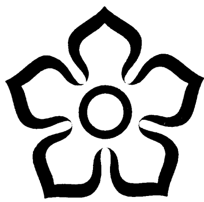

Leicester
City Council

Minutes of the Meeting of the
HEALTH AND WELLBEING BOARD

Held: TUESDAY, 27 OCTOBER 2015 at 2.00pm

Present:

Councillor Rory Palmer (Chair)	–	Deputy City Mayor, Leicester City Council.
Ivan Browne	–	Deputy Director of Public Health
Richard Clark	–	Chief Executive, The Mighty Creatives.
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.
Chief Superintendent Sally Healy	–	Head of Local Policing Directorate, Leicestershire Police.
Sue Lock	–	Managing Director Leicester City Clinical Commissioning Group.
Councillor Abdul Osman	–	Assistant City Mayor, Public Health, Leicester City Council.
Balhu Patel	–	Vice Chair, Healthwatch Leicester.
Councillor Sarah Russell	–	Assistant City Mayor, Children's Young People and Schools, Leicester City Council.
Sarah Theaker	–	Head of Operations and Delivery NHS England (Central Midlands)

In attendance

Graham Carey	–	Democratic Services, Leicester City Council.

Sue Cavill – Head of Customer Communications and Engagement NHS Arden and Greater East Midlands Commissioning Support Unit.

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13. APOLOGIES FOR ABSENCE

Apologies for absence were received from Karen Chouhan (Chair Healthwatch Leicester) Andy Keeling (Chief Operating Officer), Dr Avi Prasad (Co-Chair, Leicester City Clinical Commissioning Group), Ruth Tennant (Director of Public Health), Trish Thompson (Director of Operations and Delivery, NHS England Local) and Professor Martin Tobin (professor of Genetic Epidemiology and Public Health and MRC Senior Clinical Fellow, University of Leicester).

14. 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.

15. QUESTIONS FROM MEMBERS OF THE PUBLIC

There were no questions from members of the public.

16. MINUTES OF THE PREVIOUS MEETING

RESOLVED:

That the Minutes of the previous meeting of the Board held on 9 September 2015 be confirmed as a correct record, subject to the Resolution in Minute 9 – Public Health Budget being amended to read:-

“1. That the update be noted and the Board unanimously oppose the proposed reduction in Council’s ring fenced public health budgets and that all health partners make strong representations to the Government to this effect.

2. That the Board be kept aware of future developments.”

17. LEICESTERSHIRE PARTNERSHIP NHS TRUST - STRATEGIC PRIORITIES

Dr Peter Miller, Chief Executive, Leicestershire Partnership NHS Trust (LPT) gave a presentation on the Trust’s strategic priorities and current challenges. A copy of the presentation had been published with the agenda for the meeting.

During the presentation the following comments were noted:-

a) The Trust had four strategic objectives:-

- Deliver safe, effective, patient-centred care in the top 20% of the Trust's peers.
- Partner with others to deliver the right care, in the right place, at the right time.
- Ensure sustainability.
- Staff will be proud to work here, and we will attract and retain the best people.

b) The current income was £2.31m with a planned surplus of £2.2m

c) The Trust is working to provide the continued integration of clinical services to provide:-
   - Improved access to services, enhancing the service user experience and allowing earlier integration.
   - Reduced duplication of contracts and activities within and across agencies.
   - Earlier intervention with reduced escalation of health conditions, improved health of patient and reduced specialist service contracts.
   - Better health and social care system integration reducing administration and management costs across statutory agencies.

d) The Trust's services could be broadly divided into:-
   - Adult Mental Health and Learning Disability Services
   - Community Health Services
   - Families Young People and Children

e) Adult Mental Health and Learning Disability Services

   i) Developing the Adult Mental Health Care Pathway, involving promoting care in crisis, reducing the time spent in hospital, reducing delays in discharge, keeping patients at home longer, and promoting alternatives to hospital admissions and remodelling the crisis services.

