Leicester
City Council

Minutes of the Meeting of the
HEALTH AND WELLBEING BOARD

Held: THURSDAY, 25 MARCH 2021 at 10:00 am

Present:

Councillor Dempster (Chair)	–	Assistant City Mayor, Health, Leicester City Council.
Ivan Browne	–	Director of Public Health, Leicester City Council.
Councillor Elly Cutkelvin	–	Assistant City Mayor, Education and Housing.
Professor Azhar Farooqi	–	Co-Chair, Leicester City Clinical Commissioning Group.
Harsha Kotecha	–	Chair, Healthwatch Advisory Board, Leicester and Leicestershire.
Hayley Jackson	–	Assistant Director of Strategy and Integration NHS England & NHS Improvement
Gordon King		Director of Mental Health, Leicestershire Partnership NHS Trust
Kevan Liles	–	Chief Executive, Voluntary Action Leicester.
Richard Morris	–	Director of Operations and Corporate Affairs, Leicester, Leicestershire & Rutland Clinical Commissioning Groups
Councillor Rita Patel	–	Assistant City Mayor, Communities, Equalities and Special Projects, Leicester City Council.
Kevin Routledge	–	Strategic Sports Alliance Group.
Councillor Sarah Russell	–	Deputy City Mayor, Social Care and Anti-Poverty, Leicester City Council.
Martin Samuels	–	Strategic Director Social Care and Education, Leicester City Council.

Councillor Piara Singh Clair	–	Deputy City Mayor, Culture, Leisure and Sport, Leicester City Council.
Caroline Trevithick	–	Executive Director of Nursing Quality and Performance and Deputy Chief Executive, Leicester, Leicestershire & Rutland Clinical Commissioning Groups
Mark Wightman	–	Director of Strategy and Communications, University Hospitals of Leicester NHS Trust.

Standing Invitees

Cathy Ellis	–	Chair of Leicestershire Partnership NHS Trust.
David Sissling	–	Independent Chair of the Integrated Care System for Leicester, Leicestershire and Rutland

In Attendance

Graham Carey	–	Democratic Services, Leicester City Council.

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17. WELCOME

The Chair welcomed Dr Katherine Packham, Mukesh Barot and David Sissling to their first meeting. Davis Sissling was the new Independent Chair of the Integrated Care System for Leicester, Leicestershire and Rutland and Dr Katherine Packham was a Public Health Consultant specialising in integrated care. It was intended to appoint them as members of the Board at the Annual Council in May.

18. APOLOGIES FOR ABSENCE

Apologies for absence were received from:-

Rebecca Browne	Acting Chief Executive University Hospitals Leicester
|Andrew Fry	College Director of Research, Leicester University
Oliver Newbould	Director of Strategic Transformation, NHS England & NHS Improvement - Midlands
Andy Williams	Chief Executive, Leicester, Leicestershire & Rutland Clinical Commissioning Groups

19. 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.

20. MINUTES OF THE PREVIOUS MEETING

RESOLVED:

The Minutes of the previous meeting of the Board held on 19 November 2020 be confirmed as a correct record.

21. LEICESTER, LEICESTERSHIRE AND RUTLAND HEALTH INEQUALITIES FRAMEWORK

Sarah Prema, Executive Director of Strategy and Planning for Leicester, Leicestershire and Rutland CCGs presented a report on the Leicester Leicestershire and Rutland System Health Inequalities Framework. The aim of the Framework was to improve healthy life expectancy across Leicester, Leicestershire & Rutland (LLR), by reducing health inequalities across the system.

