Leicester
City Council

Minutes of the Meeting of the
HEALTH AND WELLBEING BOARD

Held: THURSDAY, 11 JULY 2013 at 5.00pm

P R E S E N T :

Present:

Councillor Rory Palmer (Chair)	–	Deputy City Mayor, Leicester City Council
Professor Azhar Farooqi	–	Co-Chair, Leicester City Clinical Commissioning Group
Dr Simon Freeman	–	Managing Director, Leicester City Clinical Commissioning Group
Elaine McHale	-	Interim Strategic Director, Children's Services
Superintendent Mark Newcombe	-	Leicestershire Police – attending for Chief Superintendent Rob Nixon
Councillor Rita Patel	–	Assistant City Mayor, Adult Social Care, Leicester City Council
Philip Parkinson	–	Interim Chair, Healthwatch Leicester
Tracie Rees	–	Director of Care Services and Commissioning, Adult Social Care, Leicester City Council
Councillor Manjula Sood	–	Assistant City Mayor (Community Involvement), Leicester City Council
Deb Watson	–	Strategic Director Adult Social Care and Health Leicester City Council

Invited attendees

Lorraine Austen	-	Head of Service, Leicestershire Partnership NHS Trust
Victoria Gaffney	-	Regional Service Development Manager, British Heart Foundation
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Dr Durairaj Jawahar	-	General Practitioner
Heather Leatham	-	Head of Nursing, University Hospital of Leicester, NHS Trust
Dianne Smith	-	Locality Manager, Alzheimers Society
Hanif Pathan	-	Silver Star Diabetes
Troy Young	-	Age UK

In attendance

Graham Carey	–	Democratic Services, Leicester City Council

Sue Cavill	–	Head of Customer Communications and Engagement - Greater East Midlands Commissioning Support Unit

Observers

Nick Carter	-	Leicester City Clinical Commissioning Group

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14. WELCOME AND INTRODUCTIONS

The Chair welcomed everyone to the meeting and asked everyone to introduce themselves to the members of the public who were attending.

15. APOLOGIES

Apologies for absence were received from David Sharp, Leicestershire and Lincolnshire NHS Commissioning Board and Chief Superintendent Rob Nixon, Leicestershire Police.

16. DECLARATIONS OF INTEREST

Members of the Board were asked to declare any interests they might have in the business on the agenda. No such declarations were made.

17. DISCUSSION SESSION - JOINT HEALTH AND WELLBEING STRATEGY PRIORITY 3: SUPPORT INDEPENDENCE

Deb Watson, Strategic Director Adult Social Care and Health and Simon Freeman, Managing Director, Leicester City Clinical Commissioning Group gave a presentation on Priority 3 of the 'Closing The Gap Strategy' on supporting independence. A copy of the presentation is attached. In addition to the points shown in the presentation the following comments were made:-

- Whilst good progress had been made there was still more to be achieved, especially around making the community aware of the issues surrounding dementia and the support that is available.
- There had been a 30% increase in the uptake of Carers personal budgets. Out of approx. 1,800 family carers who are receiving support from adult social care, 978 are now purchasing their support through a personal budget, giving them increased choice over their support and increased control over arrangements.
- 250 carers had received training to support them in their role, including developing coping strategies, recognising the various trigger points when things can go wrong and information on where to get help.
- Although there were 30,000 carers in the City, only a small proportion of carers made formal contacts to seek help. More needs to be done encouraging people to identify themselves as carers and to promote the

use of services available to them.

- Significant contributors to the poorer life expectancy for people in the City were diabetes, cardio-vascular and respiratory diseases.
- Leicester had low rates of recorded diagnosis of respiratory conditions but a high rate of hospital admissions resulting from respiratory conditions.
- Up-skilling of GP's, using risk stratification to focus interventions on people at high risk of deterioration and using a case management approach for people with multiple illnesses/conditions are vital to reduce/prevent people from a 'revolving door' syndrome of discharge and re-admissions to hospitals.
- Half of the hospital admissions for people aged over 65 years accounted for 65% of the time and resources for emergency admissions.
- The Integrated Commissioning Board has submitted an application to become one of 10 'Integration Pioneers' pilot sites for integrated health and social care delivery.

