Leicester
City Council

Minutes of the Meeting of the
HEALTH AND WELLBEING BOARD

Held: THURSDAY, 17 AUGUST 2017 at 4:00 pm

P R E S E N T :

Present:

Councillor Rory Palmer (Chair)	–	Deputy City Mayor, Leicester City Council.
Karen Chouhan	–	Chair, Healthwatch Leicester.
Andrew Brodie	–	Assistant Chief Fire Officer, Leicestershire Fire and Rescue Service
Ivan Browne	–	Deputy Director of Public Health
Councillor Piara Singh Clair	–	Assistant City Mayor, Culture, Leisure and Sport, Leicester City Council.
Frances Craven		Strategic Director, Children's Services, Leicester City Council.
Professor Azhar Farooqi	–	Co-Chair, Leicester City Clinical Commissioning Group.
Steven Forbes	–	Strategic Director of Adult Social Care, Leicester City Council.
Wendy Holt	–	Better Care Fund Implementation Manger, Central NHS England, Midlands and East (Central England).
Helen King	–	Chief Finance Officer, Office ofthe Police and Crime Commissioner.
Debra Mitchell	–	Integrated Services Programme Lead, University Hospitals of Leicester NHS Trust.
Richard Morris	–	Director of Operations and Corporate Affairs,

		Leicester City Clinical Commissioning Group.
Supt Shane O'Neill	–	Local Policing Directorate, Leicestershire Police.
Councillor Abdul Osman	–	Assistant City Mayor, Strategic Partnerships and Change, Leicester City Council.
Councillor Sarah Russell	–	Assistant City Mayor, Children's Young People and Schools, Leicester City Council.

In attendance

Graham Carey	–	Democratic Services, Leicester City Council.

84. APOLOGIES FOR ABSENCE

Apologies for absence were received from:-

John Adler	Chief Executive, University Hospitals of Leicester NHS Trust
Lord Willy Bach	Leicester, Leicestershire and Rutland Police and Crime Commissioner
Councillor Adam Clarke	Assistant City Mayor Energy and Sustainability, Leicester City Council
Andy Keeling	Chief Operating Officer, Leicester City Council
Will Legge	Divisional Director, east Midlands Ambulance Service NHS Trust
Roz Lindridge	Locality Director Central NHS England – Midlands and East (Central England)
Sue Lock	Managing Director, Leicester City Clinical Commissioning Group
Dr Peter Miller	Chief Executive, Leicestershire Partnership NHS Trust
Toby Sanders	Senior Responsible Officer, Better Care Together Programme
Ruth Tennant	Director of Public Health, Leicester City Council

85. 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.

86. MINUTES OF THE PREVIOUS MEETING

RESOLVED:

That the minutes of the previous meeting of the Board held on 17 August be confirmed as a correct record subject to Councillor Osman's title being amended to Assistant City Mayor, Strategic Partnerships and Change, Jill Smith being amended to Julie Smith and Professor Farooqi's name being amended to Professor Azhar Farooqi.

87. PRIMARY CARE STRATEGY AND GENERAL PRACTICE FORWARD VIEW

Leicester City Clinical Commissioning Group submitted a report detailing the approach to delivering the General Practice Forward View (GPFV) in Leicester City and how delivering this national work links to the development of the Sustainability and Transformation Plan delivery across Leicester, Leicestershire and Rutland.

The Director of Operations and Corporate Affairs presented the report and the following comments were noted:-

a) Access to primary care was still a concern to patients in the city and the CCG had met the national milestone of 50% of the public having access to week-end and evening GP appointments by March 2018. The 3 hubs at Westcotes, Belgrave and Saffron had provided 1,300 extra appointments a week, equivalent to an additional 135 hours. The hubs were operating at 95% capacity but there was a noticeable drop off in demand on Sunday afternoons. The CCG were continuing to work with GPs to have extended access in all GP practices.

b) There was continued local recruitment for GPs which recently resulted in the appointment of 11 new GP. The second phase of the recruitment in May had resulted in a further 4 new GPs and expressions of interest from others. A further initiative to recruit from overseas, based upon pilot scheme in Lincolnshire, was planned. There were also now 9 clinical pharmacists working in GP practices. The local NHS England target was to recruit an additional 25 GPs in the city by 2020. As 25% of GPs were currently over 55 years old, retention of existing GPs was also important.

c) A toolkit looking at all models of care and case studies from elsewhere, was being developed. A second edition of the toolkit was going live later in the year and a number of practices were already moving forward with the intitiative.

d) The CCG had re-invested more than £500k from existing funds to bring the base line for GP practices in Leicester up to and above the national

minimum level of funding of £85 per patient. It had also recycled approximately £2m of funding from within its existing budgets to provide additional funding for primary care services in Leicester. £200k has also been made available for training in primary care.

