Leicester
City Council

Minutes of the Meeting of the
HEALTH AND WELLBEING BOARD

Held: MONDAY, 3 APRIL 2017 at 2:00 pm

P R E S E N T :

Present:

Councillor Rory Palmer (Chair)	–	Deputy City Mayor, Leicester City Council.
John Adler	–	Chief Executive, University Hospitals of Leicester NHS Trust.
Councillor Piara Singh Clair	–	Assistant City Mayor, Culture, Leisure and Sport, Leicester City Council.
Councillor Adam Clarke	–	Assistant City Mayor, Energy and Sustainability, Leicester City Council.
Steven Forbes	–	Strategic Director of Adult Social Care, Leicester City Council.
Chief Inspector Jed Keen	–	Local Policing Directorate, Leicestershire Police.
Richard Morris	–	Leicester City Clinical Commissioning Group
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.
Michael Smith	–	Healthwatch Leicester
Ruth Tennant	–	Director of Public Health, Leicester City Council.

In attendance

Graham Carey	–	Democratic Services, Leicester City Council.

61. APOLOGIES FOR ABSENCE

Apologies for absence were received from:

Lord Willy Bach	Leicester, Leicestershire and Rutland Police and Crime Commissioner
Andrew Brodie	Assistant Chief Fire Officer, Leicestershire Fire and Rescue Service
Karen Chouhan	Healthwatch Leicester
Frances Craven	Strategic Director Children's Services, Leicester City Council
Prof. Azah Farooqi	Co-Chair, Leicester City Clinical Commissioning Group
Andy Keeling	Chief Operating Officer, Leicester City Council
Chief Supt Andy Lee	Head of Local Policing Directorate, Leicestershire Police
Roz Lindridge	Locality Director Central NHS England, Midlands and East (Central England)
Dr Peter Miller	Chief Executive, Leicestershire Partnership NHS Trust
Dr Avi Prasad	Co-Chair, Leicester City Clinical Commissioning Group
Toby Sanders	Senior Responsible Officer, Better Care Together Programme

62. DECLARATIONS OF INTEREST

Members were asked to declare any interests they might have in the business to be discussed at the meeting. No such declarations were made.

63. MINUTES OF THE PREVIOUS MEETING

RESOLVED:

That the Minutes of the previous meeting of the Board held on 6 February 2017 be confirmed as a correct record.

64. CCG GP FIVE YEAR FORWARD VIEW

The Board received a report from the Leicester City Clinical Commission Group (CCG) on the Blueprint for General Practice – Delivering the General Practice Five Year Forward View; that had been jointly published on 24 February 2017 by all 3 CCGs in Leicester, Leicestershire and Rutland.

The Chief Executive, Leicester City Clinical Commissioning Group introduced the report and commented that primary medical care was the foundation of a high performing health care system and was critical to the successful implementation of the LLR Sustainability and Transformation Plan. Ensuring the development and resilience of Primary Care would assist in bringing about the system-wide transformation required to focus on prevention and the moderation of demand growth.

The Plan had been prepared by the three separate CCGs in LLR each had distinct geographical, political, social and economic environments, with very differing health needs. All three CGGS were committed to the development of our response to the GP 5 Year Forward view as a collective, and consequently there was a focus in the plan on what brought them together and how they would jointly tackle the challenge, whilst also highlighting locally sensitive solutions to their own areas of responsibility.

GPs from each CCG Board had actively engaged in the development of the plan and fully supported it. There were many challenges facing General Practice, including workforce, funding and rising demand. All CCGs would work together to develop and co-design a resilient and sustainable model in which general practice could thrive and meet the challenges in the future.

The CCGs had a clear direction for the future of primary care in which general practice was the foundation of a strong, vibrant, joined up health and social care system. The new system was patient centred, engaging local people who use services as equal partners in planning and commissioning which results in the provision of accessible high quality, safe, needs-based care. This would be achieved through expanded, but integrated, primary and community health care teams; offering a wider range of services in the community with increased access to rapid diagnostic assessment and, crucially, patients taking increased responsibility for their own health.

