Leicester
City Council

Minutes of the Meeting of the
HEALTH AND WELLBEING BOARD

Held: THURSDAY, 7 MARCH 2024 at 9:30 am

Present:

Councillor Sarah Russell (Chair)	Deputy City Mayor - Social Care, Health, and Community Safety, Leicester City Council (LCC)
Councillor Adam Clarke	Deputy City Mayor – Climate, Economy & Culture, LCC
Rob Howard	Director of Public Health (DPH), Leicester City Council
Dr Kath Packham	Consultant in Public Health (PH), Leicester City Council
Helen Mather	City Place Lead - Leicester, Leicestershire, and Rutland Integrated Care Board (LLR ICB)
Dr Avi Prasad	Place Board Clinical Lead, LLR ICB
Harsha Kotecha	- Chair of Healthwatch Leicester and Leicestershire
Kevin Routledge	- Strategic Sports Alliance Group
Rachna Vyas	- Chief Operating Officer, LLR ICB
Simon Pizzey	Director of Strategy & Partnerships, University of Leicester Hospitals Trust (UHL)
Alison Gilmour	Director of Strategy and Partnerships, Leicestershire Partnership NHS Trust (LPT)

In Attendance

Sally Le-Good	Senior Cancer Service Manager, LLR ICB Senior Integration & Transformation Manager, LLR ICB
Jeremy Bennett	Programme Manager - HWB (Public Health, LCC)
Diana Humphries	Deputy Director of Public Health, LCC
Jo Atkinson	Project Manager, Public Health, LCC
Nazira Vania	Programme Manager – Long Term Conditions (PH – LCC)
Amy Endacott	Live Well Operations Manager, Public Health, LCC
Carla Broadbent	Healthy Lifestyle Service Manager, Public Health,
Harpreet Sohal	LCC
Jacob Mann	Senior Governance Support Officer, LCC
Georgia Humby	Senior Governance Support Officer, LCC
Julian Yeung	Governance Support Assistant, LCC

Helen Reeve	Senior Intelligence Manager, Public Health, LCC
Nathan Smith	Tobacco Control Project Manager, Public Health, LCC
Ashlee Brown	Public Health Intelligence Analyst, LCC
Denise Stone	Business Manager, Public Health, LCC
Nazira Vania	Project Manager, Public Health, LCC
Claire Mellon	Programme Manager, Public Health, LCC
Joel Carter	Programme Officer, Public Health, LCC
Matthew Tarleton	Programme Officer, Public Health, LCC
Alison Williams	Public Health Admin, Leicester City Council (minute taker)

48. APOLOGIES FOR ABSENCE

Apologies for Absence were received from:

- Councillor Vi Dempster - Deputy City Mayor (Education, Libraries & Community Centres), LCC
- Councillor Elly Cutkelvin - Deputy City Mayor (Housing & Neighbourhoods), LCC
- Rani Mahal - Deputy Police and Crime Commissioner for Leicester, Leicestershire, and Rutland
- Prof Andrew Fry – College Director of Research, Leicester University
- Sarah Prema – Chief Strategy Officer, LLR ICB
- Jean Knight – Deputy Chief Executive, LPT
- John Macdonald – Chair of UHL NHS Trust

49. 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.

50. MINUTES OF THE PREVIOUS MEETING

RESOLVED:

- That the Minutes of the previous meeting of the Board, held on 18 January 2024, be confirmed as a correct record.
- That Members refrain from using acronyms and jargon – as it excludes members of the public.
- That the Chair passed thanks on to everyone involved in the recent Mental Health and Social Isolation Conference – which gave small voluntary sector organisations a chance to make connections and learn from peers.
- That the Chair passed her thanks on to Healthwatch for the swift removal of the names of the Hotels accommodating Asylum Seekers.

51. QUESTIONS FROM MEMBERS OF THE PUBLIC

No questions from members of the public had been received.