Following questions from Members the following responses were received:-

a) The Merlyn Vaz Centre had been a walk Centre for a number of years and it had now been procured as 4th hub. It would initially offer the existing walk in facility but would also have a new pre-booked focus with the aim of increasing the level of pre- booked appointments.

b) The CCG would aim to replace gaps in GPs services as and when established practices closed. Some practices were currently understaffed, but the CCG had no powers to direct staffing levels in existing GP practices as this was the responsibility of the individual GP.

c) The CCG tried to encourage continuity of care and encourage more GPs to be employed by individual practices in preference to being locums who moved around several practices. It was however, that some of the younger GPs preferred to be a locum. All hubs and GP practices had access to a common computer system so they all the ability to see a patients full record. Training was provided on safeguarding issues and every practice has a safeguarding lead.

d) It was recognised that new GPs wanted a portfolio career often involving 3 days in a GP practice and 1 day in a university or hospital setting. The CCG were working with all involved to assist the development of this offer for new GPs. The CCG had also made podcasts of new GPs who had been following this portfolio approach to promote the system and proactively promote their experiences and the benefits of working in Leicester.

e) It was not known if the reduction of appointments in the hubs on a Sunday afternoon had resulted in increased activity at A&E or created a spike on Monday mornings in GP practices.

f) The University had altered their undergraduate course and students now spent more time in GP practices as part of the training.

RESOLVED:

That the report be received and that a monitoring report be submitted on a quarterly basis.

88. HEALTH AND WELLBEING WORKSHOPS OVERVIEW

The Director of Public Health submitted a report that explained the purpose of the workshops, the key findings and how these would be applied to the draft strategy and future work. The report was supported by a presentation.

It was noted that:

a) The Health Start workshop was scheduled for September and others had already taken place.

b) Increases in life expectancy had resulted in a significant gap between health life and life expectancy; both nationally and in Leicester. It was now estimated that males and females in Leicester could expect 20 years of not being in good health. This was attributable to the increase in the inequalities of living a health life expectancy and more people living longer in poor health

c) The outcomes of the Workshops that had already been held were summarised on the slides of the presentations which are attached to these minutes.

d) Due to the reducing budgets for public health it would be necessary to have a targeted approach in future. Feedback supported continued working collectively across all health systems to avoid missing those most in need and them and causing stigma. The community based approach would help to target whole families as opposed to individuals.

The Chair commented that the next Health and Wellbeing Strategy needed to be different from the current one as it needed to be more challenging and aspirational; with the aim of bringing about improvements in health well beyond the 5 year life of the plan. The challenges would be around how this could be done differently to achieve the aspirational aims within the limited resources that would be available.

Members commented that low physical activity often contributed to poor health, and whilst 1 in 5 were happy to participate in physical activity, more was needed to address the cultural change to enable people to engage in more physical activities. The City had quality open spaces and 33 open space gyms and initiatives to increase their usage would be important. The challenge was to reach those sections of the community that didn't take regular exercise, such as those on low incomes, unemployed people and BME women.

RESOLVED:

That the report and the feedback from the workshops be received and welcomed and that these be fed into the revised draft strategy. Members of the Board were also encouraged to submit comments and suggestions to shape the next Strategy.

89. LEICESTER CHILDREN AND YOUNG PEOPLE'S HEALTH AND WELLBEING SURVEY 2016

The Director of Public Health submitted a report on the Leicester Children and Young People's Health and Wellbeing Survey 2016 that provided a cross-

sectional snapshot of health and wellbeing issues for children and young people in the city. A presentation was made at the meeting which had previously been circulated with agenda.

The results of the survey provided the views of approximately 3,000 children in years 6, 8 and 10. The majority of those surveyed had generally expressed positive experiences. The west of the city had poorer outcomes in health and education and differences had been observed in the risk factors. It was felt the survey was a useful tool to triangulate data on risks and risks in specific groups.

