Leicester
City Council

Minutes of the Meeting of the
HEALTH AND WELLBEING BOARD

Held: THURSDAY, 12 JULY 2018 at 5:30 pm

P R E S E N T :

Present:

Councillor Clarke (Chair)	–	Deputy City Mayor, Environment, Public Health and Health Integration, Leicester City Council.
John Adler	–	Chief Executive, University Hospitals of Leicester NHS Trust.
Andrew Brodie	–	Assistant Chief Fire Officer, Leicestershire Fire and Rescue Service.
Harsha Kotecha	–	Chair, Healthwatch Advisory Board.
Councillor Piara Singh Clair	–	Assistant City Mayor, Culture, Leisure and Sport, Leicester City Council.
Councillor Danny Myers	–	Assistant City Mayor, Entrepreneurial Councils Agenda, Leicester City Council.
Professor Azhar Farooqi	–	Co-Chair, Leicester City Clinical Commissioning Group
Steven Forbes	–	Strategic Director Social Care and Education, Leicester City Council.
Sue Lock	–	Managing Director, Leicester Clinical Commissioning Group
Councillor Sarah Russell		Assistant City Mayor, Children's Young People and Schools, Leicester City Council.
Ruth Tennant	–	Director of Public Health, Leicester City

		Council.
Superintendent Natalee Wignall	–	Neighbourhood Policing, Local Policing Directorate

In attendance

Graham Carey	–	Democratic Services, Leicester City Council.

124. APOLOGIES FOR ABSENCE

Apologies for absence were received from:-

Lord Willy Bach	Leicester, Leicestershire and Rutland Police and Crime Commissioner
Chief Supt Andy Lee,	Head of Local Policing Directorate, Leicestershire Police
Roz Lindridge	Locality Director Central NHS England – Midlands & 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
Mark Gregory	General Manager, Leicestershire, East Midlands Ambulance Service NHS Trust

It was noted that Toby Sanders was no longer the Senior Responsible Officer for the Better Care Together Programme as he had now taken up an appointment outside of the Leicester, Leicestershire and Rutland area.

125. 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.

126. MEMBERSHIP OF THE BOARD

The Board noted its membership for 2018/19 approved by the Council on 17 May 2018:-

City Councillors

Councillor Adam Clarke, Deputy City Mayor – Environment, Public Health and Health Integration

Councillor Piara Singh Clair, Deputy City Mayor - Culture, Leisure and Sport and Regulatory Services

Councillor Vi Dempster, Assistant City Mayor – Adult Social Care and Wellbeing

Councillor Danny Myers, Assistant City Mayor - Entrepreneurial Councils Agenda

Councillor Sarah Russell, Deputy City Mayor – Children, Young People and Schools

NHS Representatives

John Adler, Chief Executive, University Hospitals of Leicester NHS Trust

Professor Azhar Farooqi, Co-Chair, Leicester City Clinical Commissioning Group

Sue Lock, Managing Director, Leicester City Clinical Commissioning Group

Dr Peter Miller, Chief Executive, Leicestershire Partnership NHS Trust

Dr Avi Prasad, Co-Chair, Leicester City Clinical Commissioning Group

Roz Lindridge, Locality Director Central NHS England – Midlands & East (Central England)

City Council Officers

Vacant - Strategic Director – Education and Children's Services (See Note below)

Phil Coyne – Strategic Director of City Development and Neighbourhoods

Stephen Forbes - Strategic Director - Adult Social Care. (See Note below)

Ruth Tennant - Director of Public Health

Note: Since the Annual Council Meeting Stephen Forbes had been appointed

to the new role of Strategic Director Social Care and Education, following the merger of the Adult Social Care and Education and Children's Services.

Local Healthwatch and Other Representatives

Harsha Kotecha, Chair, Healthwatch Advisory Board

Lord Willy Bach, Leicester, Leicestershire and Rutland Police and Crime Commissioner

Chief Superintendent, Andy Lee, Head of Local Policing Directorate, Leicestershire Police

Andrew Brodie, Assistant Chief Fire Officer, Leicestershire Fire and Rescue Service

Standing Invitees: (Not Board Members)

Toby Sanders, Senior Responsible Officer, Better Care Together Programme
Mark Gregory, General Manager, Leicestershire, East Midlands Ambulance Service NHS Trust

127. TERMS OF REFERENCE

The Board noted the Terms of Reference approved by the Annual Council on 17 May 2018.

