Leicester
City Council

Minutes of the Meeting of the
HEALTH AND WELLBEING BOARD

Held: THURSDAY, 28 JULY 2022 at 9:30 am

Present:

Councillor Dempster (Chair)	–	Assistant City Mayor, Health, Leicester City Council.
Kash Bhayani	–	Healthwatch Advisory Board, Leicester and Leicestershire.
Councillor Elly Cutkelvin	–	Assistant City Mayor, Education and Housing.
Richard Mitchell	–	Chief Executive, University Hospitals of Leicester NHS Trust.
Dr Katherine Packham	–	Public Health Consultant, Leicester City Council.
Dr Avi Prasad	–	Co-Chair, Leicester City Clinical Commissioning Group.
Mark Powell	–	Deputy Chief Executive, Leicestershire Partnership NHS Trust
Kevin Routledge	–	Strategic Sports Alliance Group.
Sue Tilley	–	Director, Leicester, Leicestershire Enterprise Partnership.
Councillor Piara Singh Clair	–	Deputy City Mayor, Culture, Leisure and Sport, Leicester City Council.
Chief Supt Jonny Starbuck	–	Head of Local Policing Directorate, Leicestershire Police.
Caroline Trevithick	–	Executive Director of Nursing, Quality and Performance, Leicester, Leicestershire and Rutland Clinical Commissioning Group

Standing Invitees

Cathy Ellis	–	Chair of Leicestershire Partnership NHS Trust.
John MacDonald	–	Chair of University Hospitals Leicester NHS Trust.
Professor Bertha Ochieng	–	Integrated Health and Social Care, DeMontfort University.

In Attendance

Graham Carey	–	Democratic Services, Leicester City Council.

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66. APOLOGIES FOR ABSENCE

Apologies for Absence were received from:-

Councillor Sarah Russell	Deputy City Mayor Social Care and Anti-Poverty, Leicester City Council.
Ivan Browne	Director of Public Heath, Leicester City Council
Professor Azhar Farooqi	Co-Chair, Leicester City Clinical Commissioning Group
Andrew Fry	College Director of Research, University of Leicester.
Angela Hillery	Chief Executive, Leicestershire Partnership NHS Trust
Harsha Kotecha	Chair, Healthwatch Advisory Board, Leicester and Leicestershire
Kevan Liles	Chief Executive, Voluntary Action Leicester
Martin Samuels	Strategic Director of Social Care and Education
David Sissling	Independent Chair, Leicester, Leicestershire and Rutland Integrated Care System
Andy Williams	Chief Executive, Leicester, Leicestershire and Rutland Clinical Commissioning Group

67. DECLARATIONS OF INTEREST

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

68. MEMBERSHIP OF THE BOARD

The Board noted the membership for 2022/23 approved by the Council on 19 May 2022 as follows:-

To note the membership of the Board for 2021/22 approved by the Annual Council on 19 May 2022:-

City Councillors: (5 Places)

Councillor Vi Dempster, Assistant City Mayor, Health (Chair)
Councillor Piara Singh Clair, Deputy City Mayor, Culture, Leisure and Sport
Councillor Sarah Russell, Deputy City Mayor, Social Care and Anti-Poverty
Councillor Elly Cutkelvin, Assistant City Mayor, Education and Housing
Councillor Mustafa Malik, Assistant City Mayor, Communities and Equalities

City Council Officers: (4 Places)

Martin Samuels, Strategic Director of Social Care and Education
Ivan Browne, Director Public Health
Dr Katherine Packham, Public Health Consultant
1 Vacancy to be nominated by the Chief Operating Officer

NHS Representatives: (7 Places)

Richard Mitchell, Chief Executive, University Hospitals of Leicester NHS Trust
Professor Azhar Farooqi, Co-Chair, Leicester City Clinical Commissioning Group
Angela Hillery, Chief Executive, Leicestershire Partnership NHS Trust
Oliver Newbould, Director of Strategic Transformation, NHS England & NHS Improvement – Midlands
Dr Avi Prasad, Co-Chair, Leicester City Clinical Commissioning Group
David Sissling, Independent Chair of the Integrated Care System for Leicester, Leicestershire and Rutland
Andy Williams, Chief Executive, Leicester, Leicestershire and Rutland Clinical Commissioning Group

Healthwatch / Other Representatives: (8 Places)

Harsha Kotecha, Chair, Healthwatch Advisory Board, Leicester and Leicestershire
Andrew Brodie, Assistant Chief Fire Officer, Leicestershire Fire and Rescue Service
Kevan Liles, Chief Executive, Voluntary Action Leicester