The following points were noted in response to discussion and questions from Members of the Board:-

a) Work on the strategy had been taking place for some time in what was a complex area. There had been a difference in approach from NHS England who had acknowledged the level of investment and resources in primary care had been inadequate. Many GPs had complained for a number of years that the lack of investment had not enabled primary care to keep on track with the rest of the health system.

b) The three key issues locally were:-

- Capacity - the ability to deliver in different parts of the workforce around the LLR area.
- The health needs challenge presented by the city arising from deprivation.
- The level of investment.

c) The Primary Care strategy was seen as an enabling document for larger strategies such as the STP to be delivered. The focus in the strategy was on:

- Providing support to patients for self care.
- An appropriate and accessible primary care service.
- Integrated care bringing health and social care teams together to care for patients.
- A home first model aimed at keeping people at home as long as possible and getting patients out of hospital as soon as possible where it was safe to do so, to avoid people becoming institutionalised the longer they stay in hospitals; which then required them to have more support when they returned home. Primary care was integral to support this.

d) The Primary Care Plan was a blue-print for the LLR and was a part of the STP. Although it was a joint plan for the LLR area it was broken down to recognise the difference in populations, health needs, and the state of health care between the county and city. Parts of the Plan looked at health care across the LLR in its entirety and parts looked at specific issues with the city.

e) Primary care continued to be the corner stone of the NHS. It was the part of the service most used by patients on regular basis and the part used to build relationships over long periods of time. There were relatively high satisfaction levels with primary care although these were lower in the city. There had been significant challenges of demand and funding over the last 15 years and recruitment and retention of GPs still remained a challenge.

f) The key points in the CCGs vision for the next 5 years were that:-

- GP practices remained at the heart of health care and central to the health service.
- Named GPs would take on more responsibility for active treatment of acute conditions. This may mean that patients attending with routine conditions and enquiries may not always see their named doctors, but may see a health professional who was qualified to provide the level of treatment required by the patient.
- Practices would come together and collaborate more than they had in the past. This might be through informal or formal collaboration arrangements. The CCG wanted to provide an

environment which would enable voluntary collaboration of GP practices without the CCG being prescriptive on the arrangements.

- The Plan incorporated the national requirement to provide access to urgent on the day GP services, and built upon the developments that had been made in the city over the last 12-18 months. The biggest development had been the opening of three GP hubs. These had provided 180,000 additional GP appointments in the city per year and were open to any registered patient of a city GP practice. They had been piloted for 18 months and the CCG had now secured funds from NHS England to continue them for the next 2 years. The hubs would be developed to provide a wider range of services for patients and communities by providing both routine diagnostic tests such as blood, urine and ECGs, but also other services that currently required an outpatient appointment. In addition to the £2.2m for continuing with the hubs, the CCGs were also making £600k available in each of next 2 years to deliver transformation measures to make the system more sustainable in the long term or engaging in collaborative working.
- The vision for GP recruitment envisaged the need for a change of skill mix with more nurses, nurse practitioners and clinical pharmacists working in practices to support GPs in order to create capacity for GPs to focus on patients with more complex conditions who needed more time and support.
- Not every GP practice in the City experienced difficulty in recruitment and some had innovative working practices to recruit GPs which would be shared with others. This included a varied portfolio providing experience of working in other parts of health service, research opportunities, lecturing at the universities and working in hospital setting. 20 GPs had been recruited in the last year and the 3rd phase of the local GP recruitment scheme had attracted 27 applications.
- There would be more investment through changing the GPs contract by increasing the current payment of £78 per patient per year to £85 per patient per year.
- There had been significant engagement with clinicians within the LLR and the Plan had been endorsed by city GPs. The Plan also built upon public views expressed in the last 2 years and further engagement would be undertaken.
- The document was written in NHS technical language and a public facing document was being prepared to enable further public views to be expressed on whether the proposals in the Plan were appropriate and met the demands that were currently seen within the service.

NHS England had published the 'Next steps on the NHS Five Year Forward View' on 31 March 2017, which set out actions to deliver NHS care fit for the future. The implications of this were being considered to see if this impacted upon the Plan and whether any changes were required as a result.

