Leicester
City Council

Minutes of the Meeting of the
HEALTH AND WELLBEING BOARD

Held: THURSDAY, 26 MARCH 2015 at 9.00am

Present:

Councillor Rory Palmer (Chair)	–	Deputy City Mayor, Leicester City Council
Karen Chouhan	–	Chair Healthwatch Leicester
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
Rod Moore	–	Acting Director of Public Health, Leicester City Council
Councillor Rita Patel	–	Assistant City Mayor, Adult Social Care
Tracie Rees	–	Director of Care Services and Commissioning, Adult Social Care, Leicester City Council
Professor Martin Tobin	–	Professor of Genetic Epidemiology and Public Health and MRC Senior Clinical Fellow, University of Leicester

Invited attendee

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 Projects – NHS Arden and Greater East Midlands Commissioning Support Unit

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60. INTRODUCTION

The Chair stated that as this was the last meeting of the Board in the current municipal cycle before the elections in May. He wished to thank everyone for their participation in the Board's work over the last four years. During this period the Board had existed in Shadow form for the two years prior to it formally coming into being on 1 April 2013. He also thanked the support officers who had worked with the Board during the last four years.

61. APOLOGIES FOR ABSENCE

Apologies for absence were received from Sir Peter Soulsby, City Mayor, Councillor Manjula Sood, Assistant City Mayor, Frances Craven, Strategic Director Children's Services, Dr Avi Prasad, Co-Chair Leicester City Clinical Commissioning Group, David Sharp, Director (Leicestershire and Lincolnshire Area) NHS England and Trish Thompson, Director of Operations and Delivery, NHS England Local.

62. DECLARATIONS OF INTEREST

Members were asked to declare any interests they might have in the business to be discussed at the meeting. No such declarations were made.

63. QUESTIONS FROM MEMBERS OF THE PUBLIC

The Chair invited questions from members of the public. No questions were received.

64. MINUTES OF THE PREVIOUS MEETING

RESOLVED:

That the minutes of the previous meeting of the Board held on 5 February 2015 be confirmed as a correct record.

65. ANNOUNCEMENTS

The Chair welcomed Karen Chouhan back to the Board, following the recent difficulties with VAL in relation to them novating the Healthwatch Leicester contract. He was pleased that Healthwatch was now on a more positive footing and was moving forward to be completely independent.

Karen Chouhan, thanked the Chair and the Council for its involvement in

helping to resolving the issue. She also requested a copy of the report on the outcomes of the workshop held on 3 February 2105 which had discussed issues in service gaps for adults and children in crisis. The Chair confirmed that this would be forwarded in due course. `

The Chair also referred to the publication of the recent OFSTED Inspection report. He did not intend to discuss the issue or repeat discussions that had already happened elsewhere but wished to give assurances that there was active and intense scrutiny taking place as a result. He wished to acknowledge the references in the report to the Board and to the wider health community. The issues in the report were of utmost concern to all partners involved with the Board. The report cited the Health and Wellbeing Board and commented that the Safeguarding of Children was not explicitly mentioned in the Board's strategy. Whilst that was an important observation, he wished to affirm that this did not mean that the issues were not of importance or significance in the day to day management of all the organisations involved with the Board. Each of the organisations had statutory responsibilities and undertook vigorous and robust work around a number of themes and issues and these were acknowledged in the report.

Following the publication of the report the Chair had written to NHS England and the Clinical Commissioning Group to seek assurances about their approach to these issues and the training given to front line health professionals around safeguarding of children. The responses received provided those reassurances. There was no place for complacency and the Board would continue to take a keen interest in these issues across all the Board's work areas. The Board had already demonstrated this by signing the protocols with the Children's Trust and the Children Safeguarding Board and had strengthened the membership of the Board by the addition of the Lead Executive Member for children's and young services.

The Board would be holding development sessions to address the issues raised by the report and to consider the Board's response to them. Other partners mentioned in the report would also be preparing their own responses. The Chair intended to bring a report to a future Board meeting on the Board's response to the OFSTED report to be considered in public.

Sue Lock, Managing Director, Leicester City Clinical Commissioning Group, supported the Chair's comments and felt it was important to recognise the high priority that is given to safeguarding. She welcomed the proposed development sessions which would help to strengthen an area that was already a firm focus within the CCG.