The purpose of the Framework was to:-

- Provide a system mandate for action to address health inequalities from communities upwards through the whole life course from birth to death across LLR.
- Establish a collective understanding of the terms 'Inequality', 'Inequity' and 'Prevention' in relation to population health, across all parts of the LLR Integrated Care System (ICS).
- Strengthen a whole system collaborative approach to reduce or remove avoidable unfairness in people's health and wellbeing in LLR as the issues affecting health were complex and joint working was important as all the factors interacted.
- Establish the high-level principles of how LLR ICS partners will approach the work of reducing health inequity at system level.
- Recognise that the framework will be implemented and agreed at system level, with much operational, political and community action being undertaken at 'place' and 'neighbourhood' level. It is the systems' minimum ask of Place in relation to reducing health inequalities.
- Set out some key actions that can be delivered at system level with support through the ICS, with recognition that some actions will be primarily for individual organisations e.g. the NHS or the Local Authority with many others requiring partners to work together.
- As the ICS developed there would be a need to adopt proportionate realism to use resources better to bring service provision delivery together around health inequalities.
- The training and development of staff was important, and organisations would need to learn from Covid-19 experiences for service delivery.
- There would be a consistent approach to health equity audits when

commissioning and delivering services to ensure there was fair access to all; e.g. digital services did not disadvantage unintentionally.

It was noted that the principles of the approach would be:-

- Health inequalities are 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 principles and actions outlined are deliberately high level – the framework is clear in identifying that it will be at place level and footprints below that specific action will be defined. Health and wellbeing Boards have a key role in leading and overseeing the work to establish local needs and action plans.
- Health outcomes are the result of a mixture of the wider determinants of health and the quality of the health service. It is estimated that non-medical factors influence as much as 80% of life expectancy.
- To optimise the health, wellbeing and safety of our population then all partners involved have to work together to impact all the factors that influence health inequalities.
- Reducing health inequalities will create a fairer society in which people are enabled to realise the best potential and contribute to our society in positive ways.
- The ICS will adopt a Population Health Management[3] and balanced approach to Prevention (across all three tiers**).**
- A focus on parity of esteem between mental and physical health.
- Public sector ICS partners will act as anchor institutions in LLR**.**
- Both qualitative and qualitative data would be used to better understand the health inequalities that exist in LLR.
- All the assets and strengths of communities and individuals would be used to reduce health inequality and inequity.
- Effective action would be taken at key points of the life course dependant on need.
- Accountability for delivering on system wide health inequalities will be an ICS system accountability.
- Actions will be undertaken at the most appropriate level of the ICS where they can be most effectively owned and delivered.
- There would be a proportionate universalism approach to invest decisions across the ICS. This would allow actions to be universal, but with a scale and intensity that is proportionate to the level of disadvantage.
- The ICS will establish a defined LLR resource to review health inequalities at the system level. This will be a virtual partnership between the NHS, the local authorities and local universities

Members of the Board supported the principle of the framework and commented that:-

- There has been a cyclical revisiting of health inequalities over the years and although there had been a data rich environment there had been no

follow up on quality of engagement and analysis.

- Training and sharing of resources to make a difference was supported.
- The challenge to address inequalities is to ensure a collaborative approach to improve healthy living conditions and education of issues. There still a need to build on the involvement of planning, transport and housing etc.
- The ICS supported the involvement of a wide range of organisations in developing the framework and the ICS would be really keen to see the framework put into action as a high priority to produce positive results.
- As the issue had been considered before communities needed to see real change and improvements. There are many people in the community that are wanting to do things to make improvements and they needed to be involved in the action to bring about improvements. There are many marginalised groups in the community, and they are not represented in the developing the proposals.
- The Board involvement in holding partners to account for actions was welcomed as discussing the actions and non-actions arising from the framework would lead to prioritising resources.
- Most of the inequality challenges were in the west of the city compared to the inequalities across the city as a whole.
- Proportional universalism was welcomed to directing resources to areas where there is an identified instead of everyone getting help regardless of their needs.
- Hospitals had traditionally treated those who turned up at hospitals and inbuilt inequalities had evolved within the system over time. There were inequalities in those not attending their first appointments. The average non-attendance rate was 7% but this could be as much as 50% from some ethnic groups. If patients did not attend the hospital appointment, then they were discharged back to their GP. If there were differential levels of discharge it could help to identify if there were underlying issues relating to non-attendance etc. There were also disparities in providing knee and hip operations depending on levels of wealth and ethnic origins. Those experiencing low levels of wealth might choose to work instead of having the operation until they were unable to work from the pain experienced. It would be important to bring consideration of ethnicity and inequalities into the health system.
- Experiences during Covid had provided information on which communities and sections of communities had been affected the most, those groups affected more by hospital admissions and which communities were reluctant to take up vaccines. Factors identified in these differences included access to open space spaces, communal living so not able to exercise social distancing, poverty, exercise and lack of active lifestyle and eating habits. Other comparable cities had been affected similarly with some more than others. It was important to use this information to look back and see how these factors can be address to bring about positive change and health improvements.
- It would be helpful to have simplified and easy to read versions of research projects to inform the work that would be needed going forward and also to inform on improvement engagement which those

experiences health inequalities.