The Healthwatch representative referred to an 'Enter and View' inspection carried out at the Westcotes Health Centre which had provided positive patient feedback on the flexibility of the system and also that some patients were using the hub as an alternative to their own GP practice. It was hoped that those GPs who needed extra help in operating their practices were not overlooked by the hubs masking an underlying issue. It was also felt that the scale and risk associated with the culture change required for patients to take more responsibility for their own health was understated in the Plan. The creation of the integrated team model was, however, a good way forward to help reshape services.

In response to the Chair's comment that the Plan had little reference to the important role that community pharmacies could play in relation to access, prevention and the self-care agenda, it was noted that a member of Pharmacy Board had recently been invited to join the Programme Board. It was also recognised that there were groups within the local population who had low levels of confidence in using pharmacies in their own countries and there would be a need to work with these communities to increase their awareness and confidence in using pharmacies.

It was also noted that NHS England, as the commissioners of pharmacy services, were in the process of launching a 5 year forward view for pharmacy services and embarking on a national campaign to promote the services pharmacies could provide.

The Chair observed that GPs had expressed views that the system was fragile and not resilient. It felt that the focus in the document was primarily on structural governance arrangements when people wanted to feel assured that they could see a doctor or nurse and get good care at home when it was appropriate. The public also wanted to have equality of access across all 3 CCG areas and for services to have equitable outcomes. At present there were high variants of cancer detection between the 3 CCG areas.

In response, it was noted that some outcomes were affected by GPs individual contracts. Evidence was emerging that by forming federations small GP practices could come together and share skills which enabled them to extend their services. GPs could choose to offer other services above their core contracts if they wished. Sometimes the physical accommodation in the building itself could be a constraint to offering additional services. A federation offered an opportunity to allow practices to work together and have a consistency of approach. Currently 12 practices had indicated that they were not interested in forming a federation. The variance in cancer outcomes for patients etc were being addressed through the STP process where system wide funds could be used by all 3 CCGs, in partnership, to provide a targeted approach to encourage people to come forward in those areas where there were low outcomes in cancer detection.

A member of the public asked a question relating to there being no reference to providing training for GPs in the strategic document and the importance of

sharing examples of good innovative practices to promote consistent standards across all GP practices. There were concerns that when GPs retired, these innovative services could be lost and thought should be given to training new GPs to ensure continuity of quality care in these instances.

In response it was stated that:-

- The CCG provided training and planned to provide training where specific health needs were identified. One such area was diabetes where the CCG had invested significant sums in providing diabetes training for GPs and nurses and had offered enhanced payments to GPs to provide increased service provision. Increased outputs in quality of care had been observed in last 2 years as a result.

- The importance of training in clinical governance and patient care was also recognised as being important for those patients with more complex health care needs in the future.

- There would be a separate work stream for training for the future and work was being undertaken on the training hub in the city in conjunction with medical students, Kings College and Nottingham University to improve training, coaching and mentoring to increase skills and share examples of best practice.

Following comments from Board Members it was noted that:-

a) The CCG was investing time and effort in meeting GPs and it was encouraging that many younger GPs had already expressed interests in the 5 year view, forming federations and wanting to help shape future services. The CCG were encouraging young GPs and practice nurses to take on leadership roles in the future.

b) The CCG had started dialogues with the PPG forum to encourage the participation of the individual PPGs and this had received a positive and productive response in the exciting opportunities the document gave them in going forward.

c) The proposals for shared investment mentioned in the 5 Year Forward would be funded by a two thirds contribution from NHS funding sources and the remainder from individual GP practice funds.

d) The STP was still awaiting approval from NHS England to enable it to proceed to the consultation stage. The proposals for primary care would not in themselves meet the thresholds for the formal consultation process, but there would be public engagement on the proposals. Once the formal consultation process had been approved it would enable more meaningful conversations with patients, carers and the public on the draft proposals.

e) The CCG had a responsibility to ensure that patients did not travel too

far to access services and this was taken into account when forming federations. The CCG also had a responsibility to ensure that qualified staff delivered services commissioned by the CCG's to their standards. The CCG would be issuing protocols in practices so that practice nurses could see and provide treatment to patients where they were qualified to do so. It was noted that these changes were being introduced nationally.

f) The current healthcare service was not sustainable in the long term and these plans were required to ensure that all staff had the appropriate skills to provide safe treatment to patients at the appropriate level for the patient's needs and health conditions. Not all health conditions required treatment from a GP.

