Minutes of a meeting of the Health and Communities Overview and Scrutiny Committee held at County Hall, Glenfield on Wednesday, 3 June 2026.

PRESENT

Dr. S. Hill CC (in the Chair)

Mr. P. King CC
Mrs. K. Knight CC
Mr. P. Morris CC
Mr. M. T. Mullaney CC
Dr. D. North CC
Mr. B. Piper CC
Mr J. Poland CC
Mr. K. Robinson CC
Mr. C. A. Smith CC

In attendance

Mr. P. Harrison CC – Cabinet Lead Member for Health and Public Health.
Mr. J. Miah CC (via Microsoft Teams)
Fiona Barber – Healthwatch Leicester and Leicestershire.
Sarah Taylor, Director of Urgent and Emergency Care, University Hospitals of Leicester NHS Trust (minute 10 refers).
Laura Rodman, Service Development Manager, LDA Collaborative (minute 11 refers).
Dr Naomi Caldwell, Deputy Chief Medical Officer, Integrated Care Board (minute 12 refers).

1. Appointment of Chairman.

RESOLVED:

That it be noted that Dr. S. Hill CC has been appointed Chairman of the Health and Communities Overview and Scrutiny Committee in accordance with Rule 6(a) of the Overview and Scrutiny Procedure Rules (Part 4E of the County Council's Constitution).

2. Election of Vice Chairman.

It was moved by Mrs Kerry Knight CC and seconded by Mr Peter Morris CC:

"That Mr Kim Robinson CC be elected Vice Chairman for the period until the Annual Meeting of the County Council in 2027."

It was moved by Mr Craig Smith CC and seconded by Mr Phil King CC:

"That Mr James Poland CC be elected Vice Chairman for the period until the Annual Meeting of the County Council in 2027".

The Chairman informed members that both candidates had been duly proposed and seconded. In accordance with Standing Order 25 (13) a ballot therefore took place.

The Chief Executive announced the results of the ballot, as follows:

Six votes for Mr Kim Robinson CC and three votes for Mr James Poland CC. The motion "That Mr Kim Robinson CC be elected Vice Chairman for the period until the Annual Meeting of the County Council in 2027" was carried.

3. Minutes of the previous meeting.

The minutes of the meeting held on 4 March 2026 were taken as read, confirmed and signed.

4. Question Time.

The Chief Executive reported that no questions had been received under Standing Order 32 (4).

5. Questions asked by members.

The Chief Executive reported that the following questions had been received under Standing Order 32(1):

1. Question from Mr. B. Piper CC:

Why are there not enough training places available/offered to UK citizens who wish to become medically trained, when there is a shortage of specialist doctors and nurses, forcing Leicestershire NHS to employ doctors from abroad and rely on temps?

Reply by the Chairman:

This issue is not unique to Leicester, Leicestershire and Rutland and as a result the question was forwarded to NHS England who have provided the following information:

> "The number of applications for medical training posts has increased significantly in recent years. Applications for specialty medical training have risen across the UK from approximately 12,000 in 2019 to nearly 40,000 in 2026. The number of eligible applicants for the Foundation Programme has also increased, partly driven by a rise in applications from graduates of international medical schools.
>
> Since the lifting of visa restrictions in 2020, UK-trained doctors have experienced increased competition from overseas-trained doctors for both Foundation Programme and specialty training posts.
>
> In March 2026, the UK Parliament passed the Medical Training (Prioritisation) Act. This legislation supports the prioritisation of UK medical graduates for Foundation Programme training places, alongside the prioritisation of UK medical graduates and doctors with significant NHS experience for specialty training posts. The Act delivers a commitment set out in the 10-Year Health Plan for England.
>
> The Act seeks to:
> - Build a more reliable and self-sufficient medical workforce;
> - Reduce reliance on an unpredictable international labour market;
> - Maximise the value of taxpayer investment in UK medical training;
> - Support more doctors with a UK medical link to progress into long-term NHS careers, including consultant roles.

