Agenda Item 1

Leicestershire County Council

Minutes of a meeting of the Health Overview and Scrutiny Committee held at County Hall, Glenfield on Wednesday, 3 September 2025.

PRESENT

Dr. S. Hill CC (in the Chair)

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

In attendance

Hardip Chohan, Voluntary Action Leicestershire (joined via Microsoft Teams).
Pete Burnett, Chief Strategy Officer, Leicester, Leicestershire and Rutland Integrated Care Board (minutes 20 and 21 refer).
Professor Nils Sanganee, Chief Medical Officer, Integrated Care Board (minute 22 refers).
Sarah Smith, Head of Emergency Care, Integrated Care Board (minute 22 refers).
Sarah Taylor, Deputy Chief Operating Officer, University Hospitals of Leicester NHS Trust (minute 22 refers).
Jean Knight, Managing Director, Leicestershire Partnership NHS Trust (minute 22 refers).
David Williams, Group Director Strategy & Partnerships, Leicestershire Partnership NHS Trust (minute 23 refers).
Alyson Taylor, Senior Mental Health and LD Transformation Lead, Integrated Care Board (minute 23 refers).
Chris Harbron, Chief Operating Officer, Vita Health (minute 23 refers).
Brendan Street, Clinical Lead, Vita Health (minute 23 refers).

13. Minutes of the previous meeting.

The Committee noted that minute no. 4. recorded the answer given to a member of the public Rachel Moore in response to her question about access to GP appointments. Point no. 2. in the answer stated “100% of practices now offer online booking, for appointments either on the same day or in the future.” However, since the meeting on 4 June 2025 discussions had been taking place between Rachel Moore and the Integrated Care Board regarding the answer given and the Integrated Care Board had now provided clarification saying that “All Practices in LLR have the *ability* to offer online appointments booking”. Therefore, whilst the minutes correctly recorded what happened on 4 June 2025 the Chairman proposed to add a note to the minute regarding the later clarification provided by the Integrated Care Board.

RESOLVED:

(a) That the minutes of the meeting held on 4 June 2024 be taken as read, confirmed and signed as an accurate record;

(b) That a note be added to the minutes of the meeting held on 4 June 2024 explaining the later clarification provided by the Integrated Care Board with regards to online appointment booking.

14. Question Time.

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

1. Question asked by Rachel Moore:

Is Leicestershire Partnership NHS Trust (LPT) planning to continue having a suicide prevention lead post within its workforce? I see from the LPT Board meeting papers of 27 May 2025 that the post is under review.

https://www.leicspart.nhs.uk/wp-content/uploads/2025/05/Paper-M_Public-Trust-Board-Patient-Safety-Report-May-2025.pdf

Reply by the Chairman:

Since the previous post holder retired an individual has been in post on a temporary basis. During this time LPT has progressed their STORM training (self-harm and suicide training) and their suicide prevention plan and contributed to the LLR suicide prevention strategy. The Trust is currently going through the approval process for a permanent recruitment.

2. Questions asked by Rachel Moore:

What suicide prevention training do LPT nurses/mental health practitioners get? In the LPT Board meeting papers of 28 January 2025 it states that there have been gaps in suicide prevention training.

https://www.leicspart.nhs.uk/wp-content/uploads/2025/01/Paper-L1_Public-Patient-Safety-Learning-Report-Jan-2025.pdf

Reply by the Chairman:

LPT has reviewed its training offer. The Trust has purchased STORM training for clinicians and 8 Practice Development Nurses (PDNs). The PDNs have further been able to offer STORM training to the clinical staff working through a priority list. This is in addition to existing training packages through LPT's on-line training, which has modules on suicide awareness training, clinical risk assessment & safety planning.

Supplementary question from Rachel Moore:

What gaps in training were LPT referring to?

Reply by the Chairman:

A further written answer would be obtained from Leicestershire Partnership NHS Trust and published after the meeting.

