Leicester
City Council

MEETING OF THE HEALTH AND WELLBEING SCRUTINY COMMISSION

DATE: **TUESDAY, 22 MARCH 2022**

TIME: **5:30 pm**

PLACE: **Meeting Room G.01, Ground Floor, City Hall, 115 Charles Street, Leicester, LE1 1FZ**

Members of the Commission

Councillor Kitterick (Chair)
Councillor Fonseca (Vice-Chair)

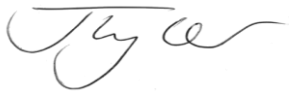
Councillors Aldred, Chamund, March, Dr Sangster and Westley

1 unallocated non-Group place.

Members of the Commission are invited to attend the above meeting to consider the items of business listed overleaf.

Standing Invitee (Non-voting)

Representative of Healthwatch Leicester



For Monitoring Officer

Officer contacts:

Jason Tyler (Democratic Support Officer):
Tel: 0116 454 6359, e-mail: Jason.Tyler@leicester.gov.uk

Sazeda Yasmin (Scrutiny Policy Officer):
Tel: 0116 454 0696, e-mail: Sazeda.Yasmin@leicester.gov.uk)

Leicester City Council, City Hall, 115 Charles Street, Leicester, LE1 1FZ

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Further information

If you have any queries about any of the above or the business to be discussed, please contact:

Jason Tyler, Democratic Support on (0116) 454 6359
or email jason.tyler@leicester.gov.uk

For Press Enquiries - please phone the **Communications Unit on 0116 454 4151**.

USEFUL ACRONYMS RELATING TO
HEALTH AND WELLBEING SCRUTINY COMMISSION

Acronym	Meaning
ACO	Accountable Care Organisation
AEDB	Accident and Emergency Delivery Board
BCF	Better Care Fund
BCT	Better Care Together
CAMHS	Children and Adolescents Mental Health Service
CHD	Coronary Heart Disease
CVD	Cardiovascular Disease
CCG LCCCG ELCCG WLCCG	Clinical Commissioning Group Leicester City Clinical Commissioning Group East Leicestershire Clinical Commissioning Group West Leicestershire Clinical Commissioning Group
COPD	Chronic Obstructive Pulmonary Disease
CQC	Care Quality Commission
CQUIN	Commissioning for Quality and Innovation
DAFNE	Diabetes Adjusted Food and Nutrition Education
DES	Directly Enhanced Service
DMIRS	Digital Minor Illness Referral Service
DoSA	Diabetes for South Asians
DTOC	Delayed Transfers of Care
ECS	Engaging Staffordshire Communities (who were awarded the HWLL contract)
ED	Emergency Department
EDEN	Effective Diabetes Education Now!
EHC	Emergency Hormonal Contraception
ECMO	Extra Corporeal Membrane Oxygenation
EMAS	East Midlands Ambulance Service
FBC	Full Business Case
FIT	Faecal Immunochemical Test
GPAU	General Practitioner Assessment Unit
GPFV	General Practice Forward View

HALO	Hospital Ambulance Liaison Officer
HCSW	Health Care Support Workers
HEEM	Health Education East Midlands
HWLL	Healthwatch Leicester and Leicestershire
ICS	Integrated Care System
IDT	Improved discharge pathways
ISHS	Integrated Sexual Health Service
JSNA	Joint Strategic Needs Assessment
LLR	Leicester, Leicestershire and Rutland
LTP	Long Term Plan
MECC	Making Every Contact Count
MDT	Multi-Disciplinary Team
NDPP	National Diabetes Prevention Pathway
NICE	National Institute for Health and Care Excellence
NHSE	NHS England
NQB	National Quality Board
OBC	Outline Business Case
OPEL	Operational Pressures Escalation Levels
PCN	Primary Care Network
PCT	Primary Care Trust
PICU	Paediatric Intensive Care Unit
PHOF	Public Health Outcomes Framework
QNIC	Quality Network for Inpatient CAMHS
RCR	Royal College of Radiologists
RN	Registered Nurses
RSE	Relationship and Sex Education
STI	Sexually Transmitted Infection
STP	Sustainability Transformation Plan
TasP	Treatment as Prevention
TASL	Thames Ambulance Services Ltd
UHL	University Hospitals of Leicester
UEC	Urgent and Emergency Care

PUBLIC SESSION

AGENDA

NOTE:

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1. APOLOGIES FOR ABSENCE

2. DECLARATIONS OF INTEREST

Members are asked to declare any interests they may have in the business on the agenda.

3. MINUTES OF PREVIOUS MEETING **Appendix A (Pages 1 - 8)**

The Minutes of the meeting held on 25 January 2022 are attached and the Commission will be asked to confirm them as a correct record.

4. CHAIR'S ANNOUNCEMENTS

5. PETITIONS

The Monitoring Officer to report on the receipt of any petitions submitted in accordance with the Council's procedures.

6. QUESTIONS, REPRESENTATIONS, STATEMENTS OF CASE

The Monitoring Officer to report on the receipt of any questions, representations and statements of case submitted in accordance with the Council's procedures.

7. COLOURS DYERS - UPDATE

Appendix B (Pages 9 - 14)

The Director of Neighbourhood and Environmental Services submits a report, which provides an update on the Colours Dyers factory that was called to Scrutiny by means of the formal petition process.

8. COVID19 UPDATE & VACCINATION PROGRESS UPDATE

There will be a presentation to provide an update on the progress concerning Covid-19 and the vaccination programme.

9. HEALTH INEQUALITIES UPDATE - ACTION PLAN

There will be a presentation to provide an update on the progress concerning the Health Inequalities Action Plan with the associated links to Covid 19.

10. SUPPORTING LEICESTER RESIDENTS WITH MENTAL HEALTH CONDITIONS TO QUIT SMOKING

Appendix C (Pages 15 - 32)

The Director of Public Health submits a report, which details proposals the local tobacco control strategy and the commitment to reduce health inequalities in the city.

11. BLACK LIVES MATTER AND NHS WORKFORCE REVIEW: PROGRESS UPDATE

There will be a verbal update on the progress of the BLM and NHS Workforce Scrutiny Review.

12. WORK PROGRAMME

Appendix D
(Pages 33 - 38)

The Commission's Work Programme is submitted for information and comment.

13. ANY OTHER URGENT BUSINESS

Leicester
City Council

Minutes of the Meeting of the
HEALTH AND WELLBEING SCRUTINY COMMISSION

Held: TUESDAY, 25 JANUARY 2022 at 5:30 pm

P R E S E N T :

Councillor Kitterick (Chair)

Councillor Aldred, Councillor March, Councillor Pantling, Councillor Dr Sangster, Councillor Whittle

In Attendance:

Councillor Dempster, Assistant City Mayor for Health

53. APOLOGIES FOR ABSENCE

Apologies were received from Councillor Fonseca.

54. DECLARATIONS OF INTEREST

Members were asked to declare any pecuniary or other interests they may have in the business on the agenda.

There were no declarations of interest.

55. MINUTES OF PREVIOUS MEETING

AGREED:

That the minutes of the meeting of the Health and Wellbeing Scrutiny Commission held on 14 December 2021 be confirmed as a correct record.

56. CHAIR'S ANNOUNCEMENTS

The Chair noted that the petition regarding Dyeworks Limited in Aylestone had yet to receive a final reply, but a joint visit from the Environmental Agency and the Council was upcoming, where the issues raised by the Commission would be considered. Responses to these would be circulated to the Commission after the visit.

It was also noted that the CQC had cancelled the registration of the Manor Park Medical Practice, meaning it was unable to provide services. This was due to a 2021 inspection which had determined that the Practice required improvement. The Chair noted that he intended to speak with Ward Councillors, Commission Members, Members of the Executive, and the CCG to look at lessons learned and discuss the necessary steps to restore service. It was noted that patients at the Practice had been informed, and that drop-in sessions would be held for patients.

It was noted that due to the nature of the public questions received for the meeting, the item on the Integrated Care System would be taken immediately after public questions.