Internationally trained doctors make a significant and valued contribution to the NHS and will continue to do so. The Act ensures that those with relevant NHS experience continue to be appropriately prioritised within the system."

Members will be interested to know that the Leicester, Leicestershire and Rutland Joint Health Scrutiny Committee has an agenda item on its work programme regarding the Overseas Doctors Training Scheme and this could be an opportunity to cover the issue raised by Mr. B. Piper CC in more detail.

Supplementary question from Mr. B. Piper CC:

Mr. Piper CC thanked the Chairman for the answer in relation to doctors but asked for clarification on the training position in relation to midwives. It was agreed that a further answer would be provided to Mr. Piper CC after the meeting.

2. Question from Mr. P. King CC

It has come to my attention that the Two Shires Medical Practice in Harborough is having an Automatic Number Plate Recognition (ANPR) camera installed in the patient carpark. The reason that has been given by the Practice for this camera is to ensure that only people attending the Practice are using the car park. If people that are not patients of the practice use the carpark they could be fined £100. The system gives a 20-minute grace period for quick visits to the Practice; patients needing a longer stay need to input their car registration details at either the practice or chemist and then there is no fine for their visit.

The system that has been introduced relies on patients remembering to register their vehicle during what is often a pressured visit. Many patients are unwell, elderly, or managing children. They are focused on their appointment, not on administrative steps. The risk of unintended non-compliance is therefore high, and a £100 penalty in those circumstances is disproportionate.

I would therefore like to know the following:

1. Why were these measures deemed necessary?
2. Why was there no consultation?
3. Why have they resorted to such extreme measures?
4. Did the Practice discuss their issues with Harborough District Council, who own the roads leading to and around this facility?
5. Who took this decision, the landlord (who is the landlord) or the Practice management?
6. Will the Practice meet with interested parties to consider this issue and discuss how alternative arrangements might be found?

Reply by the Chairman

The decision to install ANPR was made by the landlords of the site who are a private company called Blackrock. Blackrock deemed that the use of their private land was above what they expected for their two tenants and that this was causing excessive damage to their private car park. This was leading to multiple repairs and now finally leading to needing resurfacing which will cost above £20,000. The work is being carried out via Blackrock's management company Workman.

The GP Practice and the Pharmacy did support the decision to install the ANPR to ensure good access during opening hours and to stop excessive repair costs being passed onto the GP Practice as holders of the lease via site maintenance fees. The GP Practice state that they accept their landlord's ability to introduce car park management services on the land, and are happy that they continue to allow patients to park freely at the site.

The GP Practice have provided reassurance that they will ensure their staff help patients to enter their car registration details into the system when required to avoid fines for those accessing services.

With regards the question as to whether the GP Practice will meet with interested parties, the GP Practice have informed that as tenants they cannot discuss alternative arrangements as this is not within their control so they feel meeting with others would not be beneficial and as such could not be agreed to.

Any further questions should be directed towards the landlords Blackrock. However, as Blackrock is a private company they would come outside of the remit of the Health and Communities Overview and Scrutiny Committee. The NHS Act 2006 only gives the Committee the right to question NHS bodies or NHS employees. Therefore, the Committee does not have the power to require Blackrock to answer questions directly. It is suggested that local members contact Blackrock themselves should they require any further information.

3. Question from Dr. S. Hill CC

Could I be told of whatever plans UHL has to improve parking at the Leicester Royal Infirmary. This is an increasing issue, particularly around delays getting onto the site. I am aware of missed appointments as a result of this. In particular details any improvements and the timeline for their implementation would be welcomed.