(Note: After the meeting Leicestershire Partnership NHS Trust provided the following answer: LPT provides several levels of training regarding suicide awareness and prevention including Suicide Awareness Training (level one), REACT Mental Health Conversations, Mental Health First Aid and Perinatal mental health training. In addition, we provide STORM which is specifically designed for frontline specialist mental health professionals, this is delivered via a train the trainer approach by our Practice Development Nurses. The January minutes from the LPT Trust Board identified that there was a gap in the STORM training which related to capacity of the PDNs which was resolved shortly after.)

15. Questions asked by members.

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

16. Urgent items.

There were no urgent items for consideration.

17. 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. B. Piper CC declared an Other Registerable interest in all agenda items as he was a member of the Mary Guppy Group which was campaigning regarding health services in Lutterworth.

Mr. J. Miah CC declared an Other Registerable interest in agenda item 10: Winter Plan 2025/26 as he had a close relative that worked at Leicester Royal Infirmary.

Mr. J. Poland CC declared an Non-Registerable interest in agenda item 11: Mental Health and Early Intervention as he was a trustee of the Loughborough Wellbeing Centre, a mental health charity.

18. Declarations of the Party Whip.

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

19. Presentation of Petitions.

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

20. NHS 10 Year Health Plan.

The Committee considered a report of the Integrated Care Board regarding the recently published NHS 10 Year Health Plan for England. A copy of the report, marked 'Agenda Item 8', is filed with these minutes.

The Committee welcomed to the meeting for this item Pete Burnett, Chief Strategy Officer, Leicester, Leicestershire and Rutland Integrated Care Board. Pete Burnett clarified that he was not attending as a government spokesperson, but was present to explain the contents of the Plan and how the Integrated Care Board intended to implement it.

Arising from discussions the following points were noted:

(i) A lot of what was set out in the NHS 10 Year Health Plan was not new and was taking place already. For example, the shift from hospital to community had been a key strategy for a while. A member raised concerns that if the content of the 10 Year Health Plan was not new then how would the Plan make a difference to the state of the NHS. It was queried how would the Plan solve the funding problems and could savings be made without staffing cuts being made. In response it was explained that treating patients in their own homes would be more cost-effective, and when those patients were admitted to hospital it would be carried out in a much more planned way than was done currently.

(ii) The 10 Year Plan set out an intention to have Neighbourhood Health Centres (NHCs) in every community which would act as local one-stop hubs, co-locating GPs, community services, diagnostics, and mental health support, open 12 hours a day, 6 days a week to improve access and ease hospital pressure. It was intended to have 250 to 300 new neighbourhood health centres nationally by the end of the plan and 40 to 50 over the course of this Parliament. In response to a query from a member, it was explained that there were enough NHS buildings in Leicestershire to house the neighbourhood health centres but not all of them were fit for purpose so renovations would have to take place.

(iii) Work on developing the Neighbourhood Health Programme was already underway in Leicestershire.

(iv) A key part of the 10 Year Health Plan was making greater use of technology and Artificial Intelligence (AI) to save time for clinicians and administrators. AI would be able to help patients stay in their own homes rather that at a hospital which would be more cost effective. AI was still developing and in the future it was likely to be possible for patients to receive AI powered advice without needing to engage with a clinician. The Rapid Health pilot was taking place in Leicestershire which was an online clinical triage system which used AI to ask patients about their problem and then allowed them to book appointments without needing to phone the practice. However, there were difficulties with AI powered advice that needed to be overcome such as governance and making it clear which organisation was accountable for the patient.

(v) In the past when the NHS had overspent in some areas, funding was often taken from the digital programme to make up the loss. There was a commitment in the 10 Year Health Plan that this would not happen going forward and the required funding for digital programmes would be ringfenced.

(vi) A member raised concerns that the NHS app had not developed and improved as quickly as had been promised and queried whether the technology proposals in the 10 Year Health Plan were too ambitious and whether there was a disconnect between the plans and reality. Members also raised concerns that not everyone would be able to access technology such as mobile phone apps. Some elderly people in particular would not have the ability to use a phone or computer due to eyesight or other physical problems. In response reassurance was given that it was not a 'one size fits all' approach and there would still be other avenues for patients to receive medical advice. Part of the role of the ICB and the Neighbourhood Teams was to know their cohort of patients well enough so that they could put measures in place to help their particular needs.

