Present:	Councillor Calum Watt *(in the Chair)*
Councillors:	Chris Burke, Debbie Armiger, James Brown, Laura Danese, Bill Mara, Rachel Storer, Dylan Stothard, Emily Wood and Natasha Chapman
Also in Attendance:	Dr Lucy Gavens, Consultant in Public Health, Lincolnshire County Council
Apologies for Absence:	Krishna Vyas, Health Inequalities Improvement Manager - NHS Lincolnshire Integrated Care Board, Councillor Biff Bean, Councillor Aiden Wells, and Martin Walmsley (City of Lincoln Council)

85. Welcome and Apologies

Councillor Calum Watt, Chair of the Community Leadership Scrutiny Committee, opened the meeting with a warm welcome to all attendees.

Apologies for absence were received from Councillor(s) Biff Bean and Aiden Wells.

Councillor Natasha Chapman was in attendance as a substitute.

86. Confirmation of Minutes - 15 October 2024

RESOLVED that the minutes of the meeting held on 15 October 2024 be confirmed and signed by the Chair as an accurate record.

87. Declarations of Interest

No declarations of interest were received.

88. Poverty and Health Inequalities - Mental Health and Physical Health

(a) Krishna Vyas, Health Inequalities Improvement Manager - NHS Lincolnshire Integrated Care Board (Verbal Report)

Councillor Calum Watt, Chair of the Community Leadership Scrutiny Committee advised members that apologies had been received from Krishna Vyas, Health Inequalities Improvement Manager - NHS Lincolnshire Integrated Care Board.

RESOLVED that the item be deferred to a future meeting of the Community Leadership Scrutiny Committee, a date to be agreed in consultation with Emily Holmes, Assistant Director of Strategic Development and Democratic Services.

(b) Dr Lucy Gavens, Consultant in Public Health - Lincolnshire County Council

Councillor Calum Watt, Chair of the Community Leadership Scrutiny Committee, introduced the topic of discussion which was Poverty and Health Inequalities - Mental Health and Physical Health.

The Committee received a presentation from Dr Lucy Gavens, Consultant in Public Health - Lincolnshire County Council. During consideration of the presentation, the following points were noted:

- Poverty occurred when a person's resources, mainly their material resources, were not sufficient for their minimum needs to be met (including social participation)
- Material possessions and finances included:
    - income (from employment, benefits, pension, interest on savings, gifts)
    - financial assets (savings, a home)
    - material goods (washing machine, car, computer)
- An individual's resources could be affected by a lack of formal in-kind goods, commodities or services which included:
    - most health services
    - children's education
    - passported benefits (additional benefits that some groups of people were automatically entitled to as a result of receiving an initial benefit, for example income based free school meals)
- Material goods impacted feelings and affected poverty, for example a child who lacked access to a phone or tablet in order that their homework be completed
- Formal in-kind goods, such as access to health services, especially across Lincolnshire was dependent on where a person resided. For example, health care was free at the point of access, however travel to healthcare providers was not always affordable
- Informal resources played a significant role in the poverty an individual experienced, for example the ability to borrow money from family and friends or to ask for help with household repairs and childcare
- Poverty could be measured by single items such as income or through composite measures such as indices of multiple deprivation
- Other important concepts included the dynamic nature of poverty; some individuals were born into poverty, and some people fell in and out of poverty
- It may be the case that an individual lived in a household that wasn't poor but that individual may not have access to the same resources as others within the home
- Seven domains comprised the composite measure of indices of multiple deprivation which included income, employment, education, health, crime, barriers to housing and services and living environment. Across the seven domains, the entirety of England had been ranked in terms of deprivation, ranked from 1st most deprived area to 32,844th least deprived area
- There were no small areas within Lincoln that were in the most affluent 20% nationally. Lincoln had more communities scoring higher across the seven domains of composite measure of indices of multiple deprivation than the rest of England
- The Marmot Review report looked at the impact of poverty on children throughout their childhood. There was a gradient across the level of income deprivation. The more deprived an individual was, the higher the likelihood was of a disability and death to be experienced at a younger age. In the most deprived communities, 73 was the average age of death
- The Health Foundation considered the proportion of population younger than 55 years that had self-reported less than good health. People living in poverty were significantly more likely to experience poor physical and mental health

