Leicester
City Council

Minutes of the Meeting of the
HEALTH AND WELLBEING BOARD

Held: TUESDAY, 2 FEBRUARY 2016 at 2.00pm

Present:

Councillor Rory Palmer (Chair)	–	Deputy City Mayor, Leicester City Council.
Karen Chouhan	–	Chair, Healthwatch Leicester.
Councillor Adam Clarke	–	Assistant City Mayor, Public Health, 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 Hoult	–	BCF Implementation Manager, NHS England – Midlands and East (Central Midlands).
Sue Lock	–	Managing Director Leicester City Clinical Commissioning Group.
Supt Mark Newcombe	–	Local Policing Directorate, Leicestershire Police.
Councillor Abdul Osman	–	Assistant City Mayor, Public Health, Leicester City Council.
Ruth Tennant	–	Director of Public Health, Leicester City Council.
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 NHS Arden and Greater East Midlands Commissioning Support Unit.

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26. APOLOGIES FOR ABSENCE

Apologies for absence were received from Chief Supt Sally Healy (Head of Local Policing Directorate, Leicestershire Police), Andy Keeling, Chief Operating Officer, Leicester City Council, Dr Avi Prasad (Co-Chair, Leicester City Clinical Commissioning Group), Councillor Sarah Russell (Assistant City Mayor), Trish Thompson, Locality Director Central NHS England – Midlands & East (Central Midlands).

27. 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.

28. MINUTES OF THE PREVIOUS MEETING

RESOLVED:

That the Minutes of the previous meeting of the Board held on 27 October 2015 be confirmed as a correct record subject to Councillor Adam Clarke, Assistant City Mayor being added to the list of those present.

29. QUESTIONS FROM MEMBERS OF THE PUBLIC

There were no questions submitted by members of the public.

30. UNIVERSITY HOSPITALS LEICESTER NHS TRUST - STRATEGIC PRIORITIES

Kate Shields, Director of Strategy, University Hospitals of Leicester NHS Trust (UHL) gave a presentation on the Trust's strategic priorities and current challenges. A copy of the presentation had been previously circulated with the agenda for the meeting.

During the presentation the following comments were noted in relation to the Trust's plans for the future and the challenges being faced in the current economic climate:-

a) UHL was the last large acute NHS Trust operating from 3 sites which needed to be addressed as part of the Trusts' 5 Year Operational Plan, the vision for which was set out in the presentation.

b) The Trust was a local, regional and national provider of health care

services and a third of the Trust's income came from providing tertiary specialist services. The Trust was working hard to ensure that hospitals referring patients to the LRI were fully supported so that the Trust could concentrate on providing the specialist tertiary services.

c) The Trust had made positive changes in a short time to change 'behavioural issues' in both staff and patients to drive forward the changes required. The Trust's beliefs and values fully underpinned the work to support behavioural change.

d) The Trust's Quality Commitment was refreshed each year. Currently the strategic aims were to reduce preventable mortality, to reduce the risk of error and adverse incidents and to improve patients' and their carers' experience of care.

e) The Life Study funding had recently been withdrawn.

f) The Estates Reconfiguration Plan would look to reduce inefficiencies of the use of sites over the next 5 years. The Trust were committing £320m of investment over the next 5 years to provide the Emergency Floor and reconfigure the estate to allow vascular services to move from the LRI to the Glenfield site, and to provide a better co-ordinated approach to general surgery to reduce the number of planned operations being cancelled due to emergency operations. Also, the Children's Hospital must be established at the LRI site by 2020 if the Trust was to retain children's congenital heart surgery.

g) The Trust had received £10m capital funding for the Emergency Floor this year which was to be welcomed. However there were increasing pressures on the capital funding nationally as it had been cut by 25% to fund revenue deficits in the NHS.

h) The Trust's current budget deficit was reducing and the Trust was confident that it would reduce in future years in accordance with the Trust's financial plan. The Trust still spent too much on agency and locum staff and efforts were being directed to making 'bank nursing' more attractive to staff in order to reduce the reliance on more expensive agency staff. The Electric Patient Record, when fully introduced, could be the biggest change to improving efficiencies within the hospital; as it would allow the full patient history to be available from primary care records and would enable faster decision making, better care and avoid duplication of recording patients' details.