(vii) The NHS was developing Shared Care Records which were a safe and secure way of bringing a patient's separate records from different health and care organisations together digitally in one place. Members raised concerns that the NHS had attempted a similar project in previous years which had not been successful and been very costly.

(viii) The 10 Year Health Plan aimed to reduce the NHS's dependence on overseas staff, and instead NHS employers would recruit more from their communities rather than looking to international recruitment agencies. The 10 Year Health Plan would be accompanied by an NHS 10 Year Workforce Plan which would set out how the NHS would tackle the issues of retention, productivity, training and attrition. One of the reasons why overseas staff had to be recruited currently was because the courses at universities in the United Kingdom were oversubscribed. The lack of courses was partly due to a lack of funding and also because of insufficient staff available to teach the courses. Training was organised on a regional and national basis and was therefore not within the control of the ICB.

(ix) The 10 Year Health Plan set the NHS a target for the next 3 years to deliver a 2% year on year productivity gain. A member raised concerns that NHS productivity in Leicestershire had decreased. In response it was explained that further multi-year guidance was due to be published which could make this issue clearer.

(x) In response to concerns from a member that NHS services would not keep pace with the amount of housing development in Leicestershire, it was explained that the NHS did apply for developer contributions under Section 106 of the Town and Country Planning Act 1990. However, the process was not straightforward and the funding did not always arrive at the time it was needed.

RESOLVED:

That the update regarding the NHS 10 Year Health Plan be noted.

21. NHS Transformation.

The Committee considered a report of the Integrated Care Board (ICB) which provided an update on the national reform of the NHS operating model across England including the integration of the Department of Health and Social Care and NHS England, and a changed role for ICBs. A copy of the report, marked 'Agenda Item 9', is filed with these minutes.

The Committee welcomed to the meeting for this item Pete Burnett, Chief Strategy Officer, Leicester, Leicestershire and Rutland Integrated Care Board.

Arising from discussions the following points were noted:

(i) NHS England and government ministers had approved a new cluster for the region which covered Leicester, Leicestershire and Rutland (LLR) and Northamptonshire. However, LLR and Northamptonshire ICBs would remain separate statutory bodies. Part of the reason for taking the clustering approach rather than merging ICBs at this stage was because Local Government Reorganisation was taking place and the footprint on which councils would be working under was still unclear. It was advisable for ICBs to work on the same footprint as Councils.

(ii) Having a shared management team would reduce costs. Anu Singh would be the Chair of the new LLR and Northamptonshire cluster replacing Paula Clark who had been chair of LLR ICB since October 2024. Anu Singh had previously worked for the Black Country ICB. A member queried whether Anu Singh had sufficient knowledge of Leicestershire. It was noted that she had a lot of experience with the NHS and local authorities.

(iii) A member raised concerns that with a larger footprint the ability to tackle health inequalities across the area would be reduced. In response reassurance was given that the ICB had a legal duty to address health inequalities and improve the health of the whole population. Data would be analysed, and based on that data decisions would be made on where health interventions needed to be made. Directors of Public Health also had a role in tackling inequalities.

(iv) A member suggested that the general public were not particularly interested in the structure of health bodies; their focus was on treatment and waiting times. In response it was explained that as part of the plans ICBs were required to reduce running costs by 50% which would free up funding for frontline services. The staff redundancies had originally been planned to have taken place by the end of December 2025 but this had been delayed due to a lack of funding for the redundancy payments.

(v) Healthwatch Leicester and Leicestershire was expected to cease to exist in the coming years but the exact date of this happening was still unclear.

(vi) It was suggested that this NHS Transformation agenda item should have been considered at a meeting of the Leicester, Leicestershire and Rutland Joint Health Scrutiny Committee and questioned whether there were enough meetings of that Committee in the diary. The Chair Dr. S. Hill CC agreed to discuss this with the Chair of the Joint Committee Cllr. Karen Pickering.

RESOLVED:

That the update on the changes to the NHS Operating Model be noted.