The Chair also noted that there would be a Special Meeting of the Commission on 15 February 2022 to look at mental health issues.

AGREED:

That the position of Manor Park Medical Practice be noted, and that relevant Ward Councillors be contacted to work on a solution.

57. PETITIONS

The Monitoring Officer reported that no petitions had been submitted in accordance with the Council's procedures.

58. QUESTIONS, REPRESENTATIONS, STATEMENTS OF CASE

The Monitoring Officer reported that several questions had been submitted by members of the public as set out on the agenda.

The following questions were asked:

From Sally Ruane:-

1. *The Health Service Journal has reported that while over half of all integrated care systems published board papers in the last year, unfortunately the Leicester, Leicestershire and Rutland integrated care system did not. Can the leaders of the Leicestershire and Rutland integrated care system confirm whether or not they have published regular papers in 2021 and of so what these papers are and where they are being published? If not, please could they tell us why not.*
2. *How is the shadow integrated care system board making itself accountable to the public?*
3. *What input have councillors been invited to make to integrated care system governance?*
4. *Will the integrated care system constitution be made available for public*

scrutiny before it is finalised?

From Jean Burbridge

1. *Has the shadow Integrated Care System board made any decisions in private session?*
2. *Can Integrated Care System leaders confirm that (a) no private companies and (b) no social enterprises will sit on (a) the Integrated Care System board and (b) in the Integrated Care System partnership?*
3. *Will elected councillors sit on the Integrated Care System board? If so, how many? If not, why not?*

UHL representatives responded as follows:

- The Integrated Care Board (ICB) had yet to be fully established, papers would be available in the public domain when it was established in July.
- ICB papers were taken through the CCG Board which were in public domain.
- Statutory accountabilities included publication of annual reports and accounts. The goal was to go further than that and have an active communications process.
- There would be other forms of formal accountability such as through the Commission.
- Councillors were involved in aspects of the Integrated Care System (ICS) governance, particularly with the Health and Wellbeing Partnership. Views from Councillors on the governance of the ICS had been considered.
- The draft constitution for the ICB couldn't be finalised until full details of legislation were available, the legislation was not expected until summer. Once the draft constitution was available it would be in the public domain.
- The ICB had yet to have any executive authority, records of ICB meetings were available in CCG Board papers.
- The ICB would not have private companies on the Board.
- Draft guidance excluded elected Councillors from holding the Partnership remit for Local Government. However, 3 voting places had been offered to Local Authorities on the ICB which would be held by Officers.
- Councillors would be able to sit on the Health and Wellbeing Partnership.

The Chair invited Questioners to ask any supplementary questions. Further concern was expressed around the transparency of the shadow ICB, relating to the regularity of CCG meetings. In addition, more clarity was sought over how Local Authority representation would be allocated.

UHL representatives replied:

- The view had been taken that the current shadow ICB had sufficient

transparency, but feedback would be considered. The intent was to hold ICB meetings in public.
- The frequency of CCG meetings was presently in line with neighbouring areas.
- The ICS had two elements two it, the ICB which was a statutory body, this was required to have Local Government representation. The Integrated Care Partnership would locally be called the Health and Wellbeing Partnership at the request of partners. Details of this Partnership had yet to be finalised.

59. TRANSITION TO AN INTEGRATED CARE SYSTEM - UPDATE

The CCGs submitted a paper providing an update on the transition to an Integrated Care System (ICS).

CCG Officers presented the item, it was noted that the start of the ICB was delayed to July to allow the legislation to be finalised. The ICs work would not be delayed and would be accountable to the CCGs before the ICB launched. Most appointments to the ICB had been completed, but partnership places still had yet to be appointed.

In response to Members' questions, it was noted that there was a confidence that the changes the ICS would bring would have a positive impact on the operating the of Service. It was felt that the changes gave a legislative framework to better facilitate the kind of partnership work that was already being moved to naturally.

It was also noted that the model constitution for the ICB was available to view, and once the draft constitution was ready it would be widely shared. It was thought that the model constitution would be very close to the official constitution.

AGREED:

1. That the Commission notes the report.
2. That the Commission requests that the CCG send out a diagram explaining the structure of the ICS.

60. COVID 19 AND VACCINATION PROGRAMME - UPDATE

The Director of Public Health gave a presentation and verbal update on the Covid 19 and Autumn/Winter vaccination programmes including recent data and vaccination patterns across Leicester.

In response to Members' questions, it was noted that:

- £485k had been allocated to Leicester as part of the Vaccination Champions programme. This would be used to empower community groups to take messages to their own communities regarding the vaccine and also other health issues. The Commission would be kept

informed on the work.

- The question of vaccinations for 5–11-year-olds was being asked, it was felt that Government still had a hesitancy to take this step. Clinically venerable 5–11-year-olds were eligible for the vaccine.
- There was variation in vaccination rates between schools.
- One of the larger issues with school vaccination was parental consent forms which were online only. Many had issues filling the forms out. A system level improvement plan was looking at improving this issue.
- There were areas of the city where vaccination rates where less than desired. Work was now ongoing to look at how to target these communities with engagement to increase rates.
- It was hoped that a local offer could include mobile vaccination centres that would be a short walk away for residents.
- There had been outbreaks in care homes, these tended to be large outbreaks in a small number of homes.
- More engagement work in care homes around the vaccine were upcoming.

AGREED:

1. That the Commission notes the update.
2. That the Commission requests that an item at a future meeting on the Vaccination Champions money and empowering communities to have their own conversations on health issues.
3. That the Commission requests that a briefing session be organised for all Councillors looking at engaging communities on the vaccine.
4. That the Commission recommends that best practice be examined from schools with high vaccination rates.

61. LONG COVID - UPDATE

The Chair noted that due to Officers having to leave the meeting, this item would be deferred and not considered at the meeting. The Commission were given the option to submit questions on this paper outside of the meeting, which officers will respond to.

62. COMMUNITY PHARMACIST CONSULTATION SERVICE - UPDATE

The CCGs submitted a paper which provided background and an overview to the NHS Community Pharmacist Consultation Service (NHS CPCS).

Officers representing the CCG presented the item, it was noted that:

- There had been 2800 referrals since November 2020 from 31 GPs. The number of referrals was increasing.
- There were 100 Community Pharmacists signed up in the city.

- There were a number of benefits to patient care from this scheme, including longer term patient education, more flexible hours, reduced contacts for GPs, and increased confidence in access to health care outside off GPs and emergency services.
- This was a national scheme, meaning there was equity across all Pharmacies. There was 97% coverage of Pharmacies across LLR.
- Work was ongoing to get urgent treatment centre referrals at Community Pharmacies. Pilots were ongoing elsewhere in England.
- 11 PCNs had been engaged face to face, and all Directors of PCNs had been engaged with.
- This service would build a foundation for wider Community Pharmacist services.
- This was funded from repurposed Pharmacy funding.

In response to Members' questions, it was noted that:

- Informed patient consent was required for the service, the patient could choose which Pharmacy they went to.
- The national service had 90% patient satisfaction, local satisfaction numbers were similar. The survey was offered to all patients who had participated in the national pilot. Cases of patient dissatisfaction were analysed.
- If the Pharmacy couldn't help the patient, they would be referred to a more appropriate service.
- One of the pre-requisites for a Pharmacy to join the service was having a consultation room with a door and soundproofing. All pharmacies in the city had a consultation room.
- There was a robust mechanism to follow up with patients, this kept patients from falling through the cracks.
- There were 3 routes for referrals for patients, online, over the phone, and face to face.

AGREED:

1. That the Commission notes the report.
2. That the Commission recommends that Officers consider further communications work to make the process more coherent for patients.

63. ORAL HEALTH SURVEY OF 3 YEAR OLD CHILDREN

The Director of Public Health submitted a briefing paper which provided information on Public Health England's National Dental Epidemiology programme and included the examination of a random sample of 3-year-old children.

The Director of Public Health presented the item, it was noted that:

- Leicester had previously been at the bottom of ratings nationally in terms of oral health for under 5s, however the survey indicated an improving

picture in this area.