- Research studies had linked deprivation to hospital outcomes eg planned and elective operations. The Michael Marmot 2020 Review examined a decade of data to understand the worsening situation of health inequality in the UK. Th report found funding cuts to be regressive and inequitable, suggesting that these financial decisions had harmed health and contributed to widening health inequalities.
- There was a need to level up services and ensure that when services are delivered, they do not create inequalities.
- Adult Social Care and Education Services had looked at data and carried out an internal to see if service delivery was equitable according to their context The department had introduced a participation model, based upon the Lundy model, which ensured staff listened and responded to the views of children and young people they work with. The adoption of this approach was getting Leicester national recognition.
- Work on Anti-smoking and Anti-Poverty had linked factors across a number of services and had shown that a change in one area helped to bring about change in other service areas and had identified the interaction of various factors affecting the outcomes. Getting the right advice at the right time can lead to people being less reluctant to open mail and missing appointments as they feel more engaged and helped.
- The existing Joint Health and Wellbeing Strategy Action Plan could be revised to incorporate and build on the work for the Framework. Officers intended to develop this and then engage partners in this work.
- The CCG had signed up to the Framework and NHS staff and GPs were also committed to it. It was useful to have good clear guidance of where to get the best evidence data or where to go to engage in services.

RESOLVED:

1) Officers were thanked for the work in producing the Framework which was supported and commented to all partners on the Board, together with the endorsement of the principles outlined in the Framework.

2) There should be a development session to discuss how the Framework can be moved forward by all participants in the Board and consider the issues of proportionate universalism and the factors affecting the inequalities of health.

22. ENGAGEMENT WORK

The Chair invited all organisations represented on the Board to present a verbal update on their engagement work during the last year.

The Chair commented that there was tendency to continually engage with the same people in the same way and partners should think about how engagement could be carried out differently. People's sense of place was often very different to officers. The recent example of the government establishing a vaccination centre at Peepuls Centre to improve vaccinations in

an area had low usage; but when it was suggested that it should be moved to a property within the community, the vaccination rates increased. Those living in the community intended to be vaccinated did not see the original location as part of their community area, but then moving it a relatively short distance into their recognised community area had achieve a better outcome.

Kevin Routledge (Strategic Sports Alliance Group) reported that professional sports clubs meet regularly in relation to the importance of physical activity as it was recognised it had a positive impact on health. Engagement was discussed together with the following :-

- How the clubs and participants had been impacted by Covid.
- Had it created opportunities and redefined how people interface with health, hospitals, health centres and GPs.
- Had there been transformation and demand changed and would that return to normal or would it be transformational.
- Was there room in this change from the normal and whether something should be done in the short term to recognise the total demand on the whole system has changed.

The Chair suggested that these issues could be picked up in a development session.

Martin Samuels (Adult and Children's Services) commented that:-

- Work had been undertaken with the Participation Strategy and the Professor Lundy Report and staff had embraced the exciting opportunities offered by a different approach to service delivery. A Rights Based Model had been embraced as recognising children had a right to a voice about the service they received for their needs and should not just be given the service determined by officers. It was an opportunity for an innovative engagement.
- There had been full consultation on the new approach during lockdown through active social media, daily polls, online consultation, webinars and topic groups to connect with young people in ways they chose and preferred.
- Children had been supported by having access to devices and they could meet in private.
- Valuable lessons had been learned and had brought out strongly the mental health of young people in a difficult year and an understanding of the pressures they had been under.
- Children did not want to use Teams and Zoom for meetings but preferred Facebook Live instead.
- Children could be far more resilient than often they were thought to be when facing pressure. They do respond well and, if officers used their preferred technology, they do engage positively.
- Professor Lundy had also said that Leicester's work was exemplary, and she uses it as a reference to others.

