Leicester
City Council

JOINT MEETING OF THE HEALTH & WELLBEING AND THE ADULT SOCIAL CARE SCRUTINY COMMISSIONS

DATE: **THURSDAY, 6 OCTOBER 2022**

TIME: **5:30 pm**

PLACE: **Meeting Rooms G.01 and G.02, Ground Floor, City Hall, 115 Charles Street, Leicester, LE1 1FZ**

Members of the Commissions

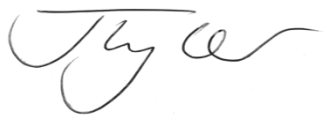
Councillors Aldred, Batool, Joshi, Kaur Saini, Khan, March, O'Donnell, Pantling, Patel, Sangster, Singh Johal and Westley

1 unallocated Labour group place
1 unallocated non-group place

Standing Invitees (Non-voting)

Representative of Healthwatch Leicester

Members of the Health & Wellbeing and Adult Social Care Scrutiny Commissions are invited to attend the above meeting to consider the items of business listed overleaf.



For Monitoring Officer

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

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  - ✓ to ensure that the sound on any device is fully muted and intrusive lighting avoided where filming, to only focus on those people actively participating in the meeting
  - ✓ where filming, to (via the Chair of the meeting) ensure that those present are aware that they may be filmed and respect any requests to not be filmed.

Further information

If you have any queries about any of the above or the business to be discussed, please contact:
Jason Tyler (Democratic Support Officer):
Tel: 0116 454 6359
E-mail: Jason.Tyler@leicester.gov.uk

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PUBLIC SESSION

AGENDA

FIRE / EMERGENCY EVACUATION

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1. APPOINTMENT OF CHAIR

2. WELCOME AND INTRODUCTIONS

3. APOLOGIES FOR ABSENCE

4. DECLARATIONS OF INTEREST

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

5. UPDATE ON THE INTEGRATED CARE SYSTEM **Appendix A**

The Chief Strategy Officer of the Leicester, Leicestershire and Rutland Integrated Care Board submits a report, which provides an update on the Integrated Care System and the latest developments around the ICS as an organisation, including updated structures regarding the ICB and ICP.

6. AUTUMN/WINTER VACCINATION UPDATE **Appendix B**

Officers from the Integrated Care System will give a presentation as an update on the Autumn/Winter Vaccination programme. There will also be input from Adult Social Care and Commissioning Officers.

The presentation slides are attached.

7. WINTER PLANNING **Appendix C**

The Chief Operating Officer of the NHS Leicester, Leicestershire and Rutland submits a report, which provides information on the winter planning programme. There will also be input from Public Health Officers.

8. SAFEGUARDING ADULTS - ANNUAL REPORT **Appendix D**

The Leicester Safeguarding Adults Board Annual Report is submitted for consideration and comment.

Fran Pearson, the former Independent Chair, will join the meeting using the Zoom link.

9. RESULTS OF 'HOW ARE YOU, LEICESTER? **Appendix E**

The Director of Health submits a report, which provides an update on the 'How are You Leicester?' initiative.

A presentation will be given at the meeting to support the information in the report.

10. COST OF LIVING IMPACT

The Director of Health will give an update and overview of the cost of living crisis in terms of impacts on Health and Wellbeing and Adult Social Care.

11. ANY OTHER URGENT BUSINESS

Appendix A

Update on the Integrated Care Structure

For consideration by:

Joint Health and Wellbeing and Adult Social Care Scrutiny Commissions

Date:

6 October 2022

LEICESTER, LEICESTERSHIRE AND RUTLAND JOINT HEALTH AND ADULT SOCIAL CARE SCRUTINY COMMITTEE

6th October 2022

1. PURPOSE OF THE REPORT

1.1 This report provides the members of the Leicester, Leicestershire and Rutland Joint Health and Adult Social Care Scrutiny Committee with an update on the Leicester, Leicestershire and Rutland Integrated Care System.

2. BACKGROUND AND MAIN CONSIDERATIONS

2.1 The Leicester, Leicestershire and Rutland Integrated Care System comprises of the LLR Health and Care Partnership and the LLR Integrated Care Board. Both came into legal existence on 1st July 2022. At the same time the three previous Clinical Commissioning Groups in LLR were disestablished.

2.2 The Health and Care Partnership is formed between all of upper tier local authorities in LLR and the LLR Integrated Care Board to improve care, health and wellbeing of the population.

2.3 The Integrated Care Board is a statutory NHS organisation responsible for developing a plan for meeting the health needs of the population, managing the NHS budget and arranging for the provision of health services in the area.

3. Update on Health and Wellbeing Partnership

3.1 In June 2022 a joint meeting between the shadow LLR Integrated Care Board and the three Health and Wellbeing Boards in LLR came together to discuss the priorities for the Health and Wellbeing Partnership. The outcome from this meeting was the following three priorities:

- The Cost of Living Crisis
- Access to services
- Harnessing the collective public sector resources to support our population

3.2 These priorities were approved at the first meeting of the Health and Wellbeing Partnership in August 2022. The partnership is due to discuss the first of these topics in more detail at a workshop event in October 2022.

3.3 The Health and Wellbeing Partnership has agreed to meet on a quarterly basis with a membership made up of Health and Wellbeing Board representation; Integrated Care Board representation and HealthWatch, see Appendix A.

3.4 In addition, each quarter a wider working group will come together to discuss the priorities set out in 3.1 together with contributing to the wider work of the partnership. This wider group is made up of members of the three Leicester, Leicestershire and Rutland Health and Wellbeing Boards and the Integrated Care Board.

3.5 A requirement of the Health and Wellbeing Partnership is to produce an Integrated Care Strategy for their system. This strategy needs to be in initial draft form and published in December 2022, this is to enable it to inform the strategic direction of the Integrated Care Board as they plan for 2023/24 and beyond. Guidance on the development of this strategy can be found at **https://www.gov.uk/government/publications/guidance-on-the-preparation-of-integrated-care-strategies/guidance-on-the-preparation-of-integrated-care-strategies**

3.6 All three local Health and Wellbeing Boards have revised their Health and Wellbeing Strategies and this gives us a really good starting point from which to develop an integrated care strategy. Work is ongoing to develop the strategy and will be considered at a working group meeting in October 2022 and approved by the Partnership in December 2022.

3.7 Given this is an initial draft there will be further work to complete in 2023 to produce a final strategy.

4. Integrated Care Board

4.1 The LLR Integrated Care Board was established on 1st July 2022. At it's first meeting the Board signed off a range of governance arrangements and policies to support it in delivering its functions. A copy of the governance structure is attached as Appendix B.

4.2 Further meetings took place in July and August 2022 which discussed a range of topics including our plans for emergency and urgent care services through Winter; primary care and elective care. In addition, assurance reports were received from the ICB's sub committees on finance, performance and quality. Details of the papers can be found at **https://leicesterleicestershireandrutland.icb.nhs.uk/about/board-meetings/**

4.3 The Integrated Care Board is required to develop a 5 year plan which takes account of the Health and Care Partnerships Integrated Care Strategy. This strategy needs to be published for March 2023. Early work has commenced on the development of the strategy with work ongoing during Quarter 3 and Quarter 4.

4.4 The LLR ICB held a public question and answer session in September 2022 which gave an opportunity for members of the public to have a conversation with the leadership of the local ICB about various aspects with a particular focus on primary care services. The event was attended by circa 40 members of the public together with a similar number online. There are plans to do this on quarterly basis based around different topics. This work is in addition to the ICB normal communication and engagement activity and will provide a valuable opportunity for ongoing dialogue.

4.5 The focus for the LLR Integrated Care Board over the next few months is to manage the winter period with a view of improving access; reducing waits; and improving discharge. In addition, the Board is working to ensure delivery of the yearly operational plan as we move into the final half of 2022/23 and start the preparation of the 5 Year plan and the 2023/24 Operational Plan.

4.6 Transformation continues across the system and some examples of the work being done can be found in the quarterly Health and Care Together Newsletter that can be found at https://leicesterleicestershireandrutland.icb.nhs.uk/wp-content/uploads/2022/09/LLR-HealthCare-E-Zine-Autumn.pdf

4.7 Topics covered in the Autumn Newsletter issue include the implementation of Virtual Wards; launch of Crisis Cafes; Tackling Cancer Inequality; Supporting Young Victims of Violent Crime; AI and Skin Cancer Diagnosis; and a grant scheme to support a wide range of improvements.

APPENDICES

Appendix A – Membership of Leicester, Leicestershire and Rutland Health and Wellbeing Partnership

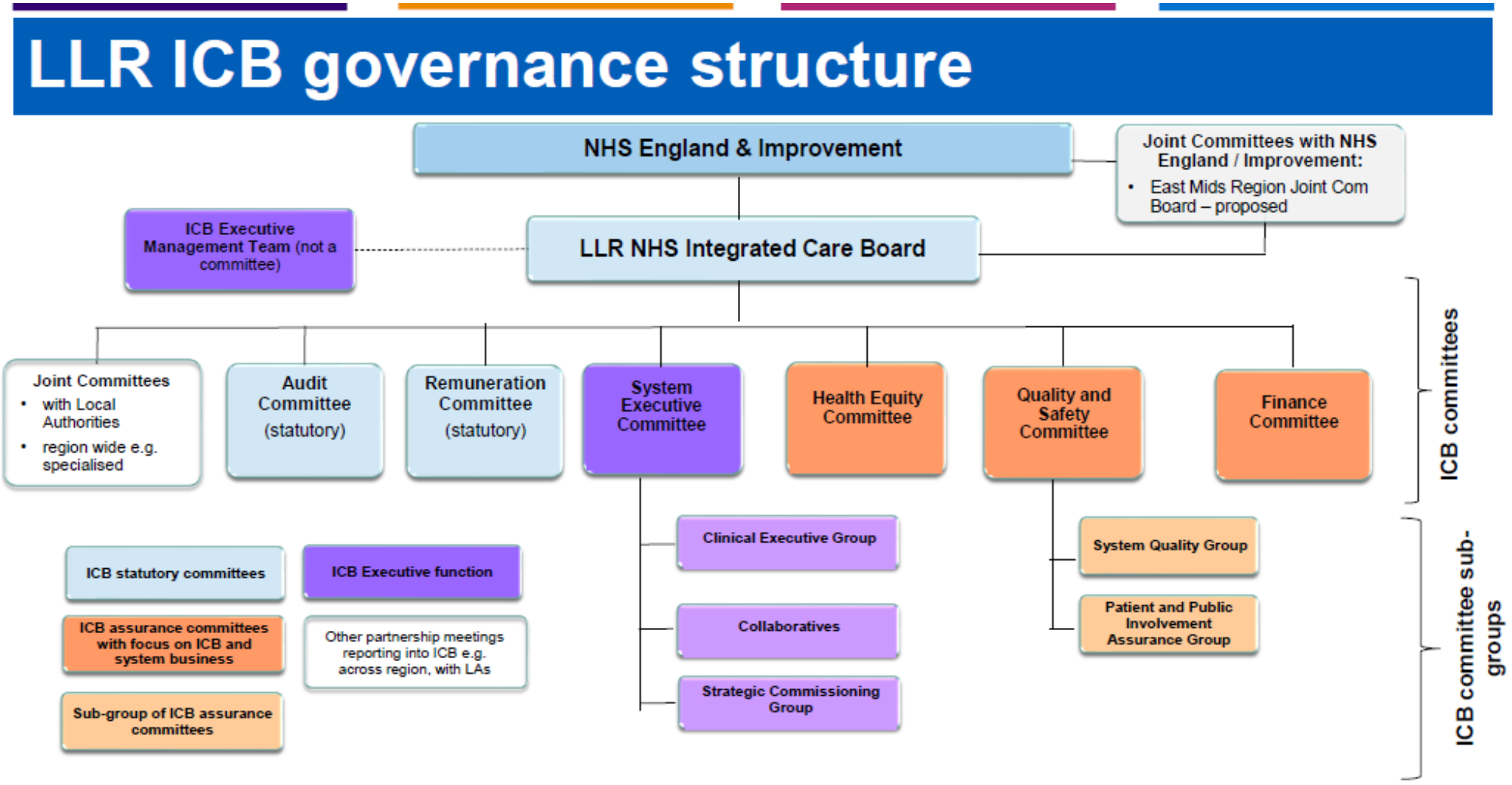
Appendix B - Leicester, Leicestershire and Rutland Integrated Care Board Governance

Report By: Sarah Prema, Chief Strategy Officer, Leicester, Leicestershire and Rutland Integrated Care Board