- Priorities and actions to tackle children's dental decay included school initiatives such as supervised brushing in an educational setting. This involved working with nurseries to support staff and provide toothbrushes and toothpaste.

In response to Members' questions, it was noted that:

- The oral health team did look at best practice from other Local Authorities.
- Oral health was now in the substantive budget for Public Health, work was presently funded from an old grant from PHE.
- There were concerns around the difficulty of finding an NHS dentist. The oral health team did try to encourage more NHS dentists, such as with highlighting achievements.

AGREED:

1. That the Commission notes the report.
2. That the Commission recommends that a future item be brought to the Commission on the broader issues of oral health, with a focus on the issue of NHS versus private practices.
3. That the Commission recommends that NHS Officers explore removing soft drinks vending machines in UHL facilities.

64. DRAFT REVENUE FUND BUDGET AND CAPITAL PROGRAMME - 2022/23

The Deputy Director of Finance submitted a report setting out the City Mayor's proposed budget for 2022/23. The Commission was recommended to consider and comment on the Health and Wellbeing element of the report. The Commission's comments would be forwarded to the Overview Select Committee as part of its consideration of the report before presentation to the meeting of Council on 23rd February 2022.

The Chair went directly to Members' questions.

In response to questions put by Commission members about the £200k reduction in the budget for the Healthy Child Program it was noted that this reduction had been agreed in previous years to take place in 2022/23. It was a general reduction in the contract price so in theory there would be no change in available services.

It was acknowledged that although applications for funding for certain schemes were ongoing, there would likely not be additional funding to Public Health Services in the future to help deliver major schemes and that this might require the Service to assess its operations and make changes to spend more efficiently. This led to a discussion around the importance of taking a holistic approach to health across the entire public sector, it was agreed that this

approach would allow more efficient spending. Health Partners suggested that a presentation could be brought to a future meeting on how work was being doing to make Health Service spending more cohesive.

AGREED:

1. That the Commission notes the Draft Revenue Fund Budget and Draft Capital Programme for 2022/23.
2. That the Commission recommends that a presentation is brought to a future meeting of the Commission on making Health Service spending more cohesive.

65. WORK PROGRAMME

The Scrutiny Support Officer submitted a document that outlined the Health and Wellbeing Scrutiny Commission's Work Programme for 2021/22 which was noted.

66. CLOSE OF MEETING

The meeting closed at 8pm.

Appendix B

Colours Dyers, update

For consideration by:
Health and Wellbeing Scrutiny Commission
Date: 22 March 2022
Lead Director: Neighbourhood and Environmental Services

Useful information

- Ward(s) affected: Saffron
- Report author: Robin Marston, Team Manager, Noise and Pollution Control Team
- Author contact details: 373055, robin.marston@leicester.gov.uk

1. Purpose of report

To give an update on a factory that was called to Scrutiny by means of the formal petition process in relation to Colours Dyers, Greenhithe Road, Leicester.

2. Summary

A formal petition was brought to the health and well being scrutiny commission in September 2021. This petition received a formal response from the Commission; however, further questions were raised in relation to health implications caused by the factory, Colours Dyer, Greenhithe Road, Leicester.

3. Recommendation

To await the joint site inspection by the EA and LCC, following which options for further assessment will be clearer. These should include an update on the OMP (Odour Management Plan) and any further stack monitoring.

4. Report/Supporting information including options considered:

This premises has been a dyeworks for a long time and has been the source of odour and noise complaints over the years. The company falls under the remit of the EA in terms of operation under the PPC Act 1999 and has an A1 permit to operate. This permit contains a number of conditions that the operators must comply with, and these include noise, odour, water, and energy efficiency.

Figure 1 shows the location of Colours Dyers, on Greenhithe Road, off Aylestone Road. As is the case with most dyeworks, it is located next to the river soar, and also within a mixed industrial and residential locality.

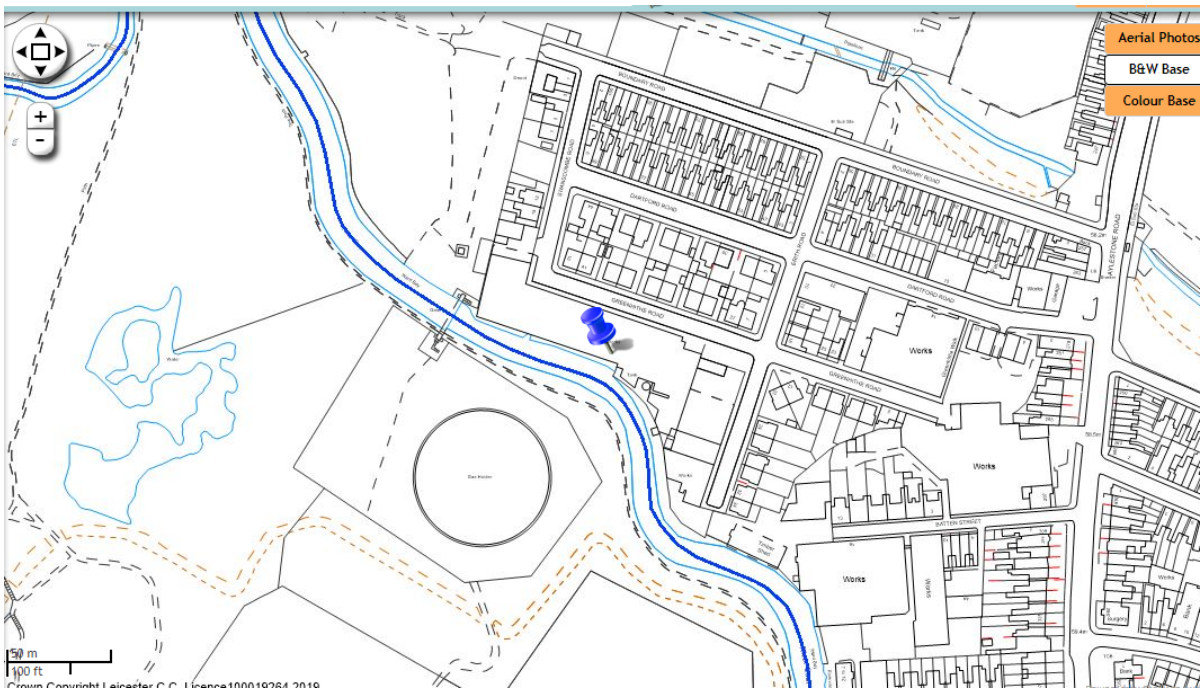

Figure 1 – Location of Colours Dyers

Following the FOIA request and health scrutiny questions in autumn 2021, more information has been requested of the EA in relation to this site.

The formal response from the EA related to three main areas:

1. Current Permit

Colours Dyers and Finishers Ltd (Colours) were issued with an environmental permit in 2003 for the pre-treating and dyeing of fabrics and textiles in a plant with a treatment capacity of more than 10 tonnes per day.

The environmental permit has a number of conditions, which are designed to protect the environment and human health and minimise the impact of the plant. The permit does not contain any emission limits on the chimneys (stacks), because these were deemed low risk. The standards under which the plant was permitted at that time were standards adopted in the UK and across the European Union. All Textile plants were permitted under these standards. Whilst the standard did not require Colours to monitor their emissions, The EA at the time put an Improvement Condition in the permit, requiring Colours to undertake some monitoring of their stenter stack. Following the monitoring, the EA then required Colours to undertake a risk assessment, using that data.

The stenter stack was monitored for benzene in 2006, as an indicator of volatile organic compounds (VOCs). When the benzene results were entered into the risk assessment, the conclusion was that the impact from the stenter stack was ‘insignificant’. No Environmental Quality Standard (EQS), Environmental Assessment Levels (EAL) or Statutory Emission Limit Values (ELV) were breached.

2. Future updates to standards for textile sector

The new European Union standards for Textile plants, which are likely to be implemented by the UK do place emission limits on air emissions from dye houses. The standards are still in draft and it's unclear if Colours will be required to monitor their emissions and be subject to an emission limit.