52. CARDIOVASCULAR DISEASE JOINT STRATEGIC NEEDS ASSESSMENT

Helen Reeve (Senior Intelligence Manager, Public Health, LCC) presented the Cardiovascular Disease Joint Strategic Needs Assessment (JSNA). The full document can be viewed on the LCC Website. The Presenting Officer went through each of the Reports headings in turn as below:-

- Risk factors associated with Cardiovascular Diseases (CVD):
- The unmodifiable and modifiable risks are listed in the report.
- Lifestyle factors such as inactivity and poor diet impact, and these are higher in the City than the UK average.
- Impact of cardiovascular diseases on Leicester's population:
- Leicester City has a relatively young population compared to County - and this may be impacting the low "crude prevalence" rates for cardiovascular diseases because prevalence is not age-standardised.
- Most cardiovascular diseases show no significantly differing rates for different ethnicities – apart from Coronary Heart Disease (which is higher in the Asian/Asian British communities).
- Hospital admission rates are significantly higher in residents from the most deprived deciles.
- Current services:
- Early detection and support for managing lifestyle factors will impact – and locally we have services that do this, including:-
  - NHS Health Checks; Leicester performs better than the national average for completed NHS Health Checks.
  - Live Well (the Councils Lifestyle Services Hub).
  - Integrated CVD Service.
- Unmet needs and service gaps:
- There are some gaps in diagnosis based on what we expect rates to be.
- There are some inequalities (as noted above) where rates are higher in the most deprived or certain ethnic groups. We have ambitions to address these through:-
  - Proportionate universalism
  - The "Core 20 Plus 5" (NHS)
  - The National CVD Prevalence Programme
  - Closing the inequality gap
- Recommendations
- In addition to the recommendations listed in the report, the presenting officer asked Members to note the unmet needs and service gaps in the report, and provide comment on areas identified for improvement.

Comments and questions from the Board:-

- The Chair thanked the presenting officer for the information - and asked whether the data could be extracted for over 50s only. The presenting officer noted that this is not currently available within the Quality and Outcomes Framework (QOF).
- Members felt that CVD prevalence by five-year age banding would be

useful at Middle Layer Super Output Area (MSOA) level – but the presenting officer noted this is not currently available.

- The Chair noted that the map of Coronary Heart Disease prevalence in the City looks similar to maps for other aspects such as smoking prevalence – but the one for Stroke looks very different. Adding age to MSOA data would help us better understand this locally.
- Cllr Clarke noted that the impact of air pollution is lacking from the report – and particularly information about the burden on the NHS caused by poor air quality. The Director of Public Health (DPH) responded that air quality can be modelled at 5% of cause mortality – but it is difficult to be precise at neighbourhood level. We are unable to, for example, state how much poor air quality contributes to a cardiovascular death. The DPH did, however, agree that air quality is an important part of the Council's strategies.
- The DPH noted that we can state whether a patient has a high BMI or smokes – but cannot say for certain that they are being impacted by poor air quality (ie the data is modelled rather than accessible). Cllr Clarke however felt that we can state whether a patient lives in an area within an air quality management system – and there are monitoring stations across the City that can be utilised to join up the data.
- Cllr Clarke asked that air quality be recognised as a wider determinant in future reports, and The Chair asked that future reports note air quality as a "contributory factor" and incorporate available data.
- Dr Packham asked members to revisit the commitment to invest in prevention (and particularly to revisit the ICB's Five Year Plan's chapter on prevention), even in the current financial climate. Without this investment/commitment she felt that patterns of cardiovascular disease will not be broken. The Chair felt that the data in the current JSNA suggests that investment is needed in the County more so than the City - so it would be difficult to argue for additional CVD prevention money for the City as it stands. She felt that the City has a younger population – but we know that our older population has high rates of ill health, so asked that this be reflected if possible.
- The COO of the ICB noted that, between Public Health and the ICB, we have the data to enable a comparison of age-standardised hospital admissions, mortality and overall costs to the NHS. She suggested that members re-read the Marmot Report which lists how we can work out return on investment for prevention. She also noted that the obesogenic environment is something we can impact on if all agencies work together.
- The City Place Lead noted that obesity and diabetes in children will result in cardiovascular disease as adults. The Chair felt that there is also an issue of a reduction in physical activity when children transition from primary to secondary school; she felt this would be a topic that can be explored at a future Health & Wellbeing Board meeting.
- Dr Packham noted that the Head of the ONS recently lectured on covid data once it has been rationalised in terms of age and ethnicity.
- Members noted that the data in the JSNA states that 50% of city residents do not consume alcohol – but this is via self-reporting. If 50% of the city genuinely do not drink at all, then it is likely this is obscuring

