Date: WEDNESDAY, 9 SEPTEMBER 2015

Time: 11:00 am

Location: MEETING ROOM G.01, GROUND FLOOR, CITY HALL, 115 CHARLES STREET, LEICESTER, LE1 1FZ

HEALTH AND WELLBEING BOARD

Councillors:

Councillor Rory Palmer, Deputy City Mayor (Chair)

Councillor Adam Clarke, Assistant City Mayor

Councillor Abdul Osman, Assistant City Mayor

Councillor Sarah Russell, Assistant City Mayor

City Council Officers:

Frances Craven, Strategic Director Children's Services

Andy Keeling, Chief Operating Officer and Acting Director Adult Social Care

Ruth Tennant, Director Public Health

1 Vacancy

NHS Representatives:

Professor. Azhar Farooqi, Co-Chair, Leicester City Clinical Commissioning Group

Sue Lock, Managing Director, Leicester City Clinical Commissioning Group

Dr Avi Prasad, Co-Chair, Leicester City Clinical Commissioning Group

Trish Thompson, Director of Operations and Delivery, NHS England Local

Healthwatch / Other Representatives:

Karen Chouhan, Healthwatch Leicester

Richard Clark, Chief Executive, The Mighty Creatives

Chief Superintendent, Sally Healy, Head of Local Policing Directorate, Leicestershire Police

Professor Martin Tobin, Professor of Genetic Epidemiology and Public Health and MRC Senior Clinical Fellow, University of Leicester.

Members of the Board are summoned to attend the above meeting to consider the items of business listed overleaf.

Members of the public and the press are welcome to attend.

G. J. Carey

For Monitoring Officer

City Mayor healthwatch Leicester Leicestershire Police Protecting our communities NHS Leicester City Clinical Commissioning Group NHS Commissioning Board

Information for members of the public

Attending meetings and access to information

You have the right to attend formal meetings such as full Council, committee meetings, City Mayor & Executive Public Briefing and Scrutiny Commissions and see copies of agendas and minutes. On occasion however, meetings may, for reasons set out in law, need to consider some items in private.

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- ✓ to respect the right of others to view and hear debates without interruption;
- ✓ to ensure that the sound on any device is fully muted and intrusive lighting avoided;
- ✓ where filming, to only focus on those people actively participating in the meeting;
- ✓ where filming, to (via the Chair of the meeting) ensure that those present are aware that they may be filmed and respect any requests to not be filmed.

Further information

If you have any queries about any of the above or the business to be discussed, please contact Graham Carey**, Democratic Support on (0116) 454 6356 or email graham.carey@leicester.gov.uk** or call in at City Hall, 115 Charles Street, Leicester, LE1 1FZ.

For Press Enquiries - please phone the **Communications Unit on 454 4151**

PUBLIC SESSION

AGENDA

NOTE:

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http://www.leicester.public-i.tv

An archive copy of the webcast will normally be available on the Council's website within 48 hours of the meeting taking place at the following link:-

http://www.leicester.public-i.tv/core/portal/webcasts

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1. APOLOGIES FOR ABSENCE

2. DECLARATIONS OF INTEREST

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

3. MEMBERSHIP OF THE BOARD

To note the membership of the Board for 2015/16 approved by the Council on 18 June 2015:-

City Councillors
Councillor Rory Palmer - Deputy City Mayor – Chair
Councillor Adam Clarke – Assistant City Mayor – Energy and Sustainability
Councillor Abdul Osman – Assistant City Mayor - Public Health
Councillor Sarah Russell – Assistant City Mayor – Children, Young People and Schools

NHS Representatives

Professor Azhar Farooqi – Co-Chair of the Leicester City Clinical Commissioning Group
Sue Lock, Managing Director - Leicester City Clinical Commissioning Group
Trish Thompson - Director of Operations and Delivery, Leicestershire and Lincolnshire NHS England
Dr Avi Prasad - Co-Chair of the Leicester City Clinical Commissioning Group

City Council Officers

Andy Keeling - Chief Operating Officer and Acting Director of Adult Social Care
Frances Craven - Strategic Director – Children's Services
Ruth Tennant - Director of Public Health
Note: Stephen Forbes will be joining the Council on 7 October 2015 as Strategic Director - Adult Social Care and will become a member of the Board.

Local Healthwatch and Other Representatives

Karen Chouhan - Chair, Healthwatch Leicester
Chief Supt Sally Healy - Head of Local Policing Directorate
Professor Martin Tobin - Professor of Genetic Epidemiology and Public Health
Richard Clark - Chief Executive, The Mighty Creatives

4. TERMS OF REFERENCE AND REQUEST FOR DELEGATION OF AUTHORITY TO THE CHAIR

Appendix A
Page 1

To note the Board's Terms of Reference approved by the Council on 18 June 2015. The Terms of Reference were amended to add the following responsibility at paragraph 3.14:-

> "The Board will agree Better Care Fund submissions and have strategic oversight of the delivery of agreed programmes."

Delegation of Urgent Action to the Chair – Better Care Fund

The Board is also requested to delegate authority to the Chair of the Board to 'sign off' information requested by NHS England about the Better Care Fund, or other data to be submitted by the Board when there is insufficient time for these to be considered at a formal Board meeting.

5. MINUTES OF THE PREVIOUS MEETING

Appendix B
Page 7

The Minutes of the previous meeting of the Board held on 26 March 2015 are attached and the Board is asked to confirm them as a correct record.

6. UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST - STRATEGIC PRIORITIES

Appendix C
Page 21

To receive a presentation from John Adler, Chief Executive, University of Leicester NHS Trust (UHL) the Trust's strategic priorities and current challenges.

7. LOCAL RESPONSE TO NHS 7 DAY WORKING

Appendix D
Page 35

To receive a report providing an update on progress in primary, community and acute care in implementing seven day services as directed by the Seven Day Services Forum.

8. GP RECRUITMENT AND RETENTION PLANNING

Appendix E
Page 39

To receive a report which sets out the detail of the plans which have been produced local and the progress that has been made in relation to the General Practice Incentive Scheme.

9. PUBLIC HEALTH BUDGET

Appendix F
Page 47

To receive a report on Leicester's response to the consultation on national plans to make in-year savings on the ring fenced public health grant to local councils, following the Government's announcement on 5 June 2015.