128. MINUTES OF THE PREVIOUS MEETING

RESOLVED:

That the Minutes of the previous meeting of the Board held on 9 April 2018 be confirmed as a correct record.

129. RETHINKING PERSISTENT ENTRENCHED ROUGH SLEEPING IN LEICESTER

The Director of Public Health to provide an overview of an ongoing project investigating a new approach to managing persistent entrenched rough sleepers in Leicester.

Leicester, in common with a number of major cities across the UK, was experiencing increased visibility of rough sleepers together with other 'street lifestyle' issues such as begging, street drinking and street based drug misuse. Despite a wide range of services being available, including hostel accommodation, outreach, and treatment and support services, provided by both the statutory and voluntary sector, there remained a persistent core of vulnerable people with complex needs who were not engaging fully with these services.

It was estimated that up to 60% of adults living in hostels in England had a diagnosable personality disorder compared to 10% in the general population. All other mental health disorders were also significantly over-represented in the hostel population with around 70% of hostel users experiencing mental health problems with mental health problems being both a cause and a consequence of homelessness. The average life expectancy nationally for rough sleepers was 42 years.

Psychologically Informed Environment (PIE) approach had been used in a number for areas across the country as a means of tackling entrenched homelessness. There was increasing local consensus across a wide coalition of local multi agencies that this approach could help manage these complex individuals. Locally there was a cohort of approximately 30 people at any one time who appeared to have difficulties in improving their lifestyles. The PIE was a place or environment in which the overall approach and day to day running had been consciously designed to take into account the psychological and emotional needs of the service users.

Members received a presentation on a feasibility study to investigate the needs of this complex group, evidence of what works to help people improve their lifestyles and a gap analysis between what was provided and what was needed to meet the needs of this specific cohort. This would then inform an options appraisal for a way forward in the future which was expected to be available in the autumn. The governance arrangements for the project were also in the presentation.

It was recognised that one of the challenges would be around providing resources for a multi-agency approach as many agencies were involved in providing specific services to help this group but no single agency had an overall lead role.

Members welcomed the initiative and recognised the work that the Street Lifestyle Operation Group had done to date to provide a co-ordinated approach to understanding and addressing the issues around persistent entrenched rough sleeping in Leicester.

RESOLVED:

That the Board support the initiatives outlined in the report and presentation and recognise that the Board provide multi-agency leadership across all the key partners.

130. INTRODUCING MINIMUM UNIT PRICING TO LEICESTER

The Board received a briefing paper and presentation on introducing Minimum Unit Pricing to Leicester and were asked to agree a collective position on the issues as well as supporting a letter being sent of their behalf to the Home Secretary recommending a minimum unit pricing of 50p per unit for alcoholic drinks.

The Chair stated that he had already circulated a copy of the suggested letter to Board Members prior to the meeting and had received overwhelming support for the proposal. He felt this demonstrated the strength of purpose in the city to attack and address street drinking in a supported way. He felt that a unified approach from the Police, Fire and Rescue Service, EMAS, the Council, CCG, UHL and LPT demonstrated a unique and powerful response to this issue and sent a send strong message to Government. The Chair stressed that this was not aimed at local business involved in the sale of alcohol but was an attack on addressing health inequality and health injustice.

A number of local agencies such as Inclusion Healthcare, Turning Point and Dear Albert etc already provided valuable services to help and support individuals with recovery from alcohol abuse and drug addiction issues.

Liver disease had increased by 400% since 1970and was now the third most common cause of premature death in the UK. It was also estimated that 9 people die every day through alcohol related cancers. It had been estimated that a minimum price per unit of alcohol could reduce alcohol related deaths by around 7,200 per year as well as reduce healthcare costs by £1.3 billion nationally.

If adopted, the initiative would also be supported by the Public Space Protection Orders to limit street drinking and through the licensing regime to restrict the strength of alcoholic drinks that could be sold from licensed premised and off-sales with the Cumulative Impact Zones in the City.