Notwithstanding the above, we feel that it would be useful to carry out a further monitoring exercise of the stenter stack at Colours, given that it's been 15 years since the last one. As I said before, there isn't a condition in the permit requiring Colours to undertake monitoring. If they are unwilling to do some monitoring voluntarily, we will look at the regulatory options available to us to get some monitoring carried out.

3. Complaints and assessment of odour

In the last two years, prior to September 2021 we received 4 complaints from residents about the smell from Colours. Since September we have received 8 complaints from residents, as well as press interest from the Leicester Mercury and letters from the local MP, Jon Ashworth and the Deputy Mayor of Leicester City Council, Adam Clarke.

We carried out an on-site inspection of Colours on 17 September this year, which included undertaking some odour monitoring in the streets around the site. During the odour monitoring we did experience odour from Colours. The intensity of an odour is measured using a scale from 0-6, with 0 being 'not perceptible' to 6 being 'offensive'. Our officers described the odour from Colours as being 'distinct' with an intensity of 3 on the odour scale. Officers noted that the odour was transient; noticeable when the stenter stack from Colours was emitting a coloured plume. When the stack emission was not visible, the odour dissipated.

4. Assessment of pollution from the site

As detailed above, the site operates under an Environmental Permit, issued by the Environment Agency. There are a large number of different processes that require permits, and these are undertaken using the specific 'sector guidance notes'. These guidance notes use current scientific knowledge and also the impact of any pollutant on different receptors, in this case the human receptor. In the case of large processes like this one, the guidance includes emissions to air, water, land, energy efficiency, and other health and safety issues.

Prior to the granting of a permit the company are required to submit plans for all areas of the proposed permit. In the case of emissions to air, samples will be taken from the chimney to ascertain levels of pollution. These are then compared to the objective levels stated in the guidance. The EA use modelling software to predict the impact of these emission, and in the case of Colours Dyers, this modelling gave a 'low impact' likelihood. This outcome meant that the company didn't have to conduct regular stack monitoring, due to the low levels of pollution emitted from the chimney.

Future proposals

- Joint site inspection to be undertaken by EA and LCC. (Postponed from the 11 March 2022 due to EA Officers sickness)
- Following this meeting, more information will be provided in terms of the OMP (Odour Management Plan), updates to the sector guidance and thus the permit, and also whether further stack monitoring is proposed.
- LCC to gather information in terms of costs of undertaking this monitoring (it is noted that LCC do not have jurisdiction in this matter, as the process is permitted by the EA)
- Joint Comms between EA and LCC in relation to pollution concerns and reporting mechanisms.

5. Financial, legal and other implications

5.1 Financial implications

There are no immediate financial implications associated with the recommendations in this report. The cost associated with any potential future monitoring will need to be considered as and when such proposals are brought forward.

Stuart McAvoy – Head of Finance

5.2 Legal implications

Potential difficulties in undertaking stack monitoring, as EA are the regulating Authority, and they should lead on requesting this work be undertaken.

5.3 Climate Change and Carbon Reduction implications

None

5.4 Equalities Implications

There are no direct equalities implications arising out of the report as it is for update.

Equalities Officer Ext 37 4148

5.5 Other Implications (You will need to have considered other implications in preparing this report. Please indicate which ones apply?)

None

Appendix C

Supporting Leicester residents with mental health conditions to quit smoking

For consideration by:
Health and Wellbeing Scrutiny Commission
Date: 22 March 2022
Lead Director: Ivan Browne

Useful information

- Ward(s) affected: All
- Report author: Amy Endacott
- Author contact details: Amy.endacott@leicester.gov.uk
- Report version number: 1

1. Summary

Prevalence of smoking in Leicester City has been declining year on year and is now at an all time low of 15.4%[1] (13.9% England average), in large part due to the provision of high-quality stop smoking support. However, the national data clearly shows that prevalence has remained much higher amongst those with a long term mental health condition (26.8%) and higher still amongst those with a severe mental illness (40.5%)[2], yet smokers with mental health conditions are no less likely to express desire to stop. There is therefore a case for identifying why this is the case, and what measures can be taken to better prevent people with mental ill-health from being disproportionately affected by smoking-related disease.

The links between smoking and mental health are complex, but the available evidence clearly outlines the wealth of benefits quitting brings to individuals with mental health conditions, as will be outlined in the supporting information section. People with mental health conditions have an equal right to be asked whether they smoke. It is vitally important to highlight that the evidence demonstrates that smokers with mental health issues are no less likely to want to quit smoking than other smokers, but that they anticipate that it will be more difficult and are less likely to receive help than other smokers.[3] Furthermore, despite overwhelming evidence about the dangers of tobacco use, many mental health professionals have reported feeling reluctant to engage with patients about smoking and/or having low expectations of patients' motivation or ability to stop smoking[4]. Staff who smoked were more likely to have reservations about the importance of the smoke free policy and the treatment of nicotine dependence among patients.[5]

Parity of esteem for those with mental health conditions was a key ambition set out in the 2017 Tobacco Control Plan for England, and the Public Health Team at Leicester City Council are committed to ensuring that people with mental health conditions have fair access to treatment and support which meets their needs.

[1] PHE fingertips

[2] PHE fingertips – 2019 (adult prevalence), 2018/19 (long term mental health conditions) and 2014/15 (SMI)

[3] NHS digital – Health Survey for England 2010 - 2011

[4] ASH-Factsheet_Mental-Health_v3-2019-27-August-1.pdf

[5] Ratschen E et al. Tobacco dependence, treatment and smoke-free policies: a survey of mental health professionals' knowledge and attitudes. Gen Hosp Psych 2009; 31(6): 576-82

Two small pilot schemes which were run with the homeless population and service users at Turning Point have demonstrated some success with engaging people who may not otherwise have accessed support, through the use of a different service delivery model.

It is important to note from the outset that the breadth of mental health conditions, the impact this has on the likelihood of smoking, the amount smoked, and the longer-term health implications is vast. The treatment provided for mental health conditions ranges from very intensive inpatient support to much lighter touch community support or self-management, and as such different levels of support options to help patients successfully quit smoking are likely to be necessary. Inpatient care is currently provided through Leicestershire Partnership Trust (LPT) which is currently developing a model of support for smokers as set out by the National Health Service (NHS) Long Term Plan. An interim project manager has been recruited by LPT to oversee this work, with plans to recruit a permanent smoke free lead. The role will primarily focus on delivery of the NHS long term plan ambitions but it is anticipated that the remit will also consider the necessity to ensure that those with mental health conditions in the community are able to receive the same high quality care as that which will be planned for those in inpatient settings. Consideration has also been given to the continuity of care between these services.

This report outlines the reasons why this group of smokers is so important to consider, the support which is currently available to all smokers, how the needs of smokers with mental health conditions may differ from 'standard care', and recommendations for how this programme could be shaped to tailor the support offer to better suit their needs.

2. Recommended actions/decision

The Health Scrutiny Commission is asked to:

- Endorse the proposed approach to supporting smokers with mental health conditions, specifically the proposed next steps outlined in section 5;
- Engage in the approach by identifying opportunities to support and advocate through stakeholders.

3. Scrutiny / stakeholder engagement

This report has been discussed at directorate management team and lead member briefings, and the recommendations have been supported.

As part of the recommendations outlined in section two, there is an intention to consult with both staff and potential service users to gain greater understanding from a 'lived in' perspective, and to shape the service delivery model to best meet the needs and capabilities of both staff and service users.
It is not anticipated that the proposals will have equalities impacts as the proposed changes are intended to reduce any equalities issues which are currently being faced by the target population. However, an equalities impact assessment has also been undertaken to ensure all equalities impacts have been fully considered.