10. DATES OF FUTURE MEETINGS

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

Tuesday 27 October 2015
Tuesday 8 December 2015
Tuesday 2 February 2016
Tuesday 5 April 2016

Meetings of the Board are scheduled to be held in City Hall, at 2.00pm unless stated otherwise on the agenda for the meeting.

11. ANY OTHER URGENT BUSINESS

Appendix A

Leicester City Health and Wellbeing Board

Terms of Reference

(As amended at the Leicester City Council meeting on 18 June 2015)

Introduction

In line with the Health and Social Care Act 2012, the Health & Wellbeing Board is established as a Committee of Leicester City Council.

The Health & Wellbeing Board has operated in shadow form since August 2011. In April 2013, the Board became a formally constituted Committee of the Council with statutory functions.

1 Aim

To achieve better health, wellbeing and social care outcomes for Leicester City's population and a better quality of care for patients and other people using health and social services.

2 Objectives

2.1 To provide strong local leadership for the improvement of the health and wellbeing of Leicester's population and in work to reduce health inequalities.

2.2 To lead on improving the strategic coordination of commissioning across NHS, adult social care, children's services and public health services.

2.3 To maximise opportunities for joint working and integration of services using existing opportunities and processes and prevent duplication or omission.

2.4 To provide a key forum for public accountability of NHS, public health, social care for adults and children and other commissioned services that the Health &Wellbeing Board agrees are directly related to health and wellbeing.

3 Responsibilities

3.1 Working jointly, to identify current and future health and wellbeing needs across Leicester City through revising the Joint Strategic Needs Assessment (JSNA) as and when required. Preparing the JSNA is a statutory duty of Leicester City Council and Leicester City Clinical Commissioning Group.

3.2 Develop and agree the priorities for improving the health and wellbeing of the people of Leicester and tackling health inequalities.

3.3 Prepare and publish a Joint Health and Wellbeing Strategy (JHWS) that is evidence based through the work of the Joint Strategic Needs Assessment (JSNA) and supported by all stakeholders. This will set out strategic objectives, ambitions for achievement and how we will be jointly held to account for delivery. Preparing the JHWS is a statutory duty of Leicester City Council and Leicester City Clinical Commissioning Group.

3.4 Save in relation to agreeing the JSNA, JHWS and any other function delegated to it from time to time, the Board will discharge its responsibilities by means of recommendation to the relevant partner organisations, who will act in accordance with their respective powers and duties

3.5 Ensure that all commissioners of services relevant to health and wellbeing take appropriate account of the findings of the Joint Strategic Needs Assessment and demonstrate strategic alignment between the JHWS and each organisation's commissioning plans.

3.6 Ensure that all commissioners of services relevant to health and wellbeing demonstrate how the JHWS has been implemented in their commissioning decisions.

3.7 To monitor, evaluate and annually report on the Leicester City Clinical Commissioning Group performance as part of the Clinical Commissioning Groups annual assessment by the national Commissioning Board.

3.8 Review performance against key outcome indicators and be collectively accountable for outcomes and targets specific to performance frameworks within the NHS, Local Authority and Public Health.

3.9 Ensure that the work of the Board is aligned with policy developments both locally and nationally.

3.10 Provide an annual report from the Health and Wellbeing Board to the Leicester City Council Executive and to the Board of Leicester City Clinical Commissioning Group to ensure that the Board is publically accountable for delivery.

3.11 Oversee progress against the Health and Wellbeing Strategy and other supporting plans and ensure action is taken to improve outcomes

3.12 The Board will not exercise scrutiny duties around health and adult social care directly. This will remain the role of the relevant Scrutiny Commissions of Leicester City Council. Decisions taken and work progressed by the Health & Wellbeing Board will be subject to scrutiny by relevant Scrutiny Commissions of Leicester City Council.

3.13 The Board will need to be satisfied that all commissioning plans demonstrate compliance with the Equality Act 2010, improving health and social care

services for groups within the population with protected characteristics and reducing health inequalities.

3.14 The Board will agree Better Care Fund submissions and have strategic oversight of the delivery of agreed programmes.

4 Membership

Members:

Up to four Elected Members of Leicester City Council (4)

- The Executive Lead Member for Health & Wellbeing (1)
- An Elected Member nominated by the City Mayor (1)
- An Elected Member nominated by the City Mayor (1)
- An Elected Member nominated by the City Mayor (1)

Up to four representatives of the NHS (4)

- The Co -Chair of the Leicester City Clinical Commissioning Group (1)
- A further GP representative of the Leicester City Clinical Commissioning Group (1)
- The Managing Director of the Leicester City Clinical Commissioning Group (1)
- The Director of the Leicestershire and Lincolnshire Area Team, NHS England (1)

Up to four Officers of Leicester City Council (4)

- The Strategic Director of Adult Social Care (Leicester City Council) (1)
- The Strategic Director Children (Leicester City Council) (1)
- The Director of Public Health (Leicester City Council) (1)
- The Chief Operating Officer of Leicester City Council (1)

Up to four further representatives including Healthwatch Leicester/Other Representatives (4)

- One representative of the Local Healthwatch organisation for Leicester City (1)
- Leicester City Basic Command Unit Commander, Leicestershire Police (1)
- Two other people that the local authority thinks appropriate, after consultation with the Health and Wellbeing Board (2)

5 Quorum & Chair

5.1 For a meeting to take place there must be at least six members of the Board present and at least one representative from each of the membership sections:

- Leicester City Council (Elected member)
- Leicester City Clinical Commissioning Group or NHS England

- One senior officer member from Leicester City Council
- Local Healthwatch/Other Representatives

5.2 Where a meeting is inquorate those members in attendance may meet informally but any decisions shall require appropriate ratification at the next quorate meeting of the Board.

5.3 Where any member of the Board proposes to send a substitute to a meeting, that substitute's name shall be properly nominated by the relevant 'parent' person/body, and submitted to the Chair in advance of the meeting. The substitute shall abide by the Code of Conduct.