some high consuming communities.

- The DPH noted that mortality data is the key indicator that shows the City has higher levels of preventable avoidable deaths. He felt that the JSNA should not be amended – but was happy for the slides to be reviewed to reflect this better and take into acount the above comments.

RESOLVED:

- That the Board thanked Officers for the presentation and asked them to take Members comments into account.
- That Members will consider ways to obtain age-standardised data at MSOA level – to give a more useful picture.
- That future reports will include reference to Air Quality as a "contributory factor and/or wider determinant of health" – and include any data available.
- That the slides can be reviewed, in light of the above comments, to see whether the data can be presented differently.
- That the HWB Programme Manager will add "drop-off in physical activity at the transition from primary to secondary school" to a future Board. agenda.

53. TOBACCO SMOKING JOINT STRATEGIC NEEDS ASSESSMENT

Helen Reeve (Senior Intelligence Manager, Public Health, LCC) presented this JSNA on the risk factors associated with smoking, impact of tobacco smoking in Leicester, current services, service gaps and recommendations.

The following points were noted:

- The latest Health and Wellbeing Survey (carried out in 2018) shows:-
  - Around 17% of men and 9% of women smoke in the City.
  - The highest tobacco smoking prevalence is in men aged 25-44 who are routine/manual workers or long-term unemployed.
  - White and Mixed ethnic groups have higher prevalence.
  - The smoking cohort also has a high prevalence of long-term mental health conditions.
  - The west and south of the city have higher prevalence.
- The rate of smoking-attributable hospital admissions in Leicester is significantly higher than the national rate (over 2,800 admissions per year). Life lost can be equated to around 2500 years.
- There has been a decline in smoking rates locally and nationally.
- Smoking at Time of Delivery (SATOD) has reduced significantly in Leicester in recent years (from 14% to just under 10%) – and is now in line with national levels.
- In Leicester we are meeting government guidelines for access to cessation support. Services offered are listed in the report and include the Live Well offer, support in hospital settings (Maternity and Acute) and tackling illicit tobacco (via Business Regulation at LCC and HMRC).
- Tobacco Harm reduction is part of the NHS Long Term Plan.
- Entrenched smokers are hard to target – and innovative methods of engagement are required to reach these groups and reduce inequalities. In addition, monitoring of niche tobacco products (including e-cigarettes,

smokeless tobacco and waterpipe smoking) is an acknowledged service gap.

- The presenting officer asked that the Board note the unmet needs and service gaps - and provide comment on areas identified for improvement.

Comments and questions from the Board:-

- The Chair noted that “White Other” has significantly high rates of smoking; if this relates to Eastern European migrants the lessons learnt from Covid indicate this group access health messages less than other communities – and have less religious/community leaders or Champions (and no Radio stations) in the City.
- The DPH noted that there is Government intention to introduce legislation to make smoking illegal for people born after 2009. If this legislation is brought in it will hopefully bring about a tobacco-free generation. In addition, the current Government have announced funding to double cessation services for the next five years (but this may be dependent on future political party changes).
- Dr Packham noted that trusted health professionals (particularly GPs) telling patients to stop smoking is a powerful intervention – and urged this to continue.
- The DPH felt that when national policy, local partnerships and funding comes together there can be a huge impact; this is evident in the significant improvement to SATOD rates in Leicester, and he paid tribute to the staff involved in this.
- The COO of the ICB noted that chewing tobacco impacts on head/neck cancers – so felt that should be embedded into business cases. The DPH agreed – and noted that there is an Action Plan following an Oral Cancer Needs Assessment (which is being presented to LCC Scrutiny in the near future). The Plan will also be presented - as part of a prestation on “Fluoridation and Oral Health” - at a future Health & Wellbeing Board.