The Healthwatch representative commented that there were a number of initiatives in primary care where people are supported to be independent with the aim of reducing the incidence of hospital admissions. The large number of small initiatives could result in a larger cumulative impact.

The Age UK representative stated that there were a number of good ideas and pilot schemes but often it was difficult to sustain these and integrate them into strategic level and statutory service provision. There was specific funding for 'supporting carers for those approaching end of life' but it was very hard to contact the right people to talk to and it often felt as though they were operating in isolation.

Professor Farooqi commented that, whilst there was widespread support for an integrated approach to service delivery, this often required reducing expenditure in the acute service sector and this presented a huge challenge. As more systems for delivering services in the community were introduced, they usually identified and uncovered unmet needs whilst there was still the same demands being made upon acute service provision.

The Alzheimer Society's representative stated that the increase in dementia sufferers of 800 cases per year would place increasing demands upon services as the current dementia carers advisory service was saturated at present, and more sufferers wished to retain their independence and remain in the community with support. There were also pressures on the follow on and emotional support for carers and dementia sufferers.

Following a member of the public's question raising the following issues:-

- Was the strategy to care for people in community and remain at home driven by a need to reduce costs of hospital services;
- It was difficult to monitor the quality of care provided in a person's home compared to that in a hospital;
- The quality of care could also be affected by multiple

procurements with private providers; and
- Hospital services could be destabilised once services were taken out of hospitals and put into the community.

In response it was recognised that most patients preferred their conditions to be managed at home rather than in hospital. Conditions such as diabetes and respiratory diseases could be managed equally well in the patient's home as in hospital. Often there were benefits in better patient outcomes through an increased awareness and knowledge of their conditions.

It was equally important to monitor the quality of care irrespective of whether it was provided in hospitals or in the community. There were checks and balances in place for both. It was, however, recognised that the care provision was cheaper to provide in someone's home as there were no 'hotel costs' involved. Providing care in the community was not about dismantling hospital services but providing care in a different way. Consultants and expert clinicians delivered services in both hospitals and community facilities and local health practices.

Dr Jawahar referred to the improvements in training in the primary care sector in increasing the diagnosis of COPD and encouraging patients to stop smoking. This could reduce the demands on secondary care services in future years.

Councillor Patel commented that recent evidence clearly demonstrated that there had been a large increase of people since 2007 electing to have personal budgets and purchase their own care packages. An increasing number of people prefer to remain in their own homes. The emphasis was now on personal choice and if the individual was not happy with their care they could change providers. There were good care providers in the community as 80% of individuals with personal care packages purchased services from the private sector. It was becoming harder to provide these services centrally as there were now less central support staff to provide them following the reductions in local government spending in recent years.

It was important to continue to integrate care provision through health workers and carers in the community and to incorporate the goodwill already within the community and existing services. The community and voluntary sector had many examples of good practice and building partnerships was essential to providing quality of care services. The challenge in the current economic climate was to achieve more with less resources. There are also some very good groups such as the Forum for Older People which recently had a presentation on memory cafes for people with dementia. The initiative was well supported and those who came from areas where there was no memory cafe provision were fully supportive of wanting one in their area.

Councillor Palmer commented that part of the solution required a stronger national framework. He also referred to the growing trend whereby 1 in 5 staff employed by care agencies were on Zero Hours contracts and questioned how care staff could be expected to remain motivated and improve quality under these difficult circumstances.

Tracie Rees commented that with the growing trend of personal budgets, there was a greater need to maintain adequate measures to ensure safeguarding. Council contracts amounted to £11m on domiciliary care with providers and the council were hoping for a national framework. The Council have put in place a local Quality Assurance Framework for residential care homes and will develop one for domiciliary care. Joint work was also progressing with the Care Quality Commission looking at themes and trends relating to quality to see the whole picture and to avoid having an isolated approach.