5.4 The City Council has nominated the Executive Lead for Health & Wellbeing to Chair the Board. Where the Executive Lead for Health & Wellbeing is unable to chair the meeting, then one of the other Elected Members shall chair (noting that at least one other Elected Member must be present in order for the meeting to be declared quorate)

6 Voting

6.1 Officer members of Leicester City Council shall not have a vote. All other members will have an equal vote

6.2 Decision-making will be achieved through consensus reached amongst those members present. Where a vote is require decisions will be reached through a majority vote of voting members; where the outcome of a vote is impasse the chair will have the casting vote.

7 Code of conduct and member responsibilities

All voting members are required to comply with Leicester City Council's Code of Conduct, including submitting a Register of Interests.

In addition all members of the Board will commit to the following roles, responsibilities and expectations:

7.1 Commit to attending the majority of meetings

7.2 Uphold and support Board decisions and be prepared to follow though actions and decisions obtaining the necessary financial approval from their organisation for the Board proposals and declaring any conflict of interest

7.3 Be prepared to represent the Board at stakeholder events and support the agreed consensus view of the Board when speaking on behalf of the Board to other parties. Champion the work of the Board in their wider networks and in community engagement activities.

7.4 To participate in Board discussion to reflect views of their partner organisations, being sufficiently briefed to be able to make recommendations about future policy developments and service delivery

7.5 To ensure that are communication mechanisms in place within the partner organisations to enable information about the priorities and recommendation of the Board to be effectively disseminated

8 Agenda and Meetings

8.1 Administration support will be provided by Leicester City Council.

8.2 There will be standing items on each agenda to include:

- Declarations of Interest
- Minutes of the Previous Meeting
- Matters Arising
- Updates from each of the working subgroups of the Health & Wellbeing Board.

8.3 Meetings will be held six times a year and the Board will meet in public and comply with the Access to Information procedures as outlined in Part 4b of the Council's Constitution

8.4 The first meeting of the Health and Wellbeing Board was on 11 April 2013

Version 9.2
As amended at Council on 18 June 2015

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.