Reply by the Chairman:

I have received the following response from University Hospitals of Leicester NHS Trust (UHL):

> "The Trust recognises the concern this issue raises for patients, visitors and staff, particularly where delays entering the site may lead to increased anxiety for those attending for urgent or planned care.
>
> The LRI is a major acute hospital located in a constrained city centre setting. Even under normal operating conditions, access and parking capacity are limited. These pressures have been further intensified by essential construction and enabling works currently underway to modernise the estate and support future clinical service developments. We are building a new £12.8 million Urgent Treatment Centre at the LRI, and essential enabling works are also taking place to pave the way for the main construction on a new Women's and Children's Hospital in 2032.
>
> The Trust is actively managing the short-term congestion being created on and around the site. Current measures include:

• Daily monitoring of traffic flow to identify pinch points and reduce on site congestion;
• Coordination of construction activity to minimise disruption wherever possible;
• Improvements to signage and way-finding to support clearer access routes;
• Review of access arrangements to optimise entry and exit points within existing constraints;
• Strengthened communication with patients and visitors, including pre attendance information to support with journey planning.

Where we identify issues, we implement mitigations promptly, although the physical limitations of the site restrict the scale of short term solutions.

Parking and access remain central considerations within the wider redevelopment planning for the LRI. This includes assessing the relationship between construction activity and parking capacity, understanding patient/visitor access needs, reviewing staff travel patterns, and exploring opportunities to support more sustainable travel. We continue to actively explore future parking expansion options and will communicate these clearly as they are confirmed.

The Trust is working closely with Leicester City Council to improve alternative travel options for patients, visitors and staff. Through the Bus Service Improvement Plan, we have secured funding to extend the operating hours of the Enderby Park and Ride service, enabling better alignment with NHS shift patterns. The Council has also confirmed its intention to incorporate all three Leicester Park and Ride sites into the LRI network later this year. These enhancements provide practical alternatives to car travel and help reduce congestion on and around the hospital site. Once final details are confirmed, the Trust will actively promote these services to ensure they are well understood and well used.

In addition, the Trust encourages the use of the fully electric Hospital Hopper service, which operates seven days a week, and provides direct links between all three hospital sites. This service supports reduced traffic volumes and offers a reliable alternative for many patients and staff.

We acknowledge the impact that current parking and access challenges are having on those attending the LRI. While some pressures are unavoidable due to essential construction works and the physical constraints of the site, we remain committed to managing congestion, improving access where possible, and working in partnership with the Council to expand sustainable travel options. We will continue to keep councillors updated as further developments progress."

Supplementary question from Dr. S. Hill CC:

Dr. Hill CC noted that Committee member Mr. J. Poland CC had recently asked a similar question of University Hospitals of Leicester NHS Trust and received a more detailed answer particularly in relation to the new multi-storey car park scheme. Dr Hill CC queried why this had not been mentioned in the answer provided to her. In response it was reported that UHL had said this was an unintentional oversight.

6. Urgent items.

There were no urgent items for consideration.

7. 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.

No declarations were made.

8. Declarations of the Party Whip.
There were no declarations of the Party Whip in accordance with Overview and Scrutiny Procedure Rule 16.

9. Presentation of Petitions.
The Chief Executive reported that no petitions had been received under Standing Order 33.

10. Healthwatch Leicestershire report - Improving Hospital Discharge.
The Committee considered a report of Healthwatch Leicester and Leicestershire which presented their findings from two pieces of work on hospital discharge. A copy of the report, marked 'Agenda Item 10', is filed with these minutes.

The Committee welcomed to the meeting for this item Sarah Taylor, Director of Urgent and Emergency Care, University Hospitals of Leicester NHS Trust.

Arising from discussions the following points were noted:

(i) The patients spoken to by Healthwatch were from both Leicester and Leicestershire. The data was not disaggregated.

(ii) The data set of those interviewed was relatively small compared to the numbers of patients discharged in Leicestershire – UHL discharged approximately 10,000 patients a year. A member therefore questioned the significance of the findings in the Healthwatch report and how much emphasis could be placed on the feedback. In support of the findings, UHL explained that they recognised the themes in the Healthwatch report from other feedback that they received.

(iii) Healthwatch Leicestershire had previously undertaken a research project on hospital discharge in October 2020 to follow up on visits to the discharge lounges at local hospitals in July 2019. Members raised concerns that there did not appear to be much improvement with discharge in Leicestershire since that original research was carried out.