The view was expressed that further thought needed to be given to how the survey results could be used proactively along with other information that was currently, held since the more sources of data that could be triangulated the more it helped to focus on groups that were at risk. It was noticeable that 1in 5 children worried about not having enough to eat and that also 1in 10 children were having takeaway meals on most days. This indicated that some children were not getting sufficient nutrition to support growing bodies and minds and this could have a significant detrimental impact on the health system in 20 years' time. This needed to be addressed by all partner organisations on the Board. There was concern that there may not be sufficient or adequate resources needed to support families adequately.

The Chair commented that the survey provided real empirical date and was a valuable resource which the Board needed to use to the full in order to inform and redesign policies.

The Deputy Director of Public Health stated that the results of the survey were available for everybody to use. It provided a realistic picture of real experiences based upon a good sized sample. There was a significant amount of core data supporting the summary which could be broken down further should Board members find this useful.

RESOLVED:

> The Board welcomed the report and survey results and supported the dissemination of the survey results to enable partner organisations to inform and implement their own initiatives.

90. BETTER CARE FUND

Leicester City Clinical Commissioning Group submitted a report on the Leicester City Better Care Fund 2017-19.

It was noted that the draft was being submitted later than usual because the planning guidance and the requirement of the Better Care Fund were not issued by NHS England until mid-July with a submission date of 7 September 2017. The draft narrative of the plan was contained in the current draft document narrative template and the final planning template had only recently been received since the Agenda was published and this was being completed.

Guidance had been drip fed to the CCG by NHS England and the Final Key Lines of Enquiry had only been received from NHS England earlier in the week and work was now progressing to complete these. The Plan, therefore, may change to reflect any additional information requested by NHS England before the formal submission date.

The current draft had been prepared jointly by the CCG, the Council, partner organisations including UHL and LPT and Police and Fire Services and had recently been considered by the patient's participation group for STP and had been largely supported.

The plan was measured against a matrix of 5 indicators to ensure the efficacy of the Plan and these were:-

- Non-elective Admissions
- Delayed Transfer of Care in both the acute and non-acute sites
- |Admissions to residential care
- Number of Patients at home 91 days after a hospital episode.

2 of the 5 matrix indicators had been achieved in 2016-17. The non-elective admissions had been missed by 203 admissions. Although this may appear significant this represents a huge decrease on the previous figures which missed the target with figures in excess of 1,000s. Delayed Transfer of Care had reduced significantly at the acute hospital site and there were now only a few local authority attributed delays as a result of previous initiatives taken under the better care together fund. The LLR A&E Delivery Board had already addressed this issue and had approved a plan to achieve the target by March 2018. Work was also progressing with health trusts to minimise delays in the future in relation to mental health and learning disability facilities.

The BCF Implementation Manager, NHS England (Midland and East) commented that she was a member of the Assurance Panel and felt the plan was well written and one of the better ones that had been received. It was pleasing to see an increased focus on delayed care, community settings and learning disabilities. The links to housing needed strengthening as this was significant to peoples' health and wellbeing.

The Healthwatch Chair expressed concerns in relation to the other challenges in Chapter 2 of the draft and felt these did not fit completely with the positive narrative following the risk assessment that had subsequently been received and asked for assurances on these aspects.

In response, it was noted that there had been a huge reduction in delayed transfer of care and non- elective surgery admissions which had reduced the previous numbers of 14-15 delayed transfers per week to the current level of 8-10. Overall there was a 2.62% reduction in the number of patients in hospital beds than in the previous year, which was considered to be a significant achievement. Year on year reductions where now being observed which was seen as a significant improvement against the previous backdrop of 5-6% growth per year.

A Member commented that the supporting appendices sent out after the agenda had been published, particularly the high impact changes to support local health and care systems to reduce transfers of care in LLR, had many actions listed in them but it was hard to see what impact these actions had achieved. For example, the care homes with most ambulances attendances and the Braunstone Blues initiative supporting care homes, which had the highest use of ambulances, by providing policy change and education (EMAS).

It was also noted that the Braunstone Blues initiative had had a dramatic impact in reducing the number of ambulance activations to the 2 care homes and the conveyance rate had increased

It was also noted that the impact of actions could be put into a summary when final plan was submitted together with a comment on the impact they made. It was felt that this would make the document easier to digest.

Members commented that any additional information that made the document easier to read from a lay perspective and enable readers to assess the impact of actions and initiatives was to be welcomed.