Following questions from Members the responses below were noted:-

a) Work was progressing with improving integrated care. Better Care Together was helping to improve integration. Glenfield Hospital was working with GPs and Public Health Consultants to see how better access could be provided to the Clinical Decisions Unit. This was similar to the work at the LRI for single streamlining into UHL.

b) The Better Care Programme was also providing an opportunity to improve the long term conditions of patients and the Trust were looking to see how respiratory and cardiology consultants could provide treatment to patients in community hospital and neighbourhood hub settings. Although there had been considerable discussions in relation to working together, further work was still needed to achieve full integration or working practices.

c) Dealing with the frail and elderly remained one of the major challenges. Space could still be used better at the LRI site and if more beds were provided they would face more pressure from the frail and elderly than surgical cases.

d) It was not always necessary to increase facilities to manage larger demands. Medical staff were keen to change service delivery and moving to 23 hour hospital stays was an effective way of increasing patients numbers for a number of minor surgical interventions using the same number of beds.

e) Using the Intermediate Care System beds provided by LPT to the maximum effect would be crucial to future service delivery, particularly under Better Care Together.

f) Although the results of staff satisfaction and patients recommending others to use the hospitals was disappointing, particularly at the LRI site, a great deal of work was being undertaken by the recently appointed Director of Human Resources to change staff perceptions and promote positive achievements such as the moving the cardio-vascular service to Glenfield, building the new emergency floor and creating the children's hospital.

g) The Trust was the 9th largest teaching hospital in the country but struggled to retain students after qualification. Students were being actively involved in shaping future services and business cases for making change. The Trust recognised that part of the solution was having an offer for students that involved LLR and not just UHL.

h) UHL were working to deliver eye casualty services in a more dynamic modern hospital setting, as it was currently considered to be outdated in its current form.

i) UHL were having discussions with NHS England in relation to orthodontic services, which had been poorly commissioned and funded nationally for many years. The Trust had the largest number of ophthalmic outpatients in the country but not the largest local population.

j) The 25% reduction in the national capital programme was of concern but it was considered that the Trust would still receive support for reducing the number of sites from 3 to 2 and the Trust had regularly briefed the

Minister on current issues and priorities. However, if capital funding was prioritised, the Women's Hospital and the Ambulatory Care Hub would be delayed as there were other projects with greater priority involving higher clinical safety issues.

The Chair thanked Director of Strategy for her presentation. He felt that both the UHL and LPT had clarity in their planning with specific deliverables and milestones and for delivery. He was less confident that this was currently in place for the BCT planning; the delivery of which was crucial to all those in the local health and social care economy.

Finally the Chair wished the Director of Strategy best future wishes in her new employment.

31. BETTER CARE FUND

The Board received a report on the Better Care Fund (BCF) from Sue Lock, Managing Director, Leicester City Clinical Commissioning Group.

The Board were requested to approve the draft BCF 2016/17 template for submission on February 8th 2016 and to delegate approval of draft narrative plans to the Chair of the JICB and the Strategic Director for Adult Social Care also for submission on February 8th 2016.

It was noted that the format of the template was not an ideal way of presenting the information but it was a prescribed national format. The template required approval each year as it was a joint plan. The submission was in two parts, one is the template currently being considered and the second part is a narrative plan which sets out how the joint partners will achieve the trajectories. This could not been completed until national guidance had been received.

Part 1 of the template showed Better Care Fund expenditure of approximately £22m and represented, at service line level, what the CCG and the Council believed would be the most effective way to integrate services aimed at preventing emergency admissions. This was based upon the successes of the previous year with an element of expansion in some of those.

There was a high level classification of whether elements were Integrated Care Teams, Support for Carers or Reablement Services etc. with expected expenditure against each one. There was approximately £190k of recurrent expenditure that would be re-prioritised through the year. In addition there was a £1m none recurrent carry forward and proposals had been invited for this.

In response to a question on the £1.9m expenditure on the Performance Fund, it was noted that this was an amount of the fund that was payable based upon the performance to reduce none elective emergency admissions. It was a retrospective payment at the year end. If the performance did not achieve the intended reductions, the payment went to the acute trust. If the performance was achieved and the reduced admissions targets were achieved; then the payment was paid into the Better Care Fund in the following year.

It was noted that in putting forward the current proposals, horizon scanning had been carried out to evaluate what had been carried out elsewhere in the country. Experience of local and national events showed evidence that local practice was effective and robust and this had been mirrored in feedback at national level. Furthermore, the City's BCF had been cited as an example of good practice to other bodies including a presentation at the House of Lords.

The Director of Public Health commented that the risk stratification work undertaken for the BCF had potential to be used to great effect outside of the BCF context to consider the benefits that could be achieved through limited resources in preventative initiatives.

