Leicester
City Council

Minutes of the Meeting of the
HEALTH AND WELLBEING BOARD

Held: WEDNESDAY, 9 SEPTEMBER 2015 at 11.00am

Present:

Councillor Rory Palmer (Chair)	–	Deputy City Mayor, Leicester City Council
Richard Clark	–	Chief Executive, The Mighty Creatives
Councillor Adam Clarke	–	Assistant City Mayor, Energy and Sustainability, Leicester City Council
Professor Azhar Farooqi	–	Co-Chair, Leicester City Clinical Commissioning Group
David Henson	–	Executive Officer, Healthwatch Leicester
Andy Keeling	-	Chief Operating Officer, Leicester City Council
Sue Lock	-	Managing Director, Leicester City Clinical Commissioning Group
Superintendent Mark Newcombe	–	Local Policing Directorate, Leicestershire Police
Ruth Tennant	–	Director of Public Health, Leicester City Council
Councillor Abdul Osman	–	Assistant City Mayor, Public Health, Leicester City Council
Councillor Sarah Russell	-	Assistant City Mayor, Children and Young Peoples Services
Professor Martin Tobin	–	Professor of Genetic Epidemiology and Public Health and MRC Senior Clinical Fellow, University of Leicester

In attendance

Graham Carey	–	Democratic Services, Leicester City Council
Sue Cavill	–	Head of Customer Communications and

Engagement - Greater East Midlands
Commissioning Support Unit

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1. APOLOGIES FOR ABSENCE

Apologies for absence were received from Karen Chouhan, Chair Healthwatch Leicester, Frances Craven, Strategic Director Children's Services, Chief Supt Sally Healey Head of Local Policing Directorate, Dr Avi Prasad, Co-Chair, Leicester City Clinical Commissioning Group, Tracie Rees, Director of Care Services and Commissioning (Adult Social Care) and Trish Thompson, Director of Operations and Delivery, NHS England Local.

2. 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.

3. MEMBERSHIP OF THE BOARD

The membership of the Board for 2015/16 approved by the Council on 18 June 2015 was noted as follows:-

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

The Board's Terms of Reference approved by the Council on 18 June 2015 were noted. 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 Chair stated that frequent requests are received from NHS England for information to be sent back at short notice which does not make it feasible to submit it to a Board meeting and asked for delegated authority to deal with these between Board meetings. Any such submissions would be circulated to Members of the Board for information.

RESOLVED:

That the Board's authority be delegated 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

RESOLVED:

That the Minutes of the previous meeting of the Board held on 26 March 2015 be confirmed as a correct record.

6. UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST - STRATEGIC PRIORITIES

The Chair stated that he had deferred this item to the next meeting as a number of apologies had been received and he felt that the presentation by John Adler should be made to the full Board membership in view of its importance.

7. LOCAL RESPONSE TO NHS 7 DAY WORKING

The Managing Director, Leicester City Clinical Commissioning Group submitted 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.

The Managing Director stated during the introduction and in response to subsequent questions from Members that:-

a) Leicester City GP Practices were successful in receiving an allocation of £3.2m from the Prime Minister's Challenge Fund to pilot a number of initiatives to promote seven day access to primary care. The GP practices had formed a Steering Group to oversee the introduction of these initiatives which involved longer opening hours during the week, opening at weekends and greater use of online services including patient registrations.

b) The CCG had a representative on this Steering Group to influence the alignment of the initiatives with local strategies and to develop key performance indicators so that their operation could be measured and assessed.

c) The four pilot sites for longer and extended opening hours were Willows Medical Centre (Rowlatts Hill Road), Belgrave Health Centre, Brandon Street, Westcotes Health Centre, Fosse Road South and Saffron Group Practice, Saffron Lane. There was a phased launch with one centre joining the initiative each week during September.

d) Each pilot site would have a GP Principal and a Nurse available at all times the service was open. GP Principals had been encouraged to provide the service rather than rely on locum Doctors. The new arrangements were seen as a success of the GP Federation working in collaboration to change working practices that would be sustainable. The pilot sites would be able to access patients' records from other GP practices through IT systems and data sharing arrangements.

e) Discussions were taking place between the pilot sites and local pharmacies to provide access to pharmacies during the extended opening hours.

f) It was recognised that effective communication plans had to be in place to underpin this initiative.

g) The effectiveness of the pilots would be assessed by the CCG in December/January and they would determine whether any improvements to the arrangements were required and whether it was effective to rollout and extend the scheme.

h) The data collected would identify where patients came from and part of

its analysis would identify whether the attendances were genuine and a true reflection of the expected demand for the extended service.

