LEICESTER CITY
HEALTH AND WELLBEING BOARD

Date: THURSDAY, 6 MARCH 2025

Time: 9:30 am

Location:
MEETING ROOM G.01, GROUND FLOOR, CITY HALL,
115 CHARLES STREET, LEICESTER, LE1 1FZ

Members of the Board are summoned to attend the above meeting to consider the items of business listed overleaf.

Members of the public and the press are welcome to attend.

For Monitoring Officer

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MEMBERS OF THE BOARD

Councillors:

Councillor Vi Dempster, Assistant City Mayor - Health, Culture, Libraries and Community Centres (Chair)

Councillor Elaine Pantling, Assistant City Mayor, Education

Councillor Geoff Whittle, Assistant City Mayor, Environment and Transport

2 Vacancies

City Council Officers:

Laurence Jones, Strategic Director of Social Care and Education

Rob Howard, Director Public Health

Dr Katherine Packham, Public Health Consultant

1 Vacancy

NHS Representatives:

Caroline Trevithick, Chief Executive, Leicester, Leicestershire and Rutland Integrated Care Board

Rachna Vyas, Chief Operating Officer, Leicester, Leicestershire and Rutland Integrated Care Board

Dr Avi Prasad, Clinical Place Leader, Leicester, Leicestershire and Rutland Integrated Care Board

Helen Mather - Head of Childrens and Young People and Leicester Place Lead, Integrated Care Board

Dr Ruw Abeyratne, Director of Health Equality and Inclusion, University Hospitals of Leicester NHS Trust

Jean Knight, Deputy Chief Executive, Leicestershire Partnership NHS Trust

Paula Clark, Interim Chair, Leicester, Leicestershire and Rutland Integrated Care System

Healthwatch / Other Representatives:

Benjamin Bee, Area Manager Community Risk, Leicestershire Fire and Rescue Service

Harsha Kotecha, Chair, Healthwatch Advisory Board, Leicester and Leicestershire

Kevin Allen-Khimani, Chief Executive, Voluntary Action Leicester

Rupert Matthews, Leicester, Leicestershire and Rutland Police and Crime Commissioner

Kevin Routledge, Strategic Sports Alliance Group

Phoebe Dawson, Director of Leicester, Leicestershire Enterprise Partnership

Barney Thorne, Mental Health Manager, Local Policing Directorate, Leicestershire Police

Professor Bertha Ochieng – Integrated Health and Social Care, De Montfort University

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- ✓ to respect the right of others to view and hear debates without interruption;
- ✓ 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 **Kirsty Wootton, Governance Officer, kirsty.wootton@leicester.gov.uk.**

For Press Enquiries - please phone the **Communications Unit on 454 4151**

PUBLIC SESSION

AGENDA

FIRE/EMERGENCY EVACUATION

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1. APOLOGIES FOR ABSENCE

2. DECLARATIONS OF INTEREST

Members are asked to declare any interests they may have in the business to be discussed at the meeting.

3. MINUTES OF THE PREVIOUS MEETING

Appendix A
(Pages 1 - 12)

The Minutes of the previous meeting of the Board held on 19th December 2024 are attached and the Board is asked to confirm them as a correct record.

4. QUESTIONS FROM MEMBERS OF THE PUBLIC

The Chair to invite questions from members of the public.

5. PHARMACEUTICAL NEEDS ASSESSMENT

Appendix B
(Pages 13 - 24)

The Senior Intelligence Manager to present a review of the first draft of the pharmaceutical needs assessment.

6. LEICESTER HEALTH AND WELLBEING SURVEY (ADULTS)

Appendix C
(Pages 25 - 146)

The Principal Public Health Intelligence Analyst will update the board on the Leicester Health and Wellbeing Survey 2024, conducted by DJS Research on behalf of Leicester City Council. The update will provide a snapshot of health and wellbeing for residents aged 16 and over.

7. SUICIDE PREVENTION STRATEGY

Appendix D
(Pages 147 - 198)

Public Health have submitted a report to inform the Health and Wellbeing Board of the Leicestershire, Leicester City and Rutland (LLR) Suicide Prevention Strategy. The report shows ambitions of the local Suicide Audit and Prevention Group (SAPG) to promote partnership to build on current efforts to support people at risk of death by suicide and people who have been affected by suicide.

8. CENTRE PROJECT

Appendix E
(Pages 199 - 204)

An overview of the activities of the Centre Project.

9. THE YOUNG VOICES CONSULTATION

Appendix F
(Pages 205 - 360)

An update will be provided for the board on a consultation completed by the NHS in Leicester, Leicestershire, and Rutland (LLR). A large-scale engagement was launched to better understand the health and wellbeing needs of children and young people aged 11-25, along with their families and the healthcare staff who support them. This initiative aimed to gather insights into their experiences, priorities, and challenges in accessing healthcare, ensuring their voices shape future services.

10. CHILDREN AND YOUNG PEOPLE'S MENTAL HEALTH SUPPORT IN THE CITY

Appendix G
(Pages 361 - 362)

The Integrated Care Board will provide an overview to the Board of Mental Health Services available to Children and Young People from preventative and early intervention to specialised services.

11. UPDATE FROM THE INTEGRATED HEALTH AND CARE GROUP

Appendix H
(Pages 363 - 392)

A standing item around activity at the Leicester Integrated Health and Care Group.

12. DATES OF FUTURE MEETINGS

To note that meetings for the 2025/26 municipal year will be circulated to Board Members via email following approval at Annual Council on 15th May 2025.

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

13. ANY OTHER URGENT BUSINESS

Appendix A

Leicester
City Council

Minutes of the Meeting of the HEALTH AND WELLBEING BOARD

Held: THURSDAY, 19 DECEMBER 2024 at 9:30 am

Present:

Councillor Russell (Chair) – Deputy City Mayor, Social Care, Healt and Community Safety, Leicester City Council.
Councillor Elaine Pantling – Assistant City Mayor, Education, Leicester City Council.

Councillor Geoff Whittle – Assistant City Mayor, Environment & Transport, Leicester City Council.

Rob Howard – Director of Public Health, Leicester City Council.

Laurence Jones – Strategic Director of Social Care and Education, Leicester City Council.

Dr Katherine Packham – Public Health Consultant, Leicester City Council.

Caroline Trevithick – Chief Executive, Leicester, Leicestershire and Rutland Integrated Care Board.

Rachna Vyas – Chief Operating Officer, Leicester, Leicestershire and Rutland Integrated Care Board.
Helen Mather – Head of Childrens and Young People and Leicester Place Lead.
Dr Avi Prasad – Place Board Clinical Lead, Integrated Care Board.
Dr Ruw Abeyratne – Director of Health Equality and Inclusion, University Hospitals of Leicester NHS Trust.
Jean Knight – Deputy Chief Executive, Leicestershire Partnership Trust.
Paula Clark – Interim Chair, Leicester, Leicestershire and Rutland Integrated Care System.
Benjamin Bee – Area Manager Community Risk, Leicestershire Fire and Rescue Service
Harsha Kotecha – Chair, Healthwatch Advisory Board, Leicester and Leicestershire.
Kevin Allen-Khimani – Chief Executive, Voluntary Action Leicester.
Rupert Matthews – Leicestershire and Rutland Police and Crime Commissioner.

Kevin Routledge – Strategic Sports Alliance Group.
Phoebe Dawson – Director, Leicester, Leicestershire Enterprise Partnership.
Barney Thorne – Mental Health Manager, Leicestershire Police.
Professor Bertha Ochieng – Integrated Health and Social Care, De Montfort University.

In Attendance

Diana Humphries – Public Health, Leicester City Council.
Kirsty Wootton Governance Services, Leicester City Council

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96. APOLOGIES FOR ABSENCE

None were received.

97. DECLARATIONS OF INTEREST

Members were asked to declare any interests in proceedings for which there were none.

98. MINUTES OF THE PREVIOUS MEETING

AGREED:

The minutes from the meeting on 26th September 2024 were agreed to be a correct record.

99. QUESTIONS FROM MEMBERS OF THE PUBLIC

It was noted that none have been received.

100. DEAR ALBERT

The Director of Dear Albert, Jon Roberts presented an overview of Dear Albert to highlight the importance of lived experience in delivering productive components of integrated social care. It was noted that:

- Dear Albert was a lived experience recovery organisation. Everybody working with the organisation had lived experience of addiction.
- Half of staff were in paid employment; the other half were volunteers.
- The aim of the service was to facilitate a sense of belonging and connection to promote social connection and wellbeing.
- The purpose of the community rehab had been that anyone could go in at any time and they could meet people who are in active

recovery.

- Dear Albert had recognised and utilised partnership working and had advocated social and shared learning.
- Many recovery pathways had neglected the social aspect. It would be beneficial to see LERO and peer-led approaches to have a bigger part.
- Dear Albert had offered harm reduction and recovery focused environments. The aim had been to make recovery visible, viable and attractive.
- Capturing lived experience allowed individuals to become more involved, they are then offered training if they want to be more involved in order to then deliver support themselves.
- There had been significant footfall at the project, over a 1000 people had attended in the first quarter.
- DATV offered broadcasted support for those who had been unable to leave home. This had allowed many to start digitally and then progress to attending in person.

As part of discussions following the presentation it was noted that:

- Dear Albert had been doing phenomenal work and the passion of those supporting individuals was demonstrated in the judgement free environment.
- Dear Albert had offered a calming, welcoming and hopeful space that gave a genuine sense of a different path being available.
- Often those who had struggled with addiction had met barriers, but Dear Albert offered pathways that had provided direction and positivity.
- The impact of Dear Albert had been seen in many ways and the work had been truly inspiring.
- It was important not to lose sight of the social element of recovery amidst the focus on KPI's and funding targets.
- Dear Albert had just signed a 6-year lease on the premises. Dear Albert welcomed partners and stakeholders to share the space.
- The recovery agenda provided wasn't substance specific.
- There had been an increase in the use of alcohol and the number of associated deaths. Despite resources aimed at the problem, it had still been worsening.
- People had used substances to change and escape how they were feeling. That needed to be addressed.
- Dear Albert had been working with Age Concern and Last Orders to address increased alcohol misuse.
- Public Health leads shared positive feedback and views on the interventions lead by Dear Albert.

Agreed:

The Board thanked Jon and Dear Albert for the report and the work they had done.

101. CHANGING FUTURES

The Changing Futures Programme Manager presented the report to update the Board on the outcomes from the programme since it began running operationally 2 years ago. It was noted that:

- The programme was lottery funded.
- Between September 2022 and August 2024, 162 individuals had been supported. Currently, 36 individuals were supported.
- The team was multi-disciplinary. There were 6 intensive support workers, 2 police officers, substance use treatment worker, team manager and administrator, data analyst and the programme manager.
- The programme had worked closely with the voluntary sector and other partners.
- The team had done outreach work with Dear Albert, Turning Point and other partners to highlight the different services that were available. The team had visited areas where there had been a high footfall of street lifestyle behaviours.
- Over 12 months, one individual had 79 emergency department admissions, 65 ambulance call outs, 49 police call outs with an estimated cost of £159,000. This excluded any costs for other services such as housing or Turning Point. This cost could be prevented through intensive support offers.
- The individuals were generally aged 25-50 and had been subjected to multiple disadvantages. The majority had been reliant on drugs or alcohol, and most had a suspected or diagnosed mental health condition and many were homeless.
- Many of the women had engaged in sex work.
- 87% of support was successful. By the end of the support, the majority were in some form of accommodation.
- These individuals had been referred as they were failing to engage with services.
- The programme worked with prison leavers by engaging them while they were still in prison in order to build a relationship before release.
- The programme was part of a steering group for prison leavers.
- It had taken part in a pilot to reduce repeat presentation at the Emergency Department by supporting individuals to use GP services or alternatives.
- 19 individuals had been supported to attend appointments or to book outpatient appointments. The team had been actively seeking out individuals to help them attend appointments if they had not been contactable.
- The team had been liaising with in patients to ensure staff were aware of and planning for the different needs, as traditionally there had been a fear of being an inpatient due to withdrawals. This support helped ensure they were medicated appropriately and had the support needed.

- Often an individual had been referred for something specific like accessing treatment, but when this had been explored there were other factors that needed to be addressed to impact their ability to treat the referral point.

As part of discussions following the presentation, it was noted that:

- The funding had allowed work to occur with a small number of people, but the impact on those most vulnerable had been huge.
- The partnership working had been effective and was positive to see.
- The figures around the cost of contact with 'the system' were quite shocking.
- Conversations with the ICB around prison leavers and offenders had led to a team member being placed with them.
- The current funding was ending. Further funding access was being considered due to the positive impact of the programme.
- The goal for the next financial year had been to map the need and to consider what was meant by multi-level disadvantage and what this meant in Leicester.
- This mapping was essential in designing a sustainable model for moving forward to demonstrate the cost effectiveness of the services offered and the savings it made to other areas. If this was achieved in a robust manner it would make a powerful argument for future funding.
- Qualitative and quantitative data was to be gathered over the next quarter.
- The programme had helped address the gap of those faced with financial exclusion, using children's services, and health needs.
- The programme provided support to make the very first steps for those using the services whether that had been making an appointment, getting on the bus with them, attending an appointment etc.
- Changing Futures intensive support workers were person centred, focused on building rapport with individuals.
- The service had provided an important element that had invested in people's wellbeing and future potential as well as demonstrating cost effectiveness.

Agreed:

The report was noted.

102. WORKWELL PROGRAMME

The Deputy Chief People Officer, Integrated Care Board presented the LLR WorkWell Programme. It was noted that:

- The WorkWell Programme was a joint partnership of Work and Pensions (DWP) and Department of Health and Social Care (DHSC).
- Work Well services were expected to begin service delivery from

autumn 2024.

- WorkWells focus was on early intervention and support, offering participants an expert assessment of their health-related barriers, along with a tailored plan to address this .
- It had also served as a pathway to support existing local services.
- WorkWell had provided advice and support to employers to triage, signpost and send referrals to clinical and non-clinical support including wider community provisions.
- The Government's agenda was to support the WorkWell scheme as it aligned with its overarching agenda to 'get Britain working again,' which also linked to Integrated Care Systems and strategic objectives.
- As the only G7 country that had not returned to pre-COVID employment levels, this initiative underscored the importance of social value, equality, and the dignity and right to work for all individuals.
- The focus and goal of WorkWell was to support people with a disability and those with long term health conditions to start, stay and succeed in work.
- LLR was one of just 15 areas in England which was to benefit from the WorkWell pilot and receive 2 years of funding from the Department for Work and Pensions (DWP) and the Department for Health and Social Care (DHSC).
- The service was to link people to local support services, offering tailored help to stay in or return to work. The focus was to be on people in work who were struggling due to a health condition or disability, those who were on long-term sick leave and at risk of losing their job, or those who were recently unemployed who had faced a barrier to return to work due to a health condition or disability.
- As part of the WorkWell journey, participants, who did not need to be claiming any Government benefits were to work closely with a Work and Health Coach to understand their current health and social barriers to work and draw up a plan to help overcome them.
- Across the LLR ICB area there was to be a specific focus on the areas with the highest levels of economic inactivity and long-term conditions, particularly musculoskeletal disorders and mental health.
- People were to self-refer to WorkWell, or they could be referred through their employer, primary care providers such as GPs, or local services including Jobcentre Plus.
- The programmes focus was to connect current service provisions through referrals following triage to strengthen services currently available.
- The DWPs focus was an integrated approach to make a significant impact. Learning from participants journeys and building a user experience into pathways.
- Key principals:
    - Improving health equity
    - Preventing illness
    - Keeping people well
    - Right care at the right time
    - Health and wellbeing hubs

  - Elective care
  - Learning disabilities and autism
  - Mental health
  - Children and young people
  - Women’s health and maternity
  - Our people

- Additional funding had been made available to make the Joy App user friendly.
- Yearly 20000 individuals had requested fit notes in LLR, they all would be eligible for this service and the aim was to refer at least 4000 of the potential prime candidates into the programme.
- There were national KPIs and the ICB were building in a qualitative user experience for outcomes and measures.
- Governance was in place and the Integrated Care Partnership had been signed off.
- 22 of 26 PCNs were onboarded in the last few months and engagement work would take place to encourage the remaining PCNS to onboard.
- The programme had added 30 additional job posts into the LLR, through staggered recruitment campaigns.
- The programme launch was to be delayed for the new year, instead of the original date in October. It was delayed due to data sharing agreements between the DWP and PCN.

As part of discussions, it was noted that:

- The point of the pilot is to test and be conscious of the gaps that are holding people back from returning to work. Impacts on reductions in sick days and the impact on SMEs tentative discussions had taken place and would be ongoing. Work was taking place with the DWP to see how engagement with SMEs could improve going forward. The work coaches would help make a holistic plan for what matters to the individual, how they could be supported in getting back into work and a sustainable impact to keep them in work.
- 26 work coaches were based in Leicester City. An estimated 4000 people were using the scheme with concerns of whether the provisions in place had been suitable.
- The VCS had concerns that there were safeguarding issues with the Joy App.
- Regular evaluations on the programme were to be ongoing and part of that was to be the impact on equity. Monthly evaluations were to be reported to the steering group which involved LLR colleagues. More work was being done to onboard the remaining PCNs to ensure the evaluations are transparent across the programme.

AGREED:

- The board noted the report.
- That ICB colleagues update the board at the next meeting on concerns raised on safe guarding issues with the Joy App and to

liase with colleagues before the next meeting.

103. LEDER OVERVIEW AND ASK

The LeDeR Clinical Lead presented the overview. It was noted that:

- This was a very emotive topic as it covered the lives and deaths of people.
- There were 6 high impact actions, and the key focus within them were:
  - Reduce avoidable mortality.
  - Focus on co-morbidities associated with premature death and DNACPR/RESPECT.
  - Importance of LeDeR reviews.
  - Understand the experience of ethnic minority groups.
  - Improve the accuracy of Learning Disability Registers and uptake of AHC.
- There had been reduced notification of ethnic minority backgrounds.
- It was paramount to highlight the individual person that lay behind the figures and data.
- A case study was presented. It was shocking, but not unusual.
- There was an inability to make reasonable adjustments for individuals accessing services.
- Learning disabilities and Autism needed to be flagged to health providers on systems.
- Preventing avoidable deaths had required ideas coming through from within the existing system.
- Improvements had been required in cancer screening, along with earlier screenings.
- There had been consideration of designing something that would actively encourage those with Learning Disability and Autism to access services.
- There were 2 important statements from LeDeR that were highlighted. The first was that LLR LeDeR urged the local system to act and enforce the MCA and ensure it becomes intrinsic to everyday care and support to people with a Learning Disability and Autistic people. Secondly, that these individuals were at increased risk of communication or pain being misinterpreted or missed altogether, despite tools having been readily available.
- Respiratory illnesses had been the leading cause of death in Leicester, Leicestershire and Rutland. Cardiovascular was the leading national cause of death.

As part of discussions following the overview, it was noted that:

- The Oliver McGowan training had a direct impact. At the end of December, 9800 individuals had been trained. This training had resulted in more awareness and had connected individuals across health services, and had operated as a gateway.

- The issue of respiratory and cardiovascular mortality rates was to be taken back to the collaboratives.
- Work had been done on HPV vaccines and cervical screening for those with Learning Disabilities. It had been important for health professionals and for the education of families to understand how important attendance was.
- The issue of diagnosis could have been impacting the recording of deaths for those who had Learning Disabilities or Autism.
- The health outcomes for this cohort had been very different from those of the general population.
- It was queried whether cancer diagnosis was improving for those with Learning Disabilities and Autism.
- Pain management tools needed to be utilised so individuals who had been unable to express their needs could have had their needs supported appropriately.
- There had been issues around reporting. Work had been done on Downs Syndrome but there had not been a means of flagging.
- Communication had been needed around ethnic minority groups and had there been more that could be done around annual health checks to help reporting.
- Digital pathways had been needed to manage this issue and it needed to be incorporated into the everyday thinking of what flags appear and where.

Agreed:

The report was noted.

104. HEALTHY WEIGHT

The Deputy Director of Public Health presented the update on the Healthy Weight programme following feedback at the September Health and Wellbeing meeting that informed the KPI’s. It was noted that:

- Children and young people had been built in following the feedback received previously.
- The areas that were highlighted in the presentation do not reflect all the work which had been going on. There had still been ‘business as usual’ with work on weight management services, along with work in schools and nurseries etc which had not been not brought here.
- Intervention training had been made available to partners, which included healthy communication skills which enabled partners to have the skills to start conversations and signpost around weight. This had upskilled workers who were already working in the areas.
- The focus on pregnancy had been extended to post pregnancy as more impact can be had in this period. A health needs assessment was

currently being completed on this.

- Training had been provided for those working with pregnant women or new mums to give more confidence to provide support and signpost. There were a number of KPI’s focused on this to monitor the impact.
- Provision of aqua natal classes and other services at affordable prices was being considered.
- Following covid, the number of schools who had participated in the daily mile had plummeted so there had been a focus to engage schools in more physical activity. This was a priority for Inspire Together and LPT nurses in schools.
- The Live Well service had not had many referrals for those with learning disabilities so there had been training for staff to ensure they had confidence in making referrals and providing support.
- Contracts had been considered and how healthier living can be built into all aspects of them.

Following the update, as part of discussions it was noted that:

- More conversations had been needed to aid collective work that had taken into account everything that was available, as well as the gaps.
- A workshop had been scheduled for January on healthy weight led by the long-term conditions collaborative.
- The influencing factors such as poverty and mental health that impact on weight management had to be considered.
- VALUES project had seen 120 clients assessed by social services. Training for support workers who needed to have access to healthy weight training needs to be considered.
- The practicality of the implementation of legislation was discussed as an option for controlling the excessive number of takeaways in an area.

Agreed:

1. Distribute materials so that they can be shared with staff working in schools.
2. Report noted.

105. INTEGRATED HEALTH AND CARE GROUP UPDATE

The Health and Wellbeing Board’s Programme Manager provided a verbal update of the report. It was noted that:

- The group was established in September 2024 and had met monthly to address different matters around health collaboratively.
- It was hoped that a clear pathway would be established for the group to feed into the Health and Wellbeing Board.
- There had been recruitment of a manager who was to attend the Health and Wellbeing Board in the future.

As part of discussion, it was noted that:

- A risk log was to be developed and fed into the broader ICS systems.
- The meetings must be meaningful. The participation of the VCS has encouraged this.

Agreed:

The report was noted.

106. HEALTH AND WELLBEING BOARD ANNUAL REPORT

The Health and Wellbeing Board's Programme Manager provided a brief verbal update of the report. It was noted that:

- The annual report had shown the progress made across the year in general work and statutory duties.
- There had been updates on case studies, the Better Care Fund and other subgroups which had fed into the Health and Wellbeing Board.
- A significant proportion of the report had focused on the 19 priorities and the 6 that were monitored on a monthly basis.
- The conclusion of the report had contained the next steps and the work plan for the next period.

Following discussions, it was noted that:

- The report had held a lot of detail and it needed to be considered how to utilise the case studies to demonstrate the excellent work.
- Moving forward, it had been decided that there will be a section for case studies on monitoring documents.
- Case studies had provided a reality around an individual's experience, and this could be used for the 4 priority areas.

Agreed:

The report was noted.

107. DATES OF FUTURE MEETINGS

The next meeting would take place on 6th March 2025.

108. ANY OTHER URGENT BUSINESS

A Councillor for Evington Ward requested to speak on concerns of a surgery closure. It was noted that:

- The surgery had served around 1000 residents, with many elderly patients.

- An alternative surgery could be up to 4 bus rides away concerns of access were raised.
- An increase in emergency department visits could result.
- It was requested that the ICB postpone the closure or allow another practise to take on the branch.

The Chair gave the ICB the right to reply. As part of the ICB's response, it was noted that:

- Mitigations had been put in place for patients.
- Public meetings were held with residents in preparation of the closure, and another was to be held in January.

The Chair thanked colleagues and Members and the meeting closed at 12.03.

Leicester
City Council

LEICESTER CITY HEALTH AND WELLBEING BOARD
DATE: 6th March 2025

Subject:	Pharmaceutical Needs Assessment
Presented to the Health and Wellbeing Board by:	Email circulation
Author:	Helen Reeve

EXECUTIVE SUMMARY:

The purpose of this report is to provide an update to the Health and Wellbeing Board in relation to the progress of the Pharmaceutical Needs Assessment (PNA), which includes an update on the timescales, an update on the statutory consultation timelines, and the work around communications.

RECOMMENDATIONS:

The Health and Wellbeing Board is requested to:

- to note this report and that updated timescales are achievable and on track (will include a brief update on current data analysis)
- to note the timelines around statutory consultations and its affect on document approval in relation to future HWB meetings
- to note the work being done around communications to ensure we achieve maximum coverage and feedback from professionals and the general public
- to receive and review a draft report in spring 2025 prior to the statutory consultation period
- to receive and review a final report in September 2025 for publication in October 2025

Pharmaceutical Needs Assessment: Context

1. The Health and Wellbeing Board has a statutory responsibility to prepare a Pharmaceutical Needs Assessment (PNA) for Leicestershire and publish it by 1st October 2025.

2. The purpose of the PNA is to:
   - Identify the pharmaceutical services currently available and assess the need for pharmaceutical services in the future;
   - inform the planning and commissioning of pharmacy services by identifying which services should be commissioned for local people, within available resources, and where these services should be;
   - inform decision making in response to applications made to NHS England by pharmacists and dispensing doctors to provide a new pharmacy. The organisation that will make these decisions is NHS England.

3. The last PNA for Leicester was produced in 2022 and can be accessed at: https://www.leicester.gov.uk/your-council/policies-plans-and-strategies/public-health/data-reports-and-strategies/pharmaceutical-needs-assessment-pna/

4. The responsibility for producing the PNA rests with Health and Wellbeing Boards in the general reforms embodied in the Health and Social Care Act (2012). The NHS (Pharmaceutical Services and Local Pharmaceutical Services) Regulations 2013 (amended) sets out the minimum information that must be contained within a PNA and outlines the process that must be followed in its development and can be found at: https://www.legislation.gov.uk/uksi/2013/349/contents

5. In October 2021, the Department of Health and Social Care published a pharmaceutical needs assessment information pack for local authority health and wellbeing boards to support in the developing and updating of PNAs. The guidelines for this year's PNA haven't been updated so we are using the previous version from 2021.The PNA guidance can be accessed via the following link: https://www.gov.uk/government/publications/pharmaceutical-needs-assessments-information-pack

6. The PNA is a statutory document that is used by NHS England to agree changes to the commissioning of local pharmaceutical services. As such, if NHS England receives a legal challenge to the services they commission based on the PNA, the local authority could also be part of that legal challenge. It is essential that the process that is followed meets the legislation that is set out and that the PNA is a robust document.

Content and Timescales

7. The regulations and guidance documents provide information on the PNA content. This has been reflected in the overview of proposed content of the PNA provided in Appendix 2.

8. Since the last PNA the Government's policy document of "Community pharmacy: delivering substance misuse services" has been implemented. The impact of these changes and an assessment of the new and emergent system should be examined to understand the implications for the PNA 2025.

9. The project plan is tight with respect to delivering a signed off PNA by the 1st of October 2025. The PNA Reference Group will monitor this and report any issues of concern to the Health and Wellbeing Board.

Scrutiny / stakeholder engagement

10. As many of the relationships required for the PNA are Leicester, Leicestershire and Rutland (LLR) wide – involving representation from NHS England, the Leicestershire Pharmaceutical Committee, Local Professional Network for Pharmacists and the Leicester, Leicestershire and Rutland Local Medical Committee - a PNA Reference Group has been established. This Reference Group will support PNA work across the three Health and Wellbeing Boards, identify any economies of scale that can be delivered through joint work and ensure that there is an effective process for consultation on the PNAs. However, there will be separate PNAs for Leicester, Leicestershire and Rutland and each will be signed off by the respective Health and Wellbeing Board.

11. Terms of reference and membership for the PNA Reference Group are attached as Appendix 1.

12. It is proposed that the Health and Wellbeing Board will approve the pre-consultation draft version and the final version of the Leicester PNA. The PNA reference group will submit the pre-consultation draft PNA for approval in the spring of 2025. The final draft of the PNA will be submitted for approval in September 2025, allowing publication towards the beginning of October 2025. The PNA Reference Group will also provide assurance to the Health and Wellbeing Board that the final PNA is an accurate reflection of the pharmaceutical needs of the population and has been developed using robust processes. Due to timings of future HWB Board dates, the draft version may have to be signed off prior to the June meeting. The Reference Group will provide assurance over the content of the draft PNA and it can be circulated to HWBB members by email for agreement to go to consultation.

13. The principal resourcing for the development of the Leicester City PNA is provided by the Leicester Public Health Intelligence Team, with information and advice provided through the PNA Reference Group by NHS England, the LPC, ICBs and others.

Consultation

14. To gather additional intelligence for the PNA, two surveys are being undertaken. One survey asks service users for their views on the current pharmaceutical provision and the second collects data on services provided, opening times etc from pharmaceutical professionals. The findings from these two survey exercises will be incorporated into the main PNA document.

The 2 surveys are open and will run from 03/02/2025 until 04/04/2025

2025 Local PNA Surveys

Public survey:
The hosting site for the survey is available here: https://www.leicestershire.gov.uk/have-your-say/current-engagement/pharmaceutical-needs-assessment.

This is the direct link to the survey: https://surveys.leics.gov.uk/snapwebhost/s.asp?k=173833722029.

The public facing survey will be advertised via social media (both Public health and corporate), Leicester City Council newsletters, ICB networks and community networks including a poster to be displayed within the pharmacies.

Professional survey:
This has been circulated to all Leicester pharmacy contractors for completion.

15. The PNA is subject to a 60-day statutory consultation period which will start in June 2025. Regulation 8 of the Pharmaceutical Services Regulations specifies that the Health and Wellbeing Board must consult with the following: -

- the Local Pharmaceutical Committee
- the Local Medical Committee
- any persons on the pharmaceutical lists and any dispensing doctors list for its area
- any LPS chemist in its area with whom NHS England has made arrangements for the provision of any local pharmaceutical services
- Healthwatch, and any other patient, consumer or community group in its area which in the view of the Health and Wellbeing Board has an interest in the provision of pharmaceutical services in its area;
- any NHS trust or NHS foundation trust in its area
- NHS England
- any neighbouring HWB.

16. Health and Wellbeing Boards must consult the above at least once during the process of developing the PNA. Those being consulted can be directed to a website address containing the draft PNA but can, if they request, be sent an electronic or hard copy version.

17. The draft PNA will be published on the Leicestershire County Council website, and they will also host the consultation for all three PNA's.

Appendix 1:

LEICESTERSHIRE COUNTY COUNCIL, RUTLAND COUNTY COUNCIL AND LEICESTER CITY COUNCIL

PHARMACEUTICAL NEEDS ASSESSMENT REFERENCE GROUP

DRAFT TERMS OF REFERENCE

Purpose:

The Pharmaceutical Needs Assessment (PNA) is a legal duty of the Health and Wellbeing Board (HWB) and each HWB will need to publish its own revised PNA for its area by 1st October 2025.

The purpose of this reference group is to oversee the development of the PNA for Leicestershire, the PNA for Rutland and the PNA for Leicester City.

The team will set the timetable for the development of the PNA, agree the format and content of the PNA and ensure that each PNA fulfils statutory duties around consultation for the PNA.

The team will be a task and finish group, meeting between December 2024 and September 2025.

Key responsibilities:

- To oversee the PNA process
- To assure itself that the development of the PNA meets the statutory duties of the HWBs and are in line with national guidance
- To ensure active engagement from all stakeholders
- To communicate to a wider audience how the PNA is being developed
- To ensure that the PNA addresses issues of provision and identifies population need for services
- To map current provision of pharmaceutical services
- To identify any gaps in pharmaceutical provision
- To map any future provision

Governance:

- Leicestershire County Council – the Health and Wellbeing Board will ensure the PNA is conducted according to the legislation.

- Rutland County Council – the Health and Wellbeing Board will ensure the PNA is conducted according to the legislation.

- Leicester City Council - the Health and Wellbeing Board will ensure the PNA is conducted according to the legislation
- The reference group will be chaired by the Public Health Director, Mike Sandys.

PNA Reference Group membership:

Local Authority PNA Leads

- Mike Sandys, Leicestershire County Council, Chair
- Representative for Rutland County Council (or Mike to cover)
- Liz Rodrigo. Consultant in Public Health, Leicester City Council

Community Pharmacy Leicestershire and Rutland

- Rajshri Owen, Chief Executive Officer

LLR NHS (Integrated Commissioning Board)

- Paul Gilbert, Clinical Pharmacy Commissioning Lead
- Amit Sammi, Head of Strategy and Planning
- Gillian Stead, Medicines Management Lead

HealthWatch

- Harsha Kotecha, Leicester and Leicestershire
- Janet Underwood, Rutland

NHS England

- Dianne Wells, Senior Commissioning Manager, Pharmacy, Optometry and Dental

UHL

- Claire Ellwood, Chief Pharmacist, ICB

Public Health Intelligence Leads

- Victoria Rice/Hanna Blackledge, Leicestershire County Council
- Amy Chamberlain, Rutland County Council
- Helen Reeve, Leicester City Council

LLR Local Medical Committee

- Charlotte Woods, Operations Manager

Voluntary Action LeicesterShire

- Kevin Allen-Khimani

Leicestershire Equalities Challenge Group

- Mathew Hulbert, True Colours

District Council Representative

- Edd de Coverly, Chief Executive, Melton Borough Council

NB: Membership will be reviewed regularly and may be extended by agreement of the Reference Group members.

Frequency of meetings: the Group will have five meetings – December 2024, February 2025, March 2025, May 2025, August 2025.

Additional meetings may possibly be required between January 2025 and May 2025 as this will be the main development phase of the PNA.

Support arrangements:

The minutes of the meetings will be taken by admin support at by Leicestershire County Council.

Confidentiality

An undertaking of confidentiality will be signed by all members of the Reference Group.

During the period of membership of the Reference Group, members may have access to information designated by the Local Authorities or other members as being of a confidential nature and which must not be divulged, published or disclosed without prior written consent. Improper use of or disclosure of confidential information will be regarded as a serious disciplinary matter and will be referred back to the employing organisation. For the avoidance of doubt as to whether an agenda item is confidential all papers will be marked as confidential before circulation to the group members.

Declarations of Interest

Where there is an item to be discussed, where a member could have a commercial or financial interest, the interest is to be declared and formally recorded in the minutes of the meeting.

APPENDIX 2

PHARMACEUTICAL NEEDS ASSESSMENT – WORKING OUTLINE

Purpose

1. To support local commissioners in deciding on the provision of NHS funded services through community pharmacies in Leicestershire. These services are part of the local healthcare provision and affect NHS and Local Authority budgets.

2. To support NHS England in the determination of market entry decisions.

3. To provide a robust governance framework should a market entry decision are contested or challenged legally by an applicant or by existing NHS contractors.

4. To provide a source of relevant reference to Leicester, Leicestershire and Rutland local authorities, clinical commissioning groups and NHS England for the commissioning of any future of local pharmaceutical services.

Publication Outline

The PNA will review and include:

- Existing pharmacy provision and services including dispensing, health care and lifestyle advice, medicines reviews and information and implementation of public health messages and services.

- Dispensing by GP surgeries.

- Services available in neighbouring Health and Wellbeing Board areas that could affect the need for services.

- Demographics of the relevant population shown as a whole and more specifically by locality with clear indication of needs specific to each area.

- Gaps in the provision of services, taking into account future requirements that could be met by providing more pharmacies or pharmacy services.

- Local area maps locating pharmacies and pharmaceutical services.

- Impact of “The Community Pharmacy Contractual Framework for 2019/20 to 2023/24: supporting delivery for the NHS Long Term Plan” document.

The PNA will not include:

- Prison pharmaceutical services;
- Hospital pharmacies.

The published document will cover the following key areas of review (this list is a guide and will evolve alongside the development of the report and subject to advice from the wider Reference Group):

1. Context for the Pharmaceutical Needs Assessment

2. Description of current services
    2.1. Essential Services
        - Dispensing
        - Repeat Dispensing
        - Disposal of Unwanted Medication

- Promotion of Healthy Lifestyles
- Sign Posting
- Support for Self-Care
- Clinical Governance

2.2. Advanced Services – these are optional services that are commissioned nationally by NHS England through the core contract

- Medicine Use Review and Prescription Intervention Service (MUR) Activity
- New Medicines Services (NMS)
- Appliance use reviews (AUR)
- Stoma Appliance Customisation Service
- Community Pharmacist Consultation Service (CPCS) Activity
- Hepatitis C Antibody Testing Service Activity
- FLU Vaccinations
- Seasonal Influenza Vaccination Advances Service (FLU) Income
- Discharge Medicine Service Income
- Covid Vaccination Service Activity

2.3. Enhanced Services which are locally commissioned (list is an example)

- Out of Hours Services
- Supply of Palliative Care Drugs
- Minor Ailment Scheme
- Advice and Support to Care Homes
- Emergency Hormonal Contraception (EHC)
- Chlamydia Screening
- Stop Smoking Services
- Alcohol Brief Interventions
- NHS Health Checks
- Supervised Consumption
- Needle Exchange
- Healthy living pharmacies

2.4. Pharmacies facilities

- Wheelchair access
- Access to disabled car parking within 100m
- Private consultation rooms
- Customer toilets
- IT facilities
- Foreign languages spoken
- Electronic prescription service

2.5. Different types of pharmacy contract

- Internet/distance selling
- 100-hour dispensing
- Dispensing practices
- Dispensing appliance contractors
- One-Stop primary care centres
- Cross-border pharmacies affecting local population
- Hospital pharmacy discharge medication arrangements
- Prison pharmacy arrangements
- Rurality

3. Each local authority will produce an overarching health needs document as part of their JSNA process which will inform the PNA.

    3.1. Local Health Needs
    - This will be the section that identifies the health needs that need to inform the commissioning of the pharmaceutical needs assessment – so the interpretation of the health needs document into the services that can be commissioned through community pharmacy
    - For example, mapping of teenage pregnancy hotspot wards to EHC provision.
    - Include a review of patients that are not within a 10-minute drive time or a 20-minute walk time of a pharmacy
    - Leicestershire and Rutland need to include a section on rurality and the changes to the areas designated as rural linked to the existing PNA

4. Changes to demography, services, etc. that will affect pharmaceutical needs
    - Demographic changes
    - Planning intentions and housing developments
    - Care homes and retirement villages
    - Issues such as the impact of the co-operative pharmacy plans

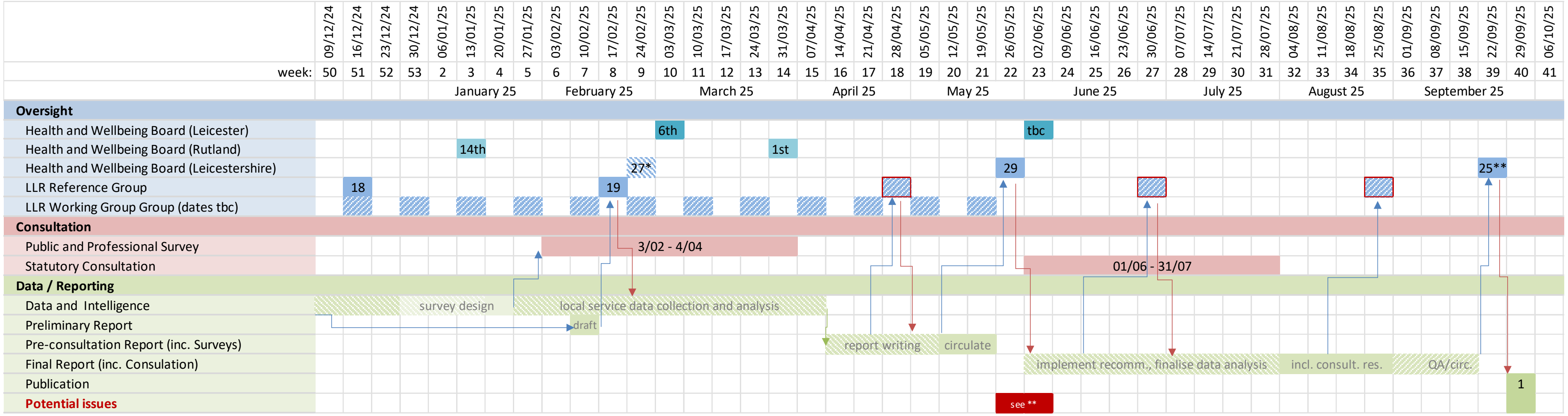
5. Key Strategic Priorities
    - Local Authority JHWS
    - NHS England Primary Care Strategy
    - NHS Long Term Plan
    - Community Pharmacy Contractual Framework 2019-2024

6. Neighbouring and Regional Services

7. Engagement

8. Conclusions
9. Recommendations
10. Equality Impact Assessment
11. Table of Abbreviations/Glossary
12. Appendices

PNA timeline



NOTES

* optional HWB - a short update as a public health item

** leaves only 3/4 working days for any amendments following the Leicestershire HWB - likely to need an earlier sign-off by the Board

Proposed LLR Reference Group date:		Focus:
18/12/2024	1	First meeting - initial process, scope, ToR etc
19/02/2025	2	Update on the analysis (preliminary reports or a presentaion), data gaps and consultation
week of 28/04/25	3	Update including local and professional survey results
week of 30/06/25	4	Report progress, any additional analyses of data (national and local)
week of 25/08/25	5	Update on statutory consultation, sign off the final report draft fot the HWB

Recommended by the guidance:

Wk 6	initial meeting - ToR, timeline, localities, content of questionnaires, structure of the document
Wk 28	review final draft (?), consider gaps in provision, current or within lifetime of the document
	review and sign off final pre-consultation draft to be submittet to the HWB **(can be by email)**
Wk 49	after the consultation - review responses and and any changes needed; agree on the response to consulation to sign-off the final document **(can be by email)**

note - guidance assumes a full year development cycle

LEICESTER CITY HEALTH AND WELLBEING BOARD
DATE

Subject:	Leicester Health and Wellbeing Survey (adults)
Presented to the Health and Wellbeing Board by:	Gurjeet Rajania
Author:	Gurjeet Rajania, Principal Public Health Intelligence Analyst, Leicester City Council.

Does the report concern any of the below groups?			
Severe Mental Illness	Learning Disability	Homelessness	Care Experience Children and Young People
☐	☐	☐	☐

EXECUTIVE SUMMARY:

The Leicester Health and Wellbeing Survey 2024, conducted by DJS Research for Leicester City Council, provides a snapshot of health and wellbeing for residents aged 16 and over. It follows similar surveys from 2010, 2015, 2018, and youth-focused surveys in 2017 and 2021.

A key purpose of the survey is to monitor health inequalities across the city and help identify those who are most in need. This will then inform the council and partners' commissioning, service planning and policy making to improve health and wellbeing.

DJS Research surveyed 2,100 residents aged 16 and over in Leicester between April and October 2024. Quotas (based on 2021 Census) were set to ensure the sample was representative of Leicester's population.

The report includes an Executive Summary and sections on the following topics:

- General health and access to health services
- Mental health and wellbeing
- Diet and physical activity
- Smoking, vaping and alcohol consumption
- Gambling
- Financial issues
- Carers
- Sexual Health
- Local place
- Housing.

Overall the survey shows a positive picture of health and wellbeing, with residents more likely to rate their health as good, most residents feel they have a support network they can rely on in difficult times, and four in five residents say they tend to bounce back quickly after hard times

The survey also identifies several health and wellbeing challenges facing Leicester residents. Nearly a quarter of residents have faced difficulties paying their food and energy bills in 2024, more than double the 2018 figure, residents face challenges in accessing medical services, particularly for NHS dentists and GPs, and one in seven have an alcohol consumption classification of ‘increasing risk’ or higher for harmful drinking.

The full report (attached) contains further details and insights.

RECOMMENDATIONS:

The Health and Wellbeing Board is requested to:

- Review the findings of the Health and Wellbeing Survey.

- Promote the use and dissemination of this unique dataset within your own organisations and in the wider voluntary and community sector.

- Consider the implications of the findings for your service areas.

- Provide recommendations on further interrogation and analysis of the survey dataset.

Leicester Health and Wellbeing Survey 2024

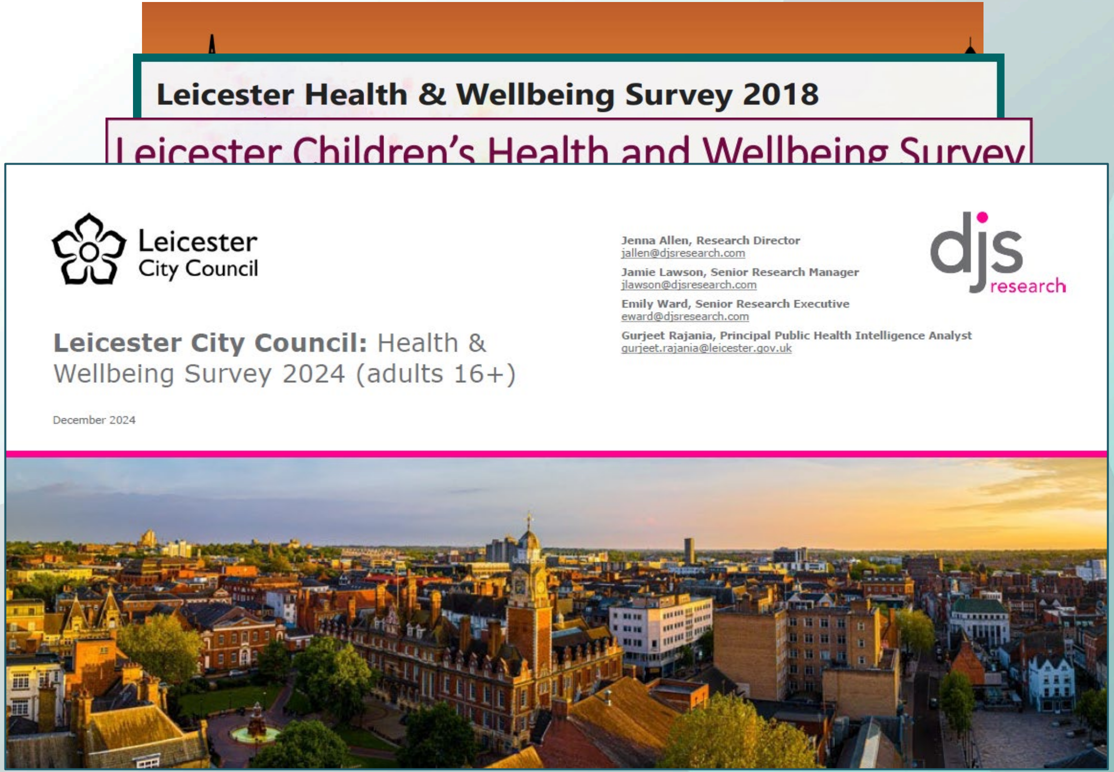
A briefing for Leicester Health and Wellbeing Board: 06/03/25

Prepared by:
Gurjeet Rajania Gurjeet.Rajania@Leicester.gov.uk
Principal Public Health Intelligence Analyst
Division of Public Health, Leicester City Council

Leicester
City Council

Contents

1. Background & Survey Methodology
2. Key Findings
3. Accessing report and results
4. Further analysis



Leicester Health & Wellbeing Survey 2018

Leicester Children's Health and Wellbeing Survey

Leicester City Council

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djs research

Leicester City Council: Health & Wellbeing Survey 2024 (adults 16+)

December 2024

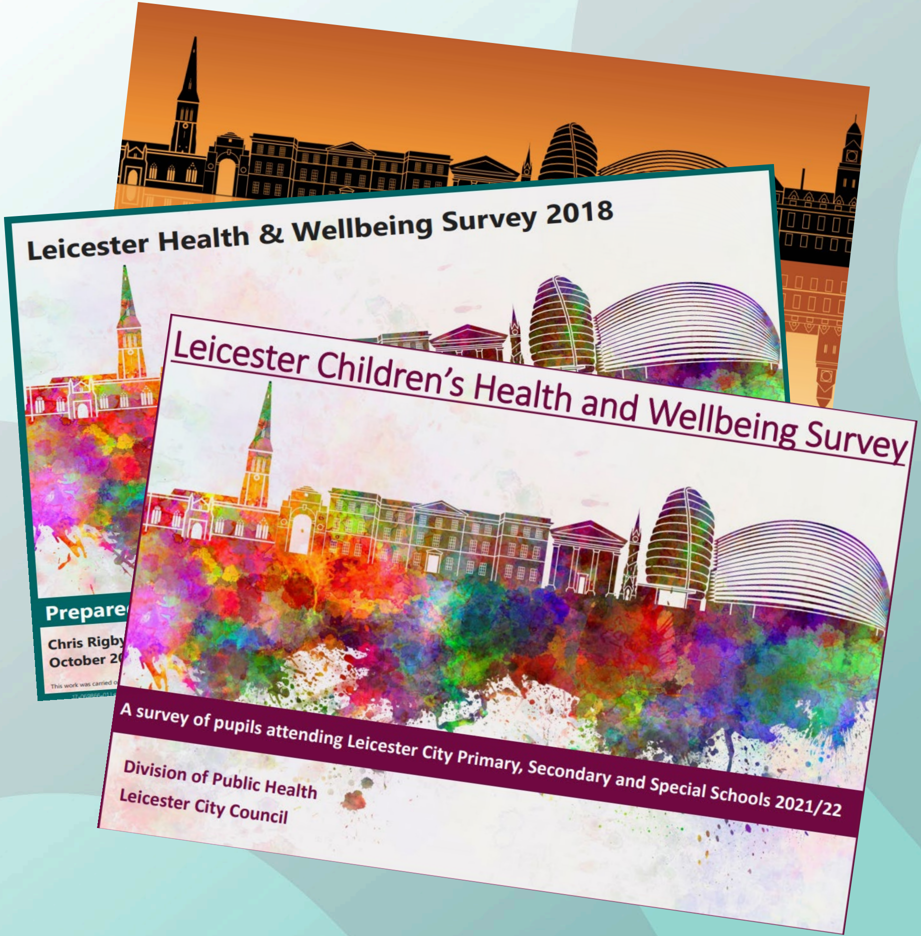
Background: The last adults (16+) Leicester Health and Wellbeing Survey was carried out in 2018.

There have been a series of Leicester Health and Wellbeing Surveys for both adults (2010, 2015 & 2018) and children (2016/17 & 2021/22).

The primary purpose of the surveys is to inform strategic and specific need assessments which are essential to the council and partners' commissioning for improved health and wellbeing.

Health and wellbeing survey data is used by Leicester City Council and its partners to contribute to a wide variety of work, including needs assessment, better targeting of interventions, funding bids, and area profiling.

It provides a source of intelligence not available via other sources.



Leicester Health & Wellbeing Survey 2018

Prepare

Chris Rigby
October 20

Leicester Children's Health and Wellbeing Survey

A survey of pupils attending Leicester City Primary, Secondary and Special Schools 2021/22

Division of Public Health
Leicester City Council

Leicester health and wellbeing surveys

Survey Methodology: To broadly follow the methodology of previous surveys to allow for trend analysis.

DJS Research were commissioned to complete the 2024 Leicester Health and Wellbeing Survey.

It was a face-to-face household survey:

- Fieldwork took place between 17 April 2024 and 2 October 2024. A total of 2,100 interviews were completed.
- A number of sampling points were randomly selected within each Leicester ward. Quotas (using 2021 Census) were set based on age, gender, ethnicity, economic status and disability to ensure a representative sample.
- 20 minute survey with sensitive questions self-complete unless assistance is requested.
- The majority of surveys were complete in English, but some were complete in another language.

Contents

New Content

- **COVID-19**
- **Access to health services**
- **Mental Health and Wellbeing**
- **Gambling**
- **Place and Active Travel**
- **Food Insecurity and support**
- **Vaping**
- **Digital inclusion and confidence**
- **Sexual Health**
- **Housing issues**

Leicester City Council

Health & wellbeing survey 2024

In 2024, Leicester City Council commissioned a health and wellbeing survey to provide a high-quality snapshot of behaviours and attitudes among Leicester's adult population. The research explores residents' views on their local area, access to services, and health and wellbeing, with results informing the delivery of services across the city. Below are the key findings.

Top five positives:

Four in five residents rate their general health as **very good** or **good**

There has been a decline of **4% points** in those who smoke cigarettes compared to 2018 (16% cf. 20%)

Three in four residents use parks, waterways and other green spaces **at least monthly**

Most residents feel they have a **support network** they can rely on in difficult times

Ranging from 67% to 87% depending on the scenario

Four in five residents say they tend to bounce back quickly after hard times

Top five challenges:

Nearly a quarter of residents have faced difficulties paying their food and energy bills in 2024, more than double the 2018 figure (23% cf. 10%)

Residents **face challenges in accessing medical services**, particularly for NHS dentists and GPs

One in 14 residents with children under 16 living at home say that they smoke in the house

One in seven have an alcohol consumption classification of 'increasing risk' or higher for harmful drinking

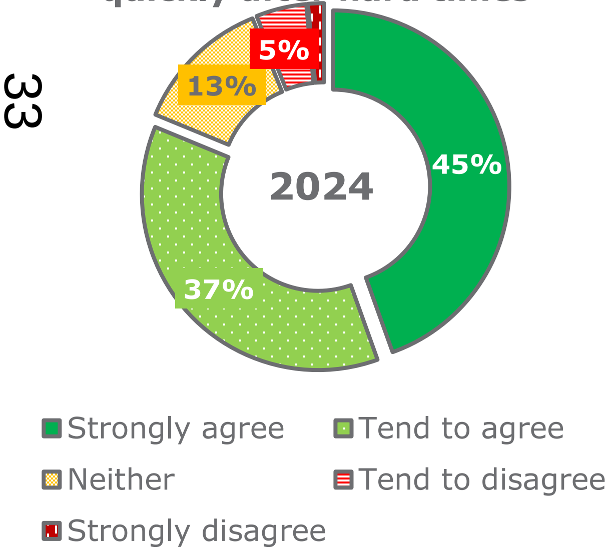
One in 20 households report the presence of damp and mould in the home

Survey conducted by DJS Research for Leicester City Council (April – October 2024) consisting of 2,100 face-to-face (CAPI) interviews across Leicester's 21 wards. The full report can be found here: www.leicester.gov.uk/your-council/policies-plans-and-strategies/public-health/data-reports-and-strategies/leicester-health-and-wellbeing-surveys. Research and design by djsresearch.co.uk

Resilience

Four in five residents believe that they bounce back quickly after hard times (81%), while 13% are neutral and 6% disagree. These results represent a significant improvement on 2018, with the percentage who agree with this statement having increased by 17% points (64% in 2018).

"I tend to bounce back quickly after hard times"



	2024	2018
Agree	81%	64%
Disagree	6%	17%

Key differences:

The percentage who agree that they bounce back quickly decreases slightly with age. Around 85% of the three youngest age groups (16-29, 30-39 and 40-49) agree, but this drops to around 75% for the three older ager groups (50-59; 60-69; 70+).

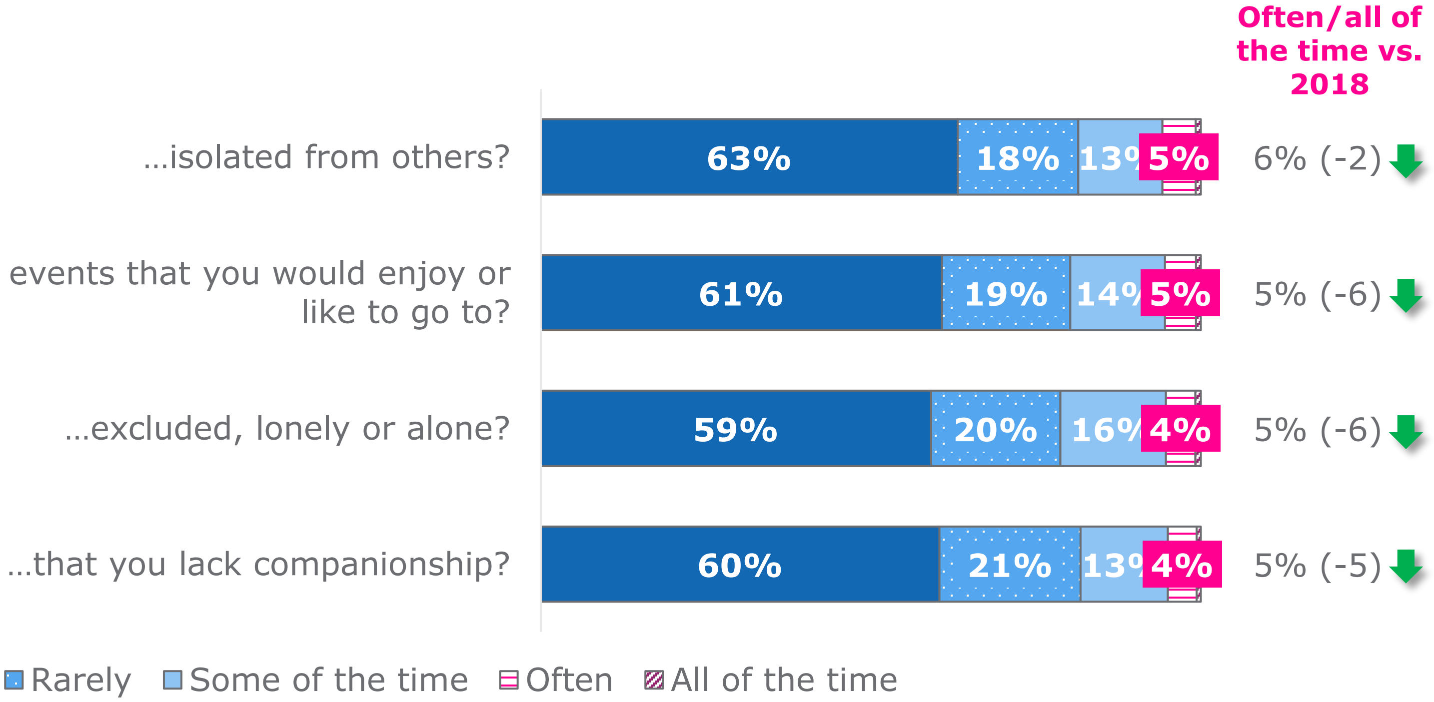
Men are significantly more likely than women to agree that they bounce back quickly (84% v 79%).

So too are those who have no long-term health conditions (86%) compared to those who have one long-term health condition (69%), or multiple (55%).

Q029. To what extent do you agree or disagree with the following statement? 'I tend to bounce back quickly after hard times'. **Base:** All respondents (2,100). Data labels <5% removed for neatness.

How often residents feel…

Encouragingly, the percentage of residents who often/always feel isolated, left out, excluded or that they are lacking companionship has fallen significantly compared to 2018.

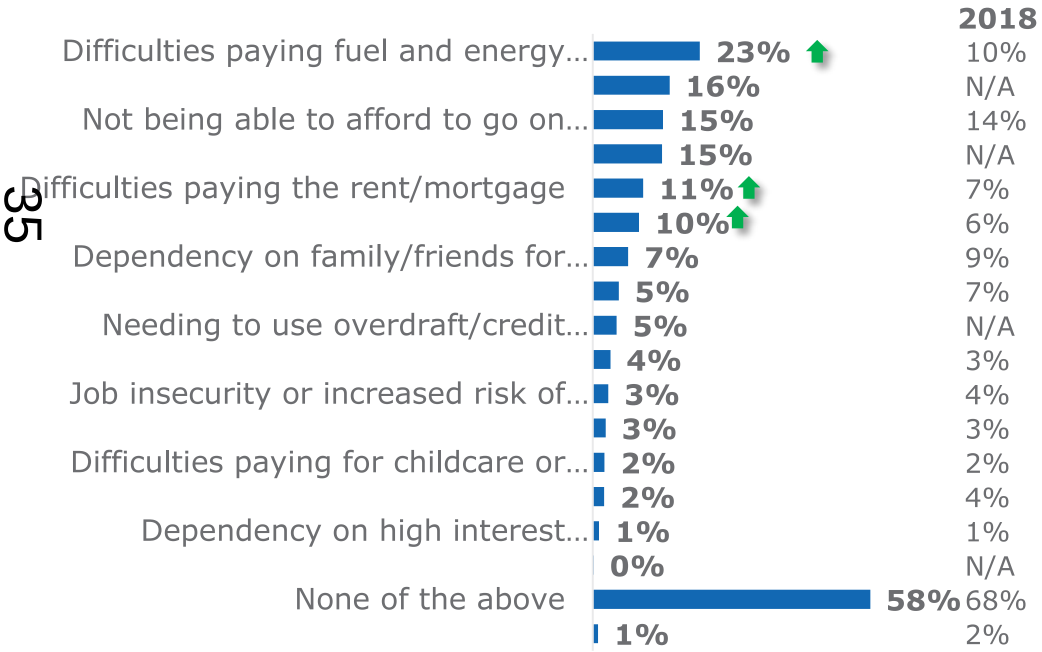


Q030. Which of these best describes how often you feel…? **Base:** All respondents (2,100). *New statement for 2024. Data labels <4% removed for neatness.

⬇ ⬆ Sig higher/lower than overall

Financial difficulties

The landscape has shifted since 2018 in terms of the struggles of Leicester residents. In 2018, the most commonly cited difficulty was not being able to afford to go on holiday, but in 2024 it is difficulties paying fuel and energy bills (23%). Indeed, this figure has more than doubled since 2018 and reflects the economic challenges experienced over the past few years.



	2024	2018
Basic living costs*	31%	14%
Employment*	5%	7%

Key differences:

Older generations are least likely to have experienced any of these issues, with 82% of those aged 70+ stating they've been affected by none of the above. In contrast, those with conditions that limit their ability to carry out day-to-day tasks, those in the North West and social renters are all significantly more likely to have experienced at least one of these difficulties.

Q017. Have you been affected by any of the following in the last 12 months? **Base:** All respondents (2,100)
Note: new codes added in 2024 which means these results are not directly comparable.
*Basic living costs include codes relating to difficulties in paying: rent/mortgage, fuel/energy, council tax, water bill, food, and interest on loans. **Employment includes: job insecurity and loss of jobs/redundancy.

⬆ ⬇ Sig higher/lower than previous survey

Further analysis available by:

- Gender
- Age
- Ethnicity
- Religion
- Long term illness/disability
- Employment status
- Deprivation
- Languages
- Qualifications/Education
- Housing tenure/Occupancy
- Lower level geographies
- Children present in household

For more information

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Principal Public Health Intelligence Analyst
Division of Public Health, Leicester City Council

Leicester City Council

The full report can be found on the Leicester City Council webpage:

https://www.leicester.gov.uk/your-council/policies-plans-and-strategies/health-and-social-care/data-reports-information/leicester-health-and-wellbeing-surveys/

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Leicester City Council: Health & Wellbeing Survey 2024 (adults 16+)

December 2024

Contents

Background, methodology and understanding the report

Background & methodology

DJS Research were commissioned by Leicester City Council to conduct a face-to-face (CAPI) survey of residents in Leicester aged 16+.

Fieldwork took place between 17 April 2024 and 2 October 2024. A total of 2,100 interviews were completed.

A number of sampling points were randomly selected within each Leicester ward. Interviewers went door-to-door within these sampling points to gather interviews.

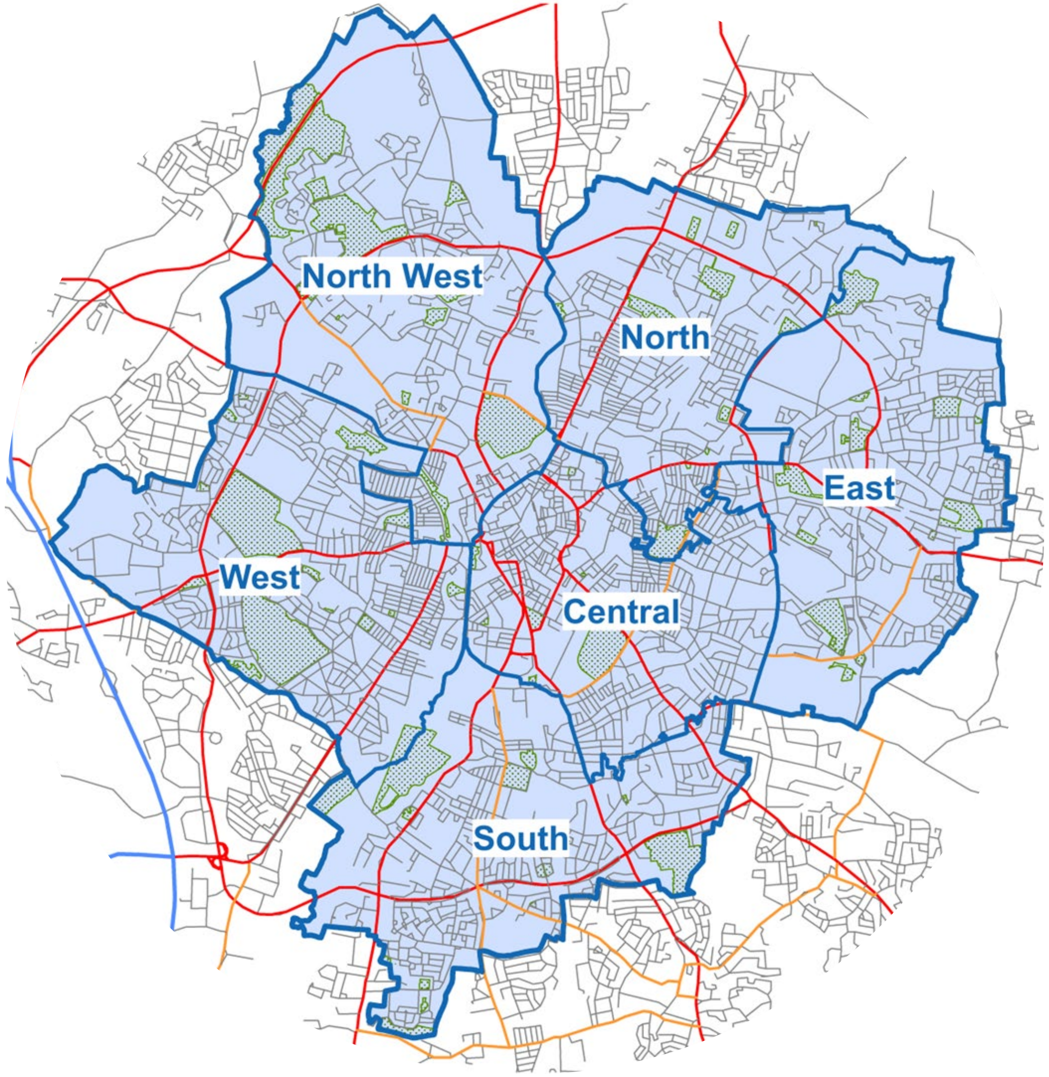
Quotas were set based by age, gender, ethnicity, economic status and disability at a ward level. Corrective weights were applied as necessary to ensure that results are representative.

Geographical areas

To aid with analysis, Leicester has been divided into six geographical areas, as was the case in previous health and wellbeing surveys. These areas are defined solely for analysis purposes and have no other significance.

- Central
- East
- North
- North West
- South
- South West

Findings for smaller geographies (e.g. Ward) can be found in the full dataset but are not presented in this report.



Understanding the report

Rounding

Throughout the report, the results are presented as whole numbers for ease of interpretation, with rounding performed at the final stage of processing for maximum accuracy. Due to rounding, there may be instances where the results do not add up to 100%. In such instances, the difference should not be more than 1% point either way – so 99% or 101%.

Significance Testing

Chi-squared testing has been used to compare subgroups against all residents not in a given subgroup. These comparisons are denoted in the report using an outline around figures. T-testing has been employed to test individual subgroups against each other and to compare the results for 2018 and 2024. All statistical tests are conducted using a 95% confidence interval.

Self-completion

All respondents were given the option to self-complete Q027-Q042 to enhance respondent privacy and reduce social desirability bias. 1,570 respondents out of 2,100 opted for the self-complete option.

Executive Summary

Executive summary - positives

Four in five residents **rate their general health as very good or good**. This is a new high across the four waves of the survey and a 4% point increase compared to 2018 (79% cf. 75%).

A **strong majority** of residents **report very high/high personal wellbeing scores** in terms of life satisfaction (84%), feelings of worthwhile (84%) and happiness (73%).

Resilience among residents is strong, with around **four in five** saying that they tend to **bounce back quickly after hard times**.

Residents are **less likely to feel isolated, left out, excluded or that they lack companionship compared to 2018** (now around 1 in 20 cf. around 1 in 10 in 2018).

Most residents feel that they **have a support network** that they can rely on in times of difficulty (ranging from 67% to 87% depending on the scenario).

Three in four residents use parks, waterways and other green spaces **at least monthly**.

Around **one in six** say that they tend to **walk or cycle** to the city centre.

More than **half of residents say that they never drink alcohol**, a rise of 4% points compared to 2018 (55% cf. 51%).

The proportion who claim to typically **eat at least five portions of fruit and vegetables** a day **has increased** from two in ten (21%) **to three in ten** (29%).

There has been a **decline of 4% points** in those who **smoke cigarettes** compared to 2018 (16% cf. 20%).

Executive summary - challenges

Residents face clear **challenges in accessing medical services,** particularly in relation to NHS dentists and GPs.

One in five residents report experiencing a **high level of anxiety.**

E-cigarette use has more than doubled since 2018 from 4% to 9%. There remains great uncertainty among the public about whether these products are a safer alternative to smoking than traditional smoking/tobacco products.

One in seven residents have an **AuditC* alcohol classification of ‘increasing risk’ or higher.**

One in twelve Leicester residents report being **affected by gambling to some degree.**

One in 14 (7%) residents with children under 16 living at home say that they smoke in the house**.**

Takeaway consumption has increased in Leicester. Now **one in five** say that they have **takeaway more than once a week**, up from one in eight in 2018.

While **confidence as an internet user is generally strong** (82%), there is a clear **lack of confidence among those aged 70+** (35%)**.**

Nearly a **quarter of residents** report that they have **faced difficulties paying their food and energy bills** in the past year. This is **more than double** the **2018** figure. Moreover, around one in seven say that they have faced difficulties paying their council tax, and one in ten in paying the rent/mortgage or for food.

A **quarter of residents** report that they **live in a house that is potentially overcrowded** (24%).

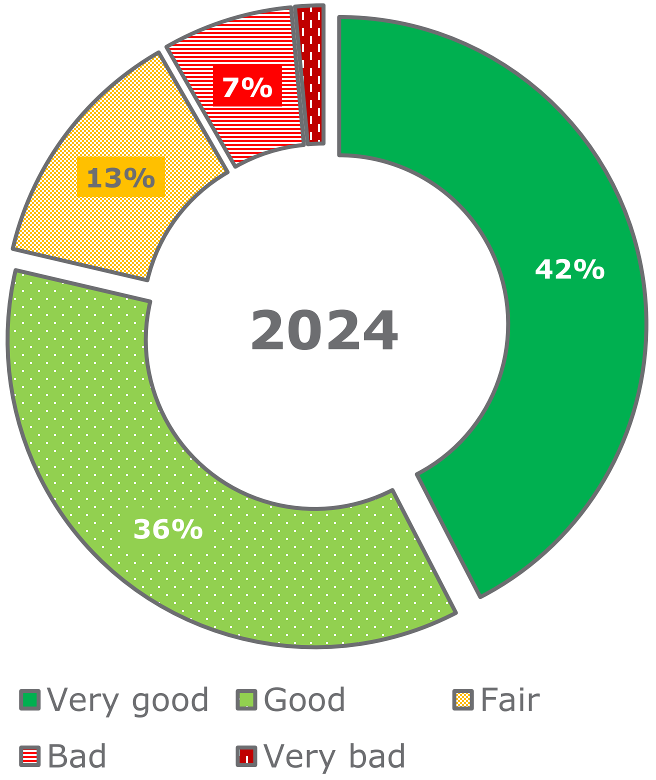
*The AUDIT-C is a brief alcohol screening tool with three questions that assess drinking frequency, quantity, and binge drinking. Scores range from 0–12, with higher scores indicating increasing levels of risk, from low-risk drinking (0–4) to potential alcohol dependence (11–12).

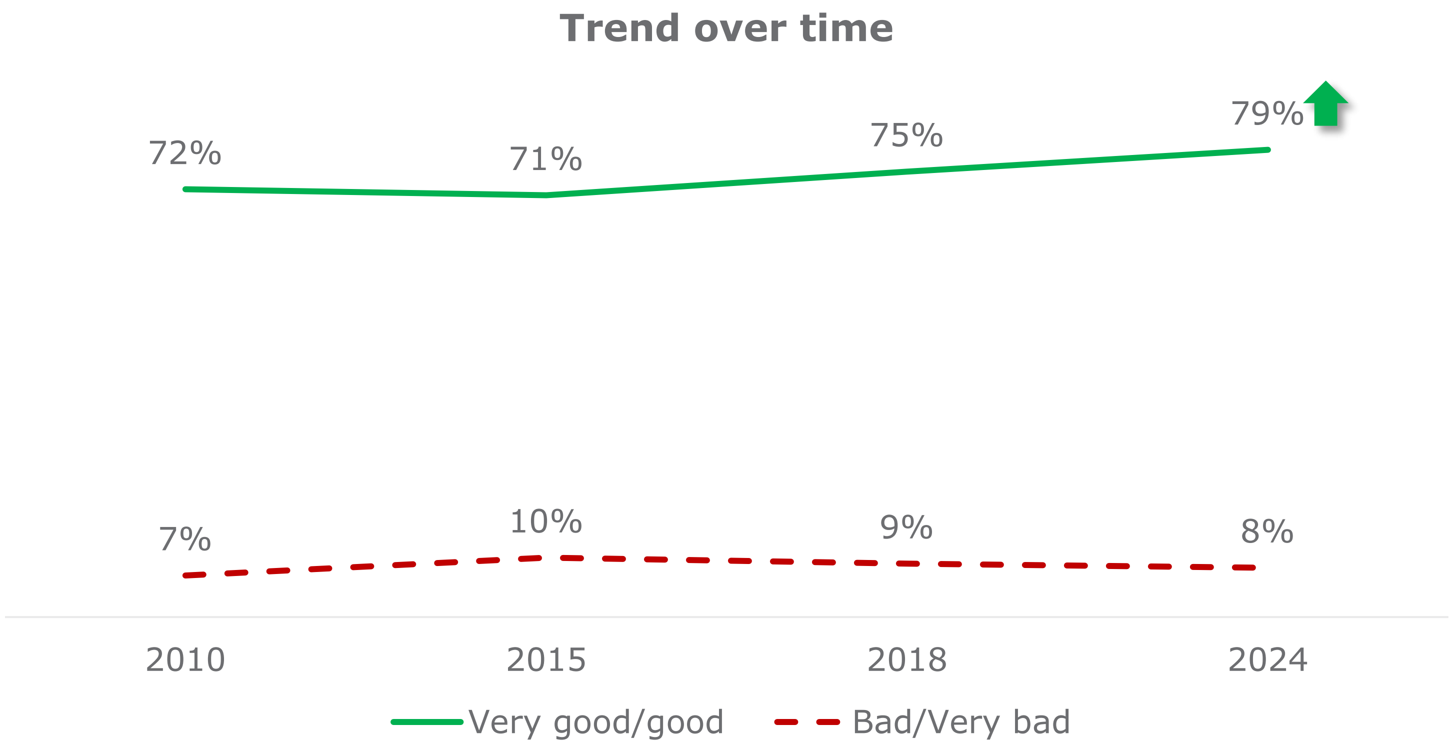
General health

- A majority of residents rate their health positively, with 79% describing it as good or very good, an increase of 4% points since 2018. Perceptions vary, with lower ratings among white British residents and those aged 50+.
- In Leicester, 23% report a long-term health condition, though this has decreased by 5% points since 2018.
- Over half of residents have had COVID-19, with a small fraction experiencing prolonged symptoms.
- Access to GPs and NHS dentists remains a concern, with registration issues and costs being significant barriers to accessing the latter.

General health overall

A majority of residents are positive about their health in general, with four in five rating it very good or good (79%). This is a significant increase of 4% points from 2018. Meanwhile, around one in twelve (8%) say that their health is very bad/bad.



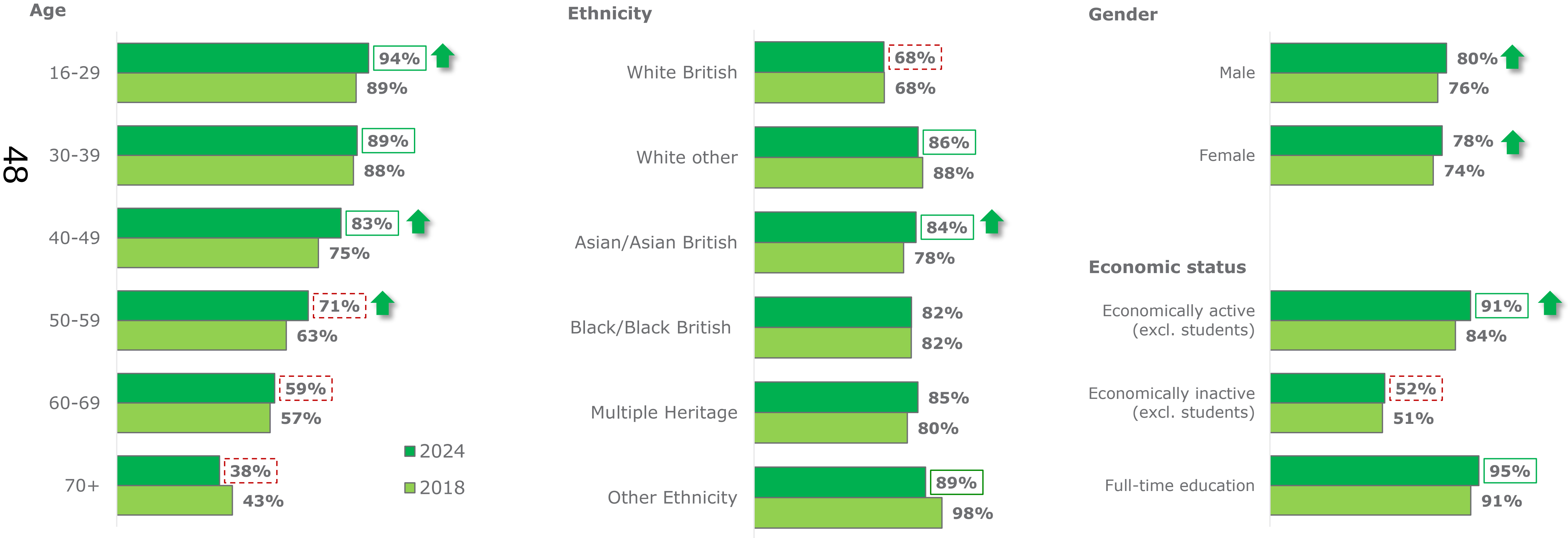


⬆ ⬇ Sig higher/lower than previous survey

Q01. How is your health in general? Would you say it is…? **Base:** All respondents (2,100). Data labels <5% removed for neatness.

General health (% very good/good) demographic breakdown

An uplift in perceptions of general health is visible across all age bands, apart from those aged 70+ where this figure has declined (non-significantly) by 5% points. Moreover, residents who are white British (68%) report significantly lower levels of good/very good general health than other ethnicities; this is, at least in-part, due to the older age profile of this ethnic group in comparison to others.



Q01. How is your health in general? Would you say it is…? **Base:** All respondents (2,100).

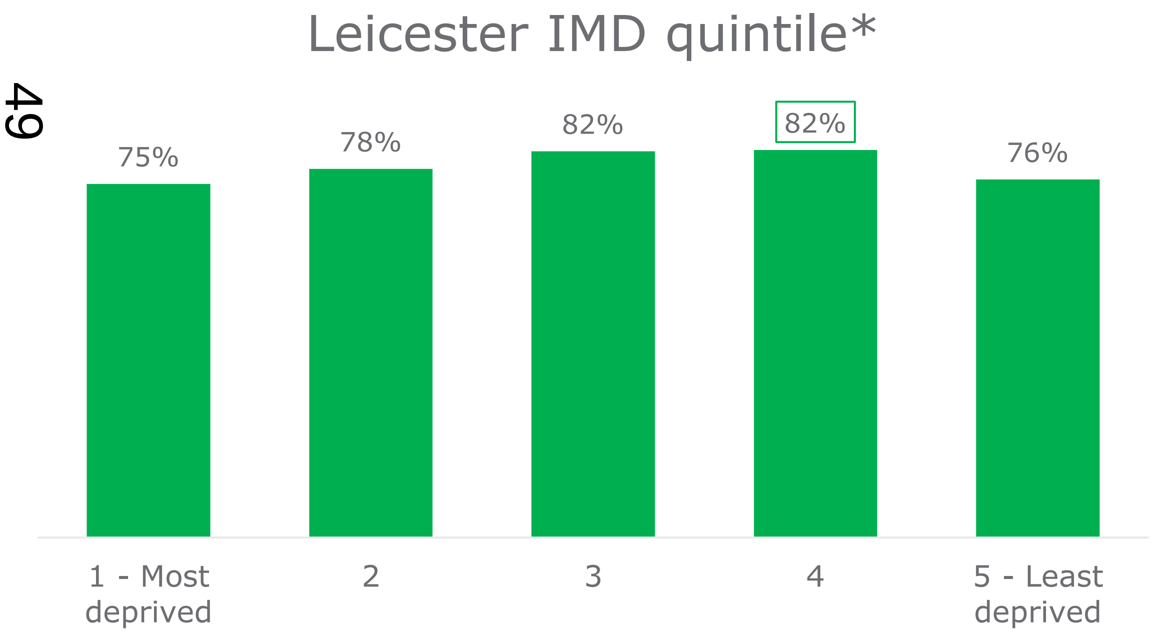
Significantly higher than all other residents

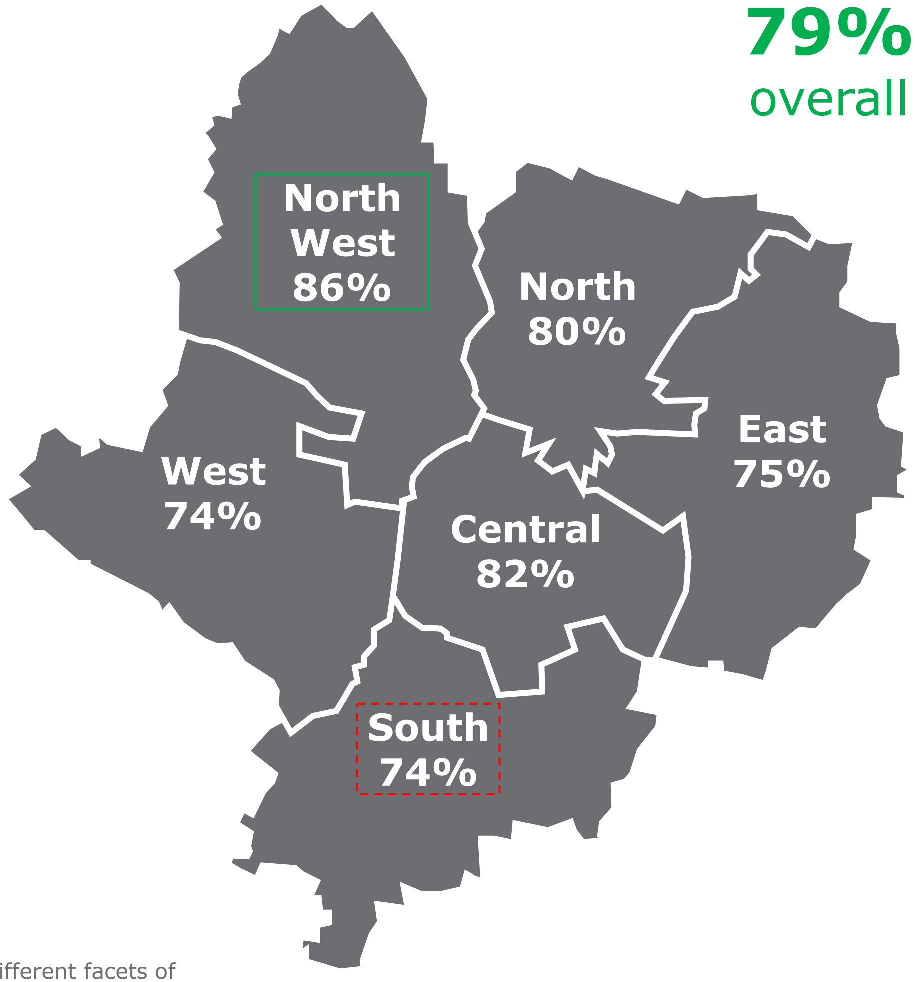
Significantly lower than all other residents

Sig higher/lower than previous survey

General health (% very good/good) geographic breakdown

Perceptions of general health are significantly higher in IMD group 4 compared to other residents. By region, perceptions are most positive in the North West and least positive in the South.





Q01. How is your health in general? Would you say it is…? **Base:** All respondents (2,100).
*The Indices of Deprivation (IMD) is a measure of relative deprivation at a small local area level. The IMD is based on seven different facets of deprivation: Income; Employment; Education, Skills and Training; Health and Disability; Crime; Barriers to Housing and Services and Living Environment. Levels of IMD are split into quintiles (1 to 5), with 1 being most deprived and 5 being least deprived. National IMD scores have been used to calculate deprivation quintiles specifically for Leicester.