RESOLVED:-

> That the Board unanimously support a letter being sent on their behalf by the Chair to the Home Secretary, the Rt Hon Sajid David, to introduce a Minimum Unit Pricing of 50p per unit of alcohol.

131. WINTER RESILIENCE

The Board received a report and presentation from Mr Mike Ryan Director of Urgent and Emergency Care, Leicestershire, Leicester City, and Rutland (LLR) System. The report summarised the recommendations and learning from the winter period 2017/18, and outlined the approach to better resilience and patient experience for 2018/19.

During the presentation the following comments were noted:-

- Winter pressures traditional saw a drop in A&E performance in December, January and February. This pressure had increased in recent years and was now being experience from October to April. This increase put added pressure across the whole health system.
- There were less patients attending the A&E in the winter compared to other time in the year.
- There was a pattern of increasing number of older patients arriving by

ambulances and being admitted to hospital in the winter. The admissions were not due to larger numbers per se but a result of more 'repeat' patients being re-admitted. 80% of patients admitted to in-patient wards in UHL were aged 70 years or older, yet this demographic group represented 20% of the population at large.

- There was a decrease in younger non-admitted patients in the winter and whilst the instances of delayed transfer of care did not increase; bed occupancy and length of stay did increase.
- On average performance in the winter is 4.2% lower than the rest of the year but this year had seen a decrease of 6.2%.
- There were 15-16 designated bays for ambulances but in the winter period in was not uncommon for 20-25 ambulances occupy the same designated area.
- There was marked decrease in the 4 hour performance target in December, January and February. It was difficult to balance resources to meet the demand when the various conditions requiring patient to be admitted were not known in advance and could vary as winter progressed.
- The pressures were about establishing continuity all year round knowing that the numbers of respiratory conditions, trips and falls and frailty etc were increasing.
- 14 key stake holders were working with A&E to address the pressures and mitigate the knock-on effects with the health and social care sector.
- The escalation level had been at 3 or 4 for most of the winter period.
- This year had also seen higher number of elective surgery cancelations than in 2016/17 following Department of Health instructions and there had also been exceptional levels of cancellations of urgent and cancer related operations unseen in previous years.

Members of the Board commented that:-

- That whilst much of the presentation made sense to clinicians it was not particularly user friendly or accessible for the public and non-clinicians to understand the issues and enable Board Members to appropriately challenge the issues.
- As slips, trips and falls in the winter period contributed to pressure on resources it was felt that it would be useful to have an holistic approach and have details of other non-clinical initiatives, such as gritting arrangements in the winter, which could contribute to reducing risks of slips, trips and falls. The Board should be taking an overarching view of all the partners initiatives that could be used to reduce hospital admission in the winter.
- There was view that the winter care arrangements were too focused on being reactive with little focus on prevention to stop individuals being admitted to hospital. Gritting highways, pavements, keeping homes warm and dry, ensuing vulnerable people had regular company and were well fed seemed a better way to address the pressures on admissions rather than remodelling capacity to meet the demand during the winter months. It was considered that non-clinical partners on the

Board had good examples of successes to reduce demands.

Health representatives on the Board commented that:-

- The issue of the presentation relying heavily on clinical data was accepted and the holistic approach was welcomed and there was a commitment to bring a further non-technical update in September to include a multi-agency approach including the lessons learnt from other partners, such as EMAS and the A&E delivery Board to learn how they predicted demand and the initiatives being used to break down inter agency barriers to improve responses across the health and social care system.
- Admission arising from frailty and multi–morbidity represented approximately two third of hospital admissions and there was potential to develop initiatives within the health and social care sector to reduce these admissions.
- The impact on staff last winter was also difficult to manage as the length of responding to the winter pressures over a longer sustained period of time had been hampered by staff sickness and absences.
- There was a limited emergency bed capacity governed by physical space and staff availability constraints
- It was, however, also possible to close the gap between demand and capacity by opening more wards or converting wards to medical wards in response to demands. A new respiratory ward was also being built at Glenfield.
- There was a need to work more efficiently and the number of stranded patients, those in hospital for over 87 days was coming down but this relied on inter agency collaboration
- The Chief Executive of the City CCG was now Charing the A&E Board and the Frailty and Multi morbidity Task Force a d this had potential to recuse the impact of 20% of the population taking 70% of health capacity.