- The Office for Health Improvement and Disparities Inequalities toolkit considered the life expectancy at birth for females. Within the most deprived 10% of communities, the life expectancy at birth for females was lower
- Low birth weight (under 2,500 grams) was associated with an increased risk of infant mortality, developmental problems in childhood and poorer health in later life. Individuals were twice as likely to be born with a low birth weight from deprived areas than more affluent areas
- There was a clear gradient present for visually obvious dental decay in 5-year-olds from within the most deprived communities
- The rate of childhood obesity was significantly higher in more deprived communities. This was attributed to factors including (but not limited to) restricted access to healthy foods and activities that burnt energy and access to safe green space
- Alcohol related hospital admissions were particularly high from within the 30% most deprived communities
- The prevalence of smoking increased in individuals that worked within a routine or manual position. This was important as 2 out of 3 smokers died from a condition related to their smoking
- The employment rate was important as good quality employment was positive for health. Individuals who suffered with a long term physical or mental health condition came from a cohort whereby 12% fewer worked than those that did not have a condition. It was the case that individuals wanted work but struggled to secure employment whereby their health needs could be accommodated
- Having money enabled individuals to live within a safe, secure and well heated home and access to employment with less hazards was easier
- Behaviours were enabled or constrained by the environment that was lived within. There was evidence to suggest that unhealthy behaviours were more prevalent in more deprived communities and included less physical activity, eating more junk food etc. Both the environment and social context influenced behaviours
- Poverty and unequal social distribution contributed to psychological health problems
- Poverty could span a life course. An individual born with a low birth weight into a poor income household affected the individual over the course of their life
- Children and adults that lived in households within the lowest 20% income bracket in Great Britain were two to three times more likely to develop mental health problems than those in the highest
- Children were very perceptive about money and what they had compared to others. There was a lot of stigma and shame around poverty which impacted mental health; sometimes preventing help being accessed straight away and by the time it had reached crisis point, it was harder to recover, and mental health impacted far more
- For health to be increased across a population, it was important for the social determinants of health to be assessed, particularly in regard to:
    - Agriculture and Food Production
    - Education
    - Work Environment
    - Living and Working Conditions
    - Unemployment
    - Water and Sanitisation
    - Healthcare Services
    - Housing

- Individuals that lived within more deprived areas, minority ethnic groups and younger people were more likely to live near tobacconists, off-licences and betting shops
- Access to proactive and preventative care was key but the challenges experienced in engaging with these opportunities needed to be considered
- It was important that children were given the best start in life as damage to health accumulated across the life course

The Chair offered his thanks to Dr Lucy Gavens and welcomed comments and questions from Members of the Committee. As a result of discussions between Members, the following points were made: -

Question: Reference was made to the rate of smoking prevalence in adults. Did the data include vaping?
Response: The data did not include information on vaping or chewing tobacco. Anecdotally, the prevalence of vaping had increased, especially within younger age groups however clear data on vaping was difficult. Young people tended to opt for disposable vapes as they were more affordable and accessible which made them a difficult product to monitor. Disposable vapes often appeared to be marketed towards children.

Question: Was there any correlation with take away outlets?
Response: The density of fast-food outlets was much higher within more deprived communities.

Question: Was there any legislation for the issue to be considered alongside Planning?
Response: It was difficult as the argument was made against the economic consideration of a shop left empty. An initiative had been implemented in Sheffield whereby consideration had been given to behaviours that lead/contributed to poor health e.g. obesity, drug and alcohol use, gambling etc. A ban on advertising was brought in for gambling/vaping/alcohol or fast food on all bus stops and on any buildings that were owned by the Council. The initiative attempted to reduce the triggers that people saw throughout the day. There were actions local areas could take.

Question: Thanks were offered for a comprehensive cover of the topic. Statistics showed some individuals in Sincil Bank lived 10 years less than in other parts of the same ward. The area suffered from heavy traffic flow which caused pollution. The amount of traffic pollution had started to be reduced.
Response: Air pollution was an important factor. The rates of childhood asthma were higher within higher rates of air pollution. There were inequalities in how things were addressed. 20mph zones were more likely to be implemented in the most affluent areas around England. A reduction in the speed of driving was not only good for reduced air pollution but it was more likely that someone would not be seriously injured if they were hit by a vehicle. This was one important way that a reduction could be supported.

Question: Was the deprivation the cause of poor health or was it the other way around? Was it correlation or causation?
Response: Some causes were bidirectional however when considered across all areas, there were lots of ways that were causation. In damp cold housing, people were much more likely to have asthma and exacerbations of asthma. The relationship was bidirectional as many factors of poverty lead to poor health however

if an individual suffered poor health, it could be harder for a well-paid job to be held down which in turn, affected income. It was a knock-on effect.