22. Winter Plan 2025/26

The Committee considered a report of the Integrated Care Board regarding the plans in place to manage health system pressures across Leicester, Leicestershire and Rutland (LLR) over winter 2025/26. A copy of the report, marked 'Agenda Item 10', is filed with these minutes.

The Committee welcomed to the meeting for this item Professor Nils Sanganee, Chief Medical Officer, Integrated Care Board, Sarah Smith, Head of Emergency Care, Integrated Care Board, Sarah Taylor, Deputy Chief Operating Officer, University Hospitals of Leicester NHS Trust, and Jean Knight, Managing Director, Leicestershire Partnership NHS Trust.

Arising from discussions the following points were noted:

(i) Each year Integrated Care Board's were asked by NHS England to submit a Winter Plan to ensure the health and care system was fully prepared to manage the increased pressures that typically arose during the winter months (October to March). For Leicestershire plans were in place to deal with expected surges in demand and also 'supersurges' where the demand was higher than expected. This year NHS England had asked for more detail about the plans and modelling of different scenarios. NHS England also required health systems to test the plans they had in place for managing winter pressures. In LLR a local test event was taking place on 11 September 2025 and a regional stress testing event was taking place on 17 September 2025.

(ii) Monitoring was taking place of the winter in the southern hemisphere to see what lessons could be learnt and implemented for the UK winter.

(iii) In response to a question from the Chair as to whether the NHS still had spare wards which could be used in the winter it was explained that this was no longer the case due to financial challenges as beds were very expensive. There was no spare capacity at Leicester Royal Infirmary. However, as part of the acute community plan the first floor of the Preston Lodge community rehabilitation unit could be used during the winter.

(iv) In response to concerns raised by members about ambulance wait times outside the Leicester Royal Infirmary Emergency Department, it was acknowledged that this was still a problem but emphasised that significant improvements had been made. The 45 minute handover target was challenging to meet but was being met some of the time and needed to be met more consistently. Work was taking place to improve flow through the hospital. Ambulance response times had improved and EMAS staff were treating more patients at the scene rather than conveying them to hospital. Patients were also being given more treatment advice over the telephone. This all helped reduce demand at the Emergency Department.

(v) There was a comprehensive communications campaign in place to ensure patients went to the most appropriate place for treatment over the winter and did not attend the Emergency Department unnecessarily. However, the public did not always pay

attention to health messaging until they needed treatment therefore it could be difficult to get the message across.

(vi) In response to a question from a member, it was explained that opening another Emergency Department in Leicestershire was not a realistic option because the department would need a resus department and specialist children's facilities to accompany it which were only available at Leicester Royal Infirmary. There were, however, plans to build an additional Urgent Treatment Centre. Data indicated that this was the type of facility needed in LLR rather than an additional Emergency Department.

(vii) It was reported that a regular theme of feedback from patients that Healthwatch had engaged with was unsafe discharge from hospital. In response it was acknowledged that this was an area that could be improved and more work needed to be carried out to ensure that the transfer of information from hospital to community services was timely and accurate and that the medication the patient needed was available when they left hospital.

(viii) Loughborough Community Hospital had x-ray facilities so patients did not need to travel to the main hospitals if they just needed an x-ray. Members raised concerns about patients that did not reside near Loughborough particularly those in south Leicestershire. There was a lack of public transport from south Leicestershire into the city centre.

(ix) There was usually an increase in respiratory problems over the winter. The NHS was no longer focusing on Covid-19 and less testing for it was taking place. However, Covid-19 disproportionately affected frail and vulnerable people therefore these high-risk cohorts still needed to be vaccinated. If they were vaccinated for Covid-19 they were far less likely to require admitting to a hospital.

(x) A comprehensive vaccination strategy was in place for Leicestershire. Vaccine uptake was generally good in the county area of Leicestershire. Further work was needed to take place to improve vaccination uptake in some groups particularly children and social care staff. The flu vaccine was only available for pre-school children and children with particular health conditions such as asthma and diabetes. A vaccine would only be given to a child if parental consent had been received, though if the child was resisting the procedure the clinician may have to make a decision not to administer the vaccine, even if parental consent had been given.