The East Midlands Better Care Fund Implementation Manager, NHS England, commented that the City's BCF was considerably further advanced with its financial information than other Health and Wellbeing Board areas covered by her post. It had been confirmed that the narrative plan would only be considered at a regional level rather than national level as in previous years. There was no prescribed template for the plan and it would focus on looking at what had worked well in the previous year, what hadn't and what had steps had been taken as a result. It was noted that the lack of national guidance had impacted upon the timetable in relation for the requirement to produce the narrative plan. However, no changes were expected to the current guidance except for changes in relation to the delayed transfer of care and non-elective admissions. The provision of the Performance Fund in the current draft BCF was commended as recognising these as issues.

The BCF Implementation Manager also stated that she could share a dashboard indicator of the 10 Health and Wellbeing Board areas within her remit which confirmed that the City was currently performing the best.

The Chair welcomed the offer of sharing the dashboard indicators with the Board. He felt that whilst the current draft had been commended for its planning, it was important to avoid being complacent in view of the fragility of future spending and budget allocations especially in relation to forthcoming spending reviews.

RESOLVED:

1) That the draft BCF 2016/17 template for submission on February 8th 2016 be approved and that approval of draft narrative plans also for submission on February 8th 2016 be delegated to the Chair of the JICB and the Strategic Director for Adult Social Care.

2) That NHS England and the Department of Health be made aware of the Board's views that:-

    a) the current presentation of information in the template was not helpful to people who had an

interest in the topic but did not have a heath background.

b) a number of schemes and interventions related to more than one scheme type and the true picture was distorted because of the inflexibility of having to badge each scheme and intervention against only one scheme type.

32. NHS PLANNING GUIDANCE - IMPLICATIONS FOR LEICESTER

The Board received and noted the NHS publication 'Delivering the Forward View: NHS planning guidance 2016/17 – 20120/21 that would have implications for the work of the Board. Sue Lock, Managing Director, Leicester City Clinical Commissioning Group introduced the key elements of the guidance.

The guidance supported the Government's NHS Spending Review in England in implementing the 5 year forward view, addressing financial sustainability and increasing the quality of service delivery.

The planning guidance required the production of a local one year Operational Plan to identify what would be done to meet the statutory guidance targets and constitutional standards and how the improved standards would be achieved.

The guidance also required the production of a Sustainability and Transformation Plan (STP) for 2016-2021 written as an overarching place based plan for the local population in relation to the health and social care economy as a whole. The Plan is required to be submitted by June 2016 and would be formally assessed in July. It had been agreed that the placed based element would cover the Leicester Leicestershire and Rutland footprint. In essence, the plan was similar to the Better Care Together but with additional strands covering specialised services, primary care services and a prevention plan element to the STP.

It was very different to the pre consultation business case developed for the Better Care Together Plan, although the identification of best practice and the relationships formed across the health and social care community for BCT had all helped to put LLR on a good footing for preparing the STP.

It was noted that:-

a) The funding in 2017/18 would be dependent upon the quality of the STP and the clarity of defining what will be done in the future and this would influence how quickly funds could be accessed. Further details were awaited on this process.

b) The Operational Plan had a requirement for 9 'must dos' for 2016/17 and would need to show in detail how the activity and finance would work together to achieve the objectives.

c) The CCG had received definite allocations for the next 3 years and indicative allocations for the following 2 years. Although there was an uplift in allocations received, this did not represent any additional purchasing power in real terms as the cost of purchasing services had also risen. The CCG had received approximately £12m extra funding but to standstill and buy the same activity would cost approximately £11.8m.

d) All CCG's were being encouraged to create stability within providers and £1.8b nationally had been allocated to provide flexibility to providers and to allow the CCGs to work with providers to get some transformation for the following year. The challenge was to reduce deficit, improve access and progress the transformation.

e) The CCG had met with the Chief Executives of UH, and LPT to see what the challenges were for the future, what the improvement trajectories would look like and how to take the process forward within the financial settlements received.

f) Although the CCG had received an extra allocation for Primary Care Contracts, the core allocation now included a number of areas of expenditure where previously non-recurrent allocations had been received; such as GP IT systems. The net impact was less than had been hoped for.

g) The New Assessment Framework for CCGs had been received recently and was currently out for consultation. A copy would be forwarded to the Chair for information. The CCG's Director of Strategy and Implementation was co-ordinating the production of the plan across LLR and representatives of local authorities had been asked to link in with this process. There would be a focus towards the constitutional targets, which would be A&E, cancer, EMAS handovers and waiting times for elective surgery.

h) There had been discussions on whether there should be a local work-stream in BCT on prevention but it was felt that this should be driven at a strategic level by the Board.

RESOLVED

1) The approach being taken be noted and endorsed.

2) That the suggestion that prevention should be led by the Board at a strategic level be endorsed and that any non-recurrent Better Care Fund money be targeted at preventative measures.