RESOLVED:

1) That the draft narrative of the Leicester City Better Care Fund plan 2017-19 be approved and that the Chair of the Health and Wellbeing Board be given delegated authority to approve the final narrative plan and planning template prior to its formal submission.

2) That the Board receive regular monitoring and progress reports so that any system critical areas of challenge can be addressed and resolved.

91. QUESTIONS FROM MEMBERS OF THE PUBLIC

The Chair invited questions from members of the public.

The Vice Chair of Healthwatch asked of the documents that had been sent to Members of the Board after the agenda had been published could be made available to the public.

It was confirmed that these documents would be published with the minutes of the meeting.

92. DATES OF FUTURE MEETINGS

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

Monday 9th October 2017 – 3.00pm

Thursday 7th December 2017 – 10.30am
Monday 5th February 2018 – 3.00pm
Monday 9th April 2018 – 2.00pm

Meetings of the Board are scheduled to be held in Meeting Room G01 at City Hall unless stated otherwise on the agenda for the meeting.

93. ANY OTHER URGENT BUSINESS

There were no items of Any Other Urgent Business.

94. CLOSE OF MEETING

The Chair declared the meeting closed at 5.18pm.

Health & Wellbeing Workshops

Ivan Browne

Health & Wellbeing Board

17th August 2017

Leicester City Council

Minute Item 88

Health & Wellbeing Strategy Workshops

To support development and delivery of the new Health and Wellbeing Strategy.

Healthy Start

Healthy Lives

Healthy Mind

Healthy Places

Healthy Lives

Many health challenges in the city are preventable. We need to focus on reducing risks to health: sedentary behaviour, poor diet, as well as continuing to reduce smoking and excessive alcohol consumption. Pushing prevention up the agenda of all our organisations is central to our vision.

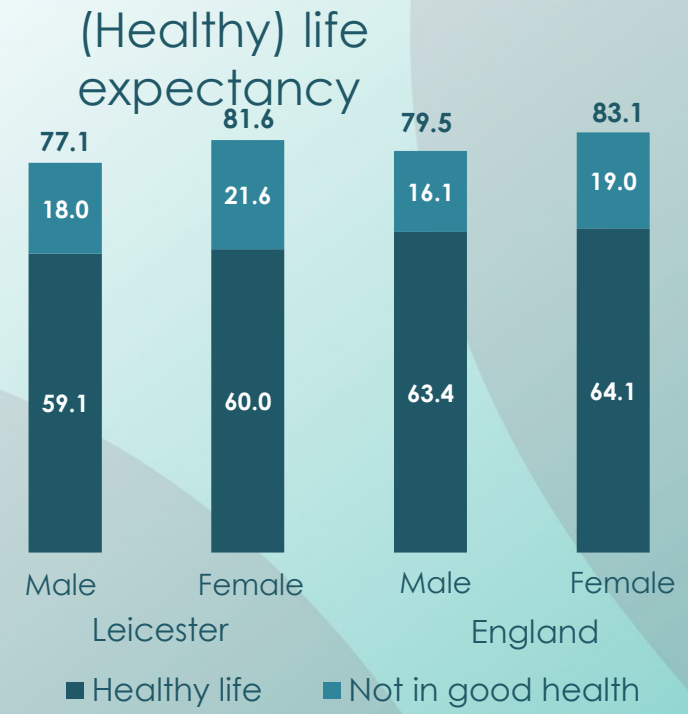
Unless checked healthy-life-expectancy will not keep pace with life-expectancy.

It is estimated that males and females in Leicester can expect about 20 years 'not in good health'.

Increases in life expectancy has resulted in a significant gap between healthy life and life expectancy both nationally and in Leicester.

These years 'not in good health' come at a high cost for health and social care services.

Life expectancy and healthy life expectancy differs across the city and is closely linked to patterns of



Source: ONS 2013-15

With a reducing budget for prevention, what are the priorities?

Working intensively to establish healthy behaviours from a young age and focussing on:

PREGNANCY – Learning starts early!! Establishing good habits, nutrition, healthy environment, stress management and tackling addiction.

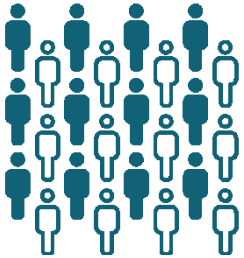
EARLY YEARS – family based initiatives, healthy diets, promoting activity, providing advice and support.