Rupert Matthews, Leicester, Leicestershire and Rutland Police and Crime Commissioner
Kevin Routledge, Strategic Sports Alliance Group
Chief Supt, Jonny Starbuck, Head of Local Policing Directorate, Leicestershire Police
Sue Tilley, Head of Leicester & Leicestershire Enterprise Partnership
1 Unfilled Vacancy

STANDING INVITEE: (Not A Council Appointed Voting Board Member – Invited by the Chair of the Board. and no set number of places)

Cathy Ellis, Chair of Leicestershire Partnership NHS Trust
Professor Andrew Fry – College Director of Research, Leicester University
Richard Lyne, General Manager, Leicestershire, East Midlands Ambulance Service NHS Trust
John MacDonald, Chair of University Hospitals of Leicester NHS Trust,
Professor Bertha Ochieng – Integrated Health and Social Care, De Montfort University

69. TERMS OF REFERENCE

The Board noted the Terms of Reference approved by the Annual Council on 19 May 2022.

70. MINUTES OF THE PREVIOUS MEETING

RESOLVED:

The Minutes of the previous meeting of the Board held on 28 April 2022 be confirmed as a correct record.

71. PHARMACEUTICAL NEEDS ASSESSMENT

Dr Katherine Packham, Public Health Consultant, Leicester City Council, presented a report providing an update on the progress of the Pharmaceutical Needs Assessment (PNA).

It was noted that:-

- The Health and Wellbeing Board has a statutory responsibility to prepare a Pharmaceutical Needs Assessment (PNA) for Leicester City and publish it by 1st October 2022.
- The PNA was subject to a 60-day statutory consultation period which opened on 6th July 2022 and would close on 4th September 2022.
- The PNA looked at current, projected and future needs and made recommendations on what could be done differently.

In response to questions from Board Members, officers stated

- Thew PNA took into account population projections for the next 10-30 years to assess the number of pharmacies per 10,000 population and

address any issues. Currently there were 85 pharmacies across the City and overall Leicester had more pharmacies per 10,000 population at 2.4 than the 2.1 average for England.

- There was a move away from hard to reach groups to a focus on making service more accessible. Those communities which were deemed to underserved by pharmacies tended to be the same groups who experienced, homelessness, language barriers and physical barriers to accessing premises. There was a need to make people aware of how to contact or when to contact services. The officer groups dealing with this would pick these issues up.
- Work was progressing with developing the support role in pharmacies to dealt with minor injuries, covid and lifestyle issues. The issue was providing incentives to pharmacy committees to increase the supply of community pharmacies and take on these additional roles.
- The increase in electronic prescribing reduced the impact on travelling distance but could give rise to the impact on overall needs if pharmacies were in the wrong locations. Customers with transport could also be disadvantaged if there were no pharmacies in a convenient location to them. Pharmacies were also competing with internet style delivery services.
- The Integrated Care Board design group engaged with pharmacies and were looking at a number of th issues commented upon especially the issues around the workforce changing and moving around facilities which could leave big gaps in service provision and were seeing how this issue could be supported.

The Chair commented that moving pharmacies to engage in primary care was crucial and the cornerstone to going forward. All Board partners were engaged in this and asked that they asked questions in their own organisations on how to engage and respond and what can be done in each organisation to help in promoting the messages to the public.

RESOLVED:- That officers be thanked for the progress made on the development of the Pharmaceutical Needs Assessment and were asked to submit the final Pharmaceutical Needs Assessment after it had been completed taking into account the comments made by the Board Members.

72. LEICESTER HEALTH CARE AND WELLBEING STRATEGY UPDATE

Dr Katherine Packham, Consultant in Public Health, Leicester City Council, presented a report providing a summary of the current status of Leicester's Health, Care and Wellbeing Strategy and the next steps.

It was noted that:-

- A refresh of Leicester's Health, Care and Wellbeing strategy had taken place over the last few months. This involved retaining the five themes of Healthy Start, Healthy Living, Healthy Ageing, Healthy Places and Healthy Minds from the previous strategy which was published in 2019.