Andy Keeling, Chief Operating Officer, commented that partners would be fully engaged in the improvement process going forward directly and not just through the various partnerships groups that existed. A further observation in the OFSTED report had been that there were good partnership arrangements in place but the impact of those partnerships in relation to safeguarding was not able to be articulated strongly enough through the inspection process. There would be an opportunity to discuss how that can be demonstrated better in the

future.

66. PHARMACEUTICAL NEEDS ASSESSMENT - UPDATE

The Acting Director of Public Health submitted a report seeking approval of the Pharmaceutical Needs Assessment (PNA).

The Acting Director commented that it is a statutory responsibility of the Board, to produce the PNA. The responsibility had transferred from the Primary Care Trust to the Health and Wellbeing Board in April 2013. One of the key functions of the PNA is to provide a basis upon which NHS England can responds to applications for new pharmacies in the area.

It was noted that there are three main components in the national contractual framework. These are Essential Services, which must be provided by all contractors, Advance Services, which community pharmacies can choose to provide following appropriate training or accreditation by NHS England, and Community Based Services, which pharmacies can offer to provide if commissioned by local health commissioners, the CCG and local authorities, to meet local health needs.

The PNA also provides information on how services in the national framework are delivered locally and on the wider voluntary role of pharmacies. It also considers the future projected needs and predicted population growths. The list of statutory consultees is outlined in section 7 of the assessment and, whilst there was no obligation to consult with the public, the public were consulted and made responses either through paper questionnaires or on-line through the website. A summary of responses from both the statutory consultees and the public were listed in the PNA. The PNA presented a number of conclusions and recommendations for commissioners to consider.

There was a duty to keep the PNA up to date and for it to be reviewed in 3 years' time. There was a requirement to publish a map of the pharmaceutical services in the City on the Council's website and it was proposed that this would become part of the Joint Integrated Commissioning Board's responsibilities to facilitate the plan being kept up to date. This would also be dependent upon NHS England to provide the information required, which was an implicit requirement within the PNA process.

Professor Farooqi referred to recent media reports which described how pharmacists were being used by some GP practices elsewhere in the country to treat patients for minor ailments as part of the process to address the shortage of GPs. He asked if there was any evidence that pharmacies were being underutilised and, if so, what plans were there to utilise these services.

In response, the Acting Director of Public Health stated that this responsibility lay with the commissioners in the first instance. There were only 3 pharmacies undertaking the maximum of 400 Medicines Use Reviews (MURs) per year in the City. This was a free NHS service offered by pharmacies to have a private consultation with a patient to discuss their knowledge and use of the

medicines. Professor Farooqi felt that this was an under-utilised resource because if people used their medications properly it did have an impact upon future health care and pressures on GP services. He felt that further work should be undertaken to understand why this was under-utilised, as it could provide an additional and much needed resource and capacity within the NHS at a time when NHS resources were under pressure. Sue Lock commented that the new co-commissioning arrangements did not bring pharmacies within the CCG's responsibilities, so further work would need to be undertaken with NHS England to understand why that capacity was underused and to take steps to maximise its potential and make best use of this resource.

It was noted that the number of New Medicines Services (NMS) reviews carried out by pharmacies also varied from 2 to 443, with most pharmacies doing approximately up to 200 reviews. NMS reviews were intended to help provide support and advice to people who were newly prescribed a medicine to help them manage a long term condition to make sure they understood how the medication should be taken to improve the self-management of their condition.

The Acting Director of Public Health stated that the pharmacy professional bodies were keen to do more and one of the recommendations in the PNA referred to the opportunity to include pharmacies and develop their roles in commissioning strategies and through the wider Better Care Together Programme plans; particularly in relation to deflecting work out of primary care general practices for treating minor ailments and emergency supplies schemes etc.

The Chair commented that it was important to regard the PNA as a live resource to inform commissioning and service provision. Although the PNA had a great deal of useful information within it, one of the limitations was that much of the information was based upon ward boundaries which often don't reflect natural neighbourhood and communities or how people exercise their lifestyle patterns. For example, people may use city centre pharmacies in preference to ones in their own neighbourhood as these might be more convenient in relation to their place of work or people may wish to preserve a degree of anonymity.

The Chair felt that it was important, in view of the comments and observations made at the meeting, that the recommendations in relation to pharmacies should be strengthened and pursued. He welcomed the accompanying Equality Impact Assessment which picked up important issues such as economic equity, ethnicity, language and sexual orientation. In particular, there was no data available to indicate whether patients within the gender reassignment group, experienced difficulties in seeking health advice or medications from their local pharmacy.