The Chair asked that information on the Participation Strategy be circulated to Board members as this would assist others to see how they could engage with

hard to reach groups.

Kevan Liles (Chief Executive, Voluntary Action Leicester) reported that they engaged with organised public groups through the website and newsletters. They also held a 3-day conference on-line and services users used Facebook portals to engage.

Cathy Ellis (Char of LPT NHS Trust) commented that they had set up in LPT People's Council in September 2020 chaired by Healthwatch which included diverse groups with protected characteristics and others. They came to a Board Meeting to report on mental health services. A Youth Advisory Board for 13-21 year olds had been set up to meeting weekly. They had engaged as mystery shoppers and taken a critical look at website and worked on 10 second tips on twitter to comply with social distancing and how to keep engaged. Participants were supported by training and developed by the Trust.

Mark Wightman (UHL Director of Strategy and Communications) indicated they had used Facebook Live to promote vaccines and address the resistance of people to have a vaccine for Covid. 6,000 people had taken part. The views of children and parents had been taken into account in relation to the building of the new children's hospital. There was merit in engaging with the public without already have an pre-determine agenda to implement in order to encourage the public to participate and find out the matters which were of importance to them.

Ivan Browne (Director of Public Health) stated that engagement had taken place though speaking to relevant people rather than issuing long consultation engagement documents. It had been beneficial to find that when the right people were engaged, they were able to pull together the right team rather than the usual group of people putting themselves forward. This had been particularly useful in relation to identified ethnic groups such as Somali and Black African Caribbean. Engagement could not be carried out without trust. Engagement work had started with Covid-19 and then developed into mental health, wellbeing and young people.

Richard Morris (Director of Operations and Corporate Affairs, LLR CCG) indicated that one size or model of engagement did not fit all situations. There was a need for a range of issues in a dynamic model as groups and communities were all different. The CCG had put in place a public involvement assurance group and had developed a citizen's panel. 1,000 people were used as a rapid testing method to give quick insight of public opinion. Engagement also took place on-line which enabled to the CCG to engage many with people who had not engaged before. It also resulted in seeing different people that would not normally come to face to face meetings. Going forward it would be important to engage through all different engagement methods to engage with as wide a base as possible. The CCG also engaged with faith and community leaders and groups to have dialogue about services with them. The engagement model had been radically changed so that engagement was not taken on issues when it was realistically too late to make a difference to one where having more open and place based discussions and consultation to

inform the development of the strategy model. There were direct benefits for engagement when it was possible to say these are the issues you said were of concern to you and this is what we are doing to address them. It would also allow better joint working with others.

Executive Members commented that:-

- It was important to build trust during engagement and the joint central resource for all to access the outcomes of engagement was welcomed. Learning outcomes should be pooled together so each organisation can draw from each other's learning outcomes and use them for future reference.
- It was important to understand that communities and geographical areas were very different and needs different aspects when undertaking engagement. For example, there's an old established Polish community in the City and also a newer more recent Polish community and each community generally lived in different areas of the City.
- It would be helpful to develop principles to draw together all the elements needed for engagement as had been done for the earlier item for health inequalities. This then would provide guidance for everyone to work to in the future. The Director of Public Health could lead on this and circulate to partners to add their contributions.

RESOLVED:-

That organisations be thanked for their updates and the items requested by the Chair above be actioned.

23. MENTAL HEALTH SERVICES

Paula Vaughan Head of Mental. Health and Learning. Disabilities and Gordon King from Leicester Partnership Trust gave a presentation on the co-design with service users of local mental health services.

