Leicester
City Council

Minutes of the Meeting of the
HEALTH AND WELLBEING BOARD

Held: THURSDAY, 26 JANUARY 2023 at 9:30 am

Present:

Councillor Dempster (Chair)	–	Assistant City Mayor, Health, Leicester City Council.
Dr Ruw Abeyratne	–	Director of Health Equality and Inclusion, University Hospitals of Leicester NHS Trust.
Ivan Browne	–	Director of Public Health, Leicester City Council.
Kash Bhayani	–	Healthwatch Advisory Board, Leicester and Leicestershire.
Councillor Elly Cutkelvin	–	Assistant City Mayor, Education and Housing.
Kevan Liles	–	Chief Executive, Voluntary Action Leicester.
Dr Katherine Packham	–	Public Health Consultant, Leicester City Council.
Mark Powell	–	Deputy Chief Executive, Leicestershire Partnership NHS Trust.
Dr Avi Prasad	–	Place Board Clinical Lead, Integrated Care Board.
Sarah Prema	–	Chief Strategy Officer, Leicester, Leicestershire and Rutland Integrated Care Board (ICB)
Kevin Routledge	–	Strategic Sports Alliance Group.
Councillor Piara Singh Clair	–	Deputy City Mayor, Culture, Leisure and Sport, Leicester City Council.
David Sissling	–	Independent Chair of the Integrated Care System for Leicester, Leicestershire and Rutland.
Chief Supt Jonny Starbuck	–	Head of Local Policing Directorate, Leicestershire Police.

Councillor Sarah Russell	–	Deputy City Mayor, Social Care and Anti-Poverty, Leicester City Council.
Andy Williams	–	Chief Executive, Leicester, Leicestershire and Rutland, Clinical Commissioning Groups.

Standing Invitees

Cathy Ellis	–	Chair of Leicestershire Partnership NHS Trust.

In Attendance

Graham Carey	–	Democratic Services, Leicester City Council.

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80. APOLOGIES FOR ABSENCE

Apologies for Absence were received from:-

Councillor Mustafa Malik	Assistant City Mayor Communities and Equalities
Susannah Ashton	East Midlands Ambulance Service, Divisional Director
Professor Azhar Farooqi	Co-Chair, Leicester City Clinical Commissioning Group
Angela Hillery	Chief Executive, Leicestershire Partnership NHS Trust
Harsha Kotecha	Chair, Healthwatch Advisory Board, Leicester and Leicestershire
Richard Mitchell	Chief Executive, University Hospitals of Leicester NHS Trust.
Oliver Newbould	Director of Strategic Transformation, NHS England and NHS Improvement
Professor Bertha Ochieng	Integrated Health and Social Care, De Montfort University.
Martin Samuels	Strategic Director of Social Care and Education

81. 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.

82. MINUTES OF THE PREVIOUS MEETING

RESOLVED:

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

83. CHAIR'S INTRODUCTION

The Chair referred to the Project Search Opportunities for Children and Young People with SEND presented to the Board in October 2021 by the Head Teacher of Ellesmere College. UHL had taken up the opportunity to take part in the scheme and had held a successful event before Christmas. The students had gone through the programme and were working at UHL as part of the hospital team. The process had all happened in three 3 months and had been a positive result for young people in this city. It was important to highlight what the Board were doing, and the Chair thanked everyone involved and looked forward to more initiatives like this.

The Chair also indicated that colorectal cancer survival would be on a future agenda of the Health & Wellbeing Board in relation to rates of survival one year after diagnosis in Leicester being the lowest in England. Members will be asked to liaise with their organisations regarding this work with a view to bringing actions to the relevant Health & Wellbeing Board that their organisation is able to commit to in order to improve colorectal cancer survival rates. It is important to promote increasing the levels of screening testing to national standards. A Task Group would be looking at the factors at play affecting the uptake of screening and vaccination.

84. BETTER CARE FUND

The Board received Better Care Fund plan previously circulated in in the summer of 2022 and the recirculated in December 2022 and Board members had been given the opportunity to raise queries and make comments with officers prior to the meeting.

AGREED:- That the Better Care Fund Plan and Action Plan be approved.

85. DELIVERY AND ACTION PLAN (2023-2025) FOR LEICESTER'S HEALTH CARE AND WELLBEING STRATEGY

Katherine Packham, Consultant in Public Health, Leicester City Council, presented a report and gave a presentation which summarised the development of the Leicester Health Care and Wellbeing Strategy Delivery Plan (2023 2025), which was last considered by the Board on 28 July 2022.

