Leicester
City Council

Minutes of the Meeting of the
HEALTH AND WELLBEING BOARD

Held: THURSDAY, 5 FEBRUARY 2015 at 10.00am

Present:

Councillor Rory Palmer (Chair)	–	Deputy City Mayor, Leicester City Council
Richard Clark	–	Chief Executive, The Mighty Creatives
Professor Azhar Farooqi	–	Co-Chair, Leicester City Clinical Commissioning Group
Chief Superintendent Sally Healy	–	Head of Local Policing Directorate, Leicestershire Police
Andy Keeling	–	Chief Operating Officer, Leicester City Council
Sue Lock	–	Managing Director Leicester City Clinical Commissioning Group
Elaine McHale	–	Interim Strategic Director, Adult Social Care (part of the meeting)
Sue Mason	–	Member of Healthwatch Leicester
Rod Moore	–	Acting Director of Public Health, Leicester City Council
Councillor Rita Patel	–	Assistant City Mayor, Adult Social Care (part of the meeting)
Dr A Prasad	–	Co-Chair, Leicester City Clinical Commissioning Group
Tracie Rees	–	Director of Care Services and Commissioning, Adult Social Care, Leicester City Council (part of the meeting)
Councillor Manjula Sood	–	Assistant City Mayor, Community Involvement, Partnerships and Equalities, Leicester City Council

Trish Thompson	–	Director of Operations and Delivery, NHS England Local Team
Professor Martin Tobin	–	Professor of Genetic Epidemiology and Public Health and MRC Senior Clinical Fellow, University of Leicester

Invited attendees

Councillor Michael Cooke	-	Chair Leicester City Council Health and Wellbeing Scrutiny Commission

In attendance

Graham Carey	–	Democratic Services, Leicester City Council
Sue Cavill	–	Head of Customer Communications and Engagement - Greater East Midlands Commissioning Support Unit

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43. WELCOME AND INTRODUCTIONS

The Chair welcomed everyone to the meeting and everyone introduced themselves.

44. APOLOGIES FOR ABSENCE

Apologies for absence were received from Councillor Dempster, Frances Craven, Strategic Director, Children's Services, Professor Azhar Farooqi, Co-Chair, Leicester City Clinical Commissioning Group and David Sharp, Director, (Leicestershire and Lincolnshire Team) NHS England.

45. DECLARATIONS OF INTEREST

Members were asked to declare any interests they might have in the business to be discussed at the meeting.

Councillor Sood declared an Other Disclosable Interest as Chair for the Leicester Council of Faiths.

In accordance with the Council's Code of Conduct the interest was not considered so significant that it was likely to prejudice Councillor Sood's judgement of the public interest. Councillor Sood was not, therefore, required to withdraw from the meeting during consideration and discussion on items involving this interest.

46. MINUTES OF THE PREVIOUS MEETING

RESOLVED:

That the Minutes of the previous meeting of the Board held on 11 December 2014 be confirmed as a correct record.

47. ANNOUNCEMENTS

There were no announcements.

48. JOINT HEALTH AND WELLBEING STRATEGY - UPDATE ON PRIORITIES

The Board were informed that a full report on the Strategy would be submitted to the March meeting. Verbal updates were received on each of the five priorities below:-

i) Improve outcomes for children and young people.

Work was continuing on initiatives such as the family support programme and a new sexual health service. A number of new initiatives for healthy eating in early years settings and in schools, and programmes to encourage food growing were also planned.

A strategic group to progress an integrated approach to readiness had been identified. Initiatives with early literacy were progressing and a shift in focus of resources and the deployment of child centre teachers to years 2 and 3 had been put in place and work was continuing with parents and families to give support to help them to support their children's early learning. A pilot had started in the south of the City and a review report would be issued in 6 months' time.

ii) Reduce premature mortality.