RESOLVED:

- That the Board thanked the Officer for the presentation and asked them to take Members comments into account.
- That Members will consider the best methods to get health messages to Eastern European communities.

54. LEICESTER CITY TOBACCO CONTROL STRATEGY 2024-26

Nathan Smith (Tobacco Control Project Manager, Public Health, LCC) presented on this recently launched strategy – which seeks to build on the local progress resulting from the previous 2020-2022 strategy by continuing to identify the need for ongoing tobacco control within Leicester City.
It was noted that:

- The vision is to achieve “A smoke free Leicester – to make Leicester smoke free by 2030”.
- The good news is that there has been a reduction in smoking prevalence – but it is still a major cause of ill health. There is a 10 year gap in life expectancy for smokers versus non-smokers.

- Locally we have the “CURE” programme (for pregnant women, acute inpatients and mental health inpatients). There is also the cessation support provided by Live Well.
- There is no national strategy – but there is an increased national focus on reducing smoking (including fines, restrictions and legislation). As part of this national commitment, Leicester City will be receiving an additional £456,669 funding for smoking cessation; this money cannot be spent on youth vaping or enforcement, however. Plans are being drawn up as to the best way to spend this over the next five years.
- There are higher smoking rates among Looked After Children compared to their peers of the same age.
- In addition to the harms noted in item 6 above – there is a 65% link to oral cancer (and Leicester has higher prevalence of this cancer than the national average).
- The priorities for the Strategy were listed as:-

i. Partnership working to address tobacco control
ii. Achieving a smoke free generation
iii. A smoke free pregnancy for all
iv. Reducing the inequality gap for those with mental ill-health
v. Deliver consistent messaging on the harms of tobacco across the system
vi. Continue to improve the quality of our services and understand impact through data collection

- Methods to achieve the priorities include:-

i. Myth-busting
ii. Reducing illicit sales
iii. Targeting services
iv. Working with Social Housing, Looked After Children and Turning Point
v. “Step Right Out” campaign (smokefree care/home pledge) - relaunching soon
vi. Working in partnership with the Oral Health team

- Since the last Strategy ended in 2022, there have been the following changes and new services:-

i. The service offer for acute inpatients, mental health inpatients and pregnant women (see above)
ii. An offer for UHL staff
iii. A pilot with Social Housing – which is now rolling out
iv. An increase in young people vaping
v. The local team have joined the East Midlands Tobacco Group
vi. The existing Live Well service offer has retained some of the remote support offered during Covid – to give flexibility of choice
vii. A workforce development framework

- The Board was requested to:-

o Endorse the Leicester City Tobacco Control Strategy 2024-26
o Work with the Public Health Tobacco Control Team to promote smokefree sites
o Promote opportunities to train up staff
o Provide an ongoing commitment to support quit attempts in all organisations.