APPENDIX A: MEMBERSHIP OF THE LEICESTER, LEICESTERSHIRE AND RUTLAND HEALTH AND WELLBEING PARTNERSHIP

Member
Chair Leicester City Health and Wellbeing Board
Chair Leicestershire County Council Health and Wellbeing Board
Chair Rutland County Council Health and Wellbeing Board
Chair Leicester, Leicestershire and Rutland Integrated Care Board
Director Public Health Leicestershire County and Rutland
Director Public Health Leicester City
Strategic Director for Social Care and Education Leicester City Council
Director of Adults and Communities Leicestershire County Council
Director of Children and Family Services Leicestershire County Council
Director of Adult Services Rutland County Council
Director of Children's Services Rutland County Council
Chief Executive LLR Integrated Care Board
Chief Executive University Hospitals of Leicester
Chief Executive Leicestershire Partnership Trust
Chief Strategy Officer LLR Integrated Care Board
Chief Operating Officer LLR Integrated Care Board
Leicester and Leicestershire Healthwatch
Rutland Healthwatch

APPENDIX B: LEICESTER, LEICESTERSHIRE AND RUTLAND INTEGRATED CARE BOARD GOVERNANCE



NHS
Leicester, Leicestershire and Rutland

Joint Health & Adult Social Care Scrutiny Committee

Autumn Vaccination Programme Update

1. COVID-19 vaccination programme:

- Vaccination eligibility
- System capacity plan
- Vaccination uptake

2. Flu vaccination eligibility

Appendix B

6 October 2022

A proud partner in the:
Leicester, Leicestershire and Rutland
Health and Wellbeing Partnership

Phase 5: Autumn 2022 COVID-19 Vaccination Programme

Eligibility:

- residents in a care home for older adults & staff working in care homes for older adults
- frontline health & social care workers
- all adults aged 50 years & over
- persons aged 5 to 49 years in a clinical risk group
- persons aged 5 to 49 years who are household contacts of people with immunosuppression
- persons aged 16 to 49 years who are carers.

Roll out:

12 Sept: Autumn COVID-19 vaccination campaign formally launched

5 Sept: Care homes & housebound vaccination commenced

19 Sept: All sites actively vaccinating.

Capacity modelling & delivery model

Delivery model includes:

- **All PCNs** opted in & includes delivery from GP practices within the primary care network (PCN), not just the “designated” site.
- Delivery from the **community pharmacies (CP),** that form part of the programme
- All 5 **hospital hubs.**

Total number of designated sites is 57, plus:

- Continued delivery of clinics at the **drive-through** *(3 days per week Sept-Dec & 2 days per week Jan-Mar)* & **Highcross** *(2 days per week Sept-Dec & 1 day per week Jan-Mar)* to support ease of access
- **2 Hyper local vehicle mobile units:** one delivering in the City & one in the County (3 days per week Sept-Dec & 2 days per week Jan-Mar)
- Ability to mobilise a surge within 2 weeks, should this be required
- Co-administration with flu, where possible.

Capacity by PCN footprint

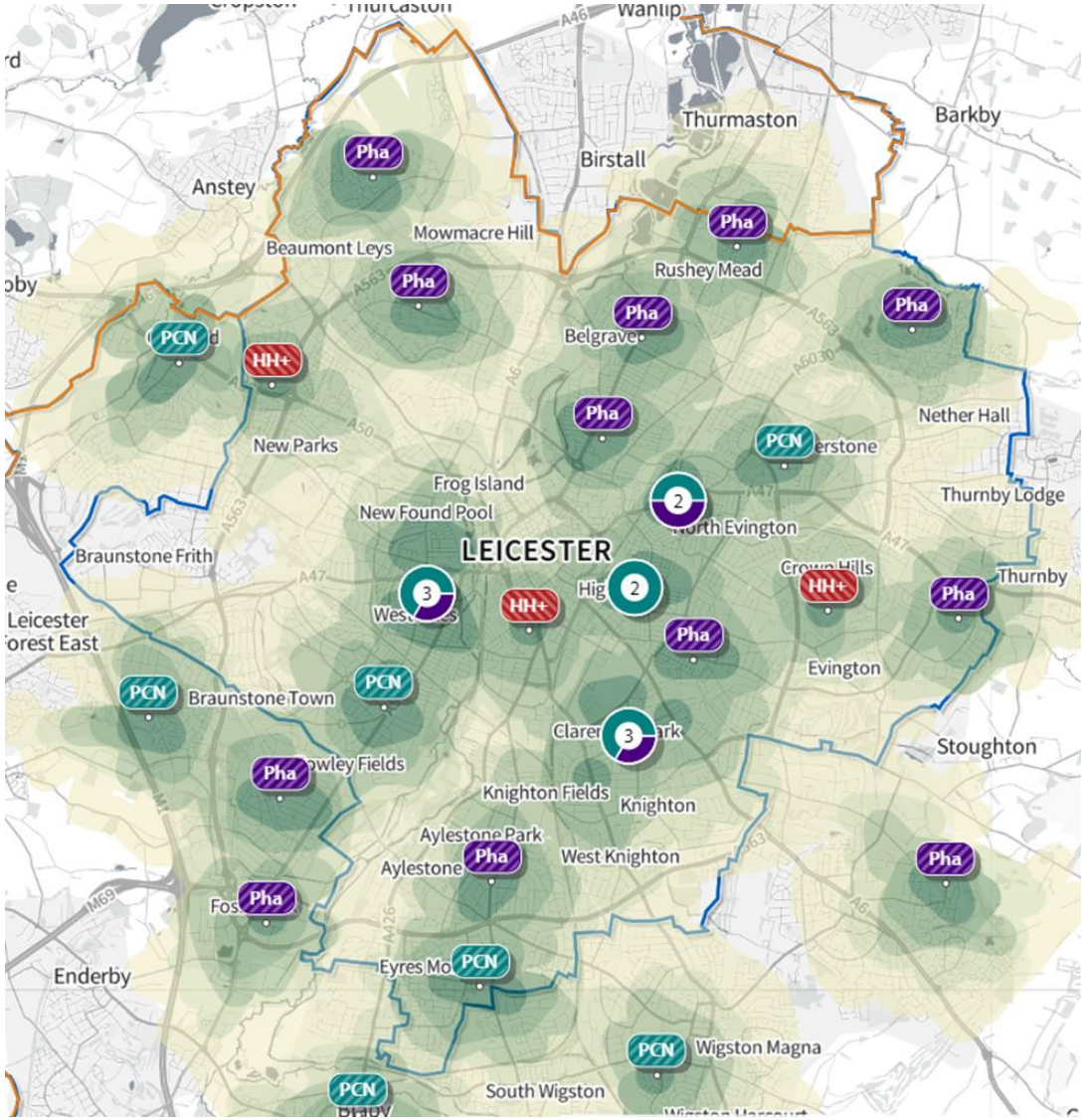
With the increase in PCN activity & spread through practice based delivery, there is sufficient capacity across the system to deliver the required demand per week, including a review of capacity within individual areas to meet this need.

Area	C1-9 demand - 74%	Highest Weekly required capacity	Weekly PCN, CP, HH site capcity	Excess Capacity
Charnwood	62,562	5,318	6,000	682
City	141,665	12,042	22,910	10,868
Cross Counties	16,805	1,428	1,430	2
Hinckley	47,574	4,044	4,400	356
Market Harborough	16,567	1,408	1,700	292
MSV	28,366	2,411	3,170	759
North Blaby	17,881	1,520	5,410	3,890
NWL	44,831	3,811	3,860	49
O&W	18,402	1,564	1,600	36
Rutland	17,905	1,522	1,550	28
SB&L	19,478	1,656	3,400	1,744
(blank)	639	54	720	666
Grand Total	**432,677**	**36,778**	**56,150**	**19,372**

City coverage: 30 min walk from site

- Based on walking time of up to 30 minutes, Leicester City is covered with the exception of the area near Braunstone Frith.
- Based on the coverage by car this area is covered.
- In addition, there are mobile vaccination clinics held each week in areas of low uptake to cover the gaps.

NB This does not include the spread of vaccination clinics due to PCN delivery clinics from the wider GP practice group.



Performance

National Covid Vaccination data is no longer available in the same format as previously reported. The only national data now publicly available is to show the number and percentage of how recently individuals aged 50 or above have been vaccinated either through the primary vaccination campaign or a subsequent booster campaign. The report focuses on the over 50's as this reflects the age groups eligible for an autumn booster.

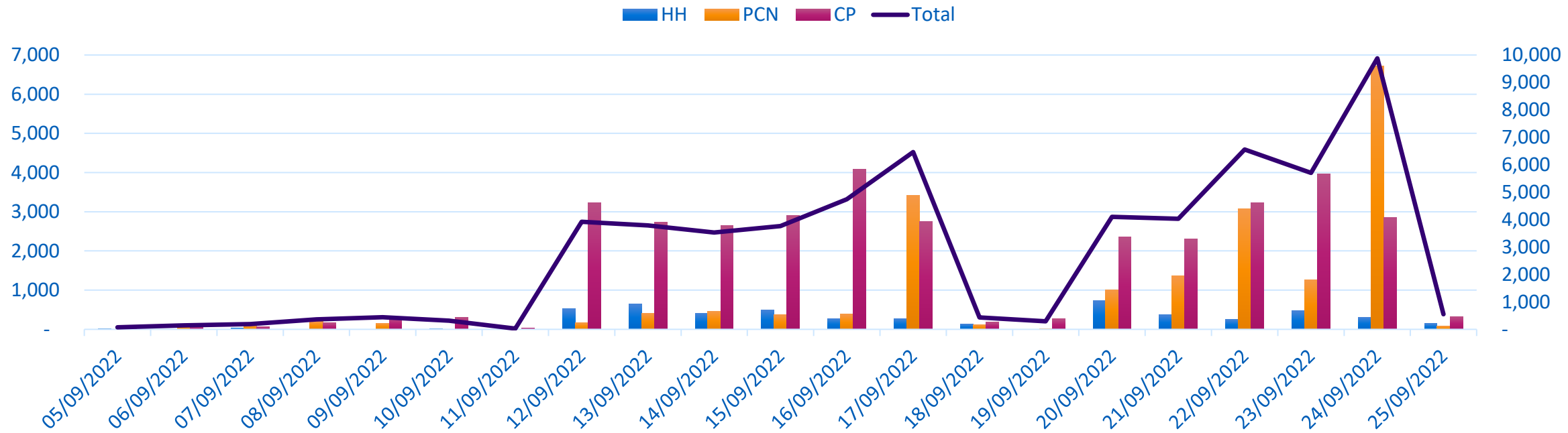
	% of people aged 50+[3] vaccinated with any dose			
ICB of Residence	0 to 6 months ago	In the last 3 months[4]	3 to 6 months ago[4]	Over 6 months ago[4]
England	21.0%	7.4%	13.5%	70.3%
NHS Leicester, Leicestershire and Rutland Integrated Care Board	20.8%	7.5%	13.3%	72.9%

LLR Covid Vaccination Uptake - 5/9 to 25/9 - **59,286**

W/C	05/09/2022	12/09/2022	19/09/2022
HH	48	2,758	2,276
PCN	525	5,338	13,541
CP	970	18,536	15,294
Total	**1,543**	**26,632**	**31,111**

	City	County
HH	496	4,586
PCN	4,335	15,069
CP	10,328	24,472
Total	**15,159**	**44,127**

LLR Daily Covid Vaccination Uptake



Flu Vaccination Programme

Eligibility:

- aged 2 & 3 years on 31 August 2022
- school aged children (all primary school aged children (reception to year 6) & eligible secondary school aged children)
- those aged 6 months to under 50 years in clinical risk groups
- pregnant women
- 50 to 64 year olds
- all those aged 65 years & over
- those in long-stay residential care homes
- carers / in receipt of carer's allowance / or main carer of an older or disabled person
- close contacts of immunocompromised individuals
- frontline health & social care staff

Roll out:

1 Sept: Flu programme began with sites vaccinating when locally procured vaccine allows.

Appendix C

Winter Planning

For consideration by:

Joint Health and Wellbeing and Adult Social Care Scrutiny Commissions

Date:

6 October 2022

NHS
Leicester, Leicestershire and Rutland

Planning for a resilient winter across the LLR health and care system

October 2022

Rachna Vyas, Chief Operating Officer, NHS LLR Integrated Care Board

On behalf of the LLR health and care Winter Board

NHS Leicester, Leicestershire and Rutland is the operating name of Leicester, Leicestershire and Rutland Integrated Care Board

A proud partner in the:
Leicester, Leicestershire and Rutland
Health and Wellbeing Partnership

Leicester, Leicestershire and Rutland

WINTER PLAN

Current context

The LLR health and care system continues to work collaboratively in order to meet the performance and quality challenges across the urgent and emergency care pathway. Whilst the system remains off-track against the challenge set to reduce ambulance handovers to less than 30 mins in September, continued successes have been noted in the impact of priority schemes across various points of the UEC pathway, particularly those focussed on demand management:

Intervention	Baseline	Actual
Number of ambulances waiting over 30 mins	2629 (April 22)	2070 (August 22)
Increase the number of F2F appts in primary care	65% (April 22)	73% (August 22)
Increase the numbers of patients diverted from the EMAS/DHU stack to a safe alternative	6-8 per day (April 22)	40-50 per day (August 22)
Reduce the number of Non-elective admissions to UHL back to 19/20 levels	8950 admissions (April 19/20)	6920 admissions (April 22/23)
Increase 2-hour urgent crisis response time compliance	69.3% (21/22)	92.4% (YTD 22/23)

Performance against discharge metrics remains variable; discharge before noon and 5pm, numbers of medically optimised for discharge patients, efficient discharge to pathway 1 and 2 services, and numbers of failed discharges remain off plan.