Progress had been made on all areas. Smoking cessation programme was working well in fairly challenging conditions with impact of e-cigarettes. A recovery plan was in place which was filling the gap which existed earlier in the year. A lifestyle support hub had been designed and commissioned with effect from April 2015 which would make it easier to enable GPs and other health professionals to refer people into lifestyle support programmes. There had been a significant decrease in alcohol consumption and alcohol related hospital admissions and various awareness campaigns were ongoing. Despite the improvements, Leicester was still above the national average for alcohol related admissions.

Clinical leadership was progressing on improving education of people with cardio-vascular conditions, in particular, and more long term conditions, in general, by improving diagnosis through NHS Healthchecks. 10 GP mentors were delivering 600 training sessions per year to other GP practices on cardio-vascular disease, lung disease, diabetes, and end of life care to increase the primary care skills in these areas. 500 primary care clinicians had received atrial-fibrillation and heart failure training and changes in improvements in clinical outcomes were now beginning to be seen.

iii) Support independence.

Work was progressing through the Better Care Fund to support Older People with services around improving integration and crisis response services for the frail and elderly. A £5m award from the Big Lottery has been made to the voluntary sector for 21 projects to combat loneliness and isolation. There has also been a successful bid for hospital to home services to support people for early discharge, which also includes food and home safety checks. The Adult Social Care Commission was looking at 'ageing well in the city' with a view to developing an 'Older Person's Strategy' as part of the aging well strategy. This will bring together a number of partners on an inter-generational approach. The Social Care Act would come into force on 1 April 2015 and the council would be writing to carers to offer them the support provided under the Act. This will increase the number of assessments carried out and increase the opportunities for people to receive services. A carers' event had been organised at Curve which would feed into the Carers' Strategy.

Dementia was one of the work-streams in the Better Care Together Programme and work was progressing to improve the diagnosis rates and the support given to people with dementia. The diagnosis rate in Leicester was currently 67% compared to the national average of 48% and Leicester was on target to reach a diagnosis rate of 72% by the end of the year. The Alzheimer's Society had secured funding for befriending services in the City specifically targeted on dementia.

iv) Improve mental health and resilience.

A workshop was held on 3 February 2015 to look at issues around gaps in service for adults, children and those in crisis. This looked at the redesigned pathway to support people currently in hospital to enable an early transfer to community care, through changes in the LPT. It also looked at the way that children with mental health issues were supported and how to build in resilience from an early age and provide more education to stop children's mental health suffering as that can lead into issues in adulthood. All the issues considered would be fed into the Joint Integrated Commissioning Board so that these could be addressed.

v) Focus on the wider determinants of health through effective deployment of resources, partnership and community working.

Public Health made a detailed submission to the Local Issues and Options Consultation Document on the Local Plan and as a result discussions are now underway to devise a model of health impact assessments for developments in the City.

The proposed Air Quality Action Plan for the City would be published soon for consultation purposes. Health aspects were now central to the Plan rather than the previous focus on transport issues. All interested parties were encouraged to look at the document and respond to the consultation, so that the final plan was ambitious and robust and based upon a solid public health narrative.

The recent announcement on standardisation of the packaging on cigarettes was welcomed as the Council had lobbied for some time for this to be achieved.

The Mental Health Workshops represented a useful model of how the Board was able to bring stakeholders together to discuss issues of concern and shape ideas and make a difference to how services are delivered and configured.

A Health and Wellbeing Survey was initiated last week in the City on a representative sample population of 2,500, the results of the responses to a number of questions to collect health and social economic data would be available to use in May/June for various needs assessments.

RESOLVED:

That the update reports be received and noted.

49. JOINT HEALTH AND WELLBEING STRATEGY - PRESENTATION BY THE DIRECTOR OF CULTURE AND NEIGHBOURHOOD SERVICES

The Director of Culture and Neighbourhood Services gave a presentation on how the department was working towards the Joint Health and Wellbeing Strategy. A copy of the presentation notes was circulated to members with the agenda.