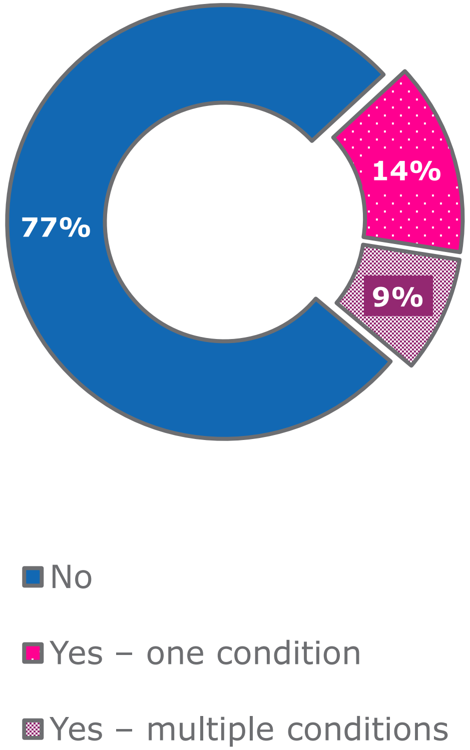
🟩 Significantly higher than all other residents

🟥 Significantly lower than all other residents

Long-term illness and conditions

23% of Leicester residents report having a physical or mental health condition lasting or expecting to last 12 months or more. Of these residents, 79% state that it impacts their ability to carry out day-to-day activities, and two in five say it impacts them a lot (38%). The percentage who say that they have a condition or illness lasting 12 months or more has declined by 5% points from 2018, reaching a new low*.

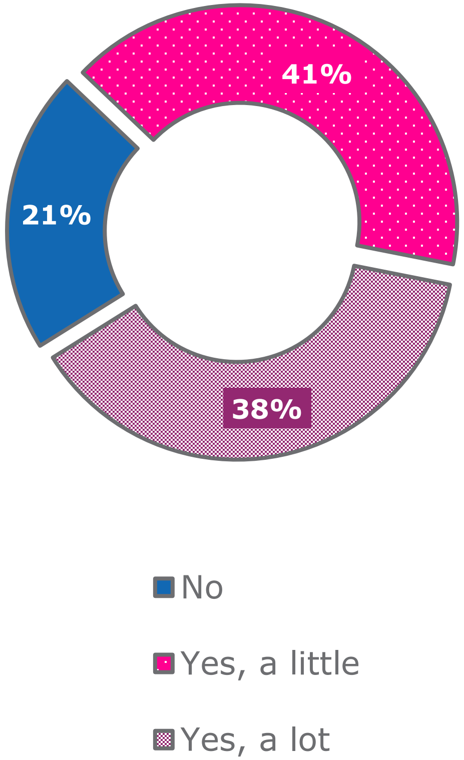
Conditions/illnesses lasting 12 months or more



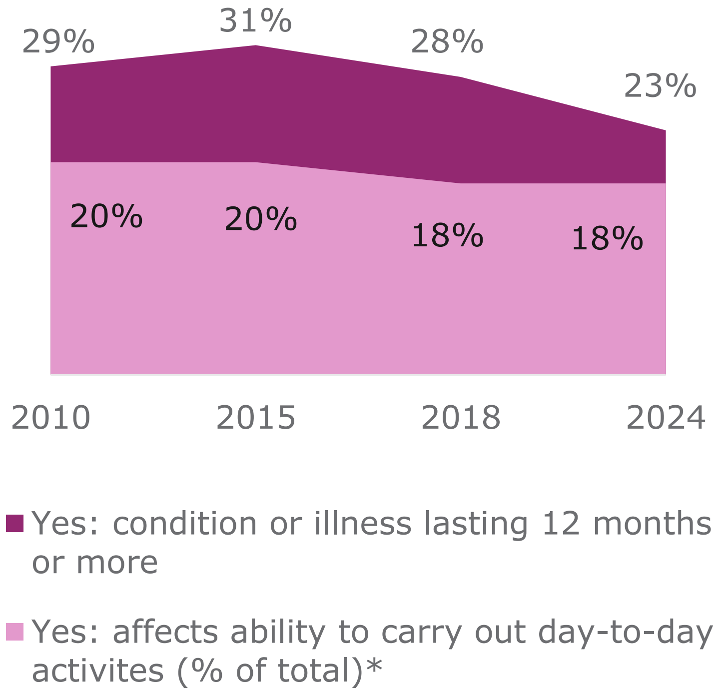
NET: Yes

23%

Affects ability to carry out day-to-day activities



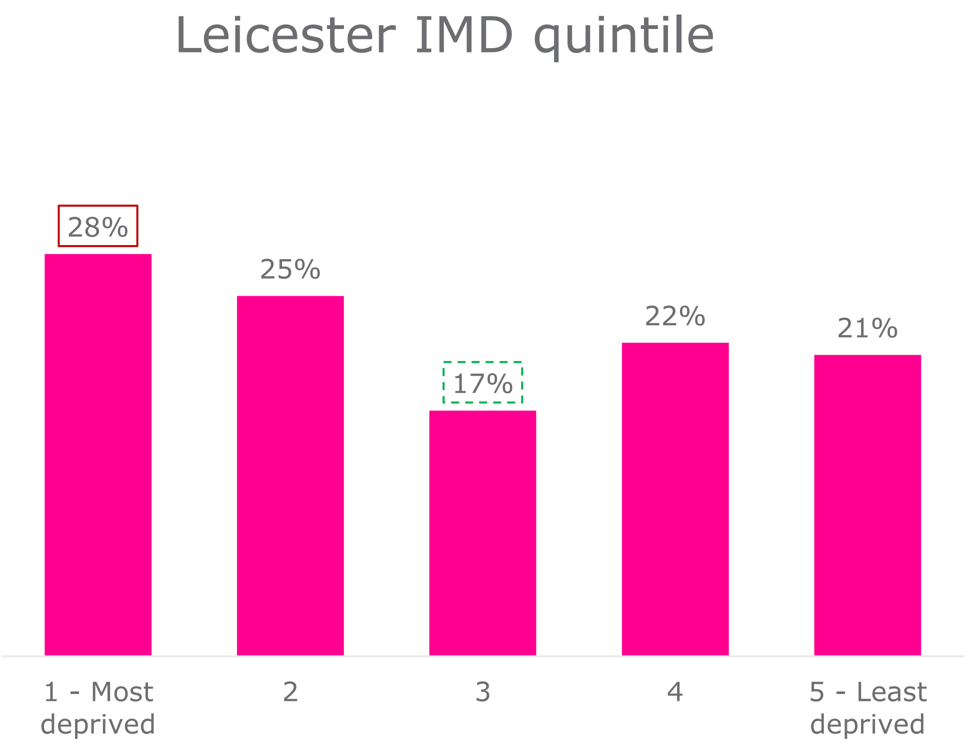
Trends

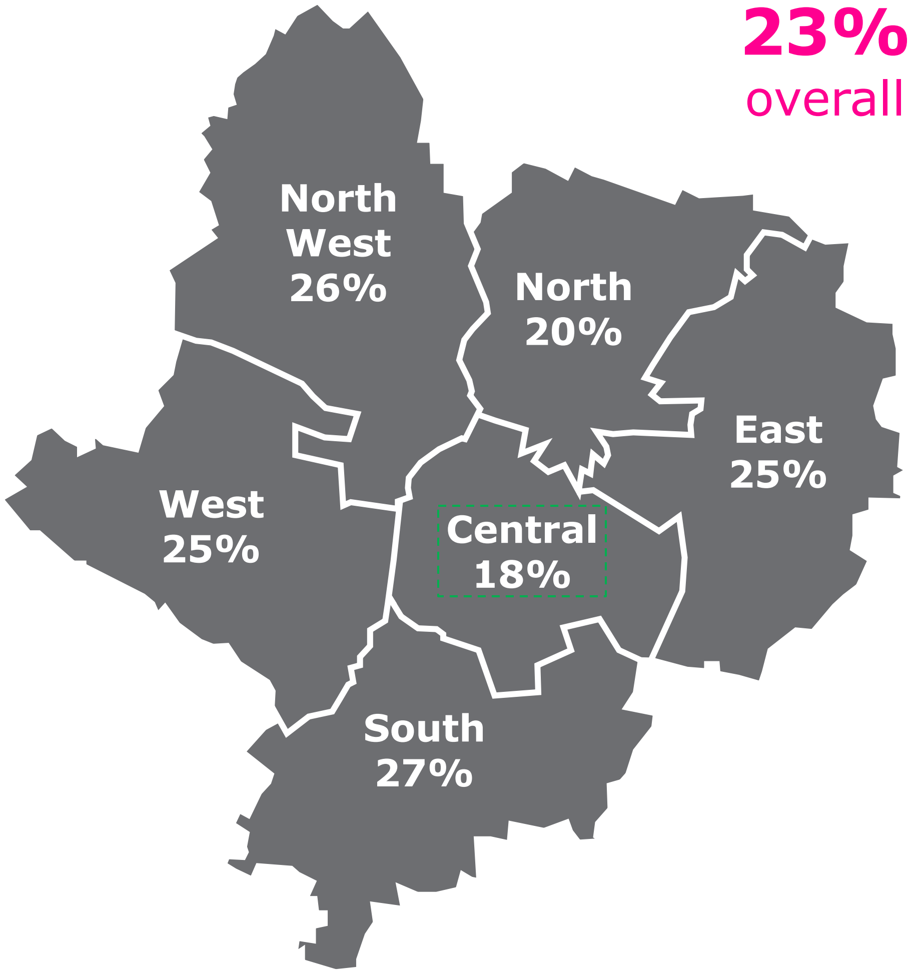


Q04. Do you have any physical or mental health conditions or illnesses lasting or expected to last 12 months or more? **Base:** All respondents (2,100).*
Q05. Do any of your conditions or illnesses reduce your ability to carry out day-to-day activities? **Base:** All respondents with a physical or mental health condition (489)
*Please note: the question wording has changed since 2018 which means comparisons are indicative only.

Long-term illness and conditions geographic breakdown

Residents in Central (18%) are significantly less likely to report a long-term illness or condition.





23% overall

Q04. Do you have any physical or mental health conditions or illnesses lasting or expected to last 12 months or more? **Base:** All respondents (2,100)

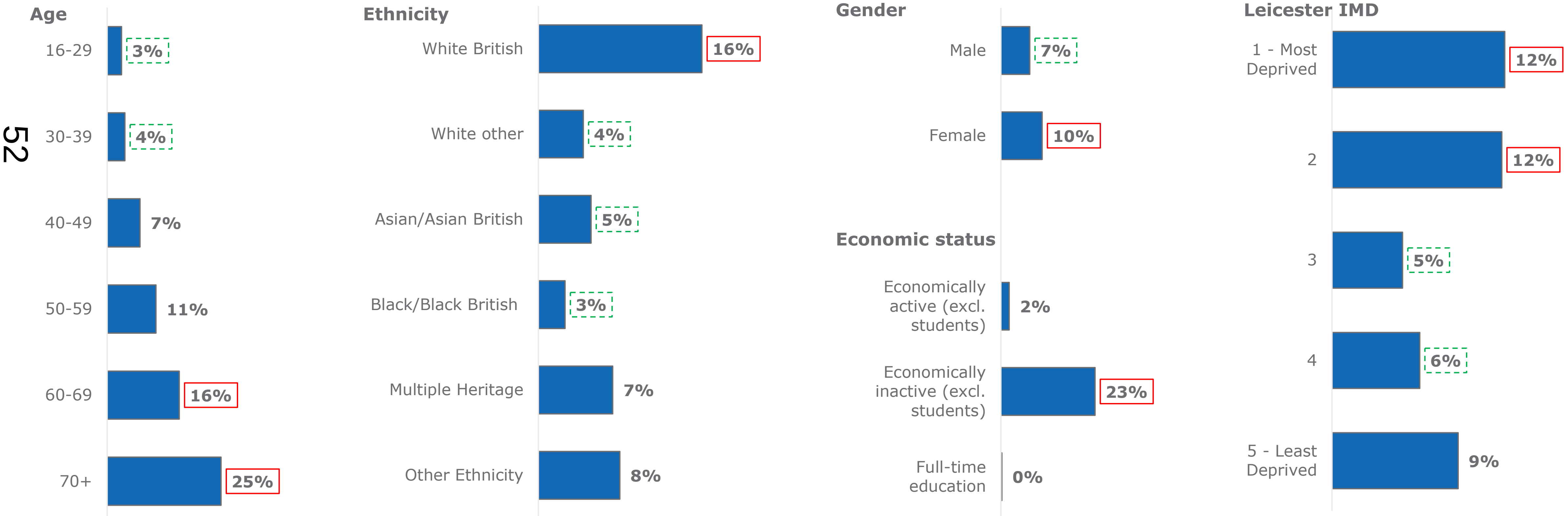
🟥 Significantly higher than all other residents

🟩 Significantly lower than all other residents

Multiple health conditions demographic breakdown

Older residents and those who are economically inactive are significantly more likely to have multiple health conditions/illnesses.

9%
overall

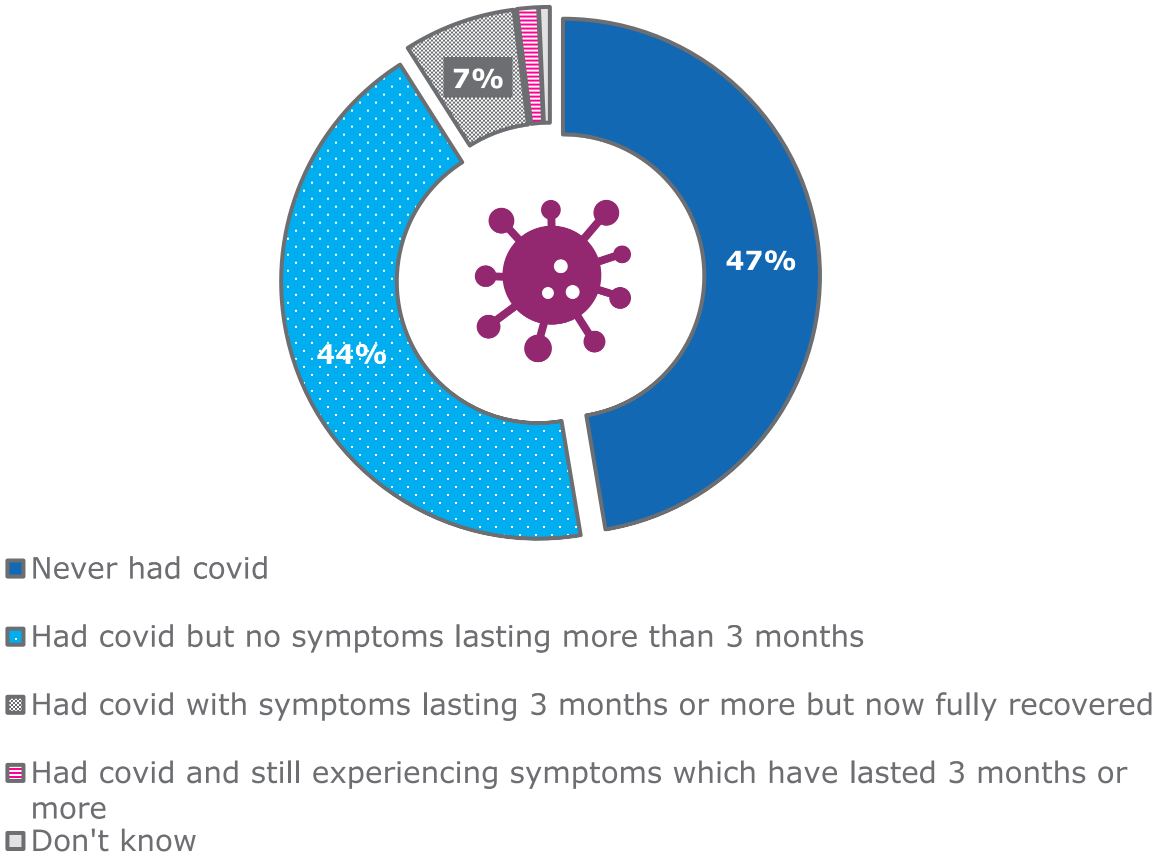


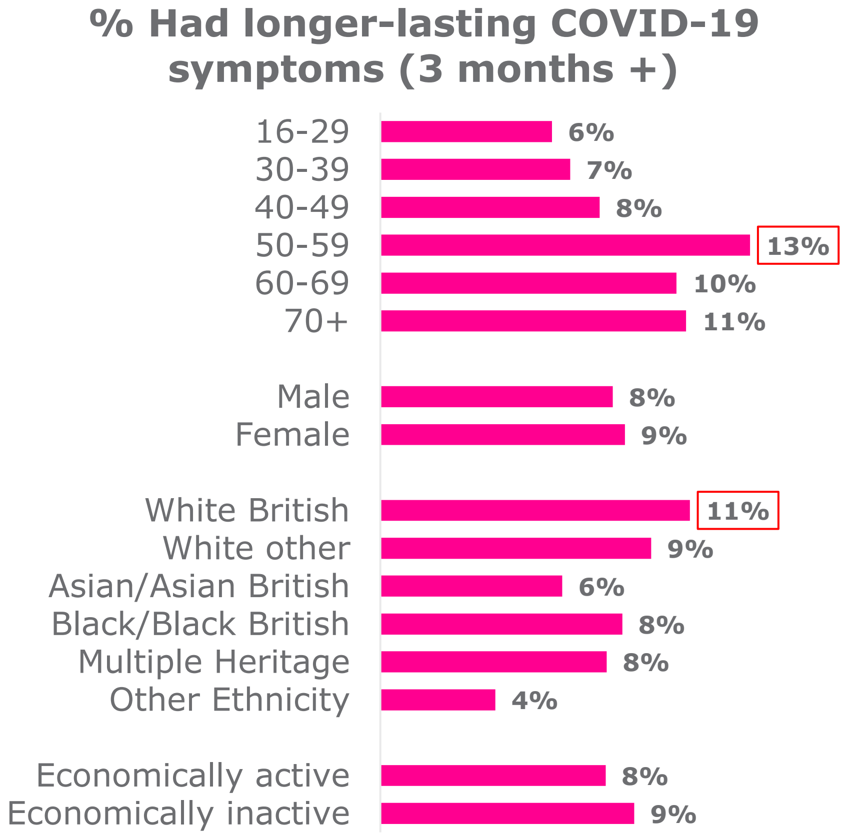
Q04. Do you have any physical or mental health conditions or illnesses lasting or expected to last 12 months or more?
Base: All respondents (2,100)

☐ Significantly higher than all other residents
☐ Significantly lower than all other residents

COVID-19

Just over half of residents have had covid-19 (52%). Of that 52%, 7% had symptoms lasting more than three months but have now fully recovered, whilst 1% are still experiencing symptoms more than three months later.





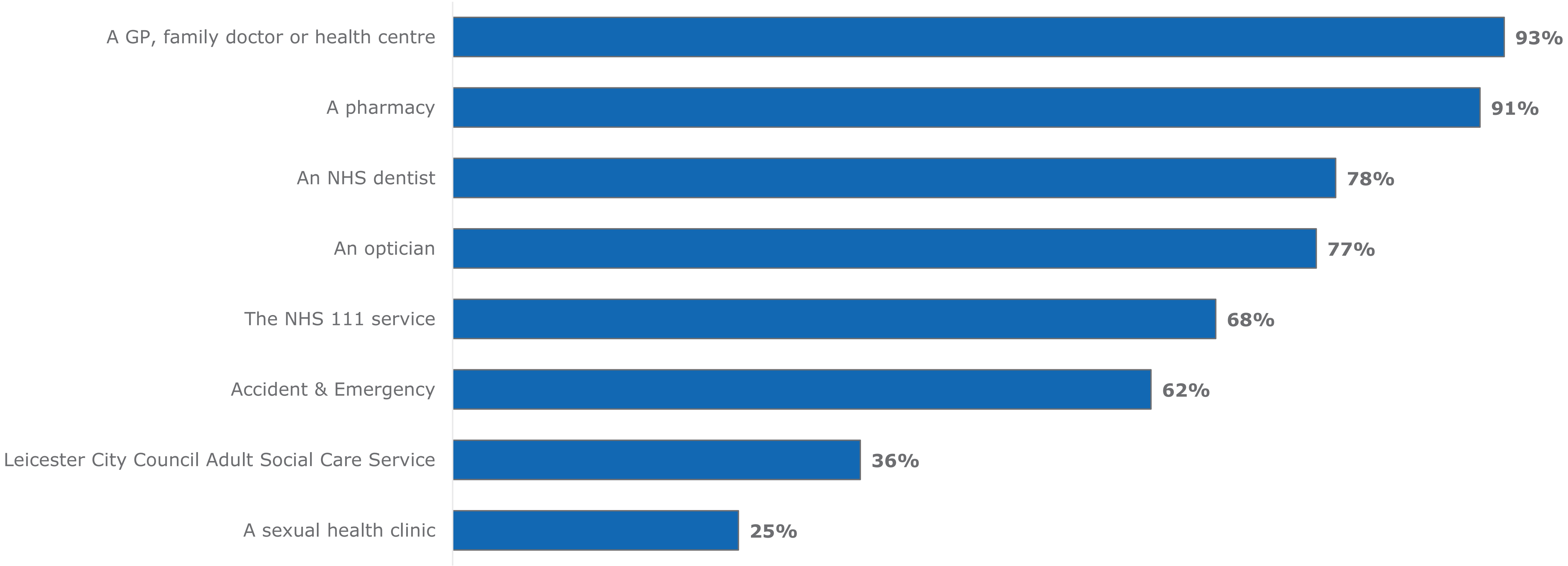
Q05b. Have you ever had COVID-19? **Base:** All respondents (2,100). Data labels <5% removed from pie chart for neatness.

☐ Significantly higher than all other residents

☐ Significantly lower than all other residents

Accessing health services

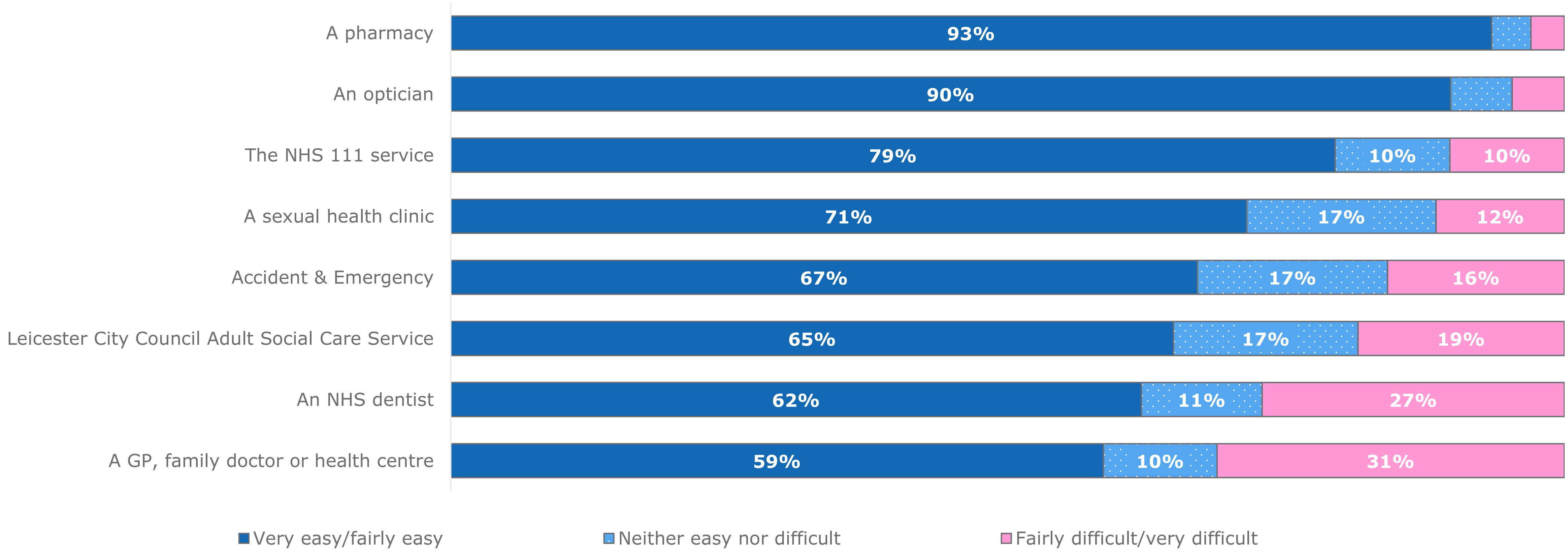
GPs, family doctors or health centres (93%), and pharmacies (91%) are the most commonly accessed medical services, while adult social care (36%) and sexual health clinics (25%) are the least common.



Q02. To what extent have you found it easy or difficult to access the following in the last year? **Base:** All respondents (2,100).
Note: results calculated based on the percentage who gave a rating for how easy or difficult it has been accessing a given service. Results are indicative only, as it assumed here that those who reported difficulty were ultimately able to access the service – the full question did allow residents to tell us that they did not access the service.

Ease of accessing health services

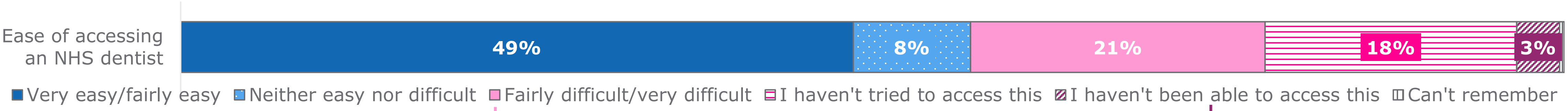
Nearly three in ten residents who gave a rating say that they have found accessing a GP fairly or very difficult, and just over a quarter report the same for an NHS dentist. Less difficulty is reported in relation to pharmacies and opticians.



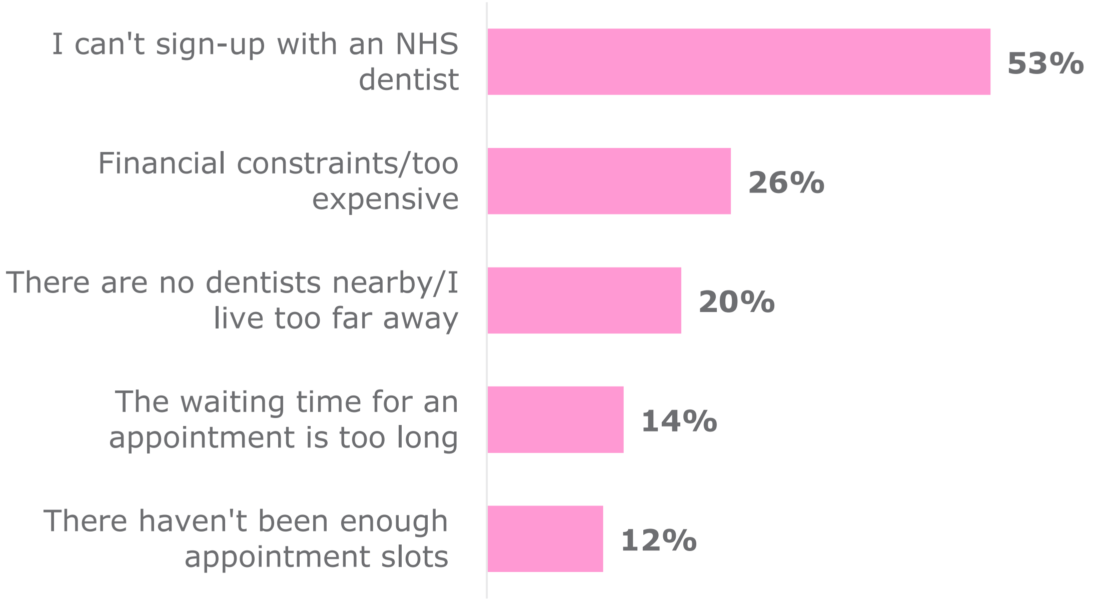
Q02. To what extent have you found it easy or difficult to access the following in the last year? **Base:** Those who gave a rating for a service (bases vary). Data labels <5% removed for neatness.

Barriers to accessing NHS dental services (I)

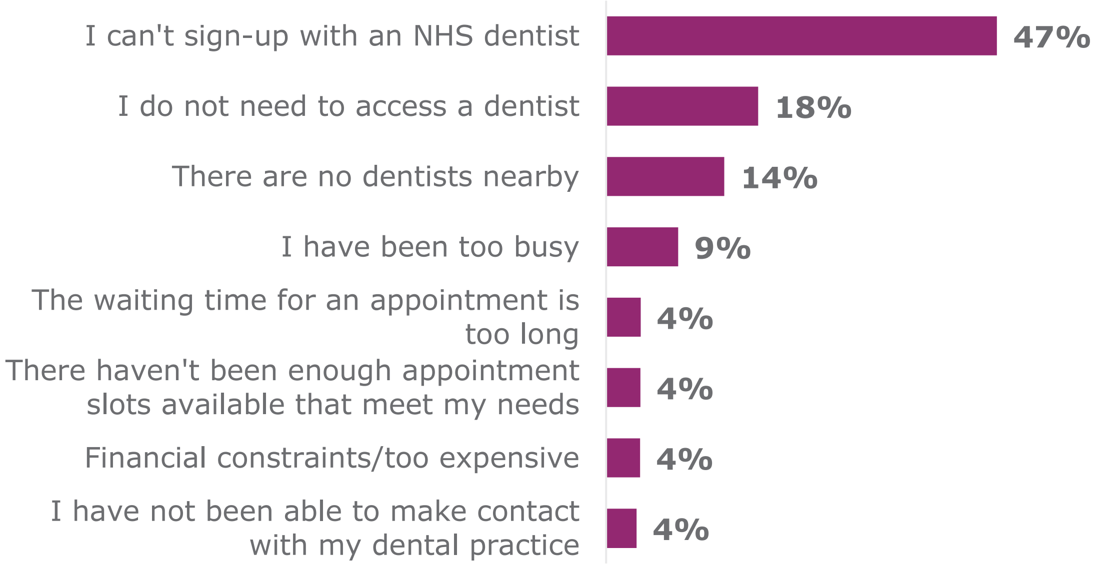
Of the 21% of residents who have found it difficult to access NHS dental services, more than half say that they can’t sign-up (53%). This is also the most common reason or the 3% of residents who say that they haven’t been able to access an NHS dentist.



Top reasons for finding it difficult to access an NHS dentist



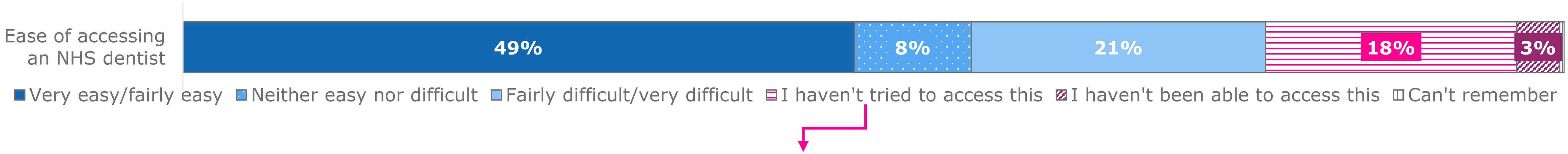
Top reasons residents have not been able to access an NHS dentist

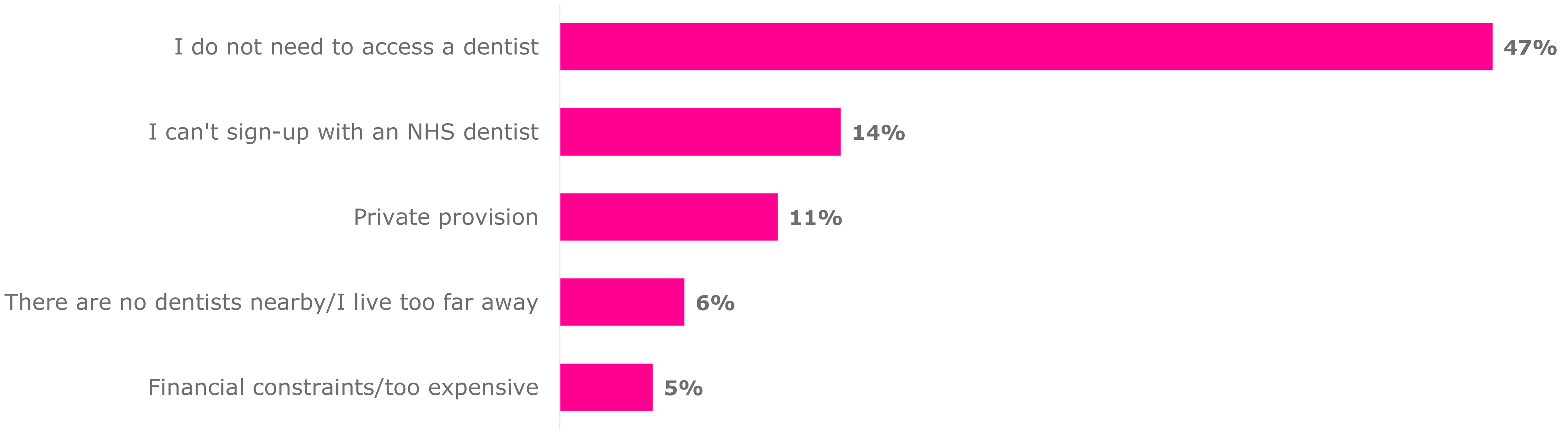


Q3. What were the main reasons for you finding it difficult to access an NHS dentist? **Base:** All respondents who found it difficult to access an NHS dentist (445).
Q3_2. Why have you not been able to access an NHS dentist? **Base:** All respondents who have not been able to access an NHS dentist (57).

Barriers to accessing NHS dental services (II)

The main reason for not trying to access NHS dental services is a lack of need (47%), being unable to sign-up (14%) and private provision (11%).





Top 5 reasons residents have not tried to access an NHS dentist

Q3_1. Why have you not tried to access an NHS dentist? **Base:** All respondents who have not tried to access an NHS dentist (394).

Mental health and wellbeing

- Four in five agree that they bounce back after hard times. This is an improvement from just more than three in five in 2018.

- Scores for life satisfaction, life worthwhile and happiness are strong, with the vast majority reporting high or very high scores. Less positively, 19% report high anxiety.

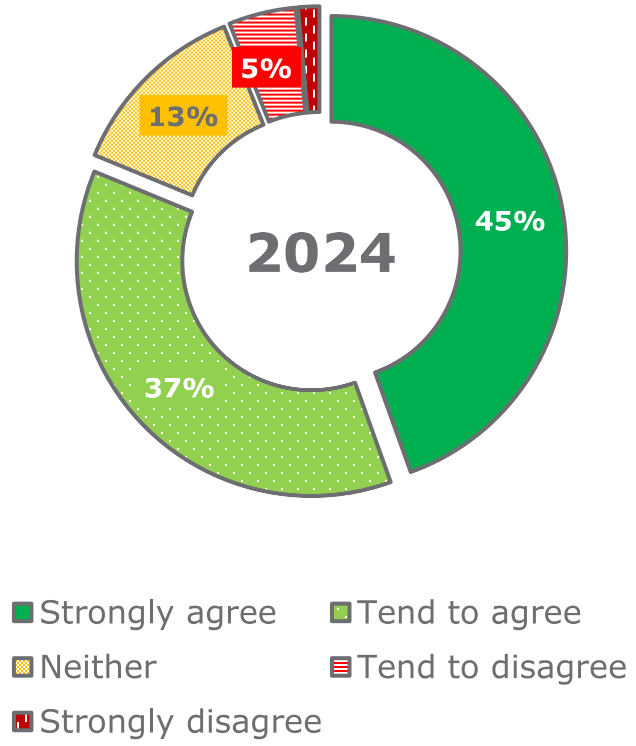
- 75% feel safe outdoors during the day. However, feelings of safety at night are lower (50%).

- Willingness to seek support in crises has risen, with 62% indicating that they would definitely reach out for help.

Resilience

Four in five residents believe that they bounce back quickly after hard times (81%), while 13% are neutral and 6% disagree. These results represent a significant improvement on 2018, with the percentage who agree with this statement having increased by 17% points (64% in 2018).

"I tend to bounce back quickly after hard times"



	2024	2018
Agree	81%	64%
Disagree	6%	17%

Key differences:

The percentage who agree that they bounce back quickly decreases slightly with age. Around 85% of the three youngest age groups (16-29, 30-39 and 40-49) agree, but this drops to around 75% for the three older ager groups (50-59; 60-69; 70+).

Men are significantly more likely than women to agree that they bounce back quickly (84% v 79%).

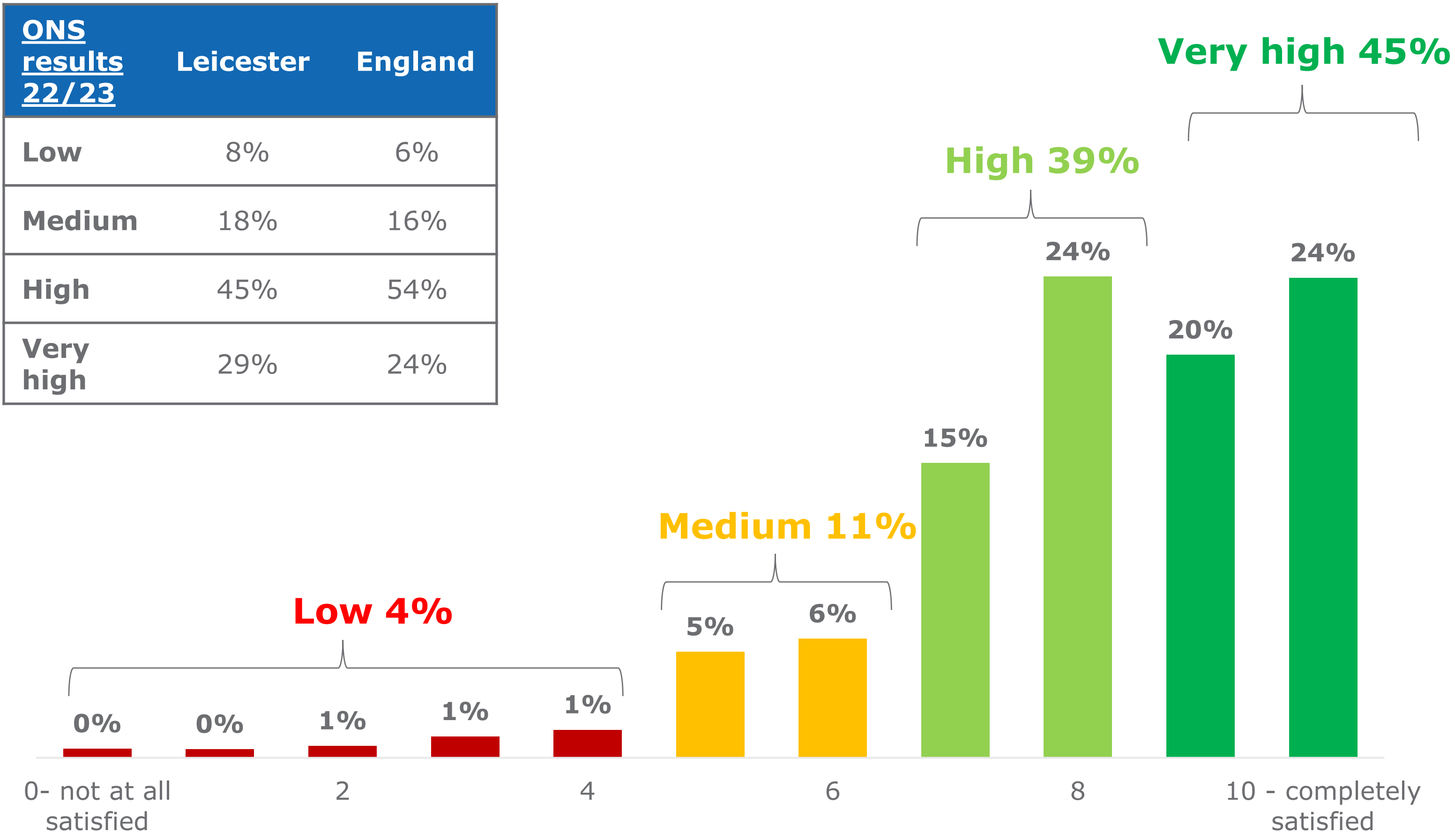
So too are those who have no long-term health conditions (86%) compared to those who have one long-term health condition (69%), or multiple (55%).

Q029. To what extent do you agree or disagree with the following statement? 'I tend to bounce back quickly after hard times'. **Base:** All respondents (2,100). Data labels <5% removed for neatness.

Life satisfaction

Life satisfaction in Leicester is generally high, with 45% reporting a very high level and 39% a high level.

ONS results 22/23	**Leicester**	**England**
Low	8%	6%
Medium	18%	16%
High	45%	54%
Very high	29%	24%



Key differences:

Proportions of residents rating their satisfaction with life as high or greater is highest in Wycliffe (95% v 84% total). Conversely, residents in Eyres Monsell are least likely to give a positive score (71%).

In terms of ethnicity, life satisfaction is highest amongst those of multiple heritage (91% high/very high).

Those in social housing give significantly lower proportions of high/very high scores (73%) than those who own their houses (88%) or rent privately (83%).

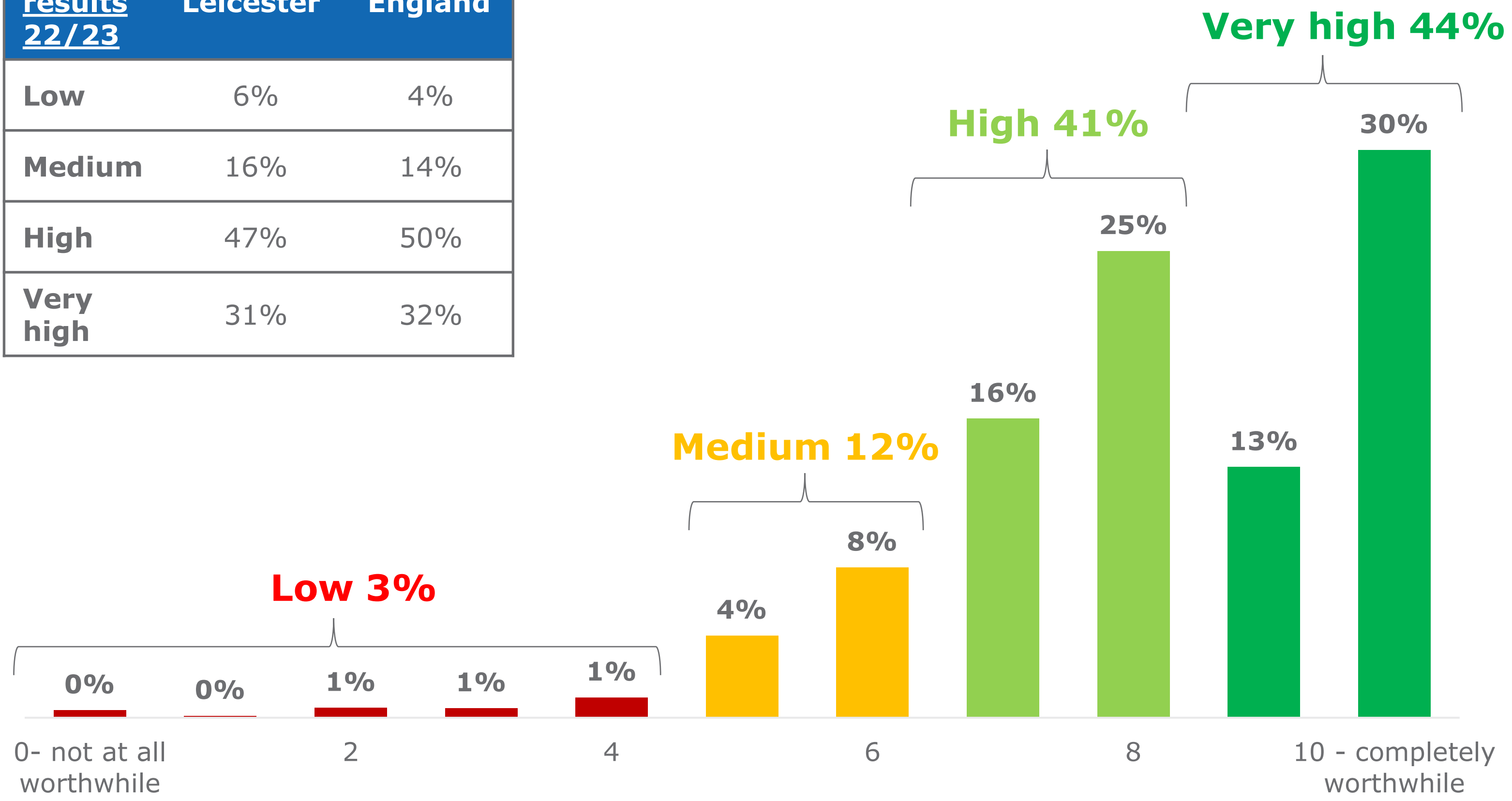
Satisfaction is also higher amongst those who don't have any long-term health conditions (89% high/very high) compared to 76% of those with one condition, and just 50% of those with multiple conditions.

Q032. Overall, how satisfied are you with your life nowadays? **Base:** All respondents (2,100).
Note: ONS annual wellbeing estimates figures accessed 4/11/24. Please note comparisons are indicative only due to methodological differences.

Feeling that things done in life are worthwhile

Results for feeling things done are worthwhile are similarly positive, with 44% reporting a very high level and 41% a high level.

ONS results 22/23	Leicester	England
Low	6%	4%
Medium	16%	14%
High	47%	50%
Very high	31%	32%



Key differences:

94% of residents in Abbey give high/very high scores with reference to feeling that things done in their life are worthwhile.

Black/Black British residents are the most likely out of all ethnic groupings to give a high score (89%), whereas White British and White Other residents are least likely (both 81%).

Those with no formal educational qualifications are 13% points less likely to give high/very high scores than those with A-levels (77% v 90%).

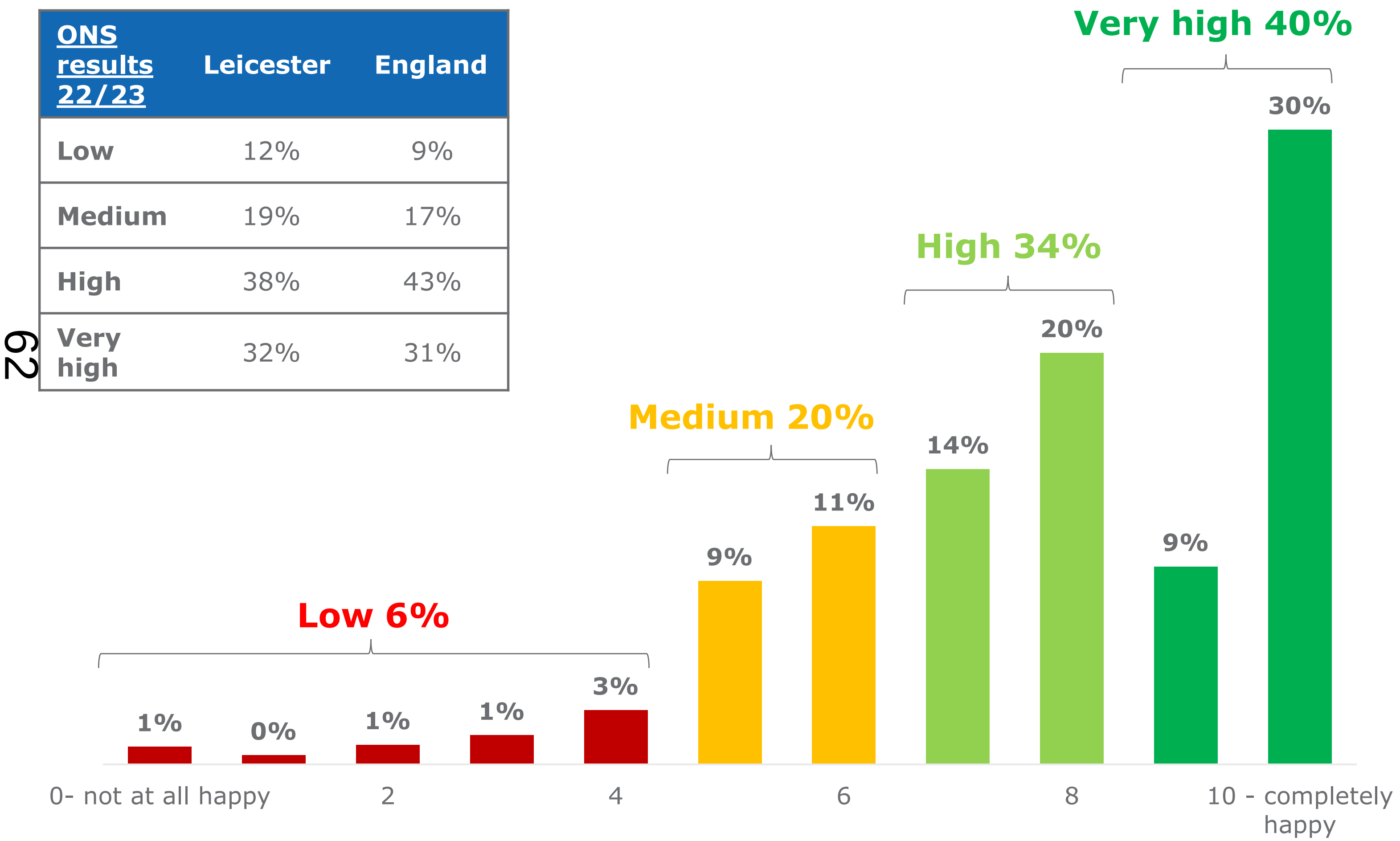
Residents showing indications of social isolation are also 33% points less likely to give a high/very high score (52%).

Q033. Overall, to what extent do you feel that the things you do in your life are worthwhile? **Base:** All respondents (2,100).
Note: ONS annual wellbeing estimates figures accessed 4/11/24. Please note comparisons are indicative only due to methodological differences.

Happiness felt yesterday

Four in ten residents report very high levels of happiness and more than three in ten have high levels.

ONS results 22/23	**Leicester**	**England**
Low	12%	9%
Medium	19%	17%
High	38%	43%
Very high	32%	31%



Key differences:

Older residents show lower levels of happiness, with 67% of those aged 70+ giving a high/very high score, compared to 73% of the total sample.

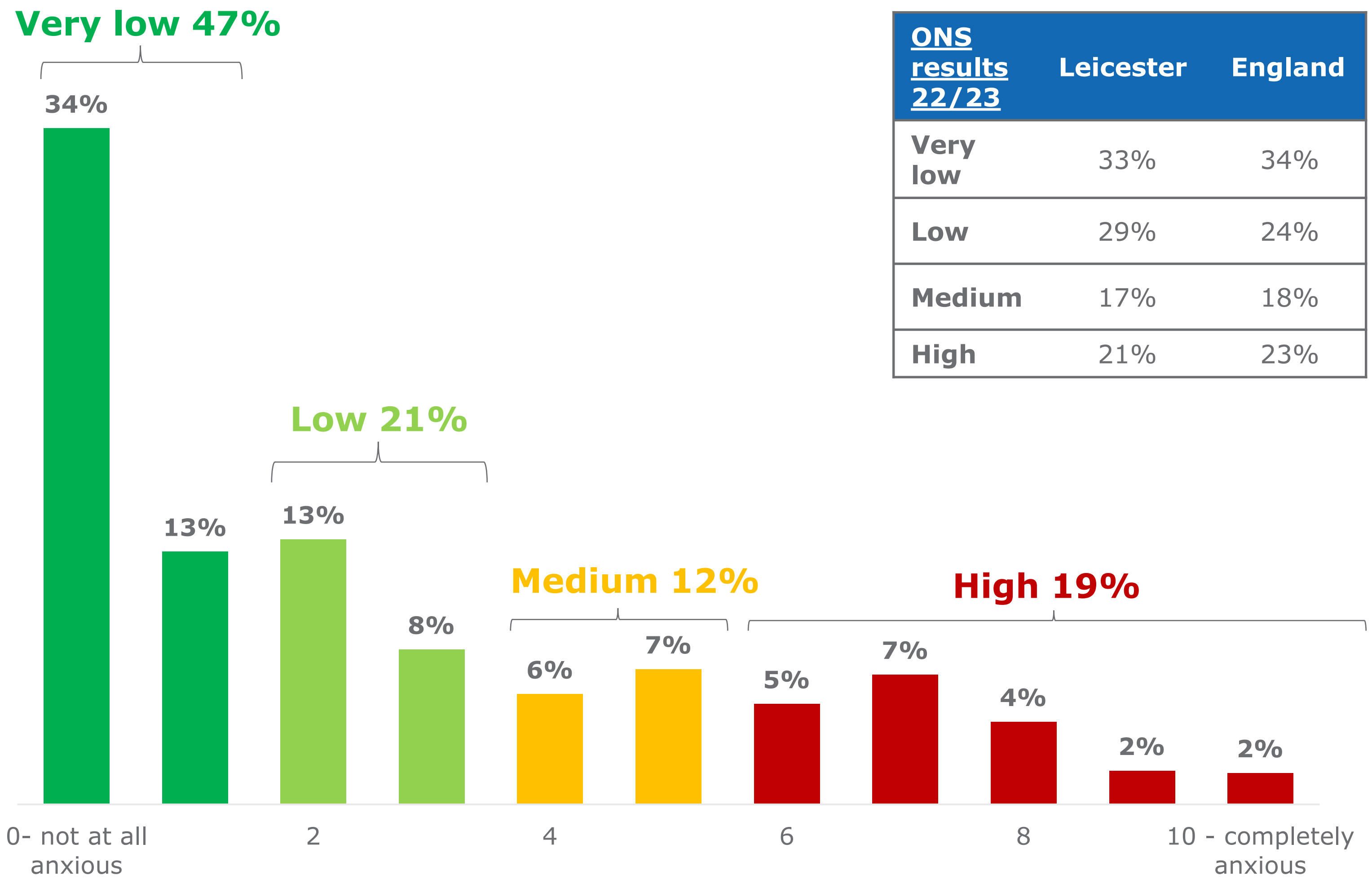
Eight in ten Black/Black British residents and those of multiple heritage give high scores for happiness (both 81%).

Conversely, there are significantly lower proportions of high scores amongst the economically inactive (66%), those living in social housing (67%) and those with 'higher risk' Audit C scores (59%).

Q034. Overall, how happy did you feel yesterday? **Base:** All respondents (2,100).
Note: ONS annual wellbeing estimates figures accessed 4/11/24. Please note comparisons are indicative only due to methodological differences.

Anxiety felt yesterday

Less positively, nearly one in five report feeling a high level of anxiety (19%).



ONS results 22/23	Leicester	England
Very low	33%	34%
Low	29%	24%
Medium	17%	18%
High	21%	23%

Key differences:

Residents aged 50-59 are 12% points less likely to give low/very low scores for anxiety than those aged 16-29 (60% v 72%).

Over eight in ten residents in Spinney Hills and Wycliffe give low anxiety scores (both 83%). In contrast, two in five residents in Beaumont Leys report high levels of anxiety (39%).

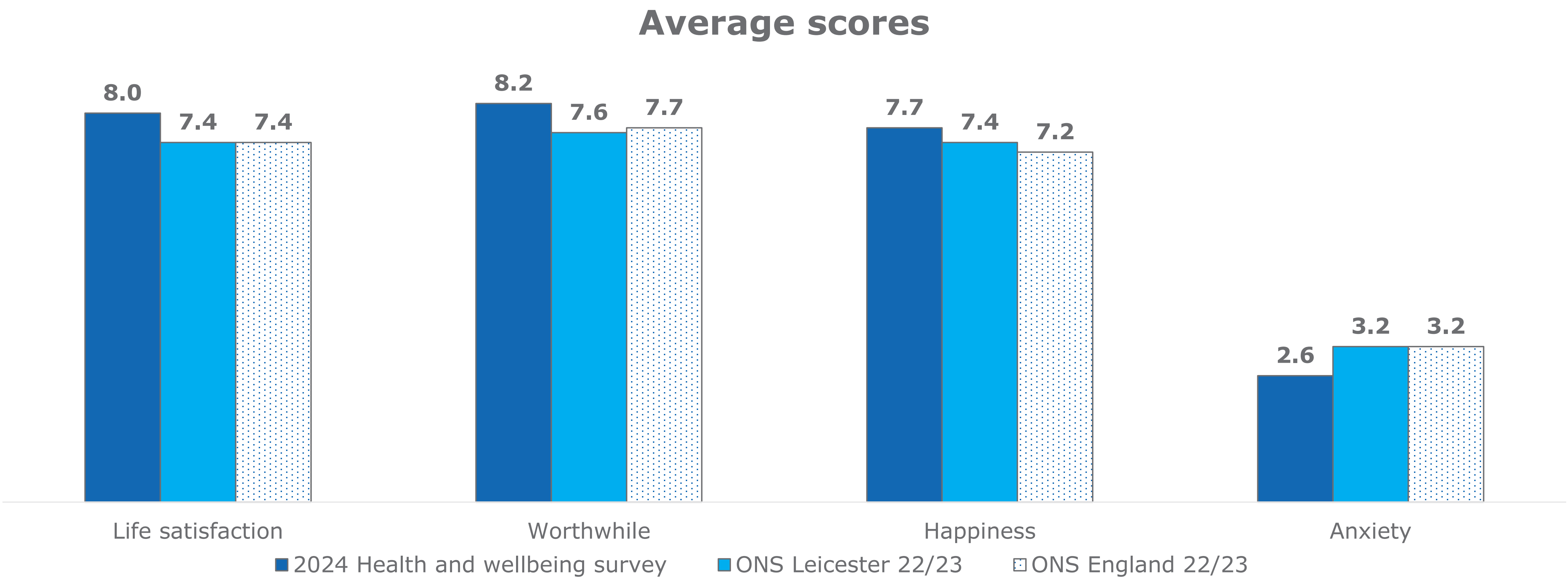
Females are 6% points more likely to report high levels of anxiety than males (22% v 16%).

One quarter of White British residents report high levels of anxiety (24%), whereas just 15% of Asian/Asian British residents say the same.

Q035. On a scale where 0 is 'not at all anxious' and 10 is 'completely anxious', overall, how anxious did you feel yesterday? **Base:** All respondents (2,100).
Note: ONS annual wellbeing estimates figures accessed 4/11/24. Please note comparisons are indicative only due to methodological differences.

Self-reported wellbeing summary

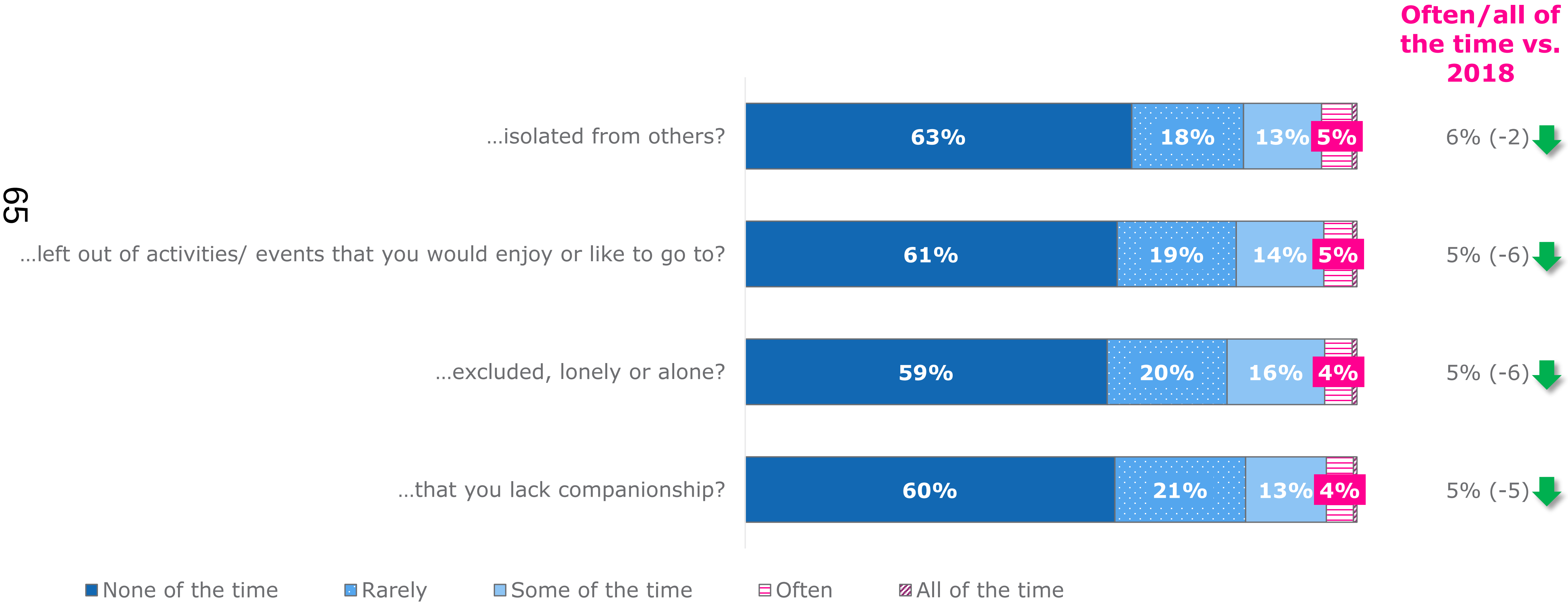
Self-reported wellbeing is stronger than the latest ONS figures for each of the four measures.



See previous slides for question wording and bases.

How often residents feel…

Encouragingly, the percentage of residents who often/always feel isolated, left out, excluded or that they are lacking companionship has fallen significantly compared to 2018.



Q030. Which of these best describes how often you feel…? **Base:** All respondents (2,100). *New statement for 2024. Data labels <4% removed for neatness.

Sig higher/lower than overall

Isolated from others: demographic breakdown

General anxiety is an indicator of feeling safe after dark, with 29% of those reporting a high anxiety score also never/rarely feeling safe in their area at night.

Groups more likely to feel isolated (often/all the time)

North West: 12%

General health (very bad/bad): 17%

Leicester IMD quintile 1 (most deprived): 10%

Feel affected by gambling: 28%

Low life satisfaction: 35%

Groups less likely to feel isolated (never/rarely)

Central: 86% | North: 87% | East: 87%

Asian/Asian British: 88%

Economically active (excl. students): 84%

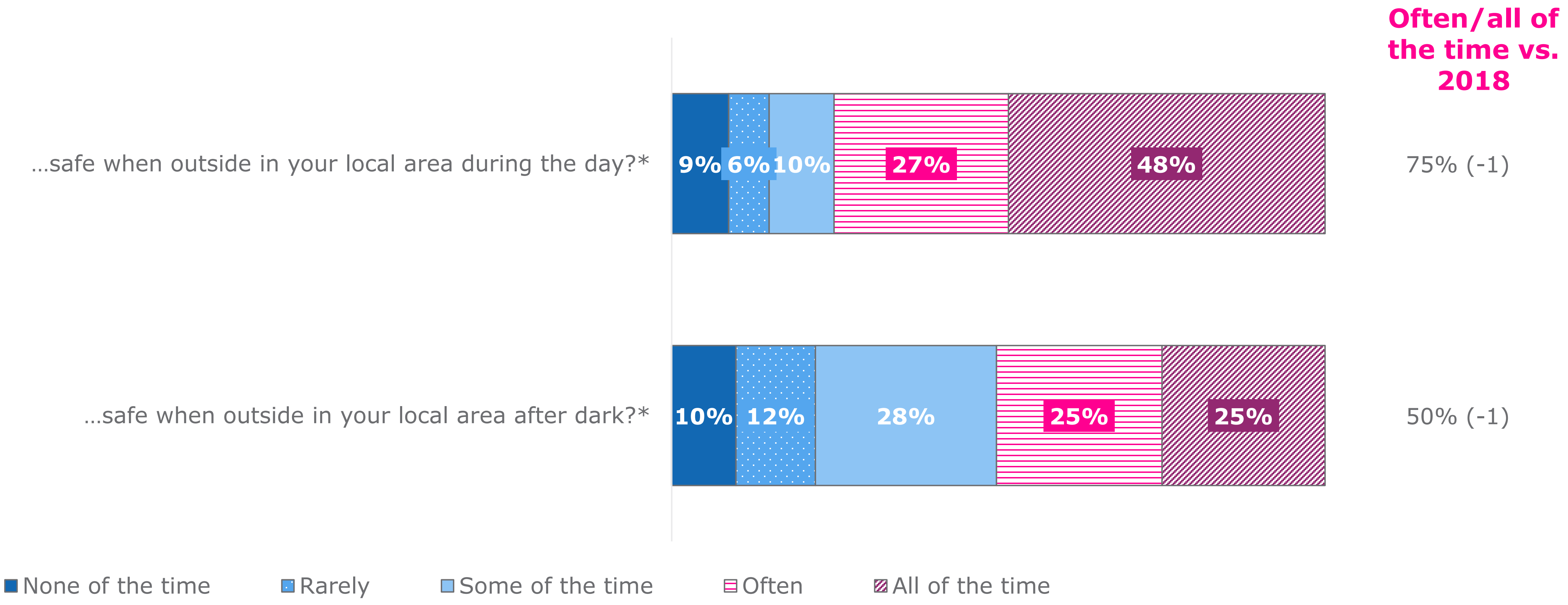
Home owner: 86% | Private renter: 85%

Physically active: 91%

Q030. Which of these best describes how often you feel…? **Base:** All respondents (2,100).

How often residents feel… (II)

One-quarter (75%) of residents say that they often/always feel safe when outside in their local area during the day, but this drops to half (50%) when outside after dark. These two results are in line with the 2018 figures.



Q030. Which of these best describes how often you feel…? **Base:** All respondents (2,100). *New statement for 2024. Data labels <5% removed for neatness.

⬇ ⬆ Sig higher/lower than overall

Feelings of safety after dark: demographic breakdown

General anxiety is an indicator of feeling safe after dark, with 29% of those reporting a high anxiety score also never/rarely feeling safe in their area at night.

Groups more likely to feel safe (often/all the time)

Physically active: 64%

Male: 57%

Black/Black British: 61%

Degree/Master's/PhD/NVQ4 and above: 58%

Very low anxiety score: 60%

Groups more likely to feel unsafe (never/rarely)

Economically inactive: 26%

White British: 24%

Female: 25%

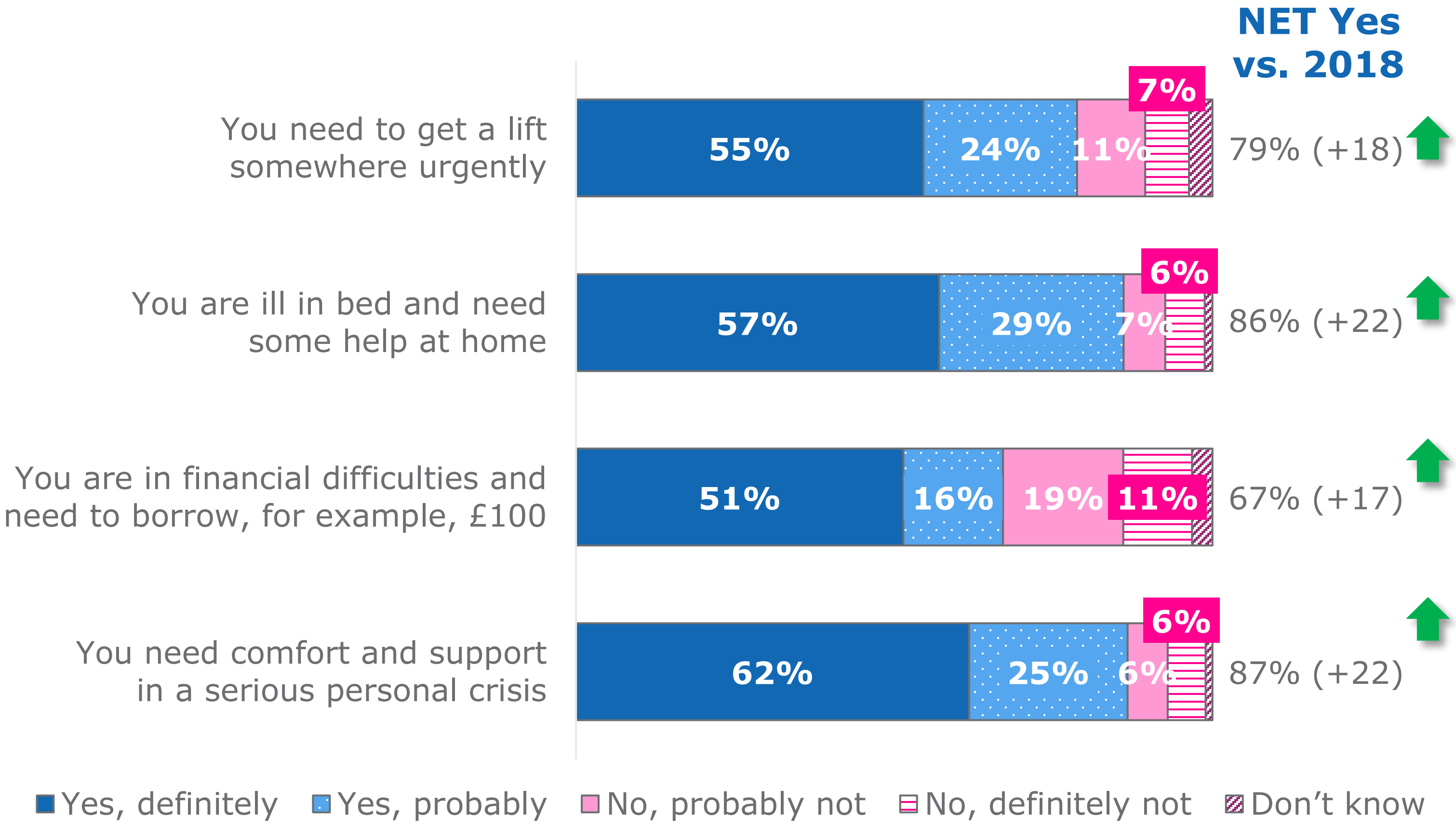
Act as carer: 31%

High anxiety score: 29%

Q030. Which of these best describes how often you feel…? **Base:** All respondents (2,100).

Help/support

The percentage of Leicester residents who would feel willing to reach out for help or support has increased vastly since 2018. People feel particularly sure that they would be willing to reach out to others if they need comfort and support in a serious personal crisis (62% definitely).



Key differences:

Anxiety seems to play a key part in residents' willingness to ask for support. Those reporting high levels of anxiety are 4% points more likely than average to say they would not ask for help if they needed a lift (22% v 18% total), 5% points more likely to say they would not ask for help if they were ill (18% v 13% total), and 6% points more likely to say they would not ask for help if they needed comfort in a crisis (18% v 12% total).

Those with restricting disabilities/ health conditions are also significantly more likely than those without to say that they would not reach out for support in any of the situations outlined.

Q031. We want to get an understanding of people's willingness to ask for support in different situations. For each situation, please tell us whether you'd be willing or not to ask anyone for help. **Base:** All respondents (2,100). Data labels <5% removed for neatness.

⬆ ⬇ Sig higher/lower than previous survey

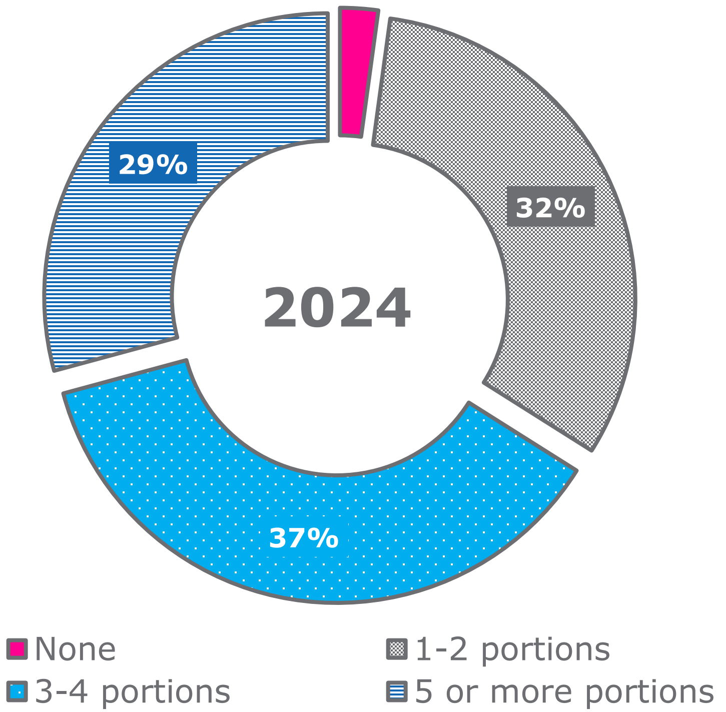
Diet

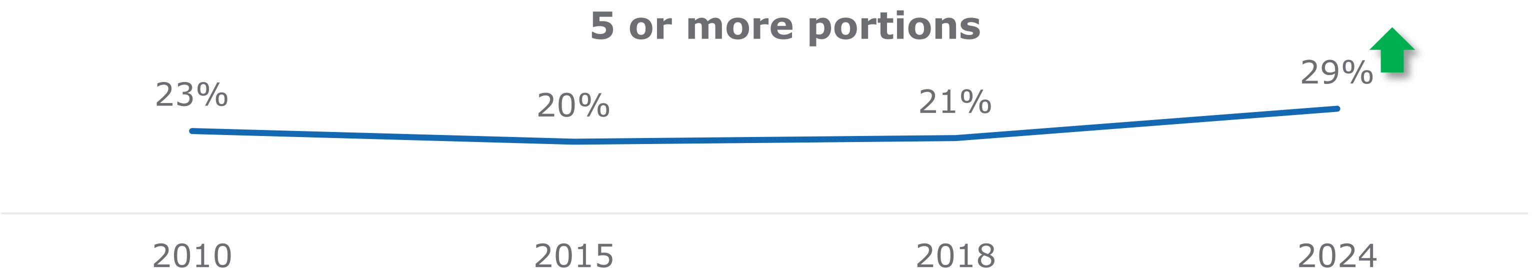
- The percentage of residents eating five or more portions of fruit and vegetables daily has risen significantly by 8% points to 29%, with increases across genders and several age groups.

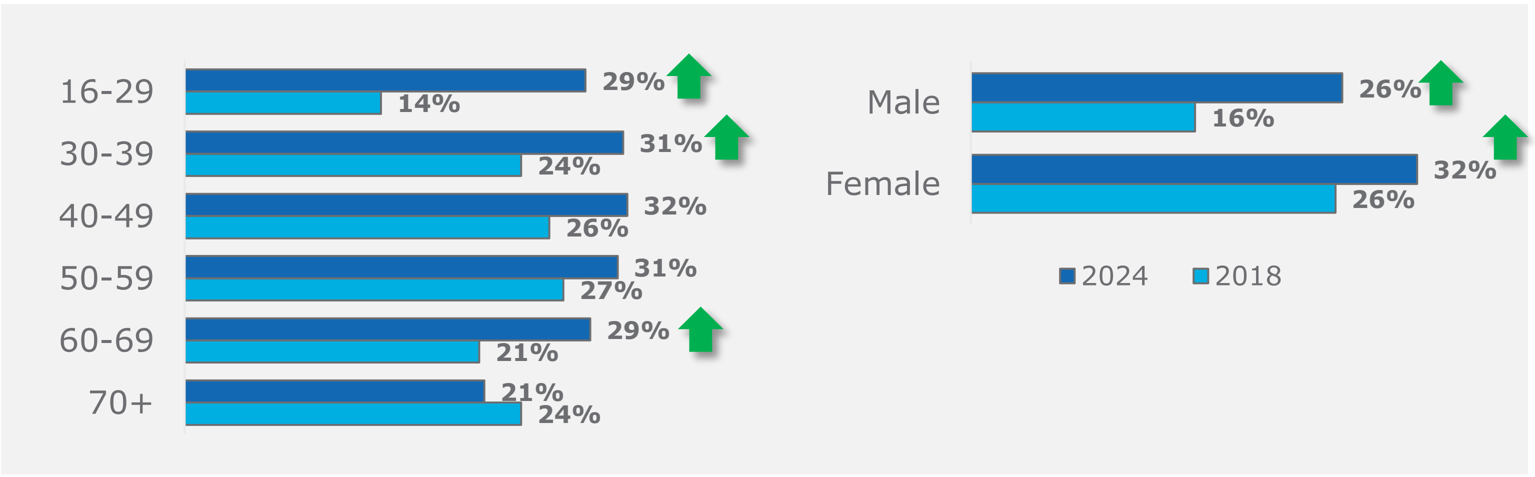
- However, takeaway consumption has also grown, with one in five residents now eating takeaways more than once a week, reflecting a broader trend since in consumer behaviour following the pandemic.

Fruit and vegetable portions consumed per day

Encouragingly, the percentage of residents who claim to eat five or more portions of fruit and vegetables per day has increased significantly by 8% points to 29%. Significant wave-on-wave increases can be seen in both males and females, as well as in a variety of age groups including those aged 16-29, 30-39 and 60-69.





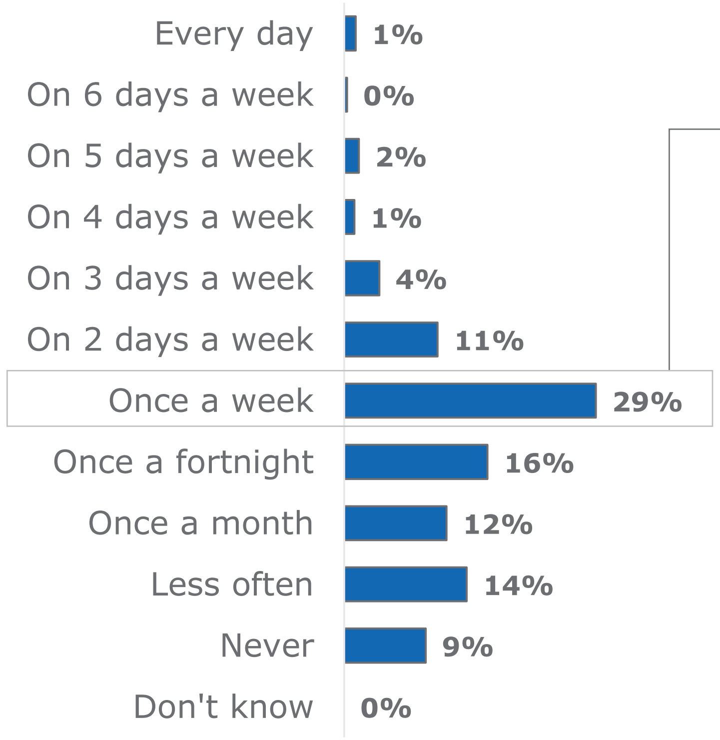


🟩 🟥 Sig higher/lower than previous survey

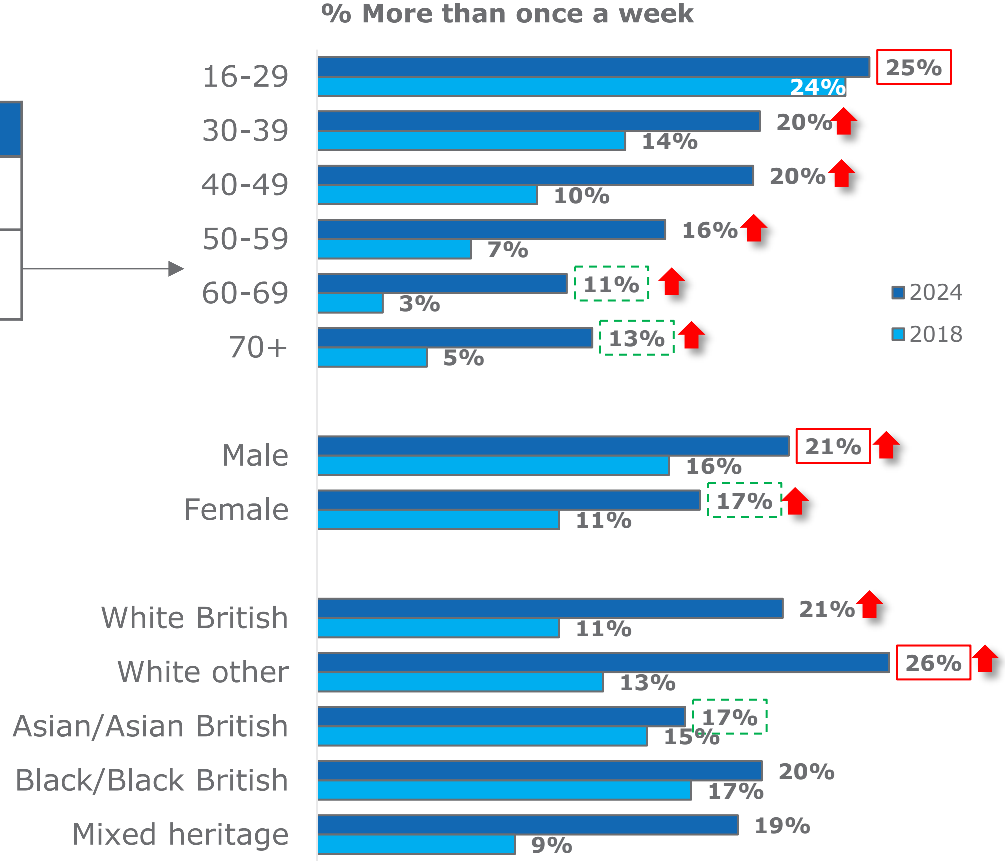
Q08. How many portions of fresh, tinned, frozen or dried fruit and vegetables do you eat on average in a day? **Base:** All respondents (2,100). Data labels <5% removed for neatness.

Takeaway consumption

Takeaway consumption has increased, with the percentage who eat this more than once a week rising significantly by 6% points to one in five residents, and the percentage who eat this once a week rising by 3% points to three in ten residents. This increase reflects a trend seen in recent analysis by the IFS which revealed that takeaway and meal delivery has grown by 50% since the pandemic, as people have substituted coffee shop and pub and restaurant out-of-home calories with takeaways.



	2024	2018
Once a week	29% ⬆	26%
More than once a week	19% ⬆	13%



Q010. Can you tell me how frequently, if at all, you eat hot food from a take-away or through a delivery service (Deliveroo/Uber Eats), such as kebab, curry, Chinese, pizza, fried fish, chicken, chips or a burger? **Base:** All respondents (2,100).

🟥 Significantly higher than all other residents

▭ Significantly lower than all other residents

⬇⬆ Sig higher/lower than previous survey

Exercise/physical activity

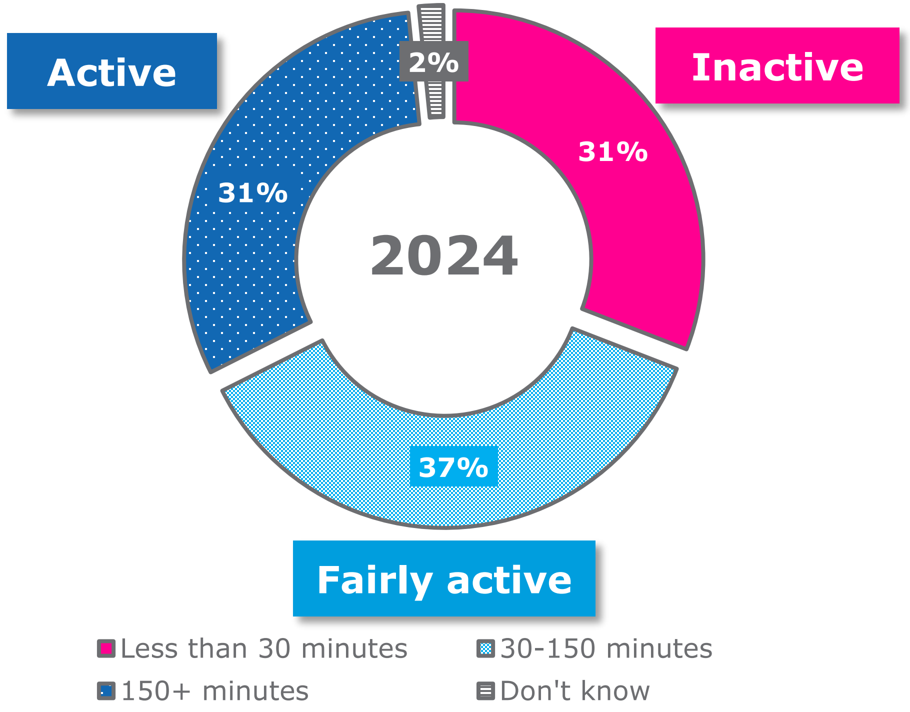
- 31% of residents self-report that they tend to exercise less than 30 minutes per week.