Winter planning

Winter planning is well underway, building on the successes and learning from both previous winters and the recent surge in activity as a result of the summer heatwave season.

Our approach to winter planning this year has been data driven, using both historic and more recent trends to understand and model predicted demand through winter 22/23. Whilst this happens annually at UHL, this year we have taken the opportunity to demand model both LPT and social care so as to understand any clear capacity gaps and therefore align actions to mitigate against these.

Building the plan across the LLR health and care system:

1. Build detailed whole-system demand model needed for ‘safe winter’, modelled on southern hemisphere flu experience and pre-COVID / summer ‘22 demand

This has been modelled in a similar manner to the SAGE approach taken through COVID. System alert levels 0-4 have been built, with assumptions made on a range of occupancy levels, predicted demand, delivery of mitigations etc. Each scenario has then been tested at organisation level and at system levels, showing a fuller picture of where resulting gaps may be.

2. Build detailed whole-system capacity model of current capacity across health and care and add where this capacity *should be* if flow were optimal

Again, built using local data, this model shows us the capacity required in each part of the system to meet the predicted demand – if every patient was in the right place, at the right time, what would capacity look like as a system? This has been added this year to ensure a collective understanding of impact on the quality of care the system could provide if we could deliver the changes needed in each part of the system.

3. Cross reference gaps with recommendations from other reports such as the 100-day discharge challenge / CQC and agree priority evidence-based interventions, mitigating gaps using monies allocated to system, whilst meeting the eight requirements set out in the NHS winter letter

Alongside this work, each ICB received a letter on August 12th *(Appendix A: Next steps in increasing capacity and operational resilience in urgent and emergency care ahead of winter)* outlining eight actions for each system and six key metrics for measurement. The System Flow Partnership has recently received the CQC, Sturgess and Missed Opportunities' reviews and has been systematically working through delivery of each action; given this, our plans have considered most of the eight actions in the winter letter already. However, where there is scope to, each plan has been adjusted and **prioritised** in order to meet the requirement and address the gaps in capacity against the demand model.

4. Agree triggers / actions for 'critical' scenarios such as elective take down and actions to spread risk across the system

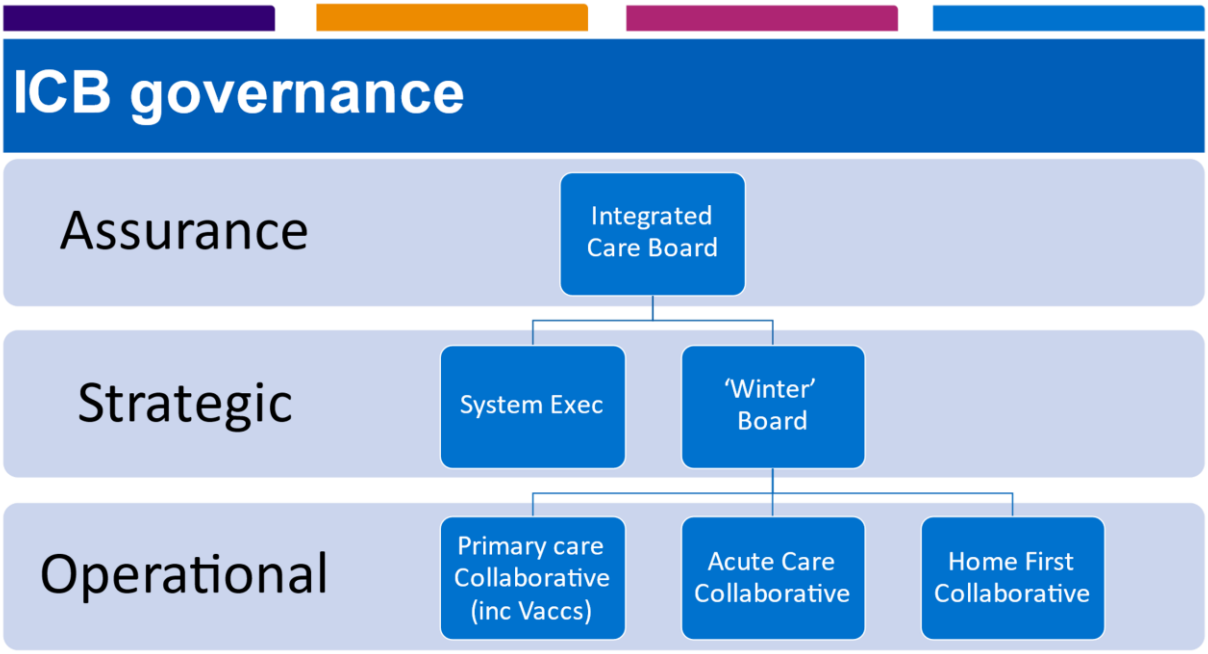
The Clinical Executive led a System risk summit on September 13th with the aim of ensuring the clinical leadership across the system were both clear on and have support to deliver the actions outlined in order to reduce the risk within the system. The Clinical Executive agreed that the actions in play are the correct actions and identified further support that the clinical community would welcome to deliver fully – actions such as patient, resident and staff communications for example.

Each of these four sections comprises the winter plan. The full plan is being finalised and will summarised on slides at the Scrutiny session, with officers present to answer specific questions.

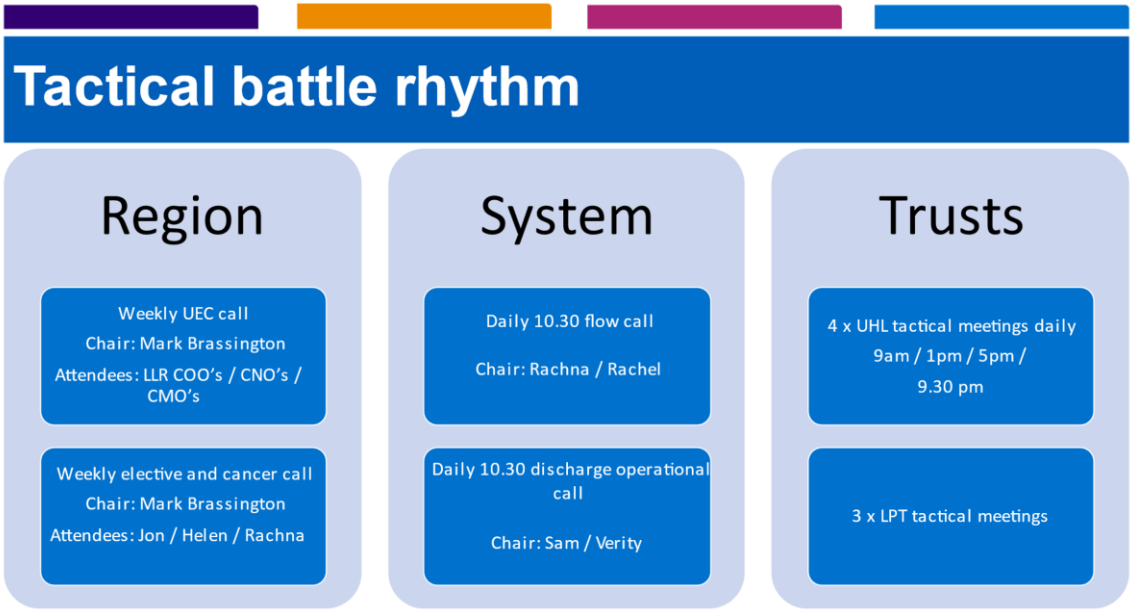
Governance

As part of the winter response, Chief Executive ownership has passed from Andy Williams to Richard Mitchell, with no change to the delivery team at system and organisational level. Rachna Vyas continues as System lead for winter with Jon Melbourne and Sam Leak as provider leads and named colleagues from each Local Authority and other provider partners included.

However, learning from last winter suggests a more agile approach is needed to governance this year, both to assure the ICB and to provide regular and accurate reporting to regional and national bodies. Therefore the System Flow Partnership will be replaced by a 'winter board' and will meet weekly on a face-to-face basis.



The ICB will gain assurance via this group. Supporting tactical arrangements are also in place, daily and weekly:



Whilst it remains clear that this winter will be difficult, mitigating actions will be put into place for the eventualities modelled. The impact of the cost-of-living crisis and fuel / food poverty are largely unknown as yet - where possible using data from public health these have been modelled in but the full scale of impact is difficult to model accurately.

The agility and ability to react therefore, at every level of the ICS, will be significant and the system will be reliant on partnership working at a scale seen only through the pandemic.

Appendix D

LEICESTER SAFEGUARDING ADULTS BOARD

Leicester Safeguarding Adults Board

WORKING IN PARTNERSHIP TO KEEP ADULTS SAFE

ANNUAL REPORT

2021/22

Leicester

Safeguarding Adults Board

Annual Report

2021/22

Report prepared and published in accordance with paragraph 4 of Schedule 2 of the Care Act 2014

Report Date: June 2022

An easy read version of this document is in development and will be published on the Safeguarding Adults Board page of the Leicester City Council website

Contents

Foreword

I am writing this foreword as my third and final year in the role of Independent Chair of the Leicester City and Leicestershire & Rutland SABs draws to a close.

I recently reflected on our journey over the last three years with the 'Statutory Partners' to the boards – the Police, NHS Integrated Care Board, and the Directors of the three local Adult Social Care services. We agreed that

- The two SABs work much more effectively together, whereas three years ago, their meetings and a number of their functions were separate
- The Statutory Partners, who the Care Act says are equally responsible for the SAB, work more closely together and have scheduled conversations about risks in the system, which in turn I have valued as chair because it helps set the context in which we work
- Links between the various strategic partnership boards that are required by law, are much stronger and the SAB members are clearer about what we contribute to issues that affect families and communities. The places where this linkage is strongest are in working between the adults' and children's safeguarding partnerships for LLR; and at a Police and Crime Commissioner committee called the Vulnerability Executive
- The two Safeguarding Adults Boards' approach to setting priorities based on data, is welcome. We are currently working on Hidden Harms and on Safeguarding in Care Homes.
- Shorter and more focused board meetings are allowing us to be more agile as a partnership. For example, we were the first partnership that I know of who tabled an urgent item on safeguarding risks associated with people arriving from Ukraine.
- There is an expectation that board members are open to scrutiny and are accountable. Alongside this, an inclusive culture has been developed thanks to everyone, and this culture means we shape the agenda so that all members are able to contribute
- Colleagues have worked together to create a comprehensive set of reports to the SABs on issues affecting the group of people with Learning Disabilities and Autism who have the most complex needs and are one of the groups of people we are most concerned about from a safeguarding perspective.
- One of the statutory functions of a SAB is to carry out Safeguarding Adults Reviews of people with care and support needs, when harm or neglect is suspected, and certain other criteria are met. Over the last three years we have become more effective at completing these reviews faster and writing for publication, using innovative approaches in some cases.

The report sets out the achievements of the board and of its partners. The Care Act guidance says that a Safeguarding Adults Board should be more than the sum of its parts and I think that the depth of items we have covered at the board and the actions carried out, show this in action.