Mr Richard Clark concurred and referred to section 2.7 of the PNA which gives an overview on Sexual Ill Health and referred to the lack of demographic mapping and analysis in relation to men having sex with men. This created some blind spots between the identification of health inequality issues identified in the report and the subsequent recommendations. There needed to be a

more integrated approach to using the available information to try and identify what the priority health needs were for seldom heard and hard to reach groups.

The Acting Director of Public Health stated that the direct link to progress these issues would be through the Joint Integrated Commissioning Board, which could discuss the issues further with the pharmacies and professional associations to put firm mechanisms in place to achieve the desired outcomes. Sue Lock also commented that the CCG had direct links into the Local Pharmaceutical Committee and could feed these issues into them. GPs also have links with their local pharmacies and, additionally, these issues could also be addressed through the proposed emerging health needs neighbourhoods.

The Chair referred to the Stoneycroft pharmacy that was mentioned in the Needs Assessment under the Essential Small Pharmacies Local Pharmaceutical Services Contract and which had faced possible closure in January. He stated that he had made representations to NHS England that the pharmacy, which served Knighton, Evington and Stoneygate, was essential to the needs of local area. Local ward councillors had also made representations and it had also been discussed at the Health and Wellbeing Scrutiny Commission

RESOLVED:

1) That the final PNA report be approved for publication.

2) That the need to update the PNA by March 2018, as set out in the Pharmaceutical Regulations be noted.

3) That the ongoing responsibilities with respect to the publication of an up-to-date map of all pharmacy provision and the arrangements that have been proposed to ensure that this takes place be noted and approved.

4) That a further report be submitted to the Board in 12 months to report the progress made with delivering the recommendations in the report and the observations made by the Board on the PNA.

67. LEARNING DISABILITIES AND AUTISM SELF-ASSESSMENT STRATEGY

The Board received reports on the Joint Health and Social Care Learning Disability Self-Assessment – Evaluating Progress in Local Authority Partnership Board Areas and for the 2014/15 Adult Autism Strategy: Autism Self-Assessment – Evaluating Progress in Local Authorities along with Partner Agencies. A copy of a presentation on the reports had also been previously circulated to members with the agenda.

Yasmin Surti, Lead Commissioner for Learning Disabilities and Mental Health presented the reports to the Board. This was the second year that these annual assessments had been submitted. There were three main areas for the self-assessments around, keeping people healthy, keeping people safe and ensuring people are living well.

In relation to Learning Disability, there had been an improvement in 5 areas, 16 areas had stayed the same and the area relating to annual reviews was flagged as 'Red'. This area of work had now been prioritised for both health and social care staff. An action plan was being developed with the Learning Disability Partnership Board and quarterly reports would be submitted to them on progress. Progress would also be reported to the Joint Integrated Commissioning Board (JICB).

Care managers, heads of service and senior directors had been asked how these assessments can be prioritised and those involved had been requested to report back on a monthly basis to monitor progress through the Joint Integrated Commissioning Board. The Council had been assured that health workers' priorities had been changed and by the end of the year 100% of annual reviews would be completed for those individuals whose care was fully funded by health. This would be monitored through contractual arrangements. In relation to the future, funds were being sought to establish a Community Interest Group comprising individual service users and carers, to provide an independent viewpoint for the self-assessments in relation to the checks made upon services where a contract was in place to provide support people with learning disabilities.

In relation to the Autism Self-Assessment, 7 areas were considered to be good, 10 areas were considered 'OK' but could improve and three areas were considered poor. The proposed actions to address these issues were shown in the presentation. Work had progressed to work with Police and the Disability Strategy Group to improve raising awareness throughout the courts, prison and probation services.

Karen Chouhan, Chair of Healthwatch Leicester, offered the involvement of Healthwatch services to support the areas for improvement.

RESOLVED:

1) That the Learning Disability Self-Assessment and the Autism Self-Assessment submissions be accepted and validated.

2) That the recommendations in both submissions for future work to ensure the Council along with partner agencies are able to meet their legal responsibilities and raise standards be supported.

3) That when the Action Plans are developed these be circulated to the Board members so that they can comment upon and support the work that is being done.