4. Background and options with supporting evidence

4.1 Existing provision for smoking cessation (and considerations for those with mental health conditions)

Currently smoking cessation support is delivered via the Live Well service, which is an integrated lifestyle service within which a dedicated smoking cessation service operates. Smoking cessation support is available to any smoker who wishes to quit and smokers are offered 12 weeks evidence-based support comprising of a weekly contact with a trained smoking cessation advisor and access to an appropriate smoking cessation medication (if desired). The service delivery model was adapted during the COVID-19 pandemic to a telephone based service, and subsequent consultation work with service users highlighted that this had been a welcome option for many service users, and that a mixture of telephone and face-to-face was desired for the future. As such, a proportion of the available appointments offered are now face-to-face.
The needs of service users have been considered in a number of ways:

- Advisors have the discretion to extend the usual 12 weeks support for clients where there is an identified need.
- Clients have the option to access a smoke free app in addition to their usual care which, amongst other features, gives them access to a 24/7 'live chat' facility whereby they can have contact with a stop smoking advisor for advice and support. This is provided to them free of charge for 12 weeks.
- The service offers flexibility with appointment times so that there is a range of options to meet individual need, i.e. morning, afternoon, evening.
- There are a number of appointments blocked out as 'emergency' appointments which can be offered at short notice to priority client groups, which includes clients with mental health issues.
- During periods when COVID restrictions are sufficiently lifted clients are offered the option to have a carbon monoxide reading at 4 weeks post quit day to highlight the extent of their success and boost motivation to continue.

Options for addressing any remaining gaps for clients with mental health conditions:

- Consideration is being given to the feasibility of offering some drop-in sessions for clients who may find it more difficult to attend a more structured appointment routine.
- Evaluation of the smoke free app will give an indication of how useful clients have found it to have contact with a smoking cessation advisor between their usual appointments and, if indications are positive, consideration will be given to how this can continue.
- Total abstinence may not feel like an achievable starting point for some service users with mental health conditions. Shorter harm reduction based KPI's can be much more helpful for building confidence and motivation to quit completely, therefore consideration will be given to how alternative measures of success can be embedded, i.e. harm reduction.

Mental health conditions vary widely in their symptoms and presentation and accounting for this neurodiversity is essential in considering how future services should be shaped. It is likely that different approaches will need to be taken dependant on the type of mental health condition rather than developing a universal approach for 'people with mental health conditions' which may inadvertently widen the existing inequality gap, and evaluation will be imperative to ensure smoking rates are reducing equally across all of the relevant mental health groups.

4.2 History with Leicestershire Partnership Trust (LPT) and community mental health teams

Since 2018 national policy has required mental health inpatient units and facilities to become smoke free. Taking into account the wealth of evidence highlighting the disproportionate impact of smoking on those with severe mental illness (SMI), it has been important for staff working in this field to be clear that their primary concern is helping their patients to get better, and that quitting smoking is evidence-based to help with improvements in mood disorders, and therefore should be included routinely as part of an effective treatment plan. Furthermore smoking contributes to health inequalities which people with mental health conditions are already adversely affected by, so it is even more important that parity of esteem is at the forefront in ensuring they are given better chances of improving their outcomes by helping them to quit.

The previous iteration of the stop smoking service (now delivered via Live Well's integrated lifestyle service) worked with LPT to support the implementation of the nationally mandated smoke free mental health trusts. This included provision of 'brief intervention' training for staff working within the Trust to support conversations about smoking, and more in depth 'level 2' training to upskill staff and enable them to provide 1-1 support to smokers who wished to quit. The stop

smoking team also worked with the Trust to implement a system whereby all new inpatients had their smoking status recorded and were offered either nicotine replacement therapy or a vaping device to support the management of withdrawal symptoms during times when smoking could not be permitted. As a result of reduced capacity in the smoking service due to cost savings, it has not been possible to provide this support to LPT recently. As result of this reduced capacity and other covid-related issues some of the previous progress has been lost. This will form part of the remit of the new smoke free lead being recruited by LPT. LPT have highlighted the additional difficulties which have been experienced as a result of the COVID-19 pandemic in maintaining the smoke free progress which had been made, and are committed to addressing this.

4.3 Engaging with LPT

It is intended that LPT will recruit a 'smoke free lead' to sustain the programmes of training and support on an ongoing basis, and to support links between inpatient and community provision. LPT are also collaborating with the LLR Long Term Plan Tobacco Dependence Steering Group through which the CURE programme is being supported and part of a phased roll out of the CURE approach to maternity and mental health services.

A report published by Action on Smoking and Health in December 2020 – Smokefree Skills: Training needs of mental health nurses and psychiatrists – highlighted the wide discrepancy in smoking cessation training provision for practitioners working in mental health roles. Recommendations from this report include that as a minimum all frontline staff should be trained to deliver brief advice around stopping smoking and referral to intensive support. The intention is that this will be implemented as part of the CURE rollout, and it is imperative that community mental health teams are also provided with this training to ensure consistency across services.

4.4 Pilot schemes with Action Homeless and Turning Point

Two pilot schemes have been delivered in Leicester working with groups who experience additional complex needs, and both based on models of support which were designed to differ from 'standard care' provided via the Live Well stop smoking team.

<u>Action Homeless</u>

Service provision was delivered on-site by a smoking cessation specialist and adaptations were made to the usual service model to meet the unique needs of the client group. Specifically these included: drop-in sessions which allowed clients to attend ad hoc, shorter appointments to aide those with concentration and memory issues, extended time allowed to reach abstinence, training staff to continue conversations about smoking between appointments and build on successes, simple instructions to demonstrate the products available, and access to free immediate treatment, including vaping devices. Of the 82 clients who

attended the service during the 15 month period, 67% disclosed additional mental health conditions. 62 clients attended more than one appointment, 20% quit smoking altogether and 45% were able to significantly reduce their carbon monoxide result indicative of harm reduction.

Turning Point

The pilot scheme was initially targeted at alcohol users due to the evidence base highlighting that 70-80% of dependent drinkers smoke, and that smoking is a factor which significantly worsens the problems experienced by change resistant drinkers[6]. Turning Point staff volunteers who service users had already built rapport with were used to deliver a 6-session intervention, in-house and on a drop-in basis, offering service users a free vaping device to stop or significantly reduce their smoking. During the 6 month pilot period 10 clients accessed support: 20% successfully quit for at least four weeks and a further 30% were able to significantly reduce their carbon monoxide level.

It is important to highlight that both of these projects successfully engaged with smokers who would not otherwise have sought support for their smoking were in not for the availability of the service in a manner that suited their unique needs. The provision of a free vaping device was also a significant factor in the success of these projects, and the service users typically could not afford to purchase the device themselves (or were unwilling to invest an amount of money on something they were not yet confident would work for them).

5. Detailed report

5.1 Overview

In 2019 the Government laid out their ambition to achieve a smoke free generation (where prevalence of smoking is 5% or less) by 2030[7]. Smoking rates have been in decline both nationally and locally over the last 20 years and are currently at their lowest ever rates of 13.9% nationally, and 15.4% locally[8] (although Leicester's Health and Wellbeing survey data in 2018 would indicate that the Leicester rate is closer to 20%). However, this trend has not translated across all groups, particularly those with mental health issues, and smoking rates have remained unfairly high in this group.

When the national Tobacco Control Plan for England was published in 2017 it specifically cited the importance of parity of esteem in supporting people with

[6] Alcohol concern: Blue Light Bulletin 23 - Vaping and problem drinkers: A missed opportunity?

[7] Advancing our health: prevention in the 2020's - 2019

[8] PHE fingertips data

mental health issues to quit, recognising that this group of smokers may need access to a different, targeted approach to quitting than that which is used by the general population. Our local tobacco control strategy reiterates this, highlighting our commitment to reducing health inequalities in the city and supporting the most vulnerable in our society to make positive changes to their health and wellbeing.

5.2 Critical data

5.2.1 Smoking and it's primary impacts

The physical health implications of smoking are well documented and include[9], but are not limited to:

- Increased risk of at least 12 types of cancer, and in particular a 70% chance of lung cancer
- Coronary heart disease and heart attack
- Stroke, peripheral vascular disease and cerebrovascular disease
- Asthma, COPD and emphysema
- Reduced fertility and impotence

Approximately half of all lifelong smokers will die prematurely, losing on average 10 years of life[10].