I would like to thank everyone for your partnership, hard work and openness. The teams that support the board keep things working behind the scenes. Over the last year they have done a wide range of very

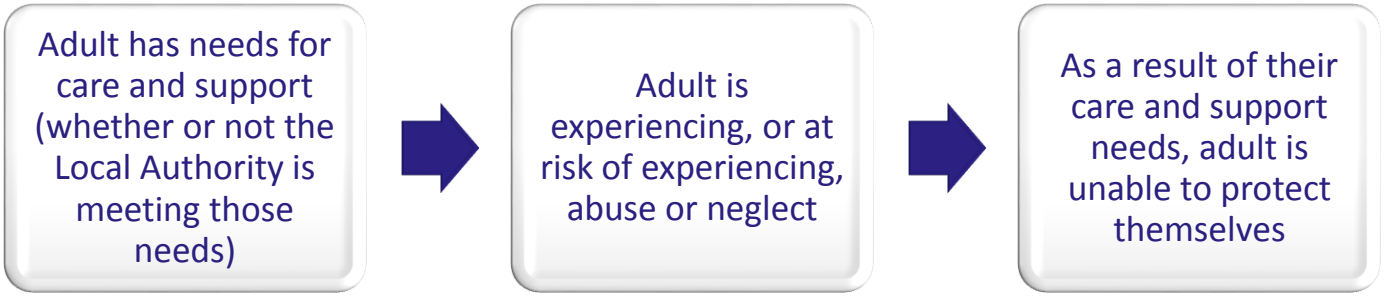
different tasks to promote learning, awareness and share their analysis of adult safeguarding data. This includes creating some really powerful adult safeguarding resources as well as overseeing review processes, including doing skilful and empathic liaison with families involved in reviews. Everyone on the board and in the various subgroups has been engaged with the board's work and I thank you all for your support and wish the very best to the next chair.

Fran Pearson

LSAB Independent Chair

The Board

The main objective of a Safeguarding Adults Board is to assure itself that local safeguarding arrangements and partners act to help and protect adults in its area who meet the following criteria:



Leicester's Safeguarding Adults Board (SAB) must seek to achieve this objective by coordinating and ensuring the effectiveness of each of its members in relation to adult safeguarding. We have a strategic role that is greater than the sum of the operational duties of our partners; we oversee and lead adult safeguarding across Leicester and are interested in a range of matters that contribute to the prevention of abuse and neglect.

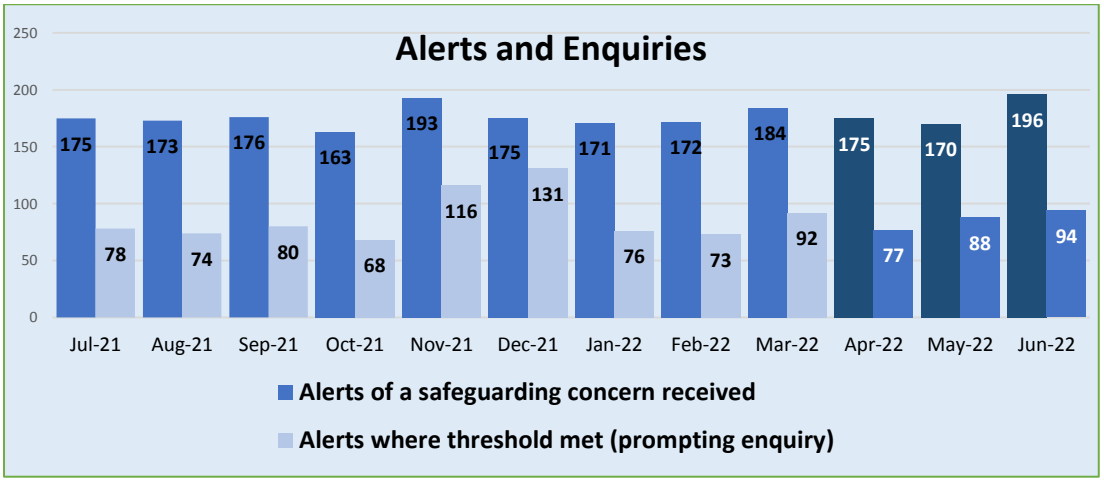
LEICESTER SAB MEMBERSHIP		
Criminal Justice	Leicestershire Police	1
	HMP Leicester	1
	National Probation Service (NPS)	1
Emergency Services	East Midlands Ambulance Service (EMAS)	1
	Leicestershire Fire and Rescue Service (LFRS)	1
Health	Leicester City Clinical Commissioning Group (CCG)	2
	Leicestershire Partnership NHS Trust (LPT)	1
	University Hospitals Leicester NHS Trust (UHL)	1
	NHS England	1
Local Authority	Adult Social Care	3
	Children's Social Care and Education	1
	Housing	1
	Community Safety	1
	Trading Standards	1
	Lead Member	1
Inspectorates	Care Quality Commission (CQC)	1
Consumer Champions	Healthwatch	1
Care Home Associations	East Midlands Care Association (EMCARE)	1

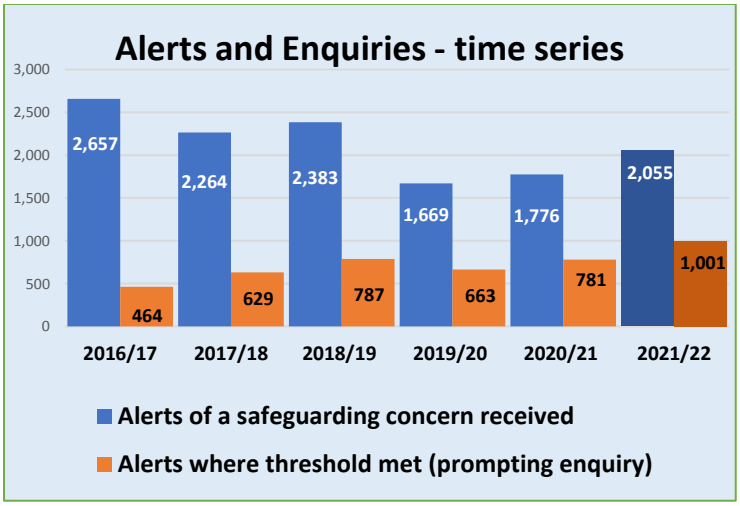
A SABs statutory partners are the Local Authority, the Police, and the Clinical Commissioning Group. As a partnership, Leicester SAB appoints an Independent Chair to oversee the work of the Board, provide leadership, offer constructive challenge, and ensure independence. To support consistency, alignment where appropriate, and a shared understanding of effectiveness across the two partnerships, our Independent Chair is shared with Leicestershire and Rutland SAB, as are a number of our subgroups (see appendix for 2021/22 structure chart). The day-to-day work of Leicester's SAB is undertaken by the subgroups. The board office supports the operational running of these arrangements on behalf of the multi-agency partnership.

Safeguarding Adults in Leicester

Information from the 2021 census notes that Leicester's population size has increased by 11.8% since 2011 to 368,600 making it the 19th largest local authority for total population in England and the most densely populated local authority in the East Midlands. 50.1% of Leicester's population is female whilst 49.4% is male. England has an aging population with more people than ever aged 65 and over recorded in the 2021 census (an increase of 20.1% since 2011). Leicester's population includes 43,500 people aged 65 or over, which is an increase since 2011 of 16.9%. Whilst awaiting the full results of the 2021 census we are reliant on information from the 2011 census for the remainder of our information. The 2011 census celebrates Leicester as one of the most ethnically diverse cities in the UK with the population being made up of people from the following ethnic groups: White (50.5%), Asian, Asian British (37%), Black/African/Caribbean/Black British (6%), Mixed/Multiple Ethnic Groups (3.5%), Other Ethnic Groups (3%). The population of Leicester is made up of 49.4% males and 50.6% females.

Safeguarding data for Leicester, collaged by Leicester City Council, Adult Social Care on behalf of the SAB demonstrates the scale of safeguarding activity across the city:





Additional national, regional, and local safeguarding adults data can be found on the NHS Digital website Safeguarding Adults Collection (SAC). In Leicester, alerts meeting the Care Act 2014 s42 threshold have increased substantially during 2021/22, in part linked to a number of care home enquiries. Looking to

2022/23 quarterly data from across the partnership is due at the Leicester, Leicestershire and Rutland (LLR) SAB Performance Subgroup, which will allow for ongoing benchmarking and further analysis.

During 2021/22 Leicester's SAB meetings have focused on several key areas, these included:

- How the SAB supports prisons in their safeguarding and consideration of what is appropriate oversight and governance around safeguarding in prisons for the SAB
- New Information Sharing Agreement (ISA) completed and signed off by key agencies
- An update on probation reunification
- Results of our multi-agency audit on neglect and older people
- Domestic abuse research project with Durham University
- Leicestershire Partnership NHS Trust report into in-patient incidents during 2021/22
- Findings from our multi-agency audit on transitions
- Consideration of system pressures
- Results of our multi-agency audit on neglect and older people

Meeting our Strategic Priorities

As a partnership, Leicester Safeguarding Adults Board outlined its strategic priorities in its five-year strategic plan which was published in 2020. Core priorities are ensuring statutory compliance and enhancing everyday business. Developmental priorities are strengthening citizen and carer engagement, raising awareness within our diverse communities, understanding how well we work together, and prevention (helping people to stay safe, connected, and resilient to reduce the likelihood of harm, abuse or neglect).

Our annual business plan priorities for 2021-22 included a shared priority with Leicestershire and Rutland Safeguarding Adults Board and local Safeguarding Children Partnerships to understand and respond to the impact of Covid-19 on safeguarding adults and children. Other priorities shared jointly with Leicestershire and Rutland Safeguarding Adults Board were Hidden Harm and Care Homes.

Core Priority 1: Ensuring statutory compliance

Safeguarding Adults Boards have a statutory duty under S.44 of the Care Act 2014 to undertake safeguarding adults reviews (SARs) in cases which meet the criteria. The purpose of a review is to identify lessons to be learnt and to apply those lessons for the future. During 2021/22 Leicester's SAB concluded two SARs (commissioned in previous years) and commissioned two new reviews which remain ongoing. The Review Subgroup was satisfied that all the referrals received were appropriate referrals. This provides a level of assurance that partners are aware of our statutory duty in relation to SARs and are making referrals in line with that duty. For the purposes of transparency, a table of 2021/22 SAR referrals, decisions, and outcomes is provided:

SAR REFERRALS AND DECISIONS 2021/22			
Referral Date	**Date Case First Heard**	**Decision Made**	**Outcome**
January 2021	February 2021	August 2021 following additional information being received. Mandatory SAR criteria not met. Decision made not to undertake a non-mandatory SAR; needs for care and support demonstrated, suspected that the death resulted from abuse or neglect but no concerns about how agencies worked together. Ongoing support and work with single provider as no multi-agency concerns identified.	No SAR
April 2021	June 2021	Decision that a discretionary SAR should be carried out. The group concluded that it was suspected that the person did have care and support needs and that there was likely to be interagency learning and an opportunity to consider a potential COVID-19 impact within the review.	Discretionary SAR under S44(4)
June 2021	July 2021	Decision that a mandatory SAR should be carried out, based on the adult's needs for care and support, suspected abuse and neglect, and concerns over how agencies worked together.	Mandatory SAR under S44(1)
February 2022	March 2022	Mandatory SAR criteria not met. Decision made not to undertake a non-mandatory SAR; needs for care and support demonstrated but no evidence that the death resulted from abuse or neglect; also no concerns about how agencies worked together.	No SAR

Details of the two SARs completed in 2021/22 are outlined below:

SAR 1: 'Robert'

This report was not published at the family's request.

Overview

Robert (pseudonym used to protect anonymity) died by suicide. There was no indication that Robert died as a direct result of abuse or neglect and no requirement to undertake a review of his death. Nonetheless, after careful consideration, the Leicester Safeguarding Adults Board (LSAB) chose to undertake a safeguarding adults review under section 44(4) of the Care Act 2014. At the request of Robert's family, the review has not been and will not be published. Here learning is outlined but case detail remains limited.

Robert was a dependent drinker with vulnerabilities relating to physical and mental health as a result of his alcohol consumption. In the months leading up to his death by suicide, there is an indication he may have begun to self-neglect. In the three months preceding his death, Robert had multiple contacts with a variety of agencies including regular 'blue light' services. For example, he attended the local emergency department, and required short inpatient admissions on five occasions. He was also a regular attendee at his GP practice; however his engagement with community alcohol services was limited. At the time of his death by suicide Robert was in breach of a Non-Molestation Order and awaiting sentence.