   ii) Enhancing integration of services working closely with the primary care and voluntary sector, focussing on recovery, increasing resilience and reducing escalation of health conditions.

   iii) Supporting people with learning difficulties to remain in the community by improving access to services, treating in the home wherever possible and improving crisis management services. The number of inpatients with learning difficulties was now a relatively small number compared to previous decades.

f) Community Health Services

   i) Improving prevention and early intervention by working with

communities to enable people to stay healthy and help prevention of health conditions to avoid the early need for acute care services. The Trust was also working with patients with long term conditions to manage their conditions and to make an early identification of patients with dementia.

ii) Improving access to care and reducing waiting times. There had been good partnership working with the primary care sector and early referrals to memory cafes.

iii) Developing out of hospital care which was important for the Better Care Together Programme. The Trust was growing the Intensive Support Services with the commissioners and an additional 130 virtual beds were being provided in the current year.

iv) Integration of whole system provision of care by aligning the care pathways with both the County, Rutland and City areas and implementing Phase 2 of a programme to develop partnership working with the voluntary and third sectors and carers to access services.

v) Numerous measures were being introduced and developed for Out of Hospital Care including:-
- Developing the capability and capacity to provide sub-acute care in community hospitals.
- Providing integrated community based specialist services for patients recovering from the acute phase of a stroke or neurological illness.
- Establish an In-Reach team to expedite the prompt and smooth transfer of patients into community based sub-acute care and Intensive Community Support Service beds.
- Providing enhanced health in care homes for people diagnosed with dementia and mental health care in order to reduce their need for a hospital admission.

vi) Funds have been secured through the Nursing Technology Fund to implement technology advances in nursing practices to connect nurses across the community hospitals and acute trusts.

vii) The Trust will be pioneering a Robotic Telepresence Solution to enable a clinician to be virtually present in another location.

viii) Bed use will be optimised to provide the same or increased volume of activity with fewer beds.

g) <u>Families Young People and Children</u>

i) Develop Asset Based Community Development (ABCD) to

strengthen, support, co-ordinate and build capacity within families and communities for self-help and to support each other.

ii) Increase knowledge and skills across the workforce through introducing new roles and integrating practice across teams. This will increase practitioners' capacity for service users, reduce referrals to specialised services and reduce the number of practitioners involved in the care of a child or a family. It would also lead to an increased quality of intervention at an earlier stage improving the service user's health and reduced workforce costs through the safe delivery of interventions by lower banded qualified and trained staff.

iii) Use of alternative technologies to change the way the Trust communicates with younger people through social media apps and virtual appointments to allow earlier intervention and reduce face to face contacts and improve service user experience. Mobile working technology increases workforce agility and reduces estate usage and travel costs as well as improves productivity.

iv) The Trust has recruited 7,000 people to research projects which will provide better quality improvement outcomes.

h) The Trust faced the following Challenges and risks:-

i) Financial stability of the health economy – the Trust Development Agency had given an extended target for the deficit recovery. Currently approximately 80% of Trusts nationally were in financial deficit.

ii) Workforce capacity, capability and engagement – the Trust was still heavily dependent upon agency and bank staff which had on going implications for staff skills and costs.

iii) Demand continued to rise and the capacity was not always available within the health system to respond to it at times.

Following questions from Members of the Board the following responses were noted:-

a) The Trust was working with commissioners to implement quality improvements to care for the physical needs of patients that had mental health illnesses.

b) Waiting times for the CAMHS service were improving and currently the average waiting time was 7 weeks and, although many users were seen early, there were still a number who may have to wait for up to 40 weeks for behavioural or non-urgent related health conditions.

c) Work was progressing with CAMHS Teams to have manageable workloads and it was hoped that in the forthcoming months everyone would be seen with 13 weeks. Currently Autism Spectrum Disorder and Attention Deficit Hyperactivity Disorder support was not provided from the Adult Mental Health services and arrangements were being put in place for this to be provided for children moving into young adulthood.

d) Dr Miller was leading on the Workforce Group in Leicester, Leicestershire and Rutland. He fully recognised that that there was a challenge to ensure that staff resources moved with patients as the left shift in patient care took effect and fewer patients were treated in the acute sector and more in the community and primary care sectors. He envisaged that staffing levels within the health sector would remain at current levels for a number of years and this would require some staff to receive additional training and acquire different skills to enable them to move from the acute sector and provide community based care. Whilst this was fully recognised as a potential risk, he felt that all appropriate steps were being taken at the present to address the issues. It also needed to be recognised that new entrants embarking on nursing training schemes would take three years to complete their qualification.