In addition to the comments contained in the presentation notes the following statements and comments were noted:-

a) The department was responsible for Arts and Museums services, libraries, community services and sports.

b) Health and wellbeing is a key part of the activities in culture and community services which contributed to people being happier, healthier and wealthier through creative industries and strong cultural centres like

Curve and King Richard III Centre.

c) The department worked closely with public health particularly in relation to sport and physical activity.

d) The department worked to the World Health Organisation's definition that 'health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity.'

e) There were over 2m users of sports and leisure facilities, 78% of which were from city residents. 38% of users were on lower incomes, 52% were women and 40% were from the BME communities.

f) Only 19.7% of adults took part in the sport and physical activity for 30 minutes three times a week; and only 33% of adults took part once a week. These were below the national averages of 26% and 36% respectively. However, the city performed better than cities with similar demographics such as Luton, Barking and Dagenham.

g) The lack of physical; activity was estimated to cost Leicester approximately £5.9m each year in healthcare, premature deaths and sickness absences. It was also estimated that at the current participation rates the value of exercise was £121m in costs avoided through improved quality of health.

h) There were 1.2m attendances at cultural and heritage venues involving 331 volunteers. There were 86,000 active library users with 27,000 children taking part in under 5's sessions. 93% of library users were from the City.

i) The department services integrated the 5 Ways to Wellbeing concept into its planning delivery (i.e Connect – Be Active – Take Notice – Keep Learning and Give).

j) The department also played an important role in raising aspiration, reputation and profile of the city and this had an impact upon wellbeing. The success of the Curve, attracting John Lewis Partnership to the Highcross, major private sector investment, partnership work with Leicester City Football Club in numerous events and attracting funds for a project for looked after children, mentoring and multi-sport, and providing the infrastructure support to attract Kasabian to play in the city were all examples of the benefits of wellbeing for residents. The Dave Comedy Festival was also worth £2m annually to the local economy.

k) A number of initiatives, activities and projects organised by the department to support and engage neighbourhoods and communities were outlined to the Board.

l) 4 case studies on the following initiatives were outlined to the Board, details of which are in the presentation attached:-

Football Investment – a partnership project with significant funding from the previous Primary Care Trust, in which over £11m has been invested in the city's sporting infrastructure to transform grassroots football and encourage more people to get fit and active.

Active Lifestyle Scheme – a joint funded project between Sports Services and Public Health taking referrals from health professionals for a range of health conditions from cardiac rehabilitation of patients to people who smoke or have family conditions. Patients are entitled to 6 months free usage of leisure facilities and whilst referrals were high retention in exercise was low. Sports Services were currently working with Public Health and the NICE guidance to change the system or offer to patients.

Get Healthy, Get Into Sport – a joint funded project between the Council, Sport England and Public Health which focuses on one area of the city where health was highlighted as being particularly poor, with higher than average levels of obesity, CVD and early mortality. Participants were offered 6 weeks of mentoring by a personal trainer, 6 months of free access to a leisure facility, the opportunity to bring a friend to encourage participation and a choice of free sports opportunities.

Culture and Neighbourhoods activity – a number of initiatives involving dementia awareness in museums, breast feeding friendly scheme in Arts and Museums venues and Community Centres, and health focused events in libraries, including displays, stands, themed story-telling and books on prescription where health professionals recommend a self-help book as part of a patient's treatment. The books are borrowed from local libraries and all libraries participated in the scheme.

Following the presentation Board members commented that:-

a) There was an opportunity for the lifestyle hub to be developed and extended to signpost and refer people to a number of the services provided by the department. The Improving Access to Psychological Therapies (IAPT) could also easily be adapted to increase signposting and provide a pathway to other services. These could be achieved at relatively small costs.

b) It was recognised that the opportunities available were not just focused on physical outputs but there were health and wellbeing benefits to be derived from initiatives such as apprenticeships and those initiatives which improved a person's confidence as these also led to long term benefits.

c) Although an individual assessment of a single initiative may only show a

small benefit, the cumulative impact and effect of a number of initiatives taken together was often overlooked.

d) Promotional displays, especially TVs in GP surgeries could also promote the opportunities that were available.

e) It would be helpful if patients referred by their GP for physical activities could book their sessions directly at the GP surgery rather than be referred by the GP and it then take some time for the referral to take effect.

RESOLVED:

That the Director be thanked for an informative and stimulating presentation and that the issues raised in the discussion be considered further by the Department.