Following a comment on the impact of the new Emergency Department on winter care it was noted that the patient experience and the physical environment had been totally transformed. However, these improvements did not solve the entire problem as they still need an efficient patient outflow. explain

Members of the Board also commented that :-

- The Board had a role in promoting and supporting interventions that would make difference and produce better outcomes.
- It was widely recognised that staff worked hard under difficult circumstance at time but the prime concern was the health and wellbeing of people in the city, It was important to have good GP hubs there was still a concern that many people admitted into hospitals had high levels of needs but their treatment was affected by the high occupancy rates.

- It would be useful for the Board to have details of the numbers of patients being re-admitted to hospital. If there were patient being discharged medical care but not needing to be in hospital then this may impact on GP services there was a lower ratio of GPs to the population than in European nations.
- Members found the term 'stranded' unhelpful as if a patient needed to need to be in hospital that is where they needed to be and should not be seen as 'stranded'.

RESOLVED:

That the presentation and report be received and that a further report on the whole system approach to winter preparedness be submitted to the September meeting.

132. HEALTH AND WELLBEING STRATEGY

The Director of Public Health gave a presentation to inform members that the new Joint Health and Wellbeing Strategy and Action plan was in final draft form and due to enter the public consultation phase in mid-July.

The presentation explained the progress that had been made and invited Board members to become involved in the consultation process and to encourage others to do the same.

It was noted that all partners had engaged in collaborative approach in developing the strategy. As part of the process, officers had made presentations to a number of partners and key stakeholders, including the Joint Integrated Commissioning Board, Children's Trust Board, Adult Social Care and Health and Wellbeing Scrutiny Commissions etc, to confirm whether the right issues were being picked up and addressed in the strategy. This process had identified some key themes that people wanted to see included in the strategy and it had been encouraging that those taking part had not been parochial about their own service areas of interest but were actively looking holistically at all the issues.

The process for the development of the emerging strategy had not focussed on a specific range of identified health conditions but on the underlying causes that were driving people into ill health, acute services and Police services etc and to look at these drivers in an holistic way.

Adult Social Care had identified key issues such as 'Social Isolation' as a key factor and, whilst other partners agreed with and welcomed this approach, they were also keen to ensure that the strategy also included other on-going health issues such as treating patients with multi morbidity issues. The strategy tried to match up key areas that came out of the workshops such as healthy places, healthy minds and healthy lives etc and then tried to make these themes match up with what was already happening in the system.

For example, officers went to New College as part of this process to discuss

the emerging key areas around their own strategy for the health and wellbeing of students. These discussions identified that the College staff felt that educating students and getting them to a better level of health was part of the day to day responsibility of the College and did not need to be included in the strategy; but what should be included in the strategy were things like domestic violence, poverty and hunger which were seen as contributing to 'blocks' in enabling staff to educate students.

There were still 18 objectives within the strategy and it was felt that these would be refined as the consultation progressed and that some would eventually be combined and others would need to be added.

There was an Action Plan behind the overall process which identified the broad objectives and had specific actions behind each objective. It was not intended to create another strategy that did not fit in with or bear any resemblance to other policies and strategies that were already in existence within the Council and partner agencies and bodies. A current challenge was trying to identify a suitable suite of metrics to use as a definitive measure of monitoring the success of initiatives.

Overall the general feedback to the engagement process had been positive and views were expressed that the strategy seemed pragmatic and was developing along the right lines

Partners and stakeholders had asked that the consultation timetable be delayed from the original summer period until autumn (September- December) in order to enable organisations to be better engaged and submit responses. It was intended to visit to organisations/partners and stakeholders such as the fire and police services and CCG etc to launch the consultation process. The Universities had already accepted invitations to talk to them. Positive feedback had also been received from Healthwatch and VAL. Officers requested that partners invite their strategic partners and stakeholders to events where officers were consulting on the strategy to enable as wide a participation as possible.

It was envisaged that the final version of the strategy would be available in December/January.