i) The provisions for seven day access to services were already built into the Better Care Together Fund as it was a key part of work to improve patient flows in and out of hospitals and reduce hospital admissions. This involved a more integrated seven day working model across front-line health and social care services as well as developments in the Clinical Response Team, Unscheduled Care Team and the Planned Care Team. Each of these has proven that integrated seven day services provide both high quality care for patients and aids the flow through the urgent care system.

j) Following an assessment of UHL in relation to Keogh's 10 Clinical Standards intended to improve consistency in services across seven day working, their commissioners required that 5 of the clinical standards required improvement by 31 March 2016 and these were listed in the report. Currently four of these were 'Green' and the one 'Amber' relating to 'Transfer to Community, Primary and Social Care' was likely to turn 'Green' in the near future. Those services not currently provided over seven days, such as diagnostics etc, would gradually be rolled out.

k) Recent commercial initiatives offering telephone access to a consultation with a doctor were attracting interest as it provided an opportunity to free up a patient's doctors' time and encourage self-care. Procurement for this service was currently underway by the CCG and it was hoped to offer this service locally in October 2015.

l) The changes in services involving seven day provision and the new pilot hubs were also being fed into the 111 telephone service provider so that they could direct enquiries to the appropriate point of contact.

m) The new pilot hubs were not intended to replace a patient's usual GP services but provide additional and more flexible opportunities of access. The hubs were also intended to deal with patients who had attended 'walk in' centres, urgent care centres or contacted 111 and who could be appropriately treated through GP services. Nor was it intended that GP practices would refer patients to the hub centres to alleviate their own practice lists.

n) Seven day working for all services at UHL were important to provide a full range of services for patients, especially for those admitted at week-ends. Evidence currently showed that survival rates were lower for week-end admissions because of the lower availability of some services in hospitals at week-ends, and this needed to be addressed for the patients' benefit.

o) It was important to understand that the hub centres were not intended to provide the full range of routine GP services available at a patient's

usual GP practice, but to provide good services over a seven day period to treat patients and keep them out of hospital, when an admission was not necessary.

p) A number of non-core services had historically been introduced piece-meal. The challenge locally was to co-ordinate a range of initiatives into a rationalised and coherent provision in the long term.

The Healthwatch representative offered to provide assistance with an independent evaluation of the discharge of patients from hospital to community care. Healthwatch also commented that the publicity of the changes of service provision was a key issue to success as it was important to make clear to the public what could be provided and what was not provided. Healthwatch offered to provide assistance with this. The Managing Director of the CCG welcomed Healthwatch's offer to be involved.

Members made the following observations and comments:-

a) Digital access to the health economy could be an item of consideration for a future Board meeting particularly looking at the cross-cutting issues of patient access etc.

b) There was some concern that the provision of seven day working for GP services could result in some employers not allowing staff to attend regular medical appointments or treatment during the week, which could result in higher weekend attendances. It was requested that these attendances be captured in the evaluation data to be collected.

c) The fragmented arrangements for commissioning services do not easily aid a systematic or strategic approach to health care provision and co-ordination. For example, the separate arrangements for commissioning dental, pharmacy and specialised services to those of GP and hospital core services.

RESOLVED:

1) That the report and developments taking place for the provision of seven day working be noted.

2) That the issue of seven day working be re-considered when the evaluation of the current hub pilot centres has been completed and that partner organisations also review their position in relation to seven day working and what it means in real terms to the people of Leicester.

8. GP RECRUITMENT AND RETENTION PLANNING

The Managing Director, Leicester City Clinical Commissioning Group submitted a report which set out the detail of the plans which have been produced locally and the progress that has been made in relation to the General Practice Incentive Scheme.

Members noted the following comments:-

a) There was a national and local shortage of GPs and a number of initiatives were being undertaken to address these shortages.

b) Professor Farooqi was the CCG's representative on the Leicester, Leicestershire and Rutland (LLR) General Practice Delivery Group, which was overseeing a 10 point plan to support the recruitment of GPs, which was outlined on the report.

c) The Government had made a commitment to train an additional 5,000 GPs by 2020, but current evidence suggested that there were insufficient numbers on GP training programmes to achieve this.

d) Currently 30% of places on the East Midlands GP training scheme were unfilled.

e) Locally issues under consideration were:-

    i) Selling the East Midlands as a place to work for GPs.

    ii) Encouraging GP's to take medical students from local universities to provide an introduction to and experience of primary care provision.

    iii) Encouraging GPs trained in Leicester to remain in Leicester. Feedback from young doctors indicates that Leicester is not seen as an attractive place to work for a number of reasons, although there were a number of highly committed GPs who valued the chance to work in an area of high need.

    iv) Incentive schemes including financial and non-financial elements were seen as useful in recruiting more GPs. Non-financial elements could include offering young GPs the opportunity of various experiences as part of their employment, including research opportunities, specialist work experience in hospitals, working in 2-3 GP practices, protected learning time within the contract of employment etc. The Council's Public Health directorate could also look at offering opportunities for experience and development.