33. MENTAL HEALTH JOINT COMMISSIONING STRATEGY

The Board received a report from the Lead Commissioner – Mental Health &

Learning Disabilities on a Mental Health Joint Commissioning Strategy developed by Leicester City Council and the Leicester City Clinical Commissioning Group; which outlined the commissioning intentions for the period 2015-2019.

The strategy has been developed in full consultation with stakeholders, including people with mental health problems and carers of people experiencing poor mental health.

The Board were requested to endorse the Mental Health Joint Commissioning Strategy as part of the sign off process prior to publication.

It was noted that:-

a) The strategy had been developed in consultation with stakeholders, including people with mental health problems and carers of people experiencing poor mental health.

b) The strategy was focused on prevention and early help for individuals to avoid them reaching crisis point before engaging with services. The strategy also aimed to build capacity in the community.

c) A dashboard had been developed to measure the strategy's impact on individuals and carers over the life span of the strategy.

d) The Mental Health Partnership Board would oversee the 2 year delivery plan for the strategy.

e) The strategy would also be reviewed and updated on an annual basis to take account of changing circumstances or guidance.

Members of the Board commented that:

a) There were a range of mechanisms within Children's and Young Peoples Services which should be used to seek the views of children and young people.

b) The work of Adult Education Centre in providing courses, qualifications and achievements had been shown to have positive benefits for peoples' mental health and this should be recognised in the strategy.

c) There was evidence that employers and the Department of Works and Pensions appeared to lack confidence in engaging people with learning difficulties.

d) That the strategy should deliver real improvements and changes to service users.

The Chair commented that he had held discussions with the Chair of the Leicester and Leicestershire Enterprise Partnership to encourage employers,

as part of their initiatives, to support people with mental health and learning difficulties through employment opportunities. He was also looking at supporting people in the community through the work of the Adult Social Care services provided by the Council.

RESOLVED:

1) That the Mental Health Joint Commissioning Strategy be endorsed.

2) That the Mental Health Partnership Board monitors the implementation and performance of the strategy and notifies the Board of any issues which they feel should be brought to its attention. These issues could be either concerns or items of positive feedback and outcomes.

34. PRIMARY CARE WORKFORCE PLANNING

The Chair requested an update following the concerns that had been expressed around the two recent closures of GP practices at Marples Surgery and Queens Road Surgery.

Professor Farooqi commented that both practices had been single GP practices and both GPs had submitted their notices to resign from their contracts. Once it became clear to the CCG that the Marples Surgery premises would not be available for future use as a surgery; the only option available was to disperse patients to other GP practices in the area. The decision of the GP to resign from his contract at the Queens Road Surgery was unexpected and the patients registered at that practice came from all parts of the City and the county. There were approximately 2,000 patients involved and these were being dispersed amongst other GP practices within the City.

It was generally acknowledged that there were significant pressures on GP practices; particularly as recent changes in the national funding formula had resulted in practices in the City receiving less funding. The CCG were working collaboratively with practices in the City to promote forming federations and offering ‘golden hello schemes’ in an attempt to address issues of recruitment and retention.

It was suggested that a 6 month period of notice would be useful to allow more time to make alternative arrangements for patients affected by the closure of a practice. In response, Professor Farooqi stated that the CCG contract with GPs had a 6 month period of notice. However, GPs general contracts were negotiated nationally and were subject to a 3 month notice period and could not be changed without further national negotiation and agreement. However, the CCG would be prepared to explore whether a voluntary agreement could be negotiated locally with single handed GP practices in order to help future planning of services to patients. This would enable more time to consider alternative options for the continued care of patients, especially in instances where there was a cumulative effect arising from more than one practice

closing in the same area of the City within a short time span.

A further suggestion was made to undertake a survey/audit of GP practices to identify any plans to assist future planning provision for GP services; particularly if this was conducted on an annual or biannual basis. It was also noted that the number of single handed GP practices in the City was gradually diminishing through the promotion of initiatives such as co-operation and federation working.

The Chair of the Council's Health and Wellbeing Scrutiny Commission stated that the Commission was currently undertaking a Task Group Review of Primary Care Workforce Planning which included both GP and practice nurses recruitment and retention.

RESOLVED:

1) That the update be noted.

2) That the CCG's willingness to explore a voluntary local extension to single handed GPs giving more than the national 3 months' notice period to resign be welcomed.

3) That the suggestion to undertake an general audit/survey of GPs to better inform future planning provision of services be supported.

35. ANY OTHER URGENT BUSINESS

There were no items to be considered.

36. CLOSE OF MEETING

The Chair declared the meeting closed at 3.50pm.