University Hospitals of Leicester NHS Trust

SPECIAL DELIVERY 2015-20

Delivering Caring at its best

Appendix C

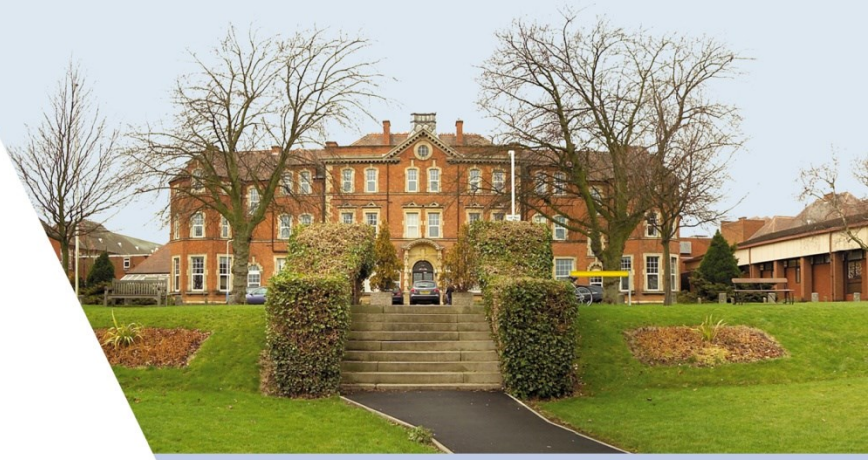
Our 5 Year Plan

July 2015

Delivering
Caring at its best

#hello my name is…

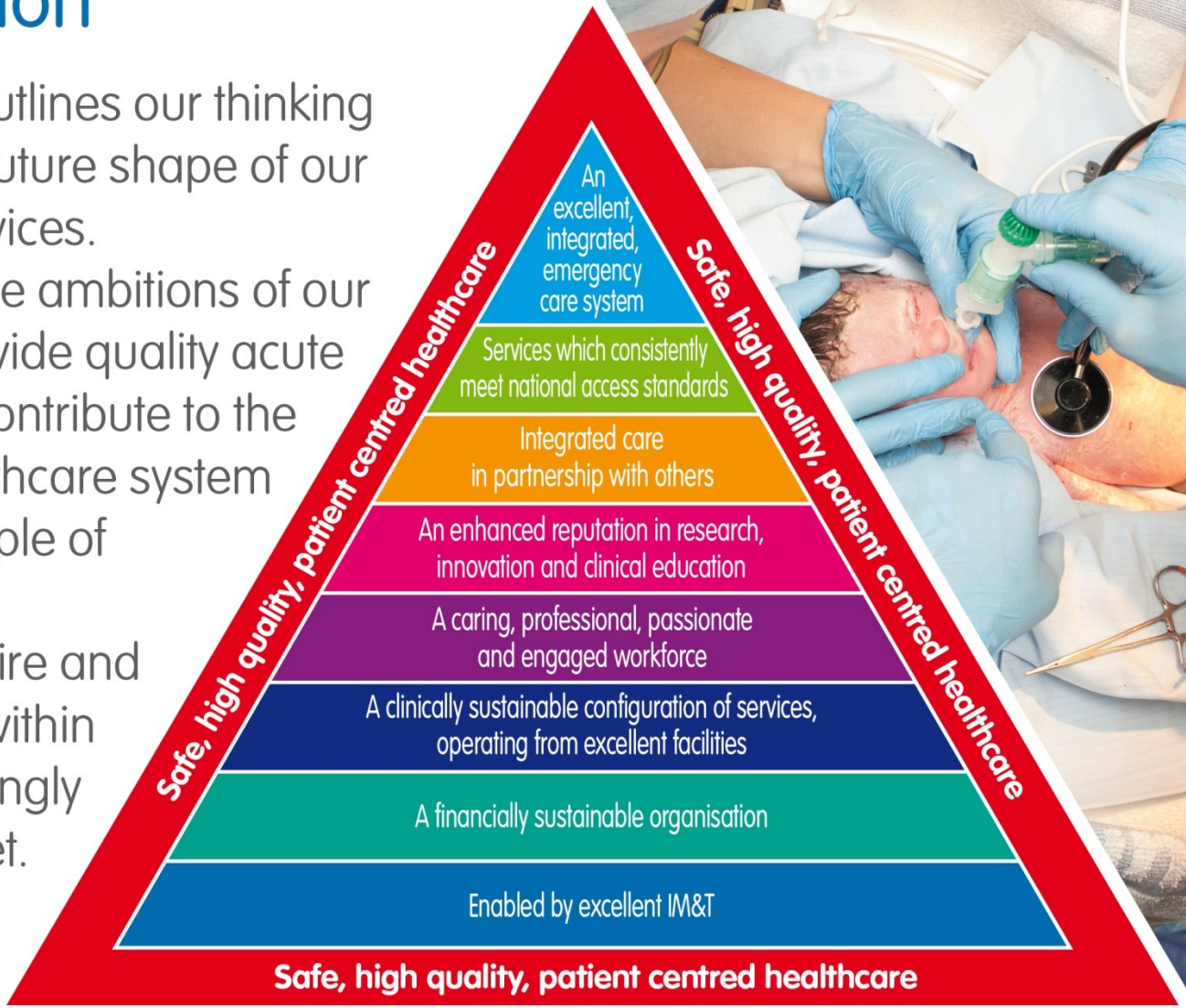
John Adler
Chief Executive



@Leic_hospital #5YrPlan
www.leicestershospitals.nhs.uk

Our vision

Our plan outlines our thinking about the future shape of our clinical services.
It reflects the ambitions of our staff to provide quality acute care and contribute to the wider healthcare system for the people of Leicester, Leicestershire and Rutland... within an increasingly tight budget.



How do we behave on this journey?

We treat people how we would like to be treated

We do what we say we are going to do

We focus on what matters most

We are passionate and creative in our work

We are one team and we are best when we work together

Safe, high quality, patient centred healthcare

Quality Commitment

	Clinical Effectiveness Improve Outcomes	Patient Safety Reduce Harm	Patient Experience Care and Compassion
Aim	To reduce preventable mortality	To reduce the risk of error and adverse incidents	To improve patients' and their carers' experience of care
2015/2016 Priorities	**Improve pathways of care:** • Review of all in-hospital deaths • Use of clinical benchmarking tools • Identify actions and work-streams where greatest potential for preventable mortality **Improve Consistency of 7 Day Services** • In line with Keogh 10 Clinical Standards **Learning and Development** Implementation of Trust M&M Database for shared learning across all areas	**Earlier Recognition & Rescue of the Deteriorating Patient** • Sepsis • Handover • Early Warning Scores • Acting on results **Consistencies in Core Practices** • Medication Safety • Infection Prevention **Learning and Development** Implementation of Safety Briefings in wards and departments	**Further expand end of life care processes** • Early identification of patients requiring supportive and palliative care (SPICT) • Strengthen bereavement support **Improve the experience of care for older people across the Trust** • 'Fixing the Basics' • Improve the Environment **Learning and Development** Triangulation and review of feedback from all sources and all key characteristic groups

An excellent, integrated emergency care system

- Improved primary care to anticipate and prevent admissions
- Improved hospital processes that design out delays
- Improved discharge processes which get the patient home safely and quickly

Services which consistently meet national access standards

- Redesigning services to cope with growing volumes and moving some into other settings
- Separating planned care from emergency care to reduce cancellations
- Building a Planned Care Treatment Centre
- To create the 'lowest wait teaching Trust in the country' by 2016/17

Integrated care in partnership with others

- Gaps in the system
- Joining up expert generalists (GPs) with specialists in hospital
- Partnerships and alliances with other hospitals to help them maintain services and protect our own
- For the first time a 5 year plan not just for UHL but the whole health and social care system... "Better Care Together"

Better care **together**

A partnership of Leicester, Leicestershire & Rutland Health and Social Care

An enhanced reputation in research, innovation education

- Research and education sets us apart
- Income, talent and new treatments for our patients
- 100,000 Genomes, Life Study, Breathonomics, Institute for Older People's Health
- Closer links with Universities

Clinically sustainable services, operating from excellent facilities

- Under investment for years... now £320m over next five
- Three big acutes for the size of population and duplication / triplication of services.

Major Building Projects - High Level Indicative Programme

	Project Title	2014/15	2015/16	2016/17	2017/18	2018/19	2019/20
	Emergency Floor						
ICU schemes	Interim Enablers at Leicester Royal Infirmary						
ICU schemes	Interim Enablers & Vascular Support to Glenfield						
ICU schemes	Interim beds at Leicester Royal Infirmary & Glenfield						
ICU schemes	Additional permanent ICU capacity						
Vascular	Vascular Hybrid Theatre						
Beds	Wards Glenfield						
Beds	Wards Leicester Royal Infirmary						
Children's	Interim East Midlands Congenital Heart Centre						
Children's	Children's Hospital Leicester Royal Infirmary						
	Treatment Centre						
	Women's Services						

Business case
Construction
Rolling refurbishment

Financially sustainable organisation

- Last year's deficit was £40m savings of £48m
- Currently most services spend more than they earn
- Running 3 acute sites is wasteful
- Spending too much on agency and locums
- 'Delivering Caring at its Best' will return us to balance

Enabled by excellent IM&T

- Some of the smartest clinical tech on the planet vs notes in shopping trolleys!
- The Electronic Patient Record will be a game changer.
- Full patient history at the touch of a hand to enable faster decision making and better care.

Caring, professional, passionate and engaged workforce

- Without you we are nothing... 1 in every 100 people in City, Leicestershire and Rutland work for us.
- If you think the hospitals do a good job and are a good place to work people listen, if you don't they still listen.
- Only half of staff would recommend us as a place to work
- A third of staff wouldn't recommend their hospitals as a place to be treated.
- ... We need to talk!

The two minute vision

- Safe, quality, patient centred care
- Delivered from 2 rather than 3, acute hospitals as simpler care moves to the community
- Hospitals and processes quicker and easier to navigate
- With more investment in buildings
- Less DGH care, but specialist services grow through partnerships and networks
- Research and talent combine to make Trust attractive to new staff, whilst staff engagement improves
- Restoring pride, returning to balance and 'Delivering Caring at its Best'.

Appendix D

LEICESTER CITY HEALTH AND WELLBEING BOARD
DATE

Subject:	Seven Day Services
Presented to the Health and Wellbeing Board by:	Sue Lock, Managing Director, Leicester City CCG
Author:	Rachna Vyas, Deputy Director of Strategy, Leicester City CCG

EXECUTIVE SUMMARY:

This paper provides the HWB with an update on progress in primary, community and acute care in implementing seven day services as directed by the Seven Day Services Forum.