- The Board has previously approved a decision to refresh the strategy to reflect challenges that had been highlighted by the pandemic or where the need had increased as a result of the pandemic.
- A Leicester Place-led Plan Core Working Group was set up to develop the strategy and priorities on behalf of the Board.
- A series of engagement events, including working with a range of community groups and an online survey, were held between November 2021 and January 2022 with ongoing engagement with a number of partnership groups.
- The strategy would be presented to Health and Overview and Scrutiny committee in August 2022 where comments and feedback would be sought, before the final strategy was brough back to the Board together with a draft delivery plan.
- The delivery/implementation plan was in the early stages of development and focused on the six 'do' priorities of:-
    - Healthy Places: Improving access to primary and community health/ care services
    - Healthy Start: Mitigating the impacts of poverty on children and young people
    - Healthy Living: Increasing early detection of heart & lung diseases and cancer in adults
    - Healthy Minds: Improving access to primary & neighbourhood level Mental Health services for adults.
    - Healthy Minds: Increasing access for children & young people to Mental Health & emotional wellbeing services.
    - Healthy Ageing: Enabling Leicester's residents to age comfortably and confidently - proposed focus on reducing health inequalities through a person-centred programme of frailty prevention. (this wording was subject to change).

Members of the Board commented:-

- That a good majority of GP practices in east and south of the City had patients from different ethnicity and languages and it would be helpful to look at a mix and match of language skills and to see if these can moved around to have a robust system to improve language access to service to overcome the barriers.
- Sports clubs would welcome a meeting with the Council as they were keen to contribute to Healthy Minds through sport and physical activity but were unsure how this could be developed and wanted to understand how to capture synergy, avoid duplication with other initiatives and add value as well as ensuring they were delivering initiatives to the right people in the right circumstances.
- The strategy should influence how services were enabled in the future. The strategy should have elements of skilling within it, so it not only built services but also taught people how to drive changes and improvements.

In response to Members comments, officers commented that:-

- Three items in the delivery plan related to language and how access to services could be improved.

- The priorities were refreshed rather than started again from scratch. There were likely to be impacts of the pandemic but these were not fully understood yet on health, employment, reduced income and cost of living crisis. The priorities would be reviewed in 5 years. The previous strategy did not have a dashboard reporting element, but this would be built into the delivery plan. Most of the priorities were still largely the same as in the last strategy
- It was recognised that a lot of public data had a time lag in their accuracy, but other current data sources were also used and monitored.
- It would be helpful if different organisations with funds available for accessing mental health services could be aligned to ensure the best outcomes based upon need. The challenge with the implementation was to make sure it happened, and partners needed to know what was needed and to work together to deliver and use resources differently based on what was identified in strategy
- The was a huge role to be played for a range of organisations. Voluntary and community sector organisations and other large employers such as the universities, police and sports groups should contact officers working on mental health issues in Public Health for assistance.
- There was merit in getting all major employers to align activities and initiatives so it improved Leicester as a good place to work and improve wellbeing.

The Chair commented that the issues in developing the delivery plan would be a major focus in a private development session of the Board which would enable a focused approach to the delivery plan

RESOLVED:- That the timelines and next steps for Leicester's Health, Care and Wellbeing Strategy be noted and the delivery plan be discussed at a private development session of the Board.

73. LLR/NHS COLLABORATIVE WORKING (MENTAL HEALTH FOCUS)

The Chair stated that consideration of the report would be deferred to a future meeting as it required further details to be added.

74. INEQUALITIES PRESENT IN MATERNITY MORTALITY EXPERIENCED BY WOMEN OF DIFFERENT ETHNICITIES

The Chair stated that consideration of the report would be deferred to a future meeting as it required further details to be added.

75. REDUCING HEALTH INEQUALITIES - CORE20PLUS5

Steve McCue – Senior Strategic Development Manager, LLR ICB and Mark Pierce, Head of Population Health, LLR ICB submitted a report informing the Board of the NHS requirement by NHS England and NHS Improvement to

deliver against the CORE20Plus5 to support wider work to reduce health inequalities across Leicester, Leicestershire and Rutland (LLR).

It was noted that:-

- NHS England defined health inequalities as the preventable, unfair, and unjust differences in health status between groups, populations or individuals that arise from the unequal distribution of social, environmental, and economic conditions within societies.

- The LLR ICS was aligned to the national vision of 'exceptional quality healthcare for all through equitable access, excellent experience, and optimal outcomes. Health inequalities exist on a gradient throughout populations, and they were committed to using a proportionate universalism approach to reduce inequity wherever it existed across LLR.