By contrast, immediate benefits (within 20 minutes) can be brought about by quitting, including a return to normal blood pressure and improved circulation. Within a short space of time oxygen levels return to normal and breathing becomes easier, and on a longer-term quitters benefit from improved lung capacity and reductions in risks of heart attack, stroke and lung cancer.

In addition to the physical effects, smokers are more likely to experience poverty, using a significant percentage of their disposable income on tobacco[11], thus widening health inequalities.

5.2.2 Smoking prevalence, practice and outcomes in mental health compared to the general population

One third of all cigarettes smoked in the UK are smoked by people with a mental health problem[12] and smoking prevalence amongst those with poor mental health is significantly higher than those without. Whilst the smoking prevalence in England has dropped to 13.9% it is much higher amongst those with a long term mental health condition (26.8%) and higher still amongst those with a severe mental illness (40.5%)[13], yet smokers with mental health conditions are no

[9] https://www.nhs.uk/common-health-questions/lifestyle/what-are-the-health-risks-of-smoking/
[10] Mortality in relation to smoking: 50 years' observations on male British doctors | The BMJ
[11] https://ash.org.uk/wp-content/uploads/2019/10/191016-Smoking-and-Poverty-2019-FINAL.pdf
[12] The Royal College of Physicians and the Royal College of Psychiatrists, Smoking and mental health, 2013
[13] PHE fingertips – 2019 (adult prevalence), 2018/19 (long term mental health conditions) and 2014/15 (SMI)

less likely to express desire to stop. It is of great concern that people with poor mental health die on average 10-20 years earlier than the general population, and smoking is the single largest contributor to this life expectancy gap[14], highlighting that there is an urgent clinical need to ensure smokers are offered effective methods to quit smoking. Smokers with a mental health condition also smoke significantly more and have greater nicotine dependence than smokers without a mental health condition[15].

It is estimated that one in four adults in the UK experience a mental health condition in any given year[16], which highlights how widespread this issue is likely to be. The umbrella of 'mental health conditions' refers to a number of conditions which differ in both their symptoms and severity ranging from relatively common conditions such as low mood to more severe conditions such as schizophrenia. Prevalence of smoking differs between different mental health conditions with rates highest in those with severe mental illness (SMI). Both adults and children with ADHD are also significantly more likely to smoke than those without, and studies have highlighted nicotine as having a regulatory effect in terms of improving concentration and reducing hyperactivity amongst this group[1718].

Benefits of quitting specific to mental health conditions

As well as the well documented benefits to physical health of quitting smoking evidence has also demonstrated that there are significant benefits to mental health. In fact, recent research has shown that the benefits of quitting smoking can be equal to that of taking anti-depressant medication.[19]

Many smokers with stress and anxiety disorders smoke in the belief that smoking will help to relieve these symptoms, but a 2021 Cochrane review of the evidence for this found that quitting smoking did not lead to a worsening of mood long-term, and may lead to improvements in mental health, such as reductions in anxiety and depression symptoms.

Furthermore, patients who are reliant on antipsychotic medications often experience unpleasant side effects from these medications. As smoking increases the metabolism of drugs quitting means that the drug dose can often be reduced, thus reducing the unpleasant side-effects experienced by the patient[20].

Data provided from the Leicestershire Health Informatics Service (LHIS) team in May 2021 to provide a snapshot view of current smoking prevalence amongst patients accessing mental health services indicated that adult smoking rates

[14] The Royal College of Physicians and the Royal College of Psychiatrists, Smoking and mental health, 2013
[15] The Royal College of Physicians. Smoking and mental health London, RCP, March 2013
[16] https://www.england.nhs.uk/mental-health/adults/
[17] Fuemmeler BF, Kollins SH, McClernon FJ. Attention deficit hyperactivity disorder symptoms predict nicotine dependence and progression to regular smoking from adolescence to young adulthood. J Pediatr Psychol 2007; 32(10): 1203-13
[18] Wilens TE, et al. Cigarette smoking associated with attention deficit hyperactivity disorder. J Pediatr. 2008; 153(3): 414-19
[19] Taylor G et al. Change in mental health after smoking cessation: systematic review and meta-analysis. BMJ 2014; 348: g1151
[20] Taylor D, Paton C, Kapur S. Maudsley prescribing guidelines. 11th Ed. Informa Healthcare, 2012.

were above the national average across all of the listed groups (SMI, anxiety disorders, ADHD, personality disorders, trauma related disorders, eating disorders and mood disorders), and exceeded 30% prevalence across all groups, with the exception of eating disorders. A similar pattern was also noted in the under 18 groups, although numbers of patients were much lower. More detailed data can be found in appendix i.

Service access data from the Live Well stop smoking team indicated that for the January 2020-January 2021 period 15.7% of service users self-disclosed a mental health condition, which is significantly lower than the estimated 25% of the population who experience a mental health condition in any given year. Data collected from Live Well's patient management system does not specify the type or severity of mental health condition but there is an option to record detail in the 'free type' fields, and this has indicated that the vast majority of mental health conditions disclosed were anxiety and depression disorders (either with or without medical intervention) rather than illnesses classified as 'severe mental illness'. This is not necessarily reflective of the number in the local population who *want* to quit, only of those who have felt that the current service offer is useful to their needs.

There was no significant difference between the quit rates between those who disclosed a mental health condition and those who did not, but it should be noted that only those who are already motivated to quit, and have been supported to do so, are likely to have accessed the service.

5.2.3 National and local imperatives to reduce smoking within those with mental health conditions

In recent years there have been a number of key guidance documents, research and reports urging action in this area. These key documents are listed and their content briefly summarised in appendix ii, but highlight the vast difference in health outcomes between smokers with poor mental health compared to those with good mental health, and include recommendations to:

- Provide intensive support to people using acute and mental health settings (and ideally by those within those settings and for an extended period of time)
- Offer harm reduction options for scenarios when quitting isn't possible
- Ensuring that offering support to quit smoking is "everybody's business"
- Taking a holistic approach to physical and mental health
- Supporting switching to vaping

Providing meaningful training to enable health professionals to support smokers in the right way.

5.2.4 Proposed next steps

A. Staff working in mental health services are in an excellent position to be advocates for stop smoking support, particularly if they can share their own positive experiences, therefore staff should be encouraged and supported to quit or remain abstinent at work through widespread promotion and support of smoking cessation services for staff.

B. For Public Health to continue to work with the interim project manager for LPT, and to encourage LPT in their recruitment of a smoke free lead to retain oversight and provide capacity to support via all of our existing mechanisms, and also to enable the joined-up approach that will be critical to developing and maintaining links between primary and secondary care services so that patients are consistently supported whatever their setting of care provision.

C. For the tobacco control lead to work with the LPT project manager/smoke free lead on engagement work with: a) smokers with mental health issues to explore views on the type of support they would find beneficial, b) staff who work in community mental health services to explore how smoking cessation support could feasibly fit within their current roles, and c) other Trusts where smoke free work has already been embedded to explore models with proven success and consider what could be adopted in Leicester/Leicestershire.

D. Based on outcomes from engagement work, and in conjunction with the Live Well, Quit Ready and mental health services (staff and service users), develop a model of support, which adequately meets the unique needs of those with mental health issues. This may mean developing a range of different support options to meet the needs of differing mental health conditions. Learning from pilot schemes offering smoking cessation support to substance misusers and the homeless population in Leicester, who also often experience mental ill-health, could be taken to identify if/how those models could be applied to this group.

E. To consider options for including harm reduction in the Live Well service specification. Currently the stop smoking service is commissioned to deliver '4 week quits' but this may not be realistic (initially) for many smokers who are suffering with additional mental health issues[21]. A more flexible approach could be considered, with key performance indicators (KPI's) linked to periods of abstinence or reduced carbon monoxide (CO) readings initially.