Comments and questions from the Board:-

- The Chair noted that the national legislative framework has impacted on lowering smoking over the last 20 years.
- The Chair asked whether “smokefree” just refers to nicotine – and has the problem moved to cannabis and/or vaping? The presenting officer responded that the local on-the-ground team are upskilled in chewing tobacco, waterpipe and shisha – and they are also linked in to research that will improve the data gap.
- The DPH noted that the upcoming Health & Wellbeing Adult Survey will ask about vaping. He felt, however, that we need to retain a focus on tobacco – and not get distracted by vaping (as the latter is less harmful than cigarettes). The Chair felt that the Healthy Conversation Skills training can help staff negotiate the complexities around what constitutes “harmful”.
- With regards to vaping - some Members expressed concern that there is a new generation using a product with very little scientific data on the long-term effects (or knowledge of what chemicals are contained in vapes). The DPH noted that we know what are in regulated vapes - but agreed that the science on long term use will take time.
- Members asked whether we can impact the national conversation – and steer focus towards vaping and cannabis use. The DPH responded that Professor Chris Whitty has urged a focus on tobacco as it has the biggest adverse impact on health.
- The DPH noted that he has written to all local leaders to ask them to support the call for a national policy towards smokefree generation legislation.
- Members asked whether the Council can consider a local planning or environmental policy (eg to not give licences to vaping shops). It was noted that Public Health had recently been asked to input into a Vaping Shop applying for a Shop Improvement Grant Scheme award; there had been no consensus on the ethics – and the DPH felt there may need to be a corporate policy developed.
- The Chair noted that national policies around not advertising vapes at the till point would be useful – but we could also consider speaking with the Retail Consortium locally in the meantime.

RESOLVED:

1. That the Board thanked Officers for the report and asked that comments from the meeting are taken into account.
2. That the presenting officer will speak with Regulatory Services about whether the Council can consider developing a local planning or environmental policy.
3. That the Board will collectively support staff to train and upskill - in order to give consistent messages around tobacco control.

55. LIVE WELL

6. LIVE WELL LEICESTER - OVERVIEW
   Harpreet Sohal (Healthy Lifestyle Service Manager, Public Health, LCC)

and Carla Broadbent (Live Well Operations Manager, Public Health, LCC) presented an overview of the service.

It was noted that:

- The in-house service is a team of 23 advisors who can help clients get the right support to help lead a healthier lifestyle. This includes eating healthier, stopping smoking, doing more exercise and drinking less alcohol.
- The service is for Leicester residents only (and over the age of 12).
- Adaptations were made so that no part of the service had to cease during the Covid pandemic – and Ms Sohal extended thanks to the team for their flexibility. The service was fully face-to-face prior to March 2020 – but is now a blend of online and in-person sessions to give client choice.
- The physical activity offer is a free 12 week programme delivered from Leisure Centres (this also includes nutrition advice).
- There is also a free falls prevention programme (24 weeks – targeted at those over 65 or clients concerned about falling).
- There is also a walks programme. Clients are encouraged to volunteer (and are trained up to be walk leaders themselves).
- The alcohol support aspect is by referral to Turning Point.
- Live Well signposts to other service that can assist with debt, housing and social isolation.
- The Key Performance Indicators (KPIs) were monitored in 2022/23 – and it was found that 80% of referrals were from those living in the two highest deprivation quintiles.
- Another KPI was for 40% of the clients to be male – and this was over-achieved at 43% in 2022/3.
- 46% of new client registrations were from BAME communities – but the presenting officers noted the Boards earlier comments (in Item 6) about Eastern European communities in the City. Ms Sohal promised that the team will do more targeting with this community in future.
- Plans have been drawn up as to how to spend the extra government funding for smoking cession; the paper will be going to Cllr Russell's Lead Member Briefing on 18.3.24.
- A new case management system will be launching on 11.3.24 – and presenting officers can return to discuss this with the Board in future.
- An evaluation of the service has been conducted; the report can be shared with the Board at a future meeting.
- Members were requested to buy-in to the service, encourage referrals and assist in embedding into the voluntary sector. Contact details for further questions are in the slides.

Comments and questions from the Board:-

- The Chair asked that the data around deprivation quintiles be drilled down further (as 72% of City residents are in quintiles 1 and 2). She would like to see details on who refers into the programme, who accesses the offer and who completes full packages (ie retention rates).
- The Member representing the Sports Alliance asked whether 7591 people accessing the service in one year is a good total. He also wondered whether a branded service is the best fit – and whether it

would benefit from being connected to the GP service. Cllr Russell noted that many people do not access their GP until they are very poorly – so the self-referral aspect of Live Well is important.