50. COMMISSIONING INTENTIONS 2015/16

Leicester City Clinical Commissioning Group

The Board received presentation on commissioning intentions of the Leicester City Clinical Commission Group for 2015/16 from Sue Lock, Managing Director. A copy of the presentation was previously circulated with the agenda.

In addition to the comments included in the printed presentation, the following comments were noted:-

a) The CCG had only recently received its allocation and were still in discussion with the providers and the other CCGs about the detail of what can be purchased within the overall allocation.

b) The commissioning intentions were formed by National Planning Guidance, The Better Care Together Programme and the CCG's priorities based upon local health needs and Equality Impact Assessments analysis. The local priorities were drawn from both the Closing the Gap Strategy and the CCG's own priorities, which are informed by the EIA analysis, and also from feedback on the provision of existing services to test that they are appropriately designed and delivered. For example, the NHS Health checks where work had been carried out to ensure that there was suitable geographical coverage as well as suitable population coverage and to ensure that all those that required the checks received them.

c) High level EIA's are produced once the high level commissioning intentions are identified. The specific detailed EIAs are then produced when the implementation of individual services are designed and introduced. The EIA's and the Quality Impact Assessments go through an internal executive committee and then onto the governing body.

They are published on the website and are tested at each stage of the governance structure.

d) The changes to the national planning guidance were outlined in the presentation notes. There were now access targets for mental health services which meant that services such as IAPT and psychosis would need to be assessed to evaluate the amount of activity that was commissioned and that they were appropriately designed to meet the level of demand. The Joint Integrated Commissioning Board were looking at the development and roll out of personal health budgets and integrated personal commissioning. There was now a greater focus on prevention services which was welcomed in order to achieve sustained improvements in patient health.

e) The commissioning intentions for the Better Care Together and the CCG's priorities were listed in the presentation. These presented an opportunity for closer working with Adult Social Care Services and for the CCG to provide more health care services in care homes to prevent hospital admissions. It was important to support people to access the various services available to them through the personal health budget process, which could be complex and daunting. Further work was also required to improve the access of older members of the Asian community and young black British men to mental health services.

f) Research and analysis was being conducted into access rates across different parts of the city and by different groups to determine if services such as dementia had the right tools to test people's understanding and memory, as one tool used by GPs for screening purposes is not suitable for older Asian people or people who do not have English as their first language or have recently moved to England; as some of the tests are reliant on responses in English and a knowledge of English culture and recent historical events. These were being assessed to see if the screening process can be improved.

Members of the Board commented that:-

a) The Chair felt that it would be good practice to have a common model for undertaking EIA's both in local authorities and the health structure, and this should be considered.

b) Community and anecdotal evidence suggested that the LGBT community had poor consumer experiences of health services. Approximately 80% of gay and homosexually active men had not 'come out' to their GP and this led to significant problems with a lack of information about how they present their health issues to their health care professionals. These issues may not be readily identified by the usual methods of on-going monitoring or reviewing service needs, which may be inhibiting the significant changes that are required to address the health inequalities that are being experienced by the LGBT community.

c) Greater involvement of key communities, of which LGBT was one, in participating in the EIA's may be a way to improving trust and confidence that the right health priorities were being commissioned.

d) There were cultural obstacles in BME communities to taking part in screening for breast, cervical and prostate cancers and this needed to be recognised in the screening process and addressed. Dedicated outreach reach workers for these groups could be considered as a way to improve the take up rates of the various screening methods. In response, it was stated that the CCG would look at individual GP take up rates of screening and would take steps to work with practices which experience lower rates in order to improve them.

The Chair recognised that there were a number of issues in considering items and topics such as this as it was difficult to articulate what would ultimately be different or better at the end of the process. Data and data gaps were a theme across a number of strategies and commissioning plans. Gaps in data were important but also there were challenges in drawing upon vast arrays of data sources and articulating that in how decisions were made and commissioning intentions and priorities were formed.