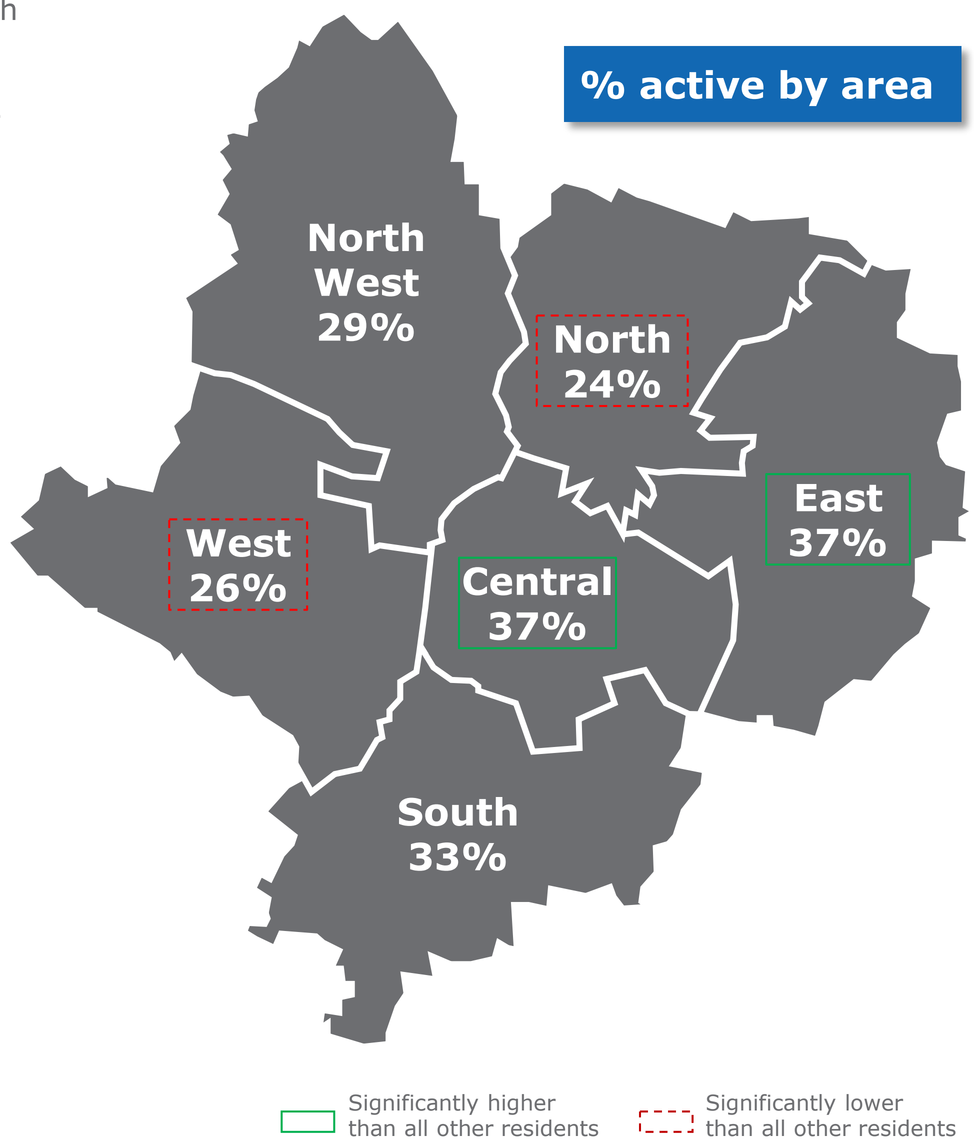
- Weekly visits to parks and council sports facilities have declined since 2018

- While the most popular mode of transport to the city centre is car, about one in five walk or cycle to the city.

Weekly physical activity

Three in ten (31%) report that they do less than 30 minutes per week of exercise, which is in line with the latest (22/23) Active Lives survey from Sports England (30%). There is, however, a clear divergence in the percentage who self-classify as 'active'. The 2024 Leicester figure is around half of the Sport England Leicester figure (31% cf. 59%), due to a much higher proportion who are classified as 'fairly active' (37% cf. 12%).





Q011. How many minutes or hours of at least moderate activity would you say you do a week? **Base:** all respondents (2,100).

Weekly physical activity: demographic breakdown

Almost nine in ten individuals with a disability that limits their day-to-day activities do less than 150 minutes of exercise per week. 81% of those aged 70+ say the same. Conversely, half of those in full time education do over 150 minutes of exercise per week.

Groups more likely to do less than 150 minutes exercise a week

- Limiting disability: 87%
- 70+: 81%
- Acts as carer in household: 76%
- No formal education: 77%
- In social housing: 76%
- North: 75% | West: 73%

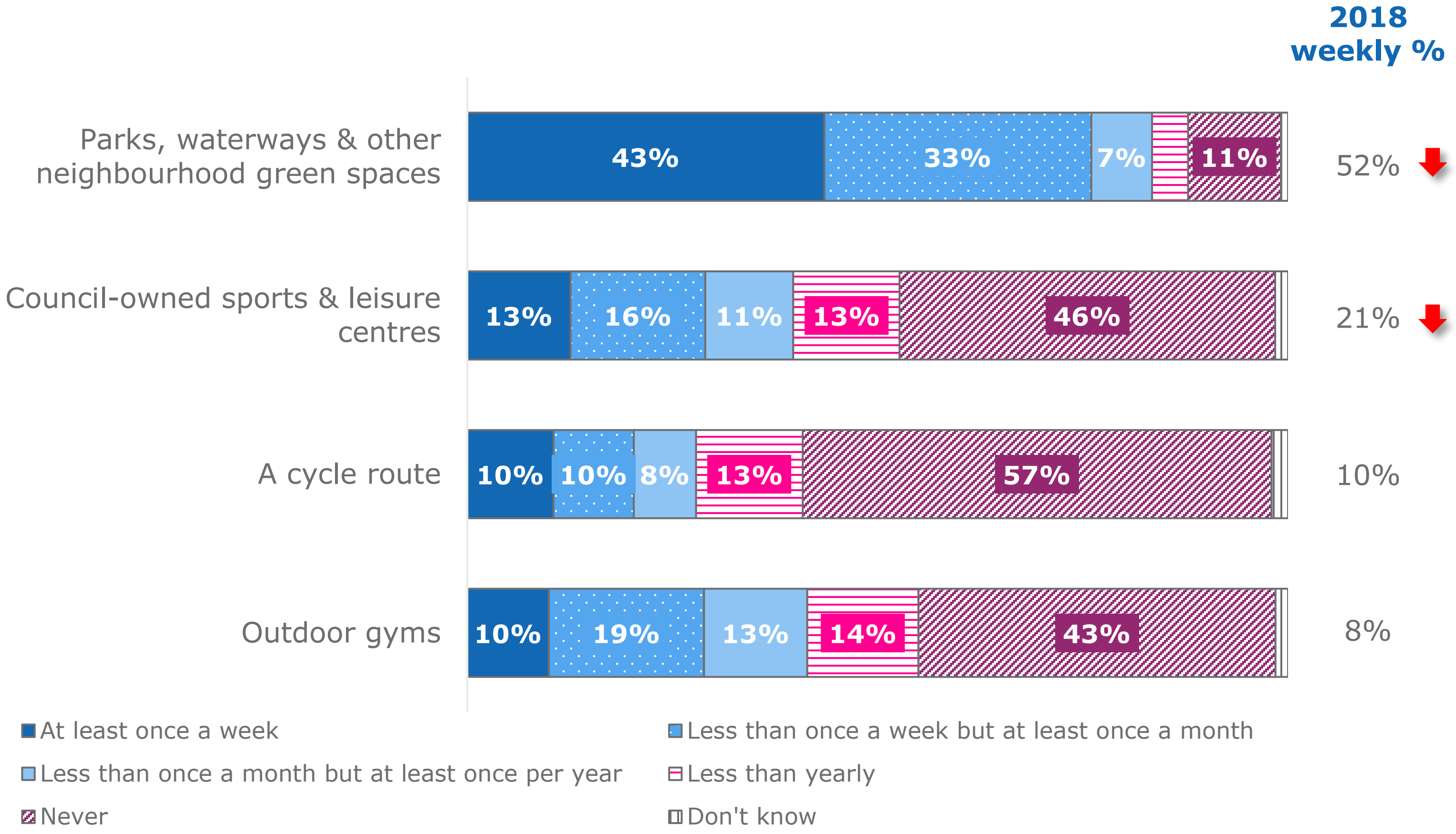
Groups more likely to do at least 150 minutes a week

- In full-time education: 49%
- 16-29: 38%
- Male: 37%
- Central: 37% | East: 37%
- Not disabled: 35%
- Home owners: 34%

Q011. How many minutes or hours of at least moderate activity would you say you do a week? **Base:** all respondents

Use of fitness facilities in Leicester

Over two in five residents visit parks, waterways or other green spaces in Leicester at least once a week (43%). However, this has decreased by 9% points since 2018 (52%). Likewise, there has been a fall in weekly attendance to council-owned sports and leisure centres (13% in 2024 cf. 21% in 2018).



Key differences:

The youngest of the residents surveyed are significantly more likely than all other age groups to have used outdoor gyms at least weekly (13%). So too are Asian/Asian British residents (12%), compared to all other ethnicities.

Residents in the North and West are more likely than those in all other regions to visit a council-owned sports and leisure centre weekly (15% and 17% respectively).

Over half of White Other individuals state that they visit parks, waterways and green spaces weekly, whereas just 35% of White British individuals say the same. White British residents are the least likely of all ethnicities to use these amenities weekly.

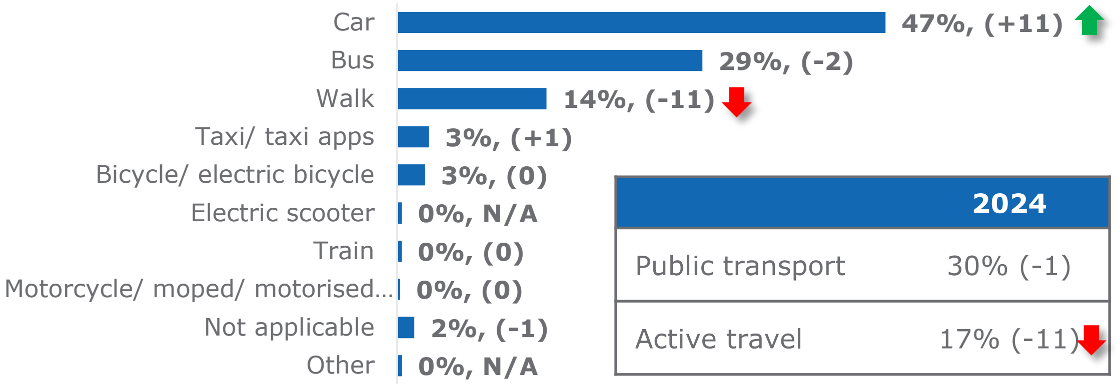
⬆ ⬇ Sig higher/lower than previous survey

Q012. How often, if at all, do you use the following in Leicester? **Base:** All respondents (2,100). Data labels <5% removed for neatness.

Active travel (I)

Overall, travel by car is the most popular form of transportation in and around Leicester. Indeed, more residents now say that they travel to Leicester by car compared to 2018 (+11 % points) while walking has declined (-11% points). This may partly be driven by changes in behaviour following the covid-19 pandemic.

Travelling to Leicester City Centre



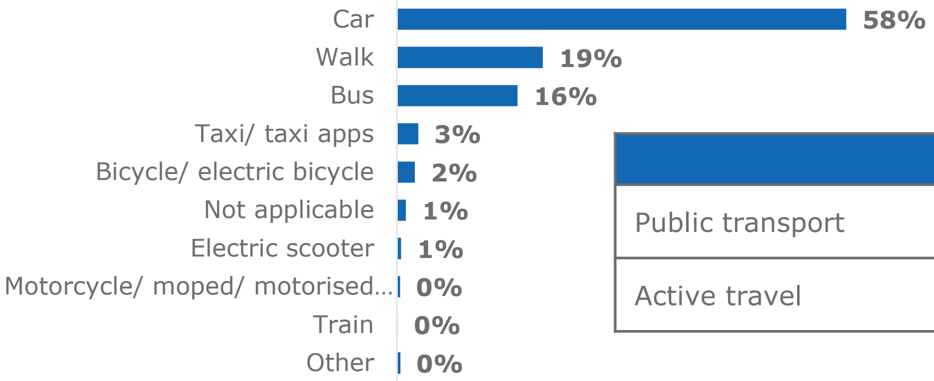
	2024
Public transport	30% (-1)
Active travel	17% (-11) ↓

Key differences:

The youngest age group are significantly more likely than other age groups to travel by bus (36%) or to walk (23%) and are less likely to take the car (33%).

The car is the most common form of transport for both males (51%) and females (44%), but females are 7% points more likely to use the bus compared to males (26%). Moreover, females are twice as likely as males to say that they use taxis (4% cf. 2%).

Travelling to the supermarket



	2024
Public transport	16%
Active travel	21%

Key differences:

Younger residents are significantly more likely than average to travel to the supermarket via public transport (21% v 16% total), or active travel (33% v 21% total). This may be because they are students and haven't brought their car with them to university.

Again, those living in Central Leicester are significantly more likely than average to go to the supermarket via active travel (28% v 21% total).

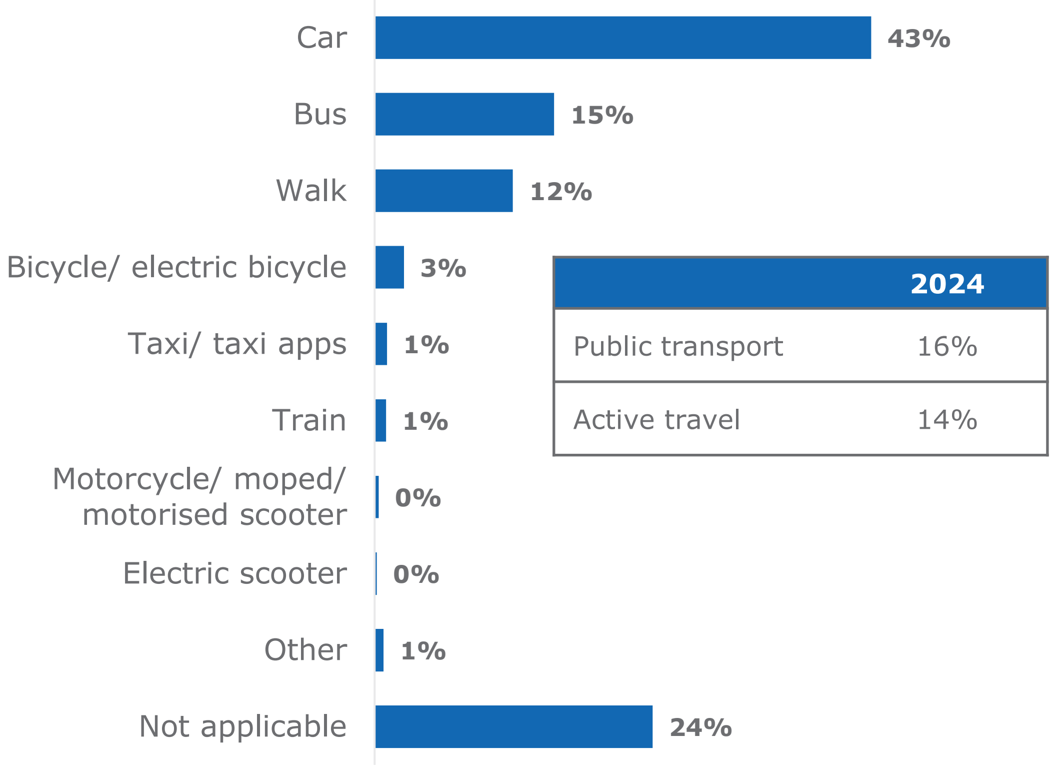
Q013. Which mode of transport do you tend to use most often when travelling to the following? **Base:** All respondents (2,100). Comparisons to 2018 shown in brackets. "Travelling to supermarket" was not asked in 2018.

↑ ↓ Sig higher/lower than previous survey

Active travel (II)

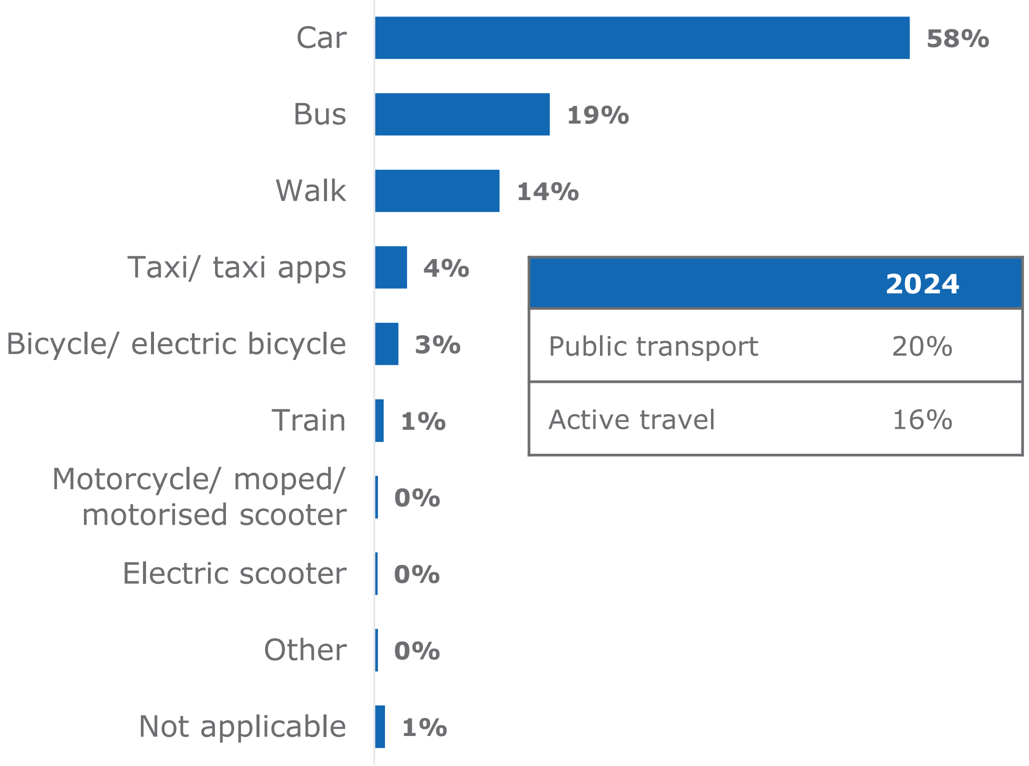
The car is also the most popular form of transport for going to a place of work/education or for leisure.

Travelling to place of work or education



	2024
Public transport	16%
Active travel	14%

Travelling for social or leisure purposes like seeing family/ friends



	2024
Public transport	20%
Active travel	16%

Q013. Which mode of transport do you tend to use most often when travelling to the following? **Base:** All respondents (2,100).

Smoking and vaping

- 13% of residents smoke regularly, with an additional 3% smoking occasionally. A majority (72%) have never smoked, and 1% have quit within the past year.

- Vaping is less common, with 5% vaping regularly and 4% occasionally, while 87% have never vaped.

- Only 49% of current smokers or tobacco users wish to quit, and 42% of vapers feel the same.

- Opinions on e-cigarette safety are mixed: 48% disagree that vaping is safer than smoking, while 18% agree, 12% are neutral, and 21% remain unsure.

- The use of other tobacco products is minimal.

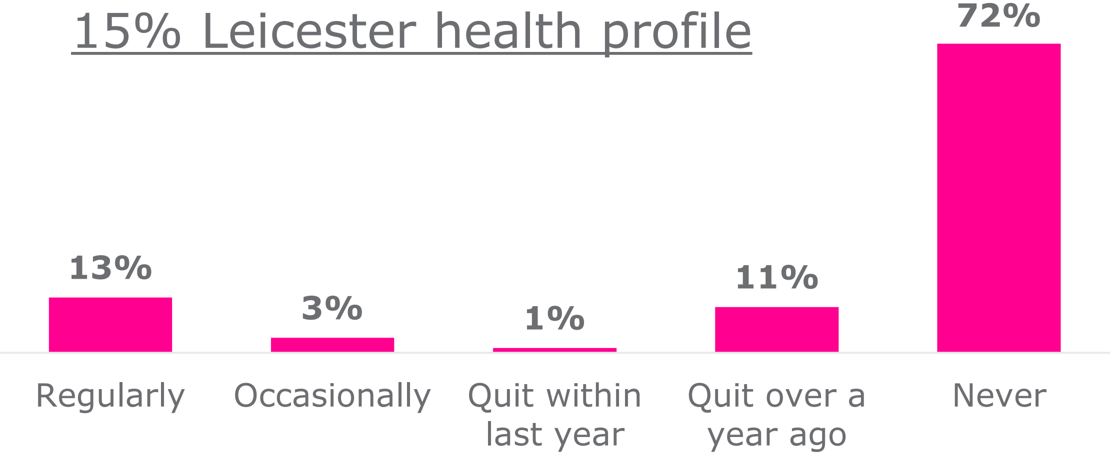
Smoking: cigarettes

13% report that they currently smoke cigarettes regularly, and 3% smoke occasionally. A small proportion of residents (1%) have quit smoking within the last year, while 11% quit over a year ago. The majority, however, (72%) state that they have never smoked.

16% (-4)⬇

smoke cigarettes

12% nationally*
15% Leicester health profile



Groups more likely to smoke cigarettes

Aged 50-59: 20%

Male: 19%

Western: 32% | Beaumont Leys: 25%

White Other: 34%

O level/GCSE/CSE/NVQ level 1-2: 23%

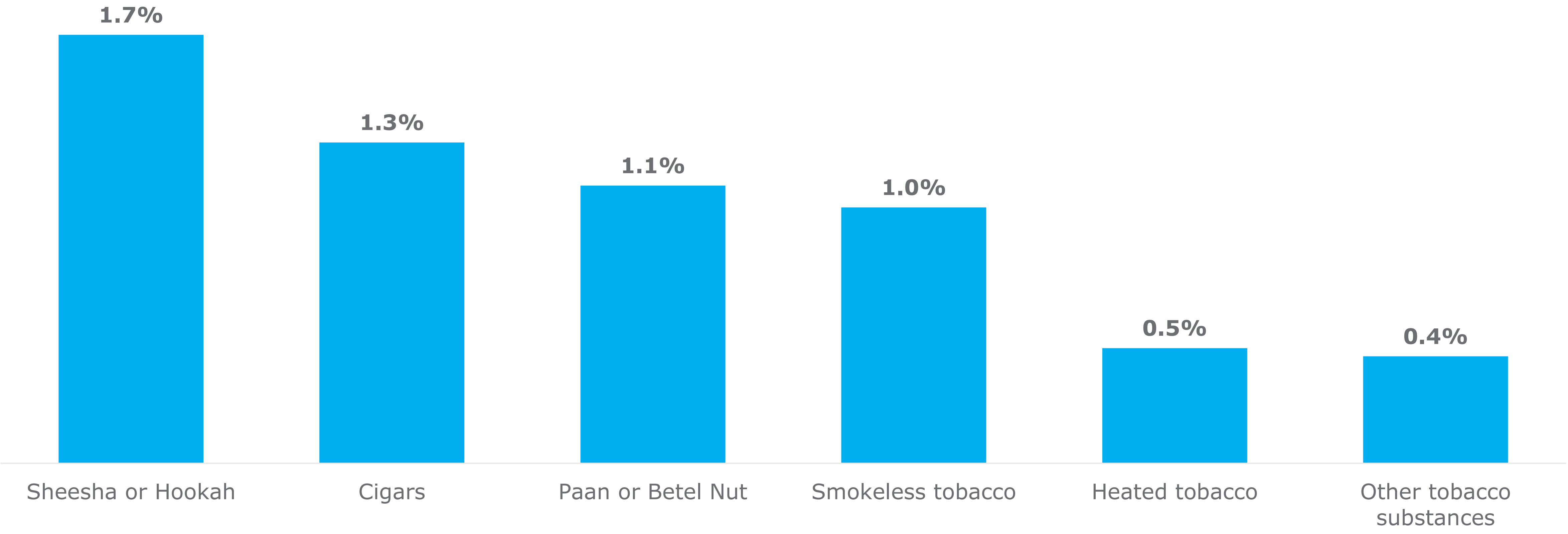
Low ratings of happiness: 36%

Q021. Have you ever smoked or used any of the following? **Base:** All respondents (2,100). 2018 data in brackets.
*Based on latest public health profile data from Public Health England. **Based on Health Survey for England 2022

⬆⬇ Sig higher/lower than previous survey

Current use of other tobacco products

Usage of other tobacco products is very low, though of all other options, sheesha/hookah is most popular (2%). 16–29-year-olds and those who identify as Asian/Asian British are most likely to use sheesha/hookah.

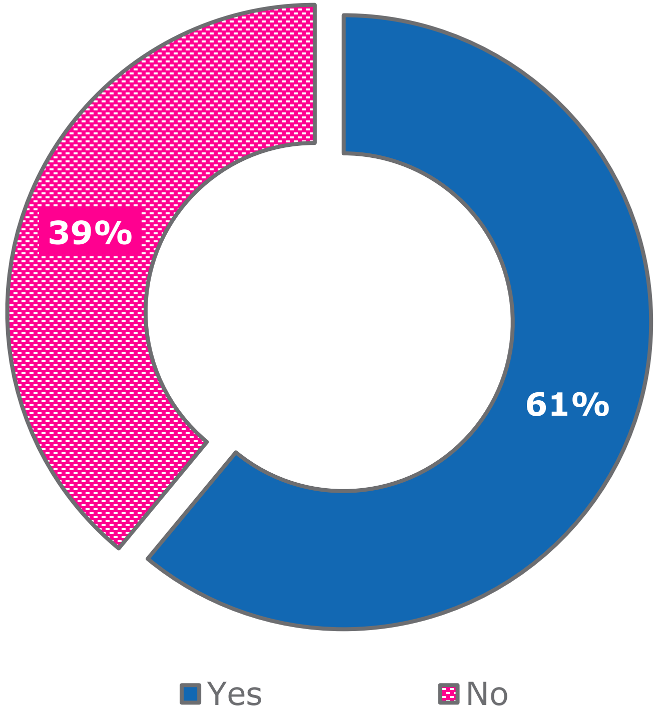


Q021. Have you ever smoked or used any of the following? **Base:** All respondents (2,100). 2018 data in brackets.

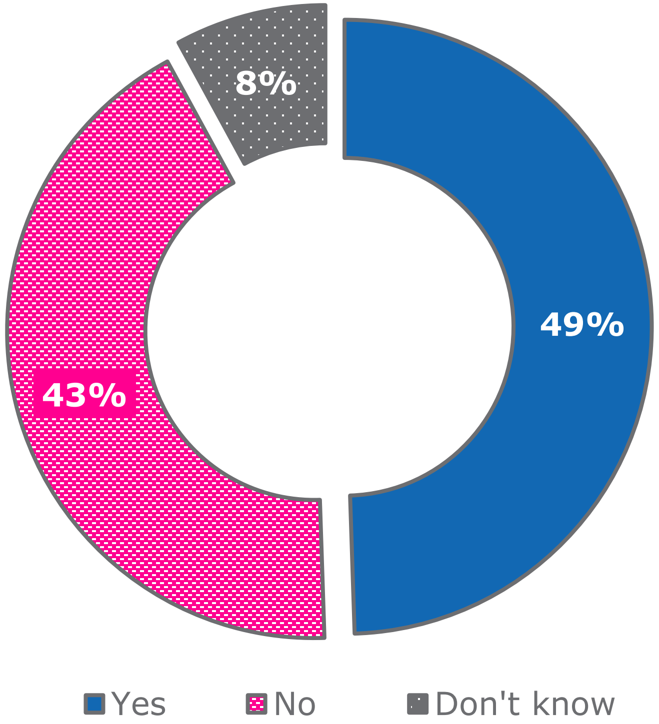
Giving up smoking

Though 61% of current smokers have tried to stop smoking in the past, just 49% of those who smoke or use tobacco products (excluding vapes) state that they would now like to quit, while 43% do not want to quit.

Ever tried to stop smoking/using tobacco in the past?



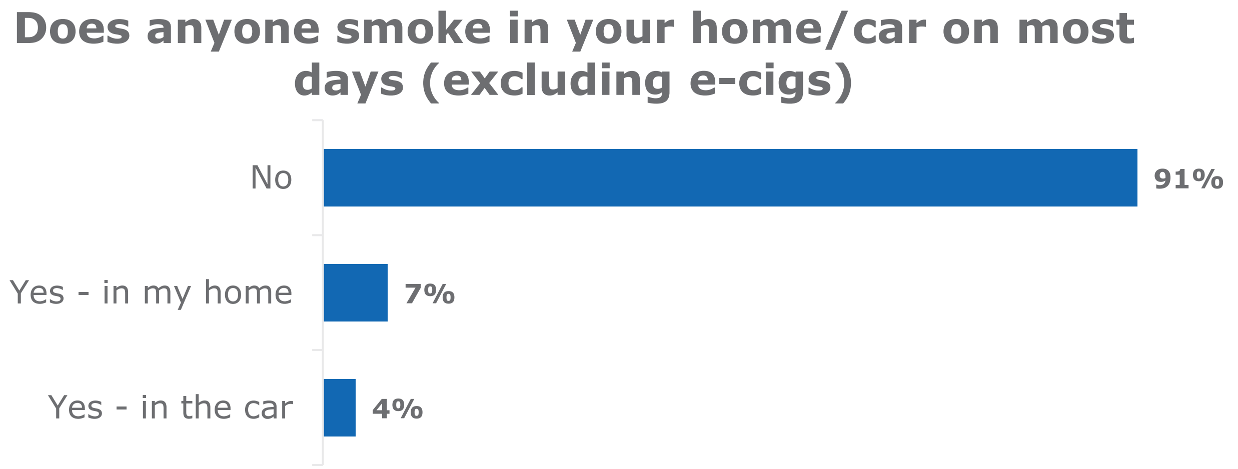
Give up smoking/ using tobacco?



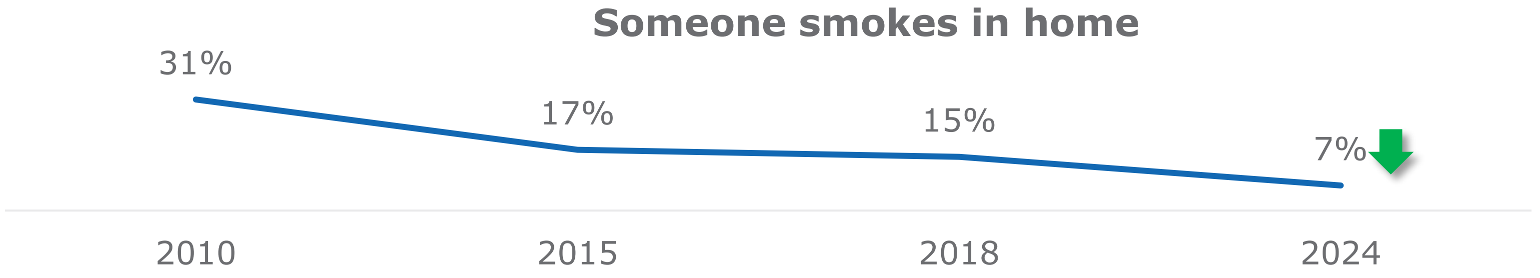
Q022. Would you like to give up smoking/ using tobacco? **Base:** All current smokers or those who smoke/use any tobacco product (376) **Q024.** Have you ever tried to stop smoking or using tobacco in the past? **Base:** All current smokers/ those who smoke/ use any tobacco product (376).

Smoking at home/in the car

The vast majority of Leicester residents do not smoke in their car or home (91%). Nevertheless, smoking in the home is more common than smoking in the car.



Does anyone smoke in your home/car on most days (excluding e-cigs)



Someone smokes in home

Key differences:

Residents aged 60-69 are 5% points higher than average to say that they smoke in their home (12%).

A similar proportion living in the West of the city smoke at home (13%). This is significantly higher than those in Central Leicester (2%) and the North (1%).

Prevalence rises even further for those without any formal educational qualifications (16%).

There are no significant differences in in-home smoking habits between those with young children in the house and those without (both 7%).

↑ ↓ Sig higher/lower than previous survey

Q026. Does anyone smoke inside your home or car on most days? We are referring to tobacco cigarettes, not e-cigarettes or other vaping devices. **Base:** All respondents (2,100).

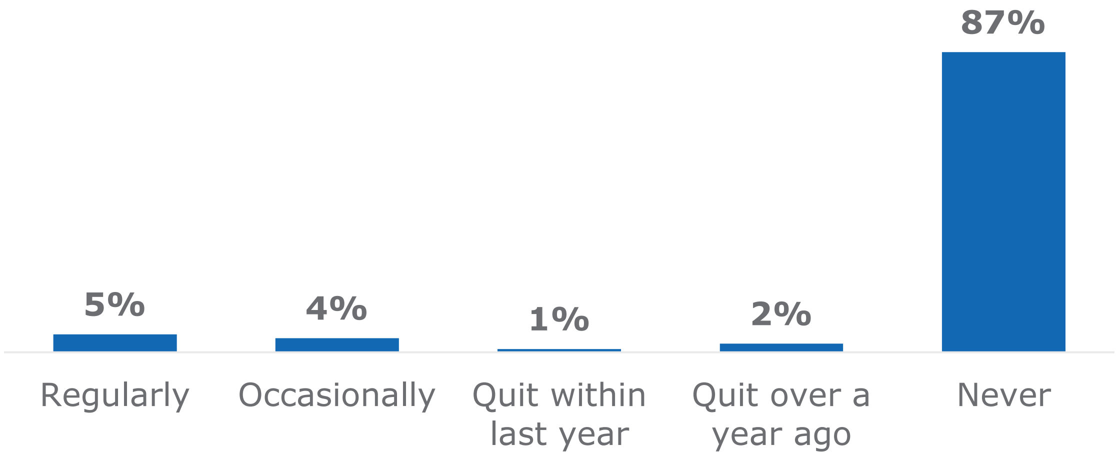
Vaping: e-cigarettes

5% of residents currently vape regularly, and 4% vape occasionally. Only 1% have quit vaping within the past year, and 2% have quit for over a year. Notably, 87% report that they have never vaped. Usage of other tobacco products is very low (<2%).

9% (+5)↑

use e-cigarettes

9% nationally**



Groups more likely to use e-cigarettes

Feel affected by gambling: 28%

White Other: 21%

Socially isolated: 20%

In social housing: 16%

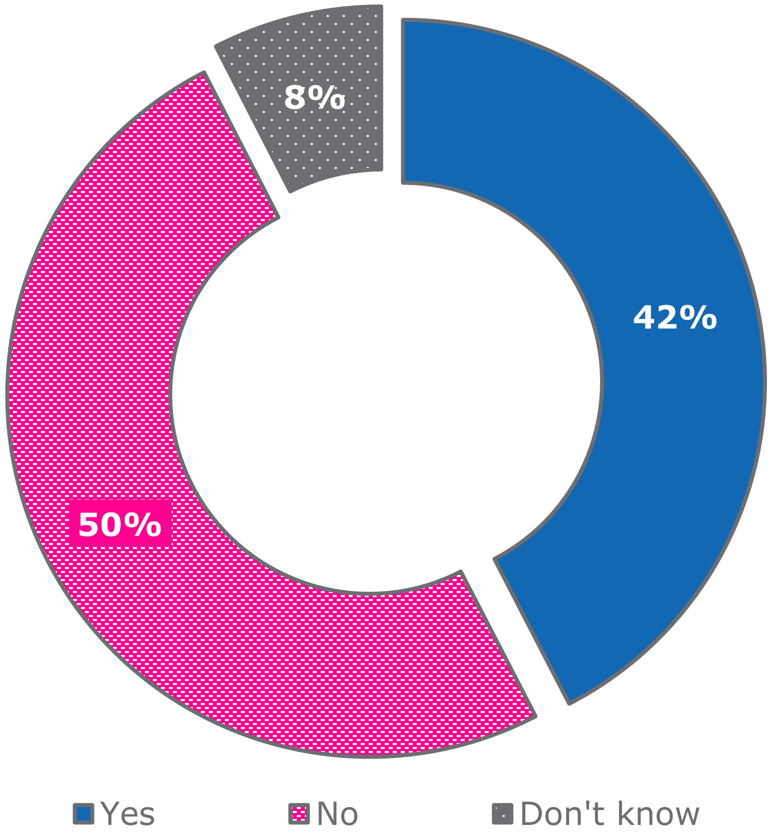
Aged 30-39: 13%

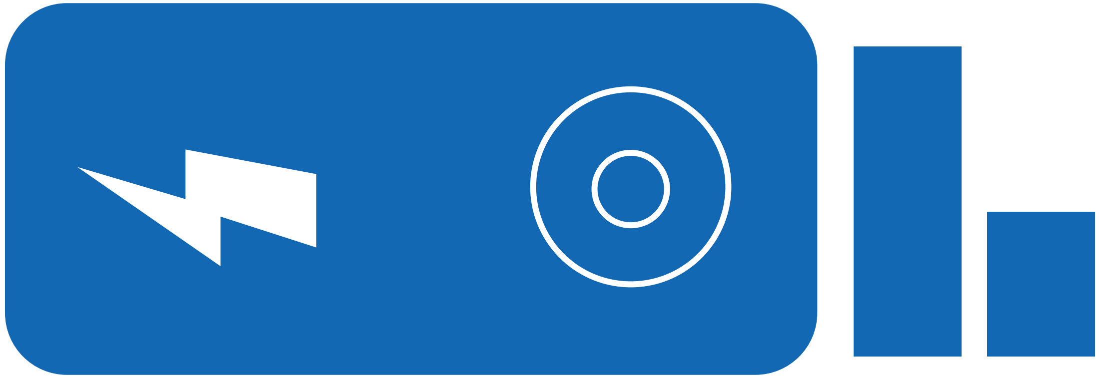
Q021. Have you ever smoked or used any of the following? **Base:** All respondents (2,100). 2018 data in brackets.
*Based on latest public health profile data from Public Health England. **Based on Health Survey for England 2022

↑ ↓ Sig higher/lower than previous survey

Giving up vaping

Amongst those who vape, 50% show no interest in giving up. Just over two in five want to quit (42%).



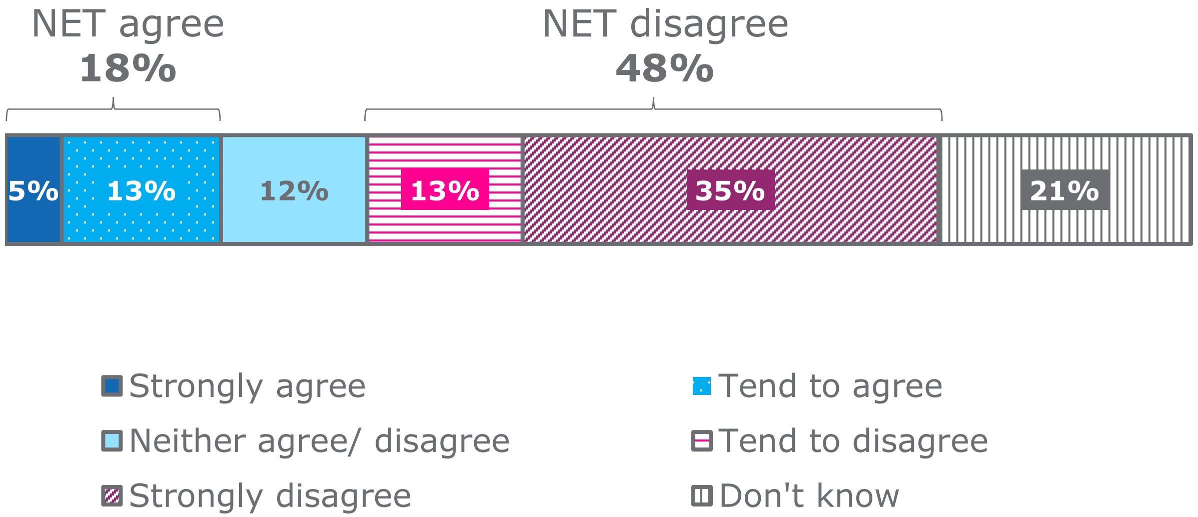


Q023. Would you like to give up e-cigarettes (vaping)? **Base:** All current vapers (187).

Safety of e-cigarettes

A plurality of Leicester residents disagree that using e-cigarettes is a safer alternative to smoking than traditional cigarettes or tobacco products (48%). Of the remainder, around one in five agree (18%), while 12% are neutral. However, there is a fair amount of uncertainty as one in five residents (21%) say that they don't know. The level of agreement with this statement rises threefold amongst those who currently vape (56%).

Agreement that using e-cigarettes (vaping) is a safer alternative to smoking traditional cigarettes/ tobacco products



Key differences:

Residents in the North West of the city are significantly more likely to agree that e-cigarettes are safer (40% v 18% total). Conversely, those living in Central Leicester are significantly more likely to express the opposite (54% disagree v 48% total).

Those of multiple heritage are also more likely than residents of any other ethnicity to disagree with the statement (64%), along with active individuals (53%) and those with low Audit C scores (50%).

Q025. To what extent do you agree or disagree that using e-cigarettes (vaping) is a safer alternative to smoking traditional cigarettes or tobacco products? **Base:** All respondents 2,100).

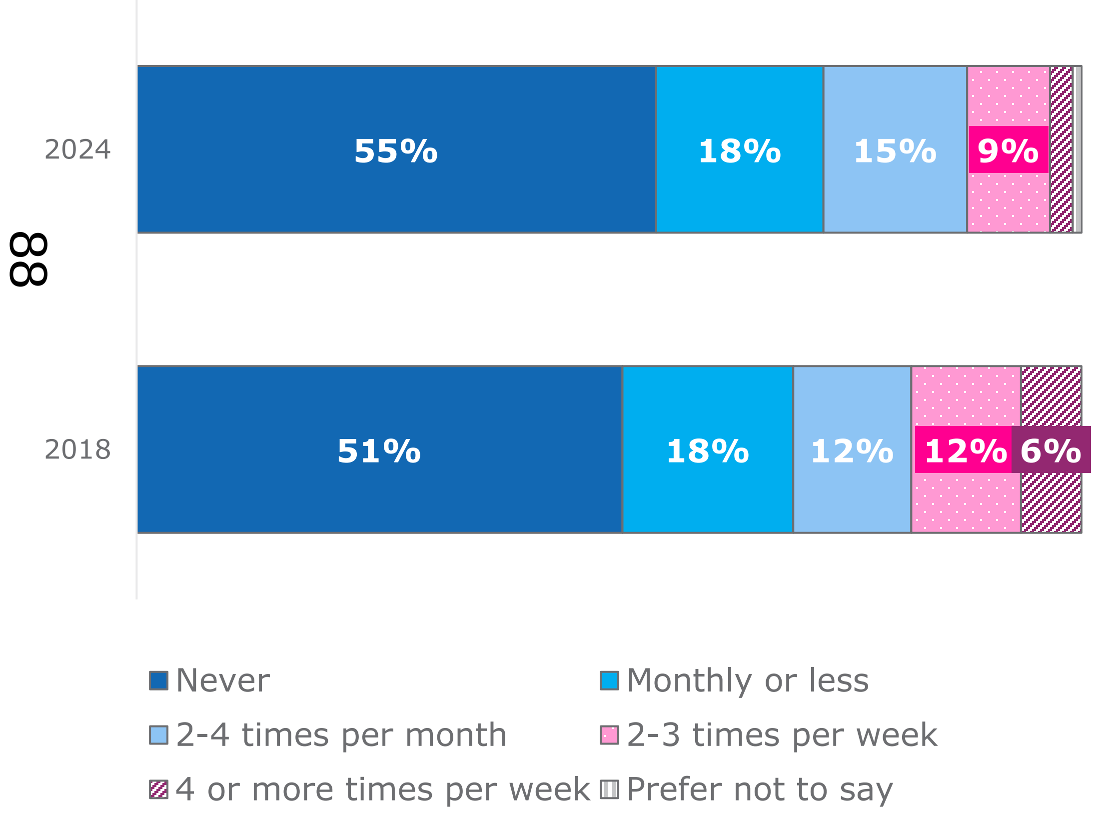
Alcohol consumption

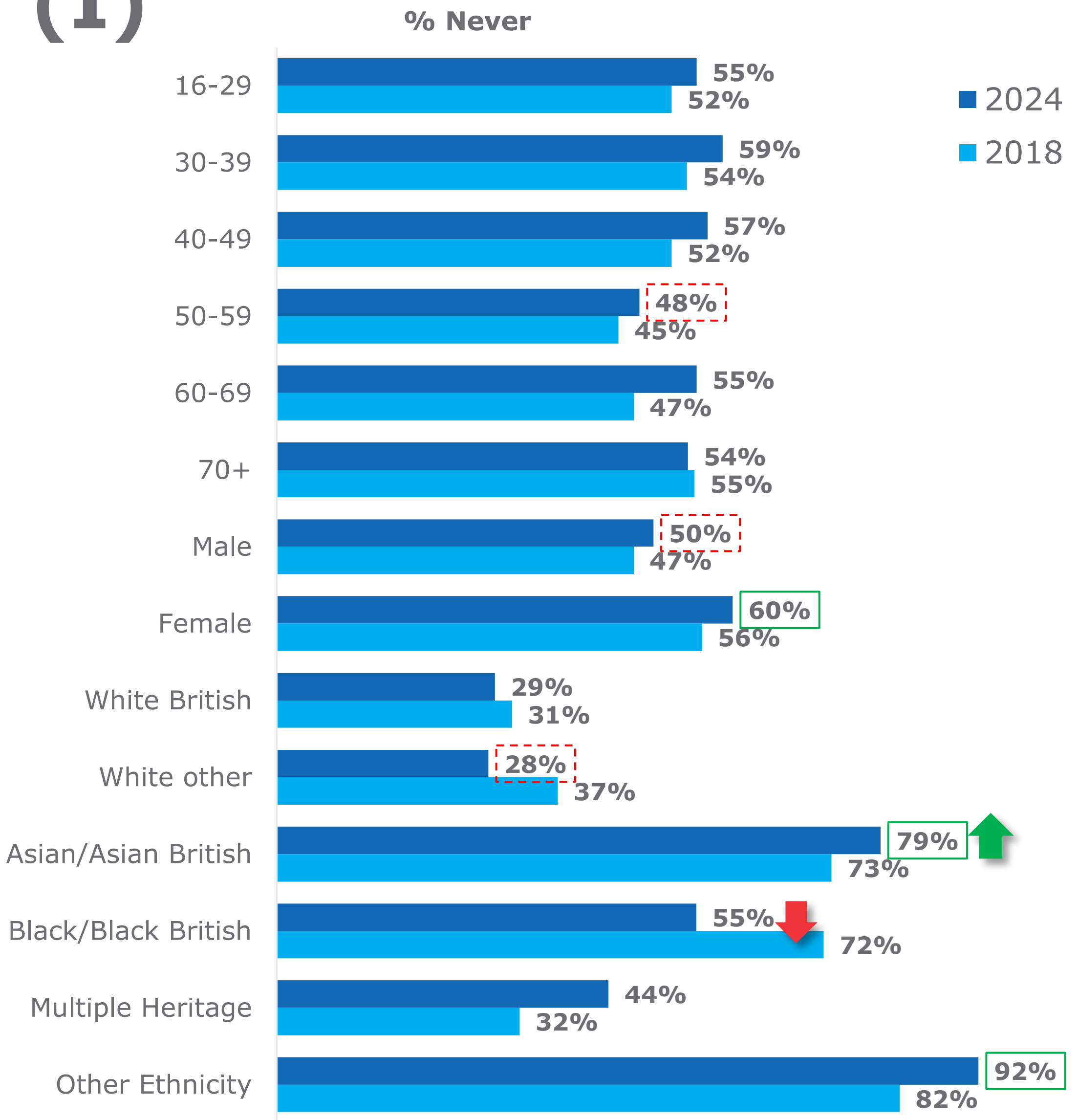
- 55% of residents abstain from alcohol. This is well above the national average of 19% and is also up 4% since 2018.
- Among those who drink, most consume only 0-2 units per session (45%), with 16% drinking 5+ units and 2% drinking 10+ units. Weekly binge drinking is reported by 9% of men and 5% of women.
- An Audit C* assessment found 86% of residents are at low risk of alcohol dependence, 12% at increasing risk, and just 1% at higher risk. Less than 0.5% have scores indicating possible alcohol dependence.

*The AUDIT-C Test (Alcohol Use Disorders Identification Test - Consumption) is a simple screening tool used to identify individuals with risky or harmful drinking behaviours. See appendix for more detail.

Frequency of drinking alcohol (I)

Abstinence continues to grow in Leicester, with more than half of residents saying that they never drink (55%), which is 4% points higher than in 2018. This is far higher than the national average (19%) as per the Health Survey for England.





Q038. How often do you have a drink containing alcohol? **Base:** All respondents (2,100).

🟥 Significantly higher than all other residents

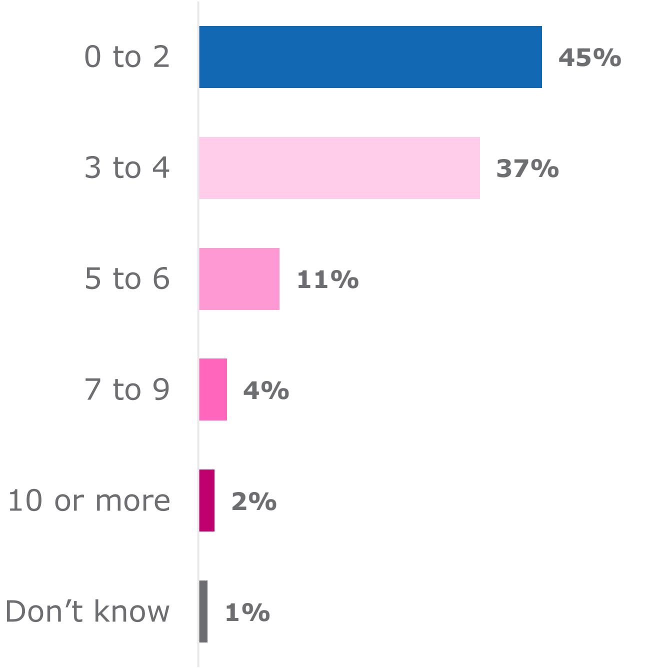
🟩 Significantly lower than all other residents

⬆ ⬇ Sig higher/lower than previous survey

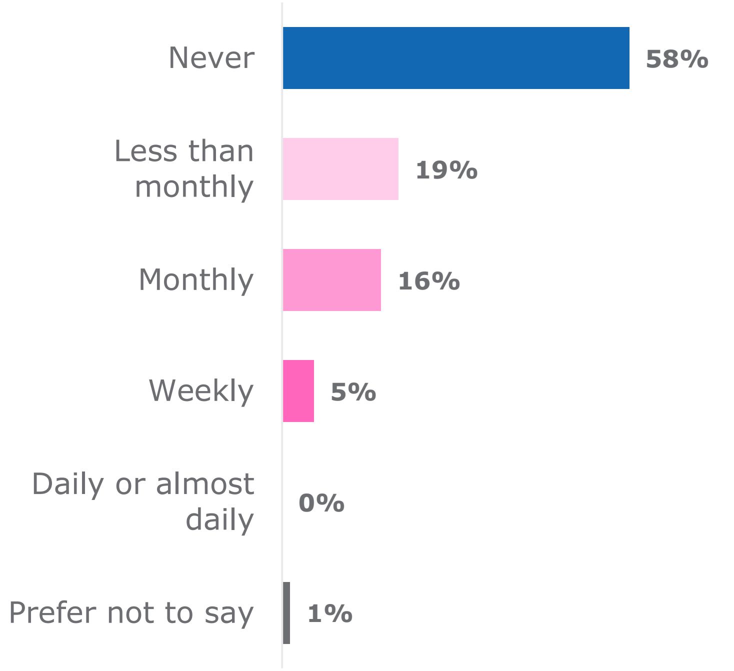
Frequency of drinking alcohol (II)

Of those who do drink alcohol, most only drink 0-2 units on a typical day when they are drinking (45%). Just 16% consume 5 or more units and 2% have 10+ units, typically. 10% of men who drink alcohol have more than 8 units on a single occasion at least weekly. In comparison, 5% of women report drinking 6+ units at least weekly.

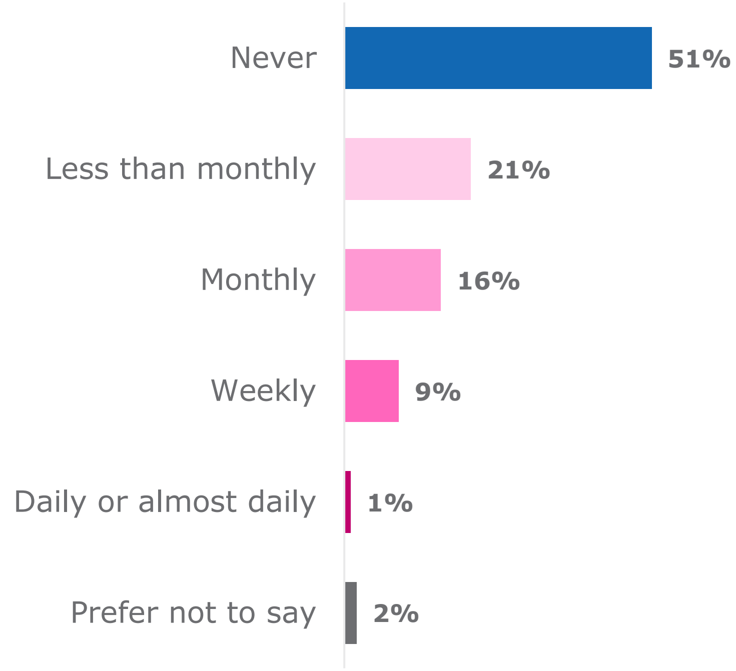
Alcohol units consumed on a typical day when drinking



Females: frequency of consuming ≥ 6 units of alcohol



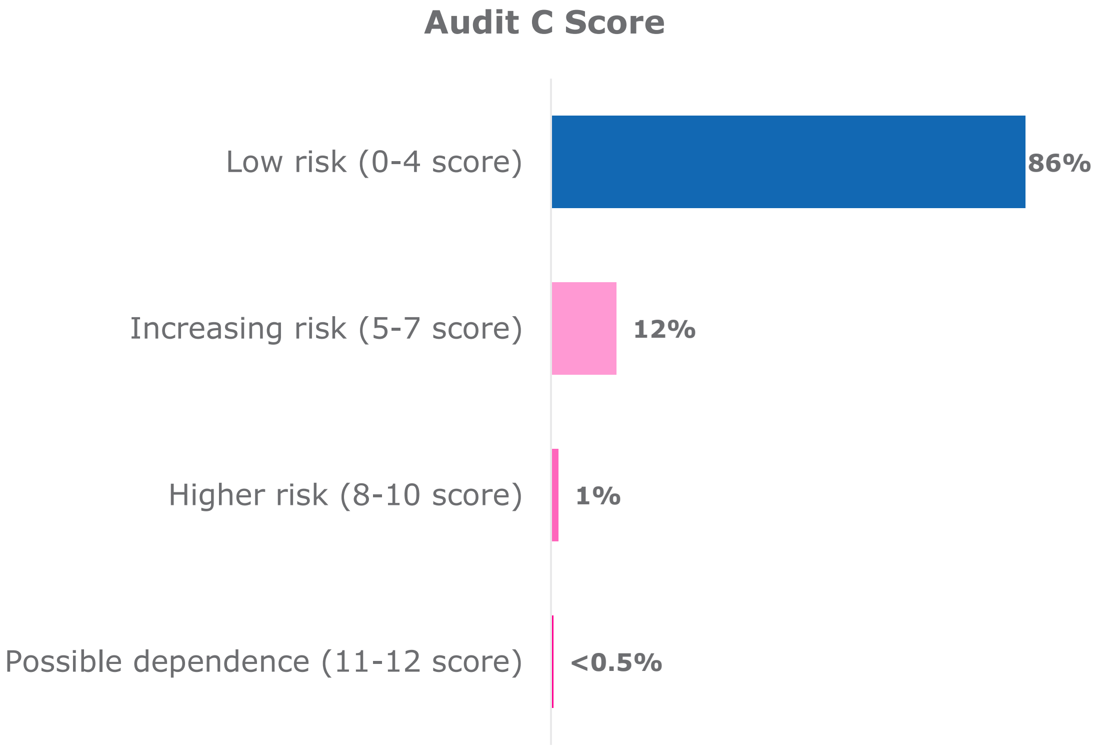
Males: frequency of consuming ≥8 units of alcohol

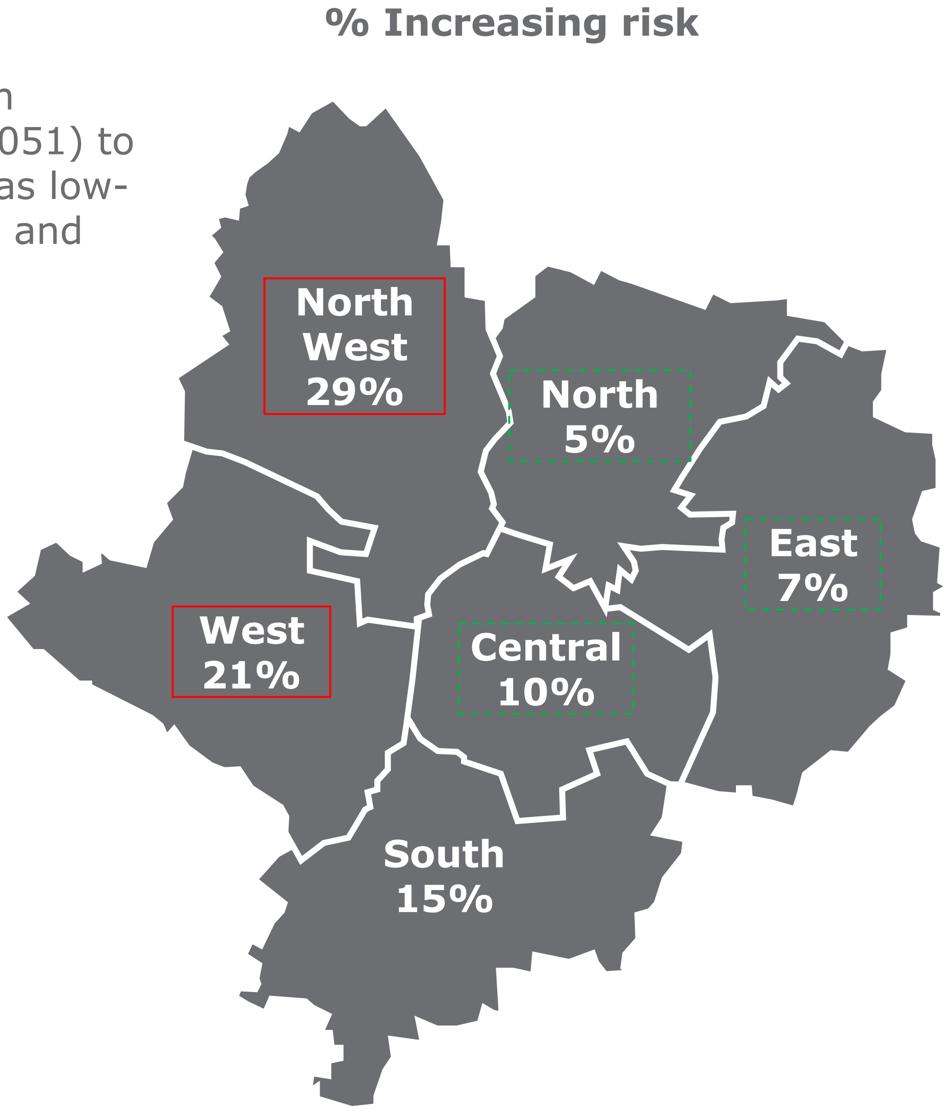


Q039. How many units of alcohol do you drink on a typical day when you are drinking? **Base:** Those who drink alcohol (927)
Q040. How often have you had 6 or more units of alcohol on a single occasion in the last year? **Base:** Females who drink alcohol (422)
Q041. How often have you had 8 or more units of alcohol on a single occasion in the last year? **Base: M**ales who drink alcohol (504)

AuditC Score

Using the previous questions, an AuditC score was calculated for each respondent who gave a valid answer to the previous questions (n=2,051) to gauge possible alcohol dependence. 86% of these residents register as low-risk, 12% have a score indicating increasing risk, 1% are higher risk, and <0.5% have scores indicating possible alcohol dependence.





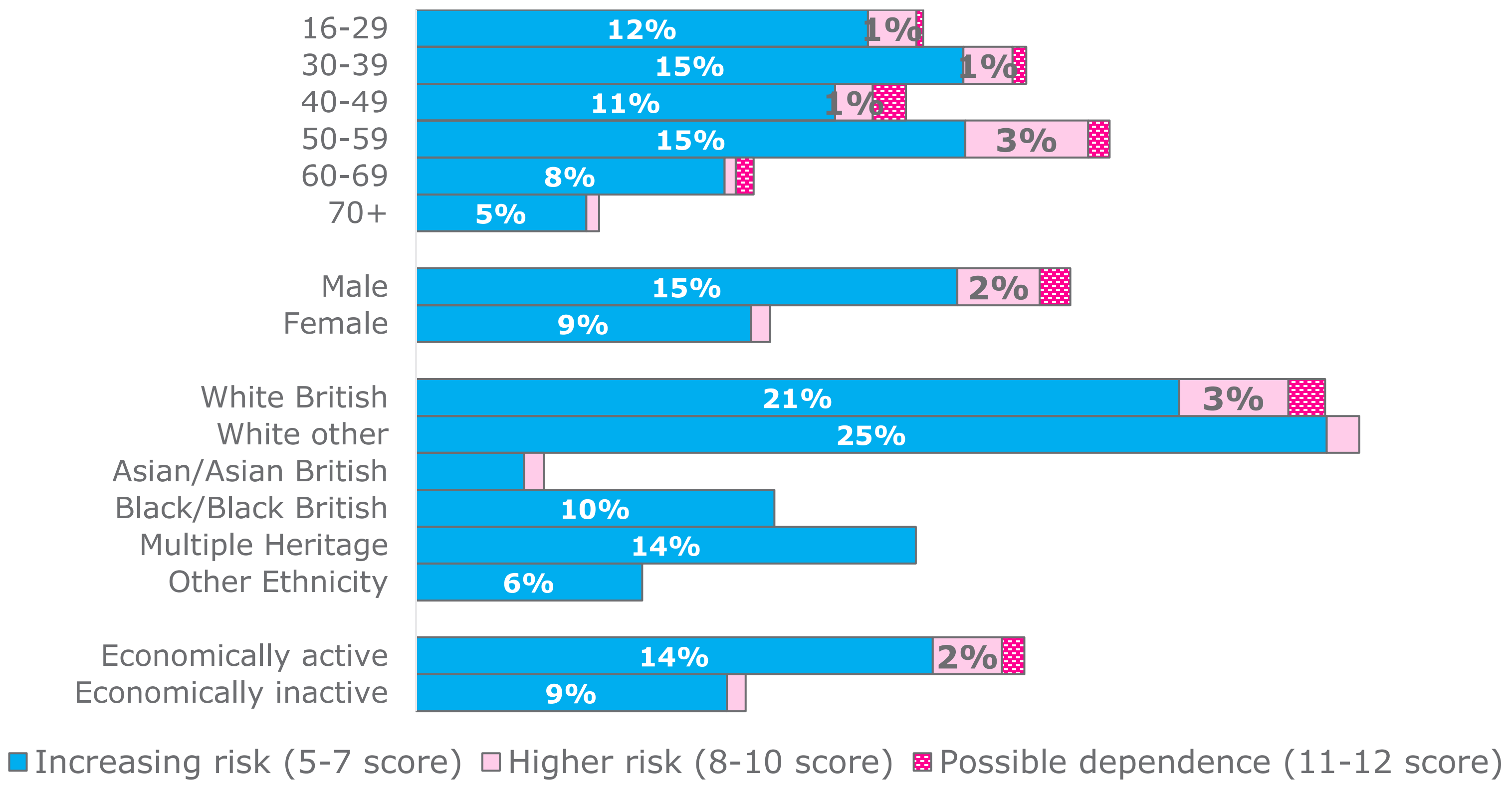
🟥 Significantly higher than all other residents

⬚ Significantly lower than all other residents

Q039. How many units of alcohol do you drink on a typical day when you are drinking? **Base:** Those who drink alcohol (927)
Q040. How often have you had 6 or more units of alcohol on a single occasion in the last year? **Base:** Females who drink alcohol (422)
Q041. How often have you had 8 or more units of alcohol on a single occasion in the last year? **Base: M**ales who drink alcohol (504)

AuditC score by demographic

50–59-year-olds are the age group with the highest proportion scoring increasing risk or higher. In terms of ethnicity, those who are white British or white other have a higher risk profile. So too do males (+8% points compared to females).



Group	% Increasing risk or higher
16-29	14%
30-39	17%
40-49	13%
50-59	19%
60-69	9%
70+	5%
Male	18%
Female	10%
White British	25%
White other	26%
Asian/Asian British	4%
Black/Black British	10%
Multiple Heritage	14%
Other Ethnicity	6%
Economically active	17%
Economically inactive	9%

Q038. How often do you have a drink containing alcohol? **Base:** All respondents (2051). Data labels <1% removed for neatness.

⬆⬇ Sig higher/lower than previous survey

Gambling

- 8% of residents feel affected by gambling, with males (10%) and White other residents (12%) reporting higher rates, while Asian/Asian British residents are least affected (5%).

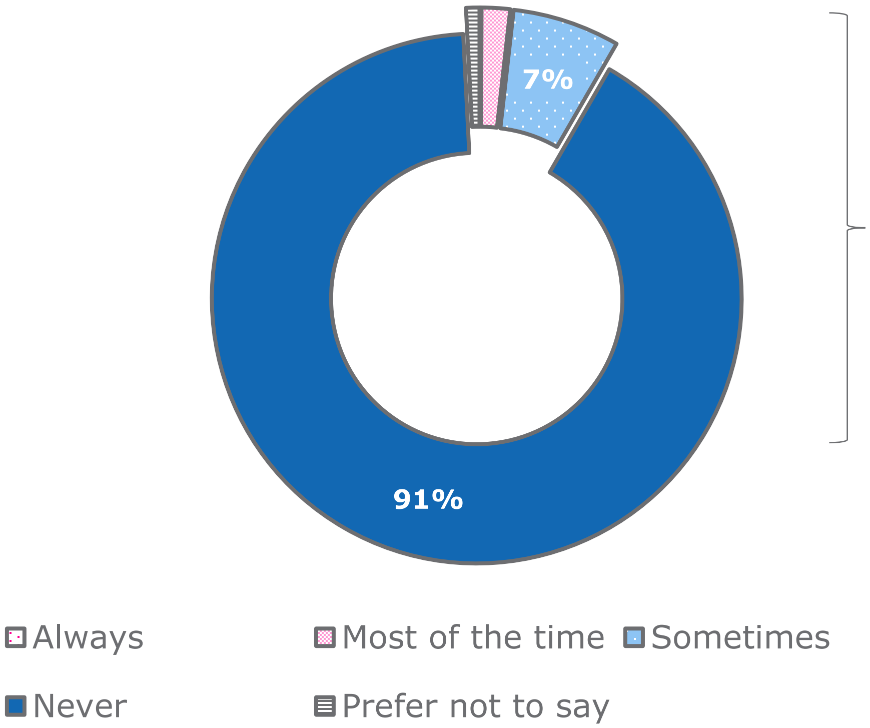
- The lottery (24%) and scratchcards (12%) are the most popular forms of gambling, but seven in ten of the population do not gamble at all.

- Gambling is more common among males (33% vs. 26% females), and White British residents (47%). Those in social housing (36%) and residents who consume alcohol (47%) are also more likely to gamble.

- Notably, 75% of those affected by gambling participate in it themselves.

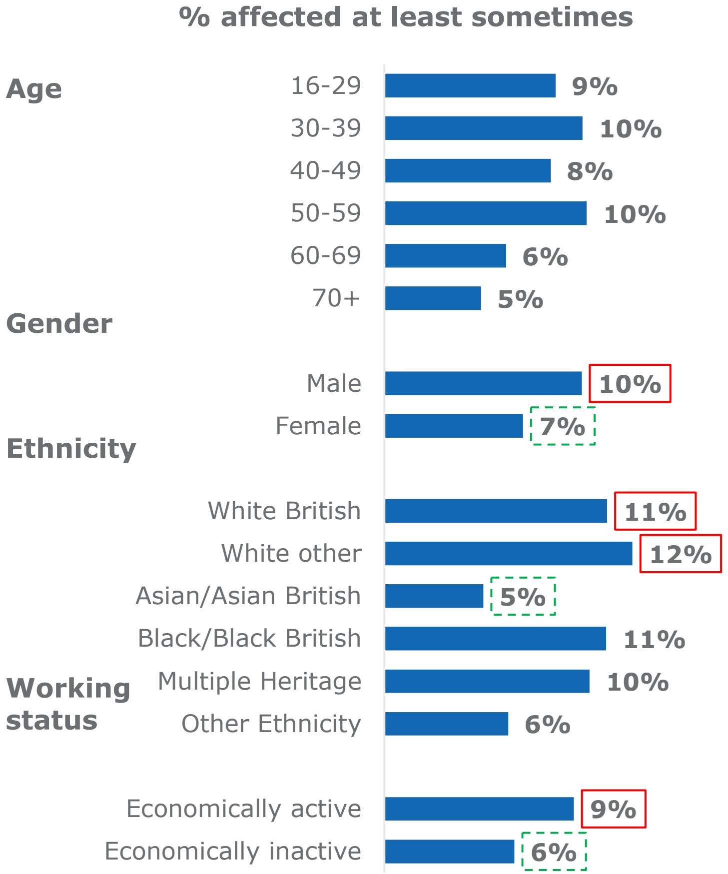
Feeling affected by gambling

One in twelve feel affected by gambling at least sometimes (8%). This rises to 10% for males, and further still to 12% for White other residents. In contrast, Asian/Asian British residents are least affected (5%).



Always/most of the time/sometimes

8%

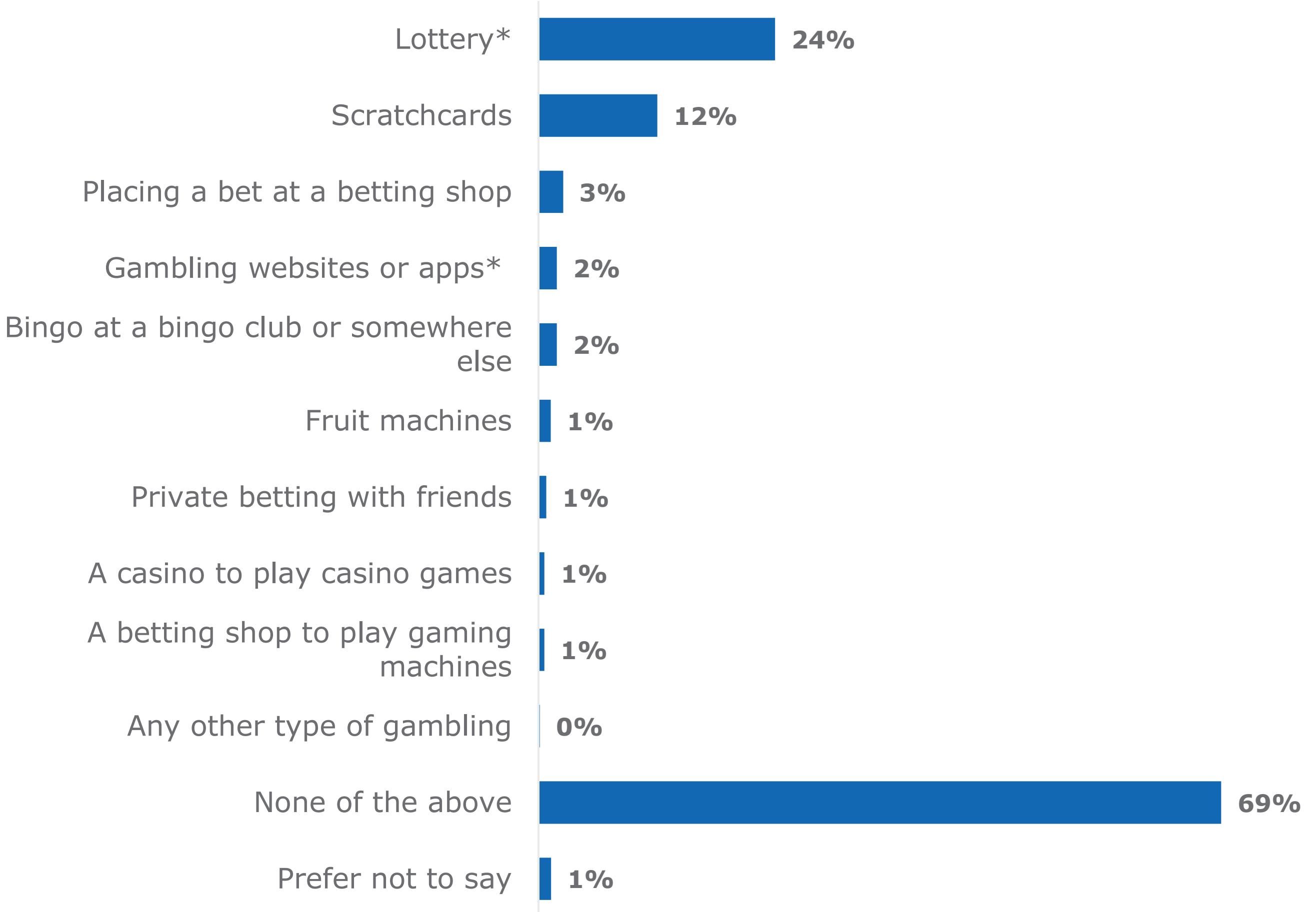


Q037. Do you feel you are affected by any gambling, either your own or someone else's? **Base:** All respondents (2,100). Data labels <5% removed for neatness.

🟥 Significantly higher than all other residents
⬚ Significantly lower than all other residents
⬆ ⬇ Sig higher/lower than previous survey

Types of gambling

While the vast majority of residents (69%) have not spent their money on any form of gambling within the last month, one-quarter report taking part in the lottery (24%) while 12% have purchased scratchcards.



Q036. Have you spent any of YOUR money on any of the following in the last month?
Base: All respondents (2,100). *Full code descriptions in notes.

Key differences:

Those aged 50-59 or 60-69 are significantly more likely than all other age groups to take part in any type of gambling (42% and 37% respectively). In contrast, just 21% of those aged 16-29 report that they gambled.

Males are 7% points more likely to report that they have gambled compared to females (33% cf. 26%).

47% of White British residents gamble in some way which is the most of any ethnic grouping. Conversely, just 16% of the Asian/Asian British community and 9% who identify as an Other ethnicity gamble.

Over one-third of residents in social housing engage in gambling of some sort (36%), with almost one quarter buying scratchcards (23% v 12% total).

Those who drink alcohol are significantly more likely than those who do not to also gamble (47% v 15% respectively).

Notably, 37% of residents who feel that their financial status has gotten worse over the past 12 months gamble in some way. This is significantly higher than the figure for those who feel better off, or about the same (both 25%).

Finally, around three-quarters of those who feel affected by gambling have participated themselves.

Financial

- In Leicester, 38% of residents have run out of money at least occasionally in the past year, with 14% experiencing this frequently.

- Difficulties in paying bills or buying groceries affect 32% of residents, with 23% struggling with energy costs, a rise of 13% points from 2018.

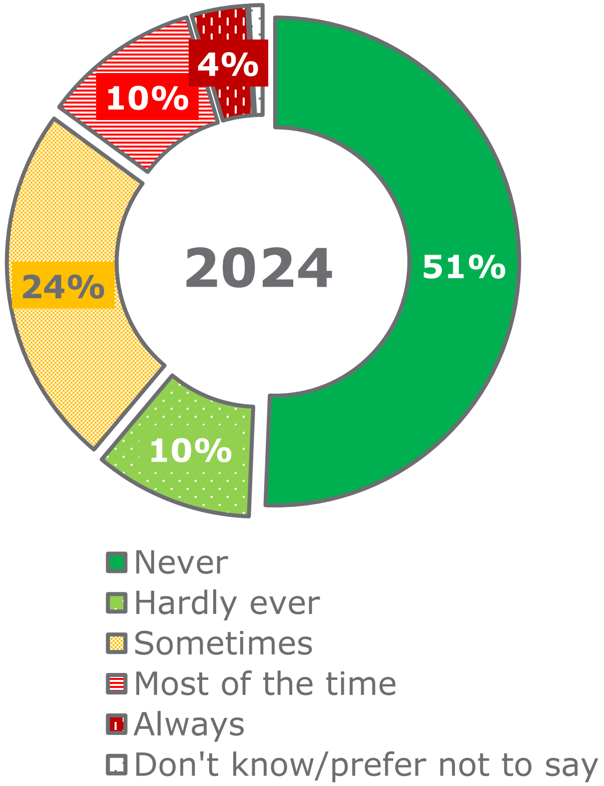
- While 53% feel financially stable compared to last year, only 11% feel better off, down 14% points.

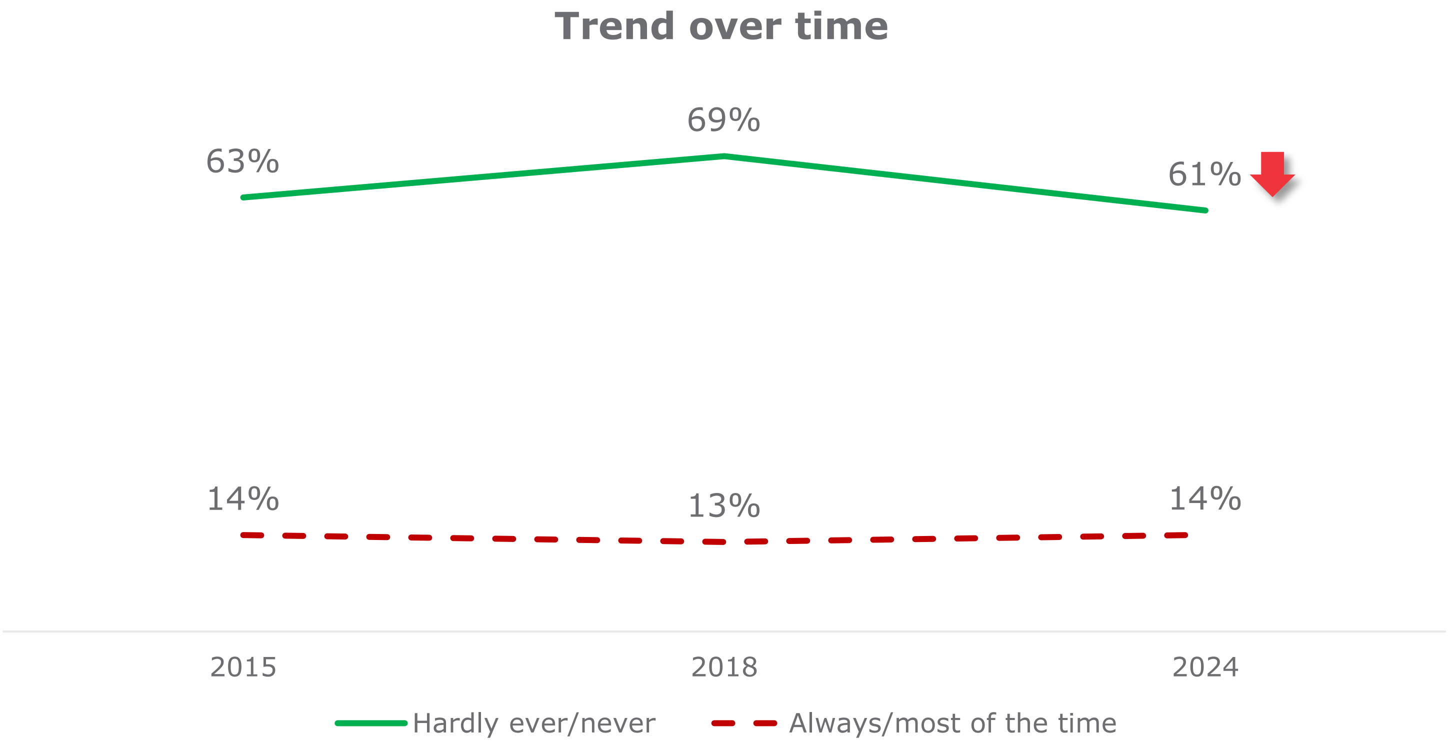
- Food insecurity impacts just under two in ten residents.

- Support service usage is lower, with Citizen's Advice accessed by 7% annually.

Run out of money

As may be expected given recent inflationary pressures, financial vulnerability has increased, with the percentage who say that they hardly ever/never run out of money falling from seven in ten (69%) to six in ten (61%) residents. This is driven by an increase in the percentage who say that they sometimes run out of money (+7% points), as the percentage who run out of money most of the time/always has remained stable (14%).



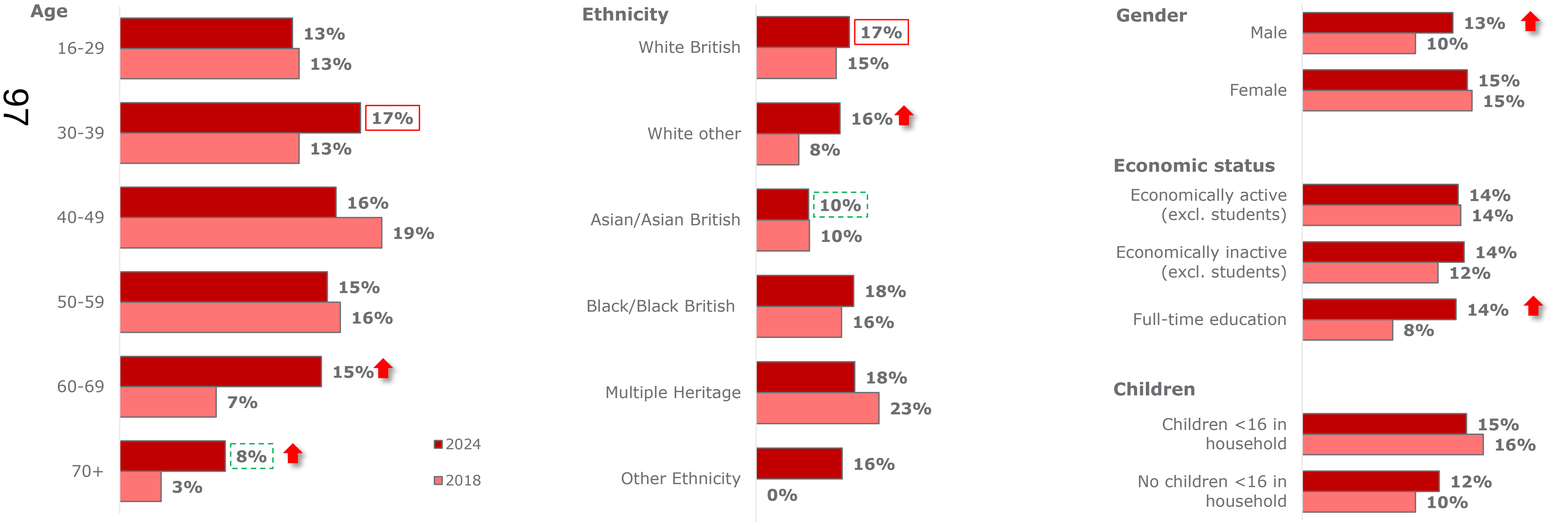


Q016. In the past 12 months, how often, if at all, have you run out of money before the end of the week or month? **Base:** All respondents (2,100). Data labels <4% removed for neatness.

⬆ ⬇ Sig higher/lower than overall

Run out of money (% most of the time/always): demographic breakdown

Those aged 30-39 are more likely than all other age groups to say that they run out of money most of the time/always. Wave-on-wave the results by age are largely stable, but the percentage of 60-69 and 70+ year-olds who report running out of money this often has doubled. This may be due to the more fixed nature of income within these age bands, as many will be retired and as such will have had a more limited ability to take on extra hours/change jobs to offset increases to the cost of living.

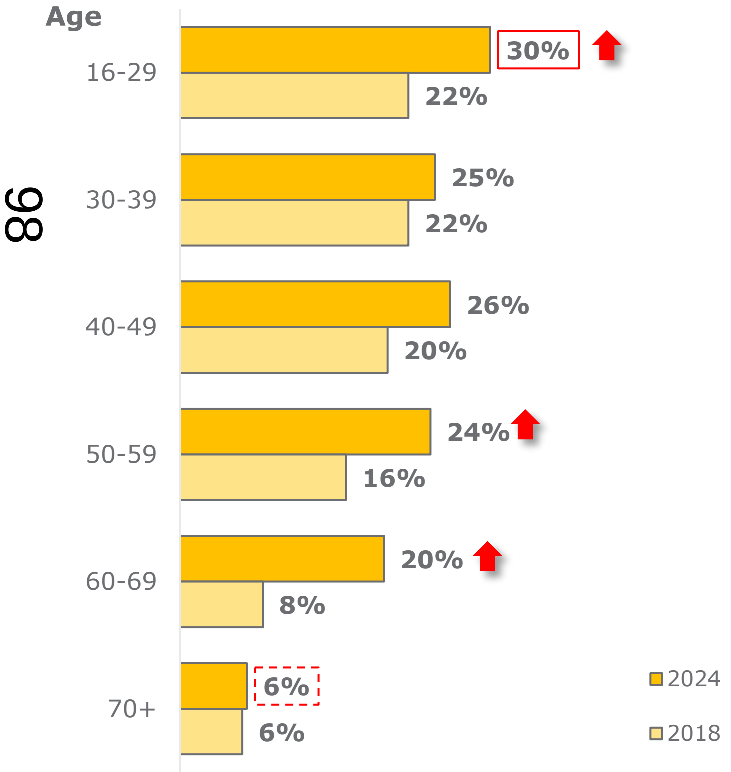


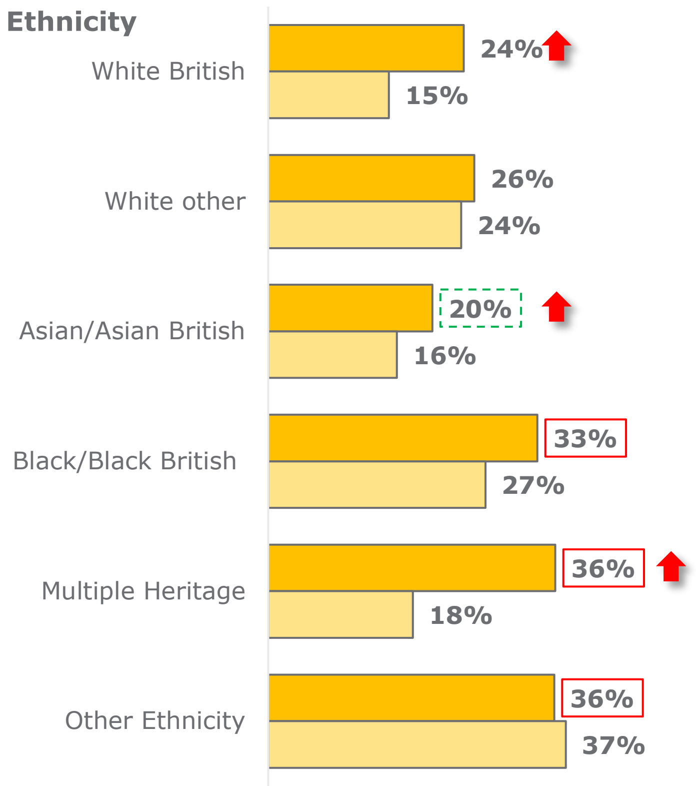
Q016. In the past 12 months, how often, if at all, have you run out of money before the end of the week or month? **Base:** All respondents (2,100).