Following Members' questions and comments it was stated that:-

a) It was more difficult for non-EU doctors to be recruited to the health services. It may be worthwhile to engage local immigrant communities to see if qualified medical practitioners could be retrained as GPs. The LLR General Practice Delivery Group currently had no data on potential numbers etc so any information in relation to this would be welcomed.

b) The current Membership of the Royal College of General Practitioners (MRCGP) training programme was more rigorous than ever before in assessing clinical skills and knowledge. The current failure rate was 15-20% but this reflected the high quality expected from doctors passing the qualification.

c) Approximately 250 medical places were available at Leicester University and yet few medical students chose to stay in Leicester when they qualified. This differed from a significant proportion of existing doctors in Leicester, aged in their 40's, who had stayed following their training at local universities.

d) A number of GP practices relied on the employment of locums to meet patient's needs and more work needed to be done in the short term to encourage these locums to become permanent members of the practice.

Members' made the following observations and comments:-

a) The issue of GP recruitment was an issue that needed to be addressed by everyone engaged in providing services across the health economy.

b) The recently established, Children's Services Improvement Board, comprising representatives of health, the Council and the Police had recently looked at the issue of Leicester as a place to work and were developing initiatives and this could be further developed to support the recruitment and retention of GPs and other NHs staff locally.

c) In relation to Leicester being seen as too challenging a place to work the LLR General Practice Delivery Group could also look at the success of the Teach First programme in addressing educational disadvantage issues in England and Wales.

d) It would be interesting to map out where recent cohorts of locally trained medical students took up employment as part of the work to understand why they did not stay locally.

e) Joint work to produce promotional material publicising Leicester as a place to live and work was fully supported together with the possibility of having joint funding from all organisations interested in this issue so that a better outcome could be achieved by pooling resources rather than each organisation producing its own material.

f) The issue of newly qualified doctors not wishing to stay in Leicester was part of a wider issue of graduate retention in the City generally, which the Council was trying to address.

g) It was felt that if 20 newly qualified medical students from one cohort could be encouraged to stay and practice in Leicester then this would make a big difference to local GP practices. If the cohort then

encouraged and influenced students in following cohorts to stay the cumulative effect would soon change the current situation dramatically.

RESOLVED:

That Board members be thanked for their helpful contributions and that the CCG consider the suggestions made at the meeting to contribute towards the enhancement of the General Practice Incentive Scheme.

9. PUBLIC HEALTH BUDGET

The Director of Public Health submitted 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.

It was noted that:-

a) The consultation had closed two weeks previously and the Deputy City Mayor had submitted a response, which had previously been sent to all Members of the Board for information.

b) There had been a great deal of negative response to the proposal to save a further £200m on local councils ring fenced public health budgets from both councils and NHS providers of services funded by the budget. It was felt by many that the Department of Health were unaware that the budget was used to fund some front line NHS services.

c) Four options had been suggested in the consultation ranging from claiming a larger share of savings from local authorities that were funded significantly above their target allocation, claiming a larger share of savings from those local authorities that had carried unspent reserves into 2015/16, reduce all local authorities allocation by a flat rate percentage reduction and or a flat rate reduction unless an authority could show this would lead to a particular hardship.

d) Leicester had expressed its reluctant preference for claiming a larger share from local authorities that were funded significantly above their target allocation. Leicester's funding was still under its target allocation and therefore it was felt that it should receive less reduction in budget than those authorities that were funded above their target allocation.

e) A number of planned programmes had already been put on hold to meet the proposed in-year reductions if they were subsequently confirmed now the consultation had closed.

f) It was uncertain whether the proposed reduction would be a recurrent saving in future years but it had been assumed this would be the case for contingency planning purposes. It was possible that the proposed

reductions could be incorporated into future spending reviews and the current ring-fenced funding for public health could also change.

g) There were some important areas around children in crisis and prevention within the Better Care Together Fund for which funds were available but it would take more effort to attract the funding than to receive it direct.

h) The proposed reductions would also have an impact across the whole of the Better Care Together Programme.

The Chair noted the Board's dissatisfaction with the recent announcement, following so closely after Simon Steven's (NHS England Chief Executive) announcements to the NHS Conference on prevention and intervention measures. Reducing public health expenditure was also contrary to the King's Fund modelling that £1 spent on primary care prevention and intervention measures can save much larger amounts in acute care expenditure in the future.

RESOLVED:

That the update be noted and that the Board be kept aware of future developments.

10. DATES OF FUTURE MEETINGS

It was noted that future meetings of the Board would 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.

Note: The dates above have been changed from those published in the Minutes of previous meetings.

11. ANY OTHER URGENT BUSINESS

There were no items of Any Other Urgent Business.

12. CLOSE OF MEETING

The Chair declared the meeting closed at 12.30 pm.