He suggested that there should be a sub-group of the Board to look at data gaps, and the data gaps in relation to the LGBT community, for example, was not just exclusive in relation to health but also in the wider importance to the public sector generally. The work should also look at the direct references from the Joint Specific Needs Assessments and the data that was available and the data that was needed to support issues which were considered at a higher strategic level. It was important to demonstrate that decision making made the best use of the resources and data that underpinned them.

<u>NHS England</u>

Trish Thompson, Director of Operations and Delivery, NHS England Local Team, stated that the report submitted by NHS England was being withdrawn as further work was required on the consultation process for the specialised services being commissioned and the proposals were not, therefore, completed.

The direct commissioning of primary care by the CCG would be picked up later in the item on the CCG Primary Care Co-Commissioning.

The Chair expressed disappointment that the report was not available before the commissioning intentions were put into operation. In response, it was stated that this situation was being experienced in other NHS England areas in relation to specialised commissioning services, and NHS England had fed their concerns back to the NHS Central Team.

RESOLVED:

1 That the CCG's commissioning intentions be endorsed.

2. That the NHS England's commissioning intentions be circulated as soon as they are available.

51. PRIMARY CARE CO-COMMISSIONING UPDATE

Sue Lock, Managing Director, Leicester City Clinical Commissioning Group (CCG), NHS England gave a presentation on the CCG's application to co-commission primary care services with NHS England. A copy of the presentation had previously been circulated with the agenda.

It was noted that:-

a) NHS England first introduced the concept of co-commissioning in May 2014. Co-commissioning was a formal arrangement between NHS England and CCGs to jointly procure General Medical Services, Personal Medical Services and Alternative Provider Medical Services.

b) The CCG had expressed an initial intention to apply for co-commissioning, and reconfirmed their intentions in January 2015 and formally confirmed it wished to apply for fully delegated commission from April 2015.

c) The summary of functions to be delegated was contained in the presentation.

d) The advantages of delegated co-commissioning were that CCGs were closer to practices and could make better informed decisions based upon local specific health needs, reduce commissioning system fragmentation, incentives could be aligned to local needs and new and innovative models of service delivery could be supported.

e) It was felt that the improved outcomes would be improved access to primary care, more services closer to home and matched to local needs. These should reduce inequalities and improve equity of access and patient experience.

f) A commissioning committee would be established which would be a formal sub-committee of the Governing Body and would meet in public. The committee would have a majority of lay and executive members. The lay members would be chair and vice-chair of the committee. Non-voting members of the committee would include the Council, Healthwatch, NHS England and the Local Medical Committee.

Trish Thompson, Director of Operations and Delivery, NHS England Local Team, stated that the approach from the CCG was welcomed as it provided an opportunity to commission services with local sensitivities.

The Chair commented that his previous concerns over capacity issues still remained. There was an ongoing issue of recruiting and retaining GPs in the City and these proposals would place a new raft of responsibilities upon them.

In response it was stated that:-

a) Local commissioning should enable the CCG to take decisions aligned with future local strategies. For example, when a GP practice closed, as had happened recently, the CCG were better placed to know where patients could be best dispersed to other local GP practices which had spare capacity. This was also compatible with the CCG's proposals to introduce health needs neighbourhood management areas for service delivery.

b) It would allow different service models to be commissioned and should allow the current fractured commissioning service to become a more co-ordinated commissioning service.

c) There would be opportunity for the Board to receive further details of the delegated responsibilities.

RESOLVED:-

That the contents of the presentation be received.

52. BETTER CARE TOGETHER STRATEGY

The Board received an update report and presentation on the Better Care Together Joint Leicester, Leicestershire and Rutland Five Year Strategy. Michael Crawley, Finance Director and Mary Barber, Programme Director, Better Care Together attended the meeting to present the report.

In addition to the points contained in the presentation notes previously circulated, it was noted that:-

a) Updates on progress had been made to the Council's Adult Social Care and Health and Wellbeing Scrutiny Commissions in January 2015 and an invitation had been made to the City's Safeguarding Board as well.

b) Key progress points to be made over the next 3 months were:-

- Establishing a joint Clinical and Social Care Leadership Group with a remit for clinical leadership for transformational change, quality improvement, innovation and organisational development. This would be chaired by Professor Farooqi.