Findings

Unlike reviews of a similar nature nationally, this review did not find that Robert's alcohol use was considered by organisations to be a 'lifestyle choice' or that there was a lack of understanding of the Mental Capacity Act 2005 or the Care Act 2014. However, this review did find a lack of a coherent response in supporting Robert, with no one agency taking the lead in coordinating an approach.

Whilst potentially not meeting the criteria for Vulnerable Adult Risk Management (VARM), Robert was clearly at risk of self-harm and suicide and practitioners would have likely benefitted from structures and systems in place which supported effective multi-agency working with people experiencing suicidal ideation.

This review also found that when agencies were focused on Robert and his needs and vulnerabilities, they were less likely to consider him as a potential perpetrator of domestic abuse. Conversely, when the main focus of agencies was on reducing the risk Robert posed to his wife and children as a perpetrator of domestic abuse, support or rehabilitation options available for Robert were not considered. In Robert's case, coordinated support including the city perpetrator programme, substance misuse services, support to address mental and physical ill health, or to find alternative accommodation, may have in turn reduced the risk that Robert posed to his wife and children as well as to himself.

The review found that the following factors were positive in relation to effective information sharing within and between agencies:

- Co-location

- Access to the same records / recording systems
- Automatic referrals which do not rely on workers to action
- Referrals which require input from practitioners, but which are then sent and received via an automated system (i.e. 'at the push of a button')
- An understanding of each other's roles and responsibilities

Recommendations:

1: It is recommended that all case findings from this review are shared with individual organisations, to provide them with an opportunity to assure themselves that these case findings are not reflective of wider systems issues within the organisation. Any wider systems issues identified by individual agencies, to be fed back to the LSAB Review Subgroup.

2: It is recommended that all systems findings and identified potential gaps in service provision noted in this review, are shared with relevant organisations and commissioning bodies for their knowledge and consideration.

3: Local partner agencies to assure themselves that practitioners are aware of the 'trilogy of risk' as well as the need for a 'whole family' approach to safeguarding adults and children.

4: It is recommended that this review is shared with relevant local strategic bodies for awareness and information, including Leicester Health and Wellbeing Board and the LLR Suicide Audit and Prevention Group.

5: EMAS to provide an overview of the EMAS SPOC role, including contact details, to SAB members for promotion within their organisations (action completed during the review).

6: For consideration to be given locally to the development of structures and systems across LLR which facilitate the multi-agency management of individuals experiencing self-harm and/or suicidal ideation (i.e. similar to the VARM guidance but for self-harm/suicide).

Impact:

Adult Social Care's front door duty teams across Leicester, Leicestershire and Rutland now have an email address to enable them to request additional information in regard to East Midlands Ambulance Service (EMAS) referrals. Where there are queries which are not urgent, or if a member of the duty team needs to speak to someone directly, they are able to contact the EMAS regional safeguarding lead. Feedback from duty teams is that this has been positive. Adult Social Care also now have quarterly meetings with EMAS safeguarding adults lead to discuss themes, any concerns around referrals, service development, and training plans. These meetings have been very positive.

SAR 2: 'Mrs Moyo'

This report has been published on our web pages alongside previous reviews.

Overview:

Mrs Moyo (a pseudonym) is a black woman of African heritage. She was in her sixties at the time of the incident and lived in a council property with her son Joseph who is a black man of African heritage and Muslim religion. Both are English speakers, with no communication or language adjustments required.

Mrs Moyo was supported through Adult Social Care due to her physical health needs. She was provided with domiciliary calls twice daily. Mrs Moyo has another son, Aaron and she also received support from him and his wife, Jasmin.

Mrs Moyo's son Joseph had a history of psychotic episodes that was induced by his use of illicit substances. At the time of the assault, Joseph was not engaged with AMHS but was under licence to probation, having been released from prison where he had been serving a sentence for supplying class A drugs.

In the six-week period leading up to the assault, Mrs Moyo's son and daughter in law, had been in contact on nine occasions with Adult Social Care; Probation; NHS 111; ambulance service; police and mental health services, concerned about Joseph's deteriorating behaviour and of Mrs Moyo's wellbeing.

On the day of the assault, Joseph began a prolonged and sustained assault to his mother, punching, kicking and trying to strangle her. Mrs Moyo managed to call the police. Mrs Moyo was taken to hospital where she received treatment for soft tissue injury and a nasal fracture. Joseph was arrested and subsequently detained for psychiatric assessment under the Mental Health Act 1983 and then recalled to prison.

Findings:

The findings in this review are many varied and can be read in full via the published review.

There were opportunities for preventative intervention that may have made a difference to the events that followed. These include the importance of a shared understanding of Joseph's mental health needs, his relapse indicators, and risk assessment; understanding the nature of carer roles and significant others and incorporating this into assessments; the need to improve communication between probation and adult mental health services; the importance of GP registration and where a person is not registered with a GP the need to consider the impact of this within discharge planning.

There were also findings focusing on the responses to escalating concerns. The chronology of events demonstrated that there was a high volume of calls from family within a short period; concerns about Joseph's presentation mirrored features of past relapse; there were unexplained inconsistencies: Mrs Moyo's assertions that all was well did not fit with Aaron and Jasmin's recurrent concerns and their description that she was fearful of Joseph.

Recommendations:

1. Procedural Development, Monitoring and Review: Leicester's Strategic Offender Management MAPPA Board should use learning from this review to inform their strategic plan for 2021-2022, specifically, the action to improve publicity, pathways and gateways into mental health services. The Strategic Offender Management MAPPA Board should seek to develop mechanisms to strengthen partnership working between AMHS and Probation pre-sentence, pre-release, and post-release. This Board should also seek assurance on the quality of the release plans and that registration with a community GP is a component within the release plan.

2. Procedural Development, Monitoring and Review: Learning from this review should be shared with the relevant Home Office departments (Her Majesty's Prison and Probation Service and Domestic Abuse). The learning should be used to influence national policy and guidance on the need for information sharing and joint work between AMHS and Probation at key junctures in the offender pathway: pre-sentence (including Fast Delivery Reports), pre-release, and post-release.

3. Procedural Development: LPT need to assure that their policies (and application of those policies) for Did Not Attend and Discharge, take adequate account of circumstances when a patient is not registered with a GP i.e.

- Reasonable attempts are made to support service users to register with a GP.
- Lack of GP registration is factored into risk assessment and,
- Risk assessment is used to inform proportionate communications with other agencies, family and carers, in line with information sharing guidance.

It is important that all agencies play a role in encouraging people to register with a GP. The contribution of the Leicester City CCG in providing guidance and raising awareness of access routes to register with GPs, will assist in this.

4. Staff Support: LSAB and its constituent agencies, should use learning from this SAR to inform training and supervision, in relation to safeguarding and domestic abuse:

- Reinforcing the value of multi-agency collaboration
- Recognition of carers and significant others within assessments, including consideration of assets, protective factors, stress factors and risks.
- Fundamentals of a robust risk assessment; understanding and working with barriers to disclosure (including safe enquiry).

Impact:

There have been some national and local changes since the scope period that are relevant to the learning. In summary:

- National development between NHS and National Offender Management Service to improve support and monitoring of offenders on release.
- National reforms of the Probation service through the reunification programme. Probation practitioners will work in both HM Prisons and in community settings which should aide continuity of care plans and the flow of information.
- Locally, the Strategic Offender Management MAPPA Board is working to improve partnership working between probation and mental health services.

- Leicestershire NHS Partnership Trust has opened a Crisis Mental Health Hub at the Mental Health Unit were people and their families can self-refer for urgent mental health support to a central access point by telephone.
- Adult Social Care is strengthening processes and training for staff within their Contact and Response team.
- Leicester City CCG have provided guidance and raised awareness of access routes to register with GPs.

In addition to learning from our own local SARs, the Leicester SAB's Review Subgroup also considers learning from other SABs across the country and considers local impact and action required. During 2021/22 reviews considered by the group included five reviews in relation to self-neglect:

- Suffolk SAB 'Mr. B'
- Leeds SAB 'Mr and Mrs A'
- Gloucestershire SAB 'Ted'
- Worcestershire SAB 'RN'
- Sandwell SAB 'Anne'

Four national reports where self-neglect was a theme were also considered. Approaches to SARs where self-neglect is involved was discussed in detail by the group. As a result, a local resource supporting the consideration of SAR referrals where self-neglect is a feature was produced and is now used to support the group's decision-making. In addition, our local self-neglect guidance was spotlighted in our local 'Safeguarding Matters' publication in order to brief practitioners across Leicester, Leicestershire and Rutland.

Norfolk's SAR on Cawston Park Hospital was considered by the Review Subgroup and also by the main Board.

Core Priority 2: Enhancing Everyday Business

Policies and Procedures: Leicester Safeguarding Adults Board works with Leicestershire and Rutland Safeguarding Adults Board to maintain up to date inter-agency adult safeguarding policies and procedures across Leicester, Leicestershire and Rutland. These policies and procedures are hosted on our dedicated policy and procedures website called the MAPP (Multi Agency Policies and Procedures). Throughout 2020/21 these policies and procedures continued to be reviewed and updated in line with learning from reviews, audits, and best practice.

Updated chapters include:

- Deprivation of Liberty Safeguards - This chapter was amended to add the note in the scope box regarding the timetable for the introduction of Liberty Protection Safeguards.
- Types and Patterns of Abuse and Neglect - Section 6.4, Financial or material abuse has been amended to include additional information about abuse by deputies and also action against fraud.
- Stage 2: Lead Agency Decision using Safeguarding Threshold Guidance whether to proceed to Referral - Section 5, Roles and Responsibilities has been updated to include information about reporting suspected crimes to Leicestershire Police.
- Safeguarding Adults Reviews - A link was added to Local Guidance and Templates, where additional SAR guidance has been added.
- Quick Reads and Audios - A quick read and audio summary about Ordinary Residence has been added.
- Publication of our LLR Multi-Agency Overarching Safeguarding Information Sharing Agreement and Guidance which covers children and adults.
- Sexual exploitation and organised sexual abuse.
- A guide to multi-agency meetings to help practitioners identify the appropriate route to explore and address concerns about the welfare of adults.
- A set of guides to support workers to assess the mental capacity of people they work with.

Training: Safeguarding adults multi-agency training has been provided throughout 2021/22 in line with business plan objectives. Training for Mental Capacity Act was rolled out across LLR, well established Mental Capacity Act forums have continued to run across the city for care home providers, a trainers' network has been facilitated across LLR, and weekly briefings and quarterly newsletters have been published and circulated.

The SAB training subgroup is now LLR and has launched its YouTube channel, the first video developed and published is the 'Tricky Friends' animation for adults with learning disability and autism. This was followed by our 'See Something Say Something' awareness-raising video. A financial abuse task and finish group was set up in response to a previous multi-agency audit, and videos for practitioners were developed including interviews with the Office of the Public Guardian (OPG). A PowerPoint resource pack on 'Professional Curiosity' has also been produced and published in response to learning from our reviews.

Developmental Priorities 1 & 2: Strengthening User and Carer Engagement & Raising awareness within our diverse communities

A resource pack was developed for Safeguarding Adults Week, November 2021 and shared across the partnership and with Voluntary and Community groups.

Throughout 2021/22 'What Is Adult Safeguarding?' briefings were facilitated to local community members and groups.

An easy read version of our 'What is Adult Safeguarding?' document was been produced, published on our SAB webpage, and promoted via social media.

Printable safeguarding information has been developed and published on our SAB webpage in English, Urdu, Punjabi, Hindi, Gujarati and Bengali.

Our "See Something Say Something" awareness campaign and video - explaining what adult safeguarding is - has been promoted with the video having reached over 1,000 views. The Engagement Subgroup is working to split this longer video into three shorter ones to make them more accessible on social media.

Developmental Priority 3: Understanding how well we work together

Multi-Agency Audits: The SAB carried out two multi-agency audits during 2021/22 and also received the results of one multi-agency audit conducted during 2020/21.

The older people and neglect audit found:

- It was good practice that local systems automatically notify the contracts team when a safeguarding alert is recorded involving a service provider.
- In almost all cases, there was evidence of the principles of Making Safeguarding Personal
- In almost all cases, the risks to the person had been reduced within the enquiry safeguarding of young adults including transition from children's services.

The transitions audit found:

- Safeguarding thresholds were applied appropriately and the principles of Making Safeguarding Personal were applied well in almost all cases.
- Where cases had not met the criteria for safeguarding there was evidence of other actions taken to address risk.