The Chair commented that he had concerns in relation to what the changes could mean for health services generally. Introducing large structural changes required considerable amounts of existing capacity, time and resources, which could impact upon the ability to provide services during the planning and implementation period. Where there was not a requirement for full formal consultation on proposals, there should still be good effective consultation with patients so that they could make informed judgements. This was particularly important in instances where there was no opportunity to challenge an individual practice in joining a federation and to help the public to understand the reasons why self-care was important in reducing the demands upon health and social care services.

AGREED:-

That the report and update be noted and that elements of the proposals be submitted to future meetings and the Health and Wellbeing Scrutiny Commission to link in with discussions on the STP.

There was a need for the Board and the Scrutiny Commission to be informed of specific timescales and proposals and to understand how the proposals specifically impacted upon the city, especially the impact of establishing federations in a particular area of the city and what services they will provide and what outcomes were expected as a result.

65. HEALTH, WELLBEING AND PREVENTION STRATEGY

The Director of Public Health submitted a report on the Draft Health, Wellbeing and Prevention Strategy which would succeed the previous Joint Health and Wellbeing Strategy 'Closing the Gap'.

The draft strategy had been developed through informal engagement within the city council and local NHS. The strategy set out a framework for prevention in the city across 5 key themes and provisionally identified bodies to take responsibility for moving forward particular elements of the strategy, led by the Health and Wellbeing Board. The key themes, responsible bodies and their responsibilities would need to be confirmed. Implementation of the strategy

would be supported through an annual action plan

Public engagement on the Strategy was provisionally planned for May. A one-page public facing version of the Strategy would also be prepared for the final version. The strategy had 5 key themes:-

- Healthy Start – covering maternity, ante-natal and childhood services.

- Healthy Lives – covering lifestyle factors and helping people to live healthier lives

- Healthy Minds – mental health and wellbeing and good services and community provision for people with low level mental health concerns to prevent them becoming more acute

- Healthy Ageing – reducing isolation and helping people live longer and healthier for longer.

- Healthy Places – how to make better use of, and recognise the importance of, 'place' which was around making the best use of resources , assets, facilities and social capital in communities to help make communities healthier. It was about linking in with opportunities that were provided by consultations and engagement on other plans such as the local plan policy framework which also shape and affect communities.

Each of the themes had key outcomes and specific indicators to measure performance.

The Chair asked for views on whether the specific indicators and the structure of the strategy were appropriate and whether the outcomes addressed the challenges being faced in communities, and by the Council and the NHS.

The Director of Public Health commented that the draft strategy had been built upon the previous work undertaken in 'Closing the Gap' and developing existing work. It was important to outline what 'prevention' would look like in a local strategy designed to bring about long term changes and differences in health needs identified in Joint Strategic Needs Assessment beyond the nominal lifetime of these 5 year strategies. There would be more engagement and consultation as the strategy developed.

The Assistant City Mayor, Children, Young People and School stressed the importance of linking the strategy with work in other strategies and with the work of other Boards. She felt that draft strategy should include an outcome around 'attachment' which could fit into any of the first three themes. Getting the outcomes right for young people was an important part of long term prevention measures.

The Chair commented that the series of public engagements and development of the prevention strategy would take place in May and encouraged partners to

take an active part in those events.

AGREED:

1) That the draft strategy be received and the overall aim and approach of the draft strategy be supported.

2) That the final version of the draft strategy be submitted to the next meeting of the Board.

66. SPORT ENGLAND BID UPDATE

The Director of Public Health submitted an update on Sport England's new strategy 'Towards and Active Nation'. The Director also made a presentation on the local proposals that were being developed by the Council and its partners.