Deb Watson commented that Adult Social Care services were being driven by two main drivers: the changing expectations of individuals and people wishing to have a wider choice of service provision. There was a clear preference for sheltered and home provision with extra care support to maintain a person's independence, and individuals only wanted to go into residential care when it is unavoidable. The Council have made improvements in commissioning these alternative services which makes it possible for people to remain in their homes longer. This type of care can be both cheaper to provide and more beneficial for the individual, although price is not the main driver. Everyone shares concerns for the quality of care provision post Francis and Winterbourne, but whenever there is poor care someone will know and as long as the system is open, approachable and transparent the system will be able to respond quickly to any safeguarding concerns that are raised

The Healthwatch representative commented that if Healthwatch was to be an effective voice for patients then it must be able to asses that care services are what people want them to be, especially for the most vulnerable. Healthwatch will also need to engage with all involved to create a reliable framework in which anyone feels able to raise concerns over the quality of the provision of care services.

The importance of the community getting involved to support clinicians, community carers, local authority and NHS staff was stressed. There was a great deal of potential support in the community but this needed to be identified and incorporated into the strategic response, which would be a significant challenge. Carers and family members need more information about where to go for help.

Councillor Sood felt that an integrated care approach was a better way forward as it could be more easily geared to the needs of the individual. It was also important to engage with new communities that were settling in Leicester to understand their specific health needs. Communications was also important between multiple providers of health services in order to reduce re-admissions.

It was recognised that too many resources were currently directed at providing acute services and there was a need to move away from this 'fire-fighting' response to one of investing resources into earlier intervention and prevention initiatives in the primary and community care sector. Too many people had high health needs and there should be investment into procedures and initiatives that would give rise to changes in generations to come. There were a number

of current initiatives for providing a single point of contact for patients which should contribute to better care for patients, such as Health and Social Care Co-ordinators and 'named clinicians' for patients care.

Lorraine Austen stated that there were now inpatient rehabilitation beds in the city for people coming out of hospital. Services for mental health were being re-designed for patients discharged from hospital to receive additional support in the community in an attempt to reduce the occurrence of future re-admissions.

The Chair thanked everyone for contributing to the discussion.

18. MINUTES OF PREVIOUS MEETING

RESOLVED:

That the minutes of the meeting held on 11 April 2013 be confirmed as a correct record.

19. MID-STAFFORDSHIRE FOUNDATION TRUST PUBLIC INQUIRY

The Board received a report on behalf of the local Clinical Collaborative The Board received a report on behalf of the local Clinical Collaborative Interface Group (CCIG) about the recommendations in the Mid Staffordshire NHS Foundation Trust Public Inquiry Report (Francis Report). At the April meeting of the Health and Wellbeing Board, it had been noted that NHS commissioners and providers in Leicester, Leicestershire and Rutland were working together on an initial response to the Francis Report. It had been agreed that this would be provided to the Health and Wellbeing Board.

The CCIG brought together the clinical leaders from the local CCGs, the NHS provider Trusts and NHS England Local Area Team. Initial proposals for actions to be delivered in partnership included:

a) A coherent system across Leicester, Leicestershire and Rutland (LLR) should be established to collect soft intelligence on patient care.
b) There should be an emphasis on clinical leadership and coherent teamwork.
c) The 'right place, right care' programme should be extended to primary care.
d) An effective single front door to the Emergency Department at UHL NHS Trust be made a high priority.

Six common themes had emerged on what the priorities should be to improve services and to safeguard against the issues highlighted in the Francis Report. These themes were transparency, listening, walking the floors, saving more lives, safe staffing levels and targeting improvement. Details of these were contained in the report.

A number of priorities for the first phase of joint work have been identified and there will be a further update in October. These priorities were listed in the

report, together with a list of each organisation's specific area for priority.

Philip Parkinson commented that it was encouraging that the responses were positive and the commitment to listening to patients, staff and stakeholders views was welcomed. He asked if there were log of reported incidents which could be placed in the public domain. Simon Freemen confirmed that this could be done and that a list of engagements could also be shared.

Professor Farooqi commented that the joint response was 'work in progress' and any feedback on the responses to the individual organisations would be helpful.

RESOLVED:

1) that the assurances on the work underway to progress the recommendation of the Francis Report be received;

2) that the priorities of work identified in the report be supported; and

3) that a further update on the progress achieved be submitted to a future meeting of the Board.