Question: District Councils were responsible for parks and leisure centres etc. Was there anything district councils could do to help?
Response: Green space was good for health for everyone. Blue space was important also (e.g. the sea, lakes and rivers). Consideration of possible change within Planning would be a positive step.
Supplementary Response: A lot of work had been done across all 7 districts regarding what a district's responsibility was in health inequalities. There were 5 areas:

- Housing and Homelessness
- Environment and Climate
- Activity and Wellbeing
- Community Engagement
- Physical Activity

Comment: The use of language was an important consideration. Many Councils had a 'crisis fund' scheme but named differently. Some individuals would not consider their predicament a 'crisis'.
Response: Language was very important, and one approach did not fit all. Consideration was needed of the social marketing approach.

Comment: Planning was rarely used as a campaign and would benefit from a reactive approach. Discussions with Planning and the Central Lincolnshire Strategic Partnership would be beneficial.

Comment: Consideration of the language used was noted during the consultation for Vision 2030. It was important that the language used did not become a barrier.

Question: Thanks were offered for the presentation. Lincoln suffered with a high suicide rate. Was there any data that linked poverty and suicide, especially the coastal areas of the county?
Response: Lincoln had one of the highest rates of suicide across the county; Lincoln City was the second highest in the country. Unemployment was a risk factor. In Lincolnshire, there were between 90 and 100 suicides in a year. Qualitative deep dives into coroners' records took place. It was known that addiction, particularly alcohol was a theme, and it was thought that gambling was probably an issue. Consideration had been given to routine and manual occupations such as the construction industry. The two most common themes that arose were shame and a feeling of being trapped; two themes that arose from poverty and therefore, arguably they were inextricable linked. Rates of suicide for those that had been in contact with drug and alcohol services were ten times higher.
Supplementary Question: Were the themes consistent across the county or were there pockets?
Supplementary Response: Lincoln's rate of suicide had stayed the highest although the reason remained unknown. Reviews took place regularly to ensure that opportunities to support individuals had not been missed. A great deal of work around suicide prevention had taken place across the county.

Question: Thanks were offered for the presentation. Some cities had a great number of gambling and betting shops in the most deprived areas which was terrible. How could the intergenerational problems be stopped? Children could be educated in schools, but they were not in control of their own health and care.

Response: Evidence demonstrated that the aspirations of children were inspired by what they saw around them. It was important to work with families as well as individuals. Children Centres and Family Hubs were important places for people to go to be supported. It was important hubs weren't focussed solely on the home learning environment and what was important to children at that point in their development, but offered support such as citizens advice.

Question: As well as looking at household income, it was important for individual access to income to be considered. The trauma from witnessing domestic violence was significant. Children who had witnessed abuse in the home suffered increased chances of mental health issues and addiction. Was there a way of measuring the effects?
Response: The measure of 'Adverse Childhood Experiences' included the witnessing of domestic violence as well as a parent with a dependency issue. Two or more adverse childhood experiences were more likely to be present within services. A large body of evidence looked at the effects, particularly across mental health conditions but there was an impact on physical health conditions also.

Question: Did the County receive support from Government with suicide?
Response: Support received from Government was limited however Lincoln benefitted from a multi-agency partnership. Discussions had taken place with the team that developed the national suicide prevention strategy in order that best practice be learnt from other areas. Support was not received in monetary form however experiences were drawn from. Funds derived from NHS Lincolnshire Integrated Care Board and Lincolnshire County Council.

Question: Was there any correlation with childhood pregnancy?
Response: Teenage pregnancy was very low as females having children under the age of 18 was much less common now than in the past. The rate of teenage pregnancy was slightly higher in deprived communities, but the focus was on ensuring that women received the best care when they discovered their pregnancy.

Question: Was there any data to suggest why childhood obesity had increased?
Response: Unfortunately, childhood obesity was a challenge in society and culture. 2 out of 3 adults were overweight or obese, nationally the rate was 63% and approximately 70% in Lincoln. Access to good quality whole foods and knowing what to do with them fed into the issue. If a parent was only just able to afford to feed their children, they were more likely to buy food they knew their children would eat. There were also challenges around physical activity. The challenge of childhood obesity stemmed back to intergenerational issues; it was difficult for one person in a family to change their diet without the rest of the household doing the same. The density of fast-food outlets was very important. Lincolnshire County Council worked with the Food Education in Schools team to ensure that snacks and food in school were balanced and healthy and to ensure that children drank milk and water. There were lots of things that impacted how the tide on obesity could be turned.

Comment: Krishna Vyas, Health Inequalities Improvement Manager - NHS Lincolnshire Integrated Care Board would be asked to present information on weight and health inequalities at a future meeting.

Question: There had been a big drive towards preventative healthcare from National Government. Had the drive impacted on work or would it in the near future?
Response: National Government provided £2.8M a year for drug and alcohol services and this was in addition to the existing £5.5M budget. Some elements of the

drive towards preventative healthcare were a continuation of work and support already in place however information regarding future changes was awaited.

RESOLVED that:

1. The Democratic Services Officer be tasked with the initiation of discussions with Planning department colleagues regarding the scope of an alteration to Planning Policy in order that health inequalities be addressed and supported.

2. Krishna Vyas, Health Inequalities Improvement Manager - NHS Lincolnshire Integrated Care Board be invited to a future meeting of the Community Leadership Scrutiny Committee; such date to be agreed in consultation with the Chair and Officers.

3. The content of the presentation and discussions be noted with thanks.

(c) <u>Martin Walmsley, Assistant Director, Shared Revenues and Benefits - City of Lincoln Council</u>

Martin Walmsley, Assistant Director - Shared Revenues & Benefits had given his apologies for being unable to attend tonight's meeting. He provided a written report on financial inclusion and mental health which was presented by Emily Holmes, Assistant Director, Transformation and Strategic Development.

Emily Holmes, Assistant Director, Transformation and Strategic Development:

a) presented a report to Members regarding the links between financial inclusion and mental health

b) confirmed that the update provided information regarding the Lincolnshire Financial Inclusion Partnership and explained how financial inclusion activity was co-ordinated in the county

c) added that Lincolnshire Financial Inclusion Partnership (LFIP) had been in existence for more than ten years, with membership growing exponentially in the last two years. City of Lincoln Council and North Kesteven District Council's Assistant Director Shared Revenues and Benefits was currently the chair of LFIP

d) highlighted that LFIP brought together organisations and partners to promote and raise the profile of financial inclusion and aimed to ensure that everyone had the capability and opportunity to access appropriate financial services and products needed to participate fully in society

e) explained that LFIP activity was focussed through a steering group, which comprised of colleagues from; Lincolnshire local authorities, Alford Hub, Citizens Advice Lincoln & Lindsey, Department for Work & Pensions, GamCare, KTR Consultancy Services, LAT Charity, Lincolnshire Community Foundation, Money & Pensions Service, and Notts and Lincs Credit Union

f) added that LFIP activity could be followed through a range of social media including LinkedIn, TikTok, Instagram and Facebook

g) stated that mental health and money problems were inextricably linked. One problem could feed off of the other whereby a vicious cycle of growing financial problems and worsening mental health that could be hard for people to escape was created

h) highlighted that the annual medium income for people with common mental health conditions was estimated to be £8,400 less than that for the wider population

i) confirmed that it was key that those suffering money problems sought help from a wide range of organisations that provided assistance, support and advice. A section on 'Financial advice and support' was included on City of Lincoln Council's (CoLC) website through the Cost-of-Living Support 'button' which appeared on the home page. This information was also available in the Council's Cost of Living Support leaflet, which was available in hard copy also

j) concluded that the area was complex, however through a co-ordinated programme of activity, LFIP and its' members aimed to tackle and reduce the links between money and mental health

k) welcomed comments and questions from Members of the Committee.

Members discussed the content of the report in further detail. The following questions and comments emerged:

Comment from Councillor Debbie Armiger: Thanks were offered to Martin Walmsley for his kindness and help which had been commented on by residents further to a referral made for support.

Comment: Some residents that were referred for support were very low and struggled with mental health. Individuals were always treated very well and respectfully by the Council and their issues were often resolved as much as could be.

Comment: A discussion point that arose from the Poverty Truth Commission was that people could feel intimidated visiting City Hall to ask for help or did not know how to access help. It may be easier to go out to individuals.

RESOLVED that the content of the report be noted with thanks.

89. Work Programme 2024/25

Consideration was given to the Committee's Work Programme. Further to scoping discussions, the Assistant Director - Strategic Development, confirmed that the focus of the Committee's upcoming work would include further attendance in relation to Anti-Poverty Strategy Development.

It was agreed that an invitation be offered to Charlotte Brooks - Local Motion, to attend Committee in March to update Members on the Lincoln Against Poverty Assembly.

It was agreed that an invitation be offered to Karen Harvey, MBE - Founder of Toiletries Amnesty, to attend Committee to present to Members information on hygiene poverty.

The Democratic Services Officer confirmed that scoping discussions would take place further to the meeting in relation to the Anti-Poverty Strategy Proposals project. It was further agreed that the arrangement of additional attendees be delegated to officers.

RESOLVED that:

1. Charlotte Brooks - Local Motion be invited to attend the next meeting.

2. That the arrangement of further attendees be delegated to officers.

3. The content of discussions be noted with thanks.

Date of Next Meeting: Tuesday 11 March 2025 (18:00)