RECOMMENDATIONS:

The Health and Wellbeing Board is requested to:

RECEIVE the paper

Seven Day Services

1. Everyone Counts: Planning for patients 2013/14 committed the NHS to move towards routine services being available seven days a week. A Forum was established to provide evidence and insight to support commissioners and providers to make this happen and to focus, in a first stage, on urgent and emergency care services and their supporting diagnostic services.

2. The Forum's Summary of Initial Findings was presented to the Board of NHS England in December 2013. Its recommendations included that by 2016/17 the NHS should adopt 10 evidence-based clinical standards to end current variations in outcomes for patients admitted to our hospitals at the weekend. NHS England's Board agreed to all of the Forum's recommendations, including full implementation of the clinical standards.

3. One of the Forum's concerns was that the scope of their first stage of work was limited to the services patients receive while inpatients in hospital, because of the weight of evidence about the risks to people admitted as emergencies at weekends. They flagged that if patients are to experience genuine seven day care, changes in the NHS will need to be accompanied by similar improvements across primary and community health services and social care.

4. NHS England Board agreed with that analysis and asked the Forum to broaden its remit, to include the creation of a fully integrated service delivering high quality treatment and care seven days a week.

5. Since then, these key messages have been reinforced in both Five Year Forward View publications in Oct 2014 and June 2015. This paper provides the HWB with an update on progress in primary, community and acute care.

Section 1: Primary Care

6. NHS England invited GP surgeries to apply for funding through the Prime Minsters Challenge Fund to pilot improvements in accessing General Practice. Part of the challenge for application was the provision of high quality access to General Practice across the seven day period.

7. Leicester City practices bid for this funding and were successfully allocated £3.2m to pilot a number of initiatives which will promote seven day access to primary care including:

Initiative	Local plan	Status
Longer opening hours, such as extended weekday opening (e.g. 8am to 8pm) and opening on Saturdays and Sundays	Implementation of 4 primary care hubs, offering extended hour access to General Practice from 6.30pm to 10pm daily and 9am to 10pm on weekends	Phased launch in September 2015
Greater use of patient online services including online systems of patient registration	A remote access doctor service covering eight specific conditions, allowing patients to receive a clinical consultation online, from anywhere, at any time.	Launch planned for October 2015

8. The project is expected to:

- Bring significant improvement in seven day access to high-quality services, contributing to improved patient experience and outcomes
- Mitigate the local challenges of clinician recruitment through increased productivity. This will be made possible by using established technology which has a robust track record in the private sector but has never been used before in the NHS
- Drive strong financial savings by (a) shifting care to low-cost settings and (b) achieving whole system savings by improving health outcomes

9. These initiatives will be robustly evaluated in order to assess patient experience and access as well as future viability of both models.

Section 2: Community services

10. Locally, across the city, there are already specific community health and social care services available over the weekend but it has been recognised that traditionally these have been poorly utilised, both for admissions avoidance and discharge. Test weekends (run during 2014) evidenced that a more integrated model of seven-day working across front-line health and social care is vital for a more responsive and patient-centred service.

11. Our Better Care Fund plans included seven-day working (where applicable & feasible) as a standard expectation to support the flow across the health and social care system. For example, most schemes mobilised in 2014/15 through the Better Care Fund were on a seven-day service expectation. This included the Clinical Response Team, the Unscheduled Care team and the Planned Care Team in the first instance; each of these has proven that integrated seven day services provide not only high quality care for our patients but tremendously aids flow through the wider urgent care system.

12. In 15/16, as the Primary care hubs described in section 1become live, all BCF services and the hubs will be provided with induction packages to ensure that the hubs become an integrated part of the pre-hospital package for our patients.

Section 3: Acute Care

13. The Seven Day Services programme has been given a high priority at UHL and is an integral part of the Trust's Quality Commitment. The Quality Commitment sets out to improve safety and quality across all clinical services, and sets out to improve consistency in services across 7 days in line with Keogh's 10 Clinical Standards.

14. In 2014/15 UHL was involved in the East Midlands collaborative of 10 Acute Trusts commissioned by the East Midlands Clinical Senate and Strategic Clinical Networks to: assess current service provision against the 10 clinical standards, and identify any gaps. This has now been completed.

15. For 2015/16, UHL's commissioners required five of the clinical standards to be improved upon by 31st March 2016, see Table 1 below. The Trust is working on all 10 clinical standards, with those providing the biggest challenge to be improved on by end of 2016/17. Some of the identified challenges include issues regarding capacity and the need for investment. All 10 hospitals in the East Midlands collaborative identified the need for investment to achieve the standards; however, investment for the programme has yet to be identified.

Table 1: Five clinical standards with milestones for achievement by end of 2015/16

CLINICAL STANDARD	MILESTONES	BENEFIT	On Track
1 Patient Experience	Analyse patient survey data across seven days in assessment units. Complete patient survey. Implement improvement plans where variance identified	Improved clinical pathway with better outcomes for patients	G
4 Shift Handover	Implement electronic handover for Medical staff		G
6 Intervention/ Key Services	Evidence key interventions and services meet specialty standards		G
9 Transfer to Community, Primary and Social Care	Identify work actioned from BCT Programme supporting this standard and evidence against standard		A
10 Quality Improvement	Monitor key outcomes over seven days. E.g. LOS; mortality; discharge; readmissions. Create a dashboard to monitor over 7 days		G

Section 4: Conclusions

16. The health and social care community in Leicester City continues to work across boundaries to successfully provide our patients with accessible, high quality services across seven days. Through 15/16 and into 16/17, we will continue to identify further areas which require further work to strengthen and integrate care around our population needs.

RECOMMENDATIONS:

The Health and Wellbeing Board is requested to:

RECEIVE the paper

Appendix E

LEICESTER CITY HEALTH AND WELLBEING BOARD
DATE

Subject:	GP Recruitment Plan
Presented to the Health and Wellbeing Board by:	Sue Lock, Managing Director Leicester City Clinical Commissioning Group
Author:	Sarah Prema, Director Strategy and Implementation

EXECUTIVE SUMMARY:

There is a national and local shortage of General Practioners, to address this there are a number of initiatives being undertaken. At a national level NHS England has published a 10 Point Plan *"Building the Workforce – the New Deal for General Practice"* and local level response to this is the Leicester, Leicestershire and Rutland Delivery Group Plan. At a city level a General Practice Incentive Scheme and Action Plan has been developed.