68. IMPROVING HEALTH SCRUTINY ARRANGEMENTS

Councillor Cooke, Chair of the Leicester City Health and Wellbeing Scrutiny

Commission, presented a progress report on the outcomes of a 'Fit for Purpose Review' carried out on the Commission's behalf by the Centre for Public Scrutiny (CfPS) with a view to improving health scrutiny. Following the publication of the CfPS Review Report, the Scrutiny Commission had developed an Implementation Plan to address the recommendations that had been made.

The CfPS concluded that there were four areas of work that needed to be improved. These were:-

Improved public and community involvement
Clarification of relationships
Effective prioritisation of issues to scrutinise
Member skills development

The Commission's responses to each of the 20 recommendations in the CfPS Review Report and the progress made on them to date were detailed in the Improvement Plan. Some improvements had been achieved by simply rearranging the seating layout for the meeting, which had made a big impact in changing the dynamics of the meeting and establishing a more forensic approach to scrutiny. Others were more complex such as the protocols on joint working arrangements, which would have benefits in the long term. The first protocol was signed in June 2014 with Healthwatch and two other protocols had been developed with NHS England and the Care Quality Commission. It was intended to sign these during April. These protocols would help to maximise mutual knowledge and help each organisation to learn from each other.

Councillor Cooke hoped that his successor would be able to bring a further report back in 6-12 months to demonstrate that further progress had be made on the Implementation Plan. He also felt that there had always been an issue of the competence of the Commission to carry out its functions and this had been reinforced recently by the publication of guidance on the function of health scrutiny. Health scrutiny was a statutory responsibility of the Council and it was important that the Commission members understood the legal framework in which they were required to operate. It was therefore essential that there should be mandatory training for health scrutiny members similar to that already for provided for members of the Planning Committee and the Licensing and Public Safety Committee. Both these had statutory regulatory responsibilities. He felt that there was capacity to provide this training in-house and there was a real need to understand how the complex NHS system worked and how the Council's scrutiny process fitted in with both the NHS structure and, equally importantly, the relationship between the Scrutiny Commission and the Board.

The Commission had undertaken some joint working which had proved both interesting and challenging. Joint scrutiny had taken place with the Adult Social Care Scrutiny Commission on topics of common interest; but it had not been possible to persuade the County Council to pursue joint scrutiny, as had happened in 2012/13, when the joint working secured a review of the Safe and

Sustainable outcomes by the Minister of State in relation to the Congenital Heart Unit at Glenfield Hospital.

The Chair supported the approach taken by the Commission to strengthen the scrutiny function around health and commented that the relationship between the Board and Commission had been constantly evolving and would continue to do so in the future with new structures and responsibilities. It was important to ensure that the governance arrangements kept pace with current and future changes and remained fit for purpose.

In response to the Chair's question on whether there were any benefits that could be adopted across other parts of scrutiny and not just health; Councillor Cooke stated that he believed there were lessons learned from the review that could be applied equally across all scrutiny commissions. He also firmly believed that member development and training was an essential part of being a councillor in order to carry out duties in a professional manner.

Following a further question in relation to recommendation 13 in the Improvement Plan on whether sufficient progress had been made on establishing clear delineations between the various roles of bodies to establish a good fit so that everyone was clear about each other's roles; Councillor Cooke commented that the protocols were not yet a finished product but would hopefully be developed further under his successor. The important factor was firstly to establish which body to work with and then to identify if the other party also sees value in it. Once signed it needs to be implemented and developed. The benefits of the Healthwatch protocol had been hampered by recent events which had delayed work on agreeing joint working methods and annual reviews. He would be leaving a legacy document for his successor who would need to build new relationships with the various bodies in order to continue the progress already made.

In response to a question from a member of the public on how the recommendations for enhanced scrutiny applied to the Better Care Together Programme; Councillor Cooke commented that the scrutiny of the programme was in its early stages and that the knowledge building stage was already underway. He could not comment on how the scrutiny would continue under his successor, but he intended to meet with the questioner as soon as possible to better understand the issues and would leave comments on how he thought the scrutiny process should progress in his legacy document.

RESOLVED:

1) That the "Improving Health Scrutiny Arrangements following the 'Fit for Purpose' Review Report" be endorsed.

2) That the "Implementation Plan" of actions and the prescribed way forward as a means to drive and co-ordinate improvement to future health scrutiny arrangements be endorsed.

3) That the need for mandatory training for all members of the Health & Wellbeing Scrutiny Commission be supported.

4) That a further update report be submitted to the Board in 6-12 months to demonstrate the further progress that had been made on the Implementation Plan.