The following was noted during the presentation:-

a) Sport England introduced a new strategy on 1 April 2017. One of the funding streams was called 'Local Delivery' which was a placed based fund. 10 local areas would be funded to implement local strategies for physical activities and sport. There was £130m available for this funding stream and there was a particular focus on addressing physical inactivity and working with under-represented groups. Sport England were not being prescriptive and were seeking genuine innovation and wanted to see a whole system approach in proposals put forward.

b) The Council had formed a coalition with 4 professional sports clubs that had existing public community projects and engagement in community. The coalition would provide leadership and oversight of project management as well as identify target communities and provide 'needs' information.

c) Both local universities were engaged to provide support to the Expression of Interest and the bid preparation and would undertake research regarding interventions.

d) A stakeholder workshop included membership from NHS, the 2 local universities, staff from the Council's parks, active transport, leisure and public health services, community groups and Voluntary Action Leicester. Other sports clubs and community groups would provide support and enable access and potential delivery of some initiatives.

e) Sports England did not require well defined plans at his stage but wanted details of the prospective proposals to address the locally identified needs through engagement with community groups.

f) The short term outcomes of after the first 2 years (2107-19) were expected to be:-

- Development of evidence based plans.
- Identification of priority audience groups and local challenges/goals.
- Building deeper understanding of audience and needs.
- Genuine engagement and consultation.
- Change in ways of working to increase collaboration.

g) It was already known that a third of the local population exercised for less than 30 minutes a week and Leicester's performance was worse than many other places with similar characteristics. The trend had changed little since 2012. Surveys had shown that many were motivated to change their lifestyle and exercise regimes but felt there were numerous barriers preventing them from doing so. If the right solutions could be found, there was a existing cohort of people who were willing to make a change. There was good information on what people had identified as the barriers stopping them from changing their routines. These included:-

- Too busy/no time – 42%
- Ill-health – 17%
- Work commitments – 17%
- Laziness – 16%
- Weather – 8%
- Tiredness – 7%
- Affordability – 5%
- Disability – 4%
- Nearness to facilities – 2%
- Afraid of injuries – 2%

h) The challenge was to normalise exercise and build it into people's lives. There were specific challenges around older people but lots could be done to achieve light exercise through swimming and GPs would need to be involved to inform patients of the exercises that were available. Other exercise could also be provided by activities such as gardening or heavy house work. Currently brisk walking was the most popular form of physical activity in the city (59%) compared with heavy house work (18%) gym/outdoor gym exercise (15%), Sports (12%) and jogging (12%)

i) Data collecting from schools indicated that 15% of primary pupils were exercising at the recommended levels and there were considerable variances across different areas in the city. Promoting active travel by encouraging pupils to walk or cycle to schools could be an important means of encouraging further physical activity.

j) There were many assets in the city and these needed to be developed as part of the strategy. The use of social media and technology such as 'fitbits' could also be part of initiative to drive change.

k) The sports sector was currently a growth sector for employment and

local pilots could provide a useful source of intelligence on what we know already works or doesn't. Sustainability presented a real challenge in using existing assets differently and sport and leisure staff had an important role in getting over other messages on exercise to people.

l) Proposals would be based upon how many people locally needed to get up to the national average levels of exercise per week.

m) Leicester already had initiatives such as the Active Leicester brand and the outdoor gyms programme was now fully installed and people were actively using these that didn't normally go to gyms for exercise.

n) The aims of the proposals were to increase physical activity in 20,000 people in Leicester over the next four years by:-

- Supporting over 2,000 5-15 year olds and 5,000 people aged over 16 years to become active.
- Helping over 2,000 5-15 years old and 11,000 people aged over 16 years to change from doing some activity each week to levels of activity recommended to maintain a healthy lifestyle.

o) The timescales for the process was:-

- Workshops held during February and March and the Expression of Interest (EOI) had been prepared and submitted by 31 March 2017.
- The EOIs were being assessed by Sports England and the selection of partners for the 10 Pilot were expected to be announced on May 17 2017.
- Sports England would then work with the selected partners to prepare their detailed bids. Should Leicester be successful, further discussions would need to take place with NHS partners to identify potential resources for the detailed bid.