(iv) Members echoed the findings of the Healthwatch reports and reported that they had received similar comments from local residents particularly in relation to poor communication with patients and a lack of medication readiness. Members were disappointed that only 58% of respondents felt involved in discussions about their discharge. In response UHL acknowledged that some patients felt they were discharged with insufficient information, and UHL provided assurance that work was taking place to improve the clarity and consistency of communication with patients about their discharge. Even if UHL felt they were providing a lot of information, work needed to take place to improve the perception of patients and make them feel more informed.

(v) Members raised concerns that patients did not always receive written communication about their discharge and that, where they did, this sometimes contradicted what they had been told verbally. UHL acknowledged that further education of staff needed to take place to ensure that verbal communications re-iterated what was written down but stated that some of this good practice was already taking place.

(vi) The Patient Advice Service was a point of contact for patients if they needed any information about their discharge.

(vii) Members raised concerns that carers felt uninvolved in the discharge process and only 16% of carers were informed of their right to a Carers' Assessment. In response it was acknowledged that carers needed to be provided with timely information and explained that the Carers' Assessment took place out of the hospital setting around 10 days to two weeks after the patient had been discharged from hospital into their own home. This gave the patient a chance to get stabilised before the assessment took place.

(viii) Some Adult Social Care staff were based on the hospital wards so they could be involved in discharge discussions at an early stage. It was important that patients received a copy of their Care Plan and the contact details for their care provider before they were discharged, and also that carers were made aware of what processes were to follow.

(ix) Whilst the Adult Social Care Team mainly supported complex discharges, wellbeing checks were also undertaken on patients that did not have a Care Plan.

(x) Patients on an end-of-life discharge pathway could be fast-tracked and they would receive their equipment at their home or care home within 24-48 hours.

(xi) In response to queries about a lack of respondents from community hospitals in the Healthwatch research it was clarified that Healthwatch had carried out a separate piece of work relating to Enter & View visits to community hospital discharge wards.

RESOLVED:

That the findings of Healthwatch Leicester and Leicestershire's work on hospital discharge be noted with some concern.

11. Learning Disability Annual Health Check - Progress Update

The Committee considered a report of Leicestershire Partnership NHS Trust which provided an update on the work carried out by the Leicester, Leicestershire and Rutland Learning Disability and Autism Collaborative to increase the number of people with a learning disability receiving an Annual Health Check from their primary care provider. A copy of the report, marked 'Agenda Item 11', is filed with these minutes.

The Committee welcomed to the meeting for this item Laura Rodman, Service Development Manager, LDA Collaborative.

Members welcomed that the number of people receiving an Annual Health Check in LLR was increasing every year, that national targets were being exceeded and performance was better than the majority of other Integrated Care System areas.

Arising from discussions the following points were noted:

(i) The register of people with learning disabilities was held by individual GP Practices. Validation of the register was carried out at each Practice by Practice Liaison Nurses. To be placed on the register and qualify for the health check a patient needed to have been diagnosed with a learning disability rather than a learning difficulty.

(ii) People with learning disabilities could still have capacity to make decisions about their own lives therefore they could not be forced to undertake a health check. They could only be encouraged to attend and educated about the importance of the procedure. The final decision about whether to take part remained with the patient.

(iii) The LDA Collaborative had been selected as one of two national pilot sites to participate in a 12-month proof of concept pilot to develop and test the feasibility of combining the established health checks for severe mental illness and learning disabilities with a new check for people with an autism diagnosis, into one combined health check. An evaluation report of the pilot was due to be published imminently. The LDA Collaborative had fed back the challenges that had been faced locally in encouraging people to undertake health checks and the importance of clear communication had been emphasised.

(iv) There was currently no autism register or specific health check for people with autism, aside from the pilot that was taking place. Therefore, a further pilot was being rolled out in LLR later in the year to target people with autism for health checks at certain key points of their life. Members suggested engaging with the target cohort through schools as well as GP Practices.