This paper sets out the detail of each of the plans and progress in relation to the General Practice Incentive Scheme.

RECOMMENDATIONS:

The Health and Wellbeing Board is requested to:

NOTE the work being done to support General Practice recruitment in Leicester City.

GP Recruitment Plan

1. Leicester City residents have high levels of health need, placing considerable demands on health and social care services in the city. Life expectancy is improving, as elsewhere, but remains significantly worse than England and East Midlands and the life expectancy gap with England is widening. Life expectancy is a key proxy measure of overall health.

2. To address these challenges a robust sustainable GP workforce is paramount. Until fairly recently, Leicester City practices were almost exclusively run on a GP partner basis, with occasional use of locums to cover study, sickness or holiday absence. More recently, there has been a significant growth in locum and salaried GPs, with fewer being attracted to the partnership model.

3. Younger doctors are showing a growing reluctance to become partners, with more of them enjoying a portfolio of different roles, one of which is as salaried or locum GPs. Numbers going through GP training are falling and for those that do complete training, they are anecdotally reported as not being attracted to working in the City.

4. The latest information indicates that Leicester now has a GP workforce made up of almost equal thirds of partners, salaried GP and locums. Sixty GP partners are likely to retire in the next 5 to 10 years – (60 out of a total of 121 partners are 50 or over, which is almost 50%). Fewer newly qualified doctors are moving into primary care, 43% of training places remain unfilled in 2015/16 in the East Midlands.

5. The issues within General Practice are recognised at a national level and NHS England has recently published a 10 Point Plan to improve the recruitment and retention in General Practice – *"Building the Workforce – the New Deal for General Practice"*. This paper provides an overview of the plan. This paper sets out the detail of the 10 Point Plan and the Leicester, Leicestershire and Rutland response to this.

6. The current structure of practice-based primary care provision is likely to undergo severe instability if new doctors cannot be attracted into the system to take their place. Effective recruitment is key to maintaining the City's local primary medical care services and therefore an urgent priority. To address this Leicester City Clinical Commissioning Group and NHS England in conjunction with Leicester City Council launched a recruitment incentive scheme in 2014. This paper also gives an overview of progress with this scheme and the next steps.

10 Point Plan - *"Building the Workforce – the New Deal for General Practice"*

7. NHS England, Health Education England and the British Medical Association GPs Committee are working together to ensure that there is a skilled, trained and motivated workforce in general practice. The result is the 10 Point Action Plan to address immediate issues and to take the initial steps in building the workforce for the future and the new models of care. It is part of the implementation of the Five Year Forward view and the New Deal for General Practice. The 10 Point Plan is:

1	There will be a marketing campaign, including a letter to all newly qualified doctors setting out the positive aspects and future careers in general practice.
2	Health Education England are working to resource an additional year of post CCT training to candidates seeking to work in areas where it is hard to recruit

	trainees. The additional year could in a related clinical speciality; leadership development; an academic programme of activity; or an aspect of medical education and training related to the primary and community care agenda.
3	There will be investment in the development of pilot training hubs, where groups of GP practices can offer inter-professional training to primary care staff, extending their skill base within general practice and developing a workforce that can meet the challenges of new ways of working.
4.	Time-limited incentive schemes to offer additional financial support to GP trainees committed to working in specific areas for 3 years will be explored.
5.	A review of the current retainer scheme will be undertaken and invest in a new national scheme.
6.	Through the GP Infrastructure Programme more training capacity will be created.
7.	A detailed review will be undertaken to identify the most effective measures to encourage experienced GPs to remain within practice. Options may include a funded mentorship scheme, opportunities to develop a portfolio career towards the end of your working life, and a clearer range of career pathways.
8.	Identify key workforce initiatives that are known to support general practice – including physician associates, medical assistants, clinical pharmacists, advanced practitioner, healthcare assistants and care navigators.
9.	New induction and returner scheme will be published recognising the different needs of those returning from work overseas or from a career break.
10.	Additional investment will be made to attract GPs back into practice increasing over time. Targeted at the areas of greatest need, the scheme will offer resources to help the costs of returning and the cost of employing these staff. A review of the performers list in its current state and its value will be undertaken.

8. The Leicester, Leicestershire and Rutland General Practice Delivery Group have developed a work programme that responds to the 10 Point Plan this is attached as Appendix 1.

Leicester GP Recruitment Incentive Pilot

9. The GP Recruitment Incentive Pilot for Leicester City Practices scheme, was developed in November 2014 and driven by the fact that practices in the city where finding it difficult to recruit GPs, both partners and salaried GPs. It was paramount to proactively do something about this to ensure local primary medical care services could continue to be delivered.

10. The scheme is an incentive based recruitment scheme with the aim of supporting practices to successfully recruit to vacancies and maintain a stable GP workforce. Eligible practices applied for recruitment incentives to appoint to posts aligned to specific criteria.

11. The scheme is currently administered by Leicester City CCG, NHS England Area Team and the Local Authority. The funding of up to £250,000 will be held by the Local Authority (Leicester City Council) and any recouped funding will be paid back into the fund held by the Local Authority.

12. In all 22 practices applied to the scheme for assistance and each application was assessed by a panel. There were 17 practices that were eligible for funding, within the budget limit of the scheme, one practice withdrew post award.

13. Seven practices have advised that recruitment has been successful but two of these recruited from with the Leicestershire and Lincolnshire area and therefore they are not eligible for the incentive payment. The remaining practices are still actively trying to recruit, three for the second time. To date £28,012 has been allocated to those practices who have successfully recruited.

14. Given that even with the incentive scheme recruitment still seems to be difficult Leicester City Clinical Commissioning Group has developed a local action plan to work in conjunction with the Leicester, Leicestershire and Rutland Delivery Group 10 Point Plan to support the recruitment of GPs. The emphasis of this local plan is on promoting the city as a place to work and live. The actions are detailed in Appendix 2.