- Many of the cases related to people who were placed from other areas and in most information had not been shared with Leicester, Leicestershire & Rutland agencies.
- Transitions of individuals from children to adult services was not always robust.
- Safeguarding enquiries were not always closed at an appropriate point, particularly when police processes were underway.
- The Police were not always involved when a potential crime had been carried out.

The strategy meetings audit found:

- In almost all cases the right organisations were being involved in strategy meetings and the principles of Making Safeguarding personal were evidenced.
- Meetings were not taking place in the timescales set out in local procedures and separate conversations were taking place between smaller groups of partners.
- The differences and processes around strategy meetings and strategy discussions caused confusion for practitioners, which led to processes not being followed.

The strategy meetings audit included interviews with practitioners to understand approaches which helped clarify the learning and will be used in future audits.

The findings from these audits have been disseminated to practitioners and are being taken forward as follows:

- Information sharing across areas to be raised with regional and national networks to improve this.
- Learning regarding transitions was fed into the scoping of the SABs work on transitional safeguarding planned for 2022/23.
- Local Authorities have reviewed how outcomes of safeguarding enquiries are recorded to support clarity of understanding and appropriate closure of these enquiries.
- Strategy Meetings and discussions guidance is being reviewed to make terminology and processes clearer and will be communicated to practitioners across organisations.

The SAB reviewed its approach to the Safeguarding Adults Audit Framework (SAAF) assessment of individual agencies safeguarding approaches and sent this out to be completed at the start of 2022/23 to focus on specific priorities and concerns of the SAB.

Developmental Priority 4: Helping people to stay safe, connected and resilient to reduce the likelihood of harm, abuse or neglect

The work of the hidden harm priority below alongside the developmental priority of raising awareness within our diverse communities above have contributed to this priority.

Business Plan Priority: Responding to COVID-19

Leicester SAB alongside Leicestershire and Rutland SAB held reflection sessions jointly with the Safeguarding Children Partnerships to give partners the space to reflect on positives and negatives from working through the pandemic. Key points included:

- Prisons in the area have assessed impacts on prisoners and listened to prisoners as they adapted to the impact and response to Covid-19 and considered safeguarding within this.
- Concern regarding remaining hidden harm in care homes when they are under pressure. The SAB needs to have a collective view of concerns across care homes to ensure safeguarding concerns do not go unreported.
- Pressure on capacity is not just in care homes, but also the domiciliary care sector, which could impact on the ability in the system to identify and respond to safeguarding matters

- There are large backlogs in various parts of the system including for routine treatment and discharge from hospital which will increase pressures even once Covid appears to have passed.
- There are additional pressures of impacts of the pandemic for example social issues impacting on mental and physical health - more complex cases, more rapidly deteriorating,
- The impact of mandatory vaccination for care staff is not yet known, but expected to reduce the capacity in the system further.
- Partners need to continue to hear and be advocates for those we work with.
- Partners need to continue work together, to identify and respond to strategic safeguarding concerns and to support a resilient workforce going forwards.

The majority of these points were identified towards the end of the year and influenced the forward business plan priories for 2022/23.

Business Plan Priority: Hidden Harm

- A domestic abuse research project with Durham University, funded by the Home Office was run throughout 2021/22 with findings to be presented in 2022/23.
- Training for Mental Capacity Act has been rolled out across Leicester, Leicestershire and Rutland.
- A multi-agency audit regarding transitions has been completed and work is being taken forward to address the learning identified.
- An awareness campaign “See Something Say Something” was launched during safeguarding adults week (November 2021).
- ‘What is Adult Safeguarding?’ sessions have been run in the city for residents throughout 2021/22.
- ‘Safeguarding Stories’ an animation has been developed to support community and professionals’ understanding of safeguarding adults, abuse, and neglect.
- Training for managers around supporting professional curiosity in staff and knowledge of local escalation policy has been scoped and will be run throughout 2022/23.

Business Plan Priority: Care Homes

- A multi-agency audit on care homes was facilitated, with findings to be presented to the SAB during 2022/23.
- NICE safeguarding in care home guidance was considered at Board during 2021/22. Contracts and commissioning teams across the Local Authority and the Clinical Commissioning Group subsequently reviewed this guidance and provided assurance to the SAB.
- The training subgroup has undertaken a review of how we link in with care homes and are now developing a summary sheet of what support is available via the SABs.
- Escalation procedures have been reviewed in line with NICE guidance.

Looking to 2022/23

Looking to 2022/23 we have developed our annual business plan jointly with Leicestershire and Rutland Safeguarding Adults Board. It has been published alongside our strategic plan, on the 'plans, reports, and strategies' page of our web pages.

Business Plan priorities for 2022/23 build on the 2021/22 priorities and are as follows:

1. Hidden Harm

Rationale:

- Local and national SARs identify people "hidden in plain sight" as a recurring theme for improvement.
- We are concerned that that during Covid-19 services have less physical contact with and 'eyes on' people to fully understand their needs and circumstances, in addition some informal care arrangements that support safeguarding of individuals may not be functioning as they were with restrictions in place.
- Specific areas of concern include self-neglect and individuals with mental ill-health and/or learning disabilities, and individuals from black and other diverse backgrounds.

Focus will be on community culture shift across practitioners and public to: Help people to a) see concerns b) have confidence to want to respond and c) respond.

2. Care Homes

Rationale:

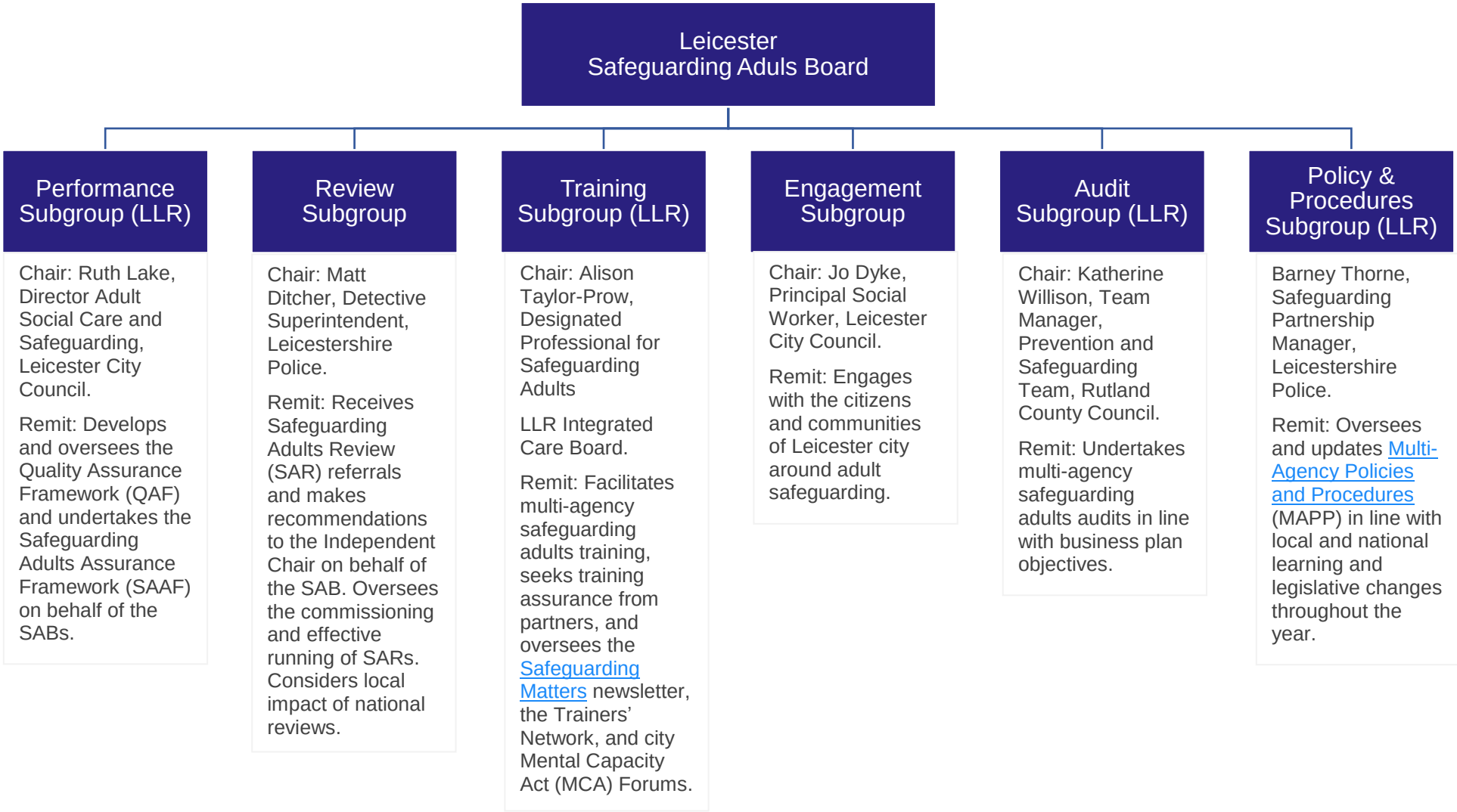
- A number of issues in care homes regarding quality of care and safeguarding have become apparent during Covid-19 lockdowns with increase in safeguarding alerts relating to care homes and care homes closing. Closure of care homes and lack of capacity in the system increases risk around safeguarding. As care homes open up for visitors more people are seeing those in care homes, and therefore potential for more concerns to be raised.

In addition to the priorities identified for 2022/23 the SABs will continue to operate business as usual to improve safeguarding of adults with care and support needs and meet its statutory obligations. The Review Subgroup will pilot a 'rapid review' scoping approach for SARs and the Training Subgroup will review the current training strategy to cover Leicester, Leicestershire and Rutland as well as work with the Local Implementation Network (LIN) regarding Liberty Protection Safeguards (LPS). The Performance Subgroup will finalise the updated performance framework.

Appendix I: 2022/23 Leicester SAB Structure Chart

Leicester Safeguarding Adults Board

WORKING IN PARTNERSHIP TO KEEP ADULTS SAFE



Appendix E

Results of 'How Are You Leicester?'

For consideration by:

Joint Health and Wellbeing and Adult Social Care Scrutiny Commissions

Date:

6 October 2022

COMMUNITY WELLBEING CHAMPIONS PROJECT

"HOW ARE YOU, LEICESTER?" REPORT

DATE REPORT FINISHED	PERIOD COVERED BY REPORT
02.09.2022	07.04.2022 - 05.08.2022

REPORT PREPARED BY

Ethan Street, Community Facilitator

Community Wellbeing Champions Team, Public Health, Leicester City Council

Email: ethan.street@leicester.gov.uk

1. INTRODUCTION

1.1 The Community Wellbeing Champions (CWC) Project aims to set up a network of organisations and volunteers from across the diverse communities of Leicester to:

- achieve a better understanding of the needs of, and barriers faced by, residents, particularly those most affected by poor health and wellbeing, and
- use these insights and relationships to help address health inequities and reduce avoidable inequalities.

1.2 To help launch the CWC Project to the public and get our community engagement underway, a short, opening engagement survey called "How Are You, Leicester?" was created. This takes the form of a brief survey, asking:

- quantitative questions ranking individuals' physical and mental health before and after the pandemic, and
- qualitative, dialogue-opening questions about perceived health and wellbeing issues faced by individuals and their communities, barriers to better health, and changes they would like to see take place to address these.

1.3 The aim of the consultation was to gain responses from a representative sample of over 16s from across Leicester, with a specific focus on making the survey accessible to groups such as refugees and asylum seekers, the elderly, those with disabilities, the homeless, and those who are digitally excluded. Therefore, local organisations working with the aforementioned groups within Leicester were contacted regarding the possibility of in-person focus groups, facilitating the completion of the survey.

1.4 385 responses were collected as of 5th August 2022 via a variety of both in-person and online methods as outlined in the following chapter.

1.5 The report starts to explore whether changes in health and wellbeing due to the pandemic are experienced differently amongst different community groups (such as cultural, area, age, ability/disability, and sexual orientation), as well as identifying

common health and wellbeing issues and barriers to good health and wellbeing amongst communities to aid future engagement. This allows for the implementation of methods that follow the principle of proportionate universalism, the concept of delivering universal services at a scale and intensity proportionate to the need of the specific population groups.

2. METHODOLOGY

2.1 Recruiting Participants:

2.1.1 The focus of the survey relates to health and wellbeing generally in Leicester, from a broad cross-section of the city and its various demographic groups and communities. Therefore, besides ensuring that respondents lived or worked in the Leicester area, there was little need for exclusions when recruiting participants.