AGREED:-

That the Expression of Interest be supported and a further report be submitted to the Board on the outcome of the initial assessments, if successful, proposals for developing the detailed bid.

67. IMPACT OF BREXIT ON THE LLR NHS AND CARE WORKFORCE

The Board discussed the possible impact of Brexit on the LLR NHS and Care workforce. The Deputy City Mayor and the Chief Executive of University Hospitals Leicester NHS Trust (UHL) made a joint presentation to the Board on the issues involved.

The Chair had asked for this to be discussed by the Board following the formal

triggering Article of 50. This was now a very big, worrying and strategic work force challenge for health and social care system. The NHS had included a useful statement in their Next Steps for the Five Year Forward View, indicating that they would work actively with the government to safeguard and secure the contribution made by international doctors and nurses and other staff as the Brexit negotiations proceeded.

The Chair felt that it was of concern that no government statement had been made to provide clarity or certainty for other nationals of EU member states working in the health and social care sector or in the private sector. The Chair had met trades union representatives earlier to explore ways of reaching out and supporting the Council's staff and was interested in hearing others views as to what they were doing in this area.

It was noted that nationally there were 10,150 doctors and 21,032 nurses & health visitors who worked in parts of NHS originally from EU countries. This represented 9.7% of doctors and 7.1% of nursed and health care workers. There had also been no statement to clarify whether the NHS would receive the £350m per week that had been inferred during the campaigning for the referendum as part of the Article 50 announcement.

Chief Executive of University Hospitals Leicester NHS Trust (UHL) stated that:-

a) UHL's employment of staff with EU nationalities was slightly higher than that of LPT as the Trust had previously had a recruitment campaign to attract nurses from EU countries.

b) Overall 6.4% of UHL's full time equivalent staff were EU nationals which was slightly higher than the national average of 5%. There were, however variances within specific service areas. For example 11% of nursing and midwifery staff were EU citizens; which was higher than the national average, whilst the 8.8% of medical and dental staff was lower than the national average.

c) There were approximately as many EU citizens as there were non-EU citizens working for UHL.

d) The turn-over rate for staff had now stabilised and was flattening out after the rise in EU staff turnover immediately prior to the referendum. The Trust had made concerted efforts to reassure EU staff that the Trust valued them and did not wish them to leave. Since the Brexit vote there were now less EU citizens coming forward for employment. Many other hospitals were focusing on recruiting in other Non-EU countries. UHL were switching their focus to recruiting staff from the Philippines. Historically staff from the Philippines tended to stay locally longer than compared to EU staff, who tended to stay for shorter periods before moving to other areas of the country.

e) UHL also recruited locally from those training in medical professions with De Montfort and Leicester Universities.

f) It was expected that there would be a net loss of 50 EU staff than those that would be recruited from the EU in the next 12 months. Whilst the EU was not the only source for recruitment, it was an important one and the sooner the employment status of existing EU citizens was regularised the better it would be for planning and retention purposes.

The Chair commented that the City's employment of EU citizens representing approximately 5% of the Adult Social Care workforce may be slightly higher than regional figures for social care workforce.

The Chair felt that the issue would dominate the health and social care agenda for some time and would be revisited again at regularly intervals. He felt there was an urgency in seeking clarity and certainty for EU citizens employed by both the NHS and the Adult Social Care Service and there would be joint working between the NHS and the Council to make views known to the government and the local MPs. The Chair also felt it was important to raise this as an issue in 5 year plan and this would be revisited and discussed further with the Chief Executive of the Leicestershire Partnership NHS Trust who was leading on workforce streams within the STP.

AGREED:-

That the initial update be noted and the issue be revisited at future meetings as the discussions under Article 50 progressed.

68. QUESTIONS FROM MEMBERS OF THE PUBLIC

There were no questions form members of the public.

69. DATES OF FUTURE MEETINGS

It was noted that future meetings of the Board would be published after the Annual Meeting of the Council on 11 May 2017. Meetings of the Board were usually held in Meeting Room G01 at City Hall.

70. ANY OTHER URGENT BUSINESS

There were no items of Any Other Urgent Business.

71. CLOSE OF MEETING

The Chair declared the meeting closed at 3.30pm.