The Board were asked to formally approve the Delivery action plan (2023 – 2025) for the six 'do' priorities of the Leicester's Health, Care and Wellbeing Strategy.

It was noted that:-

- This strategy would be published on a microsite of Leicester City Council's website. This microsite was in its final stages of development. The strategy contains 19 priorities. These were divided into do, sponsor and watch categories, with the six 'do' priorities given highest priority.
- The six 'do' priorities were:-
    - Healthy Places: To improve access to primary and community health/care services.
    - Healthy Minds: To improve access for children and young people to mental health and emotional wellbeing services.
    - Healthy Minds: To improve access to primary and neighbourhood level mental health services for adults.
    - Healthy Start: To mitigate against the impacts of poverty on children and young people.
    - Healthy Lives: To increase early detection of heart and lung diseases and cancer in adults.
    - Healthy Ageing: To enable Leicester's residents to age comfortably and confidently through a person-centred programme to support self-care, build on strengths, and reduce frailty.
- Following the development day session an extra column had been added to the 'Do Priorities' page to include Outcome statements.
- The other groups of priorities outside the 6 'do' priorities were still important and would continue to be recommended e.g. digital access. The focus would be on those groups with had the most impact on poor health.
- The Summary of key actions were included in the report and work would now move to implementing the Action Plan. The reporting of progress was not intended to be too onerous by making it an extra task. Progress would be shared with the Board on a quarterly basis.

In response to questions officers stated:-

- Discussions had been held with asylum seekers and there was a high demand English courses and officers were looking to see if any funding was available to enable them to be provided to meet the demand. It was recognised that digital access and social mobility for linguistic improvement would lead to big improvements.
- A small core group would continue to meet including Council officers and the ICB and there were workshops for many projects already funded. There may be some that might need extra funding for those not going so well. The progress in a year was aspirational and we needed to know what we were doing was working for what we want to improve health equity and life expectancy. It was not expected to see large shifts in a single year.

Board members commented that:-

- In relation to digital literacy and access it was important to not make the link that if a person does not have English skills they can't access

services, as they often used filters etc to provide translations and were often very digital aware compared to other English-speaking groups. There was also a huge benefit to be gained from easy read leaflets, as had been demonstrated by the ones produced for covid vaccinations. This had been used by used by others because it was not technical and people could see the benefits for the help they gave.

- Joint Health and Wellbeing was considered to belong to all partners and real positive things had happened so far. Language was an important issue but it did not necessarily mean there was a need to find additional money to do it; but making approached to education staff to let them know this was a priority for the Board and could they do anything to monitor and make improvements.
- The plus groups were supported as they were currently defined, and they would make a difference. There was a homeless link to Changing Futures Programme and a health element could easily be added.
- Communities had joined together to engage with the vaccinations and resources were already in the community that with a small amount of resource can nudge progress along. A programme of bids across the city could help need to join intelligence and efforts.

AGREED:- That the Delivery Action Plan (2023 – 2025) for the six 'do' priorities of the Leicester's Health, Care and Wellbeing Strategy be approved.

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

Rob Howard (Consultant in Public Health, Leicester City Council) and Dr Ruw Abeyratne (Director of Health Equality and Inclusion – University Hospitals of Leicester NHS Trust) provided a verbal update on the progress being made to tackle inequalities in maternal mortality faced by Black and Asian women in the City.

It was reported that:-

- There was a Task and Finish Group to look at what was available and what could be done to improve it.
- Rob Howard came out of MBRRACE-UK report on research into perinatal morbidity and at deaths in ethnicity. Although the numbers were relatively small the rates for women of black origin was 4 times higher than white women, of Asian origin twice as high and women of mixed heritage were three times higher.
- Further work had been undertaken to categorise issues around attitudes, language, being dismissive of concerns and knowledge or lack of knowledge/assumptions about pain levels for ethnic women. There needed to be better coding for data and more community based work.
- UHL had undertaken a lot of work on the development of culture in the care process. Focus Groups had bene held to address the concerns and problems that were not understood and care of health and wellbeing in the challenging environment staff worked in. There was a need to recognise cultural competency and sensitivity to women and their

families. There were recurrent themes about trust and not being listened to and practitioners needed to change how these concerned were respond to. There was a need to move from listening to concerns viewpoints towards showing practitioners had learned from what people had said. Languages were a challenge and how this was utilised as a tool for care and allowed to be a barrier. It was important to make applications acceptable to women and their families. Collecting local data was essential and even though the numbers were a small a dashboard in development.