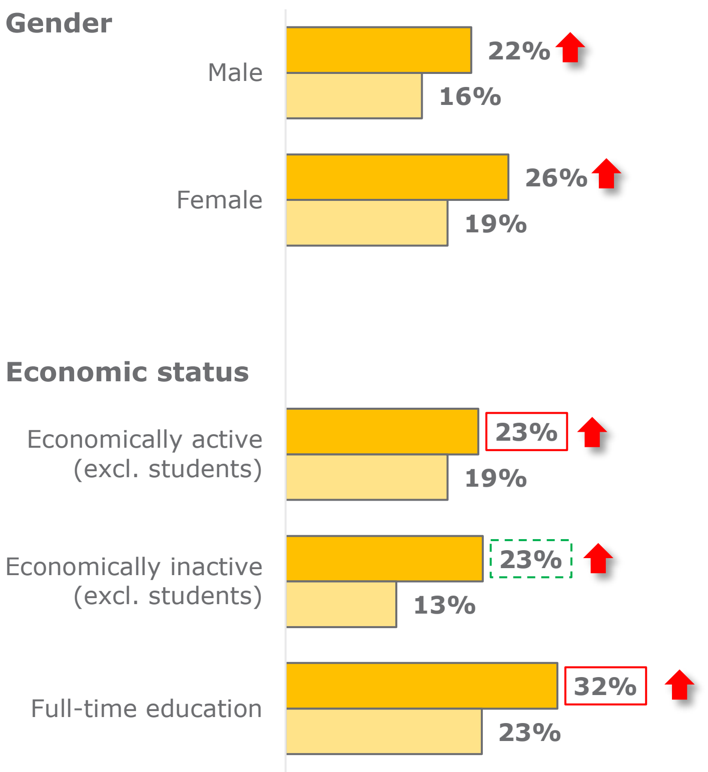
🟥 Significantly higher than all other residents
▭ Significantly lower than all other residents
⬆⬇ Sig higher/lower than previous survey

Run out of money (% sometimes): demographic breakdown

The growth in the percentage who 'sometimes' run out of money is primarily driven by the youngest age group, along with 50-59 and 60-69 year-olds. There is also a substantial increase in this figure among those who are White British. It is, however, black, multiple heritage and those who identify as an 'other' ethnicity who are significantly more likely than other ethnicities to run out of money sometimes.







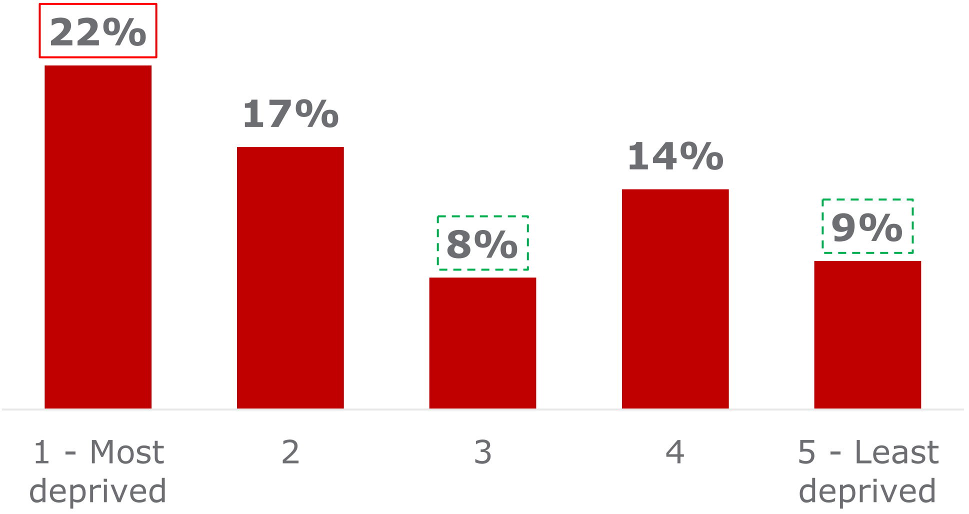
Q016. In the past 12 months, how often, if at all, have you run out of money before the end of the week or month? **Base:** All respondents (2,100).

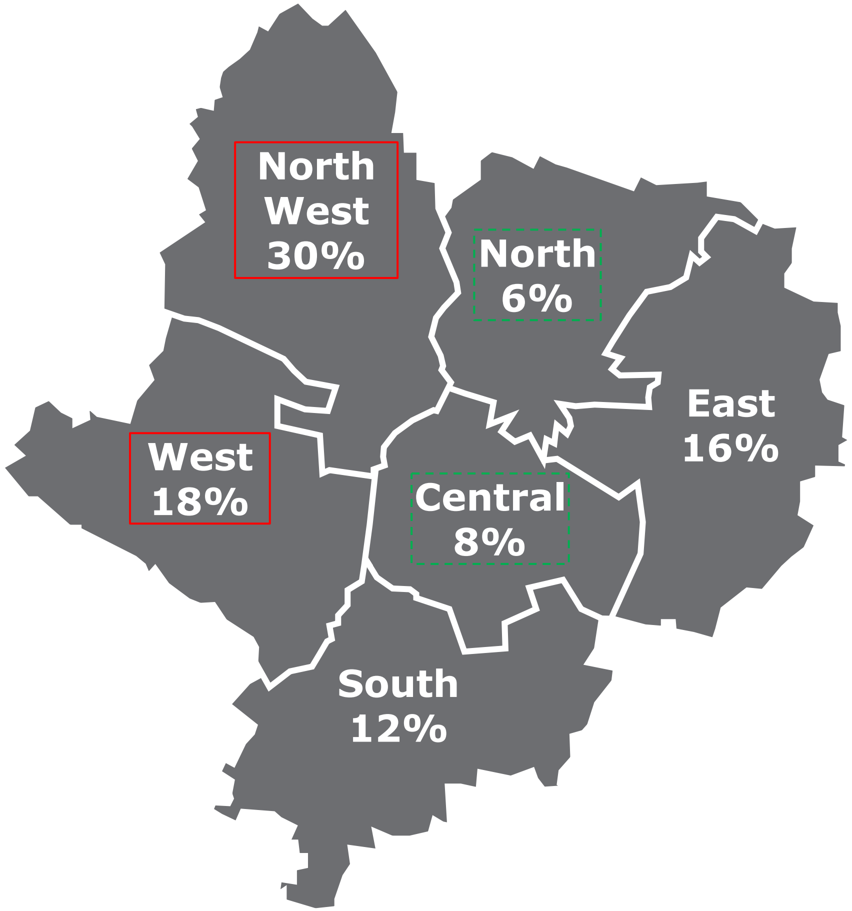
🟥 Significantly higher than all other residents
🟩 Significantly lower than all other residents
⬆ ⬇ Sig higher/lower than previous survey

Run out of money (% most of the time/always) demographic breakdown

There are clear disparities in financial vulnerability by region, with those in the North West (30%) being five times more likely to say that they run out of money compared to those in the North (6%).

Leicester IMD quintile



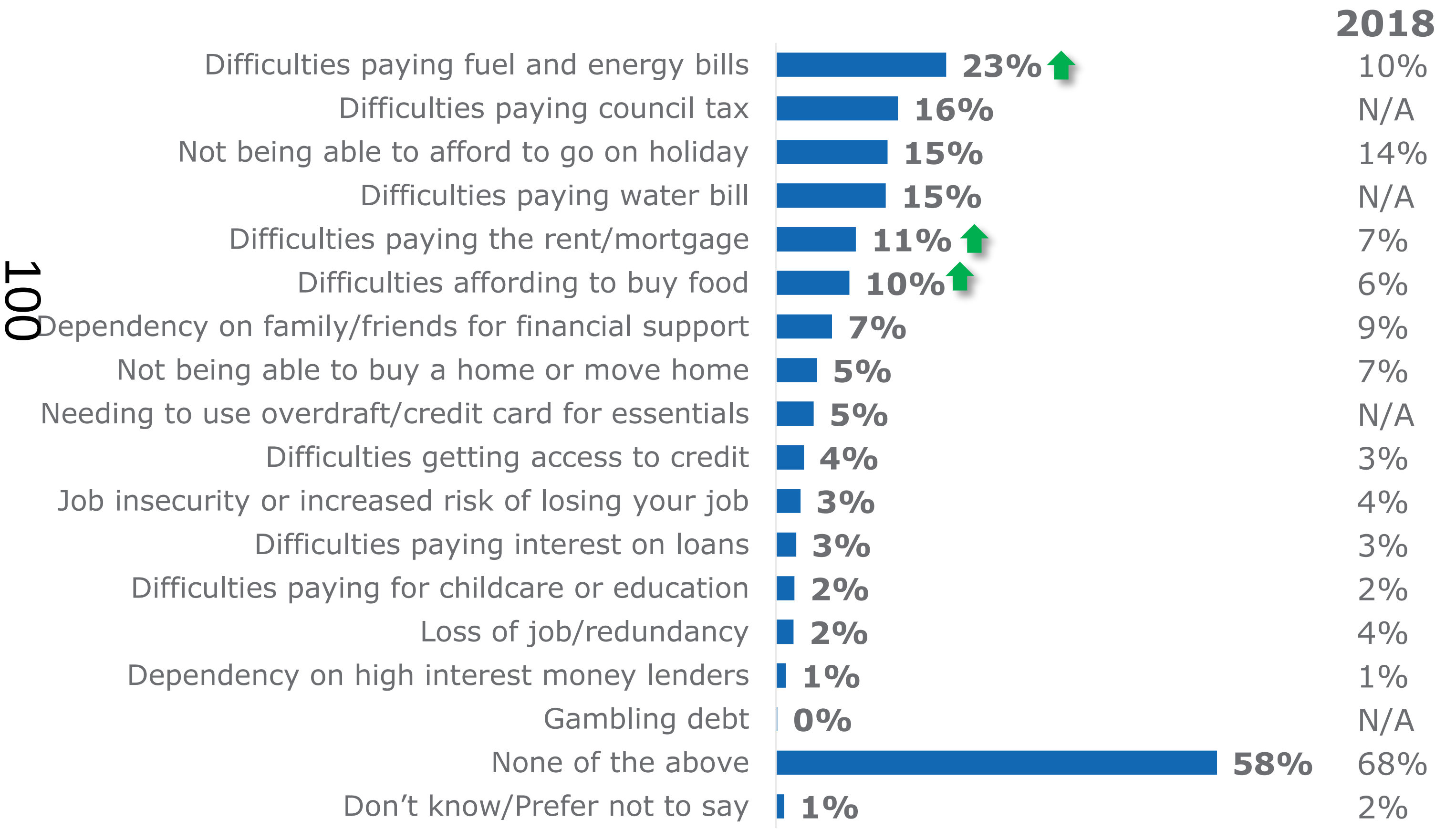


Q016. In the past 12 months, how often, if at all, have you run out of money before the end of the week or month? **Base:** All respondents (2,100).

□ Significantly higher than all other residents
□ Significantly lower than all other residents

Financial difficulties

The landscape has shifted since 2018 in terms of the struggles of Leicester residents. In 2018, the most commonly cited difficulty was not being able to afford to go on holiday, but in 2024 it is difficulties paying fuel and energy bills (23%). Indeed, this figure has more than doubled since 2018 and reflects the economic challenges experienced over the past few years.



	2024	2018
Basic living costs*	31%	14%
Employment*	5%	7%

Key differences:

Older generations are least likely to have experienced any of these issues, with 82% of those aged 70+ stating they've been affected by none of the above. In contrast, those with conditions that limit their ability to carry out day-to-day tasks, those in the North West and social renters are all significantly more likely to have experienced at least one of these difficulties.

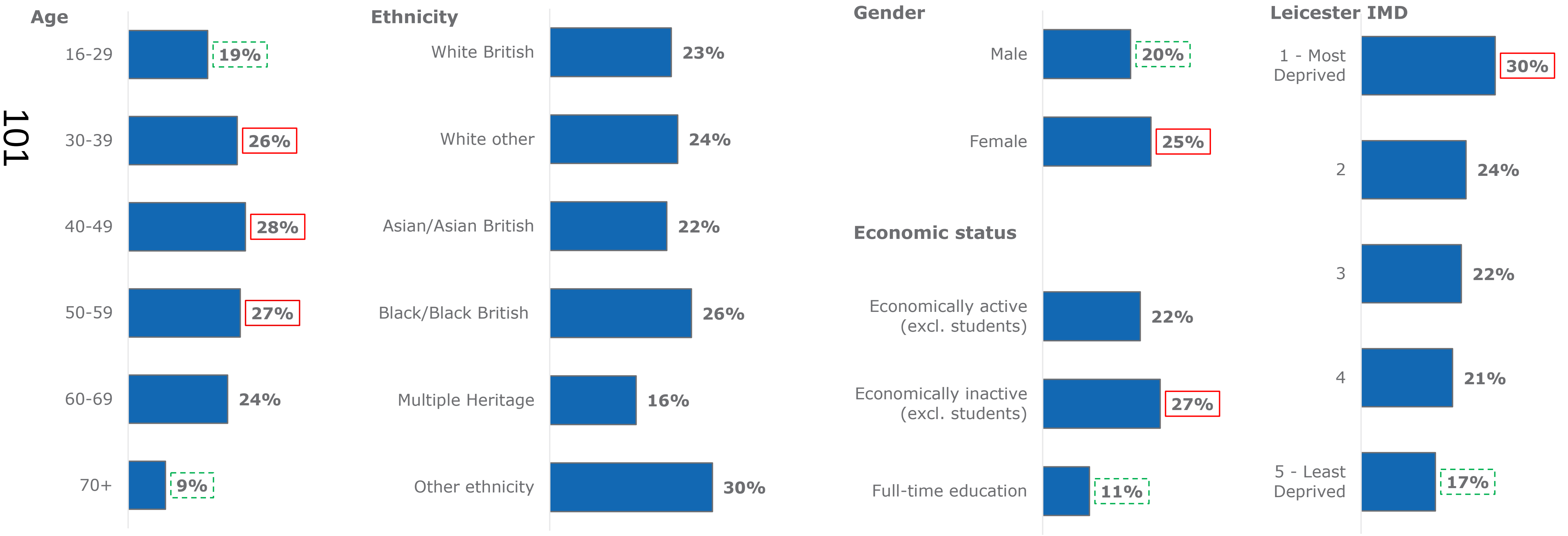
Q017. Have you been affected by any of the following in the last 12 months? **Base:** All respondents (2,100)
Note: new codes added in 2024 which means these results are not directly comparable.
*Basic living costs include codes relating to difficulties in paying: rent/mortgage, fuel/energy, council tax, water bill, food, and interest on loans. **Employment includes: job insecurity and loss of jobs/redundancy.

⬆ ⬇ Sig higher/lower than previous survey

Difficulties paying for fuel and energy bills: demographic breakdown

Residents who are economically inactive are substantially more likely to report difficulties in paying for fuel and energy bills. 30-59 year olds, the most deprived residents, and women are also more likely to report this.

23%
overall



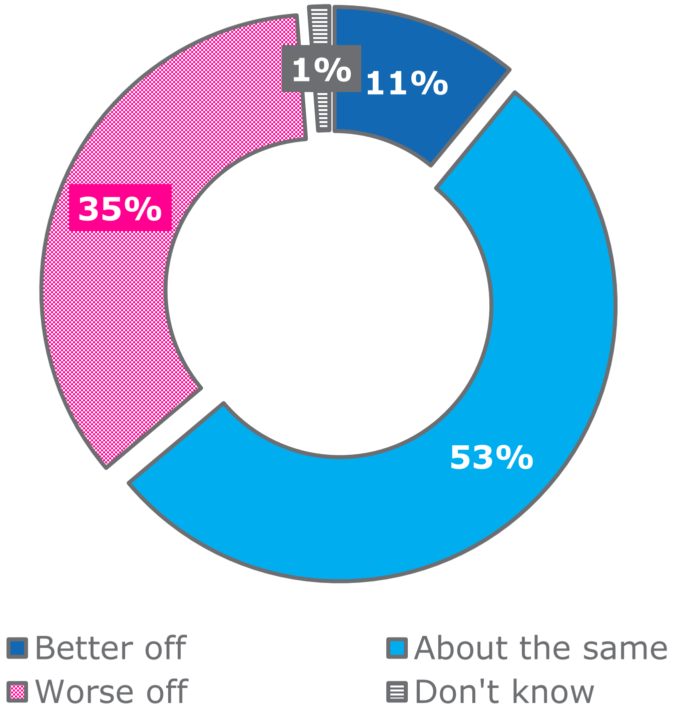
Q017. Have you been affected by any of the following in the last 12 months? **Base:** All respondents (2,100) Charts based on those stating that they have difficulties paying for fuel and energy bills (474)

🟥 Significantly higher than all other residents

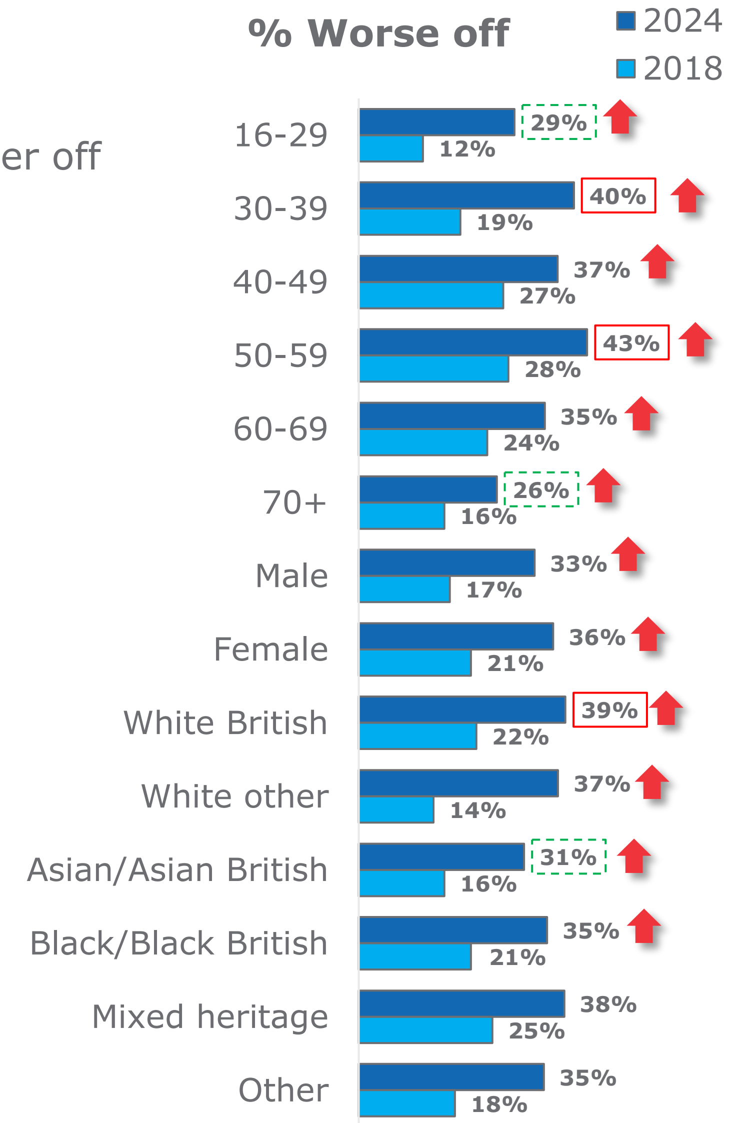
▨ Significantly lower than all other residents

Financial situation

Responses are decisively less positive compared to 2018, laying bare the challenging economic climate of the post-covid era. The percentage who report that they are better off financially compared to 2018 has more than halved compared to 2018, while the percentage who say they are worse off has near doubled.



	2024	2018
Better off	11%	25%
About the same	53%	54%
Worse off	35%	19%



Q018. Do you feel better off, worse off, or about the same financially than you did 12 months ago?
Base: All respondents (2,100).

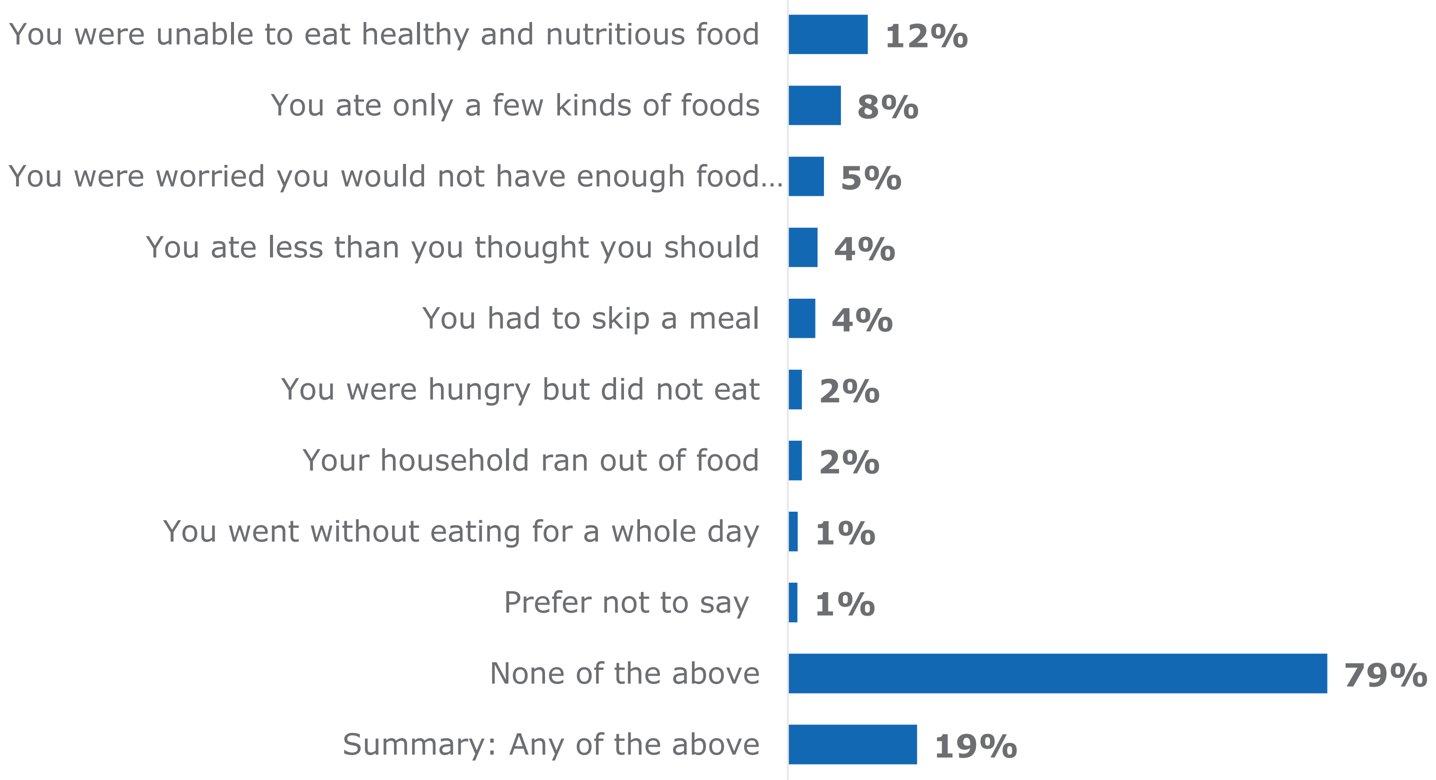
🟥 Significantly higher than all other residents

⬚ Significantly lower than all other residents

⬆ ⬇ Sig higher/lower than previous survey

Food insecurity

Due to a lack of money or other resources, one in five had to limit the types of food they ate – 12% were unable to eat healthy foods, and 8% had to limit the variety in their diet. One in twenty say that they were worried about not having enough food.



Key differences:

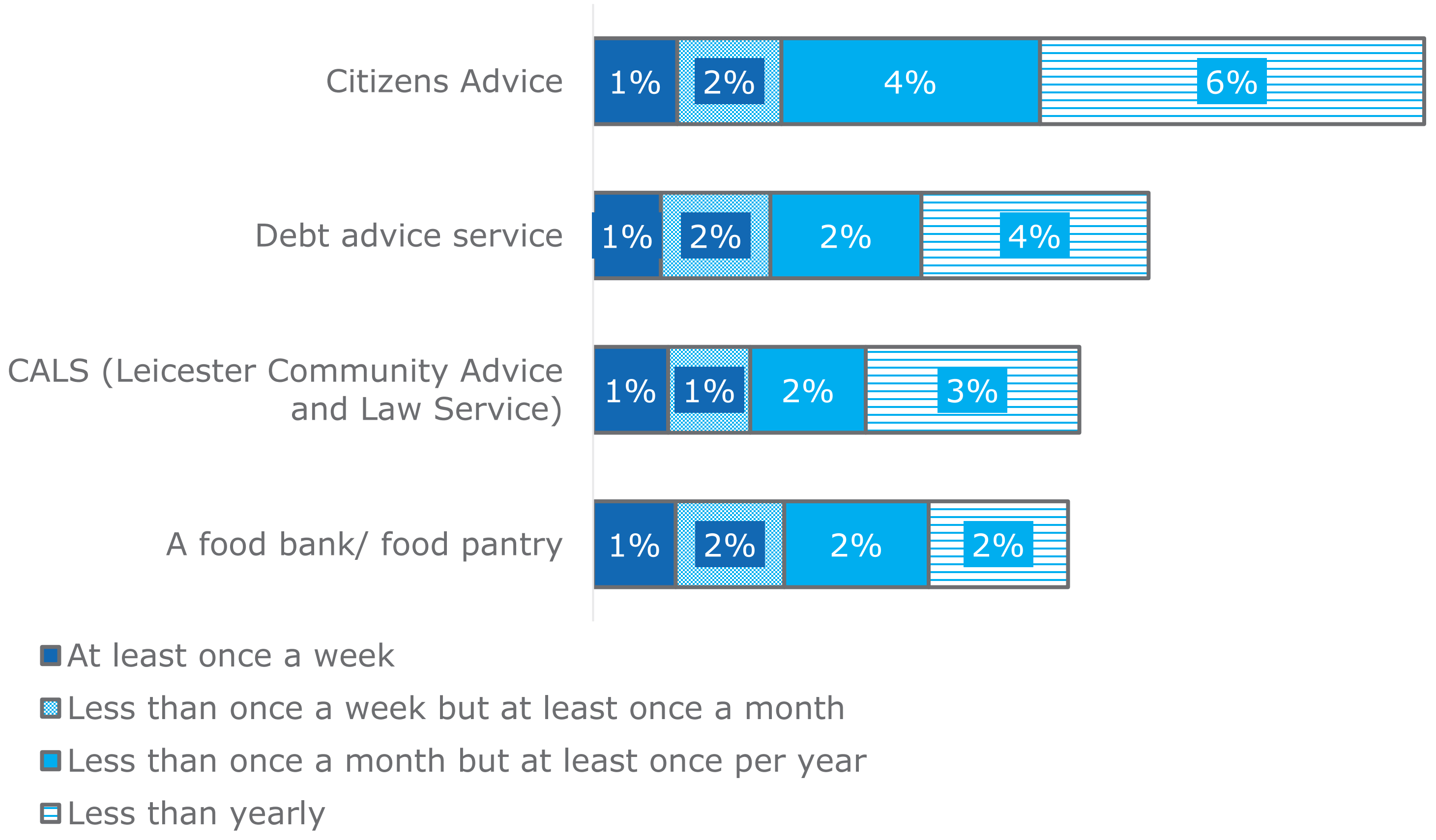
Around 20% of each age group say that they have experienced at least one of these things, apart from those aged 70+ where it drops to 8%.

Those who are white British (24%) or of multiple heritage (34%) are more likely to have experienced any of these also, along with carers (27%), those who have a health condition or disability that reduces their ability to carry our day-to-day tasks (33%) and social (29%) and private (22%) renters.

Q019. During the last 12 months, was there a time when because of lack of money or other resources…? **Base:** All respondents (2,100).

Use of support services

Use of support services in Leicester is limited. The most commonly used service is Citizens Advice, with 13% reporting using it, although around half report using it less frequently than yearly. 1% report relying on a food bank at least once a week and 2% at least once a month.



Key differences:

Residents in the North West of the city are more likely to use a food bank/pantry, with 19% having used one at some point (compared to 8% of the total sample). Likewise, 23% of North West residents have accessed debt advice services, compared to 9% of the total sample.

Those who are socially renting are significantly more likely to have accessed debt advice services (20% cf. 5% owned and 7% privately rented).

Q20. How often, if at all, have you used the following in Leicester? **Base:** All respondents (2,100).

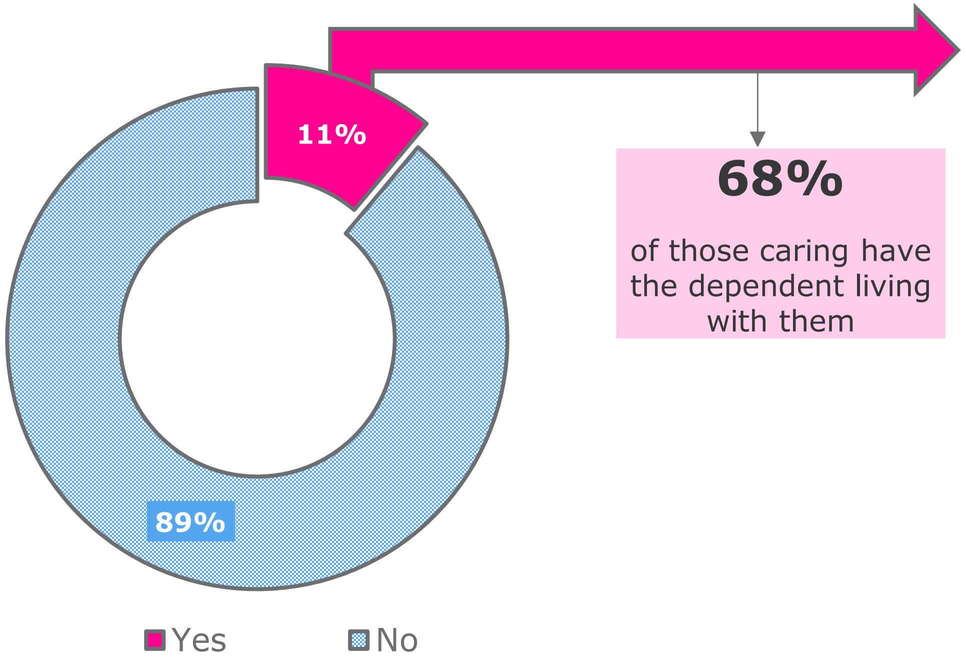
Caring and caring responsibilities

- In Leicester, 11% of residents provide care for someone with long-term health conditions. This represents a fall of 2% points since 2018 (13%).

- 68% of these carers live with the person they support.

Caring and caring responsibilities (I)

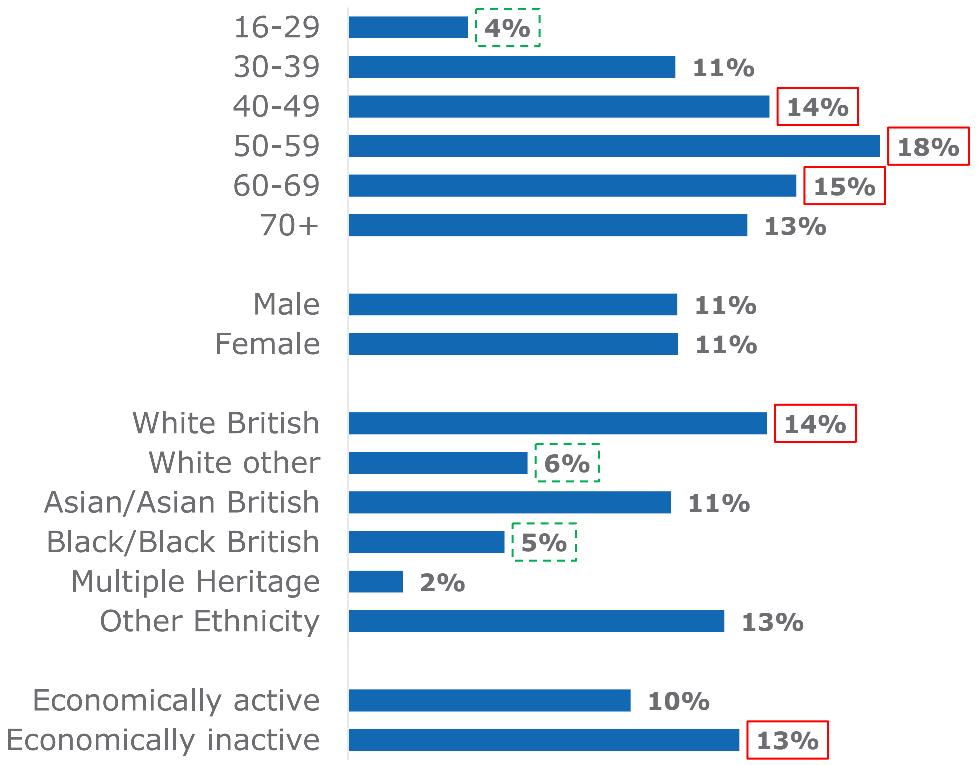
One in ten (11%) residents state that they look after or give help/support to someone because they have long-term, physical or mental health conditions or illnesses, or problems related to old age. Of those who act as carers, over two-thirds report that the person they care for lives with them (68%). Caring is particularly prevalent among 40-69 year-olds and those who are White British.



68%

of those caring have the dependent living with them

% caring responsibilities

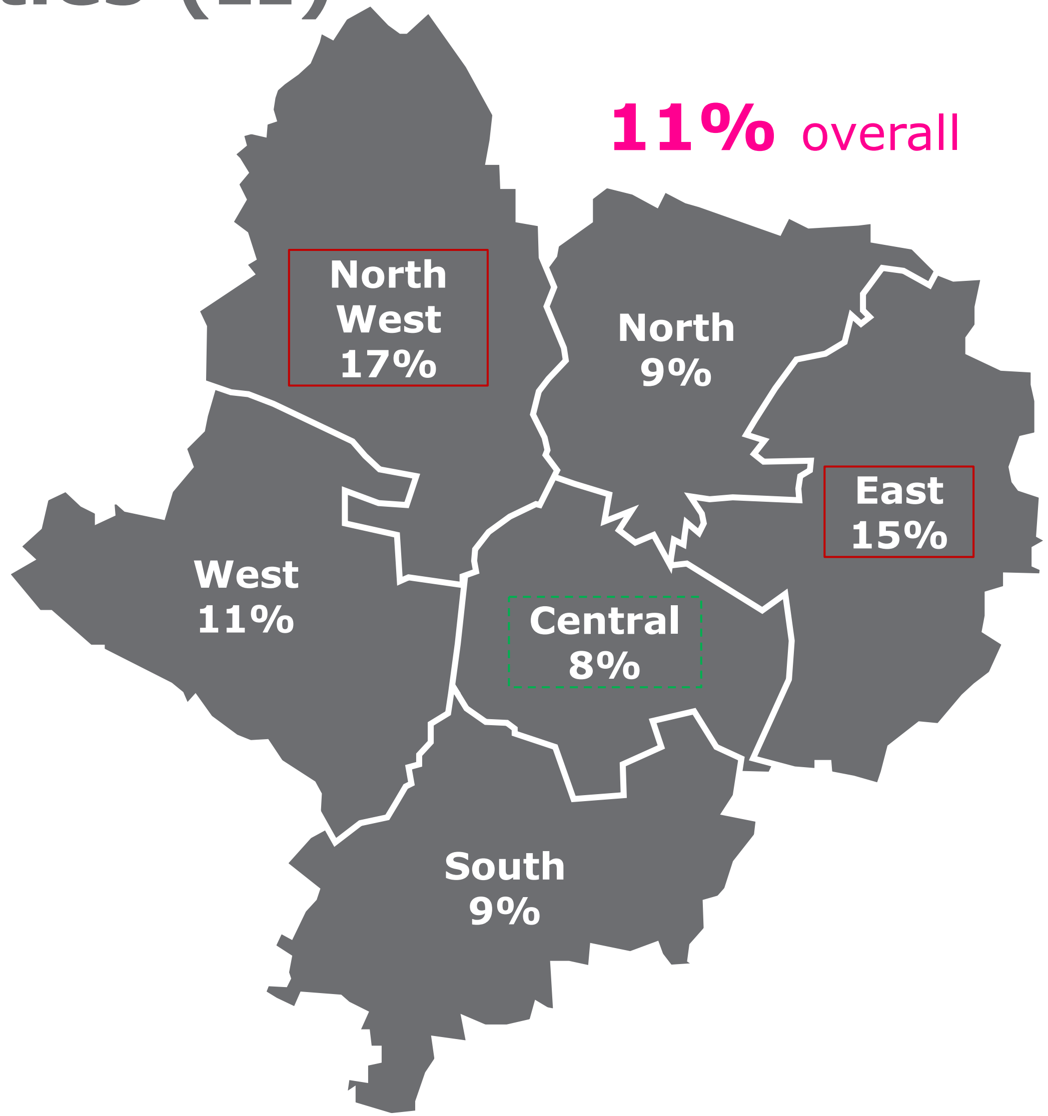


Q06. Do you look after or give any help or support to anyone because they have long-term, physical or mental health conditions or illnesses, or problems related to old age? Exclude anything you do as part of your paid employment. **Base:** All respondents (2,100).
Q07. Does this person live with you? **Base:** All respondents who give help or support (242).

🟥 Significantly higher than all other residents
⬚ Significantly lower than all other residents

Caring and caring responsibilities (II)

The percentage of residents with caring responsibilities is highest in the North West (17%) and East (15%) of Leicester, and lowest in Central Leicester (8%).



11% overall

Q06. Do you look after or give any help or support to anyone because they have long-term, physical or mental health conditions or illnesses, or problems related to old age? Exclude anything you do as part of your paid employment. **Base:** All respondents (2,100).

☐ Significantly higher than all other residents

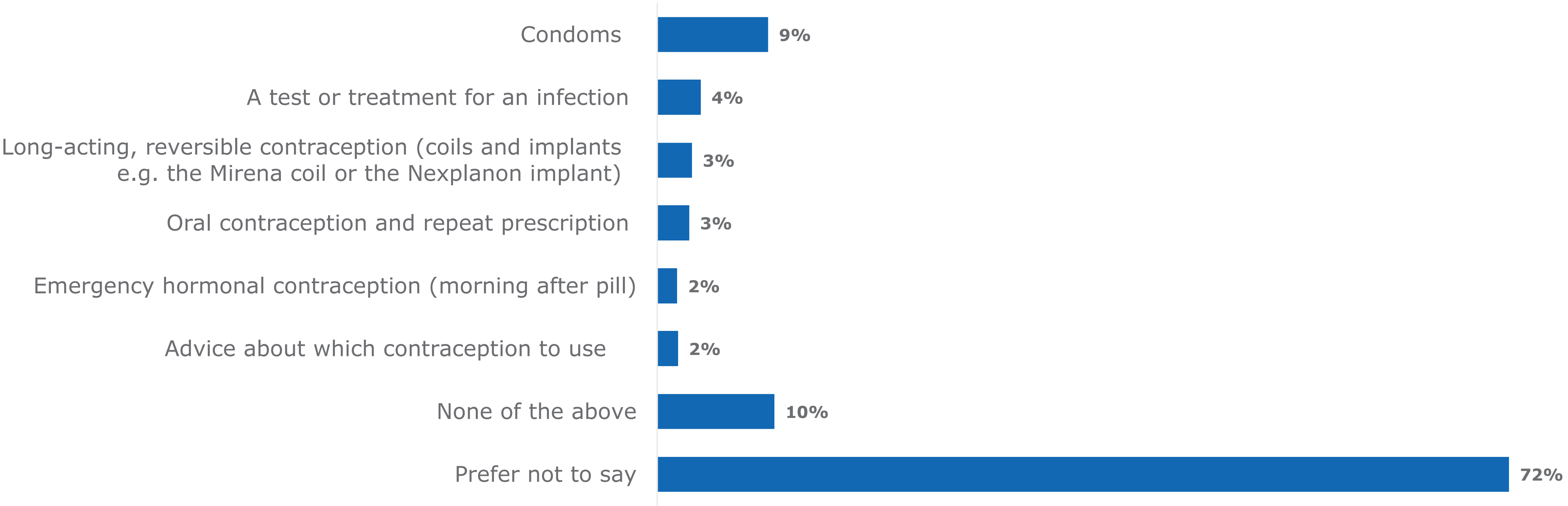
⬚ Significantly lower than all other residents

Sexual health services

- While 72% of residents chose not to disclose their use of sexual health services, 9% have accessed free condoms, and 4% have sought infection testing or treatment.
- Pharmacies are the primary source for condoms (78%), oral contraception (56%), and emergency contraception (83%), with 25% opting to access emergency contraception online.

Use of sexual health services

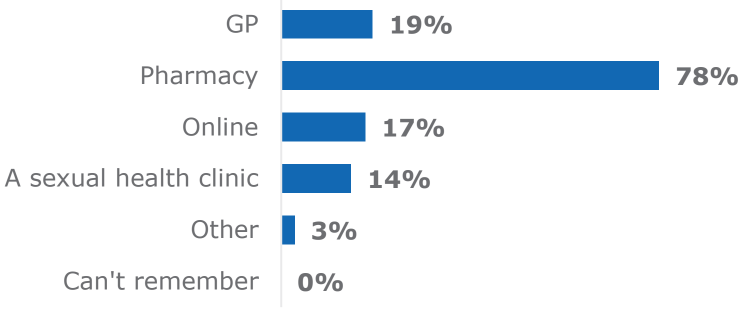
Though the majority of residents opted not to disclose information about their use of sexual health services (72%), 9% have accessed condoms free of charge, and 4% have had a test or treatment for an infection.

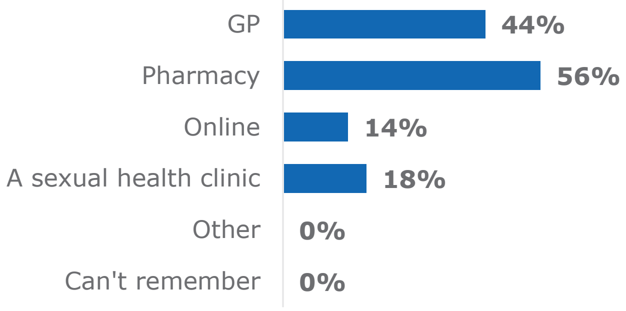


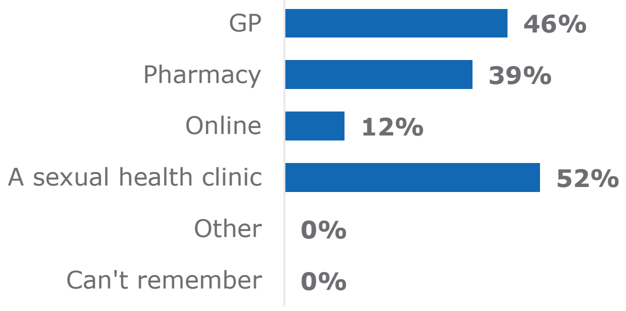
Q041. Which of the following, if any, have you accessed free of charge from these services within the last 2 years **Base:** All respondents (2,100).
Note: Self-completion was offered for this question. Around three-quarters of residents took up this option.

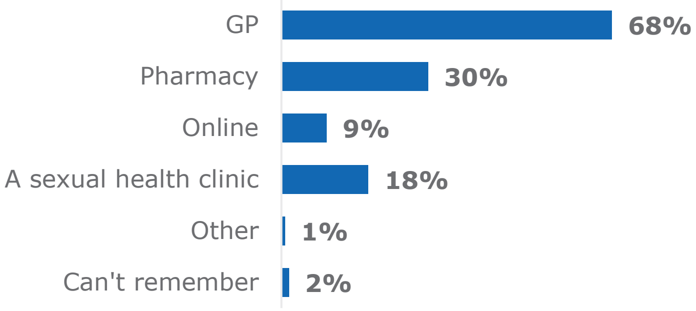
Method of access for sexual health services

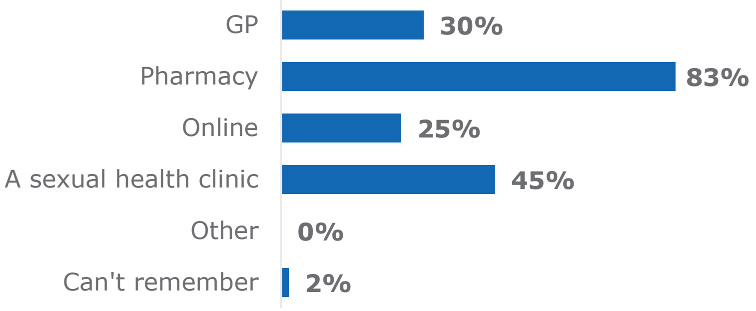
Of those who were willing to comment, we see that residents are most likely to visit a pharmacy for access to condoms (78%), oral contraception (56%), and emergency contraception (83%). Interestingly, one-quarter of recipients opted to access emergency contraception online.

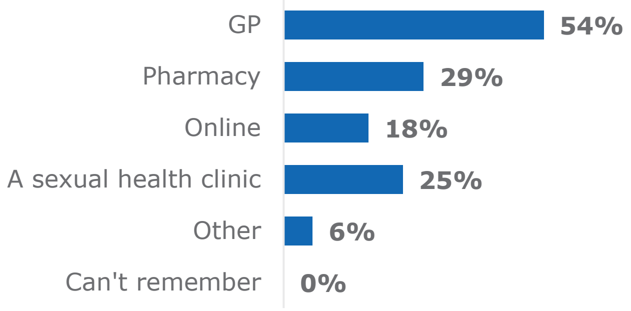

Condoms


Oral contraception


Reversible contraception


Test/treatment for infection


Emergency contraception


Advice about contraception

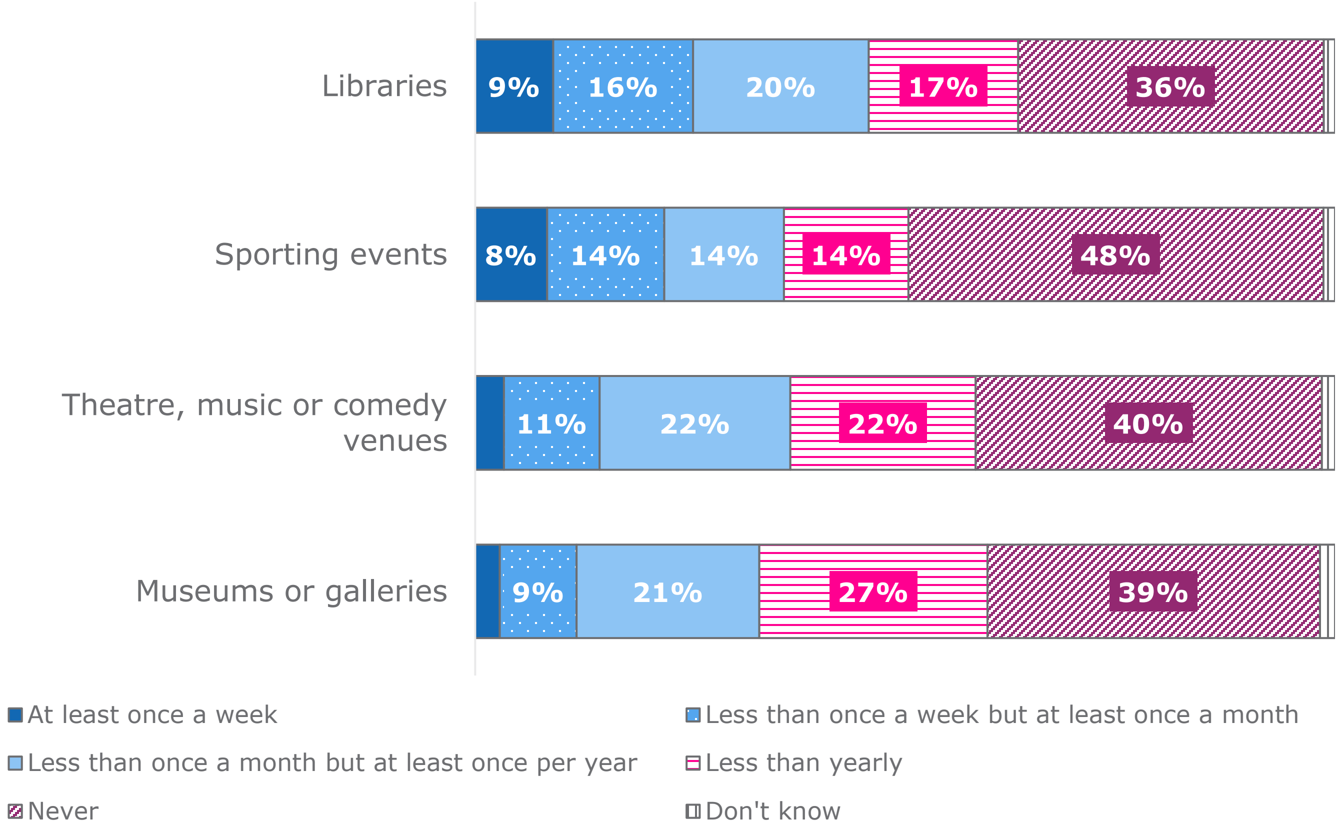
Q042. You say you have accessed [INSERT OPTION FROM Q041]. Where did you access this? **Base:** Those who accessed a given service (base varies).

Place and volunteering

- About one in ten residents visit a library once a week, this rises to one in four visits monthly.
- Just over one in three residents attended a Leicester sporting event in the last year.
- Just over one in ten residents provide unpaid help, with 11% supporting a group or organisation and 12% helping an unrelated individual—both lower than in 2018, with a notable 11% point drop in helping others.

Use of culture-related facilities in Leicester

One quarter of residents visit libraries in Leicester at least once a month (25%). This rises to 45% visiting at least once per year. Whilst 36% of residents attend sporting events in Leicester, half of the population have never attended one (48%).



Key differences:

'White other' residents are significantly more likely than any other ethnicity group to theatres, music/comedy venues (7%), as well as museums/galleries (8%) and libraries (14%). Black residents are more likely than residents of all other ethnicities to attend sporting events weekly (13%).

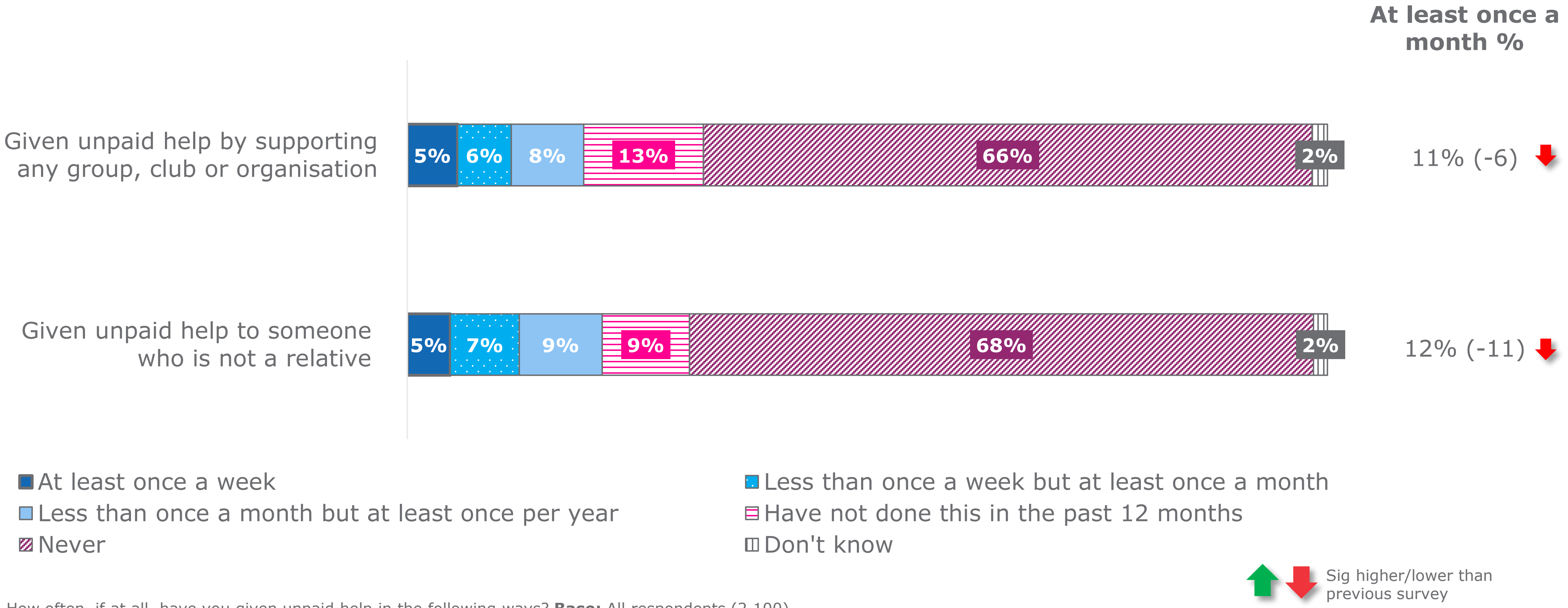
Younger residents (16-29) are significantly more likely to have used libraries at least weekly (14%). So too are residents with A-level level education (13%), and those currently in full-time education (28%).

Those aged 16-29 or 30-39 are more likely to attend sporting events at least weekly (11% for both), as well as the economically active (11%) and those who feel affected by gambling (14%).

Q012. How often, if at all, do you use the following in Leicester? **Base:** All respondents (2,100).
Note - New statements added for 2024 – comparison to 2018 data is not possible.
Data labels <5% removed for neatness.

Unpaid help (I)

Just over one in ten residents is likely to give unpaid help, either by supporting a group, club or organisation (11%) or to a person who is not related to them (12%) on at least a monthly basis. Both figures are lower than those observed in 2018. In particular, giving help to another person has fallen by 11% points.



Q015. How often, if at all, have you given unpaid help in the following ways? **Base:** All respondents (2,100).

Unpaid help (II)

Residents in the North West are 18% points more likely than average to formally give unpaid help (29% v 11% total).

Giving unpaid help to a club/organisation

More likely

- Feel affected by gambling: 41%
- Acts as carer outside of household: 27%
- North West: 26%

Less likely

- No formal education: 7%
- 70+: 7%
- Financially better off than 12 months ago: 7%
- Central: 6%

Giving unpaid help to someone who is not a relative

More likely

- Feel affected by gambling: 43%
- North West: 29%
- Financially worse off than 12 months ago: 17%

Less likely

- Central / North: 8%
- 70+: 6%
- Very bad/bad health: 2%

Q015. How often, if at all, have you given unpaid help in the following ways? **Base:** All respondents 2,100).

Housing

- 39% of residents note that they have an issue with their current housing situation. Around one in ten mention that their house is too expensive to heat or that their rent is too expensive (both 9%).

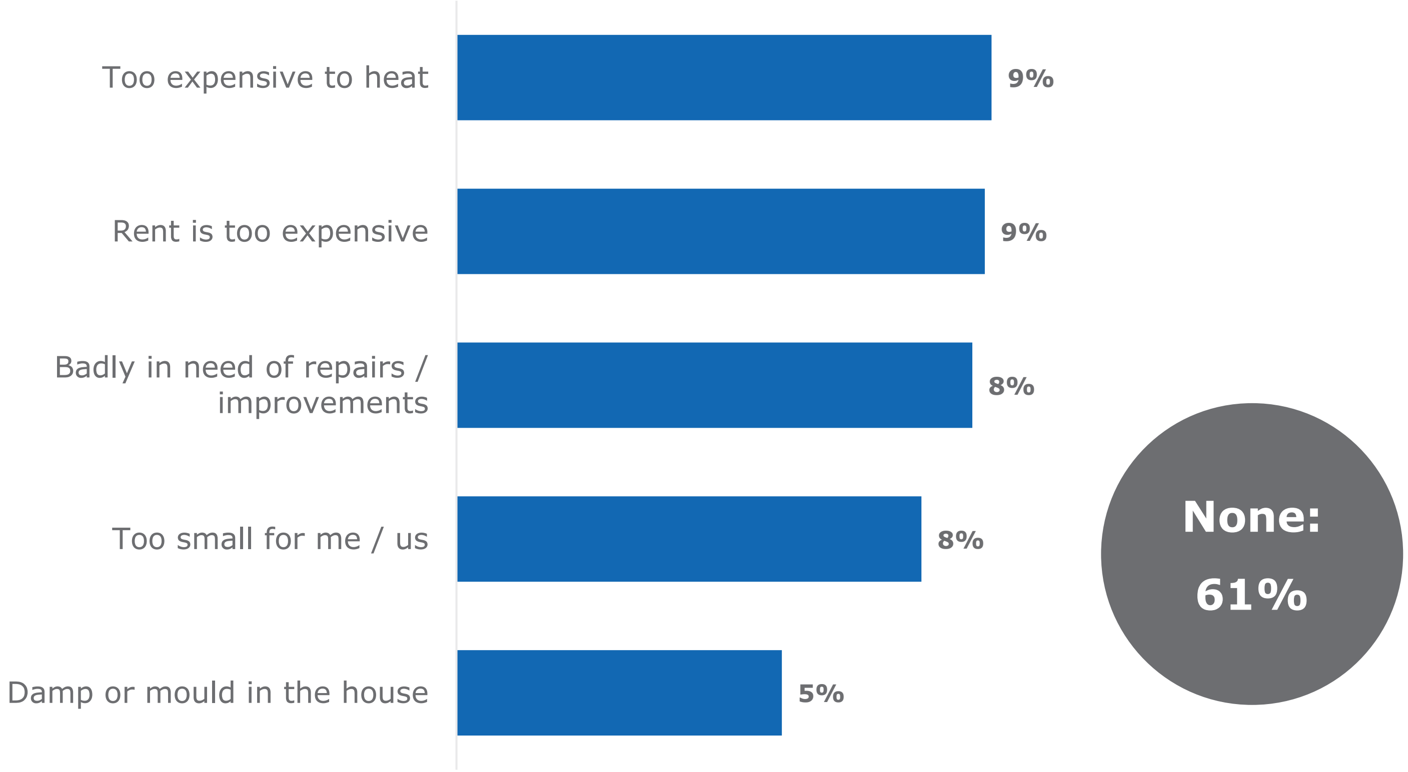
- One-quarter of households show signs of being potentially overcrowded (24%).

- One third of households mention living with children under 16 (35%), while one quarter have elderly people living in their household (26%).

Issues with the home

Almost two-fifths of residents note some sort of issue with their current housing situation (39%). The cost of heating their home currently affects one-tenth of Leicester residents (9%), with the same proportion reporting that their rent is too costly.

Most common issues



Key differences:

Residents aged 30-39 are significantly more likely than all other cohorts to mention that one of the issues outlined applies to their home (48% v 39%). This group are 7% points more likely than average to say that their rent is too expensive (16% v 9%).

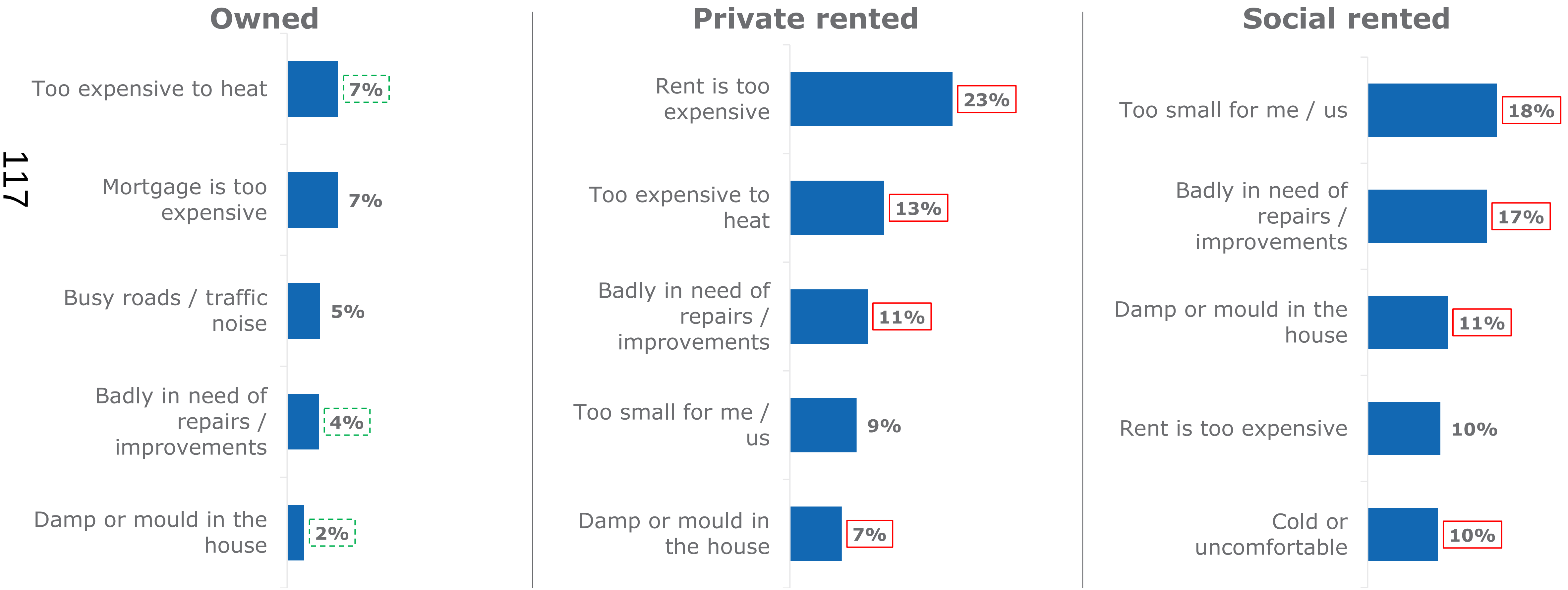
So too are those living in the West of the city (48% v 39%). One in ten feel that their house is not safe/secure enough (9%).

51% of those living in social housing have encountered one of these issues, with almost one-fifth stating that their house is too small for them (18%) and a similar proportion saying that their house is badly in need of repairs (17%).

C06. Which, if any, aspects apply to your present home? **Base:** All respondents (2,100). Only showing codes of 5% or more.

Issues with the home: tenure breakdown (top 5)

Private renters are more likely to report issues with the expense of heating or their rent, while social tenants are more likely to report problems with the size of their home or the need for repairs/improvements. Both social and private tenants are more likely to say there is a problem with damp or mould in their house.



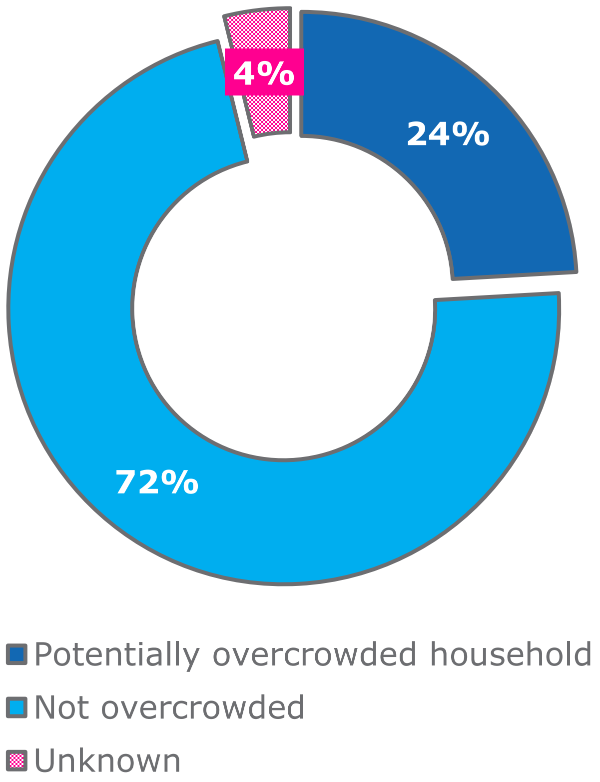
C06. Which, if any, aspects apply to your present home? **Base:** All respondents (2,100). Only showing codes of 5% or more.

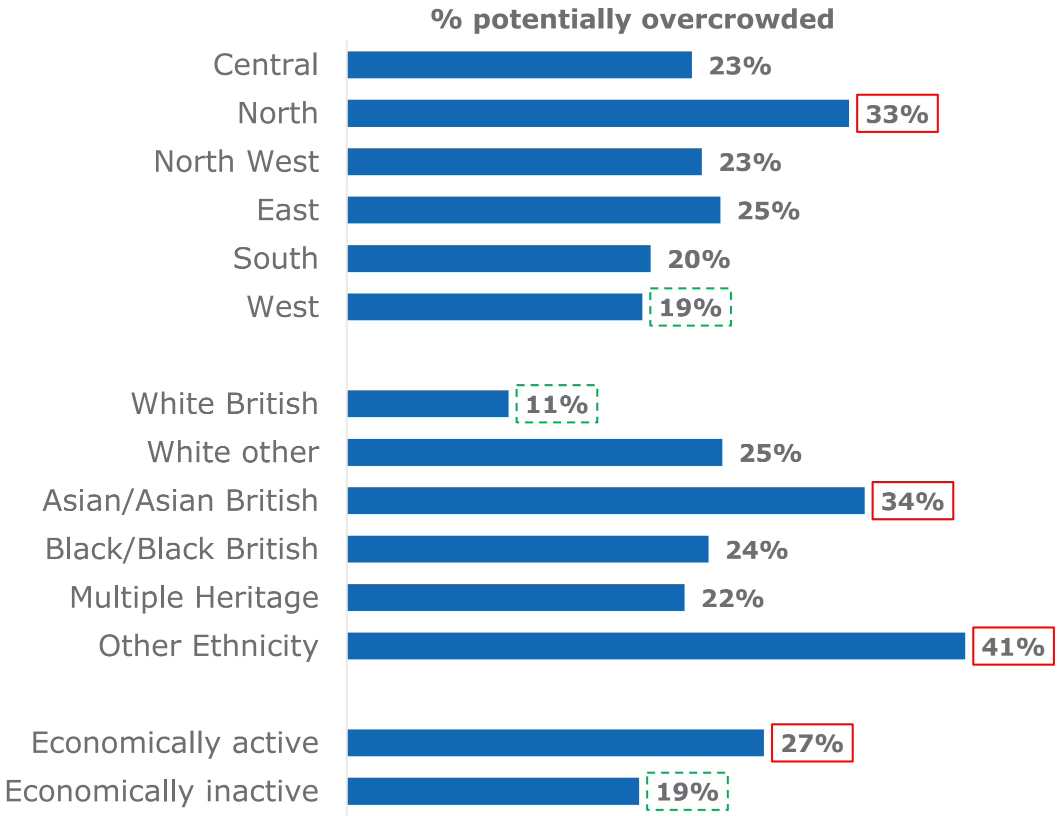
🟥 Significantly higher than all other residents

🟩 Significantly lower than all other residents

Overcrowding

One quarter of households across Leicester are potentially overcrowded (24%). This rises to one third of residents living in the North of Leicester (33%) and those of Asian/Asian British heritage (34%) and is higher still for those of an ‘other’ ethnicity (41%).



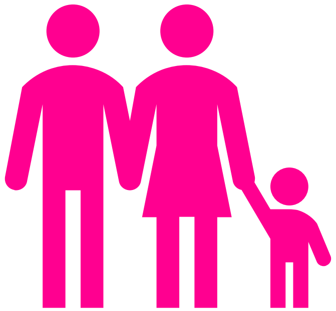


C7. How many rooms do you have for use by your household only? **C8.** In total, how many people live in your household, including yourself? **Base:** All respondents – excluding some pilot responses (2061).

▭ Significantly higher than all other residents
⬚ Significantly lower than all other residents

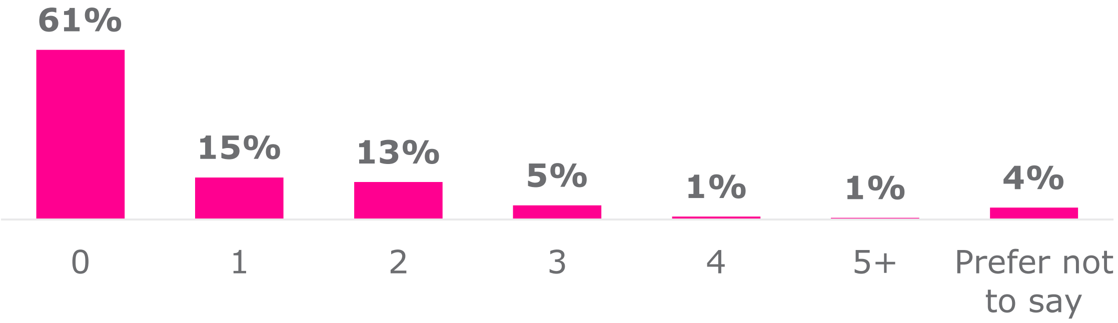
Household composition

Over one-third of residents have young children living in their household (35%). Another quarter live with people aged 65+ (26%). 4% of households contain both under 16s and those aged over 65.



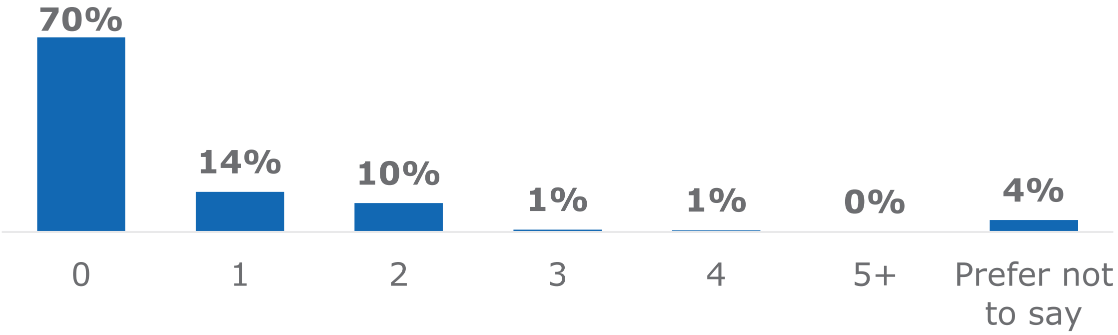
35%

have children under 16 living at home



26%

have older people (65+) in the household



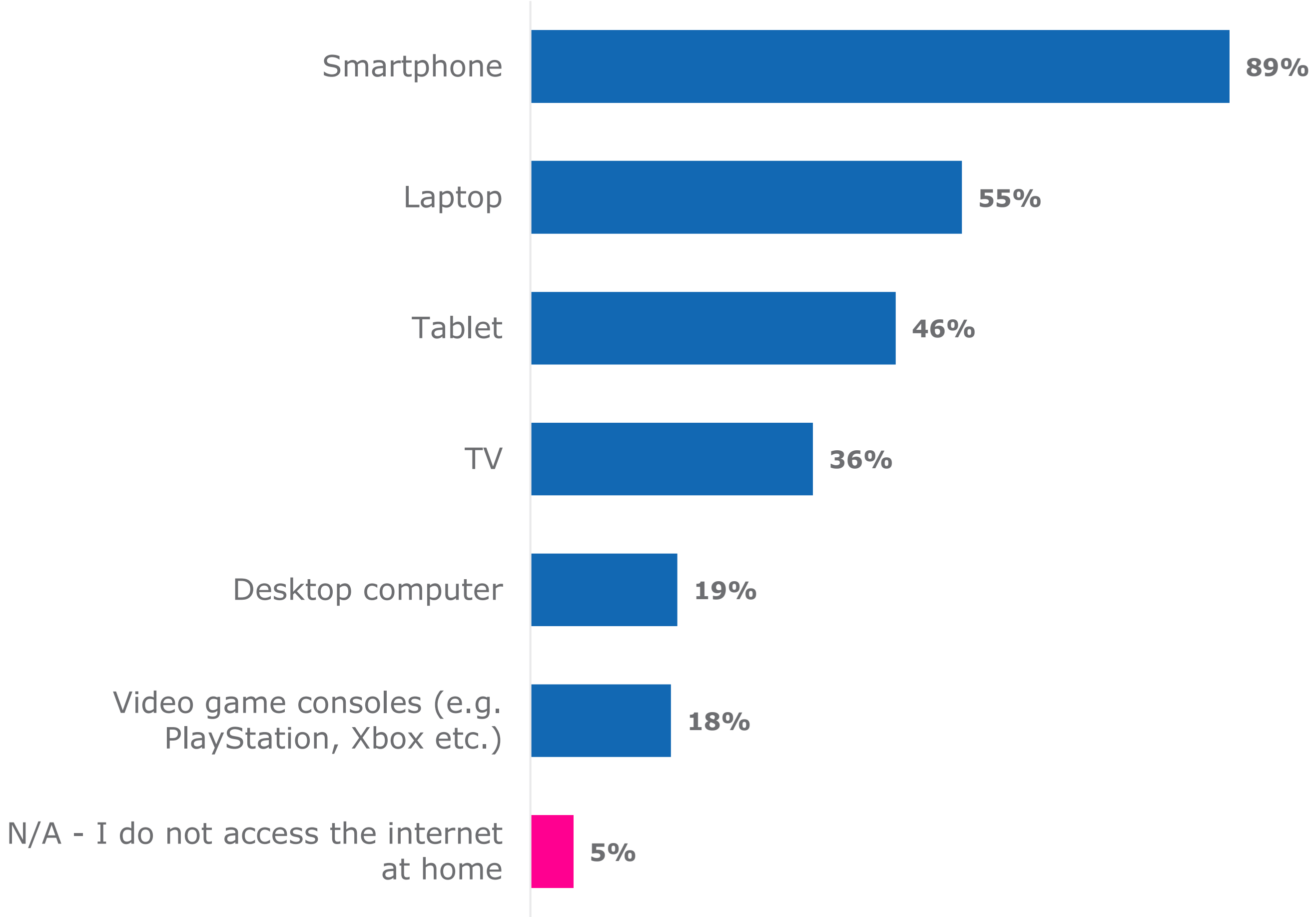
C09. How many people in the following age ranges are currently living in your house? **Base:** All respondents – excluding some pilot responses (2,062).

Digital inclusion

- 95% of residents access the internet at home, primarily via smartphones (89%).
- Most residents (82%) feel confident online, though confidence drops with age, with only 35% of those 70+ feeling confident.
- Confidence in assessing online information's truthfulness is slightly lower (76%), and those with lower education levels report the lowest levels of confidence.

Use of digital devices to access the internet

Nearly all residents (95%) access the internet at home in some way. Most commonly this is through a smartphone (89%).



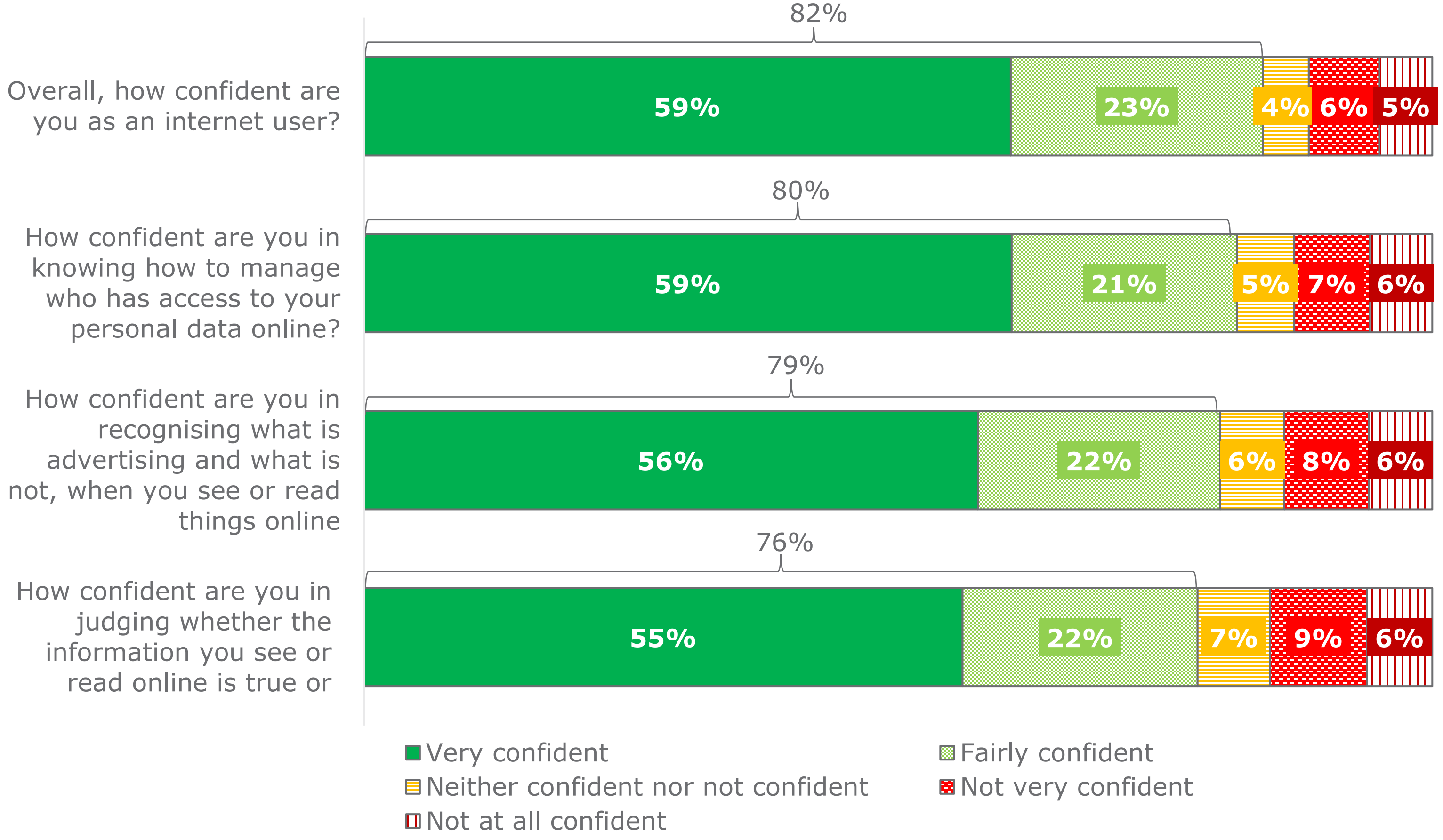
Key differences:

The percentage who don’t access the internet at home does not exceed 3% for the age groups ranging from 16-29 through to 50-59. This increases sharply to 12% of 60-69-year-olds and then near trebles to 33% of those aged 70+.

Q043. Do you access the internet at home on any of the following devices? **Base:** All respondents (2,100).

Confidence using the internet

82% feel fairly/very confident as an internet user compared to 11% who feel not very/not at all confident. There is marginally less confidence when it comes to judging the truthfulness of online information, although confidence is still high (76%). 15% indicate they do not feel confident doing this.



Key differences:

As could be expected, older generations are less likely to feel confident as an internet user – 62% of those aged 60-69 are either fairly or very confident compared to 82% of the total sample. This drops further to just one-third of residents aged 70+ (35%).

Those with lower levels of education are less confident across all areas (with the percentage who are not confident ranging from 41%to 53%). These scores are significantly higher than all other education subgroups.

Q044. Overall, how confident are you…? **Base:** All respondents (2,100).

Groups of interest

123

Risk factor Leicester profile

Risk Factor	%	Change since 2018
Currently smoking	16%	Sig. lower
Less than 150 minutes exercise per week	68%	N/A
Alcohol dependence: increased risk or higher	14%	N/A
High anxiety level	19%	N/A
Always/mostly run out of money by end of month	14%	Consistent
Low digital confidence as internet users	11%	N/A
Affected by gambling	8%	N/A
Social isolation (often/all of the time)	6%	Sig. lower

Note: N/A text in the change to 2018 column indicates that a comparison is not available due to this not being asked in the 2018 survey or concerns about comparability.

Groups of interest: children in the household

Risk Factor	%	Compared to all other subgroups*	Change since 2018
Currently smoking	16%	Consistent	Consistent
Less than 150 minutes exercise per week	67%	Higher risk	N/A
Alcohol dependence: increased risk or higher	10%	Reduced risk	N/A
High anxiety level	15%	Reduced risk	N/A
Always/mostly run out of money by end of month	15%	Consistent	Consistent
Low digital confidence as internet users	6%	Reduced risk	N/A
Affected by gambling	5%	Reduced risk	N/A
Social isolation (often/all of the time)	5%	Consistent	Sig. lower

Those with children in the household…

Are significantly more likely to do less than 150 minutes per week of exercise. More positively, they are less likely to report high levels of anxiety, low digital confidence or being affected by gambling.

Changes since 2018:

The percentage reporting feeling socially isolated has fallen.

*The comparator for the following tables is those who **do not** fall within the group of interest. For example, the comparator group for this table is those who do not belong to the children in household group.

Note: N/A text in the change to 2018 column indicates that a comparison is not available due to this not being asked in the 2018 survey or concerns about comparability.

Groups of interest: disability*

Risk Factor	%	Compared to all other subgroups	Change since 2018
Currently smoking	25%	Higher risk	Consistent
Less than 150 minutes exercise per week	87%	Higher risk	N/A
Alcohol dependence: increased risk or higher	12%	Consistent	N/A
High anxiety level	31%	Higher risk	N/A
Always/mostly run out of money by end of month	23%	Higher risk	Consistent
Low digital confidence as internet users	32%	Higher risk	N/A
Affected by gambling	8%	Consistent	N/A
Social isolation (often/all of the time)	13%	Higher risk	Sig. lower

Those with a disability…

Are significantly more likely to be at risk of nearly all these factors. The only factors where this group do not deviate significantly is audit C risk and being affected by gambling.

Changes since 2018:

This group follows the overall trend and is less likely to report that they feel socially isolated.

*Those who have a disability/condition lasting or which is expected to last 12 months or more which limits their ability to carry out day-to-day activities.
Note: N/A text in the change to 2018 column indicates that a comparison is not available due to this not being asked in the 2018 survey or concerns about comparability.

Groups of interest: carers

Risk Factor	%	Compared to all other subgroups	Change since 2018
Currently smoking	22%	Higher risk	Consistent
Less than 150 minutes exercise per week	69%	Consistent	N/A
Alcohol dependence: increased risk or higher	16%	Consistent	N/A
High anxiety level	25%	Higher risk	N/A
Always/mostly run out of money by end of month	22%	Higher risk	Consistent
Low digital confidence as internet users	14%	Consistent	N/A
Affected by gambling	10%	Consistent	N/A
Social isolation (often/all of the time)	7%	Consistent	Consistent

Carers…

Are significantly more likely to report smoking, having a high anxiety level and being in a financially precarious situation.

Changes since 2018:

Results are consistent with 2018.

Note: N/A text in the change to 2018 column indicates that a comparison is not available due to this not being asked in the 2018 survey or concerns about comparability.

Groups of interest: 16-29 years of age*

Risk Factor	%	Compared to all other subgroups	Change since 2018
Currently smoking	13%	Reduced risk	Sig. lower
Less than 150 minutes exercise per week	60%	Reduced risk	N/A
Alcohol dependence: increased risk or higher	14%	Consistent	N/A
High anxiety level	20%	Consistent	N/A
Always/mostly run out of money by end of month	13%	Consistent	Consistent
Low digital confidence as internet users	2%	Reduced risk	N/A
Affected by gambling	9%	Consistent	N/A
Social isolation (often/all of the time)	5%	Consistent	Consistent

16-29-year-olds…

Are significantly less likely to report that they smoke, do less than 150 minutes exercise per week or have low confidence as an internet user.

Changes since 2018:

There has been a significant decline in the percentage of this age group who smoke compared to 2018.

*39% of 16-29-year-olds are in full-time education.
Note: N/A text in the change to 2018 column indicates that a comparison is not available due to this not being asked in the 2018 survey or concerns about comparability.

Groups of interest: 70+ years of age

Risk Factor	%	Compared to all other subgroups	Change since 2018
Currently smoking	9%	Reduced risk	Consistent
Less than 150 minutes exercise per week	81%	Higher risk	N/A
Alcohol dependence: increased risk or higher	5%	Reduced risk	N/A
High anxiety level	13%	Reduced risk	N/A
Always/mostly run out of money by end of month	8%	Reduced risk	Sig. higher
Low digital confidence as internet users	47%	Higher risk	N/A
Affected by gambling	5%	Consistent	N/A
Social isolation (often/all of the time)	3%	Consistent	Consistent

70+-year-olds…

Are significantly less likely to smoke, have a level of alcohol use that puts them at risk, have a high anxiety level or be consistently in a financially vulnerable position at the end of each month. They are, however, more likely to do less than 150 minutes of exercise per week and have low confidence as internet users.