During the presentation it was noted that:-

- Following new funding of £815k, there was a for a new piece of work on mental health and wellbeing and to do a piece of work in partnership with primary care networks as key partners. Initially groups within the networks would be asked to do the following 5 things
    - Have a real understanding and intelligence and narrative around the mental health needs of their local in neighbourhoods
    - Have a quantative assessment impact of Covid on mental health and wellbeing needs in each of the communities
    - Have conversations in the neighbourhood about what would make an impact in making lives better for them in the community.
    - Formalise the partnerships in the local community in a more formal way to enable those involved in the partnerships such as local voluntary sector, faith and youth groups etc to meet, talk and work together.
    - Think about the investment we have given them and what sort of

things would they want to put in place locally that would work specifically for their community and we will help them to measure the outcomes in a common format to see what the impact the community assets and investments have been.

- It would be launched in the next week or two. LPT and CCG some management capacity and resources to help with this piece of work.
- Poor mental health services had always tried to be at the heart of understanding how the inequalities and the wider determinants of poor mental health play through around poverty, race, trauma and discrimination. Chronic mental health was also strong driver for poverty. It also carried a lot of baggage around race and dangerousness and we will use that to inform specific work we will be doing around black mental health and the wider BAIME agenda.
- Undertaking a wider public engagement with service users on the wider transformation changes ready for public consultation. There is a legal duty and also a moral duty to do this address stigma etc.
- Targeted engagement to address historical lack of engagement from some groups around patient engagement on mental health.
- At the heart of delivery is daily engagement and co-production.
- It was important to ensure that everything done on a care plan, a care pathway people's medication plan, work with CPN and other organisation staff was how engagement was delivered in a way that was a genuine partnership to deliver high level mental health care and attain recovery for the patient. Recovery required agency in mental health and people having some hope and some control of what happens. If work was in partnership better outcomes were delivers for people.
- There was a recovery and collaborative care plan and cafe which was a 9-week programme shared space focusing on chine, connectivity, hope, opportunity and identity and meaning.
- Service users and carers were heavily involved in research. The psychologists team at Willows House and Stuart House engaged with service users on research on recovery on mental stress and recruitment panels to make sure we have the right representation of backgrounds of people when we recruit.
- Also doing work on self-assessments tools, central access points, and work around absconsion.
- Outcomes were only meaningful if they were developed by service users as they know how it feels to receive services and they know the outcomes they are looking for.

Board members commented:-

- Working at neighbourhood and community level was welcomed as targeted services were important including cultural specific services which should involve voluntary and community groups in providing them.
- When large contracts were awarded it could prevent small groups that were making local services and a vital contribution from being considered. There was a need to people who needed services a choice, so they could go to different groups to provide what they needed. Small

groups should not be excluded by organisations when going the tendering process as this could lead to
Part of the infrastructure being lost and depriving small groups of investment to continue to deliver their valuable services.

- It was desirable to embed genuine wellbeing and resilience within communities. It was also important to not just treat illnesses but to foster positive spirits and resilience. Mental health was not just about the absence of disease but also about positivity and hope.
- LPT had made and excellent way of making material available to people to focus on small habits and actions that foster wellbeing as opposed to dealing with poor mental health during the Covid restrictions. It was not just about addressing the consequences of not being well but using green spaces and access to transport were huge factors in promoting wellbeing to foster positive attitude and resilience in the future for people.

The Chair thanked Paula Vaughan and Gordon King for this important piece of work. Mental health was equally as important as physical health and needed to have equity of resources and parity of esteem. The changes being made were welcomed and a further update on these to a future meeting would be helpful. Numerous conversations with black ethnic communities all mentioned mental health issues as being important to the them. It would be desirable to have a symposium with members of the black community so that engagement can be taken forward on this issue and to learn lessons as engagement progressed from this piece of work. The Council's community, leisure and neighbourhood centres could be used help with this initiative.

24. DATES OF FUTURE MEETINGS

The Board noted that future meetings of the Board would be held on dates to be approved at the Annual Council Meeting in May 2021. These will be circulated when they were approved.

Meetings of the Board would currently continue to be held in a virtual format until such time as meetings are allowed to be held again in City Hall.

25. ANY OTHER URGENT BUSINESS

The Chair stated that no items of Any Other Urgent Business had been notified to be discussed.

26. CLOSE OF MEETING

The Chair declared the meeting closed at 12.05pm.