20. HEALTH PROTECTION BOARD

The Strategic Director for Adult Social Care and Health presented a report on the first meeting of the Health Protection Board (HPB) which had taken place on 5 June 2013. The Board had made a number of minor changes to its Terms of Reference which were listed in full in the report. The HPB will meet quarterly and further report will be brought to the health and Wellbeing Board in due course.

RESOLVED:

that the report and the changes to the Terms of Reference be noted.

21. WINTERBOURNE VIEW CONCORDAT

The Board received a letter from Norman Lamb MP (Minister of State for Care and Support) about the Winterbourne View Concordat together with a report summarising progress.

The Strategic Director for Adult Social Care, Health and Housing explained the background to the concordat which had arisen following the 'Panorama' exposé of the treatment of people at the Winterbourne View hospital who had learning difficulties/autism and displayed challenging behaviour or serious mental health issues.

The Minister had asked partners on Health and Wellbeing Boards to provide a stocktake of the local progress following the Winterbourne View Concordat. The stocktake for Leicester had been completed and a timeline had been

identified for moving on/discharge for each person. There was shared understanding of the current care arrangements for the 17 adults and 2 children affected and the register was being updated to ensure the dataset reflected the requirements of the Winterbourne Joint Improvement Programme. The reports also contained other actions that had been carried out in response to the concordat.

RESOLVED:

that letter from the Minister be noted together with the stocktake report that was submitted to the Winterbourne View Joint Improvement Board on 5 July 2013.

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22. ANNOUNCEMENTS

The Chair made the following announcements:-

LGA Peer Challenge

The Chair had accepted an invitation from the Local Government Association to take part in a Peer Challenge Review for Health and Wellbeing Boards next February. He would circulate the details to Board Members.

Integration Pioneer Initiative

The CCG had made an application to become a health and social care integration pioneer. The City Council supported the bid and if it was successful it could result in national and international support to 'pioneers' for 5 years which would help to achieve innovative changes.

Joint Integrated Commissioning Board

The Chair had agreed to the Joint Integrated Commissioning Board having responsibility for taking the Closing The Gap Joint Health and Wellbeing Strategy forward, as it was more appropriate to use an existing organisational structure than create a new one for this purpose.

City of Culture 2017

The City had been successful in becoming one of four Cities on the final shortlist for the City of Culture 2017 together with Dundee, Hull and Swansea Bay. The health community could make a considerable contribution to the bid if it was successful as it could underline and contribute to cultural activities.

23. QUESTIONS FROM MEMBERS OF THE PUBLIC

The Chair invited questions from members of the public and the following questions were received and answered:-

Question - Number of residents not registered with a GP

The number of residents not registered with a GP practice was raised at the last meeting of the Board and what steps had been taken since then to reduce the numbers and how many were still not registered?

Response

The on-going campaign included arrangements for people who attended emergency centres at UHL for treatment to register at the centre if they were not already registered. A campaign would continue to run in part of the City where lower than expected levels of registration were observed. Publicity was undertaken in shopping precincts etc to encourage people to register. The Square Mile Project around the University survey responses suggested that nearly all residents were registered with a GP. The focus of this campaign would now centre on when people last saw their GP and would follow up on those not registered.

It was stated that non- registration had been a longstanding issue but there was no overwhelming evidence to suggest that the level of non-registration was a significant problem or a barrier to the provision of healthcare when it was needed. Registration was important for immunisation and core screening programmes.

NHS England were also known to be undertaking a national clearing exercise of GP lists as the number of people registered with GP's was greater than the total population. It was estimated that this could result in a 2-3% reduction in the number of people registered. The main reason for the discrepancy in numbers appeared to be people who had moved away from an area but were still registered with the GP in that area.

It was also noted that the Secretary of State for Health was considering charging patients from overseas for GP services and if this was introduced it could discourage people from registering.

The Chair stated that he would consider a methodology for asking questions in advance of the meeting so that a detailed written response could be prepared and the questioner may have the opportunity to then ask a supplementary question.

24. DATES OF FUTURE MEETINGS

The Board noted that future meeting would be held on the following dates:-

Tuesday 8 October 2013
Thursday 30 January 2014
Thursday 3 April 2013
Thursday 3 July 2014
Thursday 9 October 2014

Meetings would take place in the Tea Room, 1st Floor Town Hall at 10.00am unless stated otherwise on the agenda for the meetings.