Changes since 2018:

While this group has fared better relative to others, they have nonetheless experienced a significant uptick in the percentage who always/mostly run out of money by the end of the month.

Note: N/A text in the change to 2018 column indicates that a comparison is not available due to this not being asked in the 2018 survey or concerns about comparability.

Groups of interest: economically inactive (excluding students)

Risk Factor	%	Compared to all other subgroups	Change since 2018
Currently smoking	17%	Consistent	Consistent
Less than 150 minutes exercise per week	80%	Higher risk	N/A
Alcohol dependence: increased risk or higher	8%	Reduced risk	N/A
High anxiety level	21%	Consistent	N/A
Always/mostly run out of money by end of month	14%	Consistent	Consistent
Low digital confidence as internet users	28%	Higher risk	N/A
Affected by gambling	7%	Consistent	N/A
Social isolation (often/all of the time)	8%	Higher risk	Sig. lower

Those who are economically inactive…

Are significantly more likely to do less than 150 minutes of exercise per week, have low digital confidence and report feeling socially isolated often/all of the time.

Changes since 2018:

This group are less likely to report feeling socially isolated frequently.

Note: N/A text in the change to 2018 column indicates that a comparison is not available due to this not being asked in the 2018 survey or concerns about comparability.

Groups of interest: social tenants

Risk Factor	%	Compared to all other subgroups	Change since 2018
Currently smoking	30%	Higher risk	Consistent
Less than 150 minutes exercise per week	76%	Higher risk	N/A
Alcohol dependence: increased risk or higher	18%	Higher risk	N/A
High anxiety level	24%	Higher risk	N/A
Always/mostly run out of money by end of month	22%	Higher risk	Consistent
Low digital confidence as internet users	17%	Higher risk	N/A
Affected by gambling	13%	Higher risk	N/A
Social isolation (often/all of the time)	10%	Higher risk	Consistent

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Social tenants…

Show a higher risk level for all of these factors.

Changes since 2018:

Results are consistent with 2018.

Note: N/A text in the change to 2018 column indicates that a comparison is not available due to this not being asked in the 2018 survey or concerns about comparability.

Groups of interest: private renters (excluding students)

Risk Factor	%	Compared to all other subgroups	Change since 2018
Currently smoking	17%	Consistent	Sig. lower
Less than 150 minutes exercise per week	66%	Consistent	N/A
Alcohol dependence: increased risk or higher	11%	Consistent	N/A
High anxiety level	19%	Consistent	N/A
Always/mostly run out of money by end of month	5%	Consistent	Consistent
Low digital confidence as internet users	6%	Reduced risk	N/A
Affected by gambling	6%	Reduced risk	N/A
Social isolation (often/all of the time)	5%	Consistent	Sig. lower

Those who are private renters (excluding students)…

Are significantly less likely to have low digital confidence or be affected by gambling.

Changes since 2018:

This group are less likely to smoke or to feel socially isolated compared to 2018.

Note: N/A text in the change to 2018 column indicates that a comparison is not available due to this not being asked in the 2018 survey or concerns about comparability.

Groups of interest: ethnicity (white British)

Risk Factor	%	Compared to all other subgroups	Change since 2018
Currently smoking	24%	Higher risk	Consistent
Less than 150 minutes exercise per week	68%	Consistent	N/A
Alcohol dependence: increased risk or higher	25%	Higher risk	N/A
High anxiety level	24%	Higher risk	N/A
Always/mostly run out of money by end of month	17%	Higher risk	Consistent
Low digital confidence as internet users	16%	Higher risk	N/A
Affected by gambling	11%	Higher risk	N/A
Social isolation (often/all of the time)	8%	Higher risk	Consistent

White British residents…

Show a higher risk level for all of these factors, apart from exercise level.

Changes since 2018:

Results are consistent with 2018.

Note: N/A text in the change to 2018 column indicates that a comparison is not available due to this not being asked in the 2018 survey or concerns about comparability.

Groups of interest: ethnicity (white other)

Risk Factor	%	Compared to all other subgroups	Change since 2018
Currently smoking	34%	Higher risk	Consistent
Less than 150 minutes exercise per week	66%	Consistent	N/A
Alcohol dependence: increased risk or higher	26%	Higher risk	N/A
High anxiety level	21%	Consistent	N/A
Always/mostly run out of money by end of month	16%	Consistent	Sig. higher
Low digital confidence as internet users	5%	Reduced risk	N/A
Affected by gambling	12%	Higher risk	N/A
Social isolation (often/all of the time)	6%	Consistent	Consistent

White other residents…

Display higher levels of smoking, drinking and being affected by gambling compared to other groups. They are, however, less likely to suffer from low digital confidence.

Changes since 2018:

This group are more likely to find themselves in a financially precarious position at the end of the month compared to 2018.

Note: N/A text in the change to 2018 column indicates that a comparison is not available due to this not being asked in the 2018 survey or concerns about comparability.

Groups of interest: ethnicity (black/black British)

Risk Factor	%	Compared to all other subgroups	Change since 2018
Currently smoking	15%	Consistent	Consistent
Less than 150 minutes exercise per week	66%	Consistent	N/A
Alcohol dependence: increased risk or higher	10%	Consistent	N/A
High anxiety level	16%	Consistent	N/A
Always/mostly run out of money by end of month	18%	Consistent	Consistent
Low digital confidence as internet users	7%	Consistent	N/A
Affected by gambling	11%	Consistent	N/A
Social isolation (often/all of the time)	5%	Consistent	Consistent

White other residents…

Do not deviate significantly from the average of other groups.

Changes since 2018:

Results are consistent with 2018.

Note: N/A text in the change to 2018 column indicates that a comparison is not available due to this not being asked in the 2018 survey or concerns about comparability.

Groups of interest: ethnicity (Asian/Asian British)

Risk Factor	%	Compared to all other subgroups	Change since 2018
Currently smoking	7%	Reduced risk	Sig. lower
Less than 150 minutes exercise per week	68%	Consistent	N/A
Alcohol dependence: increased risk or higher	4%	Reduced risk	N/A
High anxiety level	15%	Reduced risk	N/A
Always/mostly run out of money by end of month	10%	Reduced risk	Consistent
Low digital confidence as internet users	10%	Consistent	N/A
Affected by gambling	5%	Reduced risk	N/A
Social isolation (often/all of the time)	4%	Reduced risk	Consistent

Asian/Asian British residents…

Display a reduced rate of risk across all factors except for levels of exercise and low digital confidence.

Changes since 2018:

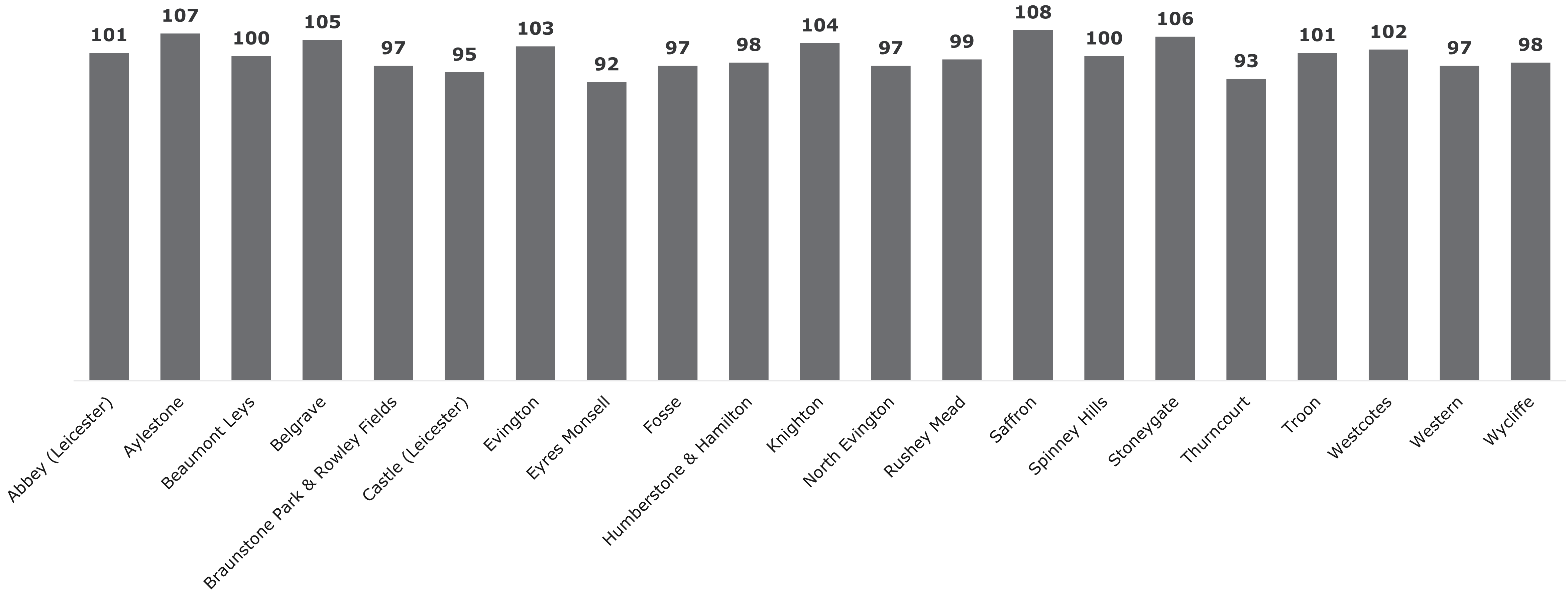
There has been a significant decline in the percentage of this population who smoke.

Note: N/A text in the change to 2018 column indicates that a comparison is not available due to this not being asked in the 2018 survey or concerns about comparability.

Appendix 1: Profile of the sample

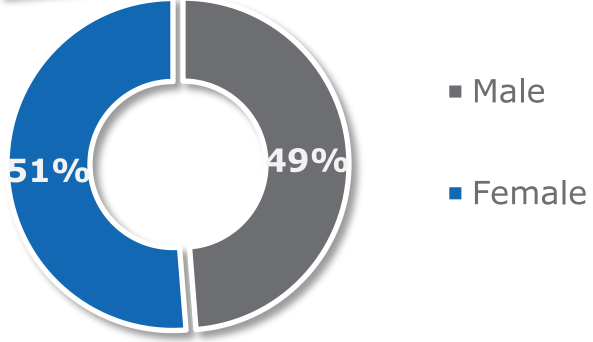
Number of responses by ward

The number of responses by ward ranges between 92 and 108.

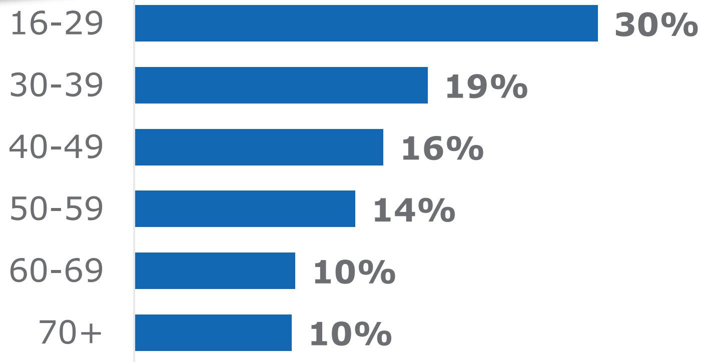


Weighted profile (I)

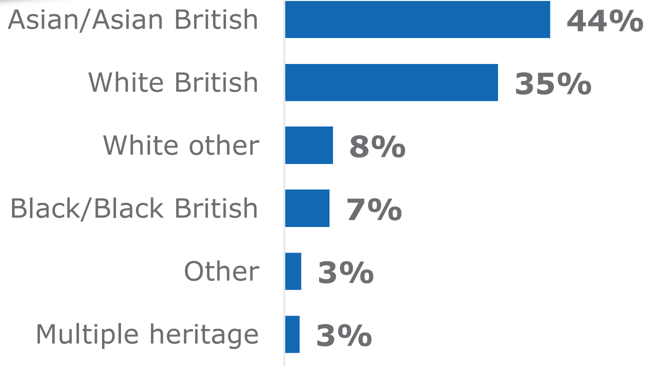
Gender



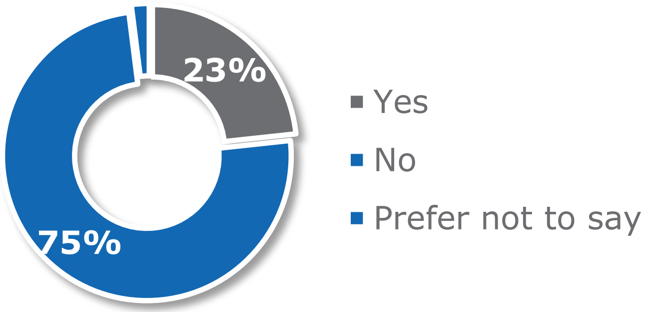
Age group



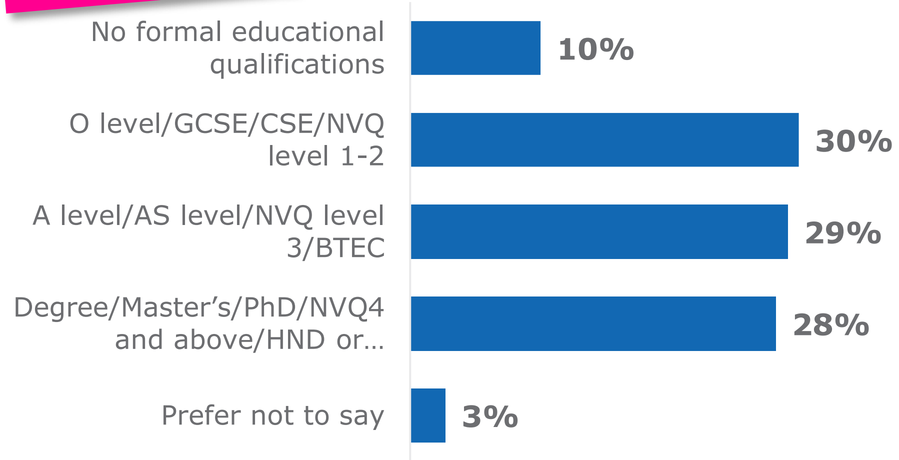
Ethnicity



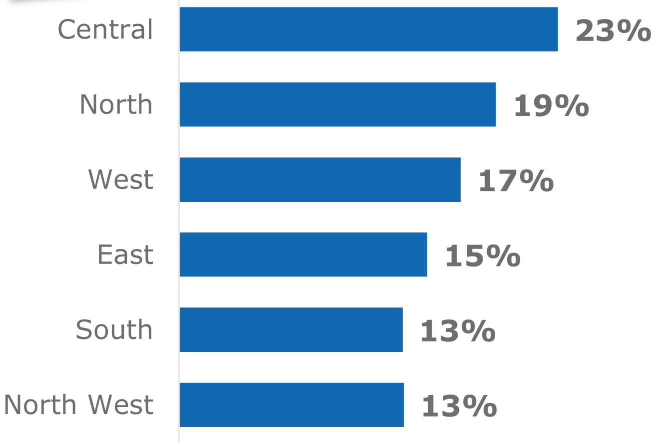
Disability



Education



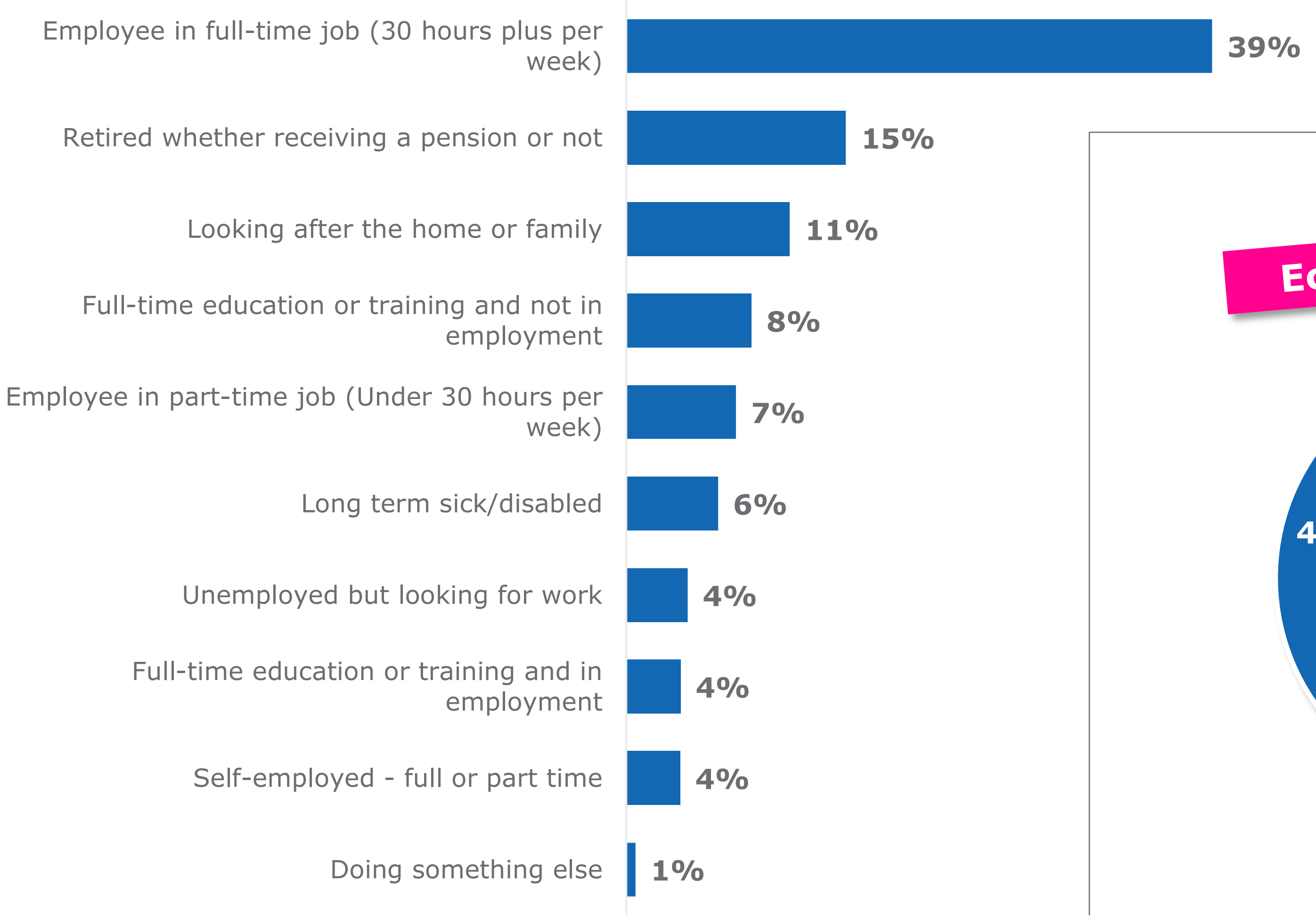
Area



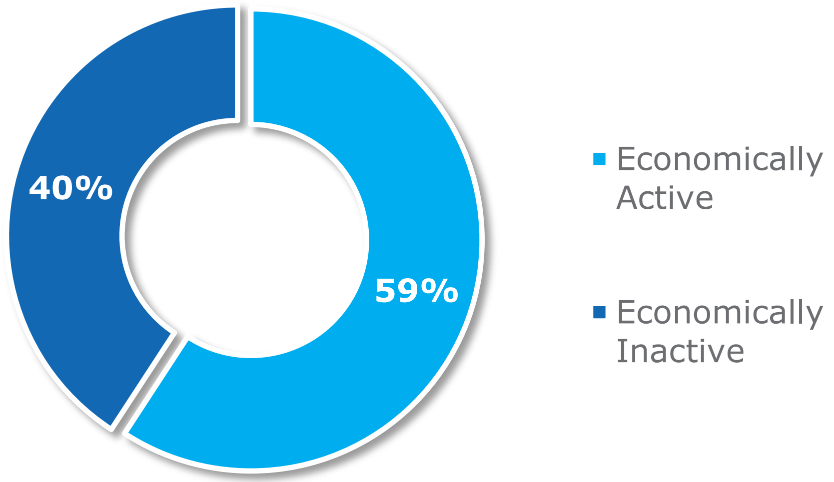
Weighted figures displayed

Weighted Profile (II)

Working status



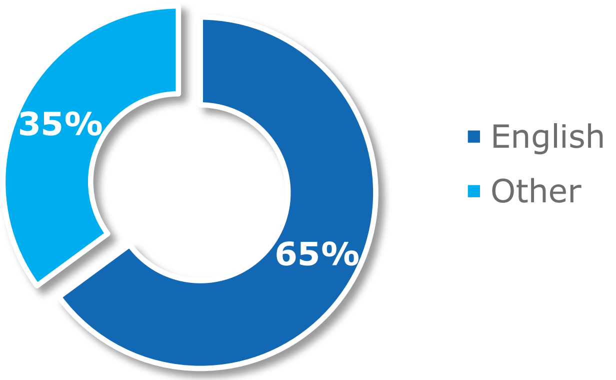
Economic activity



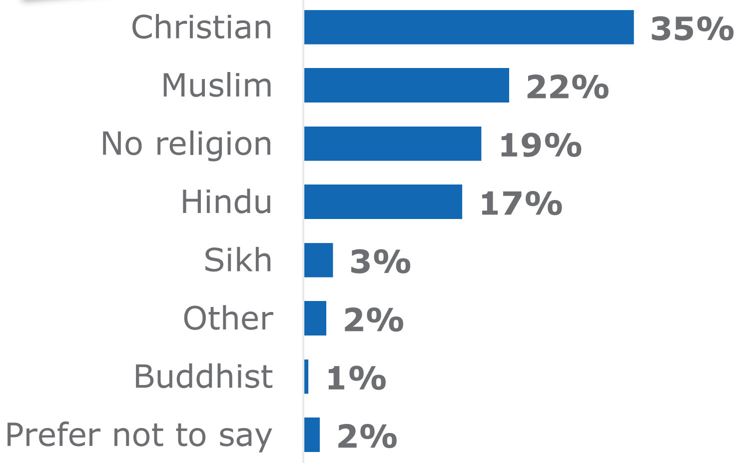
Weighted figures displayed. *Note, bars for those on zero hour contracts and those who would prefer not to say have been hidden as figures are <1%.

Profile (III)

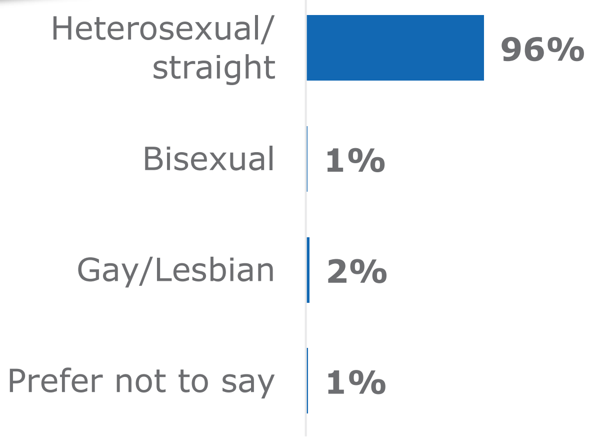
Language spoken



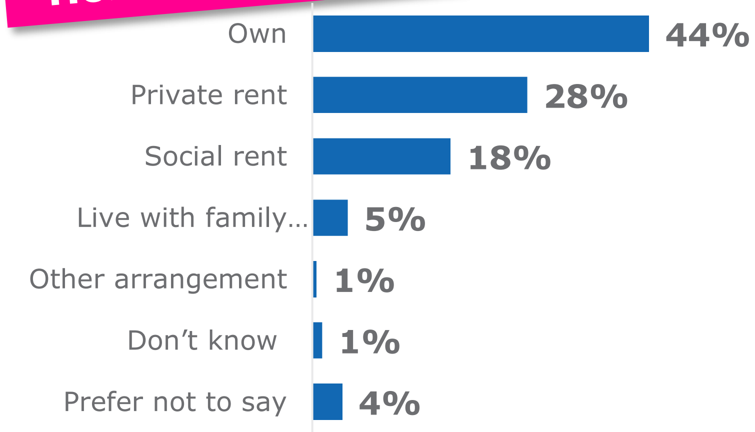
Religion



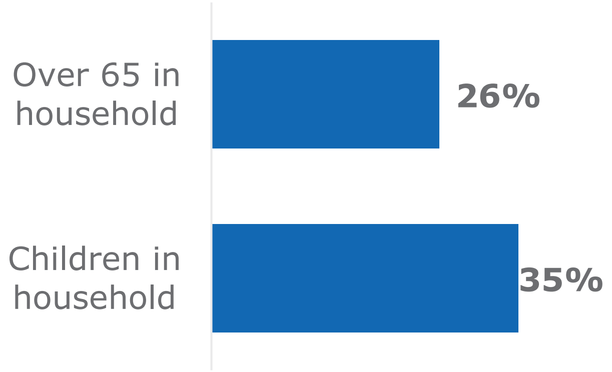
Sexual orientation



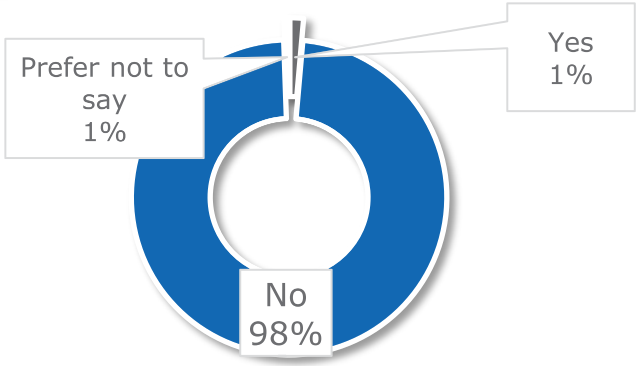
Home ownership



Household composition



Identify as Trans*



Weighted figures displayed. *Note: this figure is likely an overestimate as a disproportionate number of respondents identified as trans in Beaumont Leys (13%) and Rushey Mead (9%). The question wording was taken from the 2021 Census to ensure comparability, but in September 2024 the ONS downgraded its gender identity question from 'official statistic' to 'official statistic in development' as concerns came to light about certain groups, particularly those with lower English skills, potentially misinterpreting the question (see notes for the ONS letter to the OSR regarding this)..

Appendix 2: AuditC calculation

AuditC calculations

The **AUDIT-C Test** (Alcohol Use Disorders Identification Test - Consumption) is a simple screening tool used to identify individuals with risky or harmful drinking behaviours. It’s a shorter version of the full AUDIT (10-item) test, focusing on the first three questions that pertain directly to alcohol consumption.

The AUDIT-C consists of three questions about alcohol consumption:

1. How often do you have a drink containing alcohol?

2. How many drinks containing alcohol do you have on a typical day when you are drinking?

3. How often do you have six or more drinks on one occasion?

Each question is scored from **0 to 4 points**, giving a possible range of **0 to 12 points**.

The scores for each of the three questions are added together to get a total AUDIT-C score. This total score determines the level of concern and possible intervention needs.

Score 0-4: Lower-risk of drinking or abstinence.

Score 5-7: Increasing risk.

Score 8-10: Higher-risk.

Score 11-12: Potential for alcohol dependence.

Appendix 3: detailed background & methodology

Background & methodology (detailed)

DJS Research were commissioned by Leicester City Council to conduct a face-to-face (CAPI) survey of residents in Leicester aged 16+. This is the fourth iteration of Leicester's Health & Wellbeing Survey, with previous waves being carried out in 2010, 2015 and 2018.

The 2024 survey took approximately 15 minutes to complete and, like in previous years, covered a range of health-related topics including: general health and wellbeing, diet, exercise and physical activity, place and volunteering, finances, smoking and tobacco use, mental health and wellbeing, gambling, alcohol consumption, access to sexual health services, and digital inclusion.

Fieldwork took place between 17 April 2024 and 2 October 2024. Circa 100 interviews were conducted in each of Leicester's 21 wards to ensure a good level of representation across the city and adequate base sizes for ward-level analysis. Within each ward, census output areas were stratified by index of multiple deprivation (IMD) score and randomly selected as sampling points. Interviewers had a target number of interviews to achieve within each sampling point, with quotas based on each ward's... …demographic profile (i.e. sex, age, ethnicity, disability and economic status). To correct for any imbalances in each ward's sample population, a corrective weight has been applied, along with weighting which corrects for the over and under sampling of wards relative to the population of Leicester as a whole. Further details on the profile of respondents can be found in the appendix.

Statistical reliability

A sample size of 2,100 gives a confidence interval of +/-2.1% based on a statistic of 50% at the 95% confidence interval.

This means we can be 95% confident that this figure lies between 47.9% and 52.1% had we interviewed every resident in the city.

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Appendix D

LEICESTER CITY HEALTH AND WELLBEING BOARD
DATE

Subject:	Leicester, Leicestershire and Rutland Suicide Prevention Strategy
Presented to the Health and Wellbeing Board by:	Mark Wheatley
Author:	Mark Wheatley

Does the report concern any of the below groups?			
Severe Mental Illness	Learning Disability	Homelessness	Care Experience Children and Young People
☐	☐	☐	☐

EXECUTIVE SUMMARY:

The Leicester, Leicestershire and Rutland Suicide Prevention strategy sets out the ambitions of the local Suicide Audit and Prevention Group (SAPG) to promote partnership to build on current efforts to support people at risk of death by suicide and people who have been affected by suicide.

The strategy is informed by past local action, and the national suicide prevention strategy for England. It has been subject to consultation at every stage to identify priority groups, suicide risk factors and supportive actions. In the last year the SAPG has consulted with individuals, meetings across local authorities, the NHS, voluntary, community and social enterprise sectors and the public.

This paper sets out the results of the public consultation held October – December 2024, and the amendments to the draft strategy.

RECOMMENDATIONS:

The Health and Wellbeing Board is requested to:

- Note the consultation on the forthcoming LLR Suicide Prevention Strategy and comment on the draft strategy

1. Summary

Update on the consultation on the draft suicide prevention strategy refresh for Leicester, Leicestershire and Rutland (LLR).

2. Recommended actions/decision

Leicester Health and Wellbeing Board is recommended to:

- Note the consultation on the forthcoming LLR Suicide Prevention Strategy and comment on the draft strategy

3. Scrutiny / stakeholder engagement

3.1 The writing and delivery of the draft LLR suicide prevention strategy has been overseen by a Steering Group, which also includes people from statutory, voluntary and community sector organisations and people with lived experience.

3.2 The initial draft of the LLR Suicide Prevention Strategy was made in consultation with interested people and organisations across LLR. Those consulted included people from statutory, voluntary and community sector organisations and people with lived experience of suicide (that is people who've survived suicidal thoughts and acts) and people who've lost someone close by death from suicide.

3.3 With regard to stakeholder and political consultation, the draft strategy was presented at the following meetings:

- ICB Operational Delivery Group (22nd October 2024)
- Leicester City Council Public Health and Health Integration Scrutiny Commission (5th November 2024)
- Leicestershire Health Overview and Scrutiny Committee (13th November 2025)
- ICB Urgent and Emergency Care System Group (14th November 2024)
- Best Practice Reference Group (14th November 2025)
- LLR Mental Health Collaborative (25th November 2024)
- Rutland Council Strategic Overview and Scrutiny Committee (28th November 2024)
- Autism Partnership Board (10th December 2024)
- LLR ICS System Quality Group (19th December 2024)
- Rutland Health and Wellbeing Board (14th January 2025)

3.4 The draft strategy was received positively, with an appreciation for the level of work that goes into suicide prevention, acknowledging limited resources and budgetary constraints. In these meetings there have been questions and discussions surrounding activities and broader mental health aspects, such as how to address loneliness and isolation, as well as how to record suicide attempts.

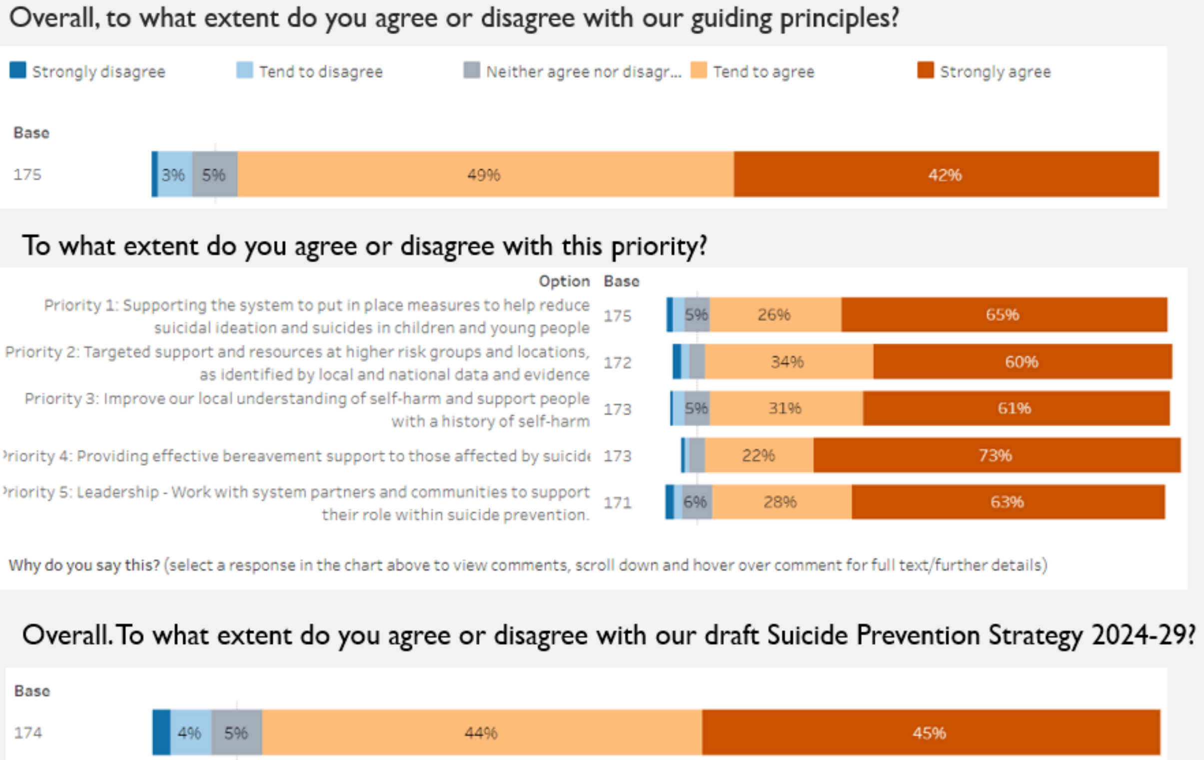
3.5 The strategy has also been subject to a full public consultation, held 28th October - 22nd December 2024. This consisted of an online survey and focus groups with residents who have lived experience of suicide, as well as the Youth Advisory Board within LPT.

3.6 The consultation summary is attached as Appendices 1 and 2.

4. Background and options with supporting evidence

4.1 There were 176 responses to the online survey. Figure 1 shows that these were overwhelmingly positive about important aspects of the draft strategy such as the underlying principles of the approach (briefly summarized as suicide prevention is ‘everybody’s business’), the priorities and overall approach.

Figure 1: Responses to the online consultation survey for the LLR Suicide Prevention Strategy October – December 2024

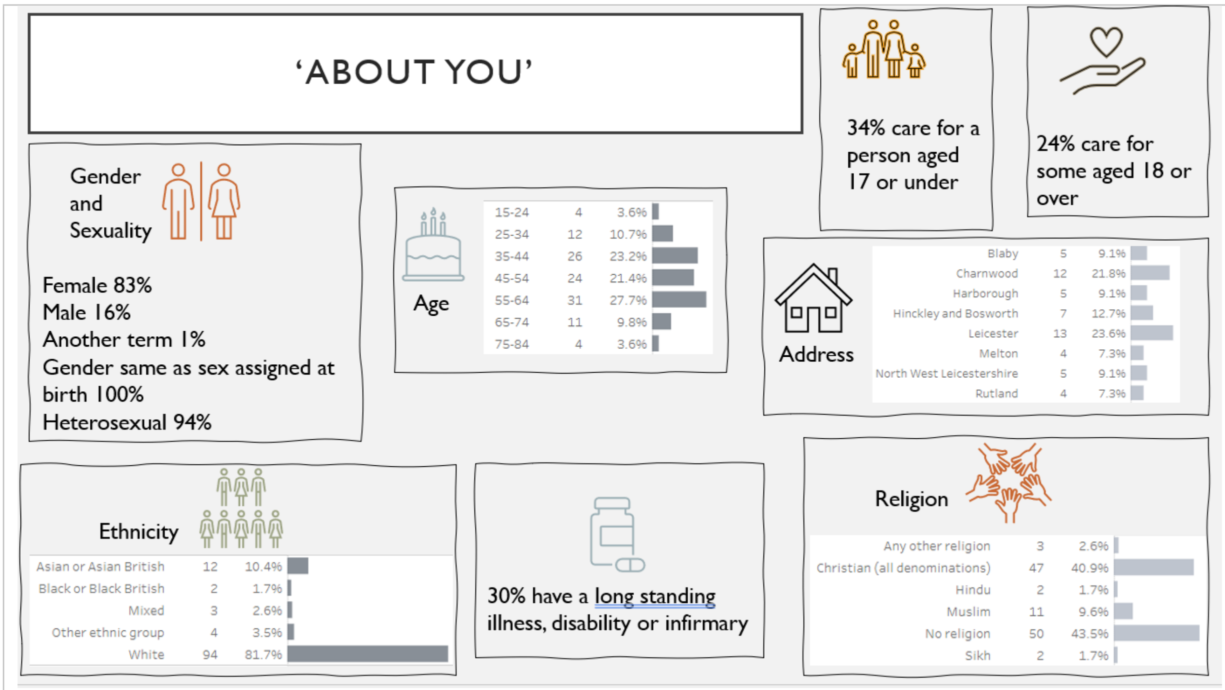


4.2 Figure 2 shows the demographic make-up of respondents who answered the ‘About You’ questions at the end of the survey. Although the data needs careful interpretation, for example, only 31% of respondents answered the question around where they live, it is possible to describe some key characteristics of the respondents:

- They were well spread across different age groups.
- They were predominantly female (83%); possibly highlighting the challenges faced in engaging with men on the topic of mental health and suicidal thoughts.
- 34% cared for someone aged under 18, and 24% caring for someone aged 18 or over.

4.3 24% (n=42) stated that they have accessed formal support for mental health within the past 12 months, with 61% (n=107) having lived or living experience of suicide.

Figure 2: Demographics of the respondents to the online consultation survey for the LLR Suicide Prevention Strategy October – December 2024



‘ABOUT YOU’

34% care for a person aged 17 or under

24% care for some aged 18 or over

Gender and Sexuality

Female 83%
Male 16%
Another term 1%
Gender same as sex assigned at birth 100%
Heterosexual 94%

Age

15-24	4	3.6%
25-34	12	10.7%
35-44	26	23.2%
45-54	24	21.4%
55-64	31	27.7%
65-74	11	9.8%
75-84	4	3.6%

Address

Blaby	5	9.1%
Charnwood	12	21.8%
Harborough	5	9.1%
Hinckley and Bosworth	7	12.7%
Leicester	13	23.6%
Melton	4	7.3%
North West Leicestershire	5	9.1%
Rutland	4	7.3%

Ethnicity

Asian or Asian British	12	10.4%
Black or Black British	2	1.7%
Mixed	3	2.6%
Other ethnic group	4	3.5%
White	94	81.7%

30% have a long standing illness, disability or infirmary

Religion

Any other religion	3	2.6%
Christian (all denominations)	47	40.9%
Hindu	2	1.7%
Muslim	11	9.6%
No religion	50	43.5%
Sikh	2	1.7%

4.4 Some feedback focused on tangible ideas and solutions which could help reduce and prevent suicide, rather than on the strategy itself. This will be used to inform the development of the action plan.

4.5 Overarching themes and topics from the consultation included:

- Raising awareness of suicide prevention is a key activity.
- The importance of early prevention, for instance conversations about protecting mental health could start in primary school, and openness about suicide.
- Lack of funding for suicide prevention work and services.
- Long waiting times for mental health services, which can impact suicide.
- Lack of support for those in crisis and those who are mentally unwell but not at crisis point.
- Better co-ordination between services and organisations required to ensure person centred care.
- Ensure a wide range of organisations and services are involved
- Signposting should be improved due to a range and variety of available services and no single point of access.
- Provide training to relevant individuals or organisations to make sure suicide prevention is everybody's business.
- Make use of data from a range of sources including voluntary and community sector.
- Address the wider determinants of suicide and tackle those issues e.g. quality of mental health services, personal finance, gambling.

- Proportionate universalism – respondents felt that there should be services for all, however there should be extra support to those groups in higher need and at greater risk.

4.6 Some remarks on the final strategy and action plan

4.6.1 As there was high level of agreement within the consultation, the final strategy has not changed dramatically from the initial draft (see Appendix 3)

4.6.2 Document changes include facts and figures on risks linked to substance use, harmful gambling and domestic abuse.

4.6.3 The consultation highlighted vulnerabilities to suicide among some people which are not demonstrated in local data, but do feature in the broader literature, including LGBTQ+ people, Gypsy or Irish Travellers and those experiencing the menopause.

4.6.4 The guiding principles have largely remained the same, with some extra wording added to reflect the need to understanding the intersectionality of factors and recognising the importance of cultural appropriateness (alterations written in red):

a. **Co-Production and Collaboration**
    i. Meaningful and authentic lived experience involvement will underpin everything we do and will be viewed as an essential part of delivering effective services and interventions.
b. **Learn from past stories**
    i. We will seek to understand our local suicides and the intersectionality of contributory factors, including wider determinants of health such as social and economic challenges. Future work will be shaped by this and informed by the realities of those affected.
c. **Data driven**
    i. Our work will be driven by our understanding of a wide range of local data, and the current and emerging evidence base to reduce suicides. We will target our work using data and evidence, ensuring we reach those that need help the most.
d. **Normalising conversations**
    i. We will strive to reduce stigma and taboo around suicide and mental health and encourage people to Start a Conversation. This will be instrumental to all of our work and our priority areas. We will ensure approaches are culturally appropriate and sensitive, recognising and respecting diverse needs, values and beliefs in our communities. We will work with local media on aspects of mental health and suicide, ensuring stories are portrayed sensitively and safely, in line with current guidance, and challenge inappropriate reporting and conversations where necessary.
e. **Settings-based approach**
    i. We will adopt a settings-based approach to integrate suicide prevention activity into local communities, organisations and sectors, emphasising education, awareness and training, with a strong focus on early intervention, and local leadership.
f. **Trauma Informed Practice and Care**
    i. We will work to adopt a Trauma Informed Approach in our interactions, delivery and commissioning: understanding past experiences and the needs of the people we serve, including being

sensitive to any trauma they may have experienced. By offering support early and being thoughtful in how we provide care, we can help improve lives.

4.6.5 The focus of each priority remains the same, however the wording for Priority 1 has been changed to be more specific:

1. Enabling partners, including educational establishments, to use sound evidence and proven measures to target and support **children and young people** at risk of suicide.
2. Targeted support and resources at **higher risk groups and locations**, as identified by local and national data and evidence.
3. Improve our local understanding of **self-harm** and support people with a history of self-harm.
4. Providing effective **bereavement** support to those affected by suicide.
5. **Leadership** - Work with partners and communities to support their role within suicide prevention.

4.7 The action planning process has started. Five groups have been established, each covering one of the priorities, to devise evidence-based action plans.

4.8 The Suicide Prevention Strategy Steering Group has oversight of the action planning process, feeding into the Suicide Audit and Prevention Group.

4.9 Mitigations have been put in place to ensure the actions are ambitious, whilst remaining realistic, and don't solely fall on public health to deliver against. This includes a prioritisation matrix, allowing actions to be based on impact and resource, and a template with clear accountability.

Appendices
1 Consultation Survey

suicide prevention
consultation results

2. Consultation Summary

The draft strategy
consultation and ou

3. Strategy

DRAFT Suicide
Prevention Strategy.

START A
CONVERSATION

Leicester, Leicestershire and Rutland

SUICIDE PREVENTION STRATEGY

2024-2029

Leicestershire County Council

Leicester City Council

Rutland County Council

Contents

If you feel that you require support, please consider visiting the Start a Conversation website – www.startaconversation.co.uk - which provides a wealth of information on matters relating to suicide and mental health. This includes providing contact details for sources of mental health support.

Foreword

Welcome to the refreshed Leicester, Leicestershire, and Rutland (LLR) Suicide Prevention Strategy 2024-2029. We have worked hard to refresh our strategy through extensive engagement, consultation, and collaboration.

We have engaged with individuals who have lived experience of suicide and its extensive effects, collaborated with stakeholders and partners to exchange information and insights, and collected high-quality data to support our efforts.

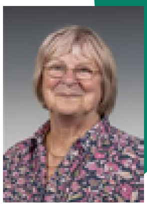
This has helped to create a strategy which aims to best fit the needs of those who are experiencing suicidal thoughts, and those impacted by suicide, whilst also aiming to stop people reaching crisis point. It is our ultimate goal to ensure that no one in our communities feels that suicide is their only option.

Suicide is complex, but it is not inevitable. By understanding the unique challenges and strengths of our diverse communities, and by working together across sectors and disciplines, we can make a significant impact.

We're grateful to everyone who has contributed to this strategy. Your voices and expertise have shaped a document that reflects our shared commitment to saving lives, supporting those affected by suicide, and fostering communities where mental health is prioritised.

Our mission - as set out in this strategy - is to prevent suicide and save lives across Leicester, Leicestershire and Rutland, and we will work together to make this happen.

Cllr Louise Richardson
Lead Member for Health and Wellbeing
Leicestershire County Council



Cllr Vi Dempster
Assistant City Mayor – Health, Culture, Libraries and Community Centres
Leicester City Council

Cllr Diane Ellison
Portfolio Holder for Adults and Health
Rutland County Council

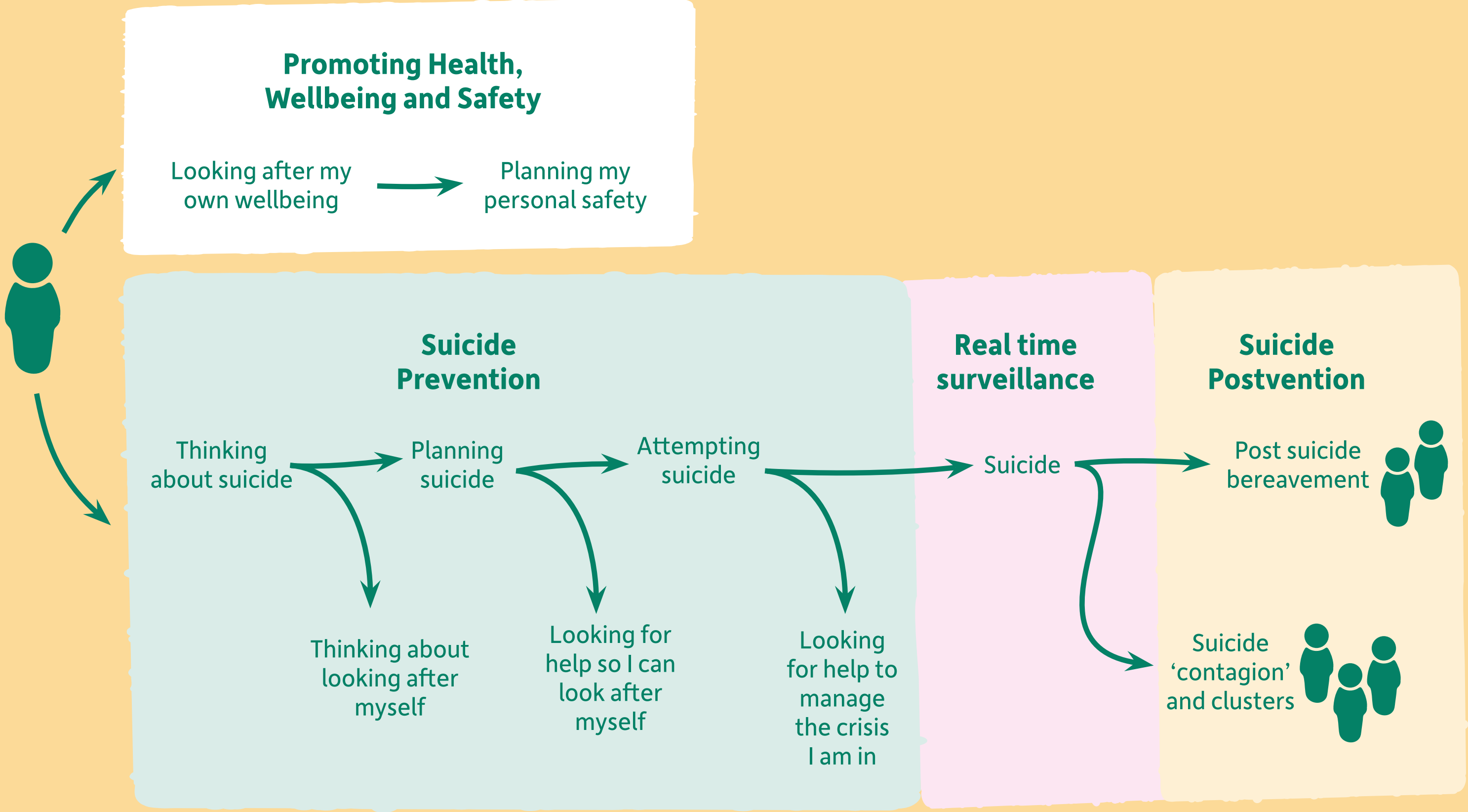
Introduction

This strategy covers LLR – a diverse area with a population of more than 1.1 million people. Every area is different, with its own community strengths and challenges. Understanding our data and populations is crucial so that we can respond to needs, which could be different across the three areas. However, we work in partnership to harness these strengths and tackle the challenges together.

We have aimed to align our LLR strategy with the National Suicide Prevention Strategy where possible, but ensure our principles and priorities are based on what is needed locally. While suicide is a hugely complex issue, it is one that we believe can be reduced through our joint efforts and collective action.

Suicide prevention can mean many different things – covering various interventions, points in people's lives, stages of deteriorating mental health, and crisis points. There are opportunities to prevent poor mental health and opportunities to support those at key points in their life where risk is higher, such as unemployment and financial hardship.

The diagram opposite sums up the prevention pathway for suicide, clearly demonstrating the touch points where suicide could be prevented, and interventions put in place. Ultimately, we want to prevent suicide at the earliest possible opportunity and stop people going into crisis or having suicidal thoughts. Our strategy aims to capture prevention at all points along the continuum but noting that we are adopting a Public Health approach by understanding our data and populations, and aiming for early interventions where possible, with local services working together to address need.



Promoting Health, Wellbeing and Safety

Looking after my own wellbeing → Planning my personal safety

Suicide Prevention

Thinking about suicide → Planning suicide → Attempting suicide

Thinking about looking after myself

Looking for help so I can look after myself

Looking for help to manage the crisis I am in

Real time surveillance

Suicide

Suicide Postvention

Post suicide bereavement

Suicide 'contagion' and clusters

NHSE Midlands Mental Health Team Suicide Prevention Forum 2024

WHO ARE WE?

We are the LLR Suicide Audit and Prevention Group, a partnership of local authorities, NHS organisations, Leicestershire Police, lived experience and local voluntary and community sector organisations who work together on suicide prevention.

Our previous strategy had 9 priorities

Target support at key High-Risk Groups and at High-Risk Settings	**Protect people with a history of self-harm**	**Preventing suicide in public places**
Support Primary Care to Prevent Suicide	**Engage with Private Sector to Enhance Their Efforts to Prevent Suicide**	**Support Provision of Enhanced Suicide Awareness Training**
Better use of media to manage messages about suicide	**Raise awareness with better data and better use of data**	**Provide a coordinated mental wellbeing approach to COVID-19**

What has been achieved since the previous strategy

Significant progress has been made across these priorities including the commissioning of the LLR Self-Harm service, expansion of the Suicide Bereavement Service and establishment of the LLR Lived Experience Network (for those who have experienced or live with suicidal thoughts, people who have attempted suicide, people living with or in relationships with those who have suicidal thoughts, and those bereaved by suicide). We have continued work on expanding our 'Start a Conversation' website and campaign, launching our new bespoke eLearning, supported by the lived experience network.

We have also worked together to improve our data and evidence, using this to drive service development. Since the previous strategy, we have also established Mental Health Friendly Places. A Mental Health Friendly Place is a public-facing organisation or community space (such as a shop or library) in Leicester, Leicestershire or Rutland that has received training, resources and support to confidently have conversations around low-level mental health and wellbeing. Greater understanding of our data has also led to important developments around high-risk locations, where community responses to local suicides are being utilised, linked to Mental Health Friendly Places, to support hyper local interventions.

However, with the launch of the strategy during the height of the COVID-19 pandemic, there were some elements that we were not able to fully address, which we are open and transparent about. We have used our learning from the previous strategy, to refresh and develop our next strategy iteration based on it being ambitious, but realistic.

Since the launch of the previous strategy, external factors beyond our control (such as the pandemic and cost of living crisis), have likely adversely affected people's mental health and financial stability, both of which are known risk factors for suicide.[1]

KEY ACHIEVEMENTS

Development of the LLR self-harm service

Expansion of the tomorrow project, supporting those bereaved by suicide

Establishment of Mental Health Friendly Places

Establishment of the Lived Experience Network

Production of adult and children's mental health COVID-19 resources

Start a Conversation eLearning, website revamp and various events and conferences

Established key working group on communications and media, high risk locations and data, which are driving our work in a targeted and evidence-based manner

Ongoing collaboration with Leicestershire Police on the Real Time Suspect Suicide Surveillance Data

How was this strategy developed?

This strategy has been informed by a wide range of data, both nationally and locally, as well as academic and expert literature, and importantly though engagement of those with lived experience. The mission, principles and priorities were driven by local Joint Strategic Needs Assessments (JSNA) and Health Needs Assessments on mental health, gambling harms, and substance use, as well as by local Health and Wellbeing Board Priorities, Child Death Overview Panel insight and recommendations on suicide, and the Leicester, Leicestershire and Rutland Integrated Care Board (ICB) 5-year plan. The strategy was also developed in line with the National Suicide Prevention Strategy.

A Health Needs Assessment was undertaken, examining our Real Time Suspected Suicide Surveillance Data (RTSSSD) from 2018-2023, as well as exploring our Office for National Statistics (ONS) data. Suicide data often doesn't show the full picture due to time lags, sensitivity and difficulties with reporting, so other sources, such as academic journals, were used to triangulate the findings, as well as explore **intersectionality** where appropriate. Literature was also systematically reviewed to determine the most recent and possible options for preventative activities and interventions.

Intersectionality is a way of understanding how different parts of a person's identity, such as their gender or ethnicity, overlap and combine to shape their experiences in the world.

Engagement with people who have lived experience, and with stakeholders working within suicide and mental health was very important to our strategy development. Focus groups and workshops were held to gather expert voice and were analysed to bring out common themes and areas, which have been translated into our Guiding Principles and Priorities.

The work has been overseen by the LLR Suicide Audit and Prevention Group (SAPG), and was developed by a steering group comprising of local authorities, Leicestershire Police, LLR ICB, Leicestershire Partnership NHS Trust, various VCSE organisations and our Lived Experience Network. This strategy is a culmination of collaboration.

National context, drivers and data

National Suicide Prevention Strategy

Suicide prevention is an important public health priority nationally, as well as locally, with suicide rates presenting a significant challenge. In England, suicide rates are 10.3 per 100,000 population, which from 2020-2022 equated to 15,415 deaths.[2] The World Health Organisation estimate that for every suicide, there are in turn 20 non-fatal attempts, which equates to 16 million attempts annually (globally).[3] In response, the National Suicide Prevention Strategy 2023-2028[4] has set forth a comprehensive plan to reduce these rates.

The ambitions set out by the national strategy are:

Reduce the suicide rate over the next 5 years – with initial reductions observed within half this time or sooner

Continue to improve support for people who self-harm

Continue to improve support for people who have been bereaved by suicide

The national strategy also sets out 8 priorities for action

1. **Tailored, targeted support to priority groups, including those at higher risk, to ensure there is bespoke action and that interventions are effective and accessible for everyone.**
2. **Improving data and evidence to ensure that effective, evidence-informed and timely interventions continue to be developed and adapted.**
3. **Addressing common risk factors linked to suicide at a population level to provide early intervention and tailored support.**
4. **Promoting online safety and responsible media content to reduce harms, improve support and signposting, and provide helpful messages about suicide and self-harm.**
5. **Making suicide everybody's business so that we can maximise our collective impact and support to prevent suicides.**
6. **Reducing access to means and methods of suicide where this is appropriate and necessary as an intervention to prevent suicides.**
7. **Providing effective bereavement support to those affected by suicide.**
8. **Providing effective crisis support across sectors for those who reach crisis point.**

Our strategy aligns closely with the National Suicide Prevention Strategy4, which underscores a multi-faceted approach to preventing suicide risk. This includes targeting support towards at-risk groups, promoting mental health education, and ensuring timely and effective interventions. Evidence from key academic literature supports these initiatives, highlighting the effectiveness of early intervention, community-based programs, and improved access to mental health services.

Risk Factors and Higher Risk Groups

There is no single explanation of why people die by suicide – suicide is complex. However, there are common risk factors, and higher risk groups. The national strategy focuses on at risk groups including:

Children and young people

- Although numbers are low, there is an increasing national trend which is concerning. In 2019 the World Health Organisation found suicide to be the fourth leading cause of death for young people, both sexes combined, aged 15-29 years.[5]
- Some studies have found that up to 54% of suicides in young people had a history of previous self-harm.[6]
- Antecedents to children and young people's suicides are varied including: academic pressures, bullying (including cyber bullying), bereavement, physical health conditions, family problems, social isolation and abuse or neglect.[6]

Middle aged men

- Men are three times more likely to die by suicide than women.[4]
- Particularly linked to this group are factors around living in the most deprived areas, unemployment and/or financial hardship and difficulties.

People with a history of self-harm

- Evidence shows that the risk of suicide among those who have self-harmed is much greater than that of the general population, with the risk elevated by between 30 to 100-fold in the year following an episode of self-harm.[7]

People in contact with mental health services

- 26% of all people who died by suicide (2011-2021) had recent contact with mental health services (12 months prior to their death).[8]

People in contact with the justice system

- People in contact with the justice system have higher rates of suicide and self-harm behaviour than the general population.[4]

Autistic people

- It is estimated that around 1 in 7 people (more than 15% of people in the UK) are neurodivergent, meaning that the brain functions, learns and processes information differently. Evidence suggest that suicide could be one of the leading causes of early death in autistic people, with those diagnosed with autism and no other learning disability being over 9 times more likely to die by suicide.[9]
- We also need to be conscious of the estimated large numbers of people who are undiagnosed, and the impact this may have on their health and wellbeing, as well as acknowledgment of the lengthy waiting times people often experience before receiving a clinical assessment. This is also prevalent in other **neurodiversity** conditions, such as ADHD.

What do we mean by neurodiversity? People's brains all work in different ways. We all think, speak, feel, act and experience the world differently. Neurodiversity is a term that covers a range of conditions including autism, ADHD, dyslexia, dyspraxia, dyscalculia and Tourette's Syndrome. Neurodiversity encourages acceptance of these differences and conditions, recognising that everyone has unique strengths and challenges.

Pregnant women and new mothers

- Suicide is the leading cause of direct maternal death in the first year following having a child.[10]

Those who have been bereaved by suicide

- It is well documented that bereavement due to suicide is different to other forms of loss, including other forms of traumatic or sudden death. Research has shown that bereavement by suicide is associated with suicide risk and poorer mental health.[11,12]
- Evidence suggests family, friends and acquaintances who are bereaved by suicide may have a risk of dying by suicide that is up to 3 times higher than the general population.

Other risk factors and high-risk groups include (but are not limited to):

- **People who misuse alcohol and drugs**
  - Studies have shown that alcohol consumption commonly precedes suicidal behaviour, potentially increasing the risk of suicide by 65%.[13]
- **People experiencing harmful gambling**
  - Data suggests between 4-11% of suicides in the UK are gambling related.[14]
  - Harmful gambling is identified as a priority area in the National Suicide Prevention Strategy
- **Access to means, such as firearms and pesticides, which can largely be driven by specific occupational groups e.g. veterinary works and those within the agricultural sector**
- **Armed forces personal and the veteran community**
- **Female nurses**
- **Financial instability and hardship, including unemployment**
- **Relationship breakdown**
- **Homelessness**
- **Lesbian, Gay, Bi, Trans and Queer / Questioning + (LGBTQ)**
  - Research shows that LGBTQ+ people report a higher risk of suicidality.[15]
- **Domestic abuse**
  - A 2017 systematic review found that past intimate partner violence was evident in up to 62·5% of female suicide cases.
- **Trauma**
  - Whether acute (such as accidents or violence) or chronic (such as ongoing abuse), trauma significantly increases suicide risk. Individuals who have experienced trauma may struggle with emotional pain, hopelessness, and suicidal thoughts.[16]
  - Childhood abuse, sexual trauma, and combat-related trauma are all associated with increased suicide risk. [17,18.19]
- **Gypsy or Irish Travellers**
  - The Leicestershire JSNA on Health Inequalities demonstrates the differences in health outcomes across different groups, with Gypsy or Irish Travellers having some of the poorest health outcomes across a range of indicators. [20]
  - There is limited published evidence, however the available evidence does point to unmet need, with one study reporting suicide prevalence six times higher for Irish Traveller women and seven times higher for Traveller men, as compared to the general population.[21, 22]

- **Data is also emerging on the relationship between menopause and suicide. Suicides in middle aged women is a growing public health concern,[23] but with limited, and often conflicting evidence this area should be closely monitored with conclusion drawn carefully and sensitively.[24]**

The **National Confidential Inquiry into Suicide and Safety in Mental Health (NCISH)** 2024 annual report provided the follow findings related to people aged 10 and above who died by suicide between 2011 and 2021 within the UK[8]:

- 26% of all people who died by suicide had recent contact with mental health services (12 months prior to their death).
- Of those who died by suicide in contact with clinical care, 48% of them lived alone, 47% had alcohol misuse, 63% had a history of self-harm, and 54% had one or more mental health diagnoses

> **Clinical prevention should focus on these common risk factors**

- Highest risk of suicide for those accessing acute mental health care settings was 1-2 weeks following discharge

> **Prevention should focus on ward environment and careful transition to the community**

- The report picked out autistic people and patients with ADHD as an emerging group at risk, with 32 deaths per year in autistic people and 15 in those with ADHD
- There were 11 deaths per year for in-patients under 35, and 9 deaths per year in students aged 18-21 under mental health care, highlighting a clearer pathway to NHS services is needed for this cohort
- There were 354 deaths per year in public locations by patients who were generally younger and more acutely unwell

> **Local suicide prevention plans should address high risk locations**

Leicestershire Partnership NHS Trust (LPT), in collaboration with the SAPG, have developed a trust wide plan to address the NCISH recommendations and the common themes associated between mental health services and suicide. Having an LPT Plan will support LLR residents who are in contact with local mental health services and ensure high quality of care. We are working closely to ensure this strategy and the LPT Plan are aligned and work together to address suicide, without duplicating efforts. Therefore, clinical mental health service (LPT delivered) and NCISH recommendations will remain within the LPT Plan.

By incorporating evidence-based strategies and drawing on the latest academic research, our local strategy aims to create a robust framework and action plan to ***prevent suicide and save lives***. This strategy not only supports individuals at risk but also builds a safer, more supportive community. Through collaboration with national initiatives and leveraging the insights from key literature, we are committed to making meaningful strides in suicide prevention.

KEY MESSAGES

1 Suicide is everybody's business

Local picture

KEY MESSAGES

2 Suicide can be preventable

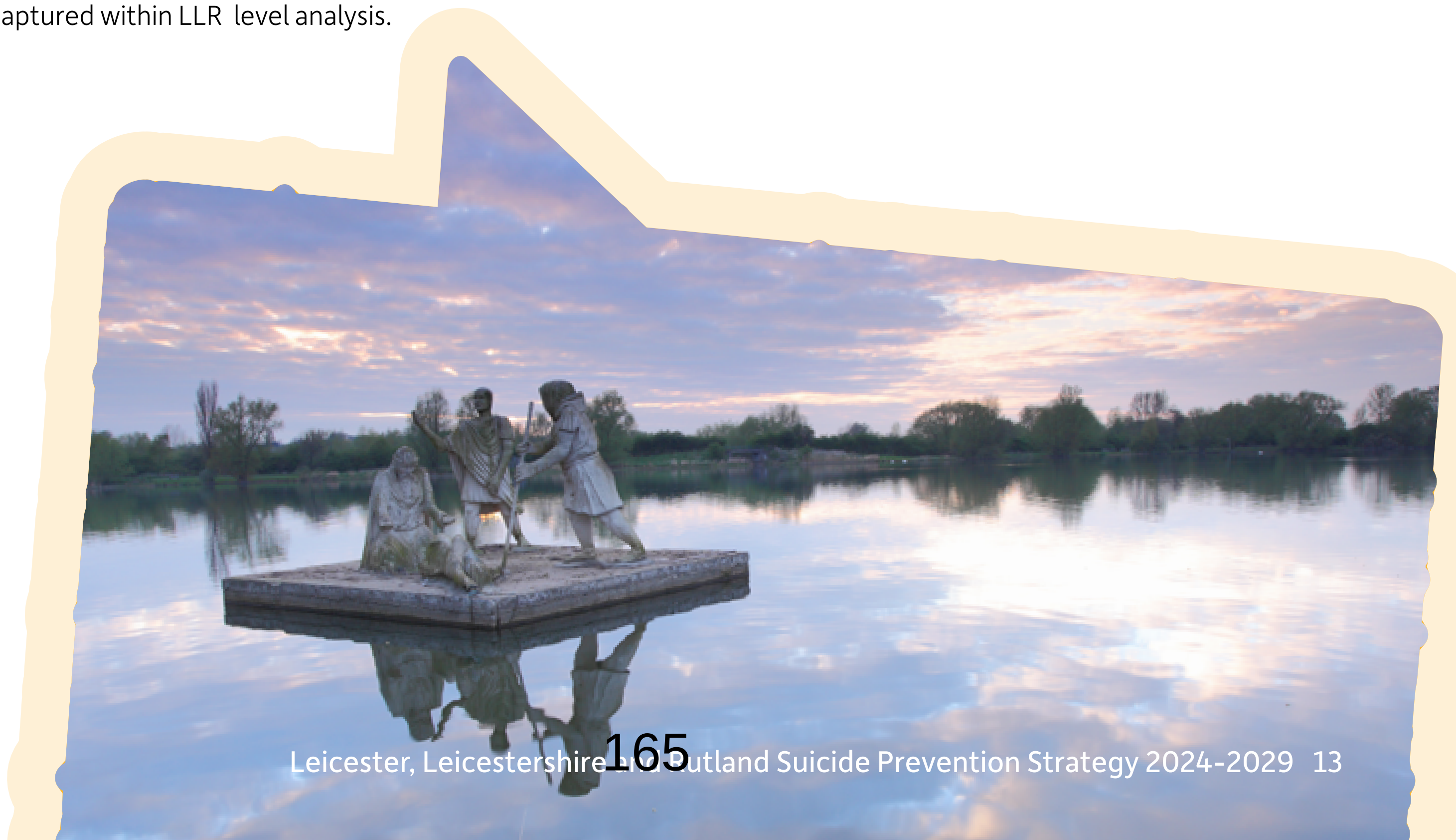
Our data monitoring

Locally we work closely as a system, relying on the hard work of Leicestershire Police, to understand our suicide data using RTSSSD. Data is extracted from the reports completed by the officers that attend the incidents recorded as a suspected suicide. The timely data that we receive from Leicestershire Police helps with identifying emerging patterns and trends, cluster analysis and the detection of vulnerable groups, allowing for real-time surveillance of suicide that enables systems to respond early and appropriate interventions to take place to reduce suicide rates across LLR. The RTSSSD also provides more granular data per suicide than nationally available data, allowing us to have a better understanding of suicides in LLR.

It is important to note that each record represents a death by suspected suicide and is reported by the date the incident occurred and not the date the death was registered. This means that the data is not conclusive as each case is still subject to a Coroner's inquest. The Local Authority level analysis carried out only applies to residents of those Local Authorities that have died by suspected suicide, whereas the LLR-wide analysis includes all cases of death by suicide attended by Leicestershire Police Officers and can therefore also include residents that live outside of LLR.

We also utilise ONS data, which uses confirmed cases of suicide, after a Coroner's inquest. There are differences between the data, as some cases recorded via RTSSSD may not be deemed as a suicide by the Coroner. There is also a time delay with confirmed suicides, with this being approximately 180 days across LLR (101 days Leicester City, 264 Rutland County and 175 Leicestershire County).[25]

RTSSSD is reported as absolute numbers and/or proportions, without calculation of rates, therefore data should be interpreted with caution, and with an appreciation and understanding of the local context and wider demography of LLR. Rutland data is often suppressed (not shown), due to low numbers, however is still captured within LLR level analysis.



Overall numbers

Between the years of 2020-2022, there were 268 confirmed cases of suicide across LLR.[2] This equates to rates of 9.2 and 9.5 per 100,000 for Leicestershire and Leicester respectively, with the number of suicides in Rutland being too small to calculate a rate. Figure 1 shows the trends of deaths by suicide over time. It can be seen that the local rates fluctuate over time, but at present are not significantly different to the England average but have shown an increase over the last few years.

KEY MESSAGES

3 Suicide has a wide impact

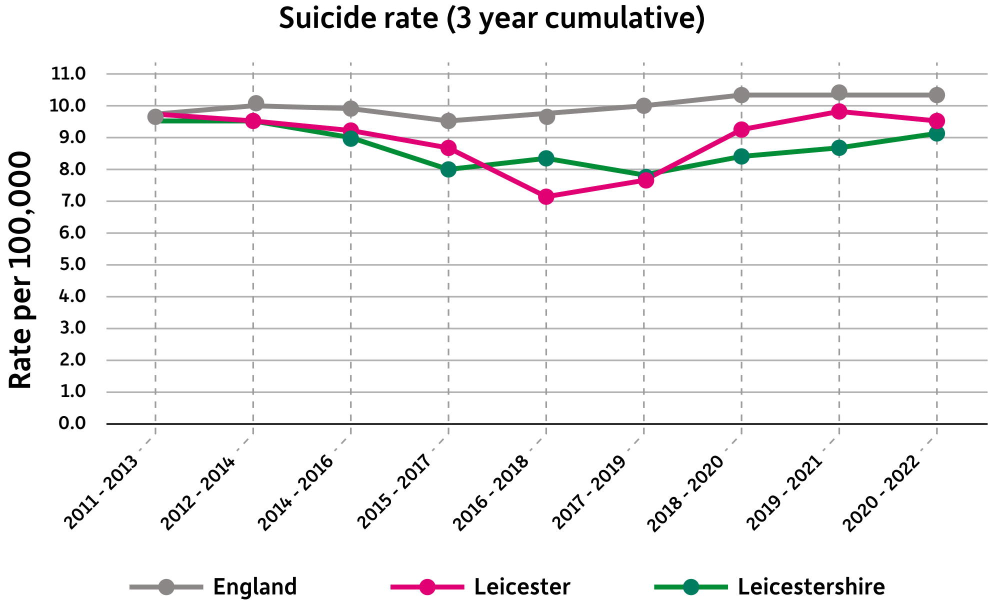


Figure 1 – Suicide rates for Leicester and Leicestershire 2011-2022

Suicides have also fluctuated over time, as demonstrated in figure 2, but have increased since 2020 (ONS).

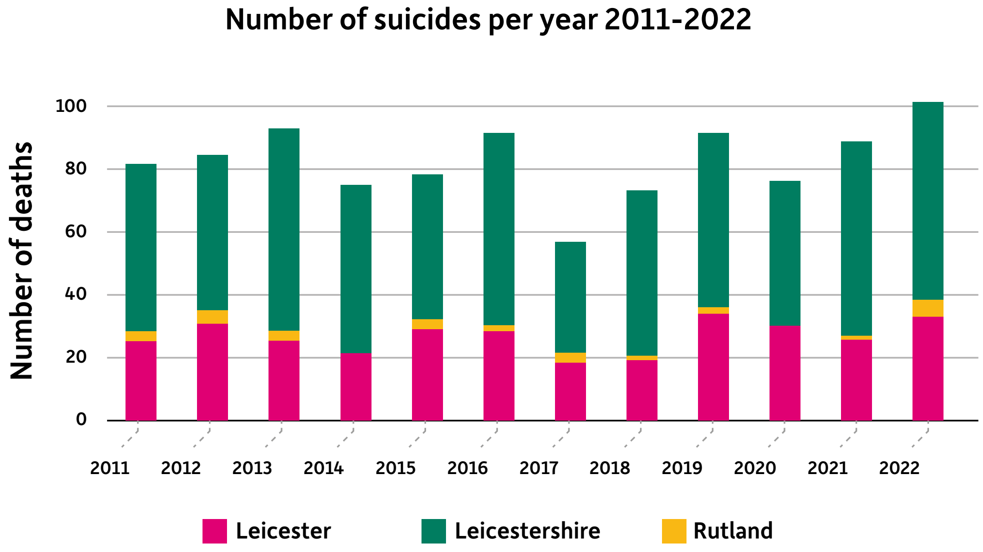


Figure 2 – Numbers of suicides within LLR 2011-2022 Source: ONS

Age

The median (the middle number in an ordered list of numbers) age of suspected suicides varies across LLR (2018-2023), likely due to the varying age demographics per place. Within Leicester, the median ages for men and women are 42 and 38 years respectively, which is younger than the Leicestershire averages at 45 years for males and 49 years for females. Ages within Rutland are again higher at 52 years for males and 57 years for females. Ages also vary across gender, as demonstrated by the RTSSSD in figure 3, with females (46 years) generally being slightly older than males overall (44 years).

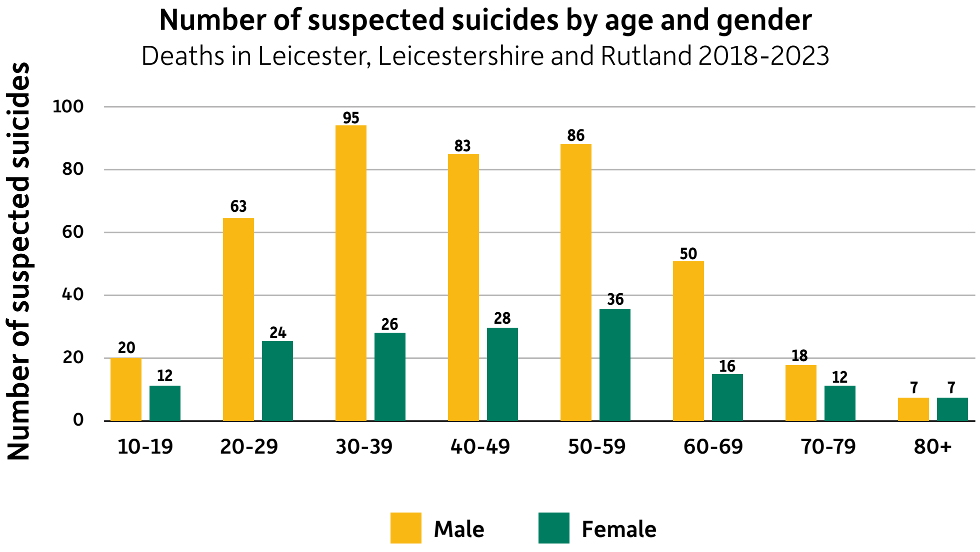


Figure 3 - Numbers of suspected suicide across LLR 2018-2023 by age category and gender

Gender

Nationally, almost 75% of suicides are by men, and this is mirrored locally, with ONS data showing 74.6% of local suicides being in males (figure 4). This can also be broken down by area (figure 5).

KEY MESSAGES

4 Some people are at higher risk of suicide

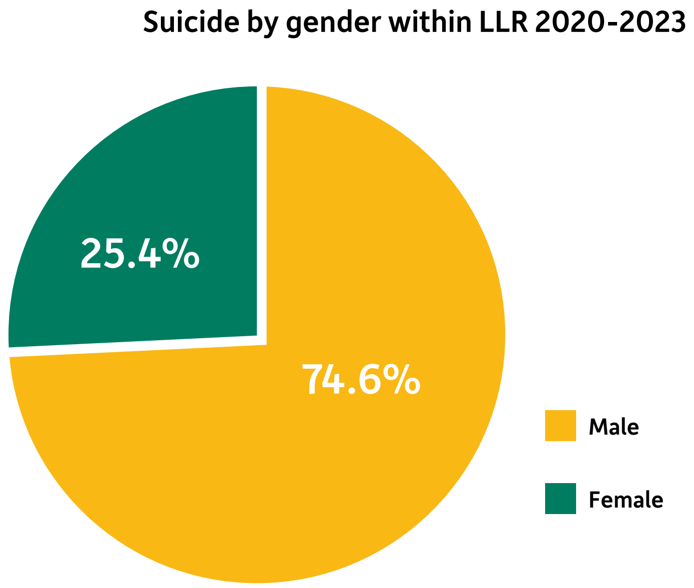


Figure 4 - Suicide by gender split 2020-2022

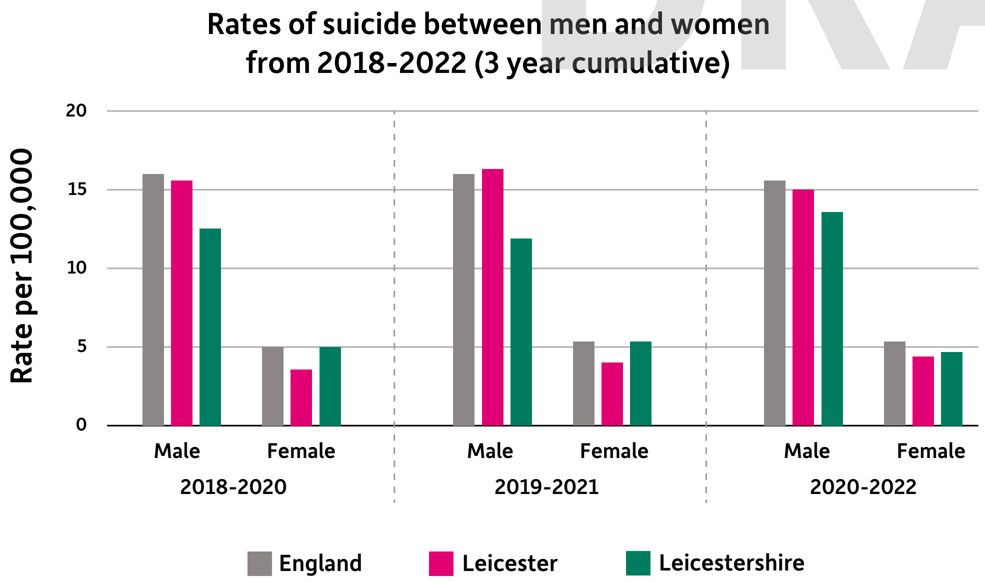


Figure 5 - Suicide rates by gender 2018-2022

Self harm and previous attempts

Self-harm and previous suicide attempt categories within the RTSSSD were only recently separated, therefore data is only available for 2023. Analysis of 2023 data shows that 42% of suspected suicides had a history of self-harm, with a similar proportion (41.2%), having a history of attempting suicide. This demonstrates the significance of the risk factors of self-harm and previous attempts in future deaths.

The Leicestershire and Rutland Adult Mental Health JSNAs estimates 40,000 people to be self-harming and/or attempting suicide per annum[19], with Rutland estimated to be 2,000.[20] Recently, both Leicester and Leicestershire have become significantly worse than the England average for intentional self-harm.

Other factors – key headlines

Other risk factors are also apparent within the RTSSSD and highlight the complexity of suicide, and the intersectionality that could be at play:

Marital Status

- Between 2018 and 2023, 51.6% of Leicestershire deaths, 62.9% of Leicester City deaths and 50% of Rutland deaths occurred in single people. Married people accounted for 18.3% in Leicester City, 26.1% in Leicestershire. 2.2% of all suspected suicides in LLR occurred in those in civil partnerships. This could demonstrate the importance of relationships as a protective factor in suicide.

Unemployment

- Employment is important, with 44.6% of suspected suicide deaths between 2018 and 2023 being in those categorised as unemployed. This is highest within Leicester City with 54.8% of deaths being in the unemployed.
- The majority of the unemployed that died by suspected suicide were unemployed for more than 3 years.

KEY MESSAGES

5 Mental health is as important as physical health

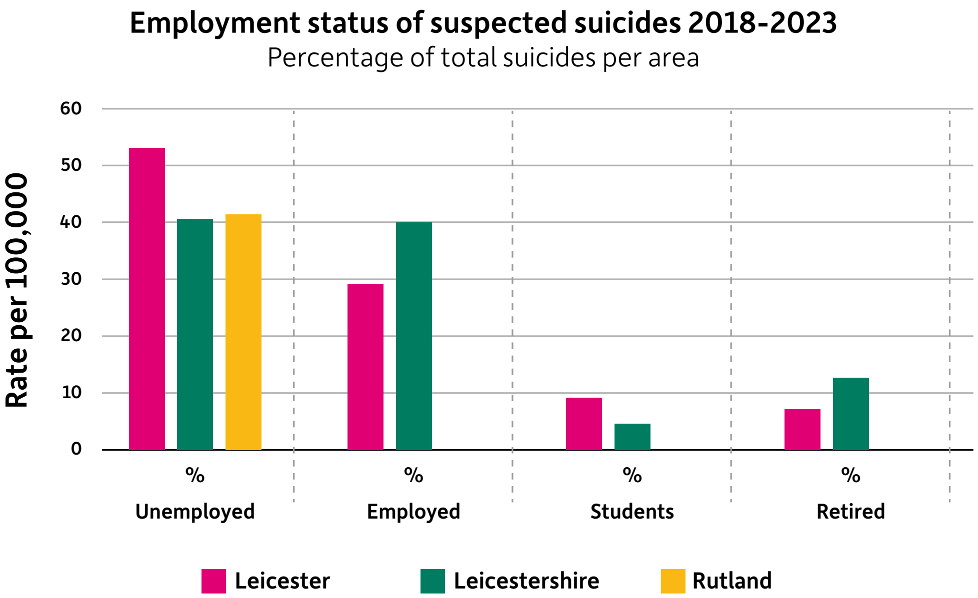


Figure 6 - Suspected suicides by employment status, per area

Financial situation

- Based on 2023 RTSSSD data, 28.6% of suspected suicides were experiencing financial difficulty across LLR. The proportions were higher in Leicester City residents (29.7%) compared to Leicestershire residents (26.7%).

Mental Health Services

- The importance of mental health services engagement and leadership in suicide prevention strategies is highlighted by our local RTSSSD data. This shows higher values than national in suicides of people who were in contact with mental health services prior to their death. Nationally 26% of all deaths by suicide were people in contact with mental health services, however within Leicestershire this value is 43.3%, 46.2% in Leicester City and 41.7% in Rutland. Mental health services also have specialist skills in the assessment and management of risk as it relates to suicide and self-harm. Further exploration of the data is needed to understand this difference.

Suicide Audit and Prevention Group

This is a **system**-wide strategy, which is overseen and delivered by the LLR Suicide Audit and Prevention Group (SAPG). The SAPG draws on expertise from the public, private and voluntary sectors. It works as a multi-agency group and as a wider network. The SAPG is responsible for suicide prevention activity development and implementation.

System includes all the organisations (statutory, public and voluntary), settings and resources which are devoted to promoting, sustaining or restoring health, as well as preventing ill health. A system works together to address challenges and help improve the health of the population and the individual.

Core membership of the SAPG and associated sub-groups strives to include:

- Voluntary sector organisations with an interest in mental health, supporting people at risk of suicide and those bereaved by suicide
- Public Health, (Leicester City Council, Leicestershire and Rutland County Councils)
- Leicester, Leicestershire and Rutland Integrated Care Board
- Local Authority commissioners of mental health services (Adult Social Care)
- Safeguarding experts
- Secondary care
- Military and Veterans representatives
- Mental Health Providers (Leicestershire Partnership NHS Trust)
- Criminal Justice System, including Leicestershire Police and Probation
- Services and local prisons
- Emergency services (East Midlands Ambulance Service)
- Universities (University of Leicester, De Montfort University, Loughborough University)
- District councils
- Other local authority services such as education psychology and business intelligence
- British Transport Police

KEY MESSAGES

6 Early intervention is vital

Our Suicide Prevention Approach 2024-2029

Mission

There is no acceptable number of suicides, and we believe that suicide does not have to be inevitable. That being said, we do need to be realistic about what can be achieved with the challenges that we face and the resources that we have. We also acknowledge circumstances out with our control which have severe and devasting effects, such as pandemics and austerity measures. We cannot put a number or target on suicide reduction due to this but strive on our mission to "**prevent suicide and save lives**".

Key messages

From reading this strategy, there are several key messages we want people to remember and share where they can. We need to raise the profile of suicide prevention, and reduce the stigma attached to suicide, and more widely around mental health. We want people to talk about their mental health and not be afraid to reach out for help. Some of these are local key messages, whilst others reflect the messages within the national strategy:

1 Suicide is everybody's business

We challenge attitudes to suicide by improving knowledge of suicide risk behaviour and the signs of mental illness. We will work together to maximise our collective impact and support, to prevent suicides within LLR, intervening as early as possible. Everyone should feel confident and have the skills to help prevent suicide.