Summary

15. Recruitment of GPs in the city is still a challenge despite the availability of an incentive scheme. Action is being taken at Leicester, Leicestershire and Rutland and city level to address these challenges.

16. The LLR work plan concentrates on promoting general practice as a career for newly qualified doctors; supporting the development of the wider primary care workforce to deliver new models of care; and develop training opportunities.

17. The city plan concentrates on selling the city as a place to live and work.

Appendix 1

LLR General Practice Delivery Group Work Programme

Scheme	Key Objectives of Scheme	Cross-Reference to 10-point Plan	Actions	Lead	Delivery Date / Review Date
Promote Awareness of LLR General Practice Workforce Delivery Group	To positively market general practice across LLR	**1**	1) Develop a work programme and achieve sign off by Let-C	AB	June
			2) Present Terms of Reference and work programme to CCG Quality committees for note	AB/SP/TS	
			3) Develop a role of GP workforce health ambassadors, aim for 10 locally	KA	July
			4) Promote the purpose and value of this group and its work programme to general practices in LLR via PLTs / workshops	AB	May
			5) To positively market the group to DMU and other HEI's for nursing.	Nursing Leads	Sept
Improving Recruitment in General Practice	To identify and implement approaches to support local recruitment within general practice	**2, 4, 5, 7, 9, 10**	1) Promote and secure Post-certificate of completion of training Fellowship posts in LLR. Aim for 4 fellowships in LLR	CB/PG/AF	August
			2) Golden Hello scheme - undertake evaluation and make recommendations for future schemes across LLR	BW / IP	August
			3) Scope, Promote and increase the number of HCA apprenticeships (Bands 1-4) in general practice (target to be confirmed) - Implementation plan to be developed	KA KA	Mar-16
			4) Increase pre-reg nurse training placements in general practice, link to CEPN development	Nursing Leads	Sept
			6) To scope innovative recruitment models for practice nursing to aid recruitment	Nursing Leads	Sept
Improve Retention in General Practice	To identify and implement approaches that's actively seek to retain out local practice workforce	**2, 4, 5, 7, 9, 10**	1) To identify professional development opportunities to support nursing revalidation	Nursing Leads	Mar-16
			2) Promote current retainer scheme opportunities for GP's through communication campaign	CB	TBC
			3) To actively participate in the HEE approach to attract GPs back into general practice	CB	TBC
			4) To pilot / deliver a model for a coordinated education programme in dermatology for GPs, GP trainees and front-line Allied Healthcare Professionals. The model aims to utilise novel IT solutions to deliver and assess education and could be transferable to other specialty areas, enabling the promotion of a coordinated LLR General Practice CPD strategy	PG	Mar-16
			5) To learns lessons from the Notts/Derby mentoring pilot	AB	Sept

Scheme	Key Objectives of Scheme	Cross-Reference to 10-point Plan	Actions	Lead	Delivery Date / Review Date
Undertake LLR wide General Practice workforce survey	To develop the wider primary care workforce including new ways of working and extended roles / new primary care practitioners to support the capacity and capability in general practice	**1, 6, 8**	1) Undertake an LLR wide workforce survey	BW	June
			2) Evaluate the survey	BW	August
			3) Develop a local TNA based on the survey results which; - Targets the existing primary care workforce to identify new capabilities, competencies, skills and behaviours to support an enhanced primary care offer. - Identifies new capabilities of new staff groups (physicians associates) to increase general practice capacity to free up GPs time to manage increased complexities - identifies roles and competencies that sit outside of primary care that will be requires to support the left shift, e.g. AHPs, Pharmacists, ECPs, Secondary care clinicians.	BW	November
			4) Learn lesson from the physicians associates scheme in LCCCG	BW	TBC
Improving the training capacity in General Practice	To work to develop a broad range of multi-professional training opportunities in general practice	**1, 6, 8**	1) Scope the number of qualified nurse mentors and develop further capacity for training opportunities	Nursing Leads	Oct
			2) Implement and evaluate the undergraduate support scheme with detailed project plan	BW	Mar-16
			3) To increase practice training capacity through the allocation of the primary care infrastructure fund	AB/TS/SP	September
			4) Jointly with the deanery, develop a prospectus promoting general practices in LLR to undergraduate students and foundation doctors	PG	Mar-16
			5) Improve the training and development opportunities for HCA's in general practice - - Scope and develop training opportunities for HCA to inform spend of wider workforce development allocation - Scope and Develop transition to pre-reg nursing for HCAs - Promote the implementation of the Care Certificate in general practice for HCAs	PF/WH/AS PF PF	Oct Dec Sept
			6) Review General Practice Training and Development Group and hosted funding arrangements, making recommendations for the future	C'OB	Sept
			7) Ensure access and enablers to learning and evidence base for general practice	PF	Nov
			8) Scope and develop professional development opportunities for practice managers	AB / TS	Nov
Develop LLR local training hubs	Develop and implement local training hubs to promote multiprofessional learning and develop aiding recruitment and	**3**	1) Undertake scoping exercise to determine LLR approach to the development of training hubs	BW	July
			2) To develop further CEPNS as a result of scoping exercise to ensure CEPN coverage in each CCG area	AB	Mar-16

APPENDIX 2

Task	Outcomes	Who	Timescale
Contact participating practices, gather latest information on: • Successful practice recruitment • Agree to consider a newly qualified GP who could combine practice and the MSc • What steps taken to try and recruit • Issues and blocks preventing successful GP recruitment	• Numbers of new recruits • Option to fill more vacancies • A clearer understanding of issues facing practices • Start of lessons learned intelligence to identify what works and what doesn't	BW CS	End September 2015
Engage with HEEM with a view to liaising with ST3s and registrars, to identify what would attract them to work in Leicester	• Start of lessons learned intelligence to identify what works and what doesn't; blocks to working in Leicester • Focus on engaging with registrars	BW	End September 2015
Survey with all LCCCG GP practices to identify those who have recently recruited GPs and identify • What worked • How did they get it to work	• Start of lessons learned intelligence to identify what works and what doesn't • Gap analysis between practice profiles which attract recruits and those who don't • what worked, what didn't work	BW	End September 2015
Develop a contact list of areas outside of Leicester to learn of their approach and what do they do that works	• Development of ideas and options open to LCCCG • Understand what other countries such as Canada and Australia are using to attract GPS	BW	End September 2015
Develop selling points for LCCCG which are different to other areas	• Develop propositions markedly different to other areas e.g.	RM	End October 2015
Develop and sell the Leicester City story	• Marketing material to sell the City and break the stereo type that may exist	RM	End October 2015
Look to develop and use the armed forces resettlement programme	• Identify how the scheme works • Develop an approach for LCCCG to 'tap-into' the scheme and see what clinical resource will becoming available	CS	End December 2015
Organise a session at PLT for a forum group to identify what we can do; what is good and works.	• Lessons learned intelligence to identify what works and what doesn't • Develop propositions markedly different to other areas e.g. • What steps taken to try and recruit • Issues and blocks preventing successful GP recruitment	BW	September 2015