The Managing Director, Leicester City Clinical Commissioning Group (CCG) stated that the CCG had recently taken over the strategic lead for children's services and had met with the Director of Children's Services to discuss the delivery of more integrated services. As the CCG was also the lead commissioner for the UHL contract this would also assist this process.

Following questions from Board members, Dr Miller stated:-

a) Although there was evidence to show that promoting resilience in an individual's treatment and recovery programme had beneficial and long term effects, it was more difficult to measure resilience in a whole community. However, this would need to be developed and be better quantified in the future as it would be one of the indicators that would affect the setting of strategic priorities of the wider health economy in the future.

b) An indication of progress in the next 12 months would be to be lower A&E admissions than present levels, that the new community capacity was fully utilised and that waiting times, especially in the CAMHS services, were achieving their waiting time targets.

c) The LPT priorities outlined in the presentation were aligned with the direction of travel of other partners in the health economy but there were some challenges to the delivery of the integration agenda by the simple virtue that partners were individual and separate statutory organisations which could present inherent challenges from time to time.

In relation to community resilience, it was noted that as the Council moved towards ensuring services became more focused and targeted at those people

who needed them it could lead to striping away parts of the universal offer. This would affect the development of community resilience such as providing networks and the ability to support one another one and this had the potential to store up future problems and issues by trying to address current issues. For example, the Play and Stay Sessions such as Toddlers Time in Libraries, where individuals develop friendships, relationships and networks to provide cross-peer support, can reassure young parents about child development matters and minor ailments and ultimately reduce the number of “worried-well” parents consulting GP and School services.

The Chair thanked Dr Miller for his very useful presentation and for the openness to responses. Whilst he acknowledged that LPT faced challenges, he wished to recognise that the organisation had improved and developed from its previous position 2 years before and he recognised Dr Miller’s leadership role in that process.

18. GENERAL DENTAL CARE SERVICES - URGENT CARE CONSULTATION AND SPECIAL CARE DENTISTRY PRE-ENGAGEMENT PROCESS

Jane Green, Assistant Contract Manager, Dental and Optometry, NHS England – Midlands and East (Central Midlands) and Semina Makhani, Consultant in Dental Public Health, Public Health England attended the meeting to present a briefing paper on the consulting the public on two options to improve access to urgent dental care services.

The consultation started on 3 August and would finish on 1 November 2015. A pre-engagement process had taken place in March and the responses had been used to shape the proposals.

The two options were:-

Option 1 Merge the existing Dental Access Centre and the dental out-of-hours services with revised opening times. The service would be delivered from the Dental Access Centre in Nelson Street (off London Road) Leicester.

Option 2 To establish two new dental practices providing urgent and routine dental care to patients from 8am to 8pm, seven days a week, 365 days a year including all Bank Holidays. When local practices are closed, the sites will provide urgent care services. The creation of the new practices is based on the oral health needs assessment and the review of existing contracting arrangements.

The report also contained details of the Specialist Care Dentistry for Leicestershire and Lincolnshire Pre-Engagement which had been extended in Leicestershire for six weeks from the original closing date of 25 September 2015.

NHS England would be considering both issues in late November with a view

to the two procurement programmes commencing in January 2016. It was intended to award new contracting arrangements in June 2016 to enable new providers to have an extensive mobilisation period to establish the new service arrangements.