2 Suicide can be preventable

Suicides are not inevitable. We need to build individual and community resilience and support those at higher risk. Suicide rates can be influenced by external factors outside of our control; however, it is important to be accountable and deliver actions to mitigate circumstances where possible and reduce suicides.

3 Suicide has a wide impact

Over the last three years, on average 90 people died per year from suicide in Leicester, Leicestershire and Rutland. The reverberations from suicide are felt far and wide, impacting on individuals, families and communities, with an estimated 10 people intimately affected by every suicide. The impacts are also financial, including costs of care, loss of productivity and earnings and are felt by local businesses, individuals and communities.

4 Some people are at higher risk of suicide

Suicide risk is higher in particular groups – men are 3 times more likely to die by suicide than women. It is important to target and tailor resources at our local higher risk groups, and that individual needs and experiences are considered in the design and delivery of local services. Those bereaved by suicide are also at higher risk.

5 Mental health is as important as physical health

We must reduce stigma surrounding suicide and mental health, increasing the value put on positive mental health, so people feel able to seek help – through the routes that work best for them. This includes raising awareness that no suicide is inevitable.

6 Early intervention is vital

Although providing support to those in crisis or having suicidal thoughts is essential, we need to act as early as possible to stop people from reaching this point.

Our Suicide Prevention Approach 2024-2029

Plan on a page

Guiding principles

- Co-Production and Collaboration
- Learn from past stories
- Data driven
- Normalising conversations
- Settings-based approach
- Trauma Informed Practice and Care

Our mission from this strategy is to prevent suicide and save lives across Leicester, Leicestershire and Rutland

Key Priorities

- Children and Young People
- High Risk Groups and Locations
- Self-Harm
- Bereavement
- Leadership

Key Messages

- Suicide is everybody's business
- Suicide can be preventable
- Suicide has a wide impact
- Some people are at higher risk of suicide
- Mental health is as important as physical health
- Early intervention is vital

Guiding Principles

Our strategy was developed through research, insight and engagement. During the process key themes kept arising, which we felt as a partnership should guide our work. Rather than being priorities, these are principles which should underpin our work, and help us deliver on our priorities, and ultimately achieve our mission to prevent suicide and save lives. Although not mentioned explicitly, upskilling individuals and organisations is crucial in our delivery and will form key aspects within our actions to deliver the priorities.

1

Co-Production and Collaboration

Meaningful and authentic lived experience involvement will underpin everything we do and will be viewed as an essential part of delivering effective services and interventions.

2

Learn from past stories

We will seek to understand our local suicides and the intersectionality of contributory factors, including wider determinants of health such as social and economic challenges. Future work will be shaped by this and informed by the realities of those affected.

3

Data driven

Our work will be driven by our understanding of local data, and the current and emerging evidence base to reduce suicides. We will target our work using data and evidence, ensuring we reach those that need help the most.

Trauma Informed Practice (TIP) is an approach that recognises and responds to the impact of trauma on an individual. It involves recognising, understanding and responding to the effects of all types of trauma in a way that emphasises safety, trust and empowerment, whilst avoiding traumatisation.

4

Normalising conversations

We will strive to reduce stigma and taboo around suicide and mental health and encourage people to Start a Conversation. This will be instrumental to all of our work and our priority areas. We will ensure approaches are culturally appropriate and sensitive, recognising and respecting diverse needs, values and beliefs in our communities. We will work with local media on aspects of mental health and suicide, ensuring stories are portrayed sensitively and safely, in line with current guidance, and challenge inappropriate reporting and conversations where necessary.

5

Settings-based approach

We will adopt a settings-based approach to integrate suicide prevention activity into local communities, organisations and sectors, emphasising education, awareness and training, with a strong focus on early intervention, and local leadership.

6

Trauma Informed Practice and Care

We will work to adopt a Trauma Informed Approach in our interactions, delivery and commissioning: understanding past experiences and the needs of the people we serve, including being sensitive to any trauma they may have experienced.
By offering support early and being thoughtful in how we provide care, we can help improve lives.

Key Priorities

Our priorities reflect areas which are most important to our stakeholders and those with lived experience, whilst also being data driven. Our priorities are areas which we believe we can directly have an impact on. When devising this strategy, a conscious effort has been made to ensure it is ambitious but also realistic. Our priorities will be driven by our guiding principles.

A robust action plan will bring partners together to ensure our priorities are achieved. We will strengthen approaches through leadership, effective training, proper use of communications and media, and supporting others to take accountability and understand their role in relation to suicide prevention and the priorities below.

Our priorities are:

1

Enabling partners, including educational establishments, to use sound evidence and proven measures to target and support children and young people at risk of suicide

Although numbers are small, the national increasing trend is a concern locally. Early interventions, and person-centred support for younger populations can lead to improved mental health and wellbeing, improved resilience and the ability to self-help, both now and into their adult lives. We want to build on the recommendations from the LLR Child Death Overview Panel, and work across the system to support partners to put measures in place to reduce suicidal ideation and behaviours. We want to understand the local system and ensure that suicide becomes everybody's businesses.

We want to normalise conversations around mental health from an early age and equip partners with tools and expertise around building resilience in our children and young people, as well as supporting other factors such as bullying, including cyber bullying, and educating young people on signs and symptoms of poor mental health and where to get help.

2

Targeted support and resources at higher risk groups and locations, as identified by local and national data and evidence

Suicide, and the reasons behind are extremely complex, numerous and interlinked. However, by using national data, our RTSSSD and academic literature we can continue to understand the risk factors, higher risk groups and high-risk locations. We will identify and target high risk groups and risk factors, which may include, but are not limited to:

- Middle-aged men
- People in contact with mental health services
- People with substance use challenges
- Autistic people
- Unemployed
- Those in financial hardship
- People experiencing harmful gambling
- Those with access to means, such as particular job sectors
- Veterans and those in the armed forces
- Impact of rurality, especially around loneliness and isolation
- Those within the agricultural and farming industries
- Care leavers
- People who have experienced domestic abuse
- People who have experienced sexual abuse
- Gypsy Roma Travellers

In addition to the higher risk groups listed above, we will remain open to new data that might highlight other groups. We will improve our data utilisation and understanding, taking into account intersectionality of factors that contribute to suicide. We will learn from past stories and put this learning into practice, targeting those higher risk groups, addressing risk factors and working with other organisations to expand our reach. Using a settings-based approach will be crucial to any intervention development and delivery. By working with different settings to strengthen community action, develop skills and knowledge (through training) and create supportive environments, we aim to have a larger impact.

By understanding where local suicides occur, we will continue our work on high-risk locations, aiming to put prevention plans in place. In the County, through our work on Health in All Policies we will work with planning colleagues on highway design, ensuring suicide is factored in through health impact assessments of planning policy and local design.

Outside of this priority, we will continue to make sure suicide is everybody's business to ensure those that do not fit into any high risk categories are not forgotten.

3

Improve our local understanding of self-harm and support people with a history of self-harm

People with a history of self-harm are a key high-risk group, as demonstrated by national and local data. Locally we will work to understand our self-harm rates better, especially regarding data, whilst also working with local services and people with lived experience of self-harm.

Ultimately, we aim to improve the support on offer to people with a history of self-harm, across all age groups, ensuring their needs are met within a timely manner.

4

Providing effective bereavement support to those affected by suicide

Every suicide can have a profound and traumatic effect on those close to the individual, as well as the wider community. This puts people experiencing suicide bereavement at risk themselves.

We will continue to develop and deliver the local suicide bereavement offer and ensure lived experience voice is captured and used. We will work on national guidance around how best to support those bereaved by suicide including providing effective and timely support and providing effective local responses to the aftermath of suicide.

5

Leadership - Work with partners and communities to support their role within suicide prevention.

We will work with key organisations, partners and the community to ensure suicide is considered a priority and everyone has an appreciation of their role within suicide prevention. Working as system leaders, we will act collectively to drive change across LLR.

It is crucial to work with our system partners and communities to understand their influences to supporting suicide prevention. We will guide them and provide access to resources and further support, such as training and communications and ensure they are engaged with our Start a Conversation campaign.

The whole is greater than the sum of its part, therefore working collaboratively is key for us achieving our aim of ‘preventing suicides and saving lives’.

How will we monitor and measure success?

A robust action plan will be developed and refreshed annually, to provide tangible and measurable actions. There will also be annual progress reports. Overall numbers of suicides will continue to be monitored and actions put in place to address new and emerging trends.

The action plan will be overseen by the SAPG and discussed as a standing agenda item. Progress against the strategy will also be reported to the relevant Health and Wellbeing Boards and place-based Mental Health meetings and collaboratives.

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Thank you to all partners involved in the creation of this strategy and who work together locally to prevent suicide and save lives.

Leicestershire County Council

Leicester City Council

Rutland County Council

Thank you to all others who have contributed to the strategy and whose voice has helped shape it.

LLR Suicide Prevention Strategy

Presentation to the Health and Wellbeing Board

NOTE: Last updated 20/2/2025
Prepared by:
***Mark Wheatley** Mark.Wheatley@Leicester.gov.uk*
Division of Public Health, Leicester City Council

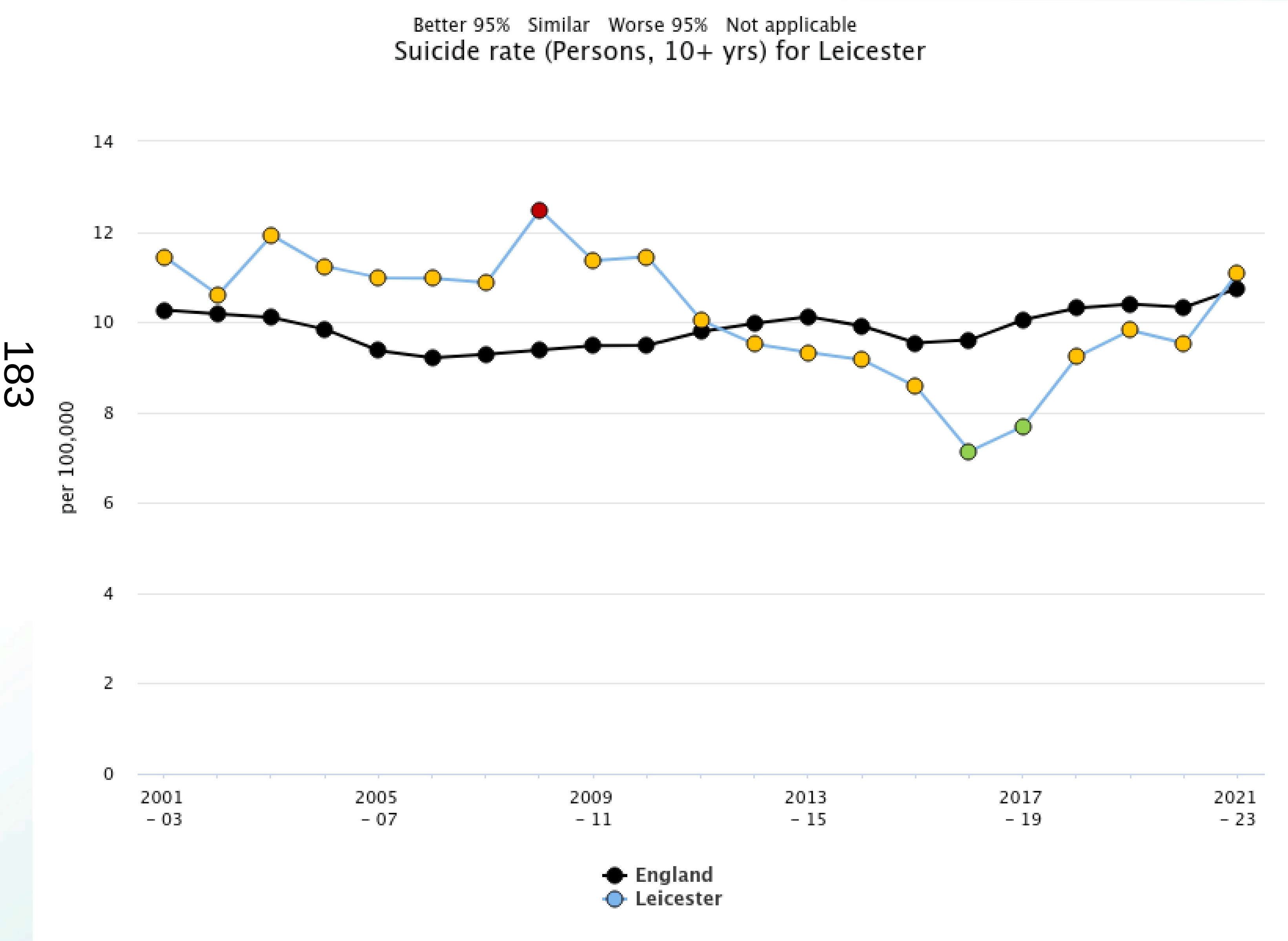
Leicester
City Council

Suicide Prevention

- Our ambition is to make suicide everybody's business. empowering, educating, and equipping individuals and organisations to support suicide awareness and prevention.
- Latest data for Leicester.
- Real time surveillance data for Leicester, Leicestershire and Rutland.
- Update on the new LLR Suicide Prevention Strategy.

Suicide rate (persons)

Leicester | Directly standardised rate - per 100,000 | ONS



- The suicide rate for all persons in Leicester was 11.1 per 100,000 population for the period 2021 – 2023.
- This rate is not significantly different to the national average suicide rate of 10.7 per 100,000 population.
- The suicide rate in Leicester has been gradually increasing since 2020

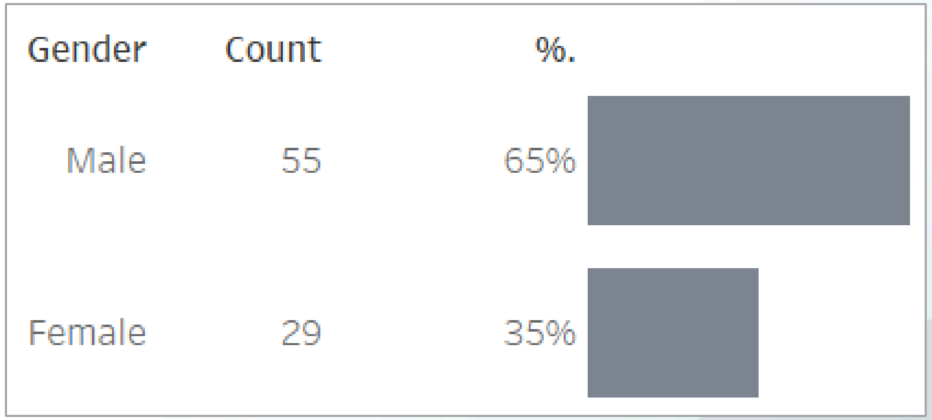
Suicide Prevention in LLR

- Local strategy is overseen by the Suicide Audit and Prevention Group.
- Our local suicide prevention work benefits from Real Time Suspected Suicide Surveillance data.

Unexpected deaths in all persons

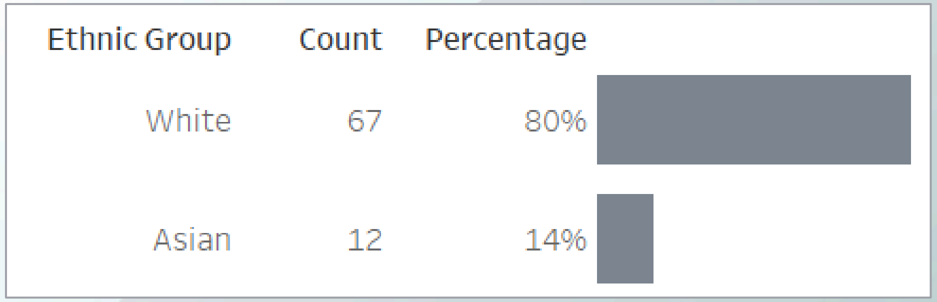
RTSSSD | Leicester, Leicestershire & Rutland | 2023

RTSSSD by Gender | 2023



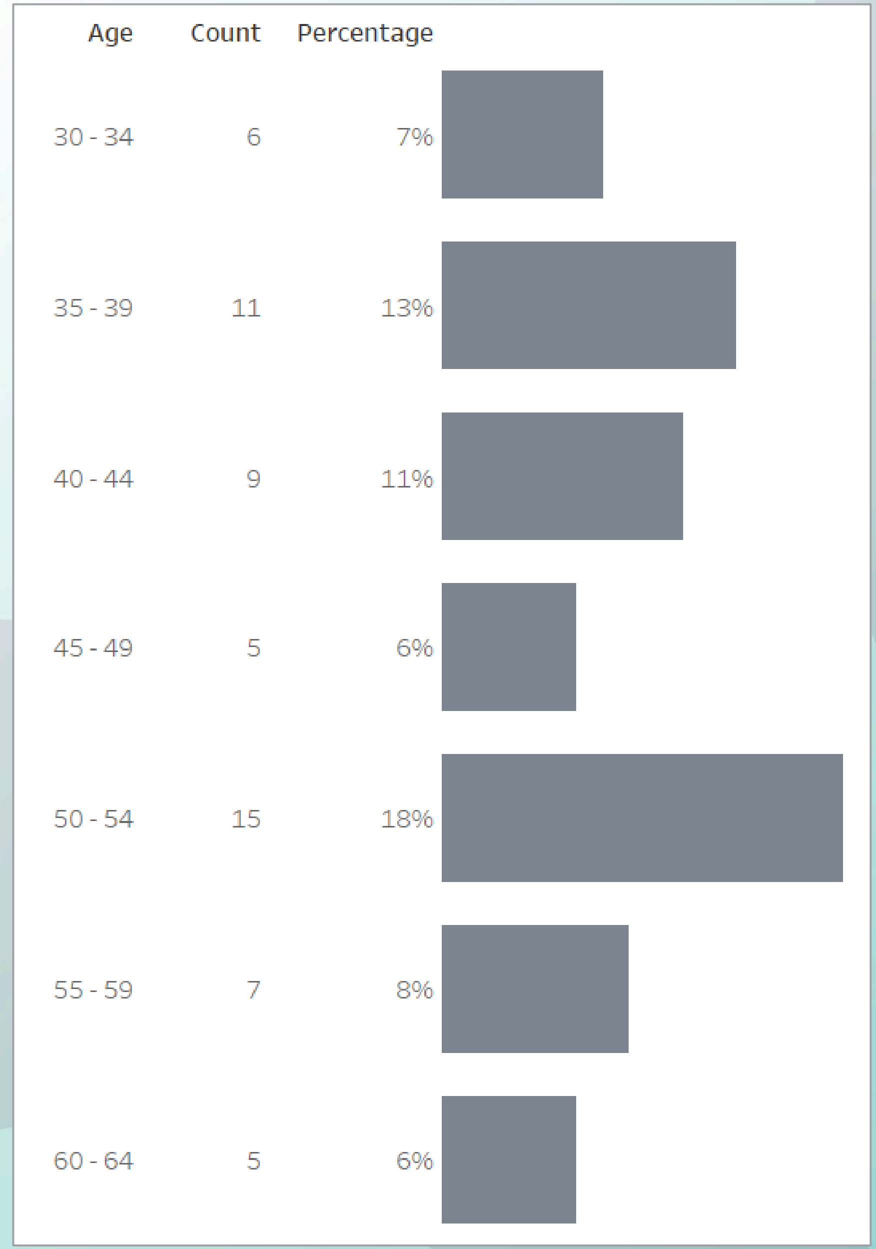
Gender	Count	%.
Male	55	65%
Female	29	35%

RTSSSD by Ethnicity | 2023



Ethnic Group	Count	Percentage
White	67	80%
Asian	12	14%

RTSSSD by Age | 2023



Age	Count	Percentage
30 - 34	6	7%
35 - 39	11	13%
40 - 44	9	11%
45 - 49	5	6%
50 - 54	15	18%
55 - 59	7	8%
60 - 64	5	6%

National Suicide Prevention Strategy

Ambitions to:

- Reduce the suicide rate over the next 5 years – with initial reductions observed within half this time or sooner.
- Continue to improve support for people who self-harm.
- Continue to improve support for people who have been bereaved by suicide.

Priorities in the National Suicide Prevention Strategy

- Improving data and evidence to ensure that effective, evidence-informed and timely interventions continue to be developed and adapted.
- Tailored, targeted support to priority groups, including those at higher risk, to ensure there is bespoke action and that interventions are effective and accessible for everyone.
- Addressing common risk factors linked to suicide at a population level to provide early intervention and tailored support.

Priorities in the National Suicide Prevention Strategy

- Promoting online safety and responsible media content to reduce harms, improve support and signposting, and provide helpful messages about suicide and self-harm.
- Providing effective crisis support across sectors for those who reach crisis point.
- Reducing access to means and methods of suicide where this is appropriate and necessary as an intervention to prevent suicides.
- Providing effective bereavement support to those affected by suicide.
- Making suicide everybody's business so that we can maximise our collective impact and support to prevent suicides.

Risk factors and high-risk groups

Children and young people

Middle aged men

Autistic people

Pregnant women and new mothers

Other risk factors

- People who misuse alcohol and drugs
- Armed forces personal and the veteran community
- Female nurses
- Financial instability and hardship, including unemployment
- Relationship breakdown
- Homelessness
- LGBTQ + people
- Domestic abuse
- Childhood abuse, sexual trauma, and combat-related trauma are all associated with increased suicide risk.
- Gypsy or Irish Travellers

LLR Strategy key messages

- Suicide is everybody’s business
- Suicides are not inevitable.
- Suicide has a wide impact
- Some people are at higher risk of suicide
- Mental health is as important as physical health
- Early intervention is vital

Guiding principles

- Co-Production and Collaboration
- Learn from past stories
- Data driven
- Normalising conversations
- Settings-based approach
- Trauma Informed Practice and Care

Key Priorities

- Enabling partners, including educational establishments, to use sound evidence and proven measures to target and support children and young people at risk of suicide.
- Targeted support and resources at higher risk groups and locations, as identified by local and national data and evidence.
- Improve our local understanding of self-harm and support people with a history of self-harm.
- Providing effective bereavement support to those affected by suicide.
- Leadership - Work with partners and communities to support their role within suicide prevention.

‘About You’

Gender and Sexuality

Female 83%
Male 16%
Another term 1%
Gender same as sex assigned at birth 100%
Heterosexual 94%

Age

15-24	4	3.6%
25-34	12	10.7%
35-44	26	23.2%
45-54	24	21.4%
55-64	31	27.7%
65-74	11	9.8%
75-84	4	3.6%

34% care for a person aged 17 or under

24% care for some aged 18 or over

Address

Blaby	5	9.1%
Charnwood	12	21.8%
Harborough	5	9.1%
Hinckley and Bosworth	7	12.7%
Leicester	13	23.6%
Melton	4	7.3%
North West Leicestershire	5	9.1%
Rutland	4	7.3%

Ethnicity

Asian or Asian British	12	10.4%
Black or Black British	2	1.7%
Mixed	3	2.6%
Other ethnic group	4	3.5%
White	94	81.7%

30% have a long standing illness, disability or infirmary

Religion

Any other religion	3	2.6%
Christian (all denominations)	47	40.9%
Hindu	2	1.7%
Muslim	11	9.6%
No religion	50	43.5%
Sikh	2	1.7%

Overall, to what extent do you agree or disagree with our draft Suicide Prevention Strategy 2024-29?

“Lets get this done”

Positive feedback	Room for improvement
• Good priorities	• Need to be more ambitious
• Looking forward to seeing change	• Focus on wider determinants
• Important	• Gain more funding for projects
• Comprehensive	• Teach self-esteem and resilience
• Evidence based	• Focus on male suicide
• Well written with an empathic tone	• Reduce barriers to accessing mental health support
• Excellent key messages	
• Easy to understand	
• Co-ordinated response	

Focus groups

3 FOCUS GROUPS (TOTAL 13 PARTICIPANTS)

- LIVED EXPERIENCE NETWORK
- SURVIVORS OF BEREAVEMENT BY SUICIDE (SOBS)
- YOUTH ADVISORY BOARD

Summary :

- The feedback on the strategy was extremely positive.
- The key messages resonated, with particular note to 'suicide is everyone's business', which participants felt was extremely important, especially in relation to breaking down stigma and ensuring people can access services when they need them.
- The SoBS group would like to see better interaction between services and family members when someone is in crisis, so that they can put measures and more support in place to mitigate suicide risk.
- There were practical comments and discussions on service provision such as MH services and CAMHS.
- Participants were happy with the inclusion of some groups, including those with autism and ADHD.

Key themes:

1. Access to Services and the Role of Organisations

- People felt that schools needed to play a bigger part within mental health and suicide prevention, however it was acknowledged that more services needed to be present in schools for young people to access.
- Bullying within schools needs to be addressed.
- Accessing services needs to be easier.

2. Suicide is Everyone's Business

- Participants felt that everyone has a role to play within suicide prevention, and by using the guiding principles, everyone can help prevent suicide.
- Training needs to be available for everyone to understand suicide and help to prevent it.
- Recognising the above has the ability to tackle stigma and taboo.

3. Supporting everyone

- Support needs to be in place for parents, carers and relatives, to raise awareness of key signs and symptoms, what they can do and where they can go for support
- Young people need to have trusted adults which they can go to for help and support

4. Delivery

- Questions were asked around how the strategy will be implemented and monitored.
- The strategy was acknowledged as being ambitious, and participants wanted assurance that it would be delivered upon.

Thank You

Leicester
City Council

Appendix E

Leicester
City Council

LEICESTER CITY HEALTH AND WELLBEING BOARD
DATE

Subject:	The Centre Project BCF funding report
Presented to the Health and Wellbeing Board by:	Eric Waweru
Author:	Eric Waweru

Does the report concern any of the below groups?			
Severe Mental Illness	Learning Disability	Homelessness	Care Experience Children and Young People
☒	☒	☒	☐

EXECUTIVE SUMMARY:

A summary report on the activities of the Centre Project

RECOMMENDATIONS:

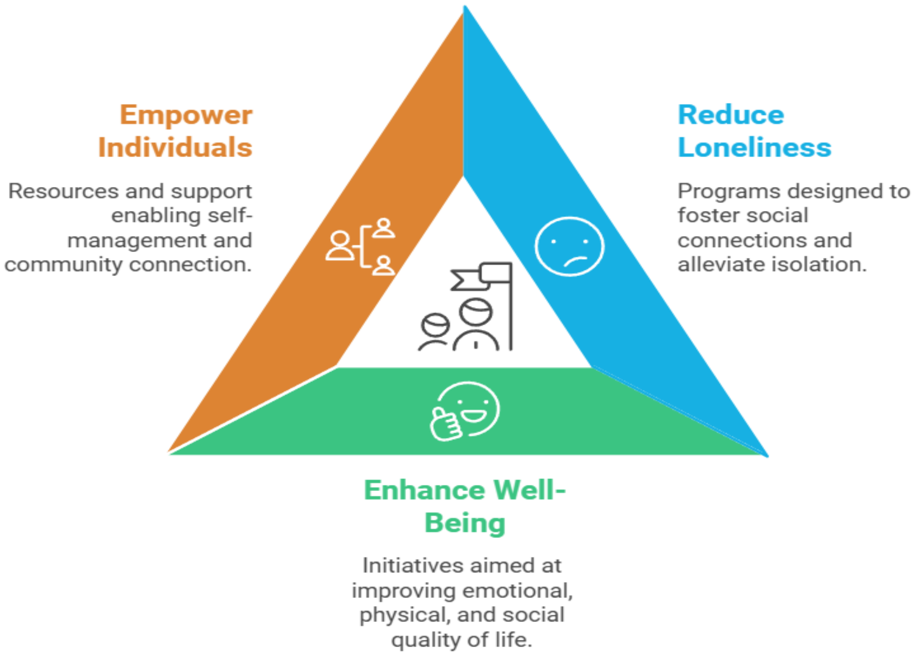
The Health and Wellbeing Board is requested to:

- Note the report
- Consider ongoing support for the project

The Centre Project
Reducing Isolation
Promoting Wellbeing

Appendix E

Our Mission



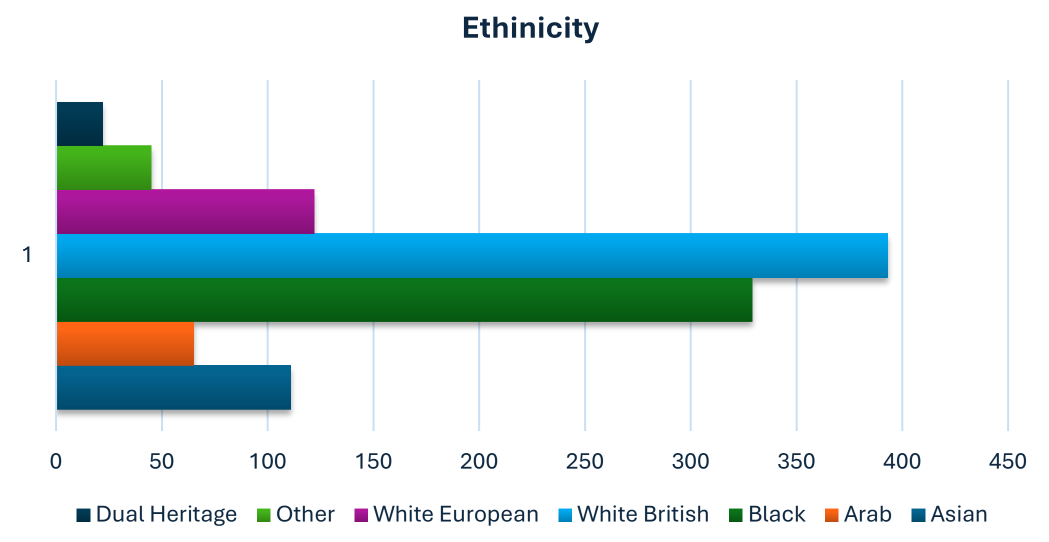
The Centre Project received funding from the BCF fund to provide an open-access, warm & welcoming space for people facing loneliness, mental ill health, homelessness, food insecurity, poverty, and new arrivals to the city. The aim is to enable people to get support at a time of crisis or critical moment and reduce the need to access emergency or other services.

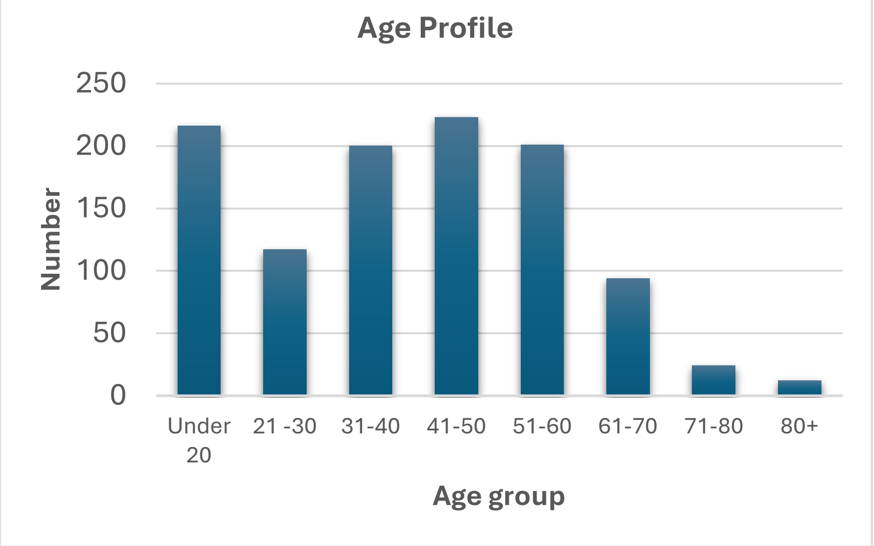
The current funding covers the cost of opening the Centre for 1 day a week for one year.

The Centre Project
Reducing Isolation
Promoting Wellbeing

Number of unique Individuals supported – 1,085.
Number of visits to the Centre Project – 10,426

♀ 78% ♂ 22%


Ethinicity


Age Profile

Support/service provided	Attendees
Appointments with external agencies (at the Centre Project)	75
Bus pass applications	25
Debt/money management – help with budgeting and managing debts	78
Digital support – access Wi-Fi, creating email accounts, scanning documents	158
Energy issues – fuel top-up vouchers, warm home discounts, meter readings	35
Homelessness – preventing evictions and accessing emergency accommodation	45
Housing issues – dealing with complaints, repairs, finding suitable place to live	199
Signposting & referrals to other agencies e.g. Adult social care, emergency food	120
Small grant applications – for household items e.g. cooker, fridge, washing machine	18
Telephone Access – to reach other services e.g. Housing options, DWP	1,024
Welfare benefits – application, dealing with sanctions, late payments	95

Client feedback

Thank you for everything you have done for me, I can always rely on you guys when I need anything ‘I really appreciate it. Thankyou

MR

Our team addresses a wide range of support needs for our clients. Those seeking our help often have multiple needs, and our goal is to ensure they feel safe, supported, empowered, and satisfied when engaging with other services. We take a person-centred approach – placing the individual at the core of our efforts – and ensure that the support provided achieves the right outcomes, manages any risks, and delivers high client satisfaction.

Case Study: EH

EH is a 43-year-old man with a history of non-engagement with the LCC Housing team, despite multiple attempts to engage him. This led to rent arrears of over £2,000 and a possession order by the LCC. We facilitated a meeting between EH and the LCC housing support officer at The Centre, where he felt comfortable, and supported him during the meetings. We also assisted him in attending Leicester Crown Court. With our support, EH developed a rapport with his LCC Housing Support Officer and Rent Officer. They supported him to apply for PIP and a Charity Link grant for furniture items. EH continued to access the foodbank while making regular payments towards his rent. Consequently, EH's LCC Housing Support Officer helped him to apply for a Discretionary Housing Payment (DHP). EH adhered to the payment arrangement and maintained engagement, resulting in the DHP being honoured and his housing arrears being wiped out.

Case study: RV

RV, a 54-year-old woman, has struggled with anxiety, low self-esteem, depression, and drug addiction. She regularly visited the Centre Project to talk to our Mental Health Support Worker. Her issues stem from various environments, family problems, physical health issues, and domestic abuse. RV expressed a desire to address her drug and alcohol problems. She was referred to local services for the necessary support and encouraged to keep attending meetings. She also joined the drama and creative writing groups, which she enjoyed, rarely missing creative writing classes except for appointments.

Case Study: PS

PS accessed the day centre in severe dental pain, contemplating extracting his teeth himself due to the discomfort. Recognising the urgency, we supported PS to find a dentist who was accepting NHS patients. With our assistance, he successfully registered and received the necessary treatment.

Case Study: MR

MR had isolated himself due to his mental health, which led to his Engage account with Clockwise being transferred to a new provider without his knowledge. During this period, he did not notify the DWP and, as a result, did not receive his monthly payment. We supported MR in obtaining the new account details and liaised with Universal Credit. An appointment was set with the local jobcentre, and within 48 hours, a payment was made into his new account.

LEICESTER CITY HEALTH AND WELLBEING BOARD
DATE

Subject:	'What You Saying?' Young Voices on Healthcare. LLR ICB Engagement Project
Presented to the Health and Wellbeing Board by:	Jacob Brown, Children, Young People and Families Engagement Officer. NHS LLR ICB
Author:	Jacob Brown, Children, Young People and Families Engagement Officer. NHS LLR ICB

Does the report concern any of the below groups?			
Severe Mental Illness	Learning Disability	Homelessness	Care Experience Children and Young People
x	x	☐	x

EXECUTIVE SUMMARY:

The NHS in Leicester, Leicestershire, and Rutland (LLR) launched a large-scale engagement to better understand the health and wellbeing needs of children and young people aged 11-25, along with their families and the healthcare staff who support them. This initiative aimed to gather insights into their experiences, priorities, and challenges in accessing healthcare, ensuring their voices shape future services.

Key statistics from the research

Overall Engagement stats
- 3002 people in total took part.
- 2239 Children and Young people
- 682 Parent/Carers
- 81 Healthcare Staff

Young people generally have a positive view on their experiences of healthcare, but there is room for improvement. Parents and carers, however, are less satisfied.

Mental health is a major concern, with issues like school pressures, social media, cyberbullying, and family breakdown affecting well-being.

Poor sleep is also a concern, which can impact on children and young people's physical and mental development.

When young people feel ill, they primarily seek health advice from parents, by google is never far way.

More needs to be done around information about accessing mental health services.

Young people said they want to be heard and taken seriously by health professionals, although some feel they aren't.

A lot of young people and families reported that they have to tell their story again when transferring to new health services and transitioning from child to adult mental health services in not clear.

Healthcare professionals need better support, including mental health resources, improved referral systems, and stronger collaboration across organisations.

RECOMMENDATIONS:

The Health and Wellbeing Board is requested to:

For information and dissemination to partners teams

Data evaluation project for Children and Young People and Families' voices on health care across Leicester, Leicestershire and Rutland: Report of Findings

The Centre for Public Innovation

September 2024

The Centre for Public Innovation is a Community Interest Company that provides research, training, support and advice in the fields of health, social care, criminal justice and community development.

Our mission is to improve the outcomes of services for their users, with a particular emphasis on the most disadvantaged.

Contents

Glossary

ADHD	Attention Deficit Hyperactivity Disorder
ASD	Autism Spectrum Disorder
CAMHS	Child and Adolescent Mental Health Service
CYP	Children and young people
EHCP	Education Health and Care Plan
LLR ICB	NHS Leicester, Leicestershire and Rutland Integrated Care Board Integrated Care Board
LGBTQ+	Lesbian, Gay, Bisexual, Transgender and Queer/Questioning
LLR	Leicester, Leicestershire and Rutland
PMLD	Profound and multiple learning disability
SEND	Special educational needs and disability
UASC	Unaccompanied asylum-seeking children

1. Executive Summary

Young people today navigate a world vastly different from that of older generations, influenced by distinct social, political, and technological factors. They occupy and operate in unique spaces, often rendering traditional engagement methods and timelines ineffective.

To understand how children and young people (CYP) experience their healthcare, it is crucial for Leicester Leicestershire and Rutland's (LLR) NHS to actively engage and incorporate CYP voices and participation. LLR faces numerous health inequalities, particularly among the Core20PLUS5[1] cohort of CYP, and there is a significant need to integrate prevention into every pathway.

The NHS Leicester, Leicestershire and Rutland Integrated Care Board (LLR ICB) publicly engaged young people, their parent/carers and healthcare professionals who work with them to answer the question:

"What do we need to do to improve the health outcomes of children and young people in Leicester, Leicestershire and Rutland?"

In total 3,002 people across the LLR area participated in the engagement. Participants comprise:

2,239 – children and young people

682 – parents and family carers of children and young people

81 – staff caring for children and young people

People participated through a number of methods shown below:

Children and young people

- 1,884 completed an online survey.
    - 1,775 completed the main version of the survey (Online: 872, Hardcopy: 903)

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[1] Core20PLUS5 is a national NHS England approach to support the reduction of health inequalities at both national and system level. The approach defines a target population cohort and identifies '5' focus clinical areas requiring accelerated improvement.

    - 109 online easy read version of the survey
- 355 participated in focus groups and other activities

Parents and family carers

- 659 completed an online survey
    - 632 completed the main version of the survey (Online: 617, Hardcopy: 15)
    - 27 completed an online easy read version of the survey
- 23 participated in focus group and other activities

Health Professionals

- 81 completed an online survey

Key headline findings

Overall Assessment of Health Services

Children and young people (CYP) generally hold a positive view of healthcare services. A significant majority (73.6% n= 1,335) rated their last health service encounter as good or excellent, and 69.5% (n= 1,135) rated their overall healthcare experience positively. Parents and carers were slightly less positive, with 59.8% (n = 364) rating their child's last service encounter positively and 52.2% (n=287) giving an overall positive assessment. Despite some concerns, the overall sentiment towards healthcare services among young people is favourable.

Health Concerns of Children and Young People

Mental health emerged as the most pressing concern across all groups, with 60.8% (n=1,103) of CYP, 92.1% (n=605) of parents, and 90% (n=72) of professionals identifying it as a key issue. Sleep was identified as the second most important issue, with significant concern from both CYP and parents.

Knowledge of How to Access Healthcare Services

A majority of young people (78.8% n= 1,399) know how to access healthcare services, with 59.7% (n= 983) knowing how to access mental health services. Parents/carers also showed high awareness, with 88% (n=566) knowing how to access health services for their child. Most young people (59.9% n=1,118) would turn to parents/carers first when facing a health concern, highlighting the critical role parents play in healthcare access. However, nearly a quarter (22.3% n= 417) said they would search online first.

Health Services Used

The most commonly used health services were dentists (74% n=1,363) and GPs (72.9% n=1,344). A notable 25% (n= 461) of young people reported using A&E in the past year.

Waiting Times and Access

Long waiting times for both primary and secondary care were a major concern. Difficulty in getting GP appointments was frequently reported, with some young people giving up on trying to secure appointments. Secondary care wait times also varied significantly.

Being Listened To

Young people value being listened to and having their concerns taken seriously. While 68% (n= 1,231) felt listened to, 12.4% (n=225) did not. This discrepancy was also noted by parents/carers and professionals, indicating a need for better communication.

Caring and Compassionate Staff

Kindness and compassion from staff significantly impact young people's perception of healthcare. Approximately 74.3% (n= 1,344) felt they were treated with care and concern, though parents/carers reported a slightly lower rate (68.6% n= 418).

Next Steps and Advice

Many young people (39% n=653) only "sort of" knew the next steps in their treatment, with 17.3% (n= 280) not knowing at all. Communication about post-treatment steps and advice needs improvement.

Onward Referrals

Only 25.4% (n=457) of young people reported getting onward appointments quickly. The quality of referrals was also a concern, with only 35.8% (n= 479) stating that the referred service had details of their condition.

Support for Professionals

Less than half (38.9% n= 28) of professionals felt fully equipped to support young people, citing a lack of mental health resources, improved referrals, and better collaboration.

2. Background and context

2.1 About the scoping and engagement project

2.1.1 Context

NHS Leicester, Leicestershire and Rutland Integrated Care Board (hereafter LLR ICB) undertook a comprehensive engagement process with children and young people (hereafter CYP) to hear about their views on their health and on health care.

The engagement process was aimed at young people aged 11 to 25 years of age.

In parallel with the engagement with young people, engagement was also carried out with parents and family carers of CYP aged 11 to 25 years and with health professionals working with this age cohort. This would enable a 3-dimensional view of services to inform future commissioning and provision of care.

The Centre for Public Innovation (CPI) were commissioned as an independent evaluator to undertake analysis of the data gathered during the engagement process and produce this Report of Findings.

2.2 About the engagement approach

The Children and Young People and Families' voices engagement on health care across LLR was open between Monday 27 November 2023 to Sunday 3 March 2024.

In undertaking a public engagement, the LLR ICB is fulfilling a duty to involve the public. Specifically meeting the duty which statute has placed on the ICB, s.14Z2 of the NHS Act 2006 (as amended):

Public involvement and consultation by ICB:

> (1)This section applies in relation to any health services which are, or are to be, provided pursuant to arrangements made by a clinical commissioning group in the exercise of its functions ("commissioning arrangements")

2) The ICB must make arrangements to secure that individuals to whom the services are being or may be provided are involved (whether by being consulted or provided with information or in other ways):

(a) in the planning of the commissioning arrangements by the group,

(b) in the development and consideration of proposals by the group for changes in the commissioning arrangements where the implementation of the proposals would have an impact on the manner in which the services are delivered to the individuals or the range of health services available to them, and

(c) in decisions of the group affecting the operation of the commissioning arrangements where the implementation of the decisions would (if made) have such an impact.

The engagement also takes into account Article 12 of the United Nations convention on the rights of the child which says every young person has the right to express their views, feelings and wishes in all matters affecting them and to have those views considered and taken seriously. The participation of young people is also protected by law in section 19 of the Children and Families Act 2014 and the Care Act 2014.

In order to maximise the reach of the public engagement and to encourage as many people as possible to participate, a multi-channel approach was used.

A population study was carried out before the engagement to understand the age, ethnicity, religious and protective characteristics demographic of LLR CYP, aged 11-25 years old. This informed the communication and engagement strategy, as well as the VCSE Alliance members the ICB commissioned, to ensure proportional representation in the results.

The Children and Young People and Families' voices engagement on health care used a survey which could be answered by respondents online (using the QuestionPro survey tool, which collected the data from respondents) or offline by completing a printed survey. CYP also had the chance to take part in creative participatory activities and focus groups to share their views. This approach ensured that the NHS heard from those with protected characteristics, the vulnerable and young carers. The vast majority of respondents to the engagement answered the questions online.

A population study was carried out before the engagement to understand the age, ethnicity, religious and proactive characteristics demographic of LLR. This informed the communication and engagement strategies to ensure we had proportional representation in the results.

In addition, the public engagement used a variety of both online and offline tools and techniques to communicate with the CYP, their families and health care professionals across LLR. These included, but were not limited to, the following activities:

- The ICB commissioned a local arts and media youth charity, Pedestrian, to work with their young people to create a relatable engaging look and feel to the campaign which would resonate with their peers. Signed off by NHS Leicestershire Partnership Trusts' (LPT) Youth Advisory Board.
- The ICB partnered with 11 Voluntary Community and Social Enterprise Alliance (VCSE) members to reach into the heart of communities and particularly reach those with protected characteristics, CORE20Plus5, young carers and those communities who are seldom heard.

- Widespread utilisation of social media, including local NHS-owned platforms, VCSE's platforms, Spotted and community pages targeting users of Facebook, Instagram and X (formerly Twitter). Activity and reach across main social media platforms for organic promotion, is circa 80,5043.
- Utilised LPT's CYP text messaging database. Sent out to all contact numbers attached to YP (11-18 years old) patients of CAMHS (4,559) and Paediatrics (4,124) - Total = 8683
- Key partners also promoted the survey including Healthwatch Leicester and Leicestershire and Healthwatch Rutland, local authorities, parish councils and military champions.

- Paid-for social media and Digital Ad Exchange advertising reaching 21,1976, enabled us in the latter stages of our promotion to target areas where responses were lower and reach out to seldom heard communities.

- Email marketing throughout the engagement to 1,366 VCSE organisations, schools, colleges and universities and key business associated across LLR.

- Email marketing to councillors (county, district and parish) delivered information about the engagement, and asked for support in disseminating within their community.

- Written communications with ICB staff and staff working at University Hospitals of Leicester, Leicestershire Partnership Trust and upper and local tier authorities.

- The survey was also communicated to the LLR NHS Online Citizens' Panel (1,200 members), through ICB Five on Friday and the Youth Advisory Board.

- Posters and postcards provided to Leicester Royal Infirmary, Leicester General Hospital Glenfield Hospital, LPT's Mental Health bases, LLR's Family Hubs, and local community venues. Disseminated to GP practices through Primary Care Networks and Patient Participation Grous (PPGs)

- Hardcopy surveys provided to mobile phone free schools

2.3 Methodology

Survey

A survey was developed specifically for the purpose of the engagement exercise and co-designed with children and young people groups. The survey addressed a wide range of areas including:

- Health issues of concern to young people,
- Knowledge/awareness of health services,
- Health services used/accessed,
- Assessment of the quality of health services,
- Referrals to other services.

Separate questions explored physical and mental health (and for the latter, transitioning from young people's mental health services to adult services).

In addition to questions on health a range of questions explored the profile of respondents, which were optional to provide, including:

- Age,
- Gender and sex,
- Religion,
- Sexual orientation,
- Ethnicity.

Data was also captured on protected characteristics and additional areas of interest, again these were optional to provide, including:

- Pregnancy,
- Caring status (whether they care for another person),
- Whether they have an Education Health and Care Plan,
- Whether they have been in care.

Respondents were also able to provide information on any health conditions that they might have.

The parent/carer survey followed the format of the young people's survey, covering the same issues.

To note, the parents and carers participating in the engagement may not be parents and carers of the young people who also took part.

Participatory Activities

In addition to the survey, to gain qualitative data, LLR ICB commissioned a number of local third sector organisations from their Voluntary, Community and Social Enterprise Alliance (VCSE) to undertake consultation with the CYP with which they worked. The commissioned VCSE targeted with protected characteristics, CORE20Plus5, young carers and those communities who are seldom heard. In total 11 organisations participated in engagement work. Participating organisations were provided with training about data collection and provided with a data capture template. The topics covered in the participatory activities closely resembled those explored in the survey.

The participatory activities took place in schools, community centres, on youth outreach buses, in hospitals, youth clubs (including church youth clubs), Madrassas, a Gurdwara, further education colleges, special education settings, a Saturday school, and in both rural and city youth outreach settings.

The commissioned VCSE were able to utilise their expertise and local knowledge to engage with their CYP, in a way which makes sense to them. It was considered that this approach would deliver more insightful and candid insight, compared to what a traditional survey-based engagement would.

A number of different participatory methods were used by the VCSE. Creative artifacts, such as posters and arts were produced by CYP to allow them to look deeper into subject matter and to take time to produce a considered response. Artifacts were submitted along with facilitator feedback from which insight could be gathered.

Other methods included training up young people as peer researchers so they could go out into their communities and speak to their peers. First aid workshops used as an way to get the CYP thinking about healthcare, and safe spaces were created, such as coffee mornings for young parents with crèche's provided, football sessions and focus groups at youth clubs.

Participation workers reported that children and young people were pleased to be given this opportunity to contribute their experiences and views on the health services they used.

In some cases, the participation workers provided detailed notes on the focus groups they facilitated and in other groups children and young people had completed questionnaires themselves.

Strengths and weaknesses of working with VCSE

The participatory activities were carried out by commissioned VCSE organisations. It should be noted that there are strengths and weaknesses in working in this way to gather insight, especially from children and young people. The strengths are that the VCSE have local knowledge, access, established relationships and the skillset to engage with seldom heard groups. In this case, a large majority of CYP taking part in participatory work were from vulnerable and seldom heard communities so may have different experiences to healthcare than general population.

VCSE organisations are also agile and flexible in changing engagement methods if things are not working. In some cases, CYP did not want to engage in participatory group work and would prefer to complete a survey afterwards. Some conversations were held over What's App, or through online group chats, as this was the CYP preferred way of giving their voice.

It should also be noted that the VCSE received training in gathering insight, however, are not professional researchers. Gathering equality information proved to be difficult in some situations, for example, Traveller communities would not identify themselves as Travellers on forms due to historical discrimination, and SEND young people are not aware of details such as their postcode.

Finally, working with CYP can be complex, and that is why this project decided to work with VCSE who have the experience and skills to support CYP to share their voice.

2.3.1 Children and young people's survey

A survey was prepared targeted at CYP. The survey was developed with support from Leicestershire Partnership Trust's Youth Advisory Board (YAB). The survey was accessible online via hyperlink and was distributed by LLR ICB. A hard copy (paper) version of the survey was also distributed to health settings and public events. Hardcopy versions were distributed to a mobile free school at their request. In parallel to the main survey, an easy read version was also developed.

The survey was open from 27 November 2023 to 3 March 2024.

In total 2,239 CYP were involved in the consultation process:

- 1,884 completed the online survey
  - 1,775 completed the main version of the survey (Online: 872, Hardcopy: 903)
  - 109 completed an online easy read version of the survey
- 355 participated in focus groups and other activities

2.3.2 Children and young people's participatory activities

The data provided by the third sector organisations indicates that 355 children and young people were consulted. This number should however be treated with a degree of caution given that a number of third sector organisations did not collect equality monitoring data in a clear format and so there is a possibility that there is some degree of double counting, as well as a possibility that data was not collected for all young people participating.

The following is a list of VCSE organisations that engaged young people. Please see note above regarding engagement numbers.

VCSE or Group	Type of participant	Participatory Activity	Area of engagement	Numbers engaged
AAA Foundation	CYP At risk of offending High multiple deprivation Experiencing health inequalities	Interactive workshops - Arts and crafts, football Online focus groups Classroom based conversations	Beaumont Leys Castle Ward Evington Ward Fosse Ward Western Ward	67
Cedars Academy	CYP Co-educational secondary school and sixth form	Health and Wellbeing Council	Birstall	13
Coalville CAN	CYP Children in care SEND YP experiencing mental health issues YP with experience of the criminal justice system	Class based conversations in schools Focus groups at youth clubs Young people were supported to complete the main CYP survey	North West Leicestershire	3
Ellesmere SEND College	CYP SEND	Classroom based conversations using visual aids	LLR wide young people	26

HCYC	CYP Irish Traveller community Young Carers	One to one face to face conversations Focus groups at youth clubs	Harborough	55
Jamelia's Legacy	CYP South Asian Young people with poor mental health	Arts and crafts to explore experiences of healthcare Online focus groups	Spinney Hill Ward	27
Leicestershire Cares	CYP Care experienced young people Unaccompanied asylum seeking young people Involved in criminal justice system Facing housing/homelessness issues	Podcast and creative arts Peer researchers conducting focus groups	Belgrave Ward Castle Ward Evington Ward Humberstone and Hamilton Ward Rushey Mead Ward Thurncourt Ward Troon Ward Spinney Hill Ward Wycliffe Ward	22
LPT Youth Advisory Board	CYP	Online focus group	Online: LLR young people	6

	Experiences of CAMHS and general population			
Project Polska	CYP Eastern European Community Young people with vulnerabilities and experiencing negative mental health	Using CPR workshops to spark conversations One to one conversations	Melton Loughborough	47
St Philips Centre	CYP Young people from Muslim (mixed ethnicity), Sikh (Indian), Christian (Black African) or Hindu (Indian)	Poster making Focus groups	Charnwood Oadby and Wigston Rutland	82
UHL Youth Forum	CYP Lived experiences of hospitals and long-term conditions	Mind mapping Focus group	Braunstone Ward, however, young people come from across LLR	7
				Total: 355

2.3.3 Parents and carers survey

A survey of parents and carers of CYP aged 11 to 25 years was prepared and, as per the CYP survey, was made available online and was promoted by LLR ICB. Also, as per the CYP survey, a parallel easy read version of the survey was also prepared. The survey ran from 27 November 2023 to 3 March 2024.

In total 682 parents and carers were involved with the engagement:

- 659 completed an online survey
    - 632 completed the main version of the survey (Online: 617, Hardcopy: 15)
    - 27 completed an easy read version of the survey
- 23 participated in focus group and other activities

The following is a list of VCSE and groups who engaged parents and carers in focus group activities.

VCSE or Group	**Type of participant**	**Participatory Activity**	**Area of engagement**	**Numbers engaged**
Carers Centre	Parent and Carers of CYP with SEND	Online focus group	Online: Parents from Leicester City and Leicestershire	19
Second Battalion Royal Anglian Regiment	Parent/Carers Military families	Focus group	Rutland	4
				Total: 23

2.3.4 Professionals survey

The final aspect of the engagement process was aimed at health professionals working with CYP aged 11 to 25 years. The survey was made available online and was distributed by LLR ICB. The survey ran from 27 November 2023 to 3 March 2024.

In total 81 professionals responded to the online survey.

2.3.5 Research ethics

Data collection and anonymity

Care was taken to ensure the anonymity of all participants in the engagement exercise.

None of the three surveys (children and young people/parents and carers/health and care professionals) collected data that could be used to identify an individual person (such as name or date of birth). While postcode data was collected for the children and young people's survey and the parents and carers survey, this was requested for the first five characters only, to avoid revealing specific addresses.

The young people's participatory activities were undertaken by local voluntary organisations who collected the data on behalf of the ICB. The notes of their sessions and completed monitoring forms were then evaluated, contributing to this Report of Findings.

Survey methodology

Both online and postal surveys included closed ('tick-box') questions and open-ended questions for comments. Key questions from the online and postal surveys were, as far as possible, replicated in the participatory activities undertaken by the VCSE sector; however, broader questions and scenarios were included to gather richer data.

Apart from the initial data protection question, none of the questions in any of the surveys were compulsory. This resulted in some surveys being only partly completed. These were included in the final analysis, leading to variation in the number of responses per question, which are identified in this report as 'valid responses'.

Data analysis

In addition to analysing the closed questions, a thematic analysis of the open comments from the online and postal surveys was completed, coding responses into themes for quantification.

This document summarises the findings from the independent analysis.

3. The profile of respondents to the consultation process

This section sets out the profile of those who engaged in the engagement process. It should be noted that the base numbers are calculated on the responses given, where the response was left blank the valid total has been calculated for those who have provided a response as opposed to the overall total response rate[2].

3.1 Children and young people

To ensure that a broad-cross section of young people with a range of characteristics were engaged and participated in the engagement process, both the survey and the participatory activities gathered data about CYP across a wide range of variables. The data on the profile of CYP was regularly reviewed through the engagement period to ensure that there were no gaps in the data – that is, groups of young people who had not contributed to the process.

Data on the profile of CYP who participated is set out below.

3.1.1 Children and young people's survey respondent profile

In total 1,884 CYP responded to the survey. The total estimated population of those aged 11 to 24 years across LLR is some 263,066. This, therefore, gives a survey sample rate of 0.7% of CYP in the area.

Sex and gender

55.7% (n=883) of respondents to the survey indicated that they were female and 41.3% (n=654) male thereby meaning that girls and young women were slightly over-represented in the survey population. 0.8% (n=12) of respondents stated that they were intersex and 3.1% indicated an 'Other' sex.

94.2% (n=1,479) of respondents identify with the gender they were assigned at birth.

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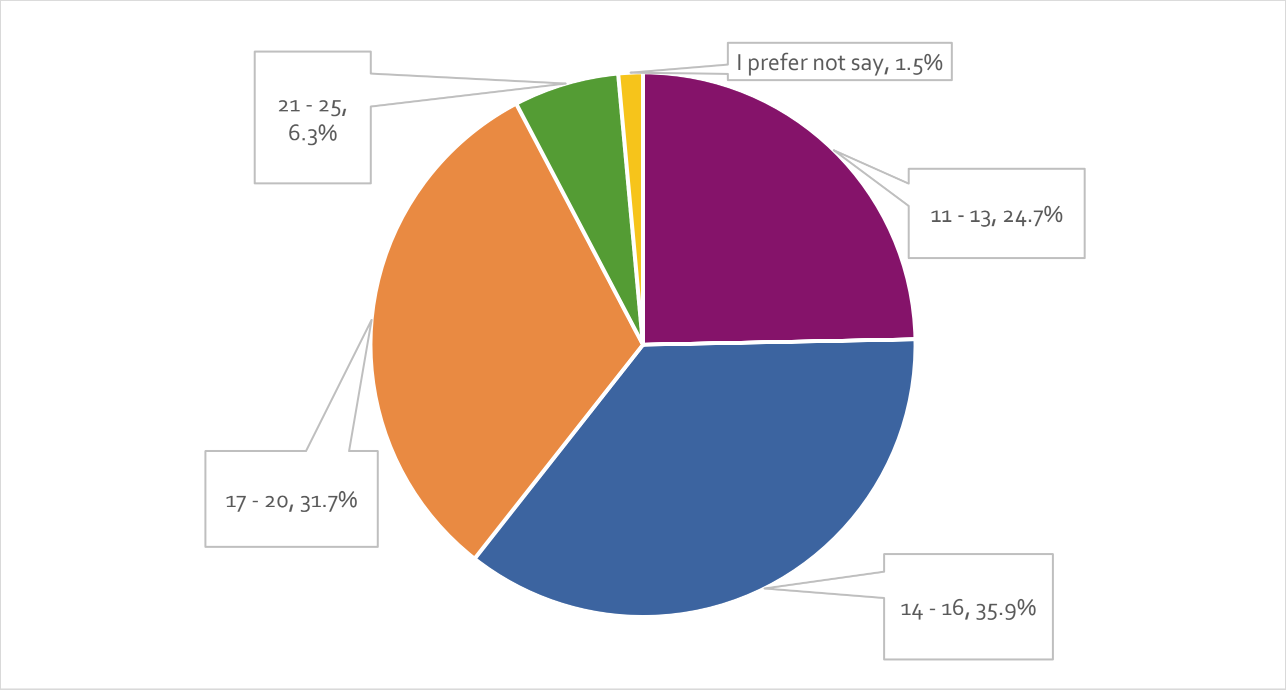
[2] The total response rate to the CYP survey was 1,884 however not all respondents completed the survey. Thus for some questions, the 'valid total' is the number of CYP who provided a response and therefore lower than the total response rate.

Age

Young people aged 14 to 16 years made up the single largest cohort of respondents (35.9%, n=569). A full breakdown of the age of the survey population is set out at Figure 1.

Figure 1: Age of survey respondents



(valid responses = 1,584)

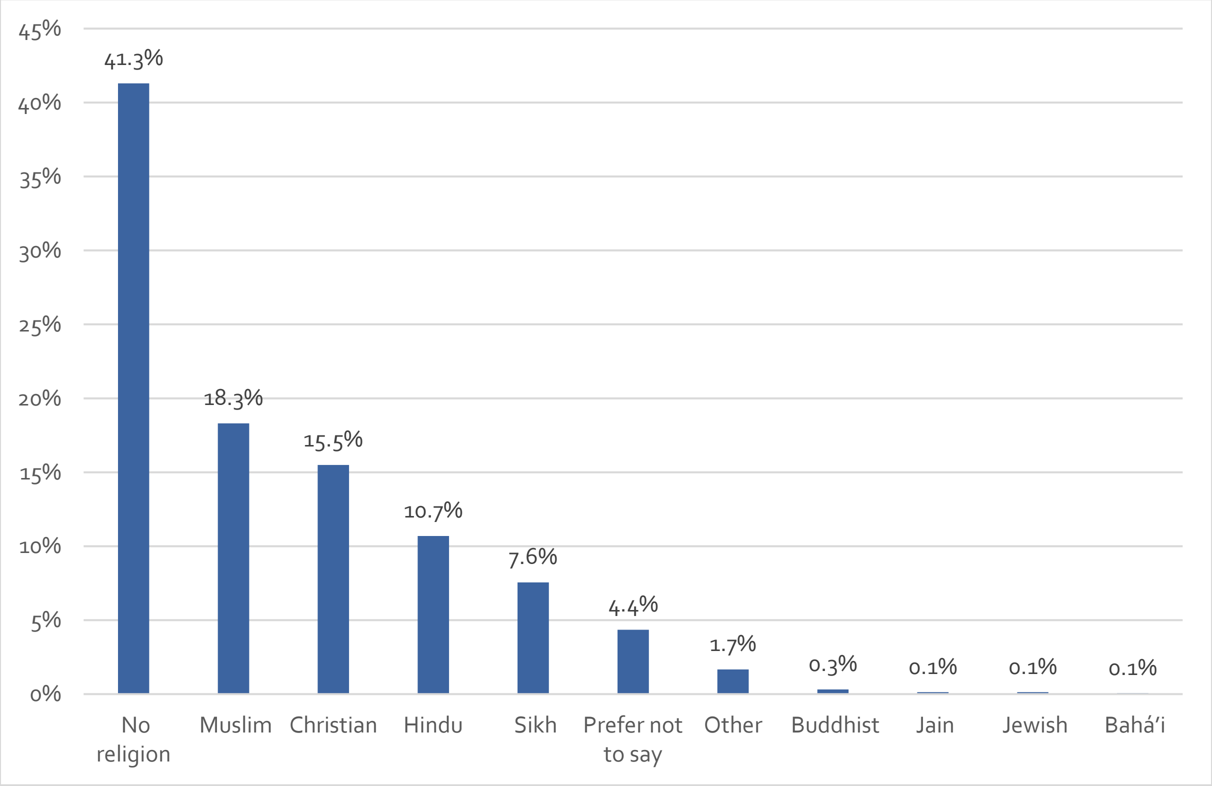
Age	Number
11 - 13	391
14 - 16	569
17 - 20	502
21 - 25	99
Prefer not to say	23

Given that there is as even split in the age categories in the population as a whole (that is in the wider 11 to 25 year old population we would expect about 25% of young people to fall into each cohort) in the survey those aged 21 to 25 years were under-represented making up 6.3% (n=99) of respondents. Conversely, those aged 14 to 16 years are over-represented.

Religion

The single most common response with regard to faith was those who indicated that they were of no faith (41.3% n=645). Muslims made up the largest cohort of those with a faith (18.3%, n=286) followed by Christians (15.5%, n=242). A full breakdown of results is set out at Figure 2.

Figure 2: Religion of survey respondents



(valid responses n=1,562)

Religion	Number
None	645
Muslim	286
Christian	242
Hindu	167
Sikh	118
Prefer not to say	68
Other	26
Buddhist	5
Jain	2
Jewish	2
Bahai	1

Ethnicity

The ethnicity of the survey population is set out at Table 2.

Table 1: Ethnicity of the survey population versus the population as a whole

	Percentage %	Number (n)
Asian	35.6%	548
Black	4.6%	76
Mixed	6.6%	102
White	48.6%	748
Other	2.7%	42
Prefer not to say	1.4%	22

(valid responses n=1,538)

Just under half (48.6%, n=748) of respondents indicated that they were White, while 35.6% (n=548) were Asian and 4.9% (n=76) Black.

The results, when compared to the population as a whole, indicate those of White heritage are under-represented in the survey population, those of Asian heritage over-represented and those of Black heritage represented in line with the population as a whole.

A full breakdown of all ethnic codes is set out at the Appendix.

Sexual orientation

77.3% (n=1,188) of respondents stated that they were heterosexual, 8.2% (n=126) stated that they were bisexual and 3.2% (n=49) stated that they were gay or lesbian. (A little under 10% (n=141) of respondents preferred not to respond to the question). [valid responses n=1,537)

Pregnant or had given birth

2.2% (n=34) of respondents stated that they were currently pregnant or had given birth in the last 26 weeks.

Provided care for someone

9.8% of respondents (n=185) stated that they provided care for someone younger than themselves (such as a brother or sister). 7.6% (n=143) stated that they provided care for someone older than themselves (such as a parent).

Looked after or currently in care

17.8% (n=275) of respondents indicated that they had ever been or were currently in care.

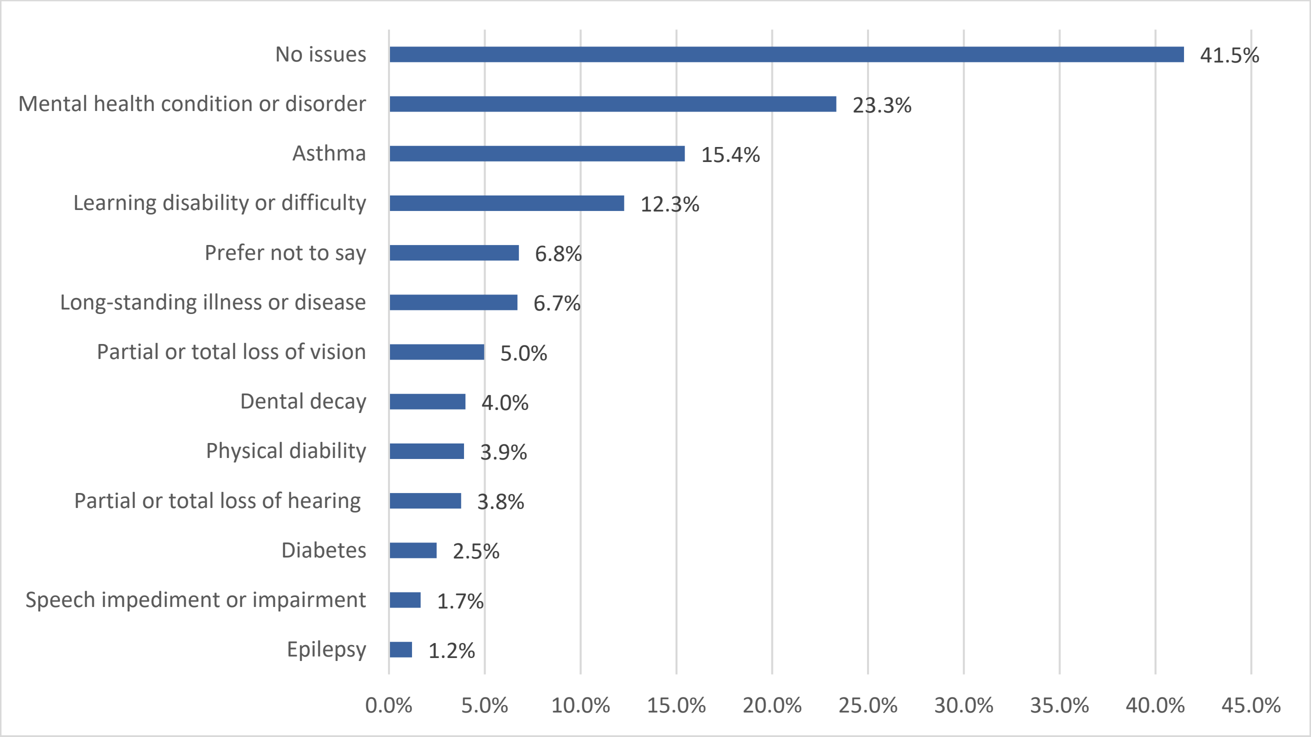
Education Health and Care Plan (EHCP)

12.5% (n=191) of respondents stated that they have an Education Health and Care Plan or receive support for a special educational need in education.

Health conditions

CYP were asked whether they had any health conditions. The results are set out at Figure 3.

Figure 3: Health conditions of respondents



(Valid total = 1,328)

Health condition	Number
No issues	551
Mental health	310
Asthma	205
Learning disability	163
Prefer not to say	90
Long standing illness	89

Health condition	Number
Vision	66
Dental decay	53
Physical disability	52
Diabetes	33
Speech impairment	22
Epilepsy	16

The most commonly cited health issue was mental health as identified by 23.3% (n=310) of respondents. This was followed by asthma, cited by 15.4% (n=205) of respondents. 41.5% (n=551) of respondents indicated that they had no issues.

3.1.2 Children and young people's participation activities profile

Young people aged 11 to 25 throughout LLR were consulted through youth participation events to give their views on their experiences of health services in LLR.

The quality of monitoring form completion was inconsistent, with some being completed (or not) by children themselves with others completed by participation workers. Some groups had made use of pie charts, or bar charts with broadly defined y-axes, which made absolute numbers difficult to calculate exactly. It was therefore hard to determine exactly how many children participated we have data from 355 children and young people were engaged between December 2023 and March 2024.

The children and young people were from diverse backgrounds and included children and young people:

- with SEND and/or a parent,
- from travelling communities,
- young carers
- with long term conditions and with serious health conditions requiring inpatient hospital care,
- young mothers under 25 years of age,
- from African Caribbean communities,
- from the Polish community,
- from South Asian backgrounds,
- Unaccompanied asylum seeking children (UASC).

There were apparently no children and young people in LGBTQ+ groups (that is, none of the data provided by the organisations who undertook the participatory work indicated engagement with CYP who identified as being LGBTQ+).

3.2 Parents and carers

As per the consultation with CYP, parents and carers were asked to provide details about themselves in order to help ensure that a wide cross-section of residents from a range of communities participated. The profile of parents and carers who responded to the survey is set out below.

2.2.1 Parents and carers survey respondent profile

Sex and gender

88% (n=461) of respondents to the survey indicated that they were female and 10% (n=50) male. (3%, n=14 - of respondents stated that they would prefer not to say.)

97% (n=510) of respondents identify with the gender they were assigned at birth. The remainder preferred not to say (n=16).

Age

Parents/carers aged 35 to 49 years made up the single largest cohort of respondents (51.9%, n=274) followed by those aged 50 to 64 years (35.8%, n=189). A full breakdown of the age of the survey population is set out at Table 4.

Table 2: Age of parents/carers

Age	Number	%
16 – 19	5	1.0
20 – 24	5	0.9
24 – 34	28	5.3
35 – 49	274	51.9
50 – 64	189	35.8
65 – 74	14	2.7
75 – 84	2	0.4
85+	1	0.2
I would rather not say	10	1.9
Total	528	100

Number of children

Almost exactly half (49.4%, n=253) of parents/carers reported that they had two children. See Table 5.

Table 3: Number of children

Children	Number	%
None	7	1.3
One	100	18.9
Two	253	47.9
Three	118	22.3
Four or more	50	9.5
Total	528	100

Age of children and young people

Parents/carers were asked about the age of their children. The results are set out at Table 6.

Table 4: Age of children

Age	Number	%
11 – 13	243	46.1
14 – 16	244	46.3
17 – 20	202	38.3
21 – 24	97	18.4
25+	80	15.2

(Valid total 527) Note that respondents could tick more than one option – i.e. one per child where they had several children thus the total percentage equals more than 100%.

Religion

The largest group of respondents to the survey (46.3%, n=243) indicated that they were of no faith. Christians made up the largest cohort of those with a faith (40%, n=210). A full breakdown of results is set out at Table 7.

Table 5: Religion of parents/carers

Age	Number	%
No religion	243	46.3
Baha'i	1	0.2
Buddhist	1	0.2

Age	Number	%
Christian	210	40.0
Hindu	17	3.2
Jain	1	0.2
Jewish	0	0.0
Muslim	9	1.7
Sikh	2	0.4
I prefer not to say	34	6.5
Other	7	1.3
Total	**525**	**100**

Ethnicity

The ethnicity of the parent/carer survey population is set out at Table 8.

Table 6: Ethnicity of parents/carers

Age	Number	%
Asian	30	5.7
Black	6	1.1
Mixed	12	2.3
White	451	85.9
Arab	0	0.0
Chinese	2	0.4
Polish	2	0.4
Somali	1	0.2
Any other	1	0.2
I would prefer not to say	20	3.8
Total	**525**	**100**

A large majority (85.9%, n=451) of respondents indicated that they were White, while 5.7% (n=30) were Asian and 1.1% (n=6) Black.

Education Health and Care Plan (EHCP)

38% of respondents (n=199) stated that their child/one of their children have an Education Health and Care Plan or receive support for a special educational need in education.

Serving in the Forces

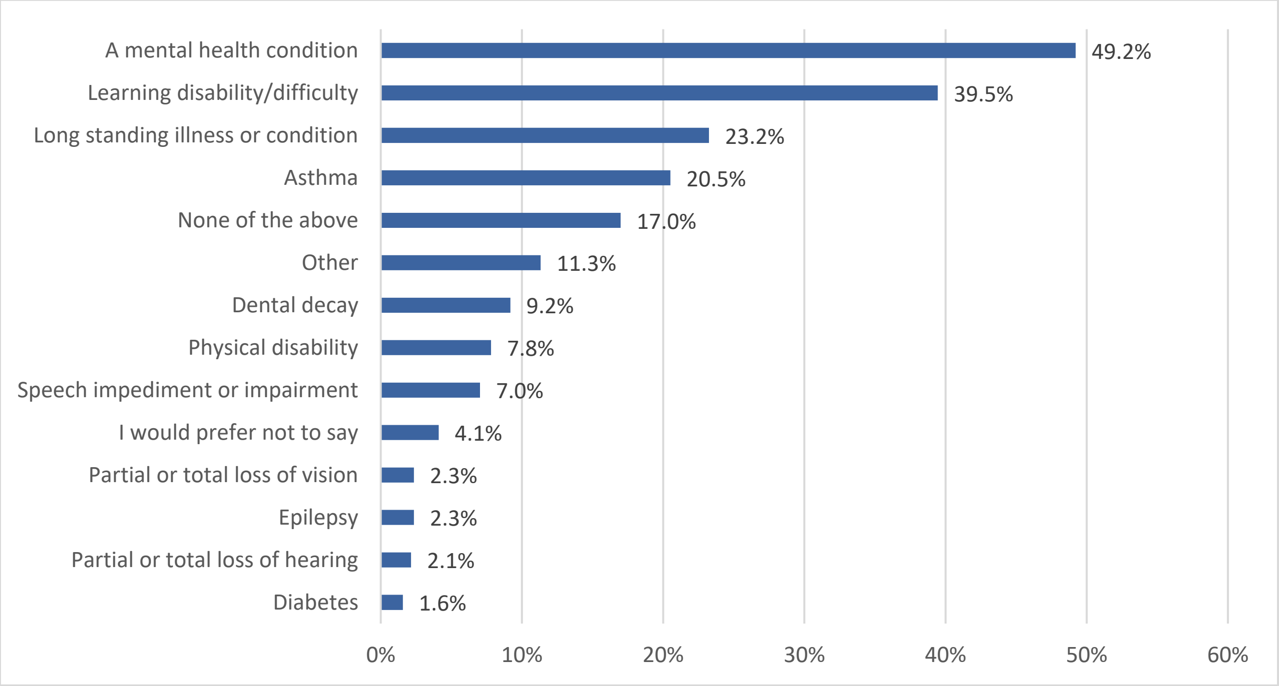
A very large majority of respondents (96.2%, n=503) stated that they had not served in the Armed Forces while 0.8% (n=4) stated that they had.

Health conditions

Respondents were asked whether any of their children had a health condition.

The most commonly cited condition was a mental health condition as noted by 49.2% (252) of respondents. This was followed by Learning Disability/Difficulty reported by 39.5% (n=202) of parents/carers. 17% (n=87) stated that their child/ren had no health conditions. The full results are set out at Figure 4.

Figure 4: Health conditions of children



Valid total 512 - Note respondents could give more than one response thus the totals equal more than 100%.

Condition	Number
Mental health condition	252
Learning disability	202
Long-standing condition	119

Condition	Number
Asthma	105
None of the above	87
Other	58
Dental decay	47
Physical disability	40
Speech impediment	36
Prefer not to say	21
Epilepsy	12
Loss of vision	12
Loss of hearing	11
Diabetes	8

3.3 Professional survey

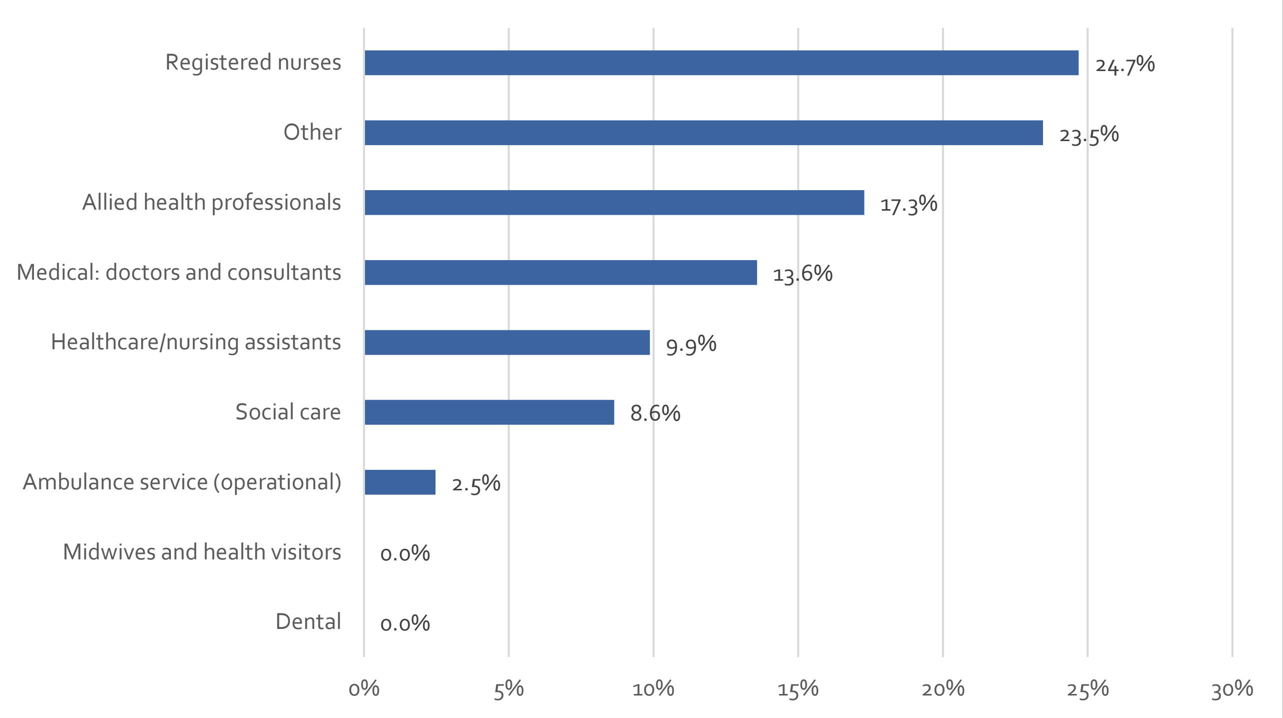
In total 81 professional responded to the survey.

Professionals were asked to give some detail about themselves.

3.3.1 Occupational group

Respondents were asked to indicate which occupational group they came from. The results are set out at Figure 5.

Figure 5: Occupation of professional respondents.



Valid total 81 - Note that people were able to tick more than one option.

Profession	Number
Allied health professional	14
Ambulance service	2
Dental	0
Healthcare/nursing assistants	8
Medical	11
Midwives and health visitors	0
Registered nurses	20
Social care	7
Other	19

The next most commonly cited profession was registered nurse (24.7%, n=20). The second most commonly cited response was "Other" professionals as given by just under a quarter of respondents (23.5%, n=19).

Of the 23.5% who cited an "Other" profession, the following roles were given[3]:

- Physiotherapist (n=3),
- Occupational therapist (n=2),
- Youth worker (n=2),
- Counsellor (n=2)
- Youth worker (n=2),
- NHS school nurse (n=1),
- Youth justice health lead (n=1),
- SEND group 11 – 16 (n=1),
- Manager (non-specified), (n=1),
- NHS Employment Support Specialist (n=1),
- Manager of a daycare service for adults with PMLD (n=1),
- Dietician (n=1),
- Pharmacist (n=1),
- Mental health practitioner (n=1),
- Speech and language therapist (n=1),
- Sixth Form College, Student welfare (n=1),
- Education Mental Health Practitioner (n=1),
- Clinical psychologist (n=1),
- Peer support worker (n=1),
- Eating disorder specialist (third sector), (n=1),
- "Holistic approach" (n=1)
- Commissioner (n=1),
- "Local government" (n=1),
- Peer support worker (n=1).

3.3 2 Where they provide health services from

Professionals were asked to indicate where they deliver health services from. The results are set out at Figure 6.

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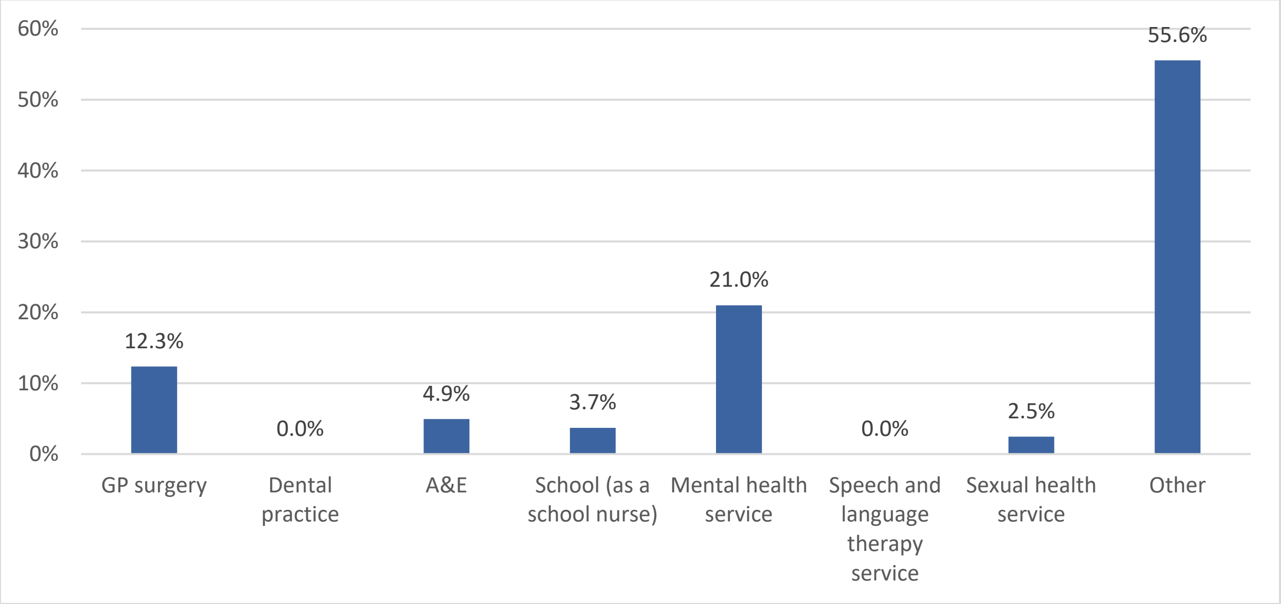
[3] It should be noted that Allied Health professionals were also able to provide an 'Other' response for their profession.

Figure 6: Where health professionals deliver services from



Valid total 81.

Location	Number
GP surgery	10
Dental practice	0
Emergency department	4
School	3
Mental health service	17
Speech and language	0
Sexual health	2
Other	45

55.6% (n=45) of professionals cited an "other" location. The following responses were given (note that some respondents gave more than one response):

- Hospital/hospital ward (n=18)
- In the community/community visits (n=12),
- Out-patient department (n=4),
- Further/Higher education setting (n=3),
- Charity (non-specified) (n=2)

- Children’s centre (n=2),
- Schools (n=2),
- Youth club (n=2),
- Youth Justice Service (n=2),
- Health centre (n=1),
- Domestic abuse service (n=1),
- Council (non-specified) (n=1),
- Community learning disability service (n=1)
- Children’s services (non-specified) (n=1),
- Day service (non-specified) (n=1),
- “Acute tertiary centre" (n=1),
- Nursing home (n=1),
- “Acute health setting” (n=1),
- Home Office (n=1).

The next most commonly cited health location given was a mental health service cited by over a fifth of respondents (21%).

4. Voices of children and young people

This section sets out the findings from the engagement with children and young people.

In total 2,239 children and young people responded to the engagement made up of 1,884 participating in the survey and 355 participating in activities coordinated by the voluntary, community and social enterprise sector. This section of the report looks at feedback from each questIon..