- Core20Plus5 was a national NHS England and NHS Improvement approach to support the reduction of health inequalities at both national and system (LLR) level. The approach defined a target population cohort – the 'Core20PLUS' – and identified '5' focus clinical areas requiring accelerated improvement.
- The Core 20 referred to the most deprived 20% of the national population as identified by the national Index of Multiple Deprivation (IMD). The IMD has seven domains with indicators accounting for a wide range of social determinants of health. In Leicester, Leicestershire & Rutland (LLR), 153,284 registered patients lived in the 20% most deprived neighbourhoods in England. In Leicester this was 31.7% of the total number of registered patients compared to 3.2% for Leicestershire and 0.4% for Rutland.

- The Core20Plus5 framework set out five clinical areas of specific NHS focus. Governance for these five focus areas sat with national NHS programmes and national and regional teams coordinate local systems to achieve national aims. The five clinical areas included;
    - Maternity: ensuring continuity of care for 75% of women from Black, Asian and minority ethnic communities and from the Core 20 part of the population
    - Severe mental illness (SMI): ensuring annual health checks for 60% of those living with SMI (bringing SMI in line with the success seen in learning disabilities)
    - Chronic respiratory disease: a clear focus on Chronic Obstructive Pulmonary Disease (COPD) driving up uptake of COVID, flu and pneumonia vaccines to reduce infective exacerbations and emergency hospital admissions due to those exacerbations.
    - Early cancer diagnosis: 75% of cases diagnosed at stage 1 or 2 by 2028.
    - Hypertension case-finding: to allow for interventions to optimise blood pressure and minimise the risk of myocardial infarction and

stroke

- Using this framework would not tackle all health issues, but it was still a good tool to improve Health and Wellbeing. There were also elements that are locally determined, and officers will be working on those and bring a report to a future meeting to see which specific needs to be involved or where services were not serving groups very well e.g. communities that experienced vaccination issues during covid etc.

During discussion Members of the Board commented that:-

- The approach was a good opportunity to have a forensic look about talking about deprivation in providing health care. There needed to be clarity on governance and what would be done if there were differences on place level and system based levels.

- It was positive that there were local decisions to be made and everyone needed to understand what these were and then take them through the ICB to make the right decision. When this was considered again it should have more details on public engagement

- There was a need to understand health inequalities in Core 20 plus 5; but health inequalities have been known for some time. There was a need to be focused on what was being done now to address inequalities and have evidence for it and, if this was not possible there was a need to ask why it can't be provided.

- The County Council were making approaches to the ICB to protect the county hospitals so it was important that the City needed to make representations about deprivation, otherwise it would lose out again.

- Proportionate universalism was supported where the resourcing and delivering of universal services at a scale and intensity proportionate to the degree of need. Services were, therefore, universally available, not only for the most disadvantaged, and were able to respond to the level of presenting need. It would be difficult to make inroads in improving health and wellbeing if the focus on the need was not paramount.

- Whilst this initiative was supported it did not engage with the remaining 80% to look at and underpin good health outcomes in education and housing. It was somewhat unfortunate that this had come through a health route and not a wider route for consideration. The aim should be on how the focus was prioritised for all and not get overshadowed by concentrating on the 20% in deprivation.

The Chair commented that there was a concern that the Board had its own strategy and priorities and there was a risk that the same thing could be created elsewhere with different name. Governance issues were important, and place was about the City and our health inequalities. Engagement of the public was crucial, and each organisation did it differently. If possible, there should be a tie up and it would be helpful to have a paper on engagement with the public looking at co-production of engagement by partners as a way

forward as there was a need for a much more joined up approach and have a system in place to consult for all partners organisations to consult together and provide feedback to the ICB as well.

RESOLVED:- That the report be received and all partner organisations work together to on an initial focus on Leicester population cohorts who already experience health inequalities and that a further report on progress of the initiative be submitted in the future taking into account the comments made by Board Members.

76. QUESTIONS FROM MEMBERS OF THE PUBLIC

No questions from members of the public had been received.

77. DATES OF FUTURE MEETINGS

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

Thursday 13 October 2022 – 9.30 am
Thursday 2 February 2023 – 9.30am
Thursday 13 April 2023 – 9.30 am

Meetings of the Board are scheduled to be held in Meeting Rooms G01 and 2 at City Hall unless stated otherwise on the agenda for the meeting.

It was noted that the meetings for October and February would be re-arranged as there were NHS meetings on those days involving a number of the Board Members.

78. ANY OTHER URGENT BUSINESS

There were no items of Any Other Business.

79. CLOSE OF MEETING

The Chair declared the meeting closed at 10.57am.