- The Chair felt that the Board would find a key measure of success to be the numbers of clients retaining healthy changes 12 months after contact with Live Well. Jo Atkinson responded that longer term outcomes are measured by taking a baseline measurement and then re-measuring at 4 weeks, 12 weeks and 12 months. This data will be collected by the new case management system and incorporated into the upcoming Evaluation Report.
- Jo Atkinson noted that Public Health offer some population level interventions (eg Beat The Street), but this needs to be balanced against targeted interventions (eg for the inactive or smokers) and school based prevention. Delivery at a larger scale would require more infrastructure and financial resource. With the current resources, the team are at their limits for the physical activity 12 week programme, but there is no waiting list currently for smoking cessation.
- Dr Prasad felt that the Board should have faith in the fact that outcomes from the service will be seen 10 or 20 years down the line – and approved of the fact that there are self-referral and digital access aspects to the service. He felt that clients may resist when told not to do something – but self-referral can offset this. He asked whether there was sufficient money in the budget to advertise more widely (eg on busses). Jo Atkinson responded that the self-referral aspect has not been widely promoted due to the capacity of the team (although the additional government funding for smoking cessation means that arm of the offer will now be promoted widely).
- Dr Prasad asked whether future reporting can incorporate modelling data on how much money is saved in the future by preventative services. The Chair noted that the usual figure quoted for prevention is "£3 saved for every £1 spent".
- The Chair noted that lifestyle offers present a challenge around whether they are targeted correctly, whether we are doing enough and whether we are collectively helping to reach clients and support them to access what is on offer.

RESOLVED:

1. That the Board thanked Officers for the report - and asked that comments from the Board be taken into account.
2. That Live Well will undertake more targeting with the Eastern European Communities in Leicester in future.
3. That Live Well will drill down into the data, providing the details that the Chair requested (see above) in future reporting to the Board.
4. That Members will feedback to partners about the service.

56. MANAGING LONG TERM CONDITIONS

Jeremy Bennett (Senior Integration & Transformation Manager, LLR ICB)

presented a paper as a response to the request to update the H&WB about detection and management of Heart Disease in Leicester City. The paper provides a brief overview of the profile of Cardiovascular Disease (CVD) across LLR and summarises some of the initiatives being delivered by the ICB's Long Term Conditions (LTC) team, with the focus on CVD in Leicester City.
It was noted that:

- A Communications Plan is key to the work – to raise awareness and allow patients to be signposted (eg diabetics to retinopathy).
- Case finding and early detection are key (eg hypertension and atrial fibrillation). The ICB's LTC Team are supporting Primary Care Networks (PCNs) to identify cases. There is also a mobile van that now has space for blood pressure and pulse monitoring.
- Secondary Prevention is key to LTC management – and there is redirection into other broader offers (eg Diabetes Services and Live Well).
- As part of the hypertension work – 500 patients were identified and invited for an appointment.
- Another example of the team's work is that there were focus groups carried out with clients who failed to attend for Pulmonary Rehabilitation; the results of those focus groups showed a lack of understanding of their medical conditions.