(v) Some people with autism were good at masking symptoms of health problems or they would not recognise that they had a health problem at all. The invite letter that was sent to people inviting them to healthchecks had been co-produced with people diagnosed with autism so that it was presented in the best way to encourage as many people to attend. The health checks could also be carried out in non-NHS venues where people with autism might feel more comfortable. Home visits also took place.

(vi) A member suggested that the health checks should take place every six months rather than on an annual basis. In response it was explained that further consideration would be given to this, but the regularity was dependent on funding. It was hoped that going forward the health checks could be carried out earlier in the year.

RESOLVED:

That the update on the work carried out by the Leicester, Leicestershire and Rutland Learning Disability and Autism Collaborative be welcomed.

12. Vaccines and Immunisations.

The Committee considered a joint report of the Integrated Care Board and the Director of Public Health, Communities, Law and Governance, Leicestershire County Council, which

provided an overview of life course vaccination delivery across Leicestershire. A copy of the report, marked 'Agenda Item 12', is filed with these minutes.

The Committee welcomed to the meeting for this item Dr Naomi Caldwell, Deputy Chief Medical Officer, Integrated Care Board.

Arising from discussions the following points were noted:

(i) The NHS used a variety of communication methods to remind people to get vaccinated including texts, phone calls and messages through the NHS app.

(ii) All partners including councillors had a role to play in encouraging people to get vaccinated.

(iii) The table at paragraph 45 of the report showed that the percentage of children receiving a second dose of the MMR vaccine was lower than the percentage receiving the first dose and members questioned why parents did not ensure children received the second dose. In response it was explained that this could be due to a number of factors including the ability to access the vaccine and concerns about the safety of the vaccine.

(iv) The table at paragraph 45 also showed that the Market Harborough and Bosworth Primary Care Network (PCN) had particularly low vaccination rates and members queried why this may be. The Cross Counties Primary Care Network had much better vaccination figures and Members suggested that analysis should take place of why one PCN was better than the other and what learning could be implemented in other PCNs.

(v) It was suggested that there was a lack of awareness amongst the public of the severity of some diseases, and publicity campaigns needed to make the possible consequences of catching the disease very clear in order to encourage people to get vaccinated.

(vi) There was a particularly low uptake of vaccines in some minority ethnic communities, for example Bangladeshi and Black African communities. In response to a query as to whether this was a cultural issue or a communication issue, it was acknowledged that the language barrier could create challenges but also explained that people from those cultures were more likely to live in areas of high deprivation. Vaccine rates were generally low in areas of high deprivation. There were also difficulties in collecting data regarding some ethnicities and cultures.

(vii) Vaccines in some other countries were not as reliable and effective as those available in the UK. Therefore, people coming from those countries to the UK could have less confidence in vaccines. Work needed to take place to improve confidence in UK vaccines and knowledge about the UK health system generally amongst immigrants. In response to a question as to whether an individual could be required as part of the UK visa application process to provide evidence that they had received particular vaccines and immunisations, it was agreed that further information regarding this would be circulated after the meeting.

(viii) Concerns were raised about vaccine hesitancy and negative information in the public domain about vaccines and specific individuals who were campaigning

against their use. It was suggested that positive data about the safety and effectiveness of vaccines needed to be better publicised to assure the public.

(ix) A member suggested that some diseases such as polio had been completely eradicated due to vaccines and therefore it should be possible to eradicate other diseases and infections regardless of the challenges which existed.

(x) Consent was required before a vaccine could be administered and there were occasions where a parent had consented for their child to be vaccinated but on the day of vaccination the child made it clear that they did not want to be vaccinated and under these circumstances the vaccine could not be administered. These situations had to be managed carefully and sensitively so as not to deter individuals from ever having themselves or their children vaccinated. Educating people was more effective than draconian approaches.

RESOLVED:

That the update on vaccination delivery across Leicestershire be welcomed.

13. Date of next meeting.

RESOLVED:

That the next meeting of the Committee take place on Wednesday 9 September 2026 at 2.00pm.

2.00 - 4.18 pm CHAIRMAN
03 June 2026