Members of the Board commented that:-

- Ethnicity could independently affect mortality and morbidity. There was a need to change the determinations which were malleable. Understanding the mortality in countries of origin and what could be learned from those countries to improve the situation was important. We should not be insular when looking at the norms. For example The advice in Japan was that it was acceptable for parents to sleep with children until they were 7 years old and the advice in the UK was that parents should not sleep with babies as this increased the risk of them dying. This was not the experience found in Japan and evidence suggested that other issues such as the use of drugs and alcohol were more important contributory factors.
- Work from this initiative could be applicable to other service areas.
- It should be recognised that there was a need for individual change as well as a collective change. Further consideration should be given to what counts as 'black community' as those of Afro Caribbean, Somali or Nigerian origins all had different complex issues. There was an opportunity to identify if there was a particular group of origin that was more disadvantaged. Change would not occur quickly because of the practice of women sharing comments with each other and if they have a bad experience that would be shared. That would have to be addressed and measures taken to avoid that and to reassure others that not everyone had bad experiences.
- Issues around cultural norms is critical to Leicester due to it being a pluralistic city and identifying what is the norm for Leicester. Measures that worked elsewhere would not necessarily work in Leicester.
- There was a difference between people of African and Caribbean origin and rates of mortality in those countries and the relationship between those countries and here. If there was a marked increase in the UK was this due to genetic or other issues.
- If ethnicity was an issue, even if adjusted for deprivation, if it was not physiological then was it equity and equality? Looking at other western European countries such as France, Germany or Sweden to see if they have similar issues. If they don't, why not as they had a similar history of diversity in immigration.

In response, officers stated that:-

- There was not data relating to women who come to the UK compared to data for women who were born and raised in this country. Mortality and morbidity factors happened before conception so there was plenty that

could be influenced to address those issues.

- The shared experiences across communities were not just maternity but involved all experiences and the role of partners, fathers and the and support from the community added extra levels of complexity.
- The questions asked by Board members were the same as those being asked by officers and whilst the answers were not yet there was work that could be done to improve the knowledge and data in these areas.

The Chair commented that this was an ongoing piece of work with different strands and a short update would be helpful at the next meeting. An update on the preliminary feedback on engagement sessions could follow to a future meeting. This work could be used for other departments across all NHS organisations and the partnership coming together to help each other. The council had good data and an award-winning team for producing it and this could be shared so it could influence all other aspects of health.

AGREED:- That officers be thanked for the update and were asked to submit further updates as the project progressed.

87. CHILDREN AND YOUNG PEOPLE IN THE CONSIDERATIONS OF THE HEALTH AND WELLBEING BOARD

The Chair stated that consideration of the report would be deferred to a future meeting as Martin Samuels was unable to attend the meeting to present the report.

88. MEETING THE NEEDS OF COMPLEX PEOPLE

Chris Burgin, Director of Housing, Leicester City Council, give a presentation setting out the increasing challenges of helping complex housing applicants and tenants, housing them and the need for Housing services and Health services to work together to ensure Health services pathways are accessible and timely for those people going through Homelessness and those complex and vulnerable people in Housing.

During the presentation it was noted:-

- There was increasing homelessness, there was a lack of suitable housing to meet challenging and more complex needs and the health and wellbeing of citizens was affected.
- There was a lack of truly affordable housing and the low levels of house building since 1969 meant there was a lack of houses to meet demand. Less than 10% of private rented properties were not available to those on benefits.
- People could be homeless if they had nowhere to stay and were living on the streets, they could also be considered homeless even if they had a roof over their head.
- The homeless population had a life expectancy of 43 years. On average men and women who were homeless at or around the time of their death lived 31 years and 38 years fewer than the average. Homelessness was associated with tri-morbidity, a combination of

physical ill health with mental illness and drug or alcohol misuse.