4.1 Survey results

In total 1,884 children and young people responded to the survey, broken down as follows:

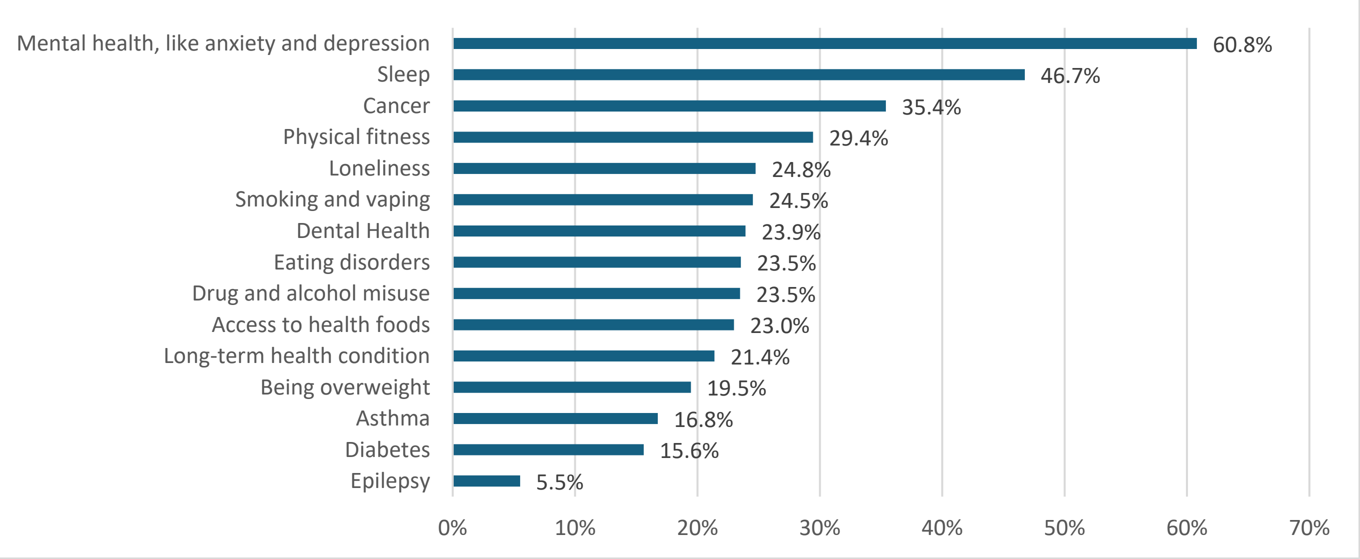
- Children and young people's survey: 1,775 respondents (Online: 872, Hardcopy: 903)
- Easy read survey: 109 respondents.

The findings from the survey are explored below.

4.1.1 Key health issues affecting children and young people

CYP were asked to indicate what health issues affect or matter most to them. The results are set out at Figure 7.

Figure 7: What health issues do you think affect or matter most to children and young people?



(Valid Total =1,814. The results equal more than 100% as respondents could select up to five options).

Conditions that matter	Number
Mental health	1,103
Sleep	848
Cancer	642
Physical fitness	534
Loneliness	449
Smoking	445
Dental health	434
Eating disorder	427
Drug and alcohol	426
Access to healthy food	417
Long-term health	388
Overweight	353
Asthma	304
Diabetes	283
Epilepsy	100

Over half of all respondents (60.8% n n=1,103) stated that mental health issues like anxiety and depression were critical health issues, followed by sleep (46.7%, n=848), worries over cancer (35.4%, n=642) and physical fitness (29.4%, n=534).

Respondents were able to give an "other" option. Of those giving an other health issue:

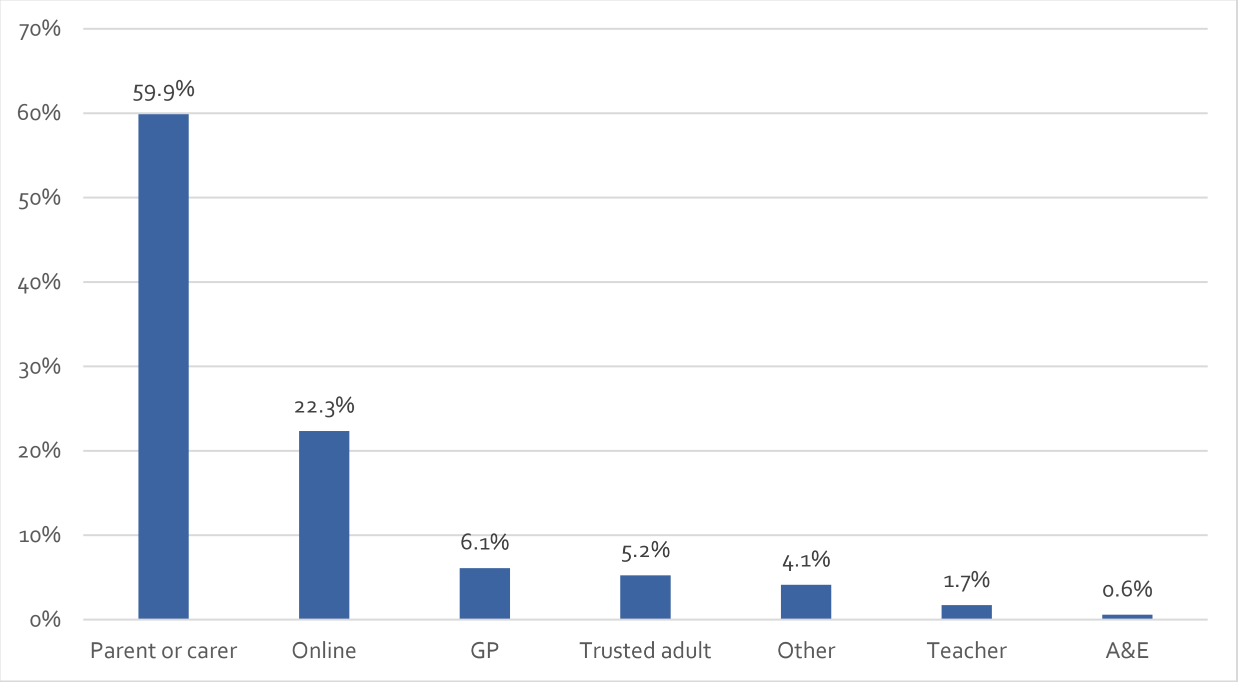
- 11 cited issues relating to neurodiversity (ASD, autism and non-specified),
- Six cited issues around female reproductive health with another three specifically referencing polycystic ovary syndrome,
- Four cited eczema,
- Three stated irritable bowel syndrome.

4.1.2 Accessing health services

Knowing about health services

CYP were asked, "If you were worried about your health, what would you do first?". The results are set out at Figure 8.

Figure 8: If you were worried about your health, what would you do first?



(Valid total = 1,867)

What would you do	Number
Parent/carer	1,118
Online	417
GP	114
Different adult	98
Other	77
Teacher	32
A&E	11

The majority of respondents (59.9%, n=1,118) who answered this question stated that they would speak to their parents or carers if they were concerned about their health. Nearly one-quarter (22.3%, n=417) stated that they would search online about a medical or health concern.

Engagement with a GP was only considered for 6.1% (n=114) of respondents.

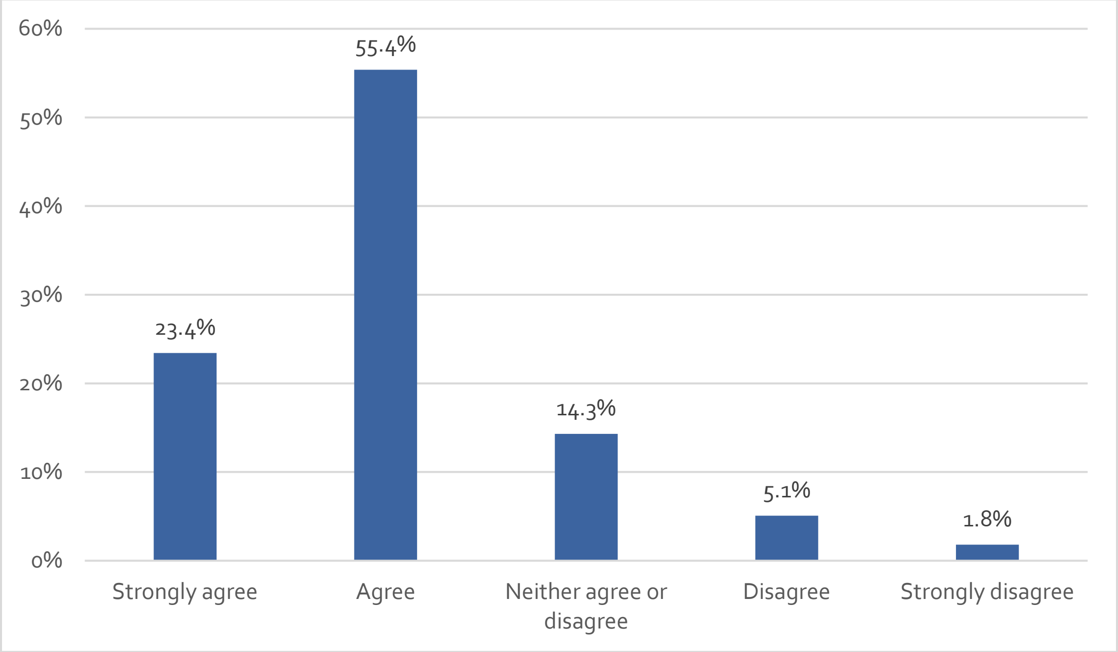
Of those who gave "other" as their response, of some concern, 17 would do "nothing" ("Nothing until I felt it was serious"). The most common response was to tell a friend (n=18).

Of some interest only one respondent indicated that they would use NHS 111 which may indicate that this service is not well known among young people.

Knowing what health services to use

Respondents were asked: To what extent do you agree with the statement: "I know what services to use if I become ill" (for example coughs, colds, serious injuries and long-term conditions). See results at Figure 9.

Figure 9: I know what services to use if I become ill



(valid total =1,775)

What services to use	Number
Strongly agree	416
Agree	983
Neither agree/disagree	254
Disagree	90
Strongly disagree	32

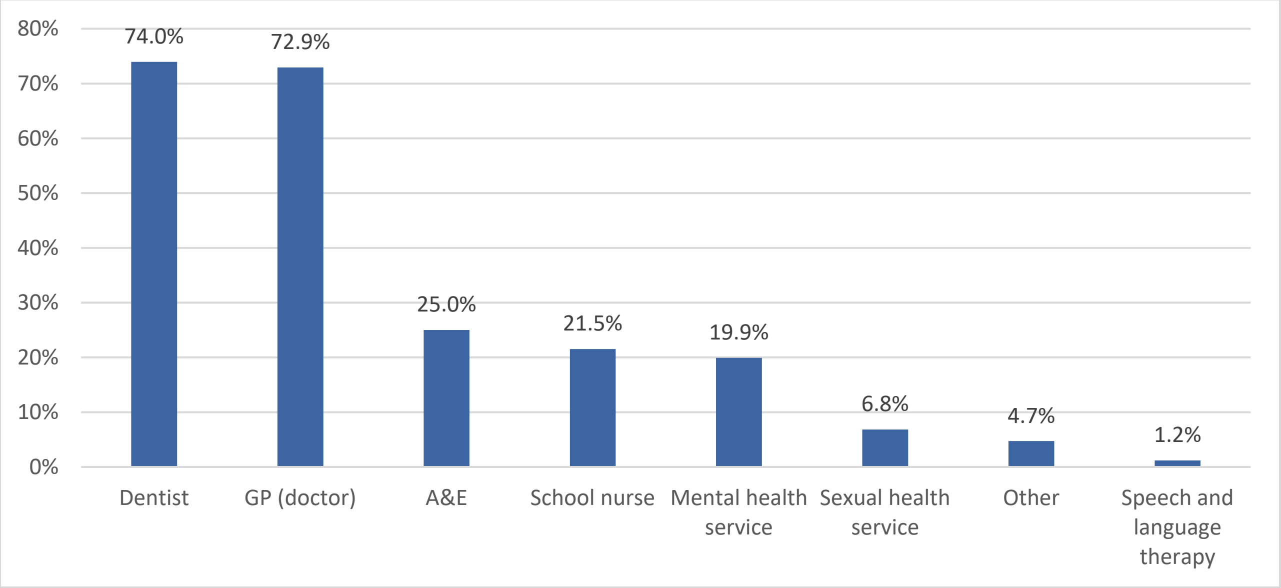
A large majority of CYP indicated that they knew what to do should they become unwell with 78.8% (n=1,399) stating that they agreed or strongly agreed with the statement. Only 6.9% (n=122) of CYP disagreed or strongly disagreed.

Health services used

When asked what health service they had used, two thirds (64.5%, n=1,216) of CYP indicated a physical health service, around one in six (14.9%, n=281) a mental health service while the remainder could not remember.

Young people indicated what health services they had used in the last 12 months. The results are set out Figure 10.

Figure 10: What health services have you used in the last 12 months



(Valid Total =1,843. The results equal more than 100% as respondents could select more than one option).

Health service	Number
Dentist	1,363
GP	1,344
A&E	461
School nurse	397
Mental health	367
Sexual health	126
Other	87
Speech and language	22

The majority of respondents stated use of the Dentist (74%, n=1,363) and GP (72.9%, n=1,344) in the past 12 months.

Reasonably high utilisation rates were noted for the emergency department (25%, n=461), school nurse (21.5%, n=397) and mental health services (19.9%, n=367).

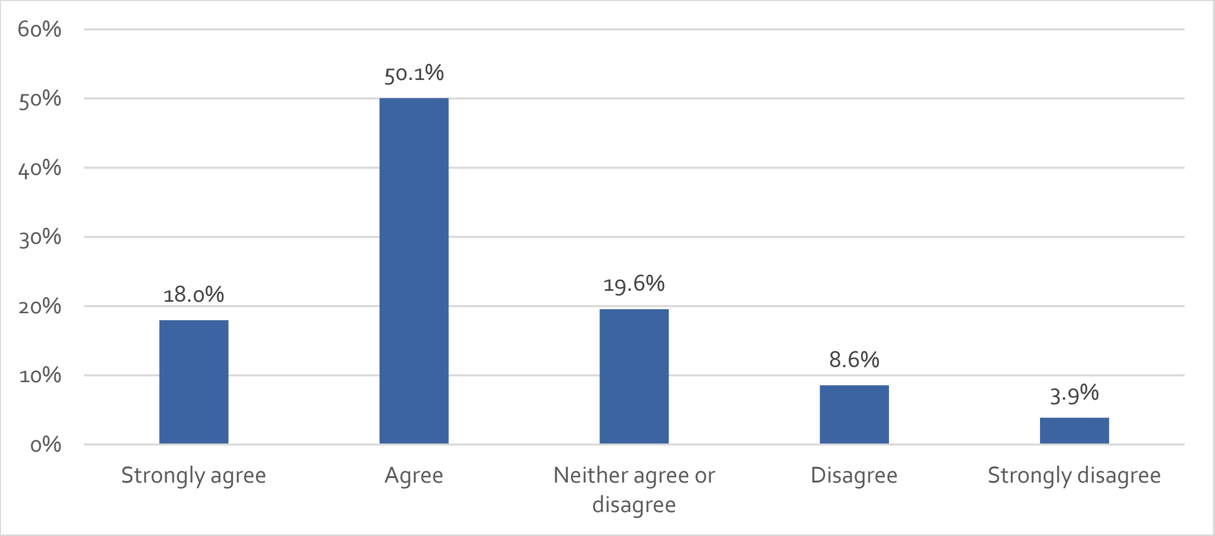
Those who gave an 'other' response were invited to specify what health services they had used.

The most commonly given other service was optician (n=25), followed by orthodontist (n=7), and physiotherapist (n=6) and NHS 111 (n=6). Of interest, only three respondents indicated that they had used a pharmacist.

4.1.3 Health professionals

CYP were asked, "Thinking about the last time you used a health service, to what extent do you agree with the statement: "I felt listened to by health staff"? The results are shown at Figure 11.

Figure 11: I felt listened to by health staff



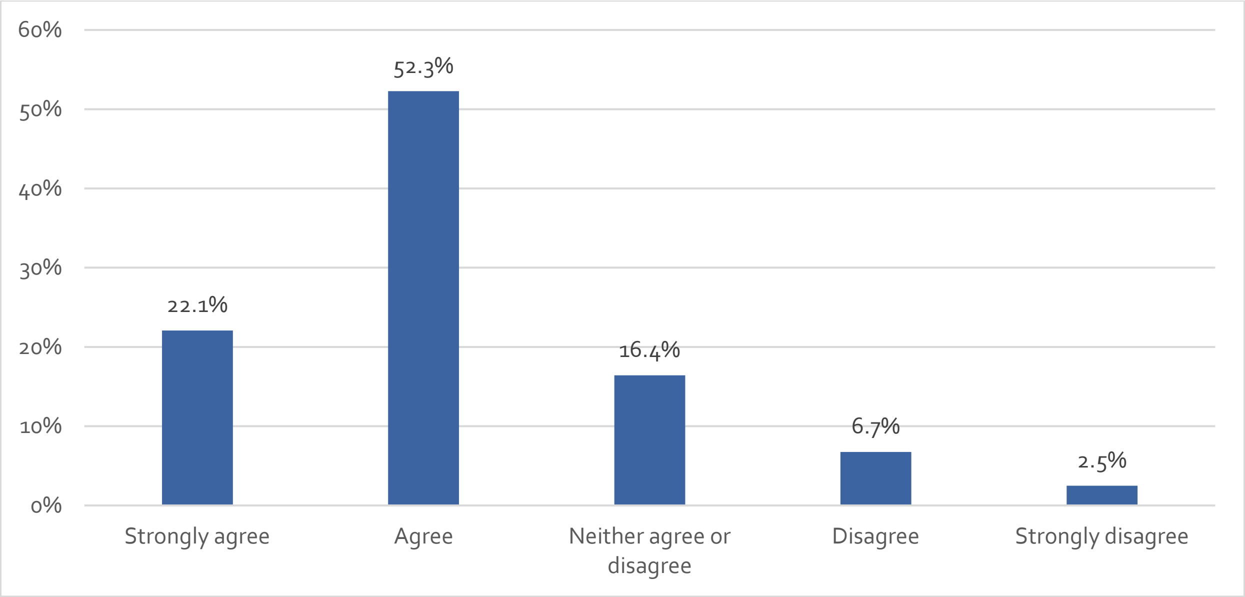
(Valid total = 1,810)

Listened to	Number
Strongly agree	325
Agree	906
Neither agree/disagree	354
Disagree	155
Strongly disagree	70

Over two-thirds (68.0%, n=1,231) of respondents said they felt listened to by health staff.

CYP were asked to respond to the statement: Thinking about the last time you used a health service, to what extent do you agree with the statement: "I was treated with care and concern"? See Figure 12.

Figure 12: I was treated with care and concern



(Valid total = 1,808)

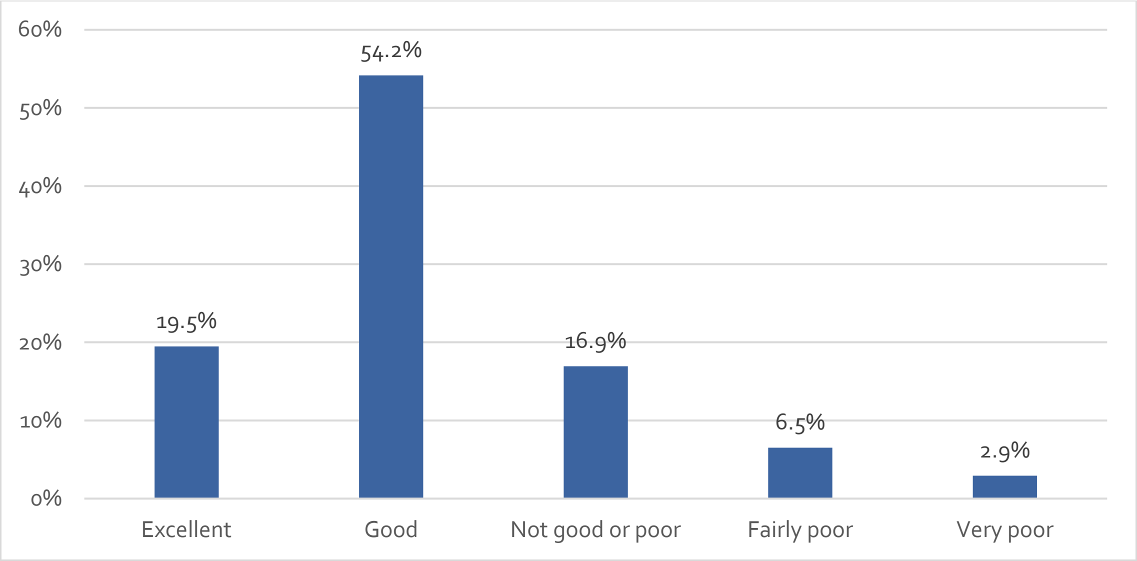
Treated with care	Number
Strongly agree	399
Agree	945
Neither agree/disagree	297
Disagree	122
Strongly disagree	45

Just under three-quarters (74.4%, n=1,344) of respondents agreed or strongly agreed with the statement that they had been treated with care and concern. Fewer than one in ten (9.2%, n=167) of respondents disagreed or strongly disagreed.

4.1.4 Assessment of health services

CYP were asked to rate the last health service that they had used. The findings are set out at Figure 13.

Figure 13: How would you rate the last health service you used?



(Valid total = 1,813)

Assessment	Number
Excellent	353
Good	982
Neither	307
Fairly poor	118
Very poor	53

Nearly three-quarters of respondents (73.7%, n=1,335) stated that the last health service they used was either excellent or good. Fewer than one in ten (9.4%, n=171) gave a negative rating.

Respondents to the survey were asked to give some further information about the rating that they had given. The results are set out in relation to the key themes that emerged.

Caring, compassionate staff

Somewhat strikingly, by far the most commonly given response were comments about caring, compassionate, understanding and supportive healthcare staff that young people had encountered (with 180 respondents giving this as the reason for their rating). A number of quotes illustrate the kind of response given about staff young people had encountered:

- "Because they were very caring and quick."

- “The staff were nice and polite while doing their job.”
- “My hospital nurse and Dr listen to me and treated me with respect even though I am young.”
- “They took the time to explain things to me and were patient. They didn't do anything that could make me feel judged or uncomfortable.”
- “I was quite worried before my appointment, but I was treated with care and respect.”
- “They were attentive and talked me through everything, I went in not feeling confident but they reassured me and made me feel safe.”
- “Lovely people and genuinely were caring and considerate.”
- “I went to Cahms to have a routine check up before my autism diagnostic exam and the man that I spoke to was very kind and provided me with useful information.”
- “The doctor helped and prescribed medicine, they seemed very concerned and caring.”
- “I was treated very well, checked upon regularly and anything I needed help with I was helped well.”
- “They always have my best interest at heart and want me to be as well as possible.”

Waiting times/long-waits

The next most commonly given issue raised was with regard to waiting times and having to wait for appointments, with this raised by 120 respondents.

- “Ok but it took a really long time to get an appointment even though I was in a lot of pain.”
- “A&E is too long of a wait.”
- “Long waiting time and no clear instructions in specific departments in the hospital after departments changed location.”
- “Because I waited 6 hours to be seen after a car crash.”
- “The waiting time was 8 hours, and I had a broken bone.”

Commonly, while highlighting long waiting time, respondents indicated that the treatment that they received was of a good quality.

- “Waiting times and diagnosis are long and difficult but actual care, when received, is excellent.”
- “It was high quality service but it took 5 hours of waiting in hospital.”
- “The treatment and care given by the staff was great but it was quite a long process and was really exhausting.”

- “I gave this rating as I had to wait 9 hours in a and e but the appointments I go to are very nice in Kettering.”
- “The nurses were lovely and it was very efficient and well done but it took a long time to get an appointment.”

A somewhat countervailing picture was offered by 50 young people who stated that they had been seen quickly:

- “It was amazing as I was in and out within an hour.”
- “I was attended to quickly and my concerns were taken seriously.”
- “I had a checkup and it was quite fast and really good.”

Being listened to

Young people very highly valued being listened to as this was the third most commonly given reason for the rating (given by 88 young people).

- “The doctor listened to me and talked me through my options well.”
- “Was seen on the same day and GP gave advice and booked scans and blood test straight away. I felt listened to and all my concerns were acknowledged.”
- “They listened to everything and quickly got everything sorted.”
- “Since they listened to what me and my parents said and gave me instructions to how to solve my problems.”
- “The staff were attentive and gave me options concerning my problem and were patient.”
- “They sat and listened to everything I had to say and did not interrupt me.”
- “They were attentive and talked me through everything, I went in not feeling confident but they reassured me and made me feel safe.”

Not being listened to

Given the importance and emphasis placed on being listened to, it is not surprising that young people gave negative assessments of their care when they did not feel that their concerns were being listened to or that healthcare staff were taking the time to hear what they were trying to say. Not being listened to was raised by 75 young people.

- “I was dismissed quite early on with no explanation.”
- “They didn’t take my injury seriously and they said I was fine when I wasn’t.”

- "Wasn't listened to by the staff when I was explaining that I was in pain and my cannula was all bruised they said it was normal and left me."
- "When talking about what was wrong with me physically and mentally they brushed me off and didn't listen to what I was telling them and blamed it on basically me being a woman and me overeating."
- "I felt like what I told them was completely disregarded but for me to actually go to a doctor I have to be really ill and this was painful and didn't seem to be clearing up on it's own."
- "Because they never listen to anything I say about my health."
- "Went in for suspected UTI - have had several before and dip test showed increased leukocytes - when advised by nurse was told it was more likely irritation from fragranced bath products. I did not want to argue as I felt vulnerable for other reasons unrelated to the appointment, and had to wait 5 days for a course of antibiotics when urine sample came back and showed I DID have a UTI, after I had suffered over the weekend and had my trip with my partner ruined by my symptoms that I was unable to manage myself. I felt I had not been listened to and that a lot of physical pain and discomfort could have been avoided if the nurse had listened to me in the first instance of contact."
- "I was prescribed an external antibiotics zineryt for 8 months instead of the maximum of 8 weeks. I brought this to my doctors attention multiple times and was either laughed at or not responded to."

Not being listened to was often accompanied by a report that a healthcare worker had not really investigated the issue that the young person was seeking help for:

- "The doctor was reluctant to look at the new rash and diagnosed it with the words 'its probably just' before they had seen it, the other symptoms were coughing up blood for a two day period."
- "I gave this rating because , last time I went to emergency a & e services they told me it was something not to worry about and then I went home with some tablets and my illness became worse and I had to go back."
- I was seen by a nurse who tried to play down how ill I was feeling and said that the pains I had were heartburn when it was an infection."

Uncaring attitude

55 young people reported an uncaring attitude displayed towards them by healthcare staff:

- "Sometimes you feel a bit dismissed by it and that they are just checking boxes."

- “I felt there was a lack of care and concern , it was like I was another name on their list of patients, no after care was given to me and I ended up having to have my procedure re done.”
- “Mental health issues get ignored and doors slammed in your face no one cares.”
- “I struggle with Urinary Retention and Constipation that happened suddenly in Easter 2023. To be told in September 2023 by a Doctor that I would ‘just have to live with it’ after only 2 tests was disgusting and heartbreaking.”
- “I was told by a doctor to 'stop crying like a baby' before an injection for a broken toe.”

Effective treatment

It is an interesting finding that the actual effectiveness of the treatment provided was highlighted less than the issue above (cited by 51 CYP) – tending to indicate that being treated in a caring fashion and being listened to are, to some extent, more important to young people than clinical outcomes:

- “I gave this rating because they helped me with my ear ache that was excruciatingly painful.”
- “I am receiving treatment for depression and anxiety. All sessions I have had has left me feeling refreshed and hopeful for a solution to my problems.”
- “I went to the GP for acne and was prescribed cream and antibiotics last week. it's already working well and my acne is reducing. I am also a patient with a new adult NHS mental health service and I receive good personalised care from my therapist who I meet with weekly and am making real progress on mental health conditions.”
- “The doctor gave a clear diagnosis, medication and coping strategies.”

Didn’t help/no help given

A small number of respondents (n=55) stated that they received no treatment and/or were discharged without any support or assistance.

- “In some ways they listened, but overall, felt they didn't do much, just sort of pushed me away.”
- “Nothing was done with the concerns I had.”
- Staff member was nice - however I’d been refused many times before for not being ill enough (including about my self harm and suicidal ideation).
- “I have a heart condition and have had a couple operations but at my last checkup I didn’t feel as though I was listened to about my family history with heart conditions as I was asking to be tested for another heart defect that runs heavily in my family in both men and women but my

doctor decided to only test my younger brother and didn't want to test me despite my history which was upsetting and dismissive."

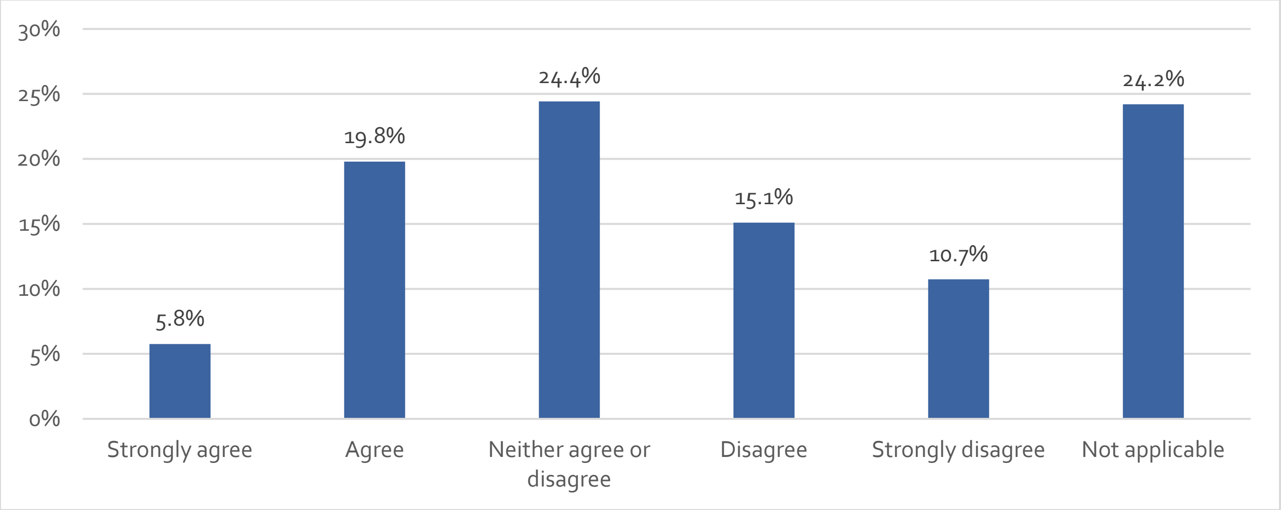
- "I have had tonsillitis multiple times in my teenage years, I went to the GP KNOWING I needed antibiotics and was told there was basically nothing wrong."

4.1.5 Transferring between health services

Speed of transfer

CYP were asked if they had been transferred from one health service to another to get a diagnosis or treatment, and whether this happened quickly. See Figure 14.

Figure 14: I got an appointment for a diagnosis and treatment quickly



(Valid total = 1,789)

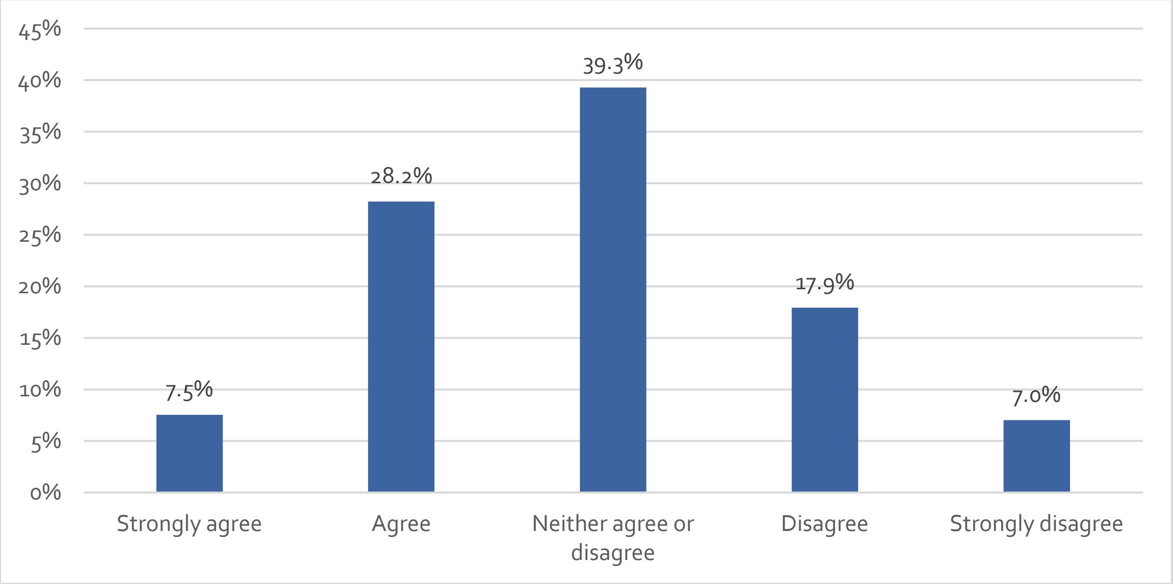
Appointment	Number
Strongly agree	103
Agree	354
Neither	437
Disagree	270
Strongly disagree	192
Not applicable	433

A quarter (25.6%, n=457) of respondents stated they agreed with the statement of accessing an appointment quickly, with a further quarter (24.4%, n=437) neither agreeing nor disagreeing. Around a quarter (24.2%, n=433) stated this question was not applicable to them.

Effectiveness of transfer

Respondents were asked 'if you transferred from one health service to another to get a diagnosis of your problem or to receive treatment to what extent do you agree with the statement: "The service I was transferred to had details of my condition and I didn't have to tell my story again"?

Figure 15: The service I was transferred to had details of my condition and I didn't have to tell my story again



(Valid total = 1,339)

Service transfer	Number
Strongly agree	101
Agree	378
Neither	526
Disagree	240
Strongly disagree	94

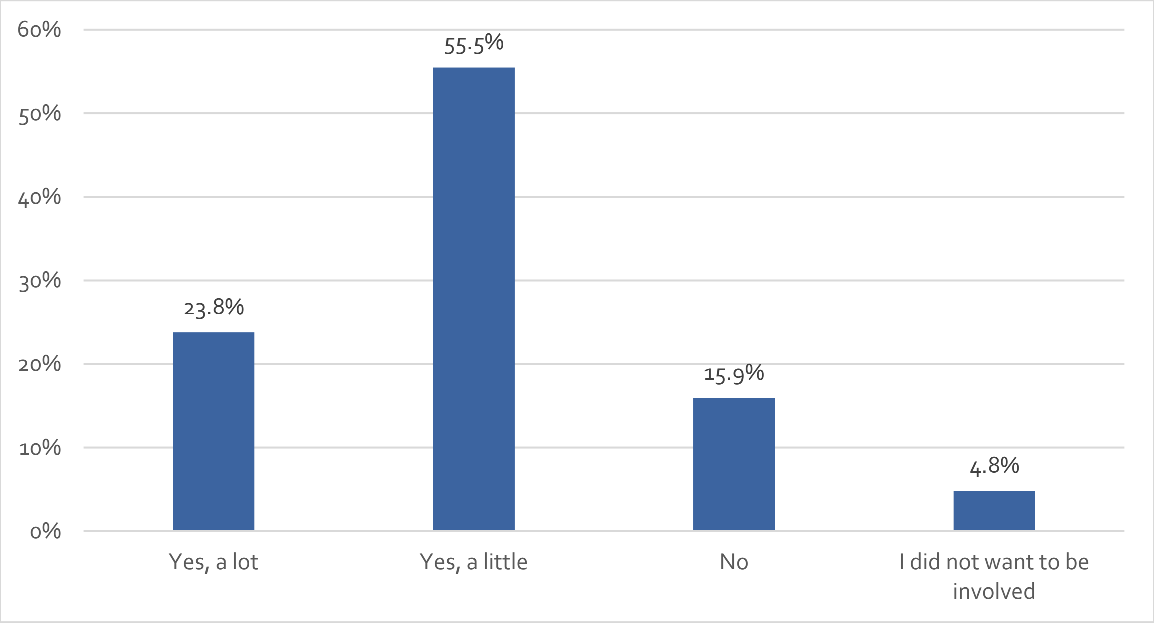
The largest grouping (39.3%, n=526) stated that they neither agreed nor disagreed with having to repeat their diagnosis, although around one-quarter (24.9%, n=479) disagreed (including strongly disagreed) with the statement.

4.1.6 Young people's engagement in health provision

Young people's involvement

Young people were asked whether they were involved in decisions about their care and treatment the last time they accessed a health service. The results are set out at Figure 16.

Figure 16: Were you involved in decisions about your care and treatment



(Valid total = 1,707)

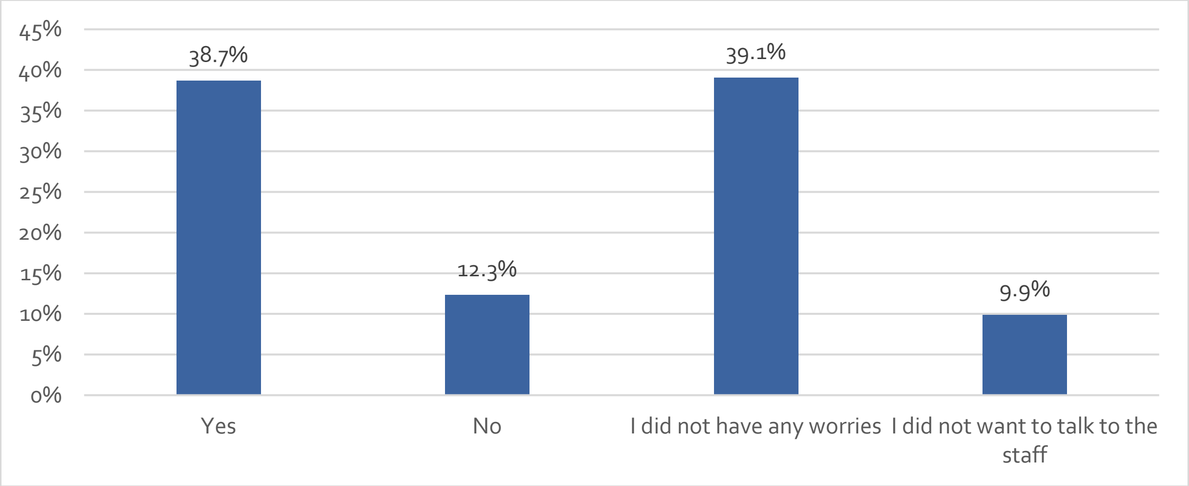
Decision making	Number
Yes a lot	406
Yes a little	947
No	272
I didn't want	82

A large majority (79.3%, n=1,353) of CYP stated that they had some involvement in their decisions about their treatment, with around one in six (15.9%, n=272) stating that they had no participation in their treatment.

Talking to health staff

Young people were asked, if they had any worries, whether a member of staff talked to them about them. See Figure 17.

Figure 17: If you had any worries, did a member of staff talk with you about them



(Valid total = 1,709)

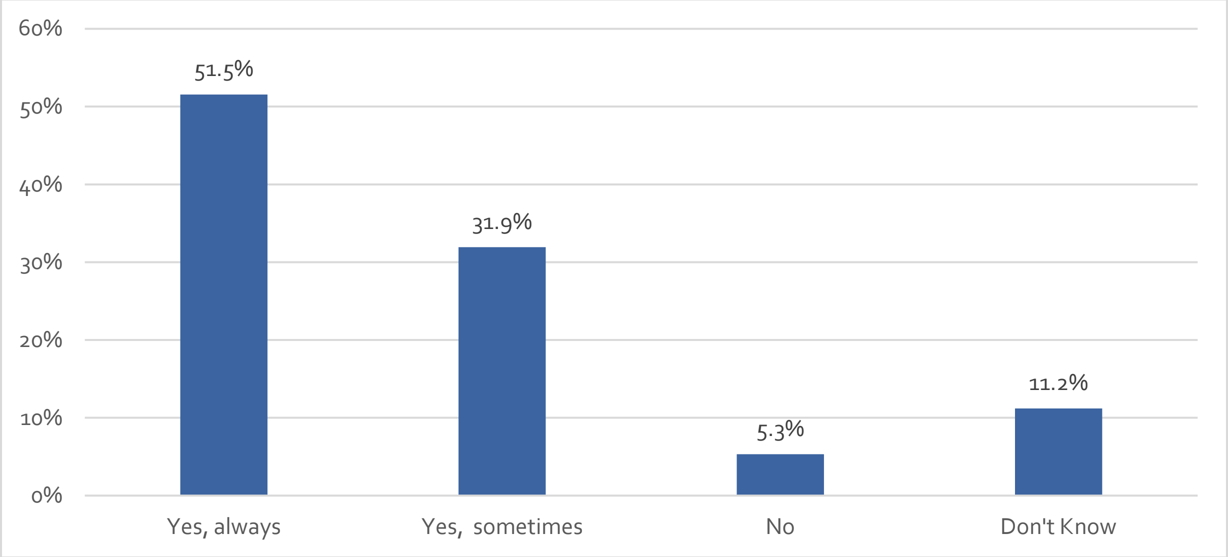
Worries	Number
Yes a lot	661
No	211
No worries	668
Did not want to talk	169

39.1% (n=668) of respondents had no worries or concerns, and 38.7% (n=661) did have concerns and spoke to a staff member about them. Only a minority of respondents (12.3%, n=169) had doubts or worries and did not speak to staff.

4.1.7 Privacy

Young people were asked whether they were given enough privacy when they received care or treatment. The results are set out at Figure 18.

Figure 18: Were you given enough privacy when you received care and treatment



(Valid total = 1,713)

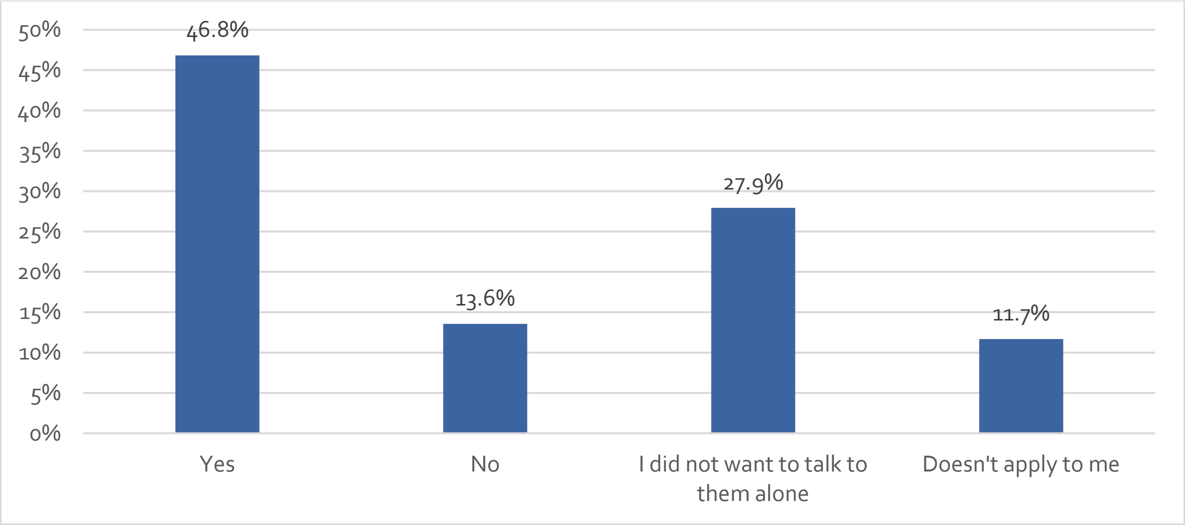
Privacy	Number
Yes always	883
Yes sometimes	547
No	91
Don’t know	192

83.4% (n=1,430) of respondents stated that they received privacy during their care and treatment either always (51.5%, n=883) or sometimes (31.9%, n=547).

Engaging health services without parents/carers

Respondents were asked whether they were able to talk to health professionals without a parent or carer being there. See Figure 19.

Figure 19: If you wanted to, were you able to talk to a health professional without your parent or carer being there?



(Valid total = 1,704)

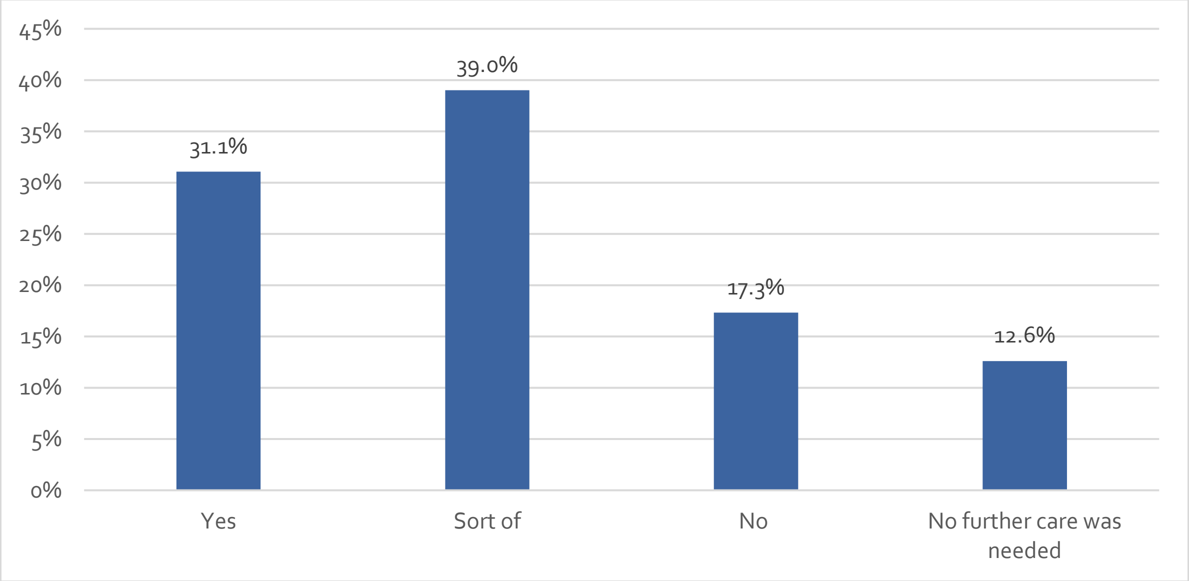
Without parents	Number
Yes	798
No	231
Did not want to talk	476
Does not apply	199

Just under half (46.8%, n=798) stated that they could talk to a health professional without a parent/carer in attendance. (Of interest 27.9% (n=476) of CYP did not want to talk to a health professional alone).

4.1.8 After treatment

CYP were asked 'when you left your treatment, did you know what was going to happen next with your care?

Figure 20: When you left your treatment, did you know what was going to happen next with your care



(Valid total =1,674)

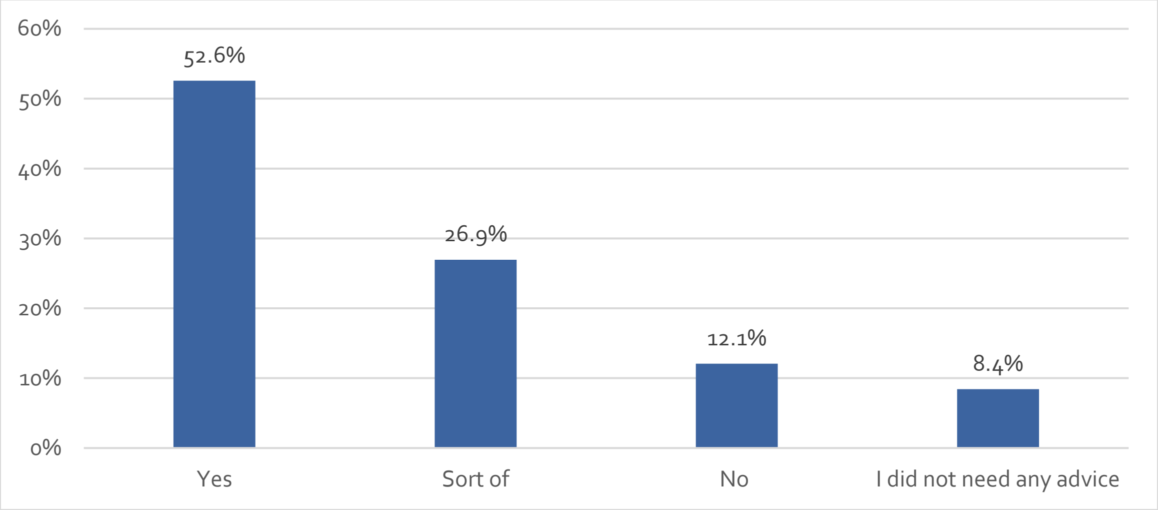
Happen next	Number
Yes	550
Sort of	653
No	290
No further care	211

Less than one-third (31.1%, n=550) of respondents stated that they were sure of the next steps in their care, with 39% (n=653) exhibiting a degree of uncertainty about their next steps. More than one in six CYP (17.3%, n=290) stated that they did not know what the next steps were going to be.

Advice from health staff

Young people were asked "Did a member of staff give you advice on how to look after yourself after you left your treatment?

Figure 21: Did a member of staff give you advice on how to look after yourself after you left your treatment



(Valid total =1,674)

Advice	Number
Yes	880
Sort of	451
No	202
No further care	141

Over half (52.6%, n=880) of respondents stated that they had received advice on looking after themselves post-treatment, with over one-quarter exhibiting a more ambiguous response (26.9%, n=451)). Around one in eight (12.1%, n=202) had not received advice.

4.1.9 Discrimination

Young people were asked whether they had experienced any discrimination or barriers when using health services.

9.8% (n=163) of young people indicated they had experienced discrimination or a barrier, while 73.4% (n=1,222) said not. 16.8% (n=279) did not know. (The remainder did not answer the question).

Respondents who had experienced discrimination or barriers were asked to give further information.

Racism

The most commonly cited form of discrimination highlighted was racism as identified by 11 CYP. Comments provided that referenced racism included:

- “A lady didn't think my chicken pocks were severe as they didn't display how it should have if I was white.”
- “The doctor was saying to test my blood that me and my mum should go to India. Me and my mum are Indian.”
- “Called a racist word p*** (short for Pakistani).”
- “Simply just being treated more kindly due to my religion choice and being treated as if I didn't understand when I have lived in England my whole life.”
- “Assumed I was Asian instead of asking ethnicity.”

Sexism

Ten young people believed that they had experienced sexism in relation to accessing healthcare services. As one noted: “As a woman with sexual health issues, I felt ignored and there were a lot of barriers that my GP put into place to getting the help I need.”

Others felt that their symptoms were discounted based on their sex, “As a woman with sexual health issues, I felt ignored and there were a lot of barriers that my GP put into place to getting the help I need”. And as another observed: “Being a female and being seen by a male professional can sometimes feel difficult or like they expect us to be emotional or over exaggerate”. One noted that, “Not receiving adequate treatment. Due to lack of understanding of women’s autonomy to receive actual treatment for lifelong symptoms rather than masking it with the pill.” Another noted, “When you’re round and a girl, every issue you tell your gp will either be down to your period or growing pains, even if severe. And they’ll probably push you to go on the pill without thoroughly going through it with you.”

Not believed

Nine respondents indicated that they felt that they were either not listened to or that healthcare staff disbelieved them on the grounds of their age. As one noted: “The long-term health condition I have now was complicated that when I was younger, my problem was dismissed as being entirely, or largely mental due to me being a 'child'. There was a failure of the duty of care due to my age.” Other comments included:

- “That fact that I'm young doctors don't think I know what I'm talking about when it come to my own health.”
- “A doctor said my anxiety wasn't something I should worry about because its normal for a teen to feel anxious.”

Transphobia and being misgendered

Five young people reported incidents of what they perceived to be transphobia or that they were misgendered. Comments included:

- “Yes, when undergoing my gender transition I felt judged and prejudged from heterosexual members of the healthcare industry. They frowned upon me for my sexuality decisions, this partly being due to my religion.”
- “I am trans and felt unsafe to get help from my gp and physio as there was no signposting for inclusivity.”
- “I was misgendered by someone who thought my long hair made me a girl and referred to me as such, which I found very upsetting. There was no need for them to refer to me as a boy or a girl.”

Neurodiversity

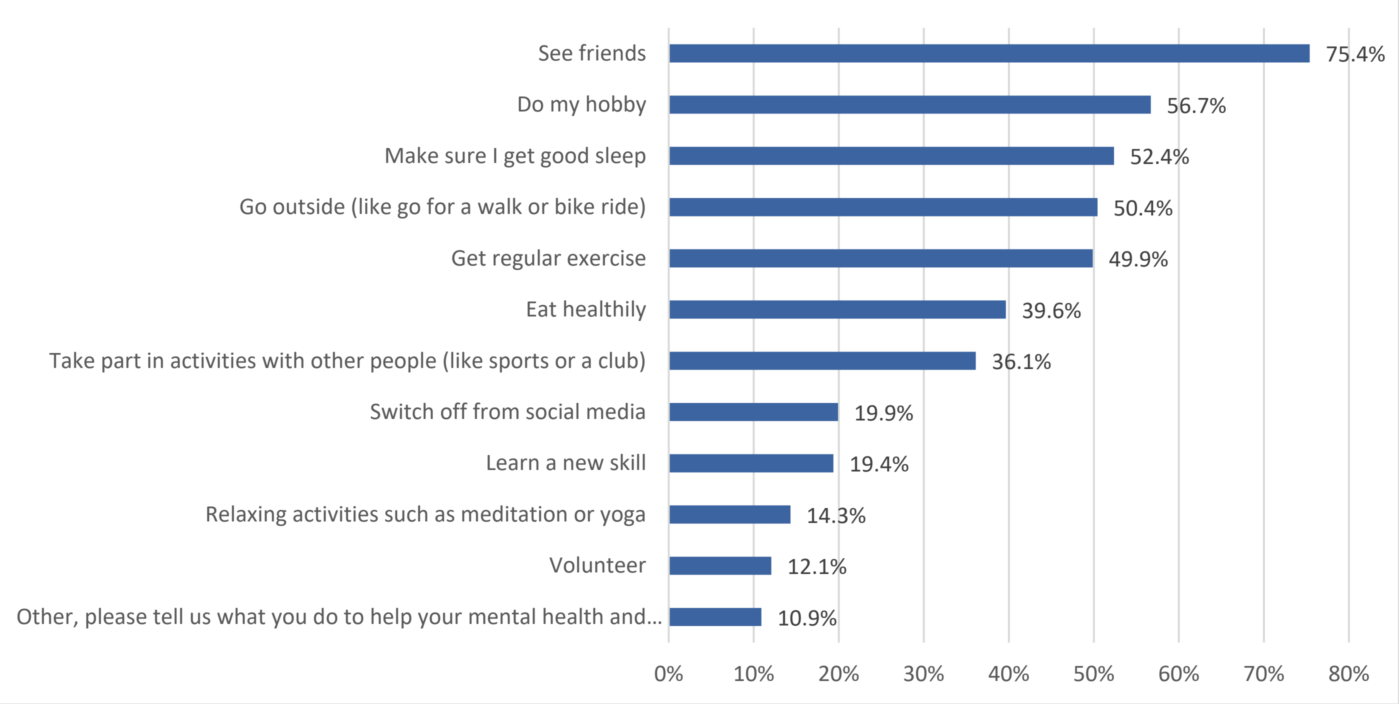
Young people with neurodiversity (n=5) felt that health services either didn’t understand their needs or failed to take their neurodiversity into account when treating them:

- “As a person with ASD I had multiple instances of my pain not being taken seriously as I ‘looked to calm to be in pain’ I find it hard to express emotions in general so of course I looked calm/expressionless. I do not see why the staff could not just take my words seriously. Fortunately that has not happened again in the last 1 year or so, which is great.”
- “Lack of autism awareness, belief that I was overreacting rather than actually being extremely distressed.”

4.1.10 Managing their health

Young people were asked what they do to help their mental health and wellbeing. The results are set out at Figure 22.

Figure 22: What do you do to help your mental health and wellbeing



(Valid total = 1,642) It should be noted that respondents could select more than one option so the totals equal more than 100%.

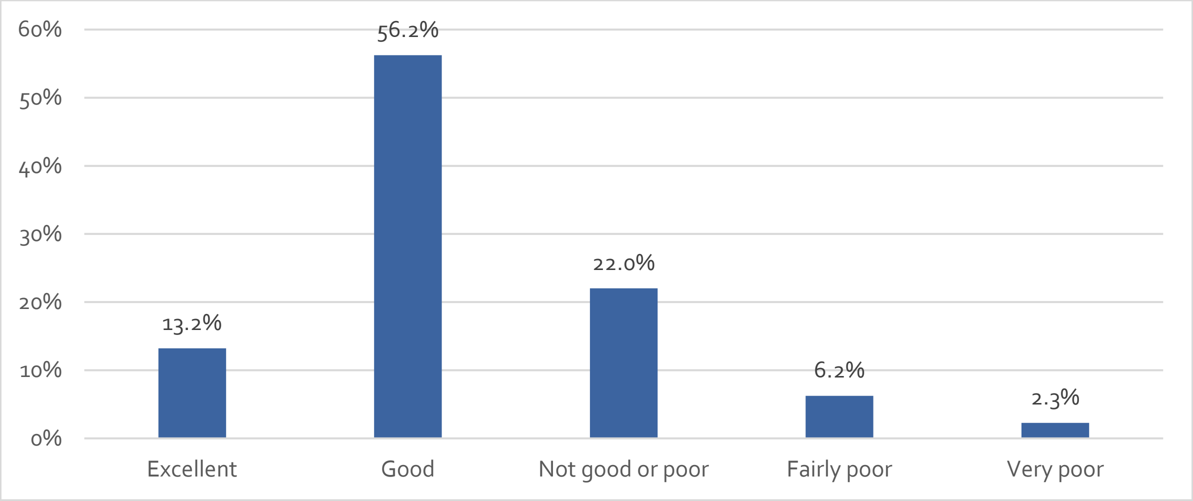
Mental health	Number
See friends	1,238
Do my hobby	931
Good sleep	860
Go outside	828
Exercise	819
Eat healthily	651
Activities	593
Switch off social media	327
Learn a new skill	318
Meditation/yoga	235
Volunteering	198
Other	179

Over three quarters of respondents, 75.4% (n=1,238) stated that they see friends to help with their mental well-being. Other activities included doing a hobby (56.7%, n=931) getting good quality sleep (52.4%, n=860), going outdoors (50.4%, n=828) and getting regular exercise (49.9%, n=819).

4.1.11 Overall assessment of healthcare

Young people were invited to give their overall assessment of healthcare. See Figure 23.

Figure 23: Overall, how would you describe your experience of your healthcare?



(Valid total =1,634)

Overall assessment	Number
Excellent	216
Good	919
Neither	360
Fairly poor	102
Very poor	37

Over half (56.2%, n=919) of respondents stated that their overall healthcare experience was good. More than two-thirds (69.5%, n=1,135) reported that their experience was positive (excellent or good).

Respondents were asked to say why they gave the rating they did for their overall assessment of healthcare experience. Around 8% (n=93) of respondents stated that they had no issues and that was the reason for their response, and a further 5% (n=58) said they did not know or had no idea.

Respondents were invited to provide further information about why they had given the rating that they had about their experience of healthcare (as set out at Figure 23). The information that they provided is analysed below.

Good or positive experiences

28% (n=240) of the comments about their rating of healthcare indicated that the respondent had had a positive experience. Positive comments included:

- "I have been treated really well, a few slip ups but still good."
- "It's good. They do what they need to do."
- "The service I got was just all round great."
- "I have had many doctors, nurses etc. over the years, and for the most part I have been treated very well and they have been very supportive during difficult times. Many got to know me on a personal basis and it make me feel supported. I appreciate everything the NHS have done for me."

Respondents also stated that they felt listened to, supported, and understood by caring and helpful staff. Comments included:

- "People dealt with my situation with good care and I felt listened to."
- "Very caring and easy to talk to. Listen to me when I raise concerns."
- "Professionals I've spoken to have always been helpful and welcoming."
- "There when I need it. Treated with compassion. Feel listened to."
- "I know that there is support around me and I feel happy."

Others stated that they had given a positive rating because they had always had good experiences of the health service.

- "I appreciate and am grateful for the free healthcare provided for people in full time education such as myself, and have not had any negative experiences or unjust treatment by any staff that I can remember."

Waiting times

Whilst the majority of comments stated that the service they had received was good (see above) over one in ten comments made (12%, n=106) cited waiting lists as an issue when assessing their overall experience of healthcare:

- "Apart from long waiting times for appointments quality of care is good."
- "Long waiting time and last minute appointment cancellations."
- "Long waits and sometimes staff do not make an effort to understand."
- "Waiting times for appointments and diagnosis is poor. It has affected my life negatively and I am losing trust that the nhs is the best place to manage my health and care."
- "The help received is good but it has long waiting times or long periods between sessions and appointments."
- "I've been on waiting lists and waiting lists for so many years my condition has taken over my entire life. it's so scary."
- "The healthcare is good however waiting lists are very long"

Mental health care

Other respondents identified issues around mental health care and accessing CAHMS as a reason for their rating. Comments included:

- "Mental health is not prioritised and often ignored especially as someone who is physically fit."
- "Physically it has been very good but trying to receive help for my mental health has been slow and pretty much unhelpful as it always leads to dead ends."
- "Within CAMHS I have felt dismissed a lot and only taken seriously when I was in crisis or in hospital after an attempt on my life."

Furthermore, respondents stated that whilst the physical health and medical care they had experience was good, accessing appropriate and good mental health care was a challenge:

- "Medical care has always been good, easy to access and care given appropriately mental health care was appalling. No support given whatsoever."
- "I had a negative experience with CAHMS, wasn't taken seriously nor listened to. However, as for physical health it has typically gone well."
- "In the physical care aspect such as my asthma and immunizations staff are lovely and quick to help or respond to any concerns. In the mental health area I feel that it is a real struggle to receive much support without it being an emergency situation."

Access to appointments

Another issue raised by respondents when giving a negative rating was how hard it is to access appointments, particularly with their GP:

- "When I do get an appointment and speak to someone it is great, but it is almost impossible to get an appointment online and I work when the reception is working so calling to book an appointment is difficult. It got to the point at which I just give up and either see a doctor when I visit my parents in my home country or just go private".
- "It's incredibly hard to get a GP appointment. Once I got one it often ended on a phone call or on a very short, vague face to face visit. I don't feel like my concerns were ever taken seriously. What seems to be a chronic condition lasting 5 years keeps being disregarded. Every time I go to the GP I'm advised to take painkillers as if I'm not doing that already. I would like to get better advice and actual diagnosis. Also the last time I spoke to a GP about my mental health, I was shown a religious quote (I'm not religious myself) saying that I should accept the things I cannot change. I made a formal complaint and never heard back about the outcome of that. It's overall really disappointing and it makes me question calling my GP for help in the first place."
- "It's hard to access care from GP and I'm always made to feel like my calls are unnecessary or that I'm wasting their time."
- "Very hard to get an appointment - staff seem to be under pressure so don't give you full priority when speaking you (reception staff can be rude)."

Additional observations

Having given an overall rating for health services (as explored above), respondents to the survey were asked to provide any last comments about their health, health services or the NHS.

Of those who provided additional comment, the most commonly referenced issue was in relation to mental health which was raised by 25 CYP. The focus of their comments was for greater attention to be paid to this issue:

- "Better services are required in Leicester for treating mental illnesses such as eating disorders, OCD etc."
- "Don't brush signs of mental health issues under the carpet and stop underdiagnosing."
- "I don't suffer with mental health issues but I have friends that do and they find it particularly hard to seek help, know where to go and when they do the waiting lists are 18 months - 2 years

long. Unless you are immediately about to harm yourself or others, there is no immediate support."

- "I feel like the mental health uni of the NHS is very poor and there is no one who listens or cares, I'm trying to get a diagnosis and I have to jump through so many hoops to access the right care.
- Mental health is not taken as seriously as it should, especially regarding diagnosis of disorders.
- Mental health services are shocking. I was kicked out of an and e whilst trying to hurt myself and kill myself whilst experiencing psychosis. I attended A & E four times and hadn't slept for a week before I was admitted to a CAMHs unit in Nottingham. Worst experience at the Leicester Royal Infirmary and by the Crisis teams EVER. disgusting and traumatising.

A number of young people specifically referenced the need for greater levels of investment:

- In general I feel that the mental health side is severely lacking in funding, resources, and dedicated and experienced staff. I feel that staff should be trained in more specific areas rather than having a basic knowledge of all areas and a lack of ability to prescribe .
- Mental health services need more funding and people who actually understand mental health running them. Need doctors to believe patients more and not just decide they are wrong or dismiss their concerns.
- Please give more funding to mental health services, they are severely understaffed and the waitlist is ridiculously long to get treatment.

In addition to the general comments on mental health, seven young people referenced issues in relation to CAMHS. Comments included:

- "With camhs I've only been to one appointments in the past year and a half, I know the wait is long but if there is anything to reduce waiting lists that would be amazing, it almost seems you need to become really ill to be treated, it shouldn't be this way."
- "Being on a long waiting list for camhs and not being given work to do at home due to my anxiety and feelings around school-this is unfair and impacts on my learning."
- "CAMHS needs better funding / improvements."
- "Fix your approach to CAMHS, for everyone there is not sufficiently cared for."

Consistent with findings elsewhere in the survey, following mental health, the next most commonly cited issue was waiting times (referenced by 22 respondents):

- “I had to wait a long time 2 to 3 years. It affected my life a lot.”
- “Waiting lists are too long, needs sorting.”
- “Waiting times are ridiculous, especially for surgeries after covid.”

Seven young people reported that there needs to be a greater focus on neurodiversity:

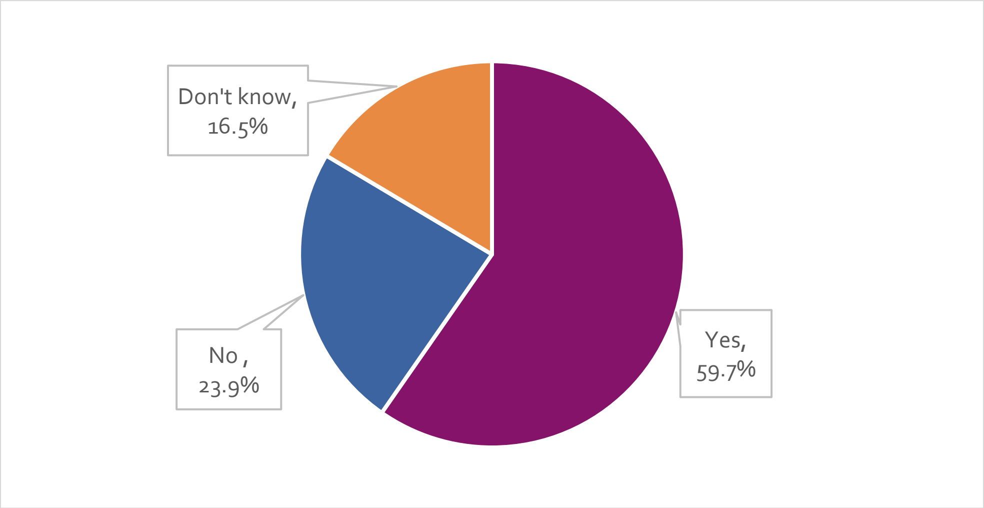
- “ASD diagnosis - Took ages, and was a battle. I have blanked out most of the process, so I do not have any idea exactly what happened.”
- “Make sure that more people get tested for things like autism and adhd as it can cause a lot of problems, I have been waiting for my diagnosis of autism since I was 5 and I am now 14 and nothing has been done.”
- “I couldn’t get a referral for an ADHD assessment and my family had to pay privately as CAHMS didn’t help at all.”
- “I've been waiting ages for my ADHD assessment appointment.”

4.1.12 Mental health

Seeking help for mental health

Respondents to the survey were asked, if they wanted help with their mental health, would they know who to contact and how to contact them. The responses are set out below.

Figure 24: If you wanted help with your mental health, would you know who to contact



(Valid total =1,632)

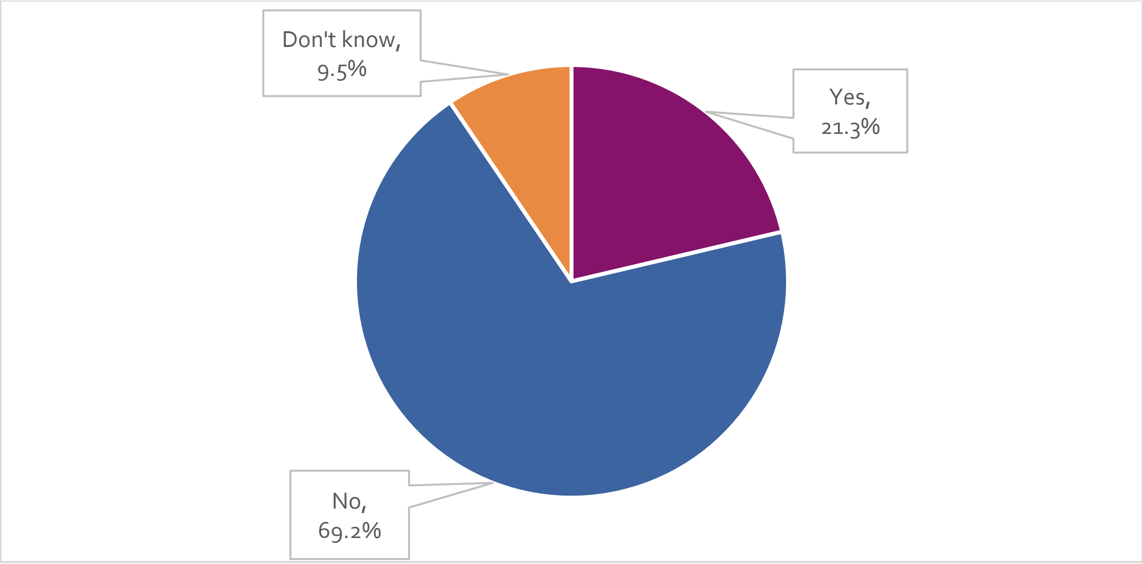
Who to contact	Number
Yes	983
No	393
Don’t know	271

Most respondents (59.7%, n=983) stated that they would know who to contact and how to contact them. Just under one quarter (23.9%, n=393) of respondents did not.

4.1.13 Use of mental health provision

Respondents to the survey were asked whether they had used a mental health service.

Figure 25: Have you used a mental health service



(Valid total =1,656)

Used	Number
Yes	353
No	1,146
Don’t know	157

Around one-fifth of CYP (21.3%, n=353) stated that they had used a mental health service at some time in the past.

Supporting mental health

CYP who accessed mental health services were asked what other support they would like.

176 young people provided information on support.

Of some interest, the most common response was "Don't know" (given by 22 young people) thereby clearly indicating that young people do not necessarily know what additional support would help.

Of those who gave an indication of what support they would like, the most given was support in schools, identified by 11 young people:

- "People to talk to in schools for EVERYONE, not just the most and in-need cases."
- "Meaningful advice in school and courses for parents."
- "More talks in schools, better skilled staff, more training for adults."
- "I think it would help within schools and universities for each academic department to have its own pastoral or mental health support, specific to that area. There could also be more awareness of anxiety and depression and other mental health conditions and basic teaching about how schools and universities can support students better that have these types of mental illnesses."

Related to support in schools, some young people also felt that teachers should receive training:

- "Giving teachers more SEND training so they have the ability to pick up on SEND more easily and earlier on. Thus providing more health and support as they grow rather than having to "fix" problems down the line."
- "More understanding/ knowledge within teaching staff."

Eight young people indicated that therapy should be more widely available and free at the point of access (some noting that they had had received therapy privately"): "Therapy one to one paid for by the NHS." As another noted, "I was referred to Cahms and adult mental health and neither of them could see me within 12 months so I have had therapy and counselling privately multiple times due to the NHS lack of help."

Young people also requested free access to counselling:

- "Making counselling more accessible and affordable as I find it really useful but depending on my finances I sometimes can't afford it and it really makes a difference."
- "Counselling without years long waiting lists."

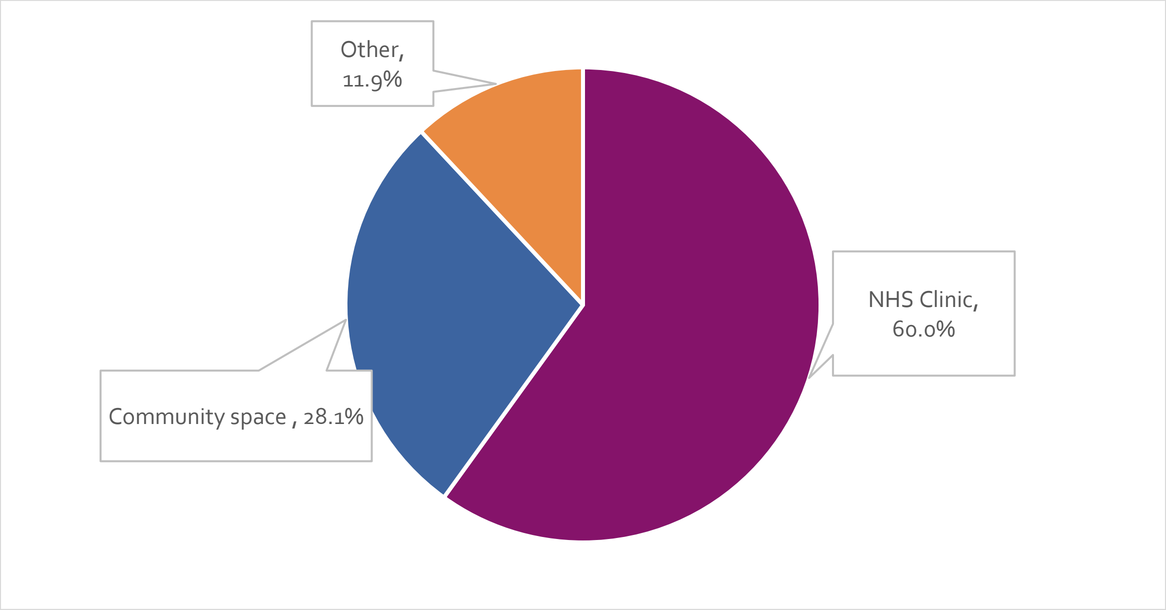
Of some interest, young people did not ask for additional support online, with only three respondents indicating that they wanted more web-based resources. One respondent stated that mental health services are: "virtually non-existent....always referred to checking out a website......not always the best advice when you feel bad."

Also of some interest, four young people wanted increased/better access to medication.

Where they wish to access mental health services

Young people who had used a mental health service (therefore a subset of the entire survey population) were asked if they had an appointment with a mental health service, where they would like it to take place.

Figure 26: If you were to have an appointment with a mental health service, where would you like it to take place?



(valid total = 477)

Where	Number
NHS Clinic	286
Community space	134
Other	57

60% (n=286) of respondents (who had used a mental health service) stated that their preference was for a mental health appointment within an NHS Clinic, with over one-quarter (28.1%, n=134) preferring a community space (e.g. a café or youth centre).

Young people who cited "other" were given the opportunity to indicate where they would like the appointment to take place:

- 10 young people indicated at home,
- Seven stated at school,
- Four that it should happen in a "private" location (non-specified),
- Three stated that it should be online/virtually.

Transitioning to adult mental health provision

18.7% (n=83) of young people with experience of CYP mental health services had transitioned from children's to adult mental health services.

Of those who had transitioned to adult mental health provision:

- 31.7% (n=63) indicated that they had understood about the transition process,
- 34.3% (n=68) had been provided with information about adult mental health services or services available in the community,
- 33.9% (n=65) said that information about adult services was easy to understand.

Young people were asked to suggest what a good mental health transition service would look like.

A key issue raised by a number of young people related to how the transition process was (or was not) communicated to them. Various aspects regarding improved communication were raised. As such all comments on this theme have been set out below:

- "Being given more knowledge on services."
- "Good communications between both services. All information transferred before transmission. Ensuring that the patient has immediate support after the transition. Making sure patient is aware of what is going to happen. Listen to their concerns and don't make decisions for them."
- "Giving warning before had that this would occur and through the process explaining how things work/ what difference there are without having a time where there is no contact with the patient."

- "Was a bit confused and didn't completely understand. Would of liked a bit more detail on the differences."
- "Someone who would explain in full detail but for a kid to understand."
- "Mental health professionals informing me, rather than teachers."
- "Digestible information with not too much information."

A commonly cited theme was the idea of a "smooth" transition. Young people offered a diverse range of ideas about what would constitute a more seamless handover. Given the range of issues explored, the comments on this theme are set out verbatim below:

- "One appointment with paediatric and adult services and me, then a quick transition to adult services. You should not be discharged from paediatric services until the adult service is in place. They need to listen to the patient on what adult service is going to work for them rather than making assumptions."
- "To not be discharged as soon as you go into adults!"
- "Having a clear profile of my information to pass on so that I don't have to tell my whole story again."
- "Being introduced by your CAMHS worker to the other workers and having a meeting together with yourself and your CAMHS worker involved with the adults team."
- "As a young person is turning 18 (in the 6 months prior) they should be introduced to their new workers and informed of who/where they need to go for different conditions."
- "Slow and steady! I felt like I was just discharged from CAMHS within a click of the fingers with no other help."
- "More appointments between the two services for a proper handover."
- "Appointments flow smoother rather than being dropped after CAMHS."
- "One that involves the same staff that know me, not having to repeat everything all the time."
- "One where the NHS don't kick you off the waiting list? Or a GP who doesn't take you off of your sleeping tablets. Reminders of the fact you are changing over to Adults Mental Health. Letting you know when you move up on the waiting list."

Three young people emphasised having a supportive environment in adult services:

- "Welcoming place."
- "A calm area with helpful staff who can explain things in a simple manner."
- "They listen and make you feel comfortable."

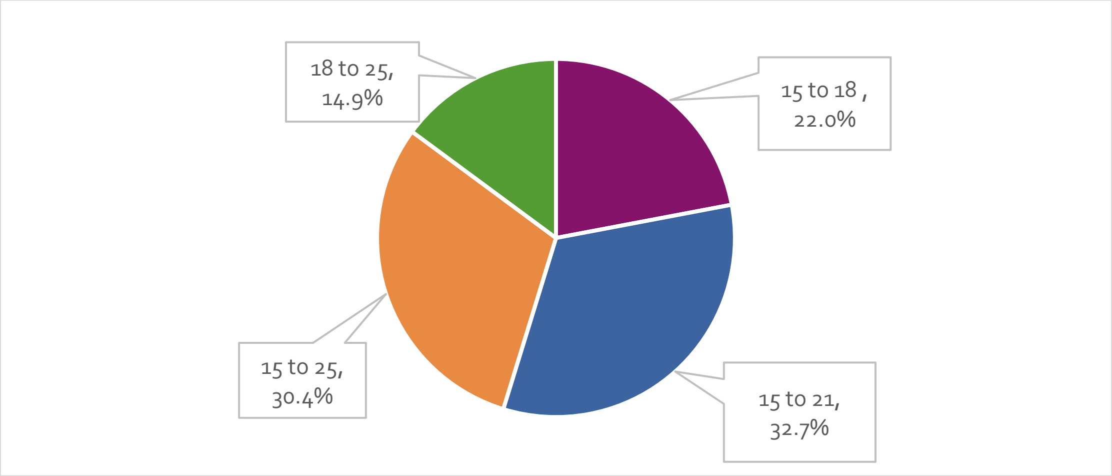
One young person explored how their gender identity was supported during the transition to adult services: "Be more accepting of my unsure identity as I felt a bit judged when using the services and explaining how I don't want to be my gender anymore. This made me feel hurt and rejected by society and I wish more transgender individuals like myself were present in the mental health service community. When undergoing my hormone treatment and surgical genital removal, I wished I had more support as I felt isolated from my classmates who laughed when I began to grow breasts."

Finally, there was an interesting observation from a young person who had elected not to transition into adult mental health service but felt that more information could have been given to inform this decision:

- "It's hard to say, I was discharged from cahms and decided not to pursue adult services at the time as I had gotten out of crisis point and mental health was improving. Now I am in treatment for trauma related to past crisis point. It would have been good to know what transitioning to adult services would look like. For example would I have counselling or someone to check in with every now and again at a local gp surgery. I feel I didn't want to go down the route of adult services at the time, but perhaps if I knew more about what it would entail I may have chosen to do that."

Young people were asked the age range that mental health transition should cover. The responses are set out below.

Figure 27: What age range should the mental health transition service cover?



(valid total = 168)

Age	Number
15 – 18	37
15 – 21	55
15 - 25	51
18 - 25	25

There was a wide range of responses to this question, with the most favoured response including a 15-21 age range (32.7%, n=55) followed by 15-25 years (30.4%, n=51). Caution is advised in the interpretation of this finding as there was a high level of non-response (i.e. from the large majority of CYP who had not accessed mental health provision.

4.2. Participatory activities

As noted in the Methodology section, 355 young people were engaged via participatory activities. All young people consulted were asked to explore both physical and mental health concerns. A range of other themes were also identified in the data from the participatory activities. These themes are explored below.

4.2.1 Health concerns

By far the main health concern that young people expressed was about their mental health with nearly two-thirds of responses being about this topic.

The conditions they commonly experienced were depression, anxiety, autism, stress, and ADHD.

The factors underlying these issues included pressures at school, while others discussed the pressure about appearance that came from social media and cyberbullying. Family breakdown was a factor for some. Others, like a group of young men, had experienced significant trauma. Young people reported that there are delays in getting support, diagnosis, and treatment for mental health difficulties and these were expressed in all focus groups and in answer to several of the topic questions.

Behavioural difficulties appear to be a grey area for treatment in specialist mental health services with one facilitator commenting that "*Without a formal diagnosis, schools may be unable to enrol these* *children in supported programs designed to address their specific needs. This lack of timely intervention not only impacts the child's learning experience but also increases the likelihood of temporary discharges, suspensions, or expulsions from school, further exacerbating their mental health struggles*".

4.2.2 Mental health self-help

Because CYP reported that they could not get timely support or treatment for their mental health difficulties a range of self-help strategies were reported. Most of them talked about their problems with someone they could trust such as a friend or family member and many used exercise to improve their emotional wellbeing. Some turned to music, journaling, religion, prayer and meditation, although as one observed "*Who wants to meditate if you have poor mental health? Why would you want to be alone with your thoughts*?"

Of some concern, several young people said they would rather just keep things to themselves. This particularly applied to the asylum seekers who felt that they might not be understood by services when they tried to explain what had happened to them. A young person from the Polish community in Leicester felt it would be "*better to just bottle things up-keep quiet*", and a young mother said her response to her mental health difficulties was to "*cry*". A few other young mothers used positive self-talk to "*tell myself I am OK*". Only one young person from all those consulted mentioned taking an antidepressant medication.

One group of young people were reluctant to go to their parents for mental health support as they felt they would not understand the pressures they felt "*The world has changed since their day*".

Although some identified social media as a source of emotional distress, several turned to TikTok to cheer themselves up. Only one group thought that limiting access to social media would be a way to support their mental health.

While young people clearly wanted to talk about their problems and to socialise to lift their mood, they did not always feel that therapy or counselling was the answer. Some said that they "*don't like to talk much about their feelings*". As one noted: "*I think it would be great if there was something where people can open up… it's not even about paying for it, it's more like therapy, but not "therapy" because people don't like the word "therapy" it's more like having social groups where you make friends and can talk about how you feel*." A group of young men were cautious about therapy because "*I had that before and then I had an appointment with the doctor for mental health. They say they're going to help you in different ways… but if you focus with them in some way, you're going to be crazy more than that [group laughs in* *agreement] because they're going to remind you of the thing you want to forget, they're going to remind you... I want to forget*."

Adding to this, one young person said: "*That's why going to a therapist is something that most of these guys would not really go to... it's easier to bury down the pain than to just open it out*." .Their trauma was such, and the experiences they had had, were so distressing that they could not face thinking about them in a therapeutic context.

A couple of focus groups revealed situations where young people felt despair, for example one who said "*I don't do anything; I just stay in bed all day*" and another who believed that "*they turned me away because I haven't killed myself yet. They could have tried to at least help me".* (It is understood that these young people have since received therapeutic support from the service conducting the focus group.)

4.2.3 Physical health concerns

Apart from the mental health concerns discussed above, key health concerns for CYP were vaping, diet and weight, and long-term health conditions such as asthma.

4.2.4 Sources of health support

Children and young people mostly went to their parents or another trusted adult in the family or a friend for health advice when they felt unwell. Several had asked a teacher or had accessed a school nurse. A young woman commented that "*The school nurse pays attention to your needs and picks out the thing that needs the most work*".

Most were familiar with going to the GP, using 111, or, for mental health problems, accessing CAMHS, a therapist or counsellor. Many young people reported going online or using social media to get health advice and information.

Some had used A&E departments or had called an ambulance but reported having been surprised at the lengthy waiting times.

Others had appropriately made use of pharmacists and walk-in centres where available.

Many young people in this participatory engagement reported using exercise to improve their physical, and often, their mental health.

4.2.5 Appointments and waiting lists

It was a universal complaint that getting a GP appointment when needed was extremely difficult and time consuming. The most common experience was being told to call at 8.00am, waiting in a long queue but then not getting an appointment at all. As noted by a young person: "*It's not easy, you have to call two or three times…. They say from 8 to 8:30, but when you call them they don't pick up*." "*You have to be on the phone bang on 8 o'clock to get an appointment*.