Councillor Russell commented that the Children's Trust had really engaged with the process and were excited to be able to be part of the strategy and had seen the strategy as a resource and a way to identify issues within their own organisation. It would also give a useful reference point of where a particular issue sat within the overall strategy, what to aim for, and what others were already doing on the issue that worked. It also gave them an opportunity to contribute to the resource if they felt they were doing something that worked well within their organisation and could be shared with others. There was a genuine feeling of being engaged and understanding their part in it the process. The strategy was seen positively as being an ongoing living document and not just a document that was produced for a specific point in time and would then be forgotten.

The Chair commented that he wanted the Board to have ownership of the strategy and drive its future agenda forward to deliver its outcomes to improve the city's health and wellbeing.

RESOLVED:-

1) That the dates of the consultation phase be noted.

2) That partners on the Board engage in the strategy through the consultation process

3) That the Board champions engagement amongst partners and stakeholders wherever possible.

133. HEALTHWATCH LEICESTER CITY ANNUAL REPORT

The Board received the Healthwatch Leicester City Annual Report 2017 and an update from Healthwatch Leicester and Leicestershire on recent arrangements that have been put in place since the contract was awarded to Engaging Communities Staffordshire.

Harsha Kotecha (Chair Healthwatch Advisory Board) and Michal Smith (Healthwatch Manager), Healthwatch Leicester and Leicestershire attended the meeting to present the Annual Report and to provide an update on local Healthwatch arrangements since Engaging Communities Staffordshire had been awarded the contract for Leicester and Leicestershire.

It was noted that Engaging Communities Staffordshire (ECS) hosted a number of Healthwatch contracts across the East and West Midlands areas as well as some in in the north. This enabled them to offer a level of consistency and substantial support for research for overseeing local health services.

Governance arrangements were overseen by the ECS Board and there was a local Advisory Board for Leicester and Leicestershire which determined local priorities. 4 members had now been appointed to the Advisory Board in addition to the Chair and they were in the process of going through an induction process on their role and determining an interim work programme involving 3 priorities. 1 for the city area, 1 for the country area and 1 for Better Care Together. The city and county priorities were aligned around GP access and the emerging out of hours service which was better and more advanced in the city and was emerging in the East and West Leicestershire CCG areas. The public were being engaged for their views on how they saw the service changing and the shift from patients seeing a GP for all consultations and moving to more consultations with other health care professionals.

Healthwatch were also looking at maternity services under the STP initiative in relation to the centralisation of the maternity services in Leicester and the closure of the birthing unit at Melton Mowbray. Healthwatch were also working with the Better Births Programme within Leicester Leicestershire and Rutland

area around the 5 year forward programme on maternity services and how they would change in the future.

Following the completion of the process of staff transferring from Healthwatch Leicester and VAL to Leicester and Leicestershire Healthwatch, ECS had a surplus of TUPE funding which they had now used to provide an extra member of staff with a focus on volunteering, volunteering recruitment and volunteer support as well as supporting the outreach who go into the community to gather the public and patient experience of local health and social care services.

The Chair thanked previous Healthwatch staff that had provided services to the Board and had represented the patients and public in the city on health and social care issues. The Chair was particularly interested in the local governance issues and how the new arrangements would be robust in bringing forward the voice of patients and the public and how these were fed into the Board's deliberations.

Michael commented that were already having conversations with key stakeholders in the health and social care environment to see how the patient voice can be fed into the process so that the Board can hear the views of the public and patients and the larger voluntary sector as Healthwatch also represented the groups that represented individuals as well

RESOLVED:

That the representatives of Leicester and Leicestershire Healthwatch be thanked for presenting the Annual Report and the update of the new local arrangements and priorities.

134. QUESTIONS FROM MEMBERS OF THE PUBLIC

There were no questions from members of the public.

135. DATES OF FUTURE MEETINGS

The Board noted that the Annual Council Meeting in May approved future meetings of the Board to be held on the following dates:-

Thursday 12 July 2018 – 5.00pm

Thursday 20 September 2018 – 5.00pm

Thursday 22 November 2018 – 5.00pm

Thursday 28 February 2019 – 5.00pm

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

136. ANY OTHER URGENT BUSINESS

There were no items of Any Other Urgent Business.

137. CLOSE OF MEETING

The Chair declared the meeting closed at 7.09pm.