Comments and questions from the Board:-

- Members asked why the stroke map (from Item 5) does not follow expected patterns – and whether the fact that PCNs are not geographically aligned impacts on focussing on the groups most in need. The presenting officer noted that the PCNs have access to all information systems – and the ICB's LTC Team support the practices to identify the correct patients. The COO of the ICB noted that, for the purposes of LTC management, practice level data is more useful than PCN level data.
- The Chair asked whether there is consistency of referrals to Live Well - and would appreciate any mapping of those referrals by GP Practice and long term condition in order to optimise our prevention services. She also felt the feedback loop is useful to evidence impact.
- The COO of the ICB noted that a joined-up plan, that is owned by the whole Board, would benefit the system. The Chair agreed, and felt this may be easier if a small piece of focussed work is chosen - that we all work on for a short time - and then show the difference that can be made when all agencies come together. Dr Prasad noted that this approach has worked well for GPs in the past (eg 10 years ago there was an atrial fibrillation drive, and then 1 year ago there was a collective focus on hypertension).
- Dr Prasad noted that the system needs space to think about how deprivation affects a family rather then constantly firefighting. This can then help develop enthused patients who create demand. The Chair agreed that all organisations involved in anti-poverty work are experiencing this firefighting to ensure clients have gas/electric and a roof over their heads. The DPH agreed that it was the remit of the Board to recognise pressures and check that resources are allocated

to those most in need (and not shirk away from withdrawing services from more affluent areas if necessary).

- The Chair asked that the Board consider what health support we can add to help alleviate the cost-of-living pressures – whilst acknowledging this may not be quantifiable. This may be a case of allowing the space to have conversations with clients about accessing existing services rather than creating new ones.
- The COO of the ICB warned about being driven by data – but instead urged members to use collective knowledge to address poverty and obesity to turn the tide of health issues in 10 years. An example of this is the three new hospital wards being built in the City.
- In response to the above comments, the presenting officer agreed that active secondary prevention is about supporting patients to make beneficial choices.
- The UHL representative noted that the Alcohol Liaison Team are an example of a cross-working team. He felt that every £1 invested in that kind of work releases £3 downstream.
- The DPH noted that there will be two new methods to progress the prevention work in 2024/25. The first is that Public Health and Social Care will be systematically working with primary care (this has been ad-hoc in the past). The second is that there will be a new Prevention and Inequalities Group for the City – which will have members from ICB, PH, Social Care, UHL and Primary Care. Plans are being drawn up – and this group will focus on specific conditions in a robust, targeted way.
- The Chair noted that many people only seek medical assistance when they are very ill – so anything we can do to encourage people to have their blood pressure or pulse taken could help early detection/diagnosis. Sports events have been used to reach people for these tests in the past – but could we now look to include the festivals/events programme in the City? Cllr Clarke noted that Star Diabetes already attend our festivals/events – but was happy for this to expand via the HWB.

RESOLVED:

That the Board thanked Officers for the report - and asked that comments from the Board be taken into account.

57. LEICESTERSHIRE'S TARGETED LUNG HEALTH CHECKS PROGRAMME OVERVIEW

Sally Le-Good (Senior Cancer Service Manager, LLR ICB) presented an overview of the Targeted Lung Health Check (TLHC) Project to be offered to those aged 55 to 74 who are at a greater risk of developing lung cancer.

It was noted that:-

- This is a new screening service being rolled out across England. It will help identify lung diseases/cancers.
- The screening is offered to anyone 55-74 who have ever smoked; in Leicester, Leicestershire and Rutland this will equate to 78,000 people.

- Those identified will be invited to be screened. This will start as a telephone triage, leading on to a face-to-face spirometry test, chest x-ray and CT Scan as required. The result can either be referral to smoking cessation or onward to care/treatment.
- The pathway is not prescriptive yet – and local decisions are required. To enable those decision to be made at a clinical level the programme has been paused. However it was hoped that the service will commence from June 2024.
- The screening will create a bulge in early-stage cancers – so an infrastructure needs to be in place.
- There is a Steering Group who will be deciding where the tests will be procured or sub-contracted from. That Group will feed into the Cancer Board (among others) for governance.
- Funding is from the East Midlands Cancer Alliance for this year and next year.

Comments and questions from the Board:-

- Members asked whether people exposed to passive/second-hand smoke should also be invited to the screening. The presenting officer noted that miners and military groups are already being considered as high risk cohorts – and was happy to ask the National Team whether passive smokers could also be added to the list. She did feel however that, as this group will be a very large cohort, it may need to be part of a phased approach. The DPH noted that there is potential for any screening to cause unnecessary worry - and he felt that the National Screening Committee's experts will have already considered the risk balance in order to exclude passive smokers from the screening. He will therefore ask someone in Public Health to look into this in the first instance – rather than making this request direct to the National Team.
- Rachna Vyas felt that we should write to the National Team, as a Board, about the fact that the age profile for the screening is incorrect with regards to Leicester. She felt that the large list can be narrowed if we invite the most at-risk cohorts first – and this is particularly important as the funding is set to end after two years. She felt this should be incorporated into a letter to the national team.
- Members agreed that the invitation letters need to be screened for health literacy and written with our local population in mind – ie be bespoke for Leicester and easy to read/understand. Public Health leads will draft a letter (on behalf of the Board) to the National Team with a request to look at the health literacy of the letter.
- Jo Atkinson noted that there need to be seamless pathways to the cessation services ("Live Well" for Leicester and "Quit Ready" for the County and Rutland. This could use an "opt out" methodology as is used for the maternity smoking cessation offer.
- The presenting officer took on board the comments about the screening letter itself – and noted that the "Gallery" blood letters were reviewed and amended in a similar way and resulted in a 93% retention rate.

RESOLVED:

1. That the Board thanked Officers for the report - and asked that

comments from the Board be taken into account.

2. That the DPH will ask someone in Public Health to look into the issue of whether passive smokers could/should be added to the list of invitees to the screening.
3. That the Board will consider writing a letter to the National Team about the current age profile of the screening, and about the possibility of inviting the most at-risk cohorts first.
4. That Rob Howard and Dr Packham will draft a letter, on behalf of the Board, to the National Team with a request to look at the health literacy (ie readability and appropriate use of language to fit our communities) of the screening invitation letter.

58. UNIVERSITY HOSPITALS OF LEICESTER: ANNUAL PREVENTION REPORT

Simon Pizzey (Director of Strategy & Partnerships, University of Leicester Hospitals Trust) presented a report on UHLs progress, in the last year, embedding prevention into services. It was noted that:-

- The report in the pack is an internal one - and is focussed on delivery.
- UHL employ 19,000 staff.
- The report ensures that prevention (and Making Every Contact Count (MECC)) is embedded despite the current financial climate.
- The key aim is to support people to lead an independent and healthy life.

Comments and questions from the Board:-

- Dr Packham was grateful that UHL are committed to MECC training for their staff - but noted that the capacity in City and County Public Health teams is insufficient to conduct this training for all UHL staff. She urged all members to consider investment in order to do MECC at a large scale. The Chair noted that the report discussed the “Train The Trainer” model; she welcomed that as it should result in added capacity.
- The DPH asked that the Board commit to at least maintaining the levels of MECC and CURE that we have currently (as a bare minimum).
- The Member representing the Sports Alliance noted that obesity and the environment were not mentioned in the report. The presenting officer will include those in future reports – and noted that substance misuse in children will also be included in future reports.
- The Chair asked whether the issue of cold homes could also be part of the prevention conversation in future.
- Cllr Clarke asked whether UHL’s reconfiguration is helping with prevention, particularly as it may mean people are accessing services differently. The presenting officer agreed that reconfiguration is helping.

RESOLVED:

1. That the Board thanked Officers for the report - and asked that comments from the Board be taken into account.

59. DATES OF FUTURE MEETINGS

To note that a meeting has been arranged for the following date (submitted to the Annual Council in May 2023). Please add this date to your diaries. Diary appointments will be sent to Board Members.

- Thursday 18 April 2024 – 9.30am

Meetings of the Board are scheduled to be held in Meeting Rooms G01 and G02 at City Hall unless stated otherwise on the agenda for the meeting.

RESOLVED:-
Governance Services officers will bring the list of meeting dates, for the remainder of 2024, to the next meeting.

60. ANY OTHER URGENT BUSINESS

There being no other business the meeting closed at 12 noon.