(xi) The Management Team at Leicestershire County Council had held discussions regarding how to increase vaccine take-up amongst staff, and options had been considered to encourage more people to get vaccinated including holding clinics at County Council buildings and offering vouchers.

(xii) A member queried whether vaccine hesitancy due to safety concerns about previous vaccines, such as MMR, was an issue. In response it was explained that whilst there were now less concerns amongst the public about vaccine safety, vaccination rates had dropped since the Covid-19 pandemic had ended which was of concern. This was not necessarily thought to be due to safety concerns.

(xiii) In response to concerns raised that the vaccination clinics would have a negative impact on the day-to-day primary care work reassurance was given that the work streams were kept separate. Weekend working and enhanced access (GP

Practices open later in the evenings) meant that there was capacity for both. Efforts were also being made to encourage people to book their vaccinations in advance so the demand could be managed better.

(xiv) A member raised concerns about the supply of vaccines to south Leicestershire. In response it was explained that vaccine supplies were based on the previous year's levels plus expected growth. In the past there had been issues with supply from the manufacturers of the vaccine but this had improved significantly as planning had improved.

(xv) The slides appended to the report referred to a group of people known as "Healthcare – ESR" that were receiving vaccines. It was explained that this related to those NHS staff on the Electronic Staff Record which was used to manage the HR and payroll for NHS employees.

RESOLVED:

That the plans in place to manage winter pressures be noted.

23. Mental Health and Early Intervention.

The Committee considered a joint report of Leicester, Leicestershire and Rutland Integrated Care Board, Leicestershire Partnership NHS Trust, and Vita Health which provided an update on the overarching provision of mental health and early intervention services available locally. A copy of the report, marked 'Agenda Item 11', is filed with these minutes.

The Committee welcomed to the meeting for this item David Williams, Group Director Strategy & Partnerships, Leicestershire Partnership NHS Trust, Alyson Taylor, Senior Mental Health and LD Transformation Lead, Integrated Care Board, Chris Harbron, Chief Operating Officer, Vita Health, and Brendan Street, Clinical Lead, Vita Health.

Arising from discussions the following points were noted:

(i) Tackling mental health issues required a partnership approach involving different organisations. Step 1 initial support was provided by GPs and included use of self-help tools, lifestyle advice, or online resources. In addition to that, NHS Talking therapies supported people with common mental health problems such as stress, anxiety and depression. Locally Talking Therapies was provided by Vita Health Group. People could access Talking Therapies mainly at one of two levels. Most people could start Step 2 support in around 9 days. Step 3 provided more specialist therapy and this could take longer because of higher demand and the need for more trained staff. The wait time was usually over 3 months. Members welcomed that the number of people waiting for Talking Therapy was falling and that the therapy appeared to be having a positive effect but expressed concerns about the wait times for the more specialist therapy. Members were pleased to note that Talking Therapy sessions were available face to face and not just over the phone/video link. It was acknowledged that not everybody had access to digital technology. The initial assessments undertaken with patients would identify which method would best suit their needs.

(ii) The existing Talking Therapy service was not as beneficial for people with neurodiversity issues such as Attention Deficit Hyperactivity Disorder (ADHD) therefore a new version of the Talking Therapy service was being developed specifically for people with ADHD. It was acknowledged that demand for this service would increase as more people were being diagnosed with ADHD.

(iii) Members were invited to attend a Talking Therapies session and were advised to get in touch with Alyson Taylor to arrange a visit. Her contact details would be circulated after the meeting.

(iv) Healthwatch reported that they had received feedback from patients that there were inconsistencies regarding the referral process for therapy and wait times depending on where in Leicestershire they were being referred from. It was agreed that Healthwatch and the Integrated Care Board would discuss this further after the meeting.