As noted by a facilitator: "*Most of the young people would say it's generally good service but could be better if they didn't have to wait 6 months for hospital appointments and GP surgeries often have no appointments left after 9am waiting 30 mins on the phone in a queue they say no more appointments left.*"

Appointments, when offered, could be in school or work hours and the advice given by a GP was not always understood or appreciated. Some young people reported that they felt "fobbed off" when told to take paracetamol without an explanation or prescribed medications that they didn't really understand.

Some thought that the NHS was understaffed and that doctors were probably underpaid, although a couple felt that doctors should not go on strike. A group also mentioned extreme difficulties in getting access to a dentist. As one young person stated: "*For someone to be able to get into a dentist is hard… it's usually referral to referral to referral*". This is despite the fact these young people are looked after by the local authority so are required to have a dental check up every six months.

Travelling out of the LLR ICB area was an option for some with one centre reporting that:

"*It is practically impossible to be seen by a specialist if you need. Many will travel to Poland [their country of origin] to see the specialist they need. This is quite common".* A carer had this experience: "*Fortunately, we were told that we could get seen sooner in Nottingham. So, we opted for that. But we are able to travel there. Some people cannot*".

4.2.6 Being listened to

Listening to patients and parents

Some young people had good experiences of being listened to, especially in cases where they had gone to A&E for injuries. A 13-year old said " *I hurt my ankle after football and my mum took me to the doctor's; they sent me for a x-ray and I thought he was fine he listened to me and checked my ankle properly*".

A 10-year old said "*I went hospital with my mum because I fell on my head tripping over something at home but it was bleeding so we went and they took care of me nicely*."

However, a very large number of children and young people felt they had not been listened to or respected in their encounters with health care professionals. Young mothers felt they were seen as "*hysterical*", "*overdramatic*", or not as capable of caring for their babies as older parents. They felt their concerns were dismissed, even in cases where it turned out that their baby was seriously ill – for example one infant who eventually went on to being fed by tube because of feeding difficulties that had been dismissed. It was reported that it felt as though health staff were often in a rush: "*They listen to what they want to listen to so they can get the appointment done quicker."*

How practitioners listened and explained could depend on the specialism or the condition being treated with specialists thought to be better than GPs.

"*It really depends on the service; GPs are not great. I go to my physiotherapist, and he is great, really approachable and communicates well with me if I have questions*". As another young person observed: "*GP's don't listen or communicate very well. Specialist CYP doctors do. It can't be hard*?"

Another reported that: "*Specialist paediatricians are very good at communicating with children with SEND. My GP is not good. I understand that people have different experiences, but speaking to children must be a skill that all doctors/nurses have*".

Parents of children with special needs expressed particularly poor experiences. For example: "*I have so many complaints lodged. I don't want to, but if I don't, nothing will get done. My kid could not do this, and shouldn't be expected either*. *The hours I have put into fighting to get my child the correct medical care are taking their toll. I have had to give up jobs to lobby to get the right care. Complaining costs money and my wellbeing*".

Communication between services

Problems were identified with services not communicating with each other. A young person with a long-term condition said "*When you don't fit into the system, communication between hospitals doesn't work. I got discharged from Great Ormond Street Hospital, and came under UHL's carer. At GOS I was having physio and I was getting better. When I arrived in Leicester, the In-patient Physio said they couldn't work with me and I had to go to the Out-patient Physio. The Out-patient Physio said I didn't meet their requirements. I ended up having to do my own research and find a charity organisation who could help me with my physio. All the time I was getting worse and worse*."

4.2.7 Equality of treatment

Many young people believed that health services treated everybody equally. This view predominated among groups of young people from mainly white focus groups (such as those conducted in some schools). One young person assumed that the NHS treated everyone equally: "*I'd think so since they campaign for race and gender equality. This is good, training staff and making sure healthcare professionals are recognising people as individuals*".

A facilitator of one group emphasised that equal treatment depended on particular variables: "*For those that did feel seen, they were happy with the care they received, yet this did depend on the healthcare professional's ethnic background or their level of cultural competence and it was different across the organisation.*"

Language, accessibility and cultural competence were all highlighted as important parts of ensuring equal treatment.

Language and interpreting

One group felt that language access was "ok" because, "*GP surgeries are ok around Highfields because they can speak their language and that helps*".

One group had other strategies: One person said he used his phone: "*For me, with any translation I use my phone. It can be a long wait for translation services, but you can just write what you want on your phone and it translates into English.*"

Others disagreed and said they would ask for translation to be provided by health services: "*First time when we came here, I'm not speaking English, so I need it. Never had any problem getting access to translation services, always been a good experience*".

Experiences of discrimination

Particular groups reported experience of discrimination, based on age, ability and race. These are explored below.

Age and gender

It was a common experience in the group of 26 mothers aged under 25 that they felt that they were looked down on, for example a 20-year old woman who said "*I feel as though people get mistreated, people such as young mums, get treated unfairly and as though we are incapable of doing what a 30-year old mum can do*" (Young Mother) and "*When I was in hospital with baby they looked down on me*"

Race and ethnicity

Young people reported experiences of racism: "*Ethnic minorities are treated with much less care because doctors assume that black people can handle pain and underestimate our symptoms*". Young people from the same group were clear that practitioners do not understand what certain conditions, such as jaundice, look like on dark skins.

One young person explained that "*There can be stereotypes and racism anywhere; just because they make you feel better doesn't mean their views on you might be good*"

4.2.8 Long-term health conditions and disability

Children with long-term health conditions were affected by appointments that took place during school hours which impacted their learning and privacy. Those who had been able to access CAMHS expressed similar difficulties with appointment times. Recently CAMHS appointments have gone online which was not satisfactory:

"*CAMHs online meetings don't really work. When dealing with mental health it is better to be face to face. I only get notified 10 mins before my online CAMHs appointment when I am at school. It is hard to find a private place in school, and Wi-Fi or my mobile data is dodgy at school*" We note that it is not clear how this will work if schools prohibit mobile phones.

Children and young people with disabilities had fundamental problems with access: "*Wheelchair access. The Adolescent area in Children's ED can't fit a wheelchair in, so you must sit with the little kids*

Both children with long-term health conditions, and carers were fed up with having to repeatedly explain their condition to professionals. "*If you have long-term conditions, building relationships with your health team is important. You need trust. But lots of professionals leave or move around. You end up having to explain everything to the new staff member*". Better record keeping and retention of key staff members would help with this, but this reflection is another comment about the importance of good listening and communication between teams and services.

4.2.9 SEND and profound and multiple learning disability

Families with children and young adults with SEND had serious difficulties in accessing services and receiving equal treatment. A group of eight mothers of children with complex needs expressed difficulties getting appropriate care for their children who were usually unable to advocate for themselves:

"*I have lost trust with the NHS. As parents of children with special needs, we have to tell our story over and over again. You have to fight for every inch of healthcare. You get drained of energy, you are angry, frustrated. Nothing changes. This then filters into our home life. It doesn't just end at the end of the telephone or at the end of the appointment*".

One mother and her son with special needs had a frightening experience of treatment that was not adjusted to the family's needs. "*My son needed a CT scan. I have a two-year old as well. I couldn't get childcare, so I had to bring the two-year-old with me. My 11-year-old son had to have a CT scan on his own. I was not allowed to go with him because I had the two-year-old with me. There was no play specialist or provision to put my two-year-old in for a few minutes. My son came out and he was very shaken by the experience. So was I*".

Another mother said "*My 22-year-old child has Down Syndrome and she can't understand everything. Especially complex medical things. If the doctor cannot explain the issue to me in a way that I can understand, how can I explain it to my child?"*

Students at a Special School wanted more accessible eye tests: some of the young people said they had been for an eye test but didn't really know their alphabet very well. As a result, they were worried they have the wrong prescription for their glasses. However, the young people also said that they like to have their appointments with the opticians on their own (without a parent), because they feel that they can handle it and there won't be any difficult questions.

4.2.10 Information and communication

The participants were well informed about sources of healthcare but wanted to understand more about the NHS and have things explained in a way that they understood. It was reported that one group said: "*Young people like the personal touch. They like verbal and face to face information given to them. It makes them feel human*. *Follow up info to refer to, young people said they like leaflets, and especially when the GP talks them through the information*".

A group of Polish young people wanted:

- Pop up sessions and roadshows,
- Dedicated apps for young people,
- Online peer to peer opportunity,

- Working with social groups and clubs to engage young people on topics like vaping/mental health.

Many young people wanted something that was integrated with school such as assemblies or in the curriculum. A higher profile for NHS health information on social media, especially YouTube and TikTok would be something they would all appreciate.

4.2.11 How could NHS services in Leicester, Leicestershire and Rutland be improved for children and young people?

The children and young people consulted had plenty of ideas for improving NHS services in LLR. The responses gathered from the activities are set out below.

More resources

They had views on the infrastructure around NHS services. Many thought that it would be a good idea to build more hospitals. They thought that the NHS needs more staff especially at GP practices. According to these participants the way to recruit more GPs would be to pay them more. Others wanted the staff that are already employed to do things differently.

Easier access

Having a better system for making appointments was commonly requested – especially answering the phone more quickly. Others wanted the attitude of staff towards young people to change "*Employ people who are passionate and care about young people. There are people who clearly don't like young people or are a bit afraid of working with them. Could we provide healthcare staff with Young People awareness training*"?

Dedicated services

Children and young people would like dedicated primary care services for their age group. Surgery times at GPs just for children and young people were one suggestion and one group suggested that there could be a separate 111 line just for young people. Many people in this consultation had used 111 and found it helpful when they couldn't get a GP appointment.

Improving health

Young people were aware of the importance of health promotion and disease prevention. Nearly all the young people were aware of the importance of exercise to improve both physical and mental health and many suggested that free gym entry or exercise programmes would be a benefit to both the NHS and the young people themselves. More advice on getting into shape would be welcome such as using social media and apps such as YouTube to encourage fun fitness activities for children.

Young people wanted more restrictions on vaping which they recognised is both addictive and very accessible.

Several groups reported that they would like regular health check-ups and blood tests as they sometimes fear they may have a serious condition which doctors are missing, or even dismissing.

Working with schools and youth workers

One group suggested that Youth Clubs are a great way to improve mental health and to better engage young people.

"*For mental health, work more with youth clubs and support these:* "*Youth clubs – they clearly work. People love going to youth clubs as a way for them to, like… Youth clubs have lots of facilities like pool tables, TVs, PS4s, that's a good way for people to enhance their mental health because it's a good place for them to relax, no stress or nothing."* Another young person felt that youth workers would be useful staff members in the NHS working alongside healthcare practitioners "*Employ more staff who have good senses of humour and are good at working with young people. These could be youth workers as well*".

Integrating more with schools would help them understand both the services that are available and how to look after their own health. There were several suggestions that there could be guest speakers from the NHS at assemblies. While acknowledging the confidentiality issues, healthcare teams need to communicate better with schools. A child with a long-term health condition said that it had taken "*ages*" for a SENCO at school to realise she was in hospital and send some work for her.

4.2.12 Being Chief Executive for the day

Young people were asked what they would do if they had the opportunity to be the CEO of the NHS for the day.

Young people wanted health chiefs to listen to them, both as individuals and in consultations.

A young mother wished that:

- Everyone is listened to,
- Everyone is treated fairly,

- More appointments available,
- More groups available, and
- Help everyone no matter the age

A group of young people made the following suggestions:

- Make ads that help children feel more comfortable with healthcare.
- Put time into teaching medical workers to take young people seriously and to make school initiatives that encourage children to not hide medical/mental illness.
- Regular engagement opportunities for young people; visibility in schools
- Improve the wait time and hire more people with the correct pay.

A group of mothers who cared for young people with complex learning disabilities wanted the Chief Executive to know that:

- MH services need investment, for all ages.
- CAMHs admissions process must be fixed. Waiting lists need to be reduced and communication to young people and parents about what is going on needs to be better.
- Waiting lists need to disappear!
- "*I'd swap my bonus and invest it in understanding neurodiversity in young people – it probably wouldn't go far!"*
- *"I want people in power to really understand our situation*."
- "*I would recognise the lost hours of children's education. They miss out on so much education to fit in their healthcare*."

CYP people wanted to feel that they had been treated fairly, seen promptly and that someone had listened to and understood their concerns. They needed treatment options and plans to be clearly communicated to them and to feel that nothing serious had been missed.

4.3 Key Findings

The key findings from the 1,884 young people who completed the survey were:

4.3.1 CYP Survey

- The most commonly cited health issue of concern to CYP was mental health, as noted by 60.8% (n=1,103) of survey respondents. Of some interest, the next most commonly cited issue was sleep as identified by 46.7% (848) of CYP. Also, of some interest cancer was identified by over a third (35.4%, n=642) of young people. Perhaps related to the concern around mental health, almost a quarter (24.8%, n=449) of respondents stated that they were concerned about loneliness. (All data Figure 7). (Note how this finding correlates with the most commonly given response given by young people regarding what they do to help their mental health, with three quarters (75.4%, n=1,238) indicating that they see friends. (See Figure 22). The concern around mental health was picked up in the free text aspect of the survey where young people, when asked what else they would like to share, were most likely to raise mental health as a key issue to be addressed. (See Section 4.1.11).
- When asked what they would do if they had a health concern, the majority of young people (59.9%, n=1,118) indicated that they would talk to a parent/carer. 22.3% (n=417) would evidently seek to "self-serve" the information they need by going online. Of considerable interest, only 6.1% (n=114) would contact their GP. (See results at Figure 8). Allowing for the fact that the majority (60.7%, n=960) of the survey population are minors and might therefore rely on their parents/carers to make decisions about contacting primary healthcare, it is also the case that over a third (38%, n=601) of those consulted were aged 17 years or older. It is somewhat surprising therefore that, given this profile, more young people did not indicate that they were prepared to contact their GP of their own accord.
- Slightly countervailing the picture set out immediately above, a large majority (78.8%, n=1,399) of young people reported being confident about knowing what services to use should they become ill. A very small minority (6.9%, n=122) were uncertain what to do should they become ill. (Data at Figure 9).
- Despite few young people reporting that they would contact a GP, the majority (72.9%, n=1,344) of CYP indicated that they had seen their GP in the last year. This may tend to imply (as suggested above) that parents/carers are the primary means by which young people access primary care. A similar proportion (74%, n=1,363) of young people reported having seen a dentist. Of some interest, a quarter (25%, n=461) had attended A&E. This is possibly indicative

of a lack of access to primary health services but this is necessarily conjectural. The data however indicates much higher levels of use of emergency medicine than might otherwise have been expected. (Data at Figure 10).

- There is a generally positive endorsement of health professionals with over two thirds (68%, n=1,231) of CYP stating that they feel listened to by health staff. (Figure 11). Equally CYP felt that they were treated with care and concern, with 74.4% (n=1,344) supporting this statement. (Figure 12). Note also that CYP were positive about the health service that they had most recently had contact with, around three quarters (73.7%, n=1,335) of CYP rating their most recent contact as excellent or good. (Figure 13). Young people's overall assessment of healthcare as also positive with over two thirds (69.4%, n=1,135) reporting their experience as good or excellent. (Figure 23).
- The accompanying qualitative data to the rating on the last health service used provides considerable insight. The most commonly given reason for giving a positive assessment of health services was that staff were caring and compassionate. Young people also emphasised the need to be listened to. Strikingly, these two themes were mentioned more often than a positive clinical outcome. Note also that uncaring staff and not being listened to were key reasons that young people gave for a negative assessment of health services. (See Section 4.1.4).
- For those young people who had been transferred from one health to another only a quarter (25.6%, n=457) of young people indicating that they got an appointment quickly. (See Figure 14). Almost exactly as many (25.8%, n=462) indicated that they had not got an appointment quickly. Note also that a quarter (24.9%, n=334) of young people who received an onward referral indicated that the service did not have details of their condition (also that the most common response was neither agree nor disagree). (See Figure 15). The results therefore tend to indicate some issues where CYP are transferred or referred between health services.
- A positive endorsement was given by young people in relation to feeling involved in decisions about their care and treatment, with the majority (79.3%, 1,353) feeling engaged (albeit that the majority - 55.5% (n=947) - felt they were engaged "a little"). A small minority, 15.9% (n=272), of young people did not feel involved in decision-making which gives some cause for concern. (Data at Figure 16).
- More strikingly, while evidently involved in decisions about their care, less than a third (31.1%, n=550) of CYP left treatment knowing what would happen next. Around one in six (17.3%, n=290) stated that they did not know what would happen next. (See Figure 20). Note also that only

around half (52.6%, n=880) of young people were given advice on how to look after themselves after treatment. (Figure 21).

- Discrimination was said to have been experienced by 9.8% (n=163) of young people. When asked to explain what they had experienced young people offered examples of racism, sexism and transphobia (albeit low numbers of young people reporting each). A small number of young people felt that health staff did not understand the needs of neurodiverse patients. (See Section 4.1.9).
- With regards to mental health, while the majority (59.7%, n=983) of young people indicated that they knew where to seek help, around quarter of respondents(23.9%, n=393) did not. (Figure 24).
- Consistent with the findings whereby mental health was the biggest health concern among CYP, just over a fifth (21.3%, n=353) of survey respondents had accessed a menta health service. (Figure 25).

4.3.2 CYP Participatory activities

The key findings from the 355 youth participation groups were:

- The prevalence of mental health conditions and concerns, together with difficulties in getting support and treatment with those concerns.
- Difficulty in getting appointments with primary care services and lengthy waiting lists for hospital treatment.
- Not feeling listened to or respected by healthcare professionals.
- Inequalities within healthcare provision for some groups of children and young people and their families.
- Most young people went to parents, friends, or family for help with healthcare, but they were also aware of, or had used, GPs, pharmacists, 111, 999, social media and A&E services.
- Information would reach them best on YouTube and TikTok, but they liked verbal information too.
- They had a variety of suggestions for how services could be improved for young people and children.

Above all, young people wish to be listened to and taken seriously and helped promptly when they ask for help.

5 Voices of parents and carers

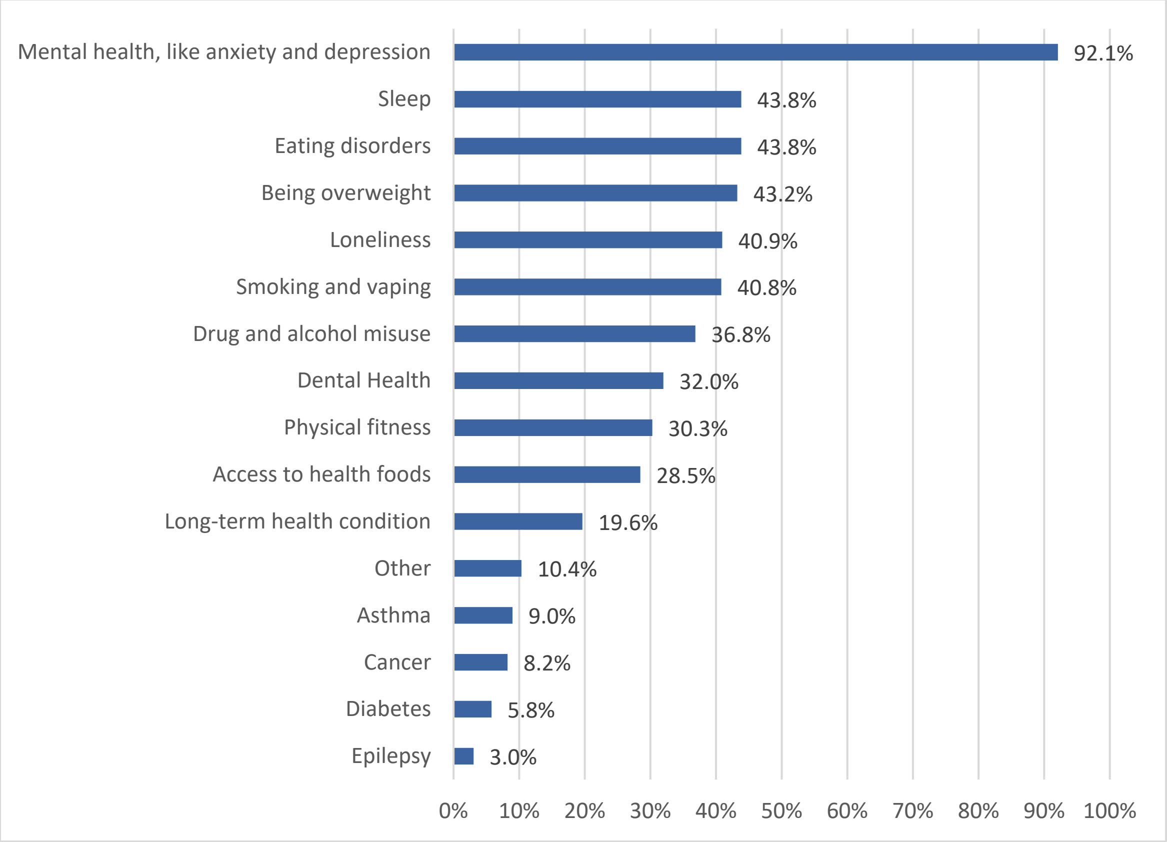
This section sets out the findings from the consultation with parents and carers. In total there were 659 respondents to the parent/carer survey.

5.1 Findings

5.1.1 Key health issues affecting children and young people

Parents/carers were asked what health issues they thought matter most to CYP. The findings are set out at Figure 28.

Figure 28: What health issues do you think affect or matter most to children and young people?



(Valid total = 657. Note that parents/carers could cite up to five health issues).

Condition	Number
Mental health, like anxiety and depression	605
Eating disorders	288
Sleep	288
Being overweight	284
Loneliness	269
Smoking and vaping	268
Drug and alcohol misuse	242
Dental Health	210
Physical fitness	199
Access to health foods	187
Long-term health condition	129
Other	68
Asthma	59
Cancer	54
Diabetes	38
Epilepsy	20

As is evidenced at Figure 28, the key health concern was mental health which was expressed by 9 out of 10 of the respondents (92.1%, n=605). Over 40% of respondents cited, Sleep (43.8%, n=288), Eating Disorders (43.8%, n=288), Being Overweight (43.2%, n=284), Loneliness (40.9%, n=269) and Smoking and Vaping (40.8%, n=268).

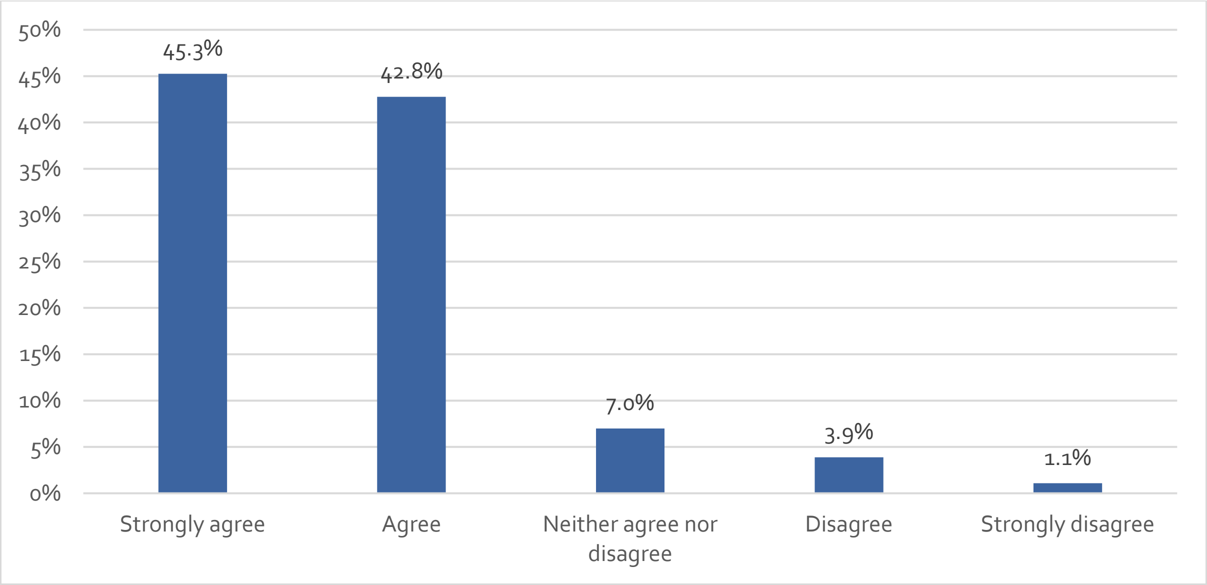
The views of parents/carers are consistent with the views of CYP who also indicated that mental health was their top concern (see Figure 7).

5.1.2 Accessing health services

Physical health care services

Parents/carers were asked to respond to the statement, "If my child became ill (for example coughs, colds, serious injuries and long-term conditions) I would know what services to use"? The results are set out below.

Figure 29: Parents/carers knowledge of what health services to use



(Valid total = 643)

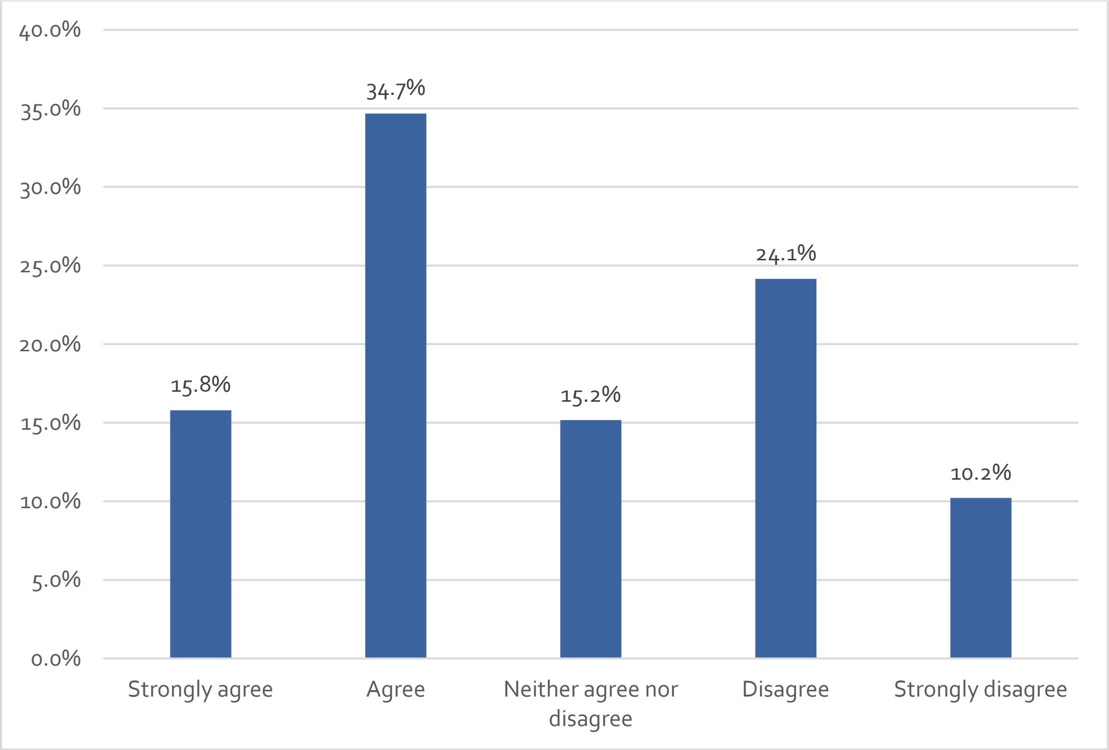
Assessment	Number
Strongly agree	291
Agree	275
Neither agree nor disagree	45
Disagree	25
Strongly disagree	7

88.1% (n=566) of parents/carers agreed or strongly agreed that they would know what health services to use should their child become ill. 5% (n=32) indicated that they disagreed or strongly disagreed.

Mental health services

Parallel with the question on physical health, respondents were asked to respond to the statement, "I know what health services to use if my child needs help with their mental health and wellbeing (for example feeling down, feeling anxious)"? The results are set out at Figure 30.

Figure 30: Parents/carers knowledge of mental health services to use



(Valid total = 644)

Assessment	Number
Strongly agree	102
Agree	223
Neither agree nor disagree	97
Disagree	156
Strongly disagree	66

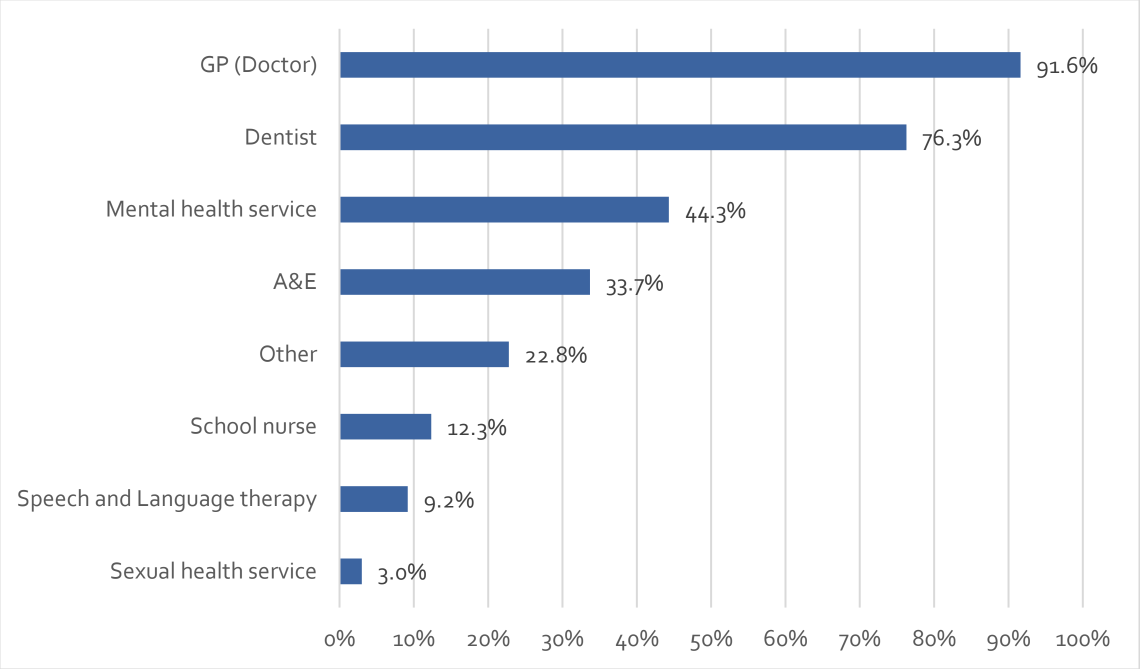
The results for mental health services differed significantly to those regarding accessing physical health services (see above). Almost exactly half (50.5%, n=325) of parents agreed or strongly agreed (down from 88.1% (n=566) for physical health) whilst 34.4% (n=222) disagreed or strongly disagreed (up from 5%). The results evidently highlight a much lower level of knowledge and confidence regarding access to mental health services for their children.

Health services used

Parents/carers were asked, the last time they had used a health service what type of service it was. Just over half (54.3%, n=327) stated that it was for a physical health service and 42.5% (n=256) a mental health service.

Parents/carers were asked what health services they had used for their child/ren in the past 12 months. The findings are set out at Figure 31.

Figure 31: What health services you have used for your child(ren) in the last twelve months



Note that parents/carers could cite multiple options, thus the valid total is 632.

Service used	Number
GP	579
Dentist	482
Mental health service	280
Emergency department	213
Other	144
School nurse	78
Speech and language	58
Sexual health	19

As per the results of the engagement with CYP, the most commonly cited health service was GPs, which made up 91.6% (n=579) of health services used in the last 12 months by parents. This compares to 74% (n=1,344) of CYP (see Figure 10).

Of the 8% who had used an "other" health service, details are provided at Table 9.

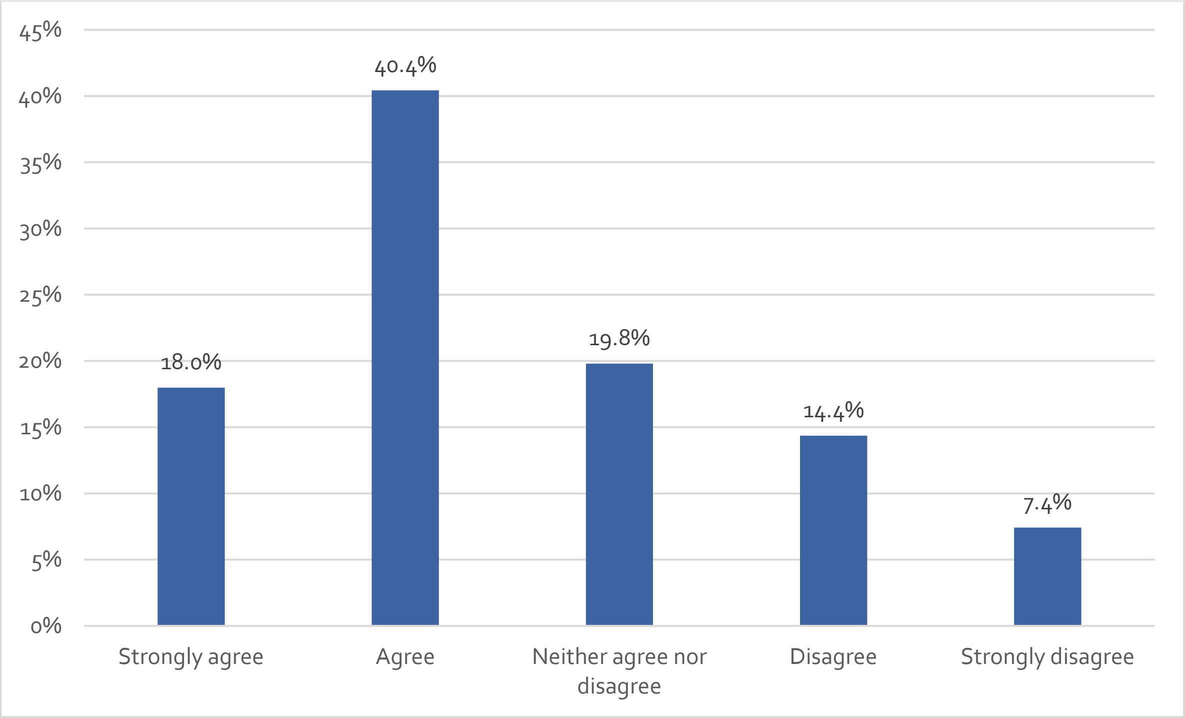
Table 9: "Other" health services used

Health Service	Comments
Mental health/CAMHS	29 families had accessed mental health, psychiatry or counselling services through the NHS. Two were still waiting for a service and two had accessed CAMHS alongside services for autism and ADHD.
Paediatrician	28 families had access services mostly described as paediatricians/hospital care/. Some were using paediatric services alongside specialist services for other conditions e.g. orthopaedics or urology.
Walk in/pharmacy/111	Eight had used one of these services with most of them using the pharmacy.
School services	School counselling had been available to two respondents
Neurodiversity	18 had sought a consultation of ADHD, through CAMHS or the ADHD nurse. Two these had accessed private healthcare for ADHD
Ophthalmic	Four had been to the opticians optometrist or ophthalmic specialist.
Other specialist	39 families had consulted a specialist for a wide range of conditions including diabetes, asthma allergies, ENT, orthopaedics, physiotherapy, dermatology, renal care; coeliac disease etc.
Urgent care	Two families had attended urgent care. One for an x-ray
Private health	Ten families had consulted private mental health practitioners. Three specifically mentioned ADHD or autism. One had been to an osteopath Others had been to private mental health therapists and psychiatrists.
Occupational therapist	Eight had seen an occupational therapist.
Vaccine	Two had had recent vaccines.

5.1.3 Health professionals

In relation to the last time their child had used a health service parents/carers were asked to respond to the statement, "My child felt listened to by health staff". The results are set out overleaf.

Figure 32: My child felt listened to by health staff



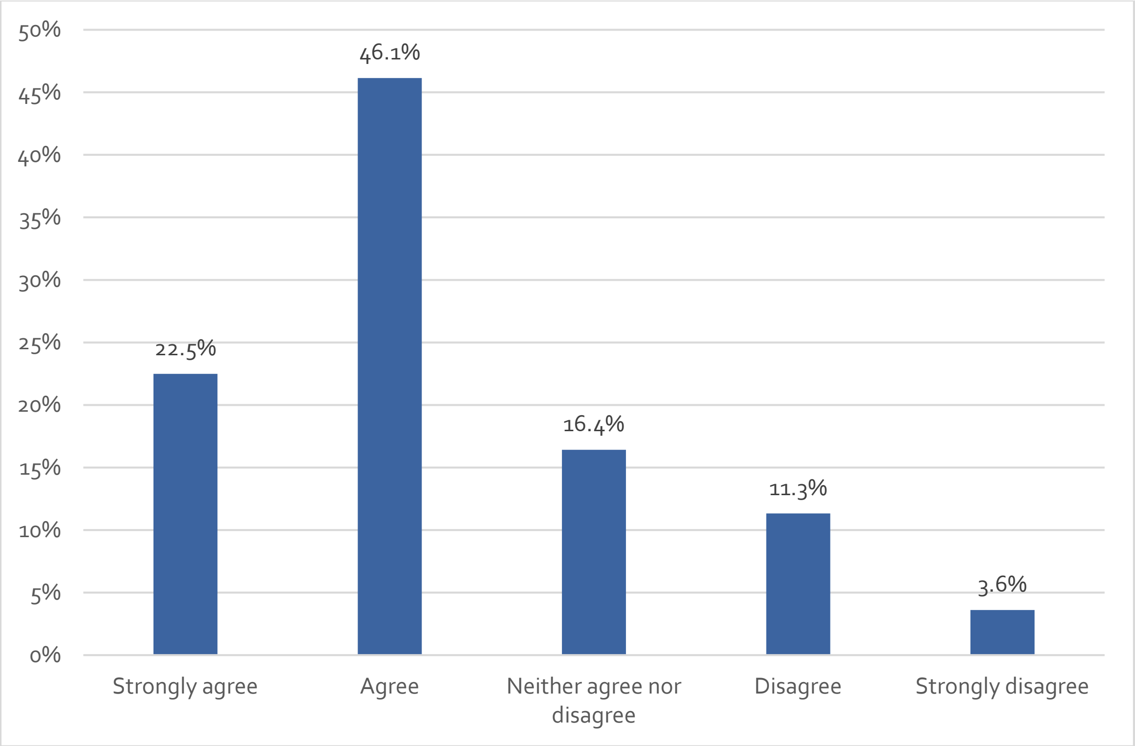
(Valid total = 606)

Assessment	Number
Strongly agree	109
Agree	245
Neither agree nor disagree	120
Disagree	87
Strongly disagree	45

58.4% (n=354) of parents/carers agreed or strongly agreed with the statement while over a fifth (21.8%, n=132) disagreed or strongly disagreed.

Parents/carers were asked to respond to the statement, "My child was treated with care and concern". The results are set out overleaf.

Figure 33: My child was treated with care and concern



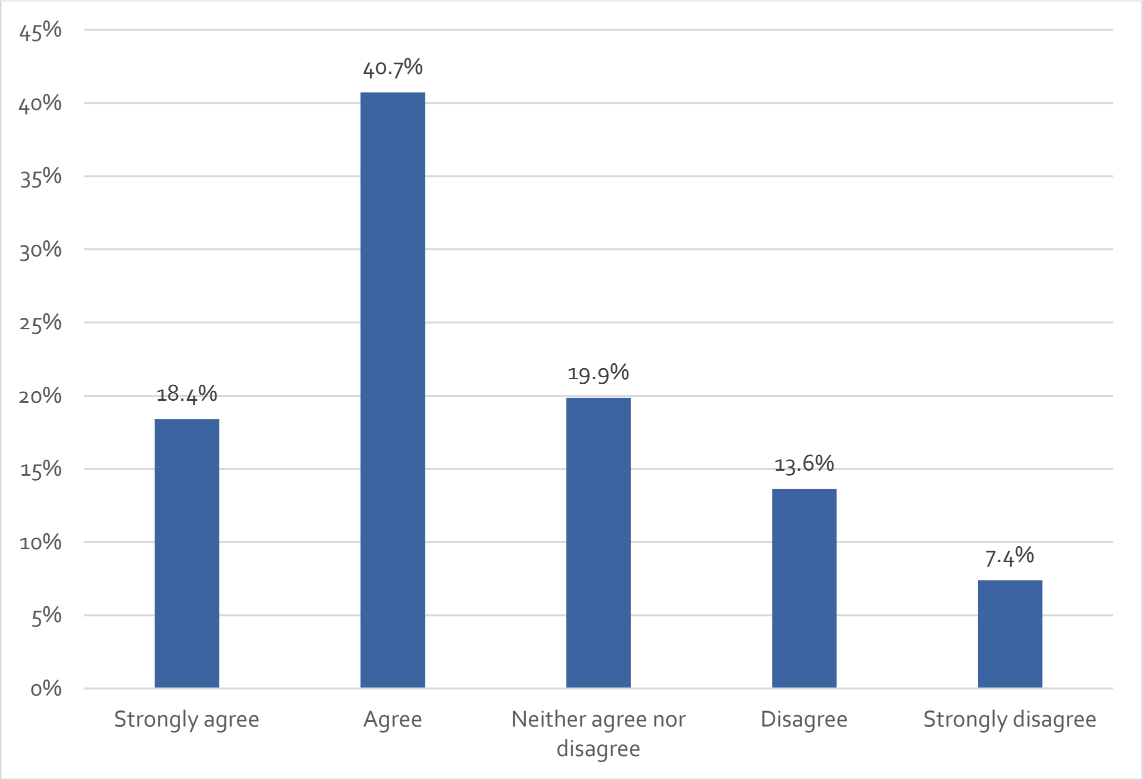
(Valid total = 609)

Assessment	Number
Strongly agree	137
Agree	281
Neither agree nor disagree	100
Disagree	69
Strongly disagree	22

A little over two thirds (68.6%, n=418) of parents/carers agreed or strongly agreed with the statement whilst 14.9% (n=91) disagreed or strongly disagreed.

Respondents were asked to what extent they agreed with the statement, “I feel that I was listened to”. See Figure 34.

Figure 34: I feel that I was listened to



(Valid total = 609)

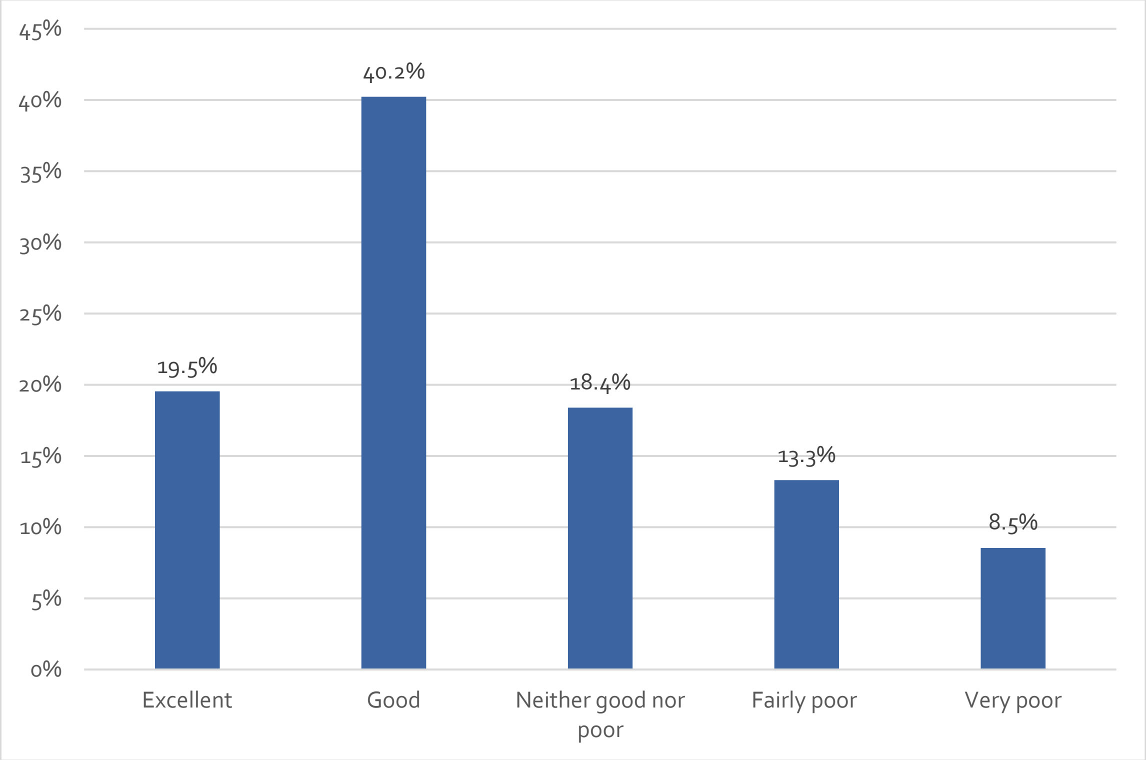
Assessment	Number
Strongly agree	112
Agree	248
Neither agree nor disagree	121
Disagree	83
Strongly disagree	45

59.1% (n=360) of parents/carers agreed or strongly agreed with the statement whilst just over a fifth (21%, n=128) disagreed or strongly disagreed.

5.1.4 Assessment of health services

Parents/carers were invited to rate the last health service you used for their child. The findings are set out at Figure 35.

Figure 35: How would you rate the last health service you used for your child?



(Valid total = 609)

Assessment	Number
Excellent	119
Good	245
Neither good nor poor	112
Fairly poor	81
Very poor	52

59.8% (n=364) of parents/carers rated the last health service they had used as good or excellent. Just over one in five (21.8%, n=133) felt that the service had been fairly poor or very poor.

Parents/carers were asked to provide information about why they had given the rating. In total 400 parents/carers gave further information. The key issues explored are set out below.

Waiting times

The most commonly cited reason given for the rating related to waiting times or delayed access to care which was cited by 85 respondents. Comments on waiting times included:

- "My daughter has been on the waiting lists to review her ADHD medication and discuss the possibility of anxiety medication for over 18 months and we've yet to speak to someone that can do this because she is not yet at crisis point they do nothing."
- "Still awaiting assessments after four years of being on the wait list."
- "My son has been waiting to see a paediatrician now for over 2 years his mental health declined massively and no body wanted to know . I had to end up paying private to get the help I needed."
- "It takes years to get through wait lists and referral loops to actually get seen by the right support by which time the child is feeling hopeless, suicidal and hates the NHS."
- "Because the waiting lists for assessments (e.g. autism) are far too long. So far, that's all we've managed to achieve, but my son needs some help now. It shouldn't take two years, just to have an assessment."

It is of some interest that a number of responses highlighting long waits noted that, once they were in contact with health services, they found the service to be helpful or that staff were supportive:

- "Consultation, Treatment & outcome good for a jaw problem but waiting time was 2 years to be seen!"
- "Each individual staff member was brilliant - it's just the epic delays in being able to access support in the first place that's the biggest concern and lead to serious deterioration in my child's health."
- "CAMHS - ridiculously long waiting lists, lots of nice staff but no actual active help. I have been seeking help for my son since he was 9. He's now 14 and it's still horrendous."

Caring and compassionate staff

The next most commonly given response related to praise for caring and compassionate staff which was highlighted by 67 respondents:

- "The appointment wasn't rushed and the nurse took the time to explain everything to both my child and I. She made my child feel in control and made us feel comfortable."

- “The adhd nurse has taken time to get to know my child and their needs, as well as having a good understanding of their condition, medication and non- medication options. My child now trusts them and will converse, they would not do this so freely with an unfamiliar person.”
- “The nurse didn't rush us, my daughter went in very anxious and wanting to let it out the term the nurse used was "like a can of pop shook up wanting to release" the nurse sat with her for over 40 mins and allowed her space and time to talk and say what was happening with school, how she felt mentally and her struggles with her ADHD, we got lots of numbers to call to get her support she needs and she is doing loads better.”
- “The last NHS service we used as our local GP surgery. Our doctor understood my child’s disabilities as she is no verbal and tried his best to communicate with her in a way she would be able to try and understand. I voiced my concerns to the go about her health and he understood my concerns and made a referral to the respiratory team at the hospital.”
- “The consultant we saw was kind and friendly. He explained everything really well so we knew what was happening and why.”
- “We were in a very relaxed environment and compassion was shown for my sons behavioural and health problems, the only concern is the waiting list times for the next stages.”

Good quality care

58 parents/carers stated that their child had received good quality care:

- “ADHD Nurses are prompt with scripts, really receptive and responsive. I know I can talk to them honestly and with no judgement. I felt that they get us as a family and treats my son as he should be!”
- “Excellent service from clinicians including their listening to my 11 year old's experiences and views.”
- “Above and beyond happy with the contact we had.”
- “Our GP is amazing and treats my daughters as individuals and listens to their concerns.”
- “We had to attend A&E and were given the best treatment throughout.”

Child listened to

Closely correlated to views about the quality of the care provided was the fact that their child had been listened to, with 56 parents/carers giving this as the reason for their assessment:

- “Myself and my child were listened to, he felt that that he was heard and could be himself without masking.”

- “Recent admission to hospital and the care was great Staff really listened to me and my child. They were very patient with my child's anxiety and autism and kept communication going throughout.”
- My son is going through assessments for ADHD and for the first time he and I felt understood when we got to speak face to face with an assessor from the ADHD clinic and she knew exactly what we were saying and describing to her how my son felt, he felt finally listened to and he felt great when leaving the appointment because someone understood what he’s going through.”
- “Treated well and spoken to like an intelligent adult.”
- “Trainee GP - listened to me and my child, enquired about the physical problem we brought to the appointment. When we asked another question about mental health we were listened to, they checked with senior Drs (as some knowledge gaps). Did not feel rushed.”

Conversely, 32 parents/carers gave a negative rating on the basis that their child was *not* listened to:

- “Although it was my teenager they still spoke to me rather than really listen to my child.”
- “Didn't listen to how she felt, didn't listen to my concerns or the family history of mental health, just told her to talk to the school nurse. You get hold of the school nurse, there isn't one in the school. She came out more anxious then calm, she still struggling now, but I'm helping her with my experience.”
- “We were not listened to about anything that we talked about and treated as if we didn't know what we were talking about. We informed them of severe superficial self harm leaving multiple scars she was disinterested and we believe she should have at least tried to ask if she could see the scars so she would have had a better understanding of the extent of the self harm.”
- “The last health professional my daughter saw was an orthopaedic surgeon having been referred by the orthopaedic team at the same hospital. She came away from the appointment crying asking why he wouldn't listen to her, why he scared her. I tried to discuss with him but he had the opinion that he knew everything and we knew nothing and wasn't prepared to listen to anything and that everyone we had seen before him was wrong. Came away feeling like it was a total waste of everyone's time. And more and more I am getting this impression from consultants...that they think they know everything and no one else knows anything and won't discuss anything. They shut you down. With this attitude it will be very difficult to get my daughter to see a consultant again because she doesn't think anyone will take her concerns seriously or answer her questions.”

No support provided/help given

55 parents/carers reported that their child had left health services without having been given support or had been told that there was nothing that could be done for them:

- "My child has not been able to get help she needed for last 5 years. I feel her mental condition has to get dangerously bad to receive support she needs. There is no suitable help to prevent it getting worse in the first place, for example by providing long term therapy to overcome anxieties caused by childhood traumas."
- "I have been fighting for my child who has clear ADHD/ASD/ODD since 2017, the referral was rejected!!! We've had to start the process again, my child is so much worse now thanks to be failed. Waiting time too long so now I have to go thousands of pounds into debt and go private. Shocking."
- "Can't get enough help with mental health you just go round in circles but no one actually helps enough."
- "My child is not at all support with issues with gender dysphoria, depression or anxiety. Services are not aware of their needs and there are no services to help my child or me. I find this despite working within health myself so can't imagine what it's like for people less informed."

Mental health/CAMHS

As can be identified from the sample of quotes set out above a large number of responses (n=62) from parents/carers specifically mentioned their child's mental health needs and/or CAMHS within the comment. On the whole the comments that cited mental health highlighted issues around waiting times and access:

- "Mental health services need to be readily available for children the process is far to long. Dr refers, then approximately a year wait just to decide where to send the child next."
- "We had to pay privately to get our child the mental health support and medication he needed due to how long the what's were and poor support through the NHS mental health service CAMHS… If we hadn't gone private, we would still be waiting to get the mental health treatment he so badly needed."
- "The consultant listened well about my daughters mental health problems. It's not the consultant themselves which is the problem it's the huge waiting lists to access them!"
- "No realistic prospect of counselling within a year + of waiting. Paid for private psychotherapy."

Some parents/carers highlighted the fact that no mental health support was available for their child:

- “I took my daughter in to the GP - she was self harming, bereaved, being bullied and at a very low state. The Dr said as you haven’t attempted to take your own life it’s not a priority and referred us to CAMS and I never heard from them. It was very distressing and I felt very alone.”
- “Concerns not addressed as they were not classed as severe enough. Its a shame that children have to be classed as suicidal to receive any meaningful help.”

Neurodiversity

Mention of neurodiversity and specific conditions such as autism and ADHD featured in 32 of the comments. As per mental health the comments were largely in relation to waiting times for their child to be seen:

- “There is not enough support for neuro diversity. You have to fight to get support and the waiting lists are faaaaar too long.”
- “My daughter is on waiting lists for assessment of both ADHD/Autism and Gender Identity. On both she will likely not reach the top of the list until she qualifies to be out on an adult waiting list.”
- “We have been using CAMHS for a neuro diversity assessment - whilst the staff are lovely and the interactions have been positive, the efficiency of the service is awful. It has taken 4 years to get from referral to medication for ADHD. 3 years to get a diagnosis and a further year to have a consultation for medication. The time frame is ridiculously long and has meant my child has gone right through the entirety of high school struggling when it needn't be necessary.”
- “My daughter is still awaiting an appointment for potential ADHD assessment. She has finished school and is well into a university course and has still not received an assessment.”

Also as with mental health parents/carers highlighted a lack of provision:

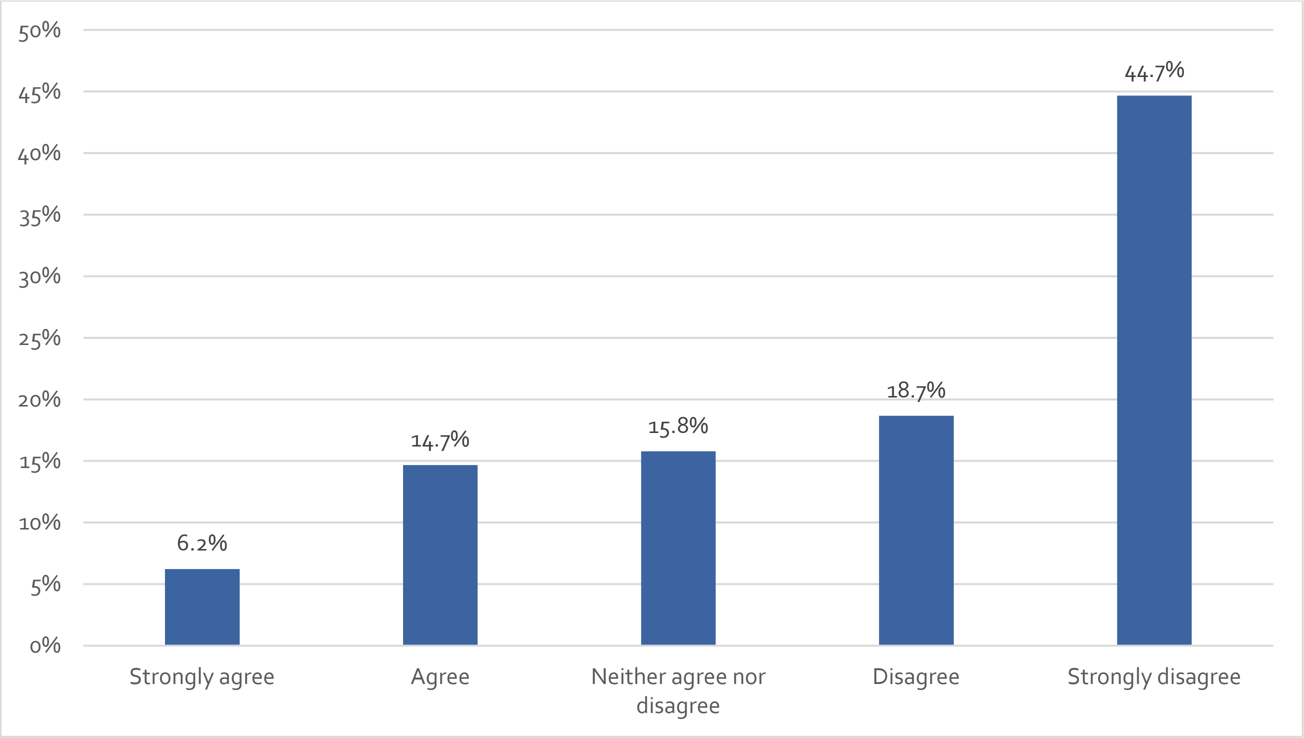
- “Waiting times for ADHD and autism assessments within Leicestershire are incredibly long so the support given to the child and parents in the meantime is insufficient. There doesn't seem to be anywhere that deals with children who might have ADHD or autism.”

5.1.5 Transferring between health services

Speed of transfer

Parents/carers were asked, if their child had been transferred from one health service to another (to get diagnosis or treatment) whether this was done quickly.

Figure 36: My child got an appointment for a diagnosis and treatment quickly



(Valid total 450)

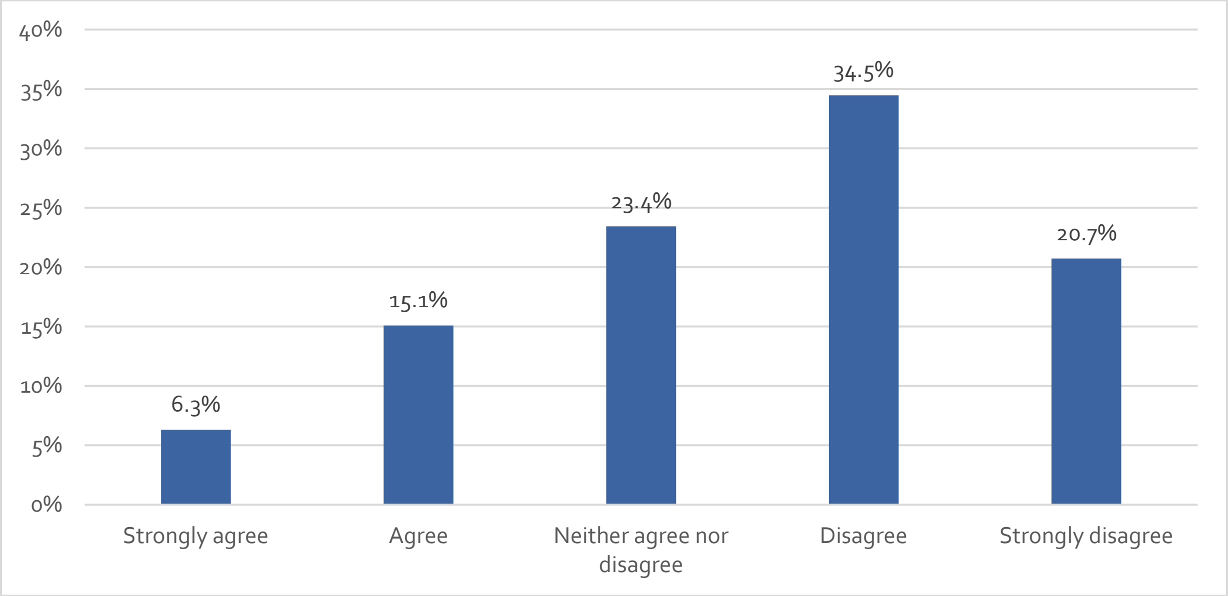
Assessment	Number
Strongly agree	28
Agree	66
Neither agree nor disagree	71
Disagree	84
Strongly disagree	201

The results at Figure 36 indicate that nearly two thirds of parents/carers did not believe that their child got an appointment quickly with 63.3% (n=285) either disagreeing or strongly disagreeing. Just over a fifth (20.9%, n=88) agreed or strongly agreed.

Effectiveness of transfer

For parents/carers who had a child who had been transferred, they were invited to respond to the statement, "The service my child was transferred to had details of their condition and they didn't have to tell their story again". The findings are set out below.

Figure 37: The service my child was transferred to had details of their condition and they didn't have to tell their story again



(Valid total 444)

Assessment	Number
Strongly agree	28
Agree	67
Neither agree nor disagree	104
Disagree	153
Strongly disagree	92

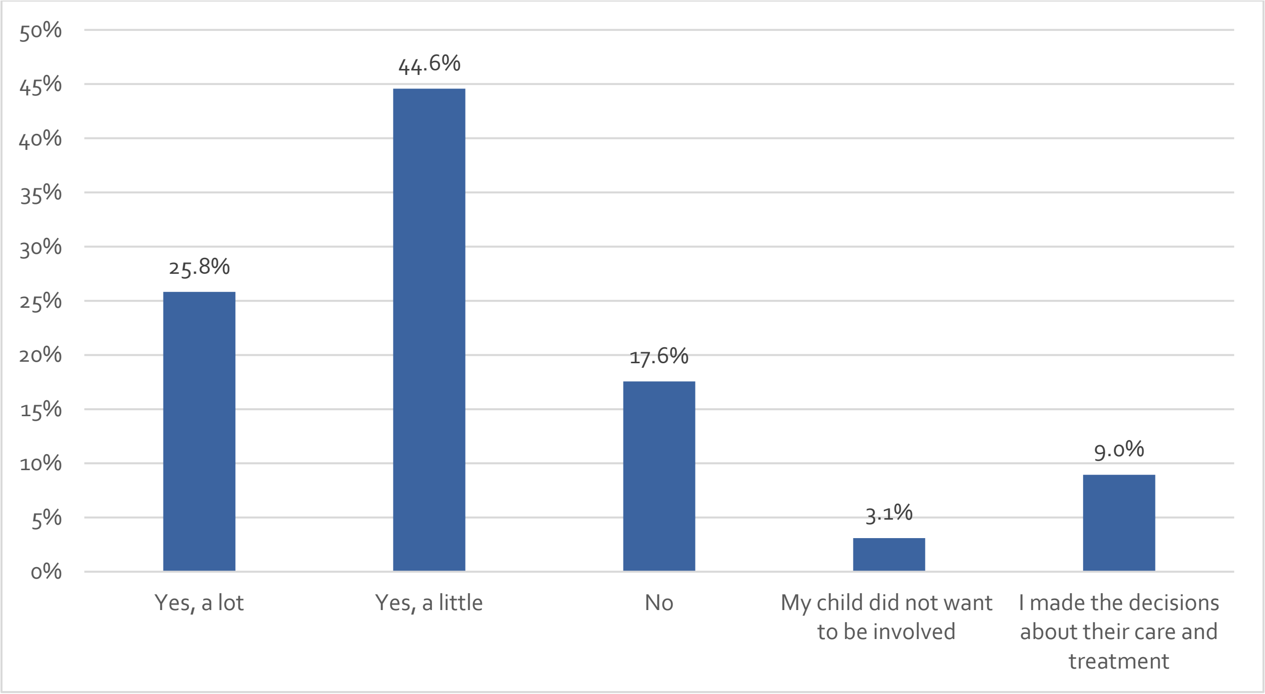
Consistent with the findings about the speed of transfer (see Figure 36), the majority of parents/carers (55.2%, n=245) disagreed or strongly disagreed with the statement. Around a fifth (21.4%, n=95) agreed or strongly agreed.

5.1.6 Young people's engagement in health provision

Young people's involvement

Parents/carers were asked the last time their child had accessed a health service, whether their child was involved in decisions about their care and treatment.

Figure 38: Was your child involved in decisions about their care and treatment?



(Valid total 581)

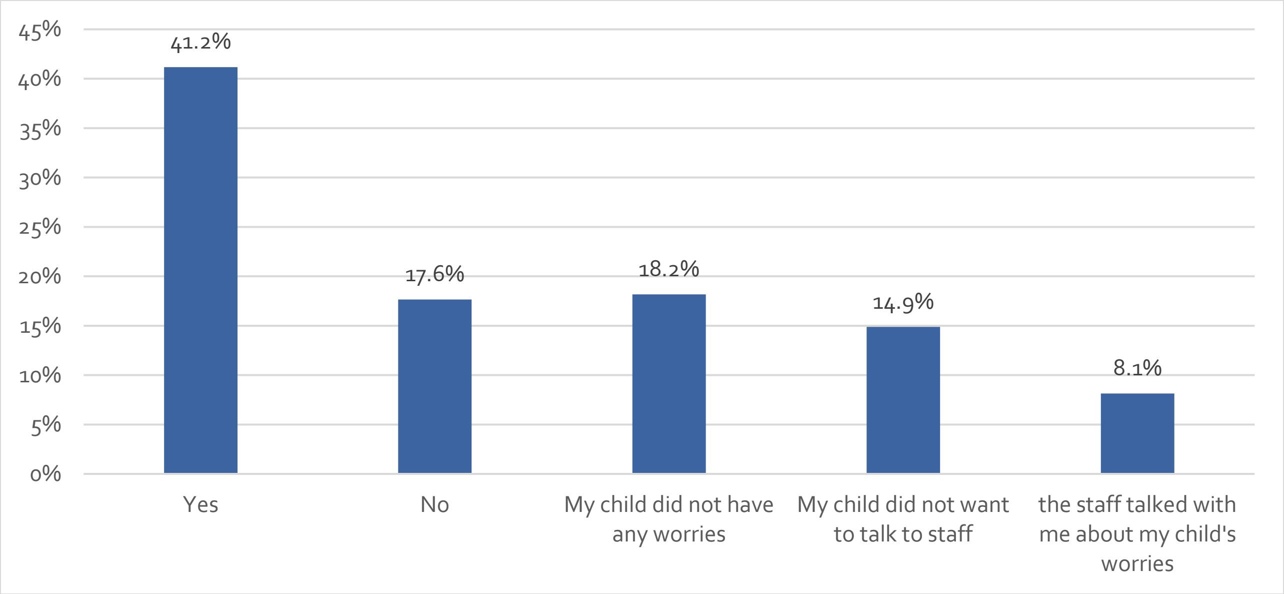
Assessment	Number
Yes, a lot	150
Yes, a little	229
No	102
Didn't want to be involved	18
I made decisions	52

The majority of parents/carers (70.4%, n=379) indicated that their child had been involved in decisions about their care. Just under one in ten (9%, n=70) parents/carers stated that they had made the decision on behalf of their child.

Talking to health staff

Parents/carers were asked, if their child had any worries, whether a member of staff talked to them about them.

Figure 39: If your child had any worries, did a member of staff talk with your child about them?



(Valid total 578)

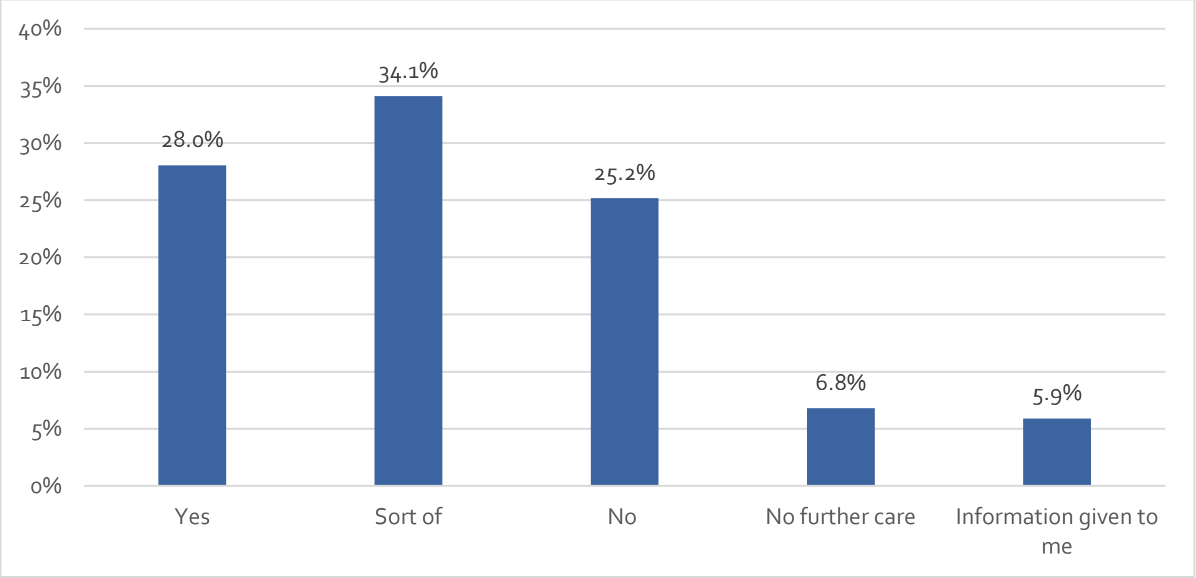
Assessment	Number
Yes	238
No	102
Child did not have worries	105
Did not want to talk	86
Staff talked to me	47

41.2% (n=238) of parents/carers stated that a member of staff had spoken to their child about their worries. 18.2% (n=105) indicated that their child did not have any worries and 17.6% (n=86) that staff did not talk to the child about their concerns.

5.1.7 After treatment

Respondents were asked, when their child left treatment, did they know what was going to happen next with their care.

Figure 40: Did your child know what was going to happen next with their care?



(Valid total = 560)

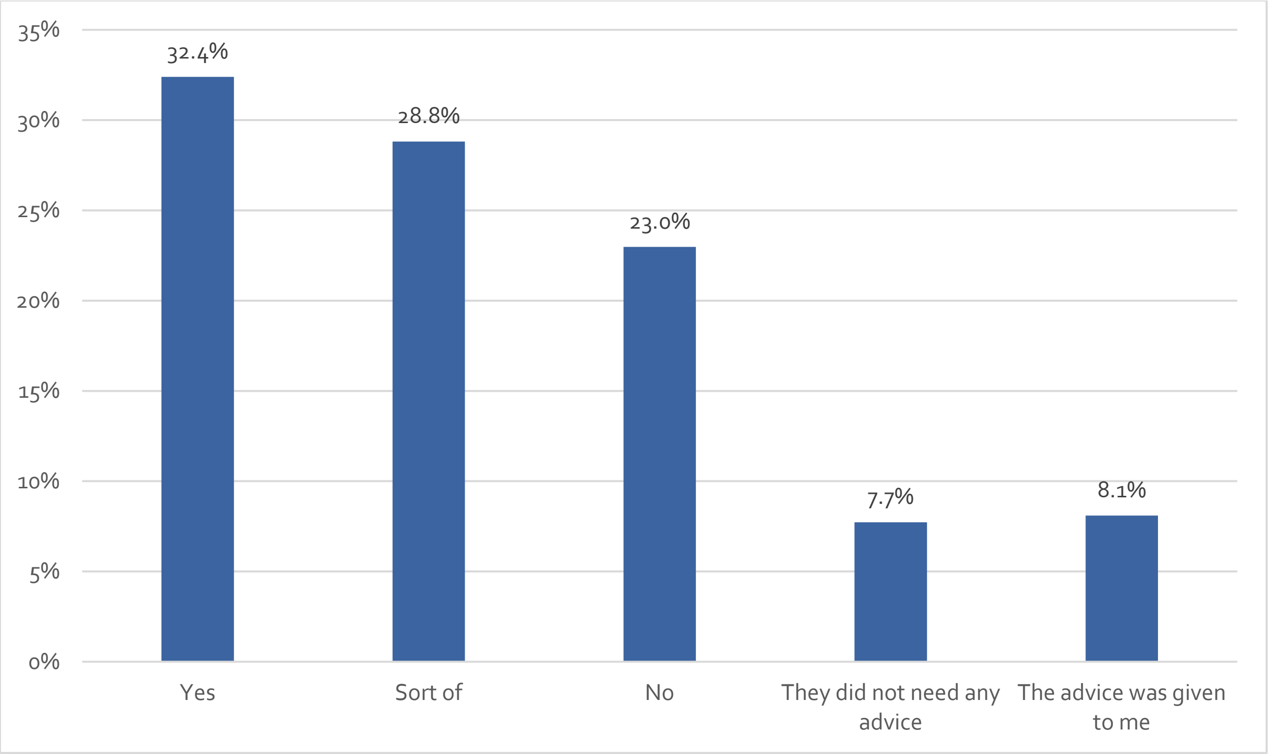
Assessment	Number
Yes	157
Sort of	191
No	141
No further care	38
Information given to me	33

Over a third (34.1%n n=191) of parents/carers indicated that their child "sort of" knew what was going to happen next with their care. Over a quarter (28%, n=157) stated that their child did know and a quarter (25.2%, n=141) that their child did not.

Advice from health staff

Parents/carers were asked, "Did a member of staff give your child advice on how to look after themselves after they left treatment"?

Figure 41: Did a member of staff give your child advice on how to look after themselves after they left treatment?



(Valid total = 558)

Assessment	Number
Yes	181
Sort of	162
No	130
Did not need advice	42
Advice given to me	43

Just under a third of parents/carers (32.4%, n=181) stated that their child had been given advice while 28.8% said that advice had "sort of" been given. Just under a quarter (23%, n=130) stated that no advice had been given.

5.1.8 Discrimination

Parents/carers were asked whether their child had experienced any discrimination or barriers when using a health service.

The majority of parents (65%, n=362) stated that their child had not experienced any discrimination while over a fifth (21.9%, n=122) said that they had. 13.1% (n=73) stated that they did not know.

Parents/carers were asked to give examples of the discrimination or the barriers that their child had experienced. A number of key themes emerged which are explored below.

Neurodiversity

The main area of discrimination reported was around neurodiversity and a lack of understanding or support, including parents/carers reporting that they and their child were not being listened to**.**

A repeated theme throughout the data was that parents/carers felt they were not listened to or understood by healthcare practitioners. In particular parents felt their child was not understood by either specialist (such as CAMHS) or general healthcare services if they were autistic meaning that some other conditions could be missed:

"Has faced barriers with communication and not being listen to, being discriminated against with physical issues assumed to be 'just autism' rather than investigated and professionals looking at reasons for overall health needs**.**"

Staff were said to talk over children with autism as if they could not understand. In relation to CAMHS, some parents mentioned that anxiety was dismissed as simply being part of autism and therefore not treated. As one parent said**:** "Mental health services are not set up for autistic kids".

A family was told that their son with ADHD should be booked in for a vasectomy as other family members had ADHD, the implication taken by the parent was that that he should not "produce any further offspring with ADHD**.**"

One child with severe mental health difficulties and selective mutism was told in A&E that, if the family could not cope with her "behaviour", arrangements could be made with Social Services for her to be taken into care.

In addition parents/carers reported not receiving timely treatment with one reporting a wait of seven years for their child to be seen.

Transphobia

Two respondents had experienced transphobia and one said: "My child is transgender and some health professionals refuse to use their chosen name and pronouns. My child is autistic and has complex mental health issues, numerous consultants immediately wrote off physical health issues as being caused by mental health without listening."

Age

Some parents felt their children had been dismissed or "fobbed off" because of their age. Young people were stereotyped and, again, not listened to so that they did not receive appropriate treatment.

Racism

Three parents reported racism with one noting: "Unconscious bias and microaggressions due to judgements being made based on faith, culture and ethnicity".

Disability

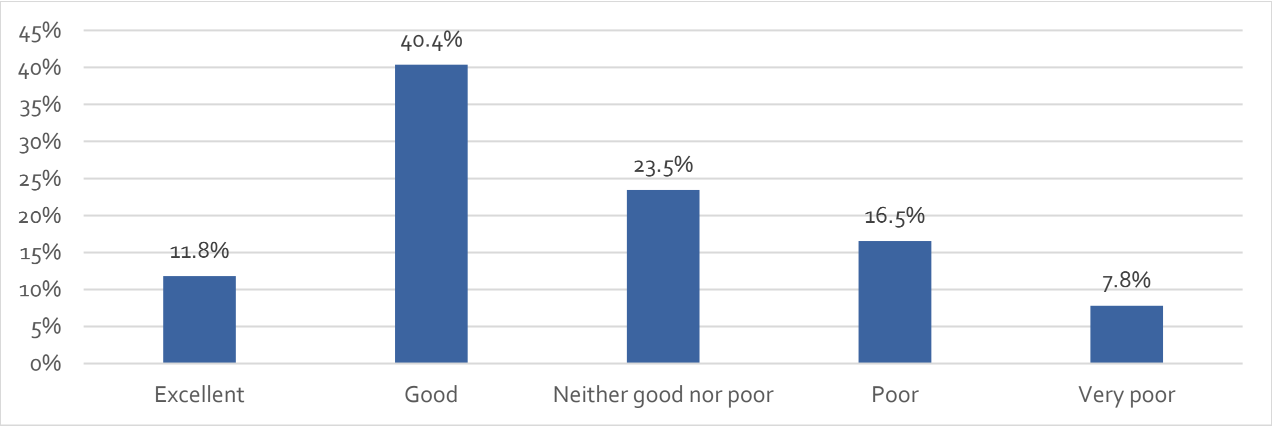
Five respondents experienced discrimination around disabilities other than neurodiversity. One child was visually impaired, one deaf and one in a wheelchair.

Some children and young people are non or pre-verbal and one parent suggested that all healthcare staff learn some basic Makaton. One young person who had a physical disability had been transferred to an adult stroke unit on transition to adult services which was not appropriate for her condition or social needs.

5.1.9 Overall assessment of healthcare

Parents/carers were asked to give their overall assessment of healthcare. The results are set out at Figure 42.

Figure 42: Overall assessment of quality of healthcare



(Valid total = 550)

Assessment	Number
Excellent	65
Good	222
Neither good not poor	129
Poor	91
Very poor	43

Over half (52.2%, n=287) of parents/carers gave a positive assessment of healthcare, rating it as good (40.4%, n=222) or excellent (11.8%, n=65). Just under a quarter (24.4%, n=134) of respondents gave a negative rating of either poor (16.5%, n=91) or very poor (7.8%, n=43).

This compares to the findings from the CYP survey where 69.5% (n=1,165) of CYP gave a positive assessment of healthcare and 8.5% (n=139) a negative assessment.

Respondents were asked to give further information about why they had given the rating. The responses are explored below under the key themes identified.

Mental health and neurodiversity services

The most prevalent reason for a negative sentiment about services related to mental health services such as CAMHS with a very large number of parents complaining of excessive waiting times for assessment, diagnosis, and treatment - often seemingly running into years - especially in cases where young people also had ADHD or autism.

- "There is not enough support for neuro diversity. You have to fight to get support and the waiting lists are faaaaar too long."
- "We have been using CAMHS for a neurodiversity assessment - whilst the staff are lovely and the interactions have been positive, the efficiency of the service is awful. It has taken 4 years to get from referral to medication for ADHD. 3 years to get a diagnosis and a further year to have a consultation for medication."

Parents noted that their children had to be in crisis to get seen, and even then there was likely to be a wait: "Still waiting for CAMHS and she is still really struggling".

Many had gone private with some going into debt and taking out loans to afford treatment. "We had to pay privately to get our child the mental health support and medication he needed due to how long the waits were and poor support through the NHS mental health service CAMHS. He is also on a waiting list for an ASD assessment to which we have been told for the past year he is at the top of that waiting list next to be seen, yet after almost 2 years of waiting we still have not been offered an appointment for this assessment. If we hadn't gone private, we would still be waiting to get the mental health treatment he so badly needed."

Some parents/carers reported that their children had left school, gone to university and had still not received an initial assessment.

Listening

It was a frequent complaint that families and children were not listened to, again, especially where they had mental health difficulties and/or a neurodiversity. "We were not listened to about anything that we talked about and treated as if we didn't know what we were talking about. We informed them of severe superficial self-harm leaving multiple scars she was disinterested and we believe she should have at least tried to ask if she could see the scars so she would have had a better understanding of the extent of the self-harm."

As another noted: "Neither my child nor I were listened to. It seemed that the staff did not really care and my child and I felt as though our concerns were being dismissed as silly."

Six parents specifically used the term "fobbed off" in their responses - in all but one instance this related to mental health care.

Parents/carers reported that it made an enormous difference to experiences when parents and children felt they were listened to and treated with respect and empathy. "Trainee GP - listened to me and my child, enquired about the physical problem we brought to the appointment. When we asked another question about mental health we were listened to, they checked with senior drs (as some knowledge gaps). Did not feel rushed."

Some health care professionals did well. "The last NHS service we used as our local GP surgery. Our doctor understood my child's disabilities as she is non-verbal and tried his best to communicate with her in a way she would be able to try and understand. I voiced my concerns to the go about her health and he understood my concerns and made a referral to the respiratory team at the hospital."

Explaining "all the options" made a difference to the acceptability of treatment, whereas for example one parent felt "fobbed off" when physiotherapy was prescribed for back pain perhaps without a proper explanation of this treatment.

GPs had a mixed reputation in this respect with some being described as very good, listening and offering clear explanations for courses of treatment, but others were thought to be harsh: "I took my daughter in to the GP - she was self-harming, bereaved, being bullied and at a very low state. The Dr said as you haven't attempted to take your own life it's not a priority and referred us to CAMHS and I've never heard from them. It was very distressing, and I felt very alone."

There were some positive comments about ADHD Nurses.

"ADHD Nurses are prompt with scripts, really receptive and responsive. I know I can talk to them honestly and with no judgement. I feel that they get us as a family and treat my son as he should be!"

Continuity of care was valued: "Adhd nurse. We see the same nurse every 3 to 6 months, so there is good communication".

Waiting times

There were many accounts of long waiting times for all types of service. The worst appear to be for neurodiversity assessments such as for ADHD, and for orthodontics - both of these were said to run into years.

- ADHD: "We have been using CAMHS for a neuro diversity assessment - whilst the staff are lovely and the interactions have been positive, the efficiency of the service is awful. It has taken 4 years to get from referral to medication for ADHD. 3 years to get a diagnosis and a further year to have a consultation for medication. The time frame is ridiculously long and has meant my child has gone right through the entirety of high school struggling when it needn't be necessary".
- Orthodontics: "We waited over 5 years from referral by the dentist to the specialist appointment at the hospital and a further 10 months for the essential op. They cancelled the last brace tightening appointment and re made it months later. The staff are great but the waiting lists are a real anxiety".

These waiting lists caused deterioration in health. "Each individual staff member was brilliant - it's just the epic delays in being able to access support in the first place that's the biggest concern and lead to serious deterioration in my child's health".

"My other child also received a referral and whilst the initial assessment has taken place and a full assessment has been determined to be necessary, he will turn 18 before the assessment can take place and so he has been referred to adult services instead. His mental health has suffered considerably and watching him struggle with depression and anxiety whilst sitting in a years-long waiting list has been incredibly hard".

5.1.10 Mental health

Parents/carers were asked whether their child had used a mental health service.

Just over half of respondents (51.6%, n=272) indicated that their child had used a mental health service, 44.6% (n=235) that they had not and the remainder did not know.

Where they wish to access mental health services

Parents/carers with a child who had accessed a mental health service were asked where they would like the appointment to have taken place.

The most commonly cited response was NHS clinic (55.3%, n=166), followed by community space (25.6%, n=77) then "other" (19%, n=57).

Among those who cited an "other" option, most respondents (n=22) wanted the mental health care to be at home as they felt their child would be more comfortable there.

Seven respondents thought the GP surgery would be a good option as it is local, familiar, neutral and private.

Four thought school was a good option as it is least disruptive to the child's learning.

Online was good for a child who neither felt able to go out nor meet people in their home. For another child online was good as they could access the treatment at school, so minimising disruption to learning.

While one person valued flexibility between face to face and online, another thought that consistency of location was very important and it should be "the same place each time".

Some parents/carers stressed that it is important that the location is local and on convenient public transport links. Comfortable spaces were said to be important - some locations are clinical and office like and this did not help children and young people. Above all the child needed to feel safe in the setting.

A couple did not mind where the appointment took place so long as they got one given the lengthy waiting times for treatment.

Assessing mental health services

Parents/carers of children who had accessed a mental health service were asked to rate the service. The findings are set out below.

Transitioning to adult mental health provision

Parents/carers of children who had accessed mental health services were asked whether their child had transitioned to adult mental health services. Over three quarters (77.2%, n=227) of respondents said that their child had not transitioned, while 12.2% (n=36) said that their child had. 10.5% (n=31) did not know.

Parents/carers of children who had transitioned into adult mental health services (n=63)[4] were asked follow-up questions:

- 23.8% (n=15) said that their child understood the transition process, while 34.9% (n=22) said that their child did not (41.3% did not know).
- A fifth (20%, n=12) said that their child had been provided with information about adult mental health services or services available in the community. 46.7% (n=28) said no information had been provided and exactly a third (33.3%, n=20) said they did not know.
- 22.8% (n=13) said that information was easy to understand. 28.1% (n=16) said that the information was not easy to understand and 49.1% (n=28) did not know.

Parents/carers were invited to provide some thoughts about what a good transition service might look like. 30 parents/carers gave a response.

Some, who had already been through the transition had had a difficult experience:

"Not the one you have at the moment. It was useless. Promised her transition to adult mental health services, and then just dropped her like a stone. Got her medication through GP in the end. Left to sort ourselves. Terrible."

Another family was still waiting for the transition to take place after two years. Others had a big gap when transferring. In one case CAMHS continued to prescribe for the young person until the transfer could be completed.

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[4] It should be noted that the numbers responding to these questions is higher than those stating their children had transitioned, as anyone could answer the questions, not just those who had selected 'Yes' to the previous question.

Where children’s services had been offered in-person for one young person the adult services were either online or phone which the young person was not comfortable with.

One family wanted the process to start sooner: “It needