Leicester
City Council

Minutes of the Meeting of the
HEALTH AND WELLBEING BOARD

Held: THURSDAY, 3 JULY 2014 at 10.00am

**Present:**

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| Councillor Rory Palmer (part of the meeting) | – | Deputy City Mayor, Leicester City Council |
| Karen Chouhan | – | Chair Healthwatch Leicester |
| Councillor Vi Dempster | – | Assistant City Mayor, Children's Young People and Schools, Leicester City Council |
| Professor Azhar Farooqi | – | Co-Chair, Leicester City Clinical Commissioning Group |
| Dr Simon Freeman | – | Managing Director Leicester City Clinical Commissioning Group |
| Andy Keeling | – | Chief Operating Officer, Leicester City Council |
| Elaine McHale | – | Interim Strategic Director, Children's Services |
| Chief Superintendent Rob Nixon | – | Leicester City Basic Command Unit Commander, Leicestershire Police |
| Councillor Rita Patel (Chair for the Meeting) | – | Assistant City Mayor, Adult Social Care |
| Dr Avi Prasad | – | Co-Chair, Leicester City Clinical Commissioning Group |
| Tracie Rees | – | Director of Care Services and Commissioning, Adult Social Care, Leicester City Council |
| Councillor Manjula Sood | – | Assistant City Mayor (Community Involvement), Leicester City Council |
| Deb Watson | – | Strategic Director Adult Social Care and Health, Leicester City Council |

**Invited attendees**

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| Councillor Michael Cooke | - | Chair Leicester City Council Health and Wellbeing Scrutiny Commission |

**In attendance**

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| Graham Carey | – | Democratic Services, Leicester City Council |
| Sue Cavill | – | Head of Customer Communications and Engagement - Greater East Midlands Commissioning Support Unit |
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## 1. APOLOGIES FOR ABSENCE

Apologies for absence were received from Councillor Palmer, who had been delayed, and from Councillor Sood. Apologies were also received from Chief Superintendent Rob Nixon, Leicestershire Police.

## 2. CHAIR OF THE MEETING

Councillor Patel announced that Councillor Palmer was unable to attend and had asked her to Chair the meeting in his absence.

Councillor Patel in the Chair.

## 3. 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 made.

## 4. MEMBERSHIP OF THE BOARD

RESOLVED:

1) That the membership of the Board as amended at the Annual Council meeting on 29 May 2014 to increase the number of members in each group to 4 be noted as follows:-

**Councillors**

Chair of the Board – Councillor Palmer - Deputy City Mayor
Councillor Dempster - Assistant City Mayor (Children, Young People and Schools)
Councillor Patel - Assistant City Mayor (Adult Social Care)
Councillor Sood MBE - Assistant City Mayor (Community Involvement, Partnerships and Equalities)

**City Council Officers**

Deb Watson – Strategic Director, Adult Social Care and Health
Andy Keeling – Chief Operating Officer
Elaine McHale – Interim Strategic Director, Children's Services
Tracie Rees, Director, Care Services and Commissioning, Adult Social Care

**NHS Representatives**

Professor Azhar Farooqi, Co-Chair, Leicester City Clinical Commissioning Group
Dr Simon Freeman, Managing Director, Leicester City Clinical Commissioning Group
Dr Avi Prasad, Co-Chair, Leicester City Clinical Commissioning Group

David Sharp, Director, (Leicestershire and Lincolnshire Area) NHS England

**Healthwatch and Other Representatives**

Karen Chouhan, Chair, Healthwatch Leicester
Chief Superintendent Rob Nixon, Leicester City Basic Command Unit Commander, Leicestershire Police
2 vacancies

2) That it be noted that the Board's Terms of Reference were amended by the Council to reflect this change in membership and also that the Board will meet 6 times a year in future and that all other Terms of Reference remained the same as before.

## 5. MINUTES OF THE PREVIOUS MEETINGS

RESOLVED:

That the Minutes of the previous meetings of the Board held on 3 April 2014 at 9.30 am and 11.30 am be confirmed as a correct record.

## 6. DIRECTOR OF PUBLIC HEALTH - ANNUAL REPORT

The Strategic Director, Adult Social Care and Health presented her Annual Report as the Director of Public Health. A presentation on the report was also made at the meeting, a copy of which is attached to these minutes.

In presenting the report the following comments were made in addition to those listed in the presentation:-

- Although there was a statutory requirement to produce a report there was no guidance on what should be included in the report. However it was customary to include an assessment of the health of population and to make recommendations about things that could be done to improve the health of population.