- Mental illness was a cause and a consequence of homelessness. 70% of homeless service users in England had mental health problems. Deliberate self-harm, including suicide, was 7 times higher than that of the general population.
- Homeless people were over-represented attenders in A&E. A homeless drug user admitted to hospital was 7 times more likely to die over the next 5 years than a housed drug user with the same medical problem. Without early intervention homeless children and young people were likely to enter such a cycle.
- There were now over 5,000 people facing homelessness in Leicester.
- A case study gave an outline of what impact a person with complex needs could have on neighbours and the ways in which the Tenancy Management and STAR services could help over a period of time.
- The Housing Service had a strong offer of services, support and interventions to assist people suffering or threatened with homelessness. The service's motto was that one needed to sleep on the streets and whilst every effort was made to assist people, some didn't accept help. There were over 200 people currently in temporary accommodation. It was known that people who were rough sleeping had frailty levels equivalent to an 89 year old.
- The initiatives housing services were undertaking were fully outline in the presentation.
- It was considered that housing and health services must commit to doing more together if the response to homelessness was to be to be successful, including joint financial support where health issues were concerned.

Following the presentation the Board Members commented that:-

- There may need to create a Task and Finish Group to look at the issues involved as homelessness affected all Board partners.
- It was felt that the homeless were a group of people that the system was systematically failing, especially those complex needs living street lifestyle supported by crime and drug issues.
- Leicester was seen nationally as being ahead compared to others in providing joined up homeless services and was often used as an example of good practice.
- The homelessness strategy and charter had been effective and there was a need to have a flexible approach with elements of variety. The Floral Lodge offer helped those with acute needs and who wanted to change. It was felt that in some instances that if the system failed them then it would have failed it its last opportunity to provide help.
- Many homelessness had low faith in the system. If they had been recognised as being neurodiverse at an early stage then they may not have been where they are now.
- There should be a multi sector approach and the Task and finish Group was supported to look at solutions to take between all partners as it impacted upon all Board members services.
- UHL were looking at the A & E attendance by this group of people with

LPT and others. It was flet that the underpinning issue was around prevention and there was a need to build a structure that worked towards prevention. It was important to attract the attention of key stakeholders in this issue.

- Cathy Ellis commented that LPT picked up on a lot of people from drop ins etc and they welcomed the work on reconfiguring the Dawn Centre and were happy to help if they could.
- Ivan Browne commented that he had been to St Mungos before covid when he took up the issues from the director of Housing. It was clear that not one single organisation could get to a place where the whole system needed to be at in order to response to the needs of the homelessness and it was important there was a collaborate and partnership working to achieve this.
- Andy Williams commented that there was an opportunity to submit bids to the ICB in order to have weight as partnership and were happy to work with the Director of Housing on that. The ICM were also looking at their plan for next year, so it was now appropriate to look at these issues to see what improvements and benefits there would be and if makes financial sense to allocate money to where it needs to be.

The Chair stated that she saw this as important issue for the Health and Wellbeing Board and the Board had an important role to play because of importance of place. This was one of the top priorities in our strategy and the need for a Task and Finish Group would be raised at a future meeting. It was not necessarily about having more money but what was done collectively to work together to maximise resources.

AGREED:- That the Director of Housing be thanked for his informative presentation and all Board members commit to working in partnership to address the issues involved in dealing with the homelessness and tenants with complex needs.

89. INTEGRATED CARE BOARD ROLES AND RESPONSIBILITIES

Sarah Prema, Chief Strategy Officer, Leicester, Leicestershire and Rutland Integrated Care Board (ICB) presented a report setting out the roles and responsibilities of the Integrated Care Boards which replaced Clinical Commissioning groups in July 2022.

In view of the time pressures for the meeting, Sarah Prema stated that she would be happy for paper to be noted. The core responsibilities were set out in paragraph 2 of the report and the legal duties were outlined in paragraph 5 and these were similar to those of the previous Clinical Commissioning Group. The wider role of the ICB within the Integrated Care System and the role of the ICB for specific areas within that were shown in paragraph 7.

The Chair commented that the ICB had been in existence for 8 months and it would evolve over time as it developed.

AGREED: That the report be noted and future updates be submitted when

necessary.

90. PHARMACEUTICAL NEEDS ASSESSMENT (PNA)

Helen Reeve, Senior Intelligence Manager, Public Health, Leicester City Council presented a report which summarised the Pharmaceutical Needs Assessment (PNA) following its development since it weas last discussed at the Board on 28 July 2022.

It was noted that the PNA had been consulted upon and had been considered at the Council's Health and Wellbeing Scrutiny Commission last week where it had been well received.