- An Adult Social Care review to identify appropriate reviews and align adult health and social care services across the programme.

- Partner organisations would be asked to approve the proposals and implementation plans for the Primary Care Reviews.

- Workforce changes including new roles, recruitment and cultural change programs had commenced.

- Scheduling further external reviews by the Office of Government Commerce, clinical senate in relation to quality risk and assurance and embedding the agreed risk assurance program across the partner organisations.

- A public campaign to raise awareness would be launched in Feb-March 2015.

- A more interactive and public led creative designs narrative and web site for the Better Care Together Programme would be launched in February 2015.

- A voluntary sector engagement event would be held in April 2015.

- Finalising the proposed formal engagement plan for review and agreement would be in May 2015.

Following questions from a member of the public, it was stated that:-

a) The Risk Register had been discussed in public recently and was published on the Better Care Together website.

b) The Board was not the appropriate body to scrutinise the details of the proposals because:-

    - The Better Care Together Programme Board was now meeting in public and the Board should not be replicating discussions held elsewhere in public.

    - The Board members had been involved in putting parts of the Better Care Together Programme together and were therefore in a position to be completely impartial in scrutinising the proposals.

    - The Council's Health and Wellbeing Scrutiny Commission was better placed to undertake the scrutiny role of the programme and had already started this long term process.

    - The Programme was also subject to other external forms of scrutiny in the form of the Office of Government Commerce.

RESOLVED:-

1) That the report and presentation be received.

2) That the assurances on the progress made during 2014/15 in developing the Leicester, Leicestershire and Rutland Health and Social Care 5 year Plan together with the supporting Strategic Outline Case and Programme Initiation Document be received.

3) That the next three months programme priorities be noted.

53. HEALTH PROTECTION BOARD ANNUAL REPORT

The Acting Director of Public Health submitted a report on the Health Protection Board Annual Report. The report purpose was to inform the three Health and Wellbeing Boards in Leicester, Leicestershire and Rutland, that the Health Protection Board was delivering its statutory functions and to provide an assurance regarding the whole system for health protection across Leicester, Leicestershire and Rutland.

RESOLVED:-

That the report be received and its contents be noted.

54. BETTER CARE FUND UPDATE

Elaine McHale, Interim Director of Adult Social Care and Sue Lock, Managing Director, Leicester City Clinical Commissioning Group submitted a report that provided an update on the progress of the Better Care Fund.

RESOLVED:-

That the report be received and its contents be noted.

55. IMPROVING HEALTH SCRUTINY ARRANGEMENTS

The Chair stated that the report on the outcomes of a 'Fit for Purpose Review' carried out by the Leicester City Council's Health and Wellbeing Scrutiny Commission to improve health scrutiny would be withdrawn and re-submitted to the next meeting.

56. QUESTIONS FROM MEMBERS OF THE PUBLIC

In response to questions from Members of the public the following comments were made:-

a) The work of the LGBT Centre was recognised by the Council and all partner organisations were encouraged to engage with the Centre as they were able to offer advice, experience and knowledge of issues affecting the LGBT community.

b) The work of the voluntary sector was both recognised and appreciated particularly in the current challenging financial situation that was faced by individual voluntary sector groups, the Council and partner groups. The concerns raised by voluntary sector organisations were taken seriously and many initiatives had been taken as a result to address them.

57. DATES OF FUTURE MEETINGS

To note that future meetings of the Board will be held on the following dates:-

Thursday 26 March 2015
Thursday 25 June 2015
Thursday 3 September 2015
Thursday 29 October 2015
Thursday 10 December 2015
Thursday 4 February 2016
Thursday 7 April 2016

Meetings of the Board are scheduled to be held in City Hall, at 10.00am unless stated otherwise on the agenda for the meeting.

58. ANY OTHER URGENT BUSINESS

There were no items of any other urgent business.

59. CLOSE OF MEETING

The Chair declared the meeting closed at 12.30 pm.