F. To work with Quit Ready and LPT to identify how a programme of training can be rolled out to community mental health teams, in line with that

[21] https://www.nice.org.uk/guidance/ph45

which is planned for inpatient teams, to provide staff with a baseline level of knowledge which builds a foundation of understanding, and to increase their skills in engaging smokers and motivating quit attempts, with the overall aim of ensuring effective and consistent approaches to addressing smoking. This should include primary prevention information which can be shared with young people and their carers who are in contact with mental health services to minimise uptake of smoking amongst this group.

6. Financial, legal, equalities, climate emergency and other implications

6.1 Financial implications

The report is highlighting how various initiatives have been implemented in the past to look at smoking cessation and its success rate, except amongst smokers with Mental Health conditions. Therefore, new initiatives are proposed which will all be funded from the current EMCA (East Midlands Cancer Alliance) earmarked reserves parked within Public Health.
The EMCA funding has got around £94k earmarked for Tobacco Control and these initiatives will all be funded from that financial envelope, together with the CURE rollout programme.

Yogesh Patel -Accountant (ext 4011)

6.2 Legal implications

There is suggestion within the report to explore feasibility for the Public Health team to support Leicestershire Partnership Trust (LPT) ***in their recruitment*** of a smoke free lead to retain oversight and provide capacity to support via all of our existing mechanisms. I note that LPT are recruiting a 'smoke free lead' post using their own money, the support element would come from us in terms of subject expertise, i.e. supporting with job description writing, offering peer support etc. Further HR/employment legal advice should be sought depending on our level of support and involvement.

In terms of the delivery of training, we need to consider if as a Local authority we are in are able to deliver this as it may be classed as a 'commercial activity'. If a LA wishes to undertake a commercial activity, then they must be able to identify a specific power to do so under The Localism Act 2011. The act provides a power for local authorities to charge for the provision of services, however this comes with its limitations and restrictions. If relevant further advice should be sought.

In terms of the CURE project and model, I note that at this stage there are still some discussions to be had and agreements to be made about the service model. There is no intention that the current service model would change for the majority, rather that the engagement work might result in additional options

being made available to support the specific needs of those with mental health conditions.
However, should there be any amendments to the model, this will need to go out to public consultation.

Ongoing legal advice should be sought as and when necessary.

Meera Patel, Solicitor (Commercial) Ext. 37 4069

There are currently no employment law implications arising from this report.

The report has indicated that the LPT will recruit a “smoke free lead”. The recruitment process will be undertaken by the LPT and any new recruit will also be employed by them. As a result of this, Leicester City Council shall not be the employer and therefore there are no employment implications arising from this.

The Council currently provides smoking cessation support via its Live Well Service. No changes are envisaged which would change the terms and conditions of existing staff within the Live Well Service. Accordingly, there are no employment implications arising from this. If, however, there are any changes in the future of the service which may impact existing staff then further HR and legal advice should be sought at the time.

Suraiya Ziaullah, Employment & Education Solicitor 0116 454 1487

6.3 Equalities implications

Under the Equality Act 2010, public authorities have a Public Sector Equality Duty (PSED) which means that, in carrying out their functions, they have a statutory duty to pay due regard to the need to eliminate unlawful discrimination, harassment and victimisation, to advance equality of opportunity between people who share a protected characteristic and those who don’t and to foster good relations between people who share a protected characteristic and those who don’t. This includes where services are contracted out – the PSED cannot be delegated.

Protected Characteristics under the Equality Act 2010 are age, disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion or belief, sex, sexual orientation.

The report looks at endorsing the proposed approach to supporting smokers with mental health conditions and the proposed next steps, if the proposal is agreed it should lead to positive outcomes for people from across a range of protected

characteristics. An Equality Impact Assessment has been drafted and is with the Corporate Equalities Team awaiting feedback/comments.

The equality impact assessment is an iterative process that should be revisited throughout the decision-making process and updated to reflect any feedback/changes due to consultation/engagement as appropriate.

Sukhi Biring, Equalities Officer, 454 4175

6.4 Climate Emergency implications

There are no significant climate emergency implications directly associated with this report.

Aidan Davis, Sustainability Officer, Ext 37 2284

Appendix i.

Table 1. Data provided by LHIS on the number of patients accessing mental health services in May 2021 who smoked compared to the number who did not smoke. N.B. numbers for under 18's are not representative of total population.

Mental health category	**Smoking prevalence (adults)**	**Smoking prevalence (young people under 18)**
SMI	**40%** Actual numbers: 1924 smokers 2890 non-smokers	**21%** Actual numbers: 5 smokers 19 non-smokers
ADHD	**34%** Actual numbers: 545 smokers 1048 non-smokers	**6%** Actual numbers: 27 smokers 388 non-smokers
Anxiety disorders	**36%** Actual numbers: 12282 smokers 26029 non-smokers	**9%** Actual numbers: 41 smokers 420 non-smokers
Personality disorders	**33%** Actual numbers: 698 smokers 1387 non-smokers	**10%** Actual numbers: 3 smokers 25 non-smokers
Trauma-related disorders	**35%** Actual numbers: 1435 smokers 2684 non-smokers	**17%** Actual numbers: 4 smokers 20 non-smokers
Eating disorders	**22%** Actual numbers: 52 smokers 186 non-smokers	**5%** Actual numbers: 3 smokers 60 non-smokers
Mood disorders	**34%** Actual numbers: 20881 smokers 40290 non-smokers	**17%** Actual numbers: 50 smokers 247 non-smokers

Appendix ii:
List of documents highlighting the need to address smoking in people with mental health conditions and a brief summary of content:

NICE guidance PH48[22] which includes a recommendation to "provide intensive support for people using acute and mental health settings" and outlines how this should be achieved, and **PH45**[23] which addresses the need to offer harm reduction from smoking in scenarios when quitting may not be possible, for example within secure mental health units.
The Stolen Years (2016)[24] which highlighted smoking as the single largest cause of the 10-20 year gap in life expectancy faced by those with mental health conditions, and set out 12 ambitions for reducing smoking prevalence amongst this group.
The Five Year Forward Plan for Mental Health (2016)[25] which set out an overview of what modern mental health services should be, highlighting that delivery of it's recommendations should be 'everybody's business'. Specific recommendations included preventing poor physical outcomes including providing access to smoking cessation services, and supporting mental health inpatient units and facilities to be smoke free by 2018.
Improving the physical health of people with mental health problems: Actions for mental health nurses (2016)[26] which reiterated that people with mental health problems have poorer physical health than the general population and are often unable to access the physical healthcare they needed, leading to health inequalities. The report recommends taking a holistic approach to physical and mental health, noting the inextricable links and the detrimental impact of regarding physical and mental health as separate entities. The report compels mental health nurses to take action to support mental health patients to quit smoking, highlighting that quitting does not have a negative impact on mental health, and outlining a series of activities to achieve this action.
The SCIMITAR trial (2019)[27] which was a randomised control trial assigning patients with SMI to either 'usual care' or a bespoke smoking cessation intervention which consisted of "behavioural support from a mental health smoking cessation practitioner and pharmacological aids for quitting, with adaptations for people with SMI such as extended pre-quit sessions, cut down to quit and home visits". The results from this trial showed that the bespoke intervention lead to greater incidences of quitting at 6 months, but that this effect waned by 12 months suggesting more effort is needed for sustained quitting.

[22] https://www.nice.org.uk/guidance/ph48
[23] https://www.nice.org.uk/guidance/ph45
[24] The Stolen Year: The mental health and smoking action report (2016) – Action on Smoking and Health
[25] The Five Year Forward Plan for Mental Health (2016) - A report from the independent Mental Health Taskforce to the NHS in England.
[26] Improving the physical health of people with mental health problems: Actions for mental health nurses (2016) – NHS England
[27] https://www.thelancet.com/journals/lanpsy/article/PIIS2215-0366(19)30047-1/fulltext

The NHS long term plan (2019)[28] which recognises the disparity in smoking rates between those with a mental health condition compared to those without, and outlines its intention to develop "a new universal smoking cessation offer" which will be "available as part of specialist mental health services for long-term users of specialist mental health, and in learning disability services," to include the option of switching to e-cigarettes whilst in inpatient settings.