The Chair thanked everyone involved in progressing the PNA and taking it through the consultation process. The report had been published in the Autumn of 2022 and Board members were invited to contact Helen Reeve if they had any questions or observations.

Ivan Browne commented that when it was discussed at the Health and Wellbeing Scrutiny Commission had referred to the provision in the west of the city and whilst there was provision in the area that met the criteria, as that part of the City was developed the pharmacy provision would need to be addressed.

The Chair commented thanked everyone involved for producing this good piece of work.

AGREED: That the Board note the conclusions and recommendations in the report and asked that the comment made above to improve the PNA be taken into consideration.

91. LLR HEALTH AND WELLBEING PARTNERSHIP DRAFT INTEGRATED STRATEGY

Sarah Prema, Chief Strategy Officer, Leicester, Leicestershire and Rutland Integrated Care Board (ICB), presented a report on the draft Integrated Care Strategy which has been developed by the LLR Health and Wellbeing Partnership, and outlined the engagement process with Health and Wellbeing Boards.

It was noted that:-

- The ICB are required to develop an Integrated Care Strategy.
- The first draft of the strategy was presented to the LLR Health and Wellbeing Partnership in December 2022. It was agreed that further engagement would take place with the three Health and Wellbeing Boards in LLR in the first quarter of 2023 to gain feedback with a view to getting a final strategy approved and published by the latest Autumn of 2023.

- A number of workshops had produced the initial draft for engagement purposes, and it was proposed to produce the final version by the end of summer and autumn allowing for the local elections in May 2023.
- The purpose of the Strategy was to reassure the wider public on how the ICB was seen to be operating within a clear framework.

Members of the Board commented that:-

- That whilst the Strategy was ambitious and impressive, there was no reference to prevention measures which were equally important. What percentage of the system's budget would be allocated to prevention measures as it was considered that without funding prevention measures the Strategy would not achieve it targets as the system would always be responding to firefighting measures. The need to change the current factors affecting health had to be accepted as well as a commitment to make changes. Given that the health and social care budgets had been cut drastically in recent years did the Strategy model the realities that would stumble the system to deliver the target, otherwise the same discussions would be repeated in future years and faith and trust would be lost in those delivering services.
- The Strategy was seen as an expression of the wider partnership with the ICB and a platform to sponsor and promote pieces of work, one of which would need to be the cost of living crisis. There should be respect for the challenges of each place within the LLR footprint as they differed in each health Boards area.
- It was suggested that the Strategy should make reference to the detailed plan put in place for Health and & Wellbeing for the City and other areas and that that the 5 Year Strategy also needed to link into this report so that those issues could also be addressed.
- It was felt that the Strategy was silent on the ambitions of partners, young people, mental health prevention etc and illustrations requiring high level financial forecasts.

In response to the issues made by Board Members officers commented that prevention should not be viewed as making changes and improvements in 5 or 10 years' time. There were issues such as the statistics for people dying younger than the national averages where early intervention can have a significant impact in short periods of time. It was everyone's responsibility to engage in prevention to address current issues.

The Chair commented that the Council had a Deputy City Mayor for Social Care and Anti-Poverty, a lead on neighbourhoods and Councillor Cutkelvin led on housing and this emphasised that there needed to be joined up approach between the representatives on the Board.

Ivan Browne commented that it was important for each partner to know what each organisation did so that each could signpost to appropriate services and initiatives to maximise service delivery.

Andy Williams commented that in relation to the need for immediacy of prevention the City had delivered the biggest vaccination programme in history

in partnership between health and Council partners. The City had also dealt with migrant issues in a similar co-ordinated response. Prevention should be seen as 'a now issue' for consideration and a case study could be incorporated. Officers would pick this up this issue.

AGREED:- That the draft Strategy be supported and officers take into account the comments made by Board members above.

92. QUESTIONS FROM MEMBERS OF THE PUBLIC

No questions from members of the public had been received.

93. DATES OF FUTURE MEETINGS

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

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

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

The Chair commented that the next meeting would have a winter themed focus together with the item on the 5 Year Forward View. Officers would write to Board members on the theme to see how everyone could contribute with reports relating to the topic.

94. ANY OTHER URGENT BUSINESS

There were no items of Any Other Urgent Business to be considered.

95. CLOSE OF MEETING

The Chair declared the meeting closed at 11.59am.