2.1.2 However, there is more control over these factors when recruiting participants via in-person surveying or focus groups, as their location can be gathered through conversation, whereas via online means, respondents of any location can complete the survey. However, to limit the impact of this, social media pages and organisations that operate solely within Leicester were prioritised to promote and facilitate the completion of the survey online.

2.1.3 Whilst generally targeting Leicester residents as a whole, specific emphasis was placed on hearing from a number of different groups who are not often reached by similar surveys, namely Asylum Seekers and Refugees, the Elderly, The Homeless, those with physical disabilities, and traveller communities. After the launch of the consultation and evaluation of the first round of results, those from South Asian ethnic groups, as well as young people in general were added to these target groups due to low initial uptake.

2.2 Ethics:

2.2.1 As the survey contains sensitive subject matter including individual's mental and physical health, disability, ethnicity, and sexual orientation, as well as many of the emotions and feelings associated with inequities and bad health being negative, empathy and respect towards respondents' experiences and views was always given.

2.2.2 Individuals were also given the option to complete the survey themselves or by vocalising their answers to the Public Health team members present. This both provides the option for additional confidentiality, as well as offering extra assistance for those who need or want it.

2.2.3 It was also made clear to participants that their data would remain private and confidential. To ensure this, the data was stored on consultations.leicester.gov, with only those with a password able to access the data reports. Completed paper surveys were also disposed of in a confidential waste bin after data were inputted.

2.3 Survey design:

2.3.1 The survey incorporates both qualitative and quantitative methods throughout. The quantitative methods involve tick boxes, and Likert scale questions to collect measurable data on health and wellbeing in Leicester, while the qualitative methods consist of open box questions aim to delve deeper into the reasons/causes behind the quantitative responses as well as inequities between different areas and communities in the city.

2.3.2 The Qualitative questions were then coded into themes in which they closest related to, and then counted to analyse the most frequent themes for each qualitative question.

3. RESULTS

3.1 Survey Demographics

3.1.1 Ethnicity:

a. 53% of those surveyed identified as White British, followed by 18.7% as Indian. This is somewhat reflective of the population of Leicester; however, this figure is lower than the percentage of Indians in Leicester of around 25%.

b. These two groups formed most respondents, with White European groups being the next highest percentage at 3.9%, somewhat expected given large Polish, Romanian, and other Slavic communities in Leicester, which make up 4.6% of the city's population. The white British majority is slightly higher than the actual percentage of white British in the city (45%).

c. There were 0 respondents from a gypsy/traveller background, making them a possible underrepresented group to target for future engagement. However, reaching out to traveller community groups in Leicester provided a challenge when promoting the survey.

d. There were also fewer Bangladeshi, (1.3%), and Pakistani, (2.3%) respondents than expected.

Option	Total	Percent
Asian or Asian British: Bangladeshi	5	1.30%
Asian or Asian British: Indian	72	18.70%
Asian or Asian British: Pakistani	9	2.34%
Asian or Asian British: Any other Asian background	2	0.52%
Black or Black British: African	7	1.82%
Black or Black British: Caribbean	5	1.30%
Black or Black British: Somali	3	0.78%
Black or Black British: Any other Black background	3	0.78%
Chinese	1	0.26%
Chinese: Any other Chinese background	1	0.26%
Dual/Multiple Heritage: White & Asian	4	1.04%
Dual/Multiple Heritage: White & Black African	1	0.26%
Dual/Multiple Heritage: White & Black Caribbean	1	0.26%
Dual/Multiple Heritage: Any other heritage background	2	0.52%
White: British	204	52.99%
White: European	15	3.90%
White: Irish	8	2.08%
White: Any other White background	4	1.04%
Other ethnic group: Gypsy/Romany/Irish Traveller	0	0.00%
Other ethnic group: Any other ethnic group	7	1.82%
Prefer not to say	16	4.16%
Not Answered	15	3.90%

Fig.1

3.1.2 Age:

a. The most common group surveyed were 46-55, with 21%. Only 4.2% of respondents were under 25 in age, compared to 38% of the population being below 24 in 2015, suggesting more work needs to be done to accurately target the younger population of Leicester.

b. Measures were taken to attempt this, such as trying to arrange in person focus groups at local colleges and Universities, however the time of year of the survey, (late spring-summer), resulted in this having little success.

3.1.3 Sexual Orientation:

a. 79.7% of respondents identified as straight, 3.9% as gay/lesbian, and 4.2% as bisexual.

b. While it is hard to measure the representativeness of this data as the 2011 census does not ask for sexuality, this data does not show a clear disparity between expected and actual percentages with regards to sexual orientation.

3.1.4 Disability:

a. 24.9% of respondents reported having a disability, slightly higher than the national figure of 18%, as well as the Leicester 2017 mid-year estimate where 17% reported that their daily activities were limited either a little or lot by a disability. Therefore, there was no issue with those with disabilities being underrepresented, (NHS Trust 2017).

b. Of those surveyed, 12% reported suffering from a mental health condition.

3.1.5 Religion:

a. In terms of religious beliefs, Christianity was the most common with 32%, with no religion and atheist combined having 28.6%, Hindu 7.8%, Muslim 13.8%, Sikh 2.9%, and 3.9% belonging to other religious groups.

b. In Leicester as a whole, Christians are 33% of the population, Muslims 19%, and Hindus 15%, therefore Hindus and Muslims can be said to be lightly underrepresented. 23% claim no religious affiliation, less than the 28.6% in our survey.

Option	Total	Percent
Atheist	35	9.09%
Bahai	0	0.00%
Buddhist	2	0.52%
Christian	123	31.95%
Hindu	30	7.79%
Jain	0	0.00%
Jewish	0	0.00%
Muslim	53	13.77%
Sikh	11	2.86%
No religion	75	19.48%
Prefer not to say	22	5.71%
Other	15	3.90%
Not Answered	19	4.94%

Fig.2

3.1.6 Gender:

a. 62.1% of those surveyed identified as Female, with 29.9% identifying as male, and the rest either preferring not to say or not answering, suggesting males were underrepresented in the results.

b. In terms of gender identity, 72.2% answered that their gender identity is the same as birth, and 1.6% answering no, and the rest answering neither yes nor no.

3.2 Results

3.2.1 Health and Wellbeing before and after the start of the pandemic:

a. There were 385 responses to the first quantitative question, Question 2, which asks: *"How good would you say your physical health and wellbeing is at the present time (with 1 being very poor and 10 being very good)".* The most common response was 7/10, therefore a favourable view on their current physical health, with 19.7% of respondents, followed by 16.4% selecting 8, and 13.8% selecting 6. The least commonly selected responses were 1, (3.6%), 2, (4.2%) and 3 and 4 respectively, (both 6%). This suggests that most respondents felt more favourably than unfavourably about their current physical health. However, the slightly favourable responses were considerably more common than very favourable, with the 3 modal responses being 7, 8 and 6.

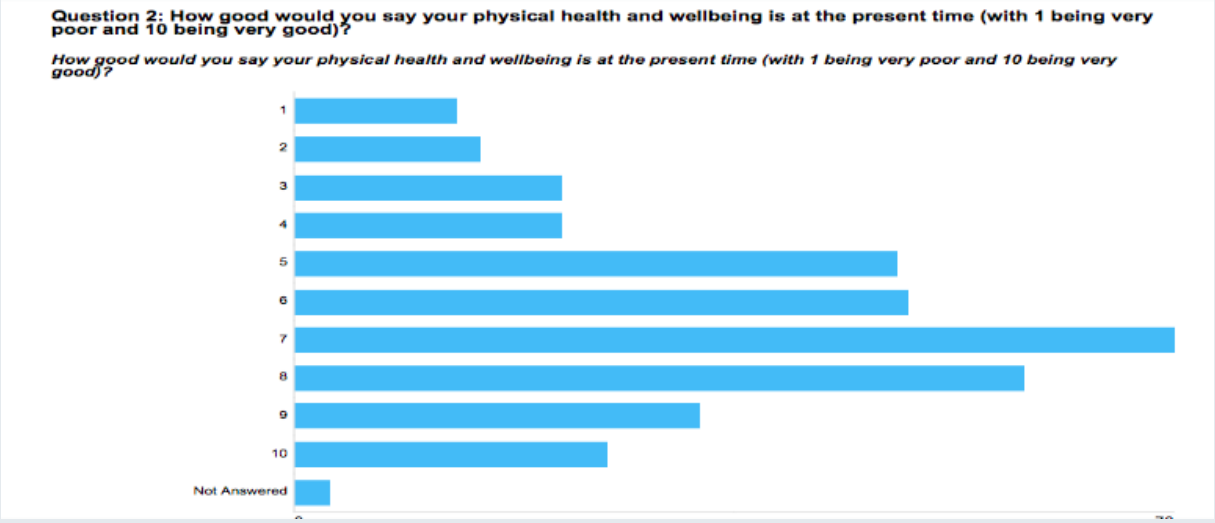


Fig.3

b. There were 385 responses to Question 5, which asks, *"How good would you say your mental health and wellbeing is at the present time (with 1 being very poor and 10 being very good)".* The most common responses were 7, (17.4%), 8, (13.8%), and 5, (12.5%), with the least common responses being 1, (3.4%), 2, (4.2%), and 3, (7.3%). This suggests that the most common feeling amongst those surveyed was to feel 'fairly good' about their current mental health, with a good proportion also feeling neutral. However, there was a wider range of commonly selected responses than question 2 which explores *physical* health at the present time, with all responses ranging from 5-10 receiving at least a 10% share of selection, compared only responses 5-8 in question 2. This suggests respondents' perceptions of their current mental health were more varied than perceptions of their current physical health, with very good options (9-10), receiving a higher share of responses suggesting more people felt very good about their current mental health than physical.

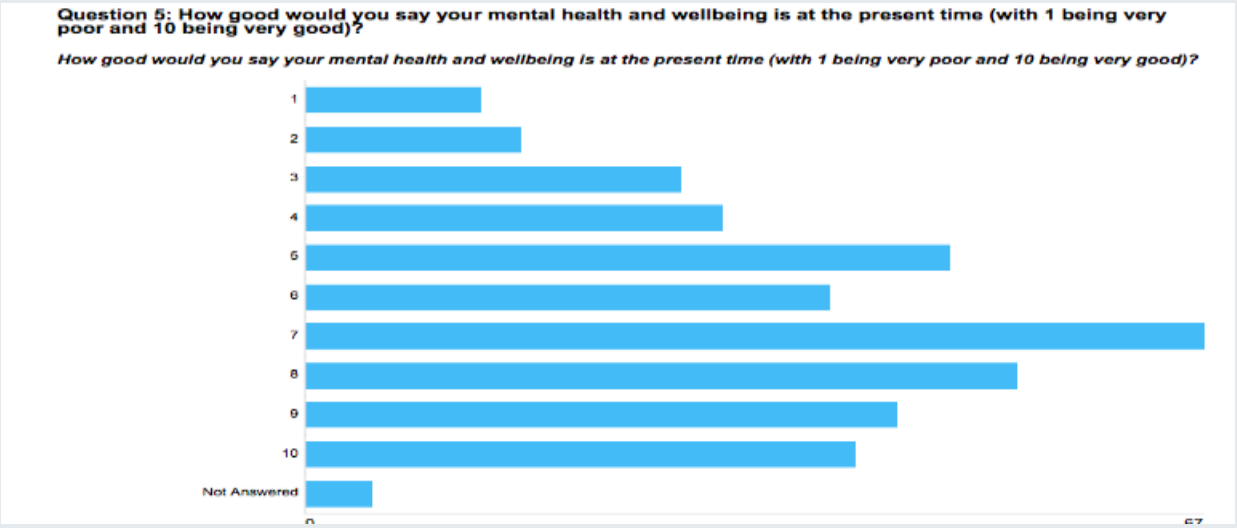


Fig.4

c. There were 385 responses to Question 3, which asks: "*Thinking about your physical health and wellbeing before the pandemic, how good would you say it was at that time (with 1 being very poor and 10 being very good)".* The most common response was 8, (24.7%), followed by 9, (20.5%), and 7, (15%), with the least common responses being 1, (1%), 2, (2.3%), and 3, (3.1%). This suggests a mostly favourable opinion of individuals surveyed perception of their physical health and wellbeing before the pandemic. As the most common responses were further along the scale than question 2, it can be inferred that despite the public's perception of their physical health and wellbeing being favourable, it is less favourable than before the pandemic, making it possible to argue that people's perception of their physical health has declined since the start of the pandemic.