The Chair also invited Board members to submit views and observations on how the Board could conduct its meetings. A number of different approaches had already been tied and feedback would be welcomed.

25. CLOSE OF MEETING

The Chair declared the meeting closed at 11.45am.

Discussing the Joint Health and Wellbeing Strategy for Leicester – Priority 3: Support independence
11 July 2013

Simon Freeman, Managing Director Leicester City Clinical Commissioning Group

Deb Watson, Strategic Director, Adult Social Care and Health, Leicester City Council

Minute Item 17

Joint Health and Wellbeing Strategy

- Major output of the Health and Wellbeing Board
- Based on the Joint Strategic Needs Assessment (JSNA)
- Focusing on priority health outcomes where we can make the biggest difference
- Takes into account multi-agency health inequalities improvement plan
- Was developed in the context of a recession and significant financial challenges across partner organisations
- Engagement with stakeholders, patients and the public is key
- Includes some areas where we have made progress, and some areas which are more of a call to action
- Strategy approved April 2013

Support independence

Why?

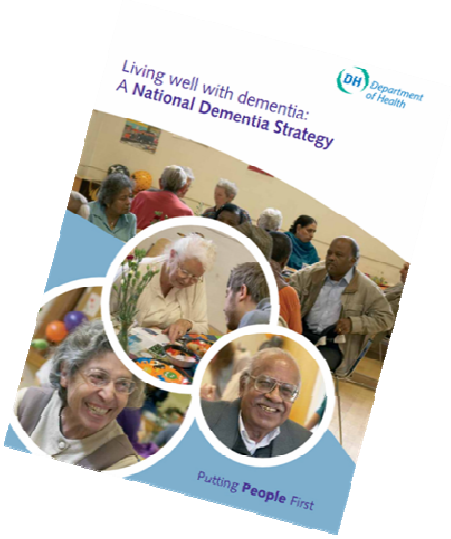
- It is estimated that there are about 37,200 (11.3%) people aged 65 and over in Leicester. Around 5,400 of these are aged 85 and over
- The 2011 census shows over a quarter (32,447) of city households in 2011 included a person with a long term health problem or disability limiting day-to-day activities
- More than 11% of people in Leicester are estimated to have high blood pressure
- Almost 7% of people are currently registered with diabetes and it is four times more common among South Asian people
- There are an estimated 3,000 people with dementia in Leicester - about 800 new cases occur in a year
- Approximately 30,000 people in the city are carers

Support independence

What we aim to achieve:

•Support independence for:
- people with dementia
- carers
- people with Long Term Conditions
- older people

Dementia



Progress

•Leicester, Leicestershire and Rutland (LLR) Dementia Strategy
(5 x Work Streams) reflects the National Strategy (Living Well with Dementia)

•**Early identification of dementia by GPs**
Clinical pathway agreed & GP training completed

- Dementia Advisors across LLR

•**Improved hospital care**
UHL CQIN – early identification of dementia on wards

•**Improved quality in care homes**
Quality Assurance Framework in place

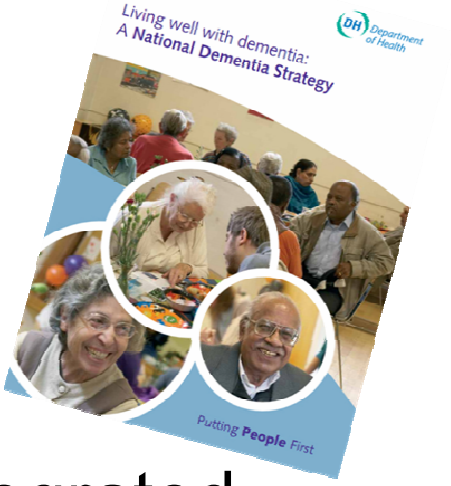
•**Improved community support**
Improved access to information, redesigned ICAT & CMHT