(v) Isolation could be a contributing factor to mental health problems. Tackling the problem required input from not just the NHS but local authorities and community organisations as well. It was important that mental health problems were not just seen as a medical issue that could be solved with medication etc. A social and community-based approach could be just as beneficial. Medication helped tackle the symptoms of mental health issues but talking therapies and social interaction could help deal with the causes. The Joy mobile phone app was available for the public to use which offered social prescribing options amongst other things. The Committee had considered a report relating to tackling isolation and all the available services at its meeting on 5 March 2025 and as new Committee members may not have read the report it was agreed that it would be circulated to members after the meeting.

(vi) Concerns were raised that the use of text messaging meant that people did not talk to each other on the phone or face to face as much. In response, this issue was acknowledged but it was pointed out that text messaging could be a positive as some people were more comfortable with it than other forms of communication. Young people in particular could find texting easier and more discreet and confidential than speaking to a health professional face to face or over the phone. The Chat Health confidential text messaging service enabled young people to have a text conversation with a nurse, mental health professional or health visitor.

(vii) A lot of the mental health support in Leicestershire was provided by Voluntary, Community and Social Enterprise (VCSE) organisations. Concerns were raised that the VCSEs did not have enough funding for mental health. In response reassurance was given that the NHS was investing a significant amount of funding in the voluntary sector. It was recognised that a collective approach was needed and there was great value in VCSE organisations. Talking Therapies worked closely with VCSE organisations, invited them to sessions and offered them training.

(viii) Leicester, Leicestershire and Rutland was the third highest performing area across the midlands for getting people back into work after severe mental illness. It was agreed that further details about this work would be circulated to members after the meeting.

(ix) Discussion took place about whether there had been an increase in mental health issues amongst the population generally or whether this was the perception

because there was more awareness and diagnosis and people were coming forward asking for help.

RESOLVED:

That the contents of the update regarding mental health and early intervention services available locally be welcomed.

24. Joint Local Health and Wellbeing Strategy Review.

The Committee considered a report of the Director of Public Health which sought the views of the Committee on recommended changes to the current Joint Local Health and Wellbeing Strategy (JLHWS) 2022-2032 as part of the current review. A copy of the report, marked 'Agenda Item 12', is filed with these minutes.

Arising from the report the following discussions took place:

(i) A member raised concerns that reference to some key health issues was proposed to be removed from the commitments in the JLHWS, such as vaccinating 1 and 2 year olds, and ensuring that there were opportunities for all 16-17 year olds to gain education, employment and training. The member questioned how progress in tackling those issues could be tracked if they were not part of the commitments. In response it was explained that rather than removing those issues from the strategy altogether, the approach was to refine the wording in the commitments and make it more concise. These issues would still be addressed in the Delivery Plans that accompany the Strategy. It was agreed that when the Health and Wellbeing Board Annual Report was presented to the Health Overview and Scrutiny Committee in future it could include the Delivery Plans. It was also noted that by simplifying the wording in the commitments it gave more flexibility to tackle emerging issues such as vaping. Some of the issues the member referred to relating to children sat better in the Children's Partnership strategy rather than the JLHWS.

(ii) A member emphasised the importance of ensuring that the final period of a person's life was as comfortable as possible and queried what was being done to help those people. The member submitted that there was a lack of focus on helping people adjust to life after retirement from work. In response reassurance was given that this was where the life course approach and the Dying Well section of the JLHWS played a role. The Staying Healthy Partnership Board sub-group covered all ages. Consideration was also being given to having more focus in Leicestershire on healthy ageing and the member welcomed this.

(iii) A member raised concerns about sedentary lifestyles and the need to get people to exercise more. In response it was acknowledged that this was an important issue that needed to be tackled. The amount of screen time people had was also a problem not just because they tended not to be exercising whilst watching a screen, but also because of the mental health impacts from some of the content on the screen. Therefore, it was hoped that the Strategy would help tackle this issue.

RESOLVED:

(a) That the contents of the revised Joint Local Health and Wellbeing Strategy be noted;

(b) That the comments now made by the Committee be reported to the Health and Wellbeing Board at its meeting on 25 September 2025.

25. Date of next meeting.

RESOLVED:

That the next meeting of the Committee take place on Wednesday 5 November 2025 at 2.00pm.

2.00 - 4.56 pm CHAIRMAN
03 September 2025