69. ITEMS FOR INFORMATION

The Board noted the reports on the following items for information:-

a) Joint Health and Wellbeing Strategy – 6 Monthly Update

This was the fourth bi-annual update report and more data was now available to show the progress with the direction of travel for 23 of the 25 measures now available. The Joint Integrated Commissioning Board (JICB) had been requested to provide summary action plans on all the measures that were showing deterioration in performance. The summary action plans for NHS Health Checks, Self-Reported wellbeing – people with a high anxiety score and smoking cessation were at Appendix 3 of the report. Summary action plans were still awaited from NHS England on the uptake of bowel cancer screening in men and women and the coverage of cervical screening in women. Both the CCG and Public Health were also pursuing these independently with NHS England to better understand the reasons for this deterioration. The CCG were also using data from GPs as part of this process to see if there was a correlation with particular geographical areas or particular sections of the population or whether there was just a general reduction in uptake of screening for no apparent reason.

The Chair commented that the Board had previously discussed the idea of having a Board Member to champion specific themes in the strategy but this had not materialised. He felt that this should be re-visited in the near future as there was now a larger membership of the Board.

b) Better Care Together – Update

The Chair commented that the engagement process needed to be effective and well communicated to the public. The scrutiny of the Programme was still best placed with the Health and Wellbeing Scrutiny Commission in view of the Board members' active involvement with initiatives with the programme. Healthwatch also had an important role in the public and patient engagement aspects of the scrutiny process.

In response to questions from members of the public, Mary Barber, Programme Director, Better Care Together, stated that:-

i) 945 questionnaires had been completed to date. This was higher than in previous baseline responses.

ii) The emerging themes of concerns expressed by the public were:-

- What were the proposals for the General Hospital?
- Will the primary care sector be able to cope with the additional services they would be expected to provide?
- What will be the impacts upon social care provision?

iii) Detailed plans were currently being developed for 2015/16 and 2016/17. Any changes to services in the 2015/16 plan would only be implemented if they did not require formal public consultation. These changes to be implemented could involve improvements in performance and increases in service provision. Services that required public consultation were currently being identified and it was intended to submit a list of these to the meeting of the Partnership Board in May.

iv) The number of beds provided within the NHS constantly changed from week to week and month to month. The primary issue was not necessarily the number of beds provided, but where the beds were provided within the system in order to provide the most effective treatment to patients dependent upon need.

v) The Programme was already the subject of public scrutiny. The Partnership Board, which meets in public, comprises representatives from the NHS, local authorities and Healthwatch. There was an opportunity for the public to ask questions at the Board meetings. Discussions were also taking place with independent organisations to see if there were any examples of good practice being developed elsewhere in the country in relation to Better Care Together which could be applied in Leicester, Leicestershire and Rutland.

A member of the public commented that Councils elsewhere in the country had commissioned independent bodies and individuals to scrutinise the process. It was felt that a large amount of feedback could be achieved for relatively small sums.

The Chair commented that:-

i) The Programme Director for Better Care Together should be invited to look at the issues raised around independent scrutiny of the Better Together Care Programme and how these could be resourced.

ii) That progress on implementing the Better Care Together Programme be revisited in future meetings.

iii) There may be merits in having joint scrutiny arrangements across Leicester, Leicestershire and Rutland to avoid duplication and provide a more meaningful forum for

scrutiny at the political level.

iv) The Better Care Together Team be invited to consider these issues and provide a response for the Board to discuss at a future meeting.

c) Leicester City Council Adult Social Care Commissioning Intentions

The report was noted.

d) Air Quality Action Plan – consultation

The Chair commented that consultation on the Air Quality Action Plan for the City had recently been launched. Improving Air Quality was a challenge in the City and the current Action Plan recognised the importance of health and wellbeing in relation to improving air quality rather than the previously traditional approach to improving air quality through mainly traffic management proposals. He urged all partners on the Board to submit responses to the consultation process.

The responses on the consultation would go through the Council's scrutiny process before going to Council for approval. It was intended to bring the final document back to the Board before it was formally approve.

The Consultation Draft – Healthier Air Quality for Leicester – Leicester's Air Quality Action Plan (2015-2025) was noted.

70. DATES OF FUTURE MEETINGS

It was noted that future meetings of the Board would be held on the following dates:-

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.

71. ANY OTHER URGENT BUSINESS

There were no items of Any Other Urgent Business.

72. CLOSE OF MEETING

The Chair declared the meeting closed at 10.20 am.