Appendix F

LEICESTER CITY HEALTH AND WELLBEING BOARD
DATE

Subject:	Public Health budget: in year reductions
Presented to the Health and Wellbeing Board by:	Ruth Tennant, Director of Health
Author:	Ruth Tennant, Director of Health

EXECUTIVE SUMMARY:

This paper provides the Board with a briefing on national plans to make in-year savings on the ring-fenced public health grant to local councils.

RECOMMENDATIONS:

The Health and Wellbeing Board is requested to note the content of the paper and to receive an update once the results of the consultation are announced.

Health and Wellbeing Board Briefing

Public health budget: in-year reductions

Lead director: Ruth Tennant

Ward(s) affected: All

Report author: Ruth Tennant, Director of Public Health

Author contact details: ruth.tennant@leicester.gov.uk

1.0 Purpose of Briefing

To provide the Health and Wellbeing Board with a briefing on national plans to make in-year savings on the ring-fenced public health grant to local councils.

2.0 Background

In 2013, responsibility for public health transferred from the NHS to upper-tier councils. Public health is funded through a ring-fenced allocation from the Department of Health.

This funding supports a number of public health services and programmes including school nursing, the national child measurement programme, drugs and alcohol services, stop smoking services, healthy weight and physical activity, sexual health, NHS Health-checks.

The grant supports nationally mandated requirements to provide public health advice to the NHS and to protect the public from threats to health. It also gives councils discretion to allocate funding on the basis of local needs and local priorities: locally, for example, this funding has been used to pay for outdoor gyms.

From October 2016, public health will also take responsibility (and associated funding) for local health visiting services.

The public health allocation is based on a number of factors, including local health need and historical spending on public health. Leicester's public health allocation in 2015/16 was £21.9 million.

3.0 Changes to the public health allocation in 2015/16

On the 5th June, the Chancellor announced proposals to make a £200 million cut to "non-NHS services" funded by the Department of Health. Locally, this would amount to approximately £1.6 million pounds. This would apply to the current year's allocation.

A consultation on the proposals took place for one month, ending on the 28th August. This set out four options:

A. Devise a formula that claims a larger share of the saving from local authorities (LAs) that are significantly above their target allocation.
B. Identify LAs that carried forward unspent reserves into 2015/16 and claim a correspondingly larger share of the savings from them.
C. Reduce every LA's allocation by a standard, flat rate percentage.

D. Reduce every LA's allocation by a standard percentage unless an authority can show that this would result in particular hardship.

The consultation does not explicitly state the criteria to be used to assess these options, although the DH preference is for option C as the "simplest and most transparent".

The impact of these options for Leicester and other councils in the East Midlands is set out below:

	Original 2014-15 allocation £000s	Original 2014-15 target £000s	Distance from target £000s	Distance from target %	0-5 funding £000s	Estimated cuts on: Option A £000s	Option B £000s	Option C £000s
Derby	14.5	16.9	- 2.5	-14.5%	0.3	0.4	-	1.1
Leicester	22.0	26.1	- 4.1	-15.7%	0.4	0.5	-	1.6
Rutland	1.1	0.9	0.2	17.2%	0.0	0.2	0.3	0.1
Nottingham	27.8	26.8	1.1	3.9%	0.5	3.0	1.0	2.1
Derbyshire	35.7	32.0	3.6	11.3%	0.5	5.9	4.4	2.5
Leicestershire	21.9	23.2	- 1.3	-5.8%	0.3	0.5	-	1.6
Lincolnshire	28.5	30.0	- 1.5	-5.0%	0.4	0.7	1.2	2.0
Northamptonshire	29.5	32.5	- 3.0	-9.1%	0.5	0.7	8.7	2.1
Nottinghamshire	36.1	36.4	- 0.3	-0.8%	0.6	2.3	4.4	2.6
East Midlands total	**217.1**	**224.9**	**- 7.8**	**-3.5%**	**3.6**	**14.2**	**20.0**	**15.7**

4.0 Response to proposals

Locally, representations have been made against these changes to the Department of Health, via the Association of Directors of Public Health and through a number of other routes, covering the following key points.

- The majority of the grant allocation is in contracts with NHS organisations and other providers, including the voluntary sector. Financial commitments have therefore been made for the duration of the financial year.
- The public health allocation supports national commitments to invest in prevention, set out in the NHS's Five Year Vision. This makes it clear that investment in prevention is essential to reducing the burden of ill-health and to the financial stability of the NHS.
- Contrary to national announcements, the ring-fenced allocation funds key front-line services, such as drug and alcohol treatment services and screening programmes such as NHS Health-checks.

A formal response has been made to the Department of Health, pointing out the local risks of proceeding with the budget reductions and making a case that if reductions to go ahead, the 'least worst' option (option A) should be implemented.

5.0 Key issues

At this stage, there are a number of uncertainties:

- If the in-year savings will go ahead

- If so, whether these will be one-off savings or recurrent

6.0 Next steps

In order to plan for anticipated savings, all public health spending is under review to identify where savings could be made in-year.
This is being done by:

- Reviewing the effectiveness of all public health programmes to identify which have the most and least impact on health outcomes & to identify areas for review and service redesign.
- Reviewing activity in public health contracts to identify where savings could be made, either in-year or as contracts come up for renewal
- Developing options for consideration by the Lead Member and Executive in September 2015.

Details of Scrutiny

An earlier version of this report has been considered by the Health and Well-being Scrutiny Commission on the 6th August 2015.