Members of the Board made the following comments:-

a) It was difficult to state a preference between the two options as they were not readily comparable. The parameters of services in Option 2 were far in excess of Option 1 but at unknown locations; whereas Option 1 was located in the City where 80% of users of the urgent care services lived.

b) If there was capacity within the existing dental services, the need to promote and offer 'routine' dental services at the urgent care service was questioned. It may be better to signpost patients to dentists with capacity and encourage registration with them so that on-going care can be provided.

c) Healthwatch received a number of calls daily from people wishing to go to an NHS dentist and there was a difficulty recommending a dentist that was known to have spare capacity. It would appear there was a mismatch of dental services availability and it would be helpful if NHS England supplied a list of dental practices that had spare capacity.

d) There was evidence that in LE2 and LE5 post code areas there was no capacity as people were waiting 6-8 months to apply to see a local dentist.

e) As 80% of the users of the urgent dental care services were currently living in the City, it was queried whether there would be a guarantee that their needs would be catered for in whichever option was adopted. It was important to have a service where City patients did not have less access to the service that the current need clearly demonstrated exists within the City.

f) It needs to be recognised that car ownership in parts of Leicester with low levels of NHS registration is less than 50% and this has a major effect upon people's ability to travel, whereas car ownership in the county is higher. A city centre location is accessible by public transport, but travel is more difficult across the City and into county areas.

In response to comments made by Members of the Board it was stated that:-

a) Not every patient contacting the services requires treatment as advice may be given.

b) There were parts of the population that don't engage regularly with dental services until they have an urgent care need.

c) Part of the rationale for offering ‘routine’ dental care services was to address the pockets around the County where there was a need to improve access to dental services particularly in relation to children. Currently only 20% of 0-2 years olds had been seen by a dentist and NHS England were working with local dental practices to encourage increased levels of attendance so that preventative advice could be given.

d) Dental practices have not been required to register patients since 2006, they were however required to see patients until a particular course of treatment had been completed. Dental practices now maintained ‘lists of patients’ that they saw over a regular period.

e) A list of dental practices was supplied to Healthwatch on a monthly basis, but it was recognised that there were pockets of demand where people were reluctant to travel to see a dentist.

f) There could be more than one provider for the service and the provider would have to guarantee the service was available during the contracted hours of operation.

RESOLVED:

1) That the Board does not feel able to indicate a preference for either Option 1 or Option 2 on the information currently provided. However, the Board would expect that whichever model of care was eventually chosen that it would provide as a minimum level of service:-

   i) The current urgent dental care capacity provided in the City would be sustained.

   ii) The opening hours of access to the service would be a minimum of 9 am to 7 pm Monday to Friday and 6 am to 6 pm at weekends and Bank Holidays.

   iii) That the service would be delivered from a city centre location which was both central located and easily accessible.

2) That the Board receive a further report in the future focussing on the strategic provision of dental services and strategies for achieving higher levels of dental registration.

19. PROPOSAL FOR A NEW PRIMARY HEALTH SERVICE FOR LEICESTER CITY CARE HOME RESIDENTS

Sue Lock, Managing Director, Leicester City Clinical Commissioning Group (CCG) submitted a report on a proposal to establish a new multi-disciplinary

primary care service for care home patients.

The CCG was currently undertaking work to determine the optimum model of care for residents of care homes within the city boundary. Patients in care homes were often the most medically complex and frail within the community. They represented a complex interface between many different agencies such as primary care, acute care, community care, mental health, palliative care and statutory services. This often resulted in unnecessary admissions to hospital, lack of co-ordinated care and gaps in service provision. In all there were twenty five external services that have an input into care homes but currently these were not well integrated with primary care services. The CCG was working on a proposal to establish a new multi-disciplinary primary care service to provide targeted and specialist input into the care of this cohort of patients.

It was noted that there were approximately 2,260 people living in 107 care homes in the City. Whilst this represented approximately 1.2% of the city's population they accounted for 8% of acute admission to hospitals. Some GP practices had no patients in care homes and others had in excess of 200. This could lead to disproportionate effect upon a GP practice where residents in care homes could account for 2% of the patient list but account for 50% of patient visits.