TEENAGE YEARS – age appropriate advice and incentives, embedding of healthy behaviours and habits for adulthood.

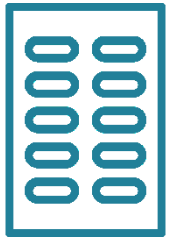
HOW:

- *Holistic support for pregnant women and their families.*
- *Encouraging a holistic family based approach to living a healthy life.*
- *Greater investment in helping teenagers develop & maintain healthy*

Should individual support only be available to certain disadvantaged or high risk groups?



Moving away from targeting only specific groups - Hard to work with definitions and inadvertently causes stigma.



Move away from solely targeting reductions in specific diseases -This is often reactive rather than preventative and it does not address other unhealthy aspects not linked to the disease.

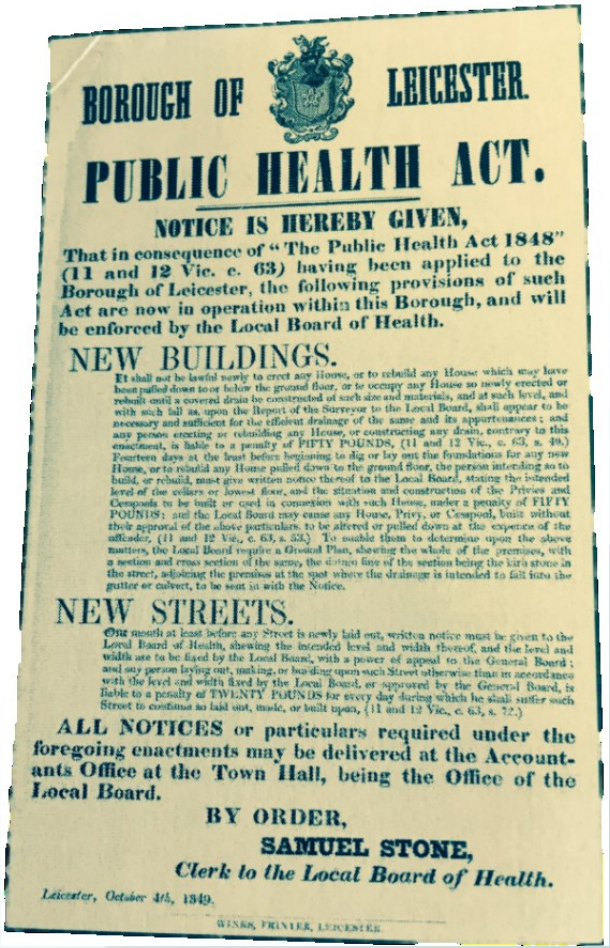
HOW:

- *Target whole families rather than individuals.*
- *Promote community based approaches to good health.*
- *Encourage community areas or workplaces to hold health MOT's.*

Healthy Places

A focus on healthy places, encourages collaboration to improve health by considering the range of environments in which people live their lives. Improving health through a focus on environment has a long history.

The Healthy Places Movement looks to address the impact the environment can have on people's health.



BOROUGH OF LEICESTER.

PUBLIC HEALTH ACT.

NOTICE IS HEREBY GIVEN,

That in consequence of "The Public Health Act 1848" (11 and 12 Vic. c. 63) having been applied to the Borough of Leicester, the following provisions of such Act are now in operation within this Borough, and will be enforced by the Local Board of Health.

NEW BUILDINGS.

It shall not be lawful newly to erect any House, or to rebuild any House which may have been pulled down to or below the ground floor, or to occupy any House so newly erected or rebuilt until a covered drain be constructed of such size and materials, and at such level, and with such fall as, upon the Report of the Surveyor to the Local Board, shall appear to be necessary and sufficient for the effectual drainage of the same and its appurtenances; and any person erecting or rebuilding any House, or constructing any drain, contrary to this enactment, is liable to a penalty of FIFTY POUNDS, (11 and 12 Vic., c. 63, s. 49.) Fourteen days at the least before beginning to dig or lay out the foundations for any new House, or to rebuild any House pulled down to the ground floor, the person intending so to build, or rebuild, must give written notice thereof to the Local Board, stating the intended level of the cellars or lowest floor, and the situation and construction of the Privies and Cesspools to be built or used in connexion with such House, under a penalty of FIFTY POUNDS; and the Local Board may cause any House, Privy, or Cesspool, built without their approval of the above particulars, to be altered or pulled down at the expence of the offender, (11 and 12 Vic., c. 63, s. 53.) To enable them to determine upon the above matters, the Local Board require a Ground Plan, shewing the whole of the premises, with a section and cross section of the same, the datum line of the section being the kirb stone in the street, adjoining the premises at the spot where the drainage is intended to fall into the gutter or culvert, to be sent in with the Notice.