Parity of Esteem – Delivering Physical Health Equality for those with Serious Mental Health Needs (2019[29]) which reiterates the importance of equating the importance pf physical health with mental health and places importance on mental health nurses being supported to develop the appropriate skills and knowledge to be able to provide this holistic care.

Smokefree Skills: Training needs of mental health nurses and psychiatrists (2020)[30] which addresses the wide gaps in training provision across mental health trusts, and the impact of this on supporting smokers to quit. The report outlines a series of recommendations for embedding training into mental health trusts to build a foundation of knowledge, improve confidence and ensure consistency across all services.

[28] The NHS long term plan. 2019. https://www.longtermplan.nhs.uk/

[29] Parity of Esteem – Delivering Physical Health Equality for those with Serious Mental Health Needs (2019) – Royal College of Nursing

[30] Smokefree Skills: Training needs of mental health nurses and psychiatrists (2020) – Action on Smoking and Health

Health and Wellbeing Scrutiny Commission

Work Programme 2021-22

Meeting Date	Topic	Actions arising	Progress
13rd July 2021	1. COVID19 Update & Vaccination Progress Update 2. Consultation Response to UHL Reconfiguration 3. Strategy on how to deal with the effects of Long COVID	1. Standing item as required for this cycle. 2. Latest update from CCGs is that a response will be ready by July. Likely that this will be discussed in detail at Joint Health (Committee administration has passed to City) 3. Item requested following information on hospital readmissions – Long COVID paper expected from UHL and an ASC perspective of Long COVID in City care homes.	3. Update to be received in 6 months.
1st September 2021	1. Community Pharmacy Service 2. Update from Chair of ICS Board 3. COVID19 Update & Vaccination Progress Update 4. Update on Sexual Health Services / Contraception	1. Verbal update from CCGs on the launch of this service. 3. CCGs to investigate the GP lists numbers/shortfall and focus on trends in the city centre area. 4. Update report expected on an annual basis, which will also include a service update on the Pre-exposure to HIV (PrEP) service	1. Update requested for Jan 2022 once quarterly data has been collected.
2nd November 2021	1. School Nursing Provision 2. Access to GP services and Community Pharmacy Services Update 3. ICS Update – Locality Based Plans 4. COVID19 Update & Vaccination Progress Update	Item 1 is a proposed joint item with CYPE Item 2 was deferred from the Sept meeting following engagement conducted by CCGs in May. Item 3 will consider the locality-based provision for the city.	

Appendix D

Meeting Date	Topic	Actions arising	Progress
14th December 2021	1. UHL Financial Adjustment Update 2. COVID19 Update & Vaccination Progress Update 3. Updates on Obesity (including Childhood Obesity) and Dietary Advice Options and Co-ordination with Food Plan 4. Alcohol Strategy Matters Arising: GP lists/CCG exercise; this is being actioned separately.	UHL accounts considered at this meeting via an initial verbal update; there is a delay until March 2022 for accounts to be released. Item 3 will bring a greater focus on the link between food and health. An update was requested in six months' time.	
25th January 2022	1. Long COVID Update 2. ICS Update 3. Community Pharmacy Service 4. COVID19 Update & Vaccination Progress Update 5. 3-year-old oral health survey 6. Draft General Fund Revenue Budget & Draft Capital Programme 2022-23	Item 1 will be considered in more detail at the joint special mental health meeting. A fuller update on Item 3 was touted for this meeting due to having further information with quarterly data included, following September's initial update on the service. Item 5 will include information on the ICS constitution and a potential delay to the legislation.	
Mental Health Services Meeting The Step Up to Great Mental Health Consultation and the findings of the LPT CQC inspection was held as a special meeting under Joint Health Scrutiny, for 15 February 2022.			

Meeting Date	Topic	Actions arising	Progress
22nd March 2022	1. Regulatory Services Report on Dyeworks Petition 2. COVID19 Update & Vaccination Progress Update 3. Health Inequalities Update – Action Plan (including the inequality impact of COVID19 on the local population) 4. Tobacco Control (Public Health) 5. Review Report – BLM and NHS Workforce: progress update	Note: UHL accounts will be considered at the LLR Joint Health Scrutiny Committee in summer 2022	

Forward Plan Items

Topic	Detail	Proposed Date
Health & Care section of Forward Plan - **No decisions** due to be taken under this heading for the current period (on or after 1 Dec 2021)		
COVID19 Update and Vaccinations Update	Standing item on the agenda. Regular information requested in between meetings to show trends.	All meetings for this year
0-19 Commissioning Update	Planned for January 2021 but current contract extended by a year due to COVID	Summer 2022

Topic	Detail	Proposed Date
Update on Sexual Health Services / Contraception and PrEP (Pre-exposure to HIV) service	Initial sexual health services presentation given in Sept 2021. Commission requested an annual report on both items going forward.	Completed in Sept 2021; tbc Sept 2022
Review Report – BLM and NHS Workforce: progress update	First Task Group meeting in March 2021. Progress update to the Commission will follow	March 2022
Manifesto Commitment Updates	Raised in March 2021 at OSC and **may** be discussed at all Commission meetings in the future.	Late 2022
Findings and Analysis of the CCG Step Up to Great Mental Health Consultation	Both items will be considered at a joint health meeting on 15 Feb 2022.	15 Feb 2022
LPT Improvement Plan Update		
Updates on Obesity (including Childhood Obesity) and Dietary Advice Options and Co-ordination with Food Plan	Completed in April 2021, an update requested in the next cycle of meetings.	Completed in Dec 2021
Consultation Response to UHL Reconfiguration; now **Updates on Reconfiguration Proposals**	Consultation response covered at both HWB and JHOSC in July 2021. Updates expected on; birthing unit, budget changes for the reconfiguration, backlog of repairs, primary urgent care locations.	Covered in July 2021, with progress updates expected at future meetings
Health Inequalities Update – Action Plan (including the inequality impact of COVID19 on the local population)	Mentioned in the January 2021 minutes, following the LLR health inequalities item. Followed up with a LLR Framework and Action Plan Update in April 2021, with a request for a further update in 2022 regarding; implementation, statement of intent and action plan.	March 2022
UHL Financial Adjustment - Update	Further information on the Development Programme from Deloitte and involvement in board selection processes – audit reports delayed from 2021 to Summer 2022.	Summer 2022; link with JHOSC
Review of contracts for vending machines and other food services at the Council's Leisure Centres	Requested as an item in the January 2021 meeting and discussed as part of April 2021's Obesity Item with agreement that the initiative to remove unhealthy snacks from leisure centres and other council premises vending machines be supported.	December 2021 – co-ordinating with Obesity items. Complete; current contracts terminated.

Topic	Detail	Proposed Date
COVID Hospital Readmissions – now Long COVID	Was initially a standing item on hospital readmission data, which has now been directed into a wider focus on Long COVID (UHL to lead on this)	Completed in July 2021, Jan 2022; update report in 6 months (July 2022)
Integrated Care Services (ICS)	Item based on the recent changes in March 2021	Updates at most Commission Meetings
Draft Revenue Budget	Standard report to go to all Commissions	January 2022
Air Quality Pollution	Joint item with EDTCE	TBC 2022
School Nursing Provision	Joint item with CYPE Scrutiny	Completed November 2021
Community Pharmacy Service	Initial update given in September 2021 with an update on evaluation data requested in three months' time.	November 2021 January 2022
Health and Wellbeing Strategy	Progress update since it was launched in 2019	TBC
Results of the survey on the health, care, and wellbeing plan; relating to ICS Place Led Plans	Leicester health, care, and wellbeing delivery plan - to improve future health outcomes of the people of Leicester.	Summer 2022
Tobacco Control	Report from the Public Health team	March 2022
Local Plan	Upcoming item for all Commissions to consider	May or June 2022 tbc