The current care model had a tendency to provide reactive care and the multi-disciplinary approach was aimed at ensuring:-

- care for the patient was better co-ordinated
- there was a continuity of care for the patient
- more specialist support leading to enhancements in care
- more end of life patients being able to die in their normal place of residence
- the need to be admitted to hospital unnecessarily was minimised

The new model would need to maintain patient choice and it would need to enhance the current primary care services and not destabilise them.

Engagement had taken place with care home patients and care home managers and both were very supportive of developing more joined up services for this cohort of patients. The exact form of the new service was currently under consideration and would be subject to a Business Case approval by Leicester City Clinical Commissioning Group's Governing Body either late 2015 or within the first quarter of 2016.

Members of the Board made the following comments:-

a) Extra care provision should also be taken into account as people often preferred to take this option in preference to living in a care home.

b) It should be recognised that people's health can deteriorate whilst living in their own homes and there should not be a two tier system of care when people were not living in care.

c) The new model should not be solely based around GPs providing care

as models elsewhere in the country had shown that some patients felt more comfortable talking to nurses rather than GPs about their care.

In response to Members' questions it was noted that:-

a) The new model of care should be able to be extended to incorporate the extra care provision and this would be considered when the options for the new care model were discussed.

b) It was recognised that patients preferred to retain their own GP but some GPs were unable to provide sufficient dedicated time for all care patients in view of their other patient commitments. The best solution was a formula where the patient received the best care package from various sources and was also able to retain a relationship with their own GP.

RESOLVED:

1) That the report on the Care Homes Primary Care Service Project be received, progress be noted and that the Board's comments be considered as the care model is developed.

2) That the Council's Adult Care Scrutiny Commission should also be apprised of the options and asked to provide a view on the preferred model of care.

20. 0-19 HEALTHY CHILD PROGRAMME UPDATE

Ivan Browne, Deputy Director of Public Health presented a report requesting the Board to note plans for the recommissioning of the 0-19 Healthy Child Programme (HCP) and to develop further integration of this programme with the Council's Early Help Offer.

It was noted that the HCP was a universal public health programme for improving the health and wellbeing of children and young people. It was currently delivered by two separate programmes:

- HCP 0-5 years delivered by the Health Visiting and Family Nurse Partnership services, and
- HCP 5-19 years delivered by the School Nursing service

Both these elements were provided by Leicestershire Partnership NHS Trust and the Council now had the opportunity to integrate elements of the HCP programmes to ensure better service provision. Integration would enable the provision of a strong comprehensive offer to children and young people, while ensuring value for money and making commissioning decisions based on the best available evidence.

The impact of an effective 0 – 19 HCP would be measured through outcomes and indicators including; life expectancy, school readiness, domestic abuse,

breastfeeding, smoking prevalence at age 15, excess weight in 4-5, 10 –11 year olds and adults, tooth decay in children aged 5 and self-reported wellbeing.

In preparation for recommissioning the integrated HCP 0-19 years, a full review of the current HCP programmes had been carried out. The review findings will inform the development of the specification for the new 0 – 19 integrated healthy child programme for Leicester.

The Strategic Director of Children's Services commented that this proposal presented a real opportunity to realign services and avoid duplication of existing children's services.

RESOLVED:

> That the plans for recommissioning the 0-19 Healthy Child Programme and to develop further alignment of this programme with the Council's Early Help Offer be noted and welcomed.

21. THE DEVELOPMENT OF THE JOINT HEALTH AND WELLBEING STRATEGY

Ivan Browne, Deputy Director of Public Health presented a report on the emerging themes for developing the strategy in preparation for it to be renewed/refreshed in 2016. Since the publication of the strategy in 2013, there had been considerable changes in the health and social care landscape. There was a clear need to for a strong and sustained focus and local leadership around prevention. This was needed to reduce the health gap in the city, meet the challenge set out in the NHS 5 Year Forward Review and to reduce pressure on social care and children's services.