- One of the report's purposes was also to inform the City Council, Health and Wellbeing Board, Clinical Commissioning Group, NHS England, Public Health England and other partners about the health of the resident population and to identify key areas where improvements could be made that would benefit the health of the population. The plan also provides information on health needs overall which informs the planning and the commissioning process within all partner organisations.

- The report also sat alongside the Joint Strategic Needs Assessment which had enabled the Board to produce its Joint Health and Wellbeing Strategy 'Closing the Gap'.

- The report also helps to provide a record of the health of the population which allows a comparison to be made over a period of time and with other places, both locally and nationally.

- The striking differences for Leicester from these comparisons were:-

    - Leicester was ranked 25th most deprived area out of 326 local authorities in England, it was noted that deprivation probably had the greatest single impact upon the health of the population.

    - Deprivation was also linked to lifestyle factors and material conditions that can affect the health of people, e.g people living in cold damp conditions have a greater risk of heart problems etc.

    - The population of Leicester has a very rich diversity. There are 18 different ethnic groups in the City with populations of 1,000 or more identified in the 2011 census. (37% Asian/Asian British, 6% Black/Black British, 46% White and 4% Other White groups from Poland and other EU succession countries).

    - Different ethnic backgrounds have different predispositions to health conditions. Lifestyle factors are deeply embedded in the lives of people from different cultures and can impact upon health either to increase the risk of, or be a protective factor against, particular health conditions.

    - Leicester's population is relatively young in nature. 34.5% of households have dependent children (29% nationally) and 20% of the population in Leicester are aged 20 – 29 years old compared to 14% nationally.

    - There are also significant socio-economic challenges in Leicester. 29% of adults have no educational qualification and 35% of 16-74 year olds were economically inactive compared to 30% nationally.

    - All these factors had a high impact upon health and health needs.

- The top three causes of deaths in the Leicester population under 75 years old were cancer, cardio-vascular disease and respiratory diseases. Although the highest cause of deaths in Leicester was cancer, the rate of deaths was comparable to the national death rate in the population. The two biggest impacts upon health in Leicester which made the most difference to life expectancy in Leicester compared to elsewhere were cardio-vascular disease (e.g. heart attacks and strokes) and respiratory diseases.

- Life expectancy at birth (which is derived from mortality rates) are used as an overall summary measure as it reflects all factors which have influenced a person's health during their lifetime.

- There were also differences in health conditions between different groups. For example, there are high rates of diabetes and cardio vascular disease in the South Asian and Black population compared to the white population. By contrast there are high rates of respiratory diseases in the white population resulting mainly from the higher prevalence of smoking among deprived white communities.

The average life expectancy for people in Leicester compared to the national averages had been widening for a number of years leading up to 2010. However there were some encouraging indications that the gap had been reducing over the last four years, and whilst it was too early to identify it as a trend, there had been numerous partnership efforts in the last four years to improve the health of the population and it was hoped that these had contributed to a cumulative positive effect upon the general health of the population.

The main lifestyle issues affecting the local population were:-

a) Whilst the majority of adults were non-or low risk drinkers, there were higher rates of alcohol related conditions and harm and higher rates of hospital admissions in Leicester compared to the East Midlands. However, young people were less likely to report ever having an alcoholic drink - 20% of 11-15 year olds in Leicester compared to the national rate of 42%.

b) Smoking was the greatest single cause of preventable premature deaths and over 20% of adults in Leicester smoke. On average 0.5% of 11 year olds smoked which rose to 11% for 15 years olds. Public Health staff work closely with schools using creative engagement techniques to avoid young people becoming 'replacement smokers' in future years.

c) The levels of overweight and obesity is increasing in the population. Whilst the rates for adults were similar to national rates, there were significantly higher rates of obesity for children aged 4-5 and 10-11 years old. Efforts needed to be concentrated around these groups.

d) Diagnosis for acute sexually transmitted infections (STIs) were above the regional and national averages and Leicester was the 6$^{th}$ highest prevalence area for HIV outside of London. This was an area for concern and needed work in the future to reduce these rates.

e) Rates of teenage pregnancy had dropped since 1998 and the rate in 2011 was 30.7% per 1,000 15-17 year old girls which is almost a 50% fall since 1998.

f) Oral health for children at age 5 years old having decayed, missing and filled teeth was the worst in England and a strategy had been put in

place to promote oral health in pre-school children.

It was also noted that 23% of the total burden of ill health in UK was attributable to mental health diseases and illness. In Leicester this equated to 10-15% of children and young people having a recognised mental health problem and 36,000 people of working age had a common mental health condition such as depression or anxiety. Approximately 8,000 of people over 65 years old suffer from depression and 3,000 have dementia. There were a number of recommendations in the strategy in relation to mental health, particularly that all partners should promote the use of the Five Ways to Wellbeing with staff as well as those who use services.

The report also showed that the long term conditions affecting the population aged 65 years and above were predominately diabetes, depression, dementia, CHD, strokes, bronchitis and emphysema and all these conditions were expected to continue to rise over time.

Other health factors mentioned in the report were:-

a) The rates of tuberculosis in Leicester were the highest in the East Midlands and higher than England but the rates was consistently falling.

b) There had been good uptake of childhood vaccinations in recent years and this was important to maintain. It was noted that there had been some deterioration in the up-take in 2013/14 compared with the previous year.

c) Cervical screening rates have also been declining locally and nationally and up-take of smear test remained significantly lower in Leicester than the national average.

d) Bowel cancer screening rates are lower in Leicester than elsewhere and twice as many tests in Leicester had a positive result, suggesting the need to significantly improve up-take of this screening test.

Leicester had one of the highest up-takes of NHS Health Checks in the Country with approximately 72% of those eligible between the ages of 40 and 74 years old having received an NHS Check by the end of 2013/14. It was noted that this had been a significant partnership effort over recent years and that Leicester City CCG had worked hard to ensure that GP practices deliver the checks. 20% of those receiving the checks needed further treatment for previously undiagnosed conditions. 4,900 people were now being treated to prevent more serious conditions or existing conditions from deteriorating. Work on prevention of illness and stopping conditions deteriorating was an essential element of the Better Care Fund Plan.

In conclusion, the Strategic Director acknowledged the time and hard work of public health staff who had produced the detailed analysis presented in the report and thanked the Divisional Director Public Health for leading this work.

Following a general discussion and questions on the report, the following comments and observations were noted:-

a) It would be desirable for data on all health inequalities to be broken down to the same level of statistical analysis for all protected characteristics, as it would enable a more targeted approach to be taken to develop strategies to tackle health inequalities related to protected characteristics. However, it was noted that this was not always possible as some health data was collected nationally and other data was collected locally without accompanying information about each person's ethnicity, sexuality or religion etc.

b) Where local data on protected characteristics was not available, national data was often extrapolated as an indicator provided it was felt that the local position was not considered to be largely different from the national picture.

c) The Director of Public Health's Annual Report provided a snapshot in time of the health of the population. The Public Health Team also undertook individual work on joint specific needs assessments on specific issues and/or groups where it was felt that particular groups were vulnerable.

d) The report's findings were also intended to be used to refine and improve existing strategies and to assist with the development of new strategies and their implementation.

e) Everyone that commissioned services for the population should consider the findings in the Annual Report to identify where there were higher or different needs in parts of the community and take these into account in order to target the limited resources available in the health economy to address them. Deprivation is a key issue.

f) It was noted that the CCG had been carrying out low level analysis to test a number of hypotheses to see if suggested health inequalities were a determinant of health outcomes. It was difficult to get sufficient data to provide a definitive answer.

g) An analysis of the take up of NHS Health Checks showed that there was no apparent differential in the take up of health checks by different ethnic groups or in different areas of the City.

h) The CCG also felt that testing a hypothesis at a low level could provide useful indications of whether health inequalities were amenable to health interventions or subject to wider determinants of health.

i) There should be a greater use of health equality audits by commissioners of services, both in relation to the protected characteristics and in relation to deprivation.

j) If all stakeholders undertook detailed health equality audits on 1 or 2 services each year it would to build a picture over time of ethnicity and other factors affecting health in the City.

k) Further work needed to be undertaken on understanding why the change in the reduction between the national and local life expectancy rates had occurred. Both deprivation and ethnicity had implications for the health of the population. Alcohol related illnesses and diabetes affected different parts of communities and there was a need to focus services where they would have the greatest impact.

l) Many of the recommendations were aimed at the strategic or system level and a number of the recommendations resonated closely with the 'Closing The Gap' strategic aims and priorities. The Board already received six monthly updates on the progress with this strategy so this would also indicate to some extent whether the recommendations were being taken up and acted upon by health partners.

m) Progress against the recommendations in the Annual Report would also feature in next year's Annual Report.

n) In addition to data provided by the Office of National Statistics and health episode statistics, there was also qualitative data held by all stakeholders and more could be done to have a stronger and collective understanding of the issues by sharing the information each stakeholder held.

o) All stakeholders should respond in brief to the Director of Public Health's Annual Report and the recommendations to outline what action they intended to take as a result or whether there were any elements they disagreed with.

RESOLVED:

1) That the Director of Public Health's Annual Report 2013/14 be received.

2) That all partner organisations and other stakeholders be commended to consider the recommendations and respond in brief to them to outline what action they intended to take as a result or whether there were any elements they disagreed with.

3) That Healthwatch's offer to suggest areas of questioning to help with developing Health Equality Audits be welcomed.

4) That the Director of Public Health be thanked for producing and extremely informative, user friendly and accessible report.

## 7. PHARMACEUTICAL NEEDS ASSESSMENT

The Divisional Director of Public Health submitted a report outlining the preparation of the Pharmaceutical Needs Assessment (PNA) for Leicester which the Board was required to publish by March 2015.

It was noted that the Board's statutory responsibility to prepare and publish the PNA was being overseen by the Leicester Joint Integrated Commissioning Board through the Leicester, Leicestershire and Rutland Pharmaceutical Needs Assessment Project Team. The terms of reference for the Project Team were submitted as part of the report.

The purpose of the PNA was to identify the pharmaceutical services currently available and to assess the need for pharmaceutical services in the future. The PNA was a statutory document used by NHS England to agree changes to the commissioning of local pharmaceutical services.

The PNA was currently going through a period of local public consultation until 14 July 2014. There would then be a period of statutory consultation for 60 days starting in September 2014 and the list of statutory consultees was listed in the report. The consultation process would also be open to the public and, whilst the consultation would be available through the Council's website, printed copies of the PNA and the consultation process would also be distributed.

RESOLVED:-

That the report be noted and that further reports be received on the progress of the PNA prior to the final PNA being submitted to the Board for approval in March 2015.

## 8. LLR HEALTH AND SOCIAL CARE 5 YEAR STRATEGY DIRECTIONAL PLAN FOR BETTER CARE TOGETHER PROGRAMME

The Programme Director for Leicester, Leicestershire and Rutland Five Year Strategy submitted a report on the Directional Plan for the Better Care Together Programme. A copy of the summary report and the Better Care Together 5 Year Strategic Plan 2014-2019 had previously been circulated to Members of the Board.

The Board received a presentation 'A blueprint for Health and Social Care in LLR 2014-19 – Phase 2 – Discussion and Review Phase' a copy of which is attached to these minutes.

During the presentation it was noted that:-

a) The strategy was produced by a partnership of commissioners, providers, local authorities and Healthwatch.

b) It was the biggest ever health and social care review locally.

c) Whilst the review was being conducted against a backdrop of a financially challenged health economy, it was not purely a financially driven plan.

d) The values and principles which underpinned the Plan together with its strategic aims and objectives were listed in the presentation.

e) The Better Care Together programme was based around a 'left shift' in the settings and models of care moving care from the acute sector of hospital health care into the primary and community care services sector. However this shift would not take place until the primary and community services necessary to support and achieve this new care model were in place.

f) The Improvement Interventions for outcomes in 5 years' time for the 8 pathways of Urgent Care, Frail Older People, Long Term Conditions, Planned Care, Maternity and Neonates, Children Young People and families, Mental Health and Learning Disabilities were set out in detail in the presentation.

g) The current phase of 'Discussion and Review' would end in September 2014. During this period further discussions would be held with partners and there would be further community and patient engagement during the summer. Detailed options for change and a final strategy for approval would be presented for approval in September 2014.

h) Phase 3 – 'Implementation and Consultation' would start in September and where formal public consultation was required, this would not take place until after the elections in May 2015.

Following questions from the public it was stated that:-

a) The plan was evidence based and all the evidence used to underpin the plan had been published in its appendices. The directional plan was by its nature a high level plan and further more detailed business cases would be developed in the future. Any evidence to support those would also be made available.

b) A Risk Register was currently being developed and would be submitted to the Better Care Together Board in due course. The risk register was being prepared on the best practice guidance of the Office of Government Commerce and they had also been asked to provide an independent assessment of the governance and risk management elements of the programme.

c) Although the Better Care Together Board did not currently meet in public this was being re-assessed as to whether it should in future.

d) There had been extensive public involvement and engagement in the development of the programme which had involved public patient

involvement groups and Healthwatch. Further discussions were being held with these partnership groups to determine the appropriate method and level of consultation which would satisfy the patient involvement groups, Healthwatch and Local Authority Scrutiny requirements.

e) The final plan will be submitted to the various provider and CCG Boards as well as all the Healthwatch, Health and Wellbeing Boards and Scrutiny Committees.

f) Only those parts of the programme that do not require consultation will be implemented initially. There would need to be a major consultation exercise on the proposal; to reconfigure the acute hospital service provision from 3 sites to 2 sites. It was not know yet whether this would be a single consultation process or a number of consultations on each part of the scheme.

g) Although the programme identified a reduction in capacity of 400 beds from the system, this should not necessarily be seen as a cause for concern. Approximately half these beds could be reduced through improved productivity of acute hospital services. Currently UHL did not undertake enough day case surgery operations as they did not have the dedicated facilities. Consequently this increased the need for inpatient beds. Investment was being provided to build dedicated facilities to allow this pressure to be removed. These better clinical processes should account for half the proposed reduction in the number of beds. The remainder of the reduction in beds would be achieved through the transfer of patients out of acute hospital care into community hospital or home based care as appropriate. This was particularly relevant to the radical changes proposed for the care of elderly and frail patients to reduce their admissions to hospital unless it was essential for them to be there, by providing more intervention and support services in the community and at primary care level.

h) Leicestershire Partnership Trust (LPT) confirmed that they would continue to support 250 community beds across the county but under the proposals there was likely to be an increase in the number of acute or sub-acute patients being admitted to them. It was critical that integrated social care services were in place to support this proposed shift in care and that the level of investment was sufficient to support this. The investment needed to work alongside the proposals to reduce admissions and to manage long term conditions differently in order to create the right flows through the system as a whole. There were significant risks in delivering this element and all parts needed to be delivered efficiently to achieve the desired outcomes.

i) The Board had a role in holding the whole system to account in delivering the Plan. Social care services needed to be fully integrated into the Plan to ensure that people at risk were identified and intervention was provided at an early stage to prevent pressure on more acute services.

At 11.33am, Councillor Palmer entered the meeting and with his agreement Councillor Patel continued to Chair the meeting.

Councillor Palmer commented that:-

a) It was imperative to secure the confidence of the public, patients and stakeholders and to demonstrate that everyone involved in the process was committed to making the process open and transparent and that decisions were made through the effective use of all available public forums.

b) A great deal of effort and work had gone into getting the plan to this stage and the roles of Philip Parkinson as Chair of the Board and that of the Interim Programme Director should be acknowledged.

c) The scale and magnitude of the plan required that high quality decisions were taken.

d) It was crucial for public confidence that the delivery of the plan was seen to be credible.

e) The Council would also be discussing the respective roles of the Health and Wellbeing Board and the Health and Wellbeing Scrutiny Commission in relation to the plan. It was likely that the Board would oversee the strategic elements of the programme and the Commission would scrutinise the details of individual parts of the programme.

f) The plan looked at an array of acute services but it was evident that it did not make any specific reference to the children's cardiac heart services. The plan should be an important vehicle to reflect the aspiration to retain this facility in Leicester.

In response, the Chief Executive of University Hospitals of Leicester NHS Trust stated that the plan contained a reference to investing in the children's services which was complementary to the LLR Plan. There were however, some complicated issues that still needed to be resolved and an operational appraisal was currently being undertaken to consider these. Children's services were currently split between Glenfield Hospital and Leicester Royal Infirmary. It was not feasible to move children's congenital heart surgery away from the adult heart surgery facilities and equally the paediatric services could not move from the Royal Infirmary as it needed to support the A&E services there. Furthermore the new Emergency Floor scheme would have a specific Children's A&E facility within it. Although there was no obvious solution to providing all children's service in one place, the Trust was still committed to providing a full range of children's services.

During general discussion members of the Board also made the following

observations:-

a) The primary care sector needed to be developed further if it was to provide more care in the community, particularly in relation to GP services.

b) Capacity and resources represented two of the largest risks in delivering the plan. The primary care sector have been considering a number of national and local policy issues to understand what the new system should look like. The Local Medical Committee was holding a solutions day the following week to map out the options for a re-configured primary care sector so that it was fit for purpose to meet the new challenges.

c) Dr Prasad commented that 90% of NHS activity took place in the GP sector of primary care and it was important to get the reconfiguration of services right as it could have a huge impact on the Better Care Together Plan. Investment in the primary care sector had reduced from 10% to 8% in recent years. There was shortage of GPs in Leicester as it was not an attractive place to work. There would shortly be a cohort of GPs retiring and recruitment was already difficult.

d) Professor Farooqi also referred to the reduced numbers of students on training programmes and many newly qualified doctors opting to work overseas.

f) It was recognised that part of the programme relied on making the most of GPs expertise and that patients needed to be directed to the right person to deliver their care such as practice nurses, pharmacists, health care assistants and other health practitioners. However this was not easy to achieve as many patients wanted to see a GP and often complained if they were directed to other health professionals, even if other health professionals could provide the appropriate level of care for the patient.

g) There needed to be a modal shift away from the patient being a consumer within the health service to recognising that they are part of a mutual society, otherwise commissioners, providers of services and patients would all suffer the consequences. Embedding this ethos in everyone would not be without its challenges. Until this cultural change took place, the public understood what other options were available to them and had the confidence to use them, then there was a huge risk to the plan succeeding.

h) The Director (Leicestershire and Lincolnshire Area) NHS England commented that recruitment issues of GPs were common across the East Midlands area, and competing for limited numbers of GPs was not necessarily the focus to solve the issues involved. Given the future aging population it was likely that the number of consultations with GPs would increase and the length of consultations would increase as the

severity of the conditions increased. The time was now right to rethink the model of primary care delivery, particularly in relation to small independent GP surgeries and to look to groups or federations of surgeries to provide the support that would be required in the future. It was suggested that the Board should re-visit this issue at a future meeting to discuss the primary care strategy that was necessary to underpin this issue.

i) It was recognised that the challenges facing the health economy required steps such as the Better Care Together initiative to be taken because maintaining the status quo was worse. Any critique of the proposals should be focussed on challenging how well the changes can be delivered and not on challenging whether the changes are required or possible.

j) There was now an opportunity to deliver things differently and better than they have been delivered before to reduce the burdens on the acute NHS services. This included more preventative measures to stop people becoming ill and to prevent existing health conditions from deteriorating.

In conclusion it was noted that comments on the proposals could be made through the Better Care Together website, through Healthwatch or direct to the Interim Programme Director.

The Interim Programme Director also undertook to discuss with Healthwatch the best way to meet the challenge of communicating the proposals and consultations with those sectors of the community that don't have access to the internet or do not speak English as a first language.

RESOLVED:-

1) The report, presentation and the proposals for developing and approving the final Better Care Together Strategy be noted.

2) That the Board receive further progress reports on the development of the Better Care Together Strategy prior to its formal approval.

3) That the City Council reconciles the differing roles of the Health and Wellbeing Board and the Health and Wellbeing Scrutiny Commission in the future consideration of the Better Care Together Strategy and its implementation.

## 9. ANNOUNCEMENTS

The Strategic Director for Adult Social Care and Health reported that the Care Act had now received Royal Assent and would be implemented from April 2015. This would introduce significant changes to the delivery of social care and would increase the costs of social care considerably. The consultation on

the draft regulations under the Act was currently being undertaken. The draft regulations were available on the Department of Health website.

## 10. QUESTIONS FROM MEMBERS OF THE PUBLIC

The Divisional Director of Public Health undertook to respond to a question from a member of the public on the number of people from Hindu, Sikh and Muslim communities that were suffering from mental health conditions.

## 11. DATES OF FUTURE MEETINGS

NOTED:

that future meetings of the Board will be held on the following dates:-

Thursday 9 October 2014
Thursday 11 December 2014
Thursday 5 February 2015
Thursday 26 March 2015
Thursday 25 June 2015
Thursday 3 September 2015
Thursday 29 October 2015
Thursday 10 December 2015
Thursday 4 February 2016
Thursday 7 April 2016

All meetings will start at 10.00am unless stated otherwise on the agenda for the meeting.

It was also NOTED that the next meeting of the Board on 9 October will be held in the Tea Room, 1st Floor Town Hall. Future meetings will be held in City Hall, 115 Charles Street as soon as the meeting rooms become available for public use.

## 12. CLOSE OF MEETING

The Chair declared the meeting closed at 12.15 pm.