
Infant mortality rate, per 1,000 - Persons	**4.1**	2022 - 24	4.0		Low		11/16	4.2	
Percentage of 5 year olds with experience of visually obvious dental decay, % - Persons	**17.0**	2023/24	19.1		Low		7/13	22.4	
Suicide rate, per 100,000 - Persons	**10.1**	2022 - 24	10.3		Low		8/16	10.9	
Under 75 mortality rate from cardiovascular disease, per 100,000 - Persons	**62.4**	2024	65.5		Low		5/16	74.3	
Under 75 mortality rate from cancer, per 100,000 - Persons	**110.3**	2024	110.2		Low		6/16	117.9	
Under 75 mortality rate from liver disease, per 100,000 - Persons	**20.6**	2024	18.5		Low		13/16	20.1	
Under 75 mortality rate from respiratory disease, per 100,000 - Persons	**20.2**	2024	22.4		Low		1/16	32.7	
Winter mortality index (age 85 plus), % - Persons	**9.9**	Aug 2021 - Jul 2022	46.9		Low		7/16	11.3	
Winter mortality index, % - Persons	**8.6**	Aug 2021 - Jul 2022	38.7		Low		7/16	8.1	

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