NEW STREETS.

One month at least before any Street is newly laid out, written notice must be given to the Local Board of Health, shewing the intended level and width thereof, and the level and width are to be fixed by the Local Board, with a power of appeal to the General Board; and any person laying out, making, or building upon such Street otherwise than in accordance with the level and width fixed by the Local Board, or approved by the General Board, is liable to a penalty of TWENTY POUNDS for every day during which he shall suffer such Street to continue so laid out, made, or built upon, (11 and 12 Vic., c. 63, s. 72.)

ALL NOTICES or particulars required under the foregoing enactments may be delivered at the Accountants Office at the Town Hall, being the Office of the Local Board.

BY ORDER,

SAMUEL STONE,

Clerk to the Local Board of Health.

Leicester, October 4th, 1849.

WINKS, PRINTER, LEICESTER.

The environment impacts upon the following:

Epidemic of chronic diseases	Cardiovascular diseases, arthritis, diabetes and cancer
High obesity rates	Around two thirds of adults in the city are overweight or obese.
Low physical activity	A third of adults inactive
Mental health disorders	Increasing prevalence

Discussions involved the following themes…

Improving air quality

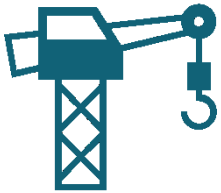
Promoting active travel

Protecting access to green space

Developing a healthy built environment

Informing the Leicester Local Plan

What opportunities do we have to make health a key component within local policies across the council and beyond?



DESIGN, PLANNING AND DEVELOPMENT- make sure that places and spaces support and encourage healthy behaviours.

TRANSPORT – reduce the number of vehicles in the town centre.

HOMES – provide living accommodation of a decent standard so as people live in a healthy environment.

HOW:

- *Involve health professionals and people in the design and planning process.*
- *Introduce and promote sustainable travel options and improve air quality.*
- *Regulate private landlords to maintain housing and ban smoking in LA*

How can we collectively deliver a healthier living environment?

TRAVEL: actions to make sustainable travel more appealing and the health and environmental benefits clearer.

ORGANISATIONAL INPUT: get businesses and organisations to 'buy in' to promoting healthy actions and behaviour amongst their workforce.

USING ASSETS: prioritise the maintenance of parks and green spaces. Greater promotion of the use of green spaces to maintain health and wellbeing.

HOW:

- *Improve city signage to include travel options, how long they take and the potential health benefits.*
- *Work with organisations to champion the benefits of a healthy workforce.*
- *Raise awareness of green spaces and ensure they are well maintained and*

What features may lead to some community assets becoming more successful than others?

ACCESSIBILITY – assets are accessible by bike, on foot or bus and accessible for all including disabled and the elderly.

SAFETY: people feel safe travelling to and using the community asset. Issues such as adequate lighting are important.

ATTRACTIVENESS: assets need to be appealing and have something to attract people of different ages and cultures.

HOW:

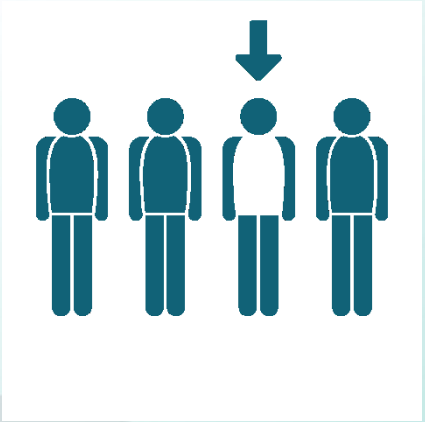
- *Plan bus, cycling, walking routes around assets and make places accessible.*
- *Generate safe routes and look into improving lighting at parks.*
- *Ensure that assets are multi-purpose and plan in activities for the young and elderly*

Healthy Mind

Sustaining mental wellbeing is crucial for people to live long healthy lives. People with mental illness often make poor lifestyle choices; they are more likely to smoke, drink alcohol, and use drugs and less likely to exercise or eat well. Therefore having much shorter life expectancies.