The Board had held a number of development sessions and the following key principles had been identified to drive the strategy's development:-

- The strategy should set out a long term vision for 20-25 years, which would act as a blueprint for how to deal with inequalities, enabling investment in prevention and reducing the gap in health outcomes between different parts of the city. The strategy should recognise that changes in life expectancy require short-term action but the impact on key outcomes such as life expectancy, will take longer to demonstrate and will need sustained focus. However, there is also a clear need to take rapid action to accelerate the pace of change in some 'high impact' areas which could lead to more rapid change in the next 3-5years.

- The strategy should focus on different stages of people's lives, looking at what would lead to sustained improvements in children's health and well-being, in adult life and in older age. It should also look at the wide range of assets and resources locally that could drive improvements in health and well-being. The strategy needed to clearly reflect and help

drive work already going on locally to improve health outcomes.

- There needed to be clear buy-in and support from the public for the ‘high impact’ areas that the strategy will focus on.

- The strategy needed to be supported by good data, including the Joint Strategic Needs Assessment and local MORI Health and Well-being Strategy and be measured against key short, medium and long-term outcome measures.

- The strategy needed to be innovative and developed and delivered in a way which uses new techniques to support behaviour change, for example using social media or local health challenges to encourage people to think differently and to encourage people across the city to get involved.

- There needed to be effective engagement of different groups from across the city to mobilise resources to deliver the strategy, including the voluntary sector, community groups, schools and local businesses.

- It should draw on external expertise, such as the Institute of Health Equity, to support the development of a clear and evidence-based framework for systematically tackling health inequalities

The strategy will be developed and delivered by a working group which would develop a draft strategy and engagement plan. The group will include:

- Key thematic leads from public health /public health data analyst
- A representative from the CCG’s strategy team
- Representatives from Adult Social Care and Children’s Services
- The council’s equalities lead
- A representative from Healthwatch
- Key HWB members

It was proposed to submit a draft strategy document to the February Board meeting and then undertake a programme of engagement with patients, the public and stakeholders to elicit feedback on the draft, including ideas about the best measures to put in place to achieve the strategy’s objectives.

RESOLVED:

That the proposals for the development of the strategy and the subsequent engagement programme be noted and supported.

22. LIVE/WORK LEICESTER CAMPAIGN

Ivan Browne, Deputy Director of Public Health presented a report on a proposed approach to developing a joint city-wide campaign to address critical gaps in areas of the local workforce and what can be done to address these.

Leicester City Council was leading on place-based marketing for the City and

work was underway to develop a consistent brand for the city and to highlight the key features of Leicester, promoting the city as a tourist destination and attracting in inward investment. This included plans to develop a clear brand and identity to be used for place marketing. This brand would be used as an over-arching identity for the campaign.

Initial discussions with key partners including the City Council, Leicester City Clinical Commissioning Group, University Hospitals Leicester and Leicester and Leicestershire Partnership Trust had indicated that there was a willingness for partners to develop and potentially contribute to a joint local campaign, with the aim of recruiting staff to key shortage areas as well as promoting the city.

It was noted that initial expressions of interest had been sought from local partners and initial scoping work had been carried out to map the feasibility of a joint local campaign and to identify potential target staff groups. This work, which would be led by the City Council, now needed to be further developed with a view to identifying and agreeing target staff groups, developing a costed proposal and seeking financial commitments from all partners, likely to be in the region of £20k per partner. Sponsorship may also be sought from major businesses in the city.

The Chair commented that the working title of Live/Work Leicester Campaign would be changed as the work was developed.

RESOLVED:

1) That Board endorse the proposed approach to developing a joint city-wide campaign and that it oversees its development and implementation.

2) That the offer of Sue Lock and Professor Farooqi to be involved in the work be welcomed and that contact be made with the Chief Operating Officer of West Leicestershire Clinical Commissioning Group to avoid duplication of effort.

23. DATES OF FUTURE MEETINGS

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

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

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

24. ANY OTHER URGENT BUSINESS

There were no items to be considered.

25. CLOSE OF MEETING

The Chair declared the meeting closed at 3.35 pm.