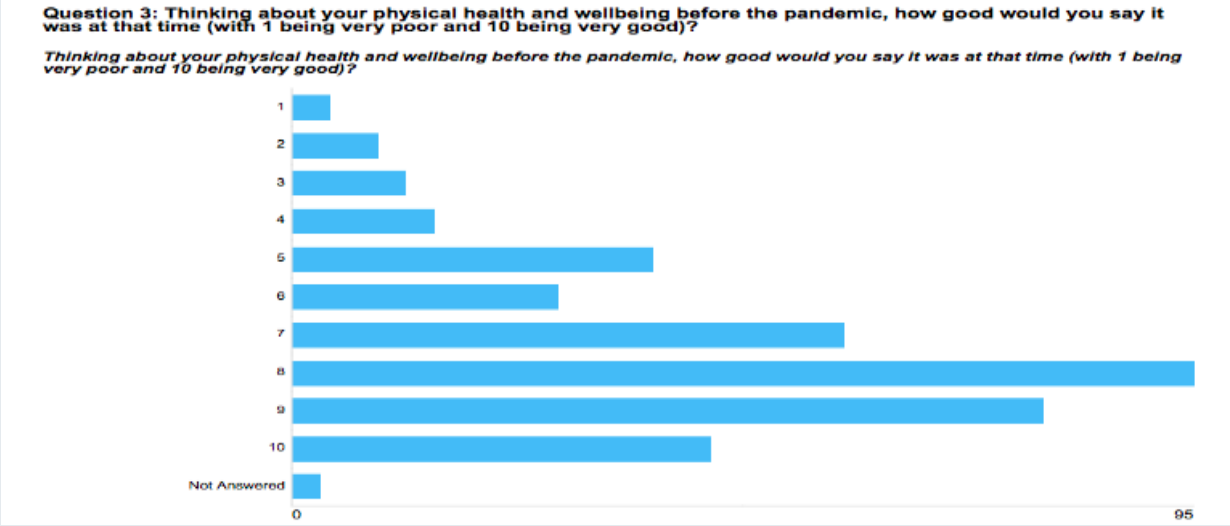


Fig.5

d. Question 6, also with 385 responses, asks, *"Thinking about your mental health and wellbeing before the pandemic, how good would you say it was at that time (with 1 being very poor and 10 being very good)".* The most selected responses were 8, (23.9%), 9, (20.3%), and 10, (15.3%), with the least being 1, (1.6%), 2, (2.3%), and 3, (3.1%). This suggests a trend towards public perception that individuals feel that their mental health was very good before the pandemic, with the 3 most favourable answers being the 3 most selected, and the 3 least favourable answers being the least selected. This also suggests that those surveyed in Leicester found their mental health to be better pre pandemic than post pandemic, despite the post pandemic results still being mostly favourable, just less strongly than the pre pandemic results. These results show a similar trend amongst physical and mental health in Leicester pre and post pandemic, and in another similarity, 8 and 9 were most selected in both mental and physical health levels pre pandemic. However, 10 was the third most common response for mental health, suggesting the trend is stronger in relation to mental health than physical.

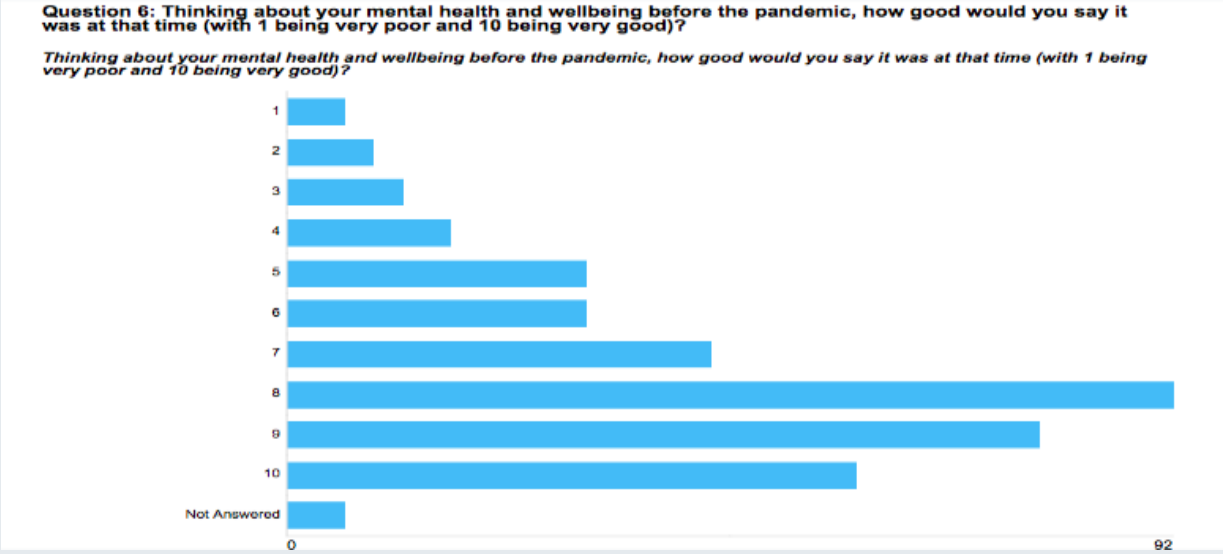


Fig.6

3.2.2 Comparing factors influencing physical and mental health:

a. Question 4 asks: "*Which of the following would you say affects your physical health and wellbeing? Please tick all that apply (with the options being* Environment, Finances, Access to healthcare, Social Isolation, Employment, Education)*".* The most selected responses, therefore the factors the sample size in the city of Leicester felt were most influential on physical health were Environment, (55.8%), Access to Healthcare, (49.7%), and Finances, (49%), with education considerably the least commonly selected option, (10.1%). The open-ended "other, specify" option for this question discovered that the most common "other" factors influencing physical health were Age and Disability (both with 9 responses), and Access to Fitness with 7 responses.

Option	Total	Percent
Environment	215	55.84%
Finances	189	49.09%
Access to healthcare	191	49.61%
Social Isolation	123	31.95%
Employment	130	33.77%
Education	39	10.13%
Not Answered	29	7.53%

Fig.7

b. Question 7 asks "*Which of the following would you say affects your mental health and wellbeing? Please tick all that apply (with the options being* Environment, Finances, Access to healthcare, Social Isolation, Employment, Education)*".* Finances, (54.3%) Environment, (54%) and Access to Healthcare, (47.3%), were the most selected responses, with education again the least selected, (11.2%). The open-ended "other, specify" option, found Both the three most selected responses, and the least commonly selected response was seen to be shared amongst both physical and mental health, however the main factor impacting mental health was instead found to be finances, compared to the environment being perceived as the main

factor impacting respondents' physical health. Education was found to have little perceived impact on neither mental nor physical health, despite the role education may play in spreading awareness on both a healthy diet and exercise regimen, as well as awareness of how to better ones' mental health and/or access help.

Option	Total	Percent
Environment	208	54.03%
Finances	209	54.29%
Access to healthcare	182	47.27%
Social Isolation	163	42.34%
Employment	143	37.14%
Education	44	11.43%
Not Answered	43	11.17%

Fig. 8

3.2.3 Main Health and Wellbeing issues in communities:

a. Respondents were also asked the Qualitative question, "Thinking about your community (or communities), what would you say are the health and wellbeing needs or issues that affect them the most?", to explore in more detail the main issues affecting not just the individuals themselves, but the wider communities to which they belong. These responses were then coded into the following themes: Access to Healthcare, Housing, Finances Access to Education, Access to Employment, Isolation, Access to Services, COVID, Discrimination, Anti-Social Behaviour, Crime, Mental Health, Cultural Barriers, Political Issues, Poverty, Digital Exclusion, Physical Health, Transport, Housing, and Other.

b. The most common issue was disproportionately found to be Access to Healthcare, with 114 responses, followed by Access to Services, (57), Finances, (56), Environment, (47), and Isolation, (45). Responses coded as "Access to healthcare", commonly related to GP access, especially about gaining telephone appointments and the waiting times involved post pandemic. Access to Services relates to both the quality, accessibility, and existence of non-healthcare related services such as gyms, community centres, and voluntary organisations for their communities. Finances relates to financial concerns and issues such as the cost-of-living crisis, but not poverty which was coded separately. Environment relates to the physical environment and issues such as littering as well as wider environmental issues.

3.2.4 Changes to address the main issues in communities:

a. Following up from this, respondents were then asked, "Thinking about the things you've talked about in the previous questions, what changes might help to make things better for you and your community's health and wellbeing?", to give those from within communities themselves the chance to identify possible solutions to mitigate the health and wellbeing issues present currently. The themes are as follows: Access to Healthcare, Housing, Finances Access to Education, Access to Employment, Isolation, Access to Services, COVID,

Discrimination, Anti-Social Behaviour, Crime, Mental Health, Cultural Barriers, Political Issues, Poverty, Digital Exclusion, Physical Health, Transport, Housing, and Other.

b. The most common theme was again relating to Access to Healthcare, (100), followed by Access to Services, (74), and Environment, (46). This suggests that the main solutions to health and wellbeing issues in communities surveyed currently relate to improving Access to Healthcare, Services, and improving the physical environment of the city

3.2.5 Survey Accessibility:

a. Respondents were asked to rank the ease of completing the survey from 1 star to 5 stars. 4.4% rated the survey 1 star, with 2.1% responding 2 stars, 10.4% 3 stars, 17.9% 4 stars, and 61.3% selecting 5 stars. This shows a majority found the survey accessible. However, a sizeable minority (16.9%), rated the survey 3 stars or below.

4.CONCLUSION

4.1 In conclusion, while the results of the survey showed a general trend towards good levels of both physical and mental health in the Leicester, with the most common responses being 7,8 and 6 for physical health, and 7, 8 and 5 for mental health, when ranking their physical and mental health at the present time out of 10, the data also shows that present levels of health and wellbeing are lower than pre-pandemic levels. This is shown as the modal results for perceived individual pre-pandemic physical health were 8,9 and 7, and pre-pandemic mental health 8, 9, and 10. Therefore we can conclude that while individuals' own perceived health and wellbeing levels in Leicester are not low, they are on the decline when compared with pre COVID-19 levels.

4.2 Another interesting finding is that respondents' perceptions of their mental health at the present time were more varied than the perceptions of their physical health at the present time, shown by a wider range of commonly selected responses, with all responses ranging from 5-10 for mental health receiving at least a 10% share of selection, compared to only responses 5-8 in for physical health. The "very good" options (9-10), received a higher share of responses for mental health also, suggesting more people felt very good about their current mental health than physical.

4.3 The main factors influencing individual physical health were found to be Environment, Access to Healthcare, and Finances, with the main factors influencing individual mental health being Finances, Access to Healthcare, and Environment, when respondents were presented with a tick-box list of potential factors. However, when respondents were asked to list the main health and wellbeing issues affecting their wider communities, and these responses were coded into themes, the most frequently appearing theme was disproportionately found to be

Access to Healthcare, with 114 responses, followed by Access to Services, (57), Finances, (56), Environment, (47), and Isolation, (45).

4.4 When asked what changes they would like to see to address these health and wellbeing issues in their communities, the most common theme was again relating to Access to Healthcare, (100), followed by Access to Services, (74), and Environment, (46). This suggests that while the most common physical health issues affecting individuals are environmental (e.g. access to green spaces, transport accessibility, and gym accessibility), and the most common mental health issues affecting individuals being financial factors (e.g. poverty, cost of living crisis, unemployment), the most common issues affecting communities according to respondents was a lack of access to healthcare, with issues such as GP waiting times, the trend towards online appointments replacing face-to-face, and difficulty getting through to GP's on the phone being frequently stated issues.

4.5 Improving communities' access to healthcare was also the modal theme when respondents were asked how the issues could be addressed, (100), followed by Access to Services, (74), and Environment, (46). This suggests that the most immediate issues needing to be addressed in communities should revolve around making access to healthcare services, including mental health services, easier, as well as signposting wider services, events, and support networks.

4.6 However, since the start of the survey, the cost-of-living crisis has worsened, and financial concerns were already a commonly occurring theme, therefore financial support is increasingly relevant.

5.REFERENCES

NHS Trust. 2017. [online] Available at: <https://www.england.nhs.uk/wp-content/uploads/2019/10/University_Hospitals_of_Leicester_NHS_Trust_Annual_Report_and_Accounts_2018-19.pdf> [Accessed 10 August 2022].