Discussions involved the following areas…

Mental health amongst Children and Young People

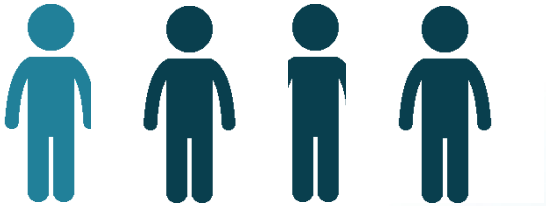


Tackling Stigma and discrimination

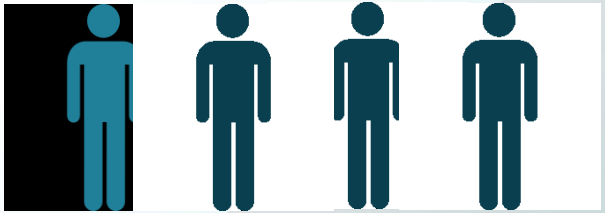
Focusing on three themes including supporting parents, raising awareness and teaching through schools, and using other agencies such as CAMHS.

Great emphasis was placed on identifying early warning signs, building resilience, and creating a parity of esteem between physical and mental health.

Children with a parent with mental health problems are more likely to experience poor mental health as an adult.

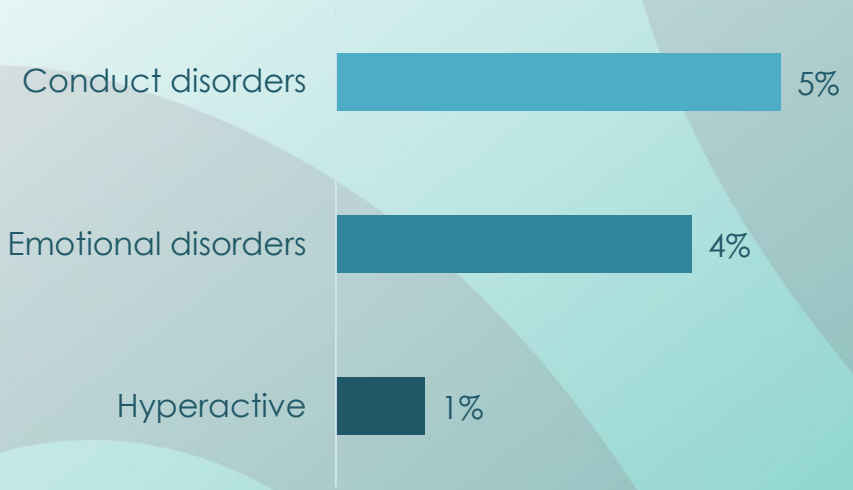


1 in 4 children have a parent at risk of common mental health problems.



1 in 4 adults in mental health care is likely to be a parent

One in ten children between 5 and 15 have a mental disorder. These include:



What actions should we take to protect children and young people's mental health?

PARENTAL SUPPORT - providing help and support to parents and families from pregnancy and then as the children grow.

EDUCATING- better support for children particularly around times of transition and enabling staff to recognise and address poor mental health.

UNITED ACTION – less emphasis on labelling children and more access to CAMHS.

HOW:

- *Make it easier for parents to get support to promote and protect their own mental health and the mental health of children*
- *Teaching mindfulness and building resilience as part of the school curriculum, particularly important at times of transition.*
- *Better join up of services supporting young people.*

Many people with a mental health problem feel isolated; they find it difficult to get employment or housing. People in work are often uncomfortable talking to their employer about mental health problems.

One in four working age adults and one in ten older people have a common mental health problem.

About 1 in 100 have a serious mental health illness.

Those with a severe mental health problem are significantly more likely to have a shorter life expectancy.

Issues in the city include:

- Under diagnosis of depression
- Higher rates of hospital admission for mental illness
- Worse than average outcomes

How can we tackle stigma and discrimination around mental health?

EARLY YEARS – Equipping children with the language to describe their feelings and seek help.

AWARENESS- ensuring that more people are able to spot the 'warning signs' particularly in schools and workplaces.

PARITY – change the language so as mental health to be treated the same way as physical health to reduce stigma.

HOW:

- *Provide lessons and training in schools*
- *Training for school staff and*

Next steps:

1. Explore feasibility and practicality of suggestions raised in the workshops

2. Deliver the Healthy Start workshop

3. Redraft the Health and Wellbeing Strategy

4. Public consultation