- Provision of carers training, Memory café's & Integrated Crisis Response

•**Workforce development**

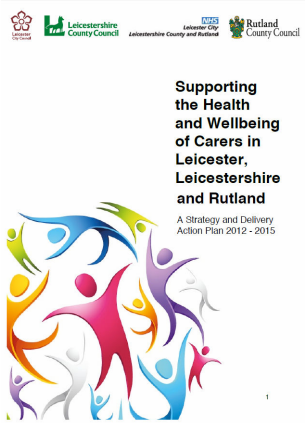
Dementia

More to do



- To continue to deliver the actions detailed in the LLR Dementia Strategy, especially integrated pathways of care
- Creation of Dementia friendly communities
- To raise awareness within the BME community

Carers



Progress

•LLR Carers Strategy – reflects the priorities of the National Strategy

- Carers are recognised and supported as an expert care partner
- Are able to enjoying a life outside caring
- Not financially disadvantaged
- Mentally and physically well; treated with dignity
- Children will be thriving, protected from inappropriate caring roles

Carers

More to do

- To improve carers' satisfaction by:
  - Delivering the actions set out in the LLR Carers Strategy
  - Supporting early self-identification and involvement in local care planning and individual care planning
  - Enabling carers to fulfil their educational and employment potential
  - Personalised support for carers and those receiving care
  - Support carers to remain healthy

Long term conditions

Progress

Optimising the care of people with long-term conditions in primary and community care and decreasing to reliance on acute care where it is appropriate, for example:

•Diabetes – more care will be provided by GP's and community services

•COPD – increasing detection and management including the use of telehealth

•CVD – improving outcomes through early detection and optimising management

More to do

- Upskilling primary care staff to deliver the above

- Developing focused interventions based on risk stratification and a case management approach for those patients at risk of admission to hospital

- Integrated care approach that supports people with a menu of services at different stages of their life

Older people

Progress:

•2012-Integrated Care Board - high level support: LCC/LPT/UHL
- Reviewed acute/community care pathways
- 20 proposals for actions
- GP survey

•2012 – Single Point of Access

•2013- Integrated Care Strategic Delivery Group

•2013 – Integrated Crisis Response Service (ICRS)

•Health and Social Care Coordinators

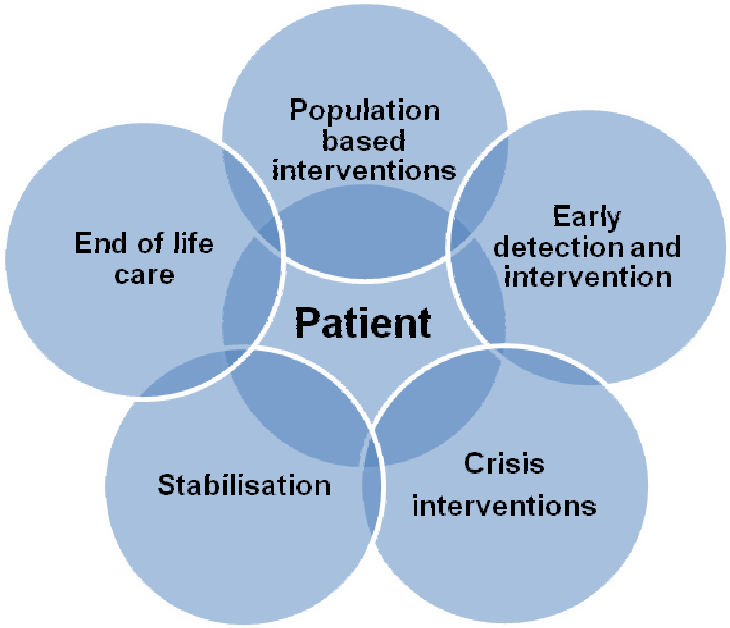
•Procurement of External Support to model range of commissioning and contracting options

•Pioneer application

More to do: integrated model of care, based around services for different points in people's lives to support the national voices definition of integrated care:

"I can plan my care with people who work together to understand me and my carer(s), allow me control, and bring together services to achieve the outcomes important to me"

Model of integration:



Above model is designed to maintain independence for as long as possible; reduce the need for hospital care; and deliver early preventative services. Integration Pioneer application made to support delivery

Questions for discussion

- What do we do well?
- What needs to change?
- How can we deliver this – ie how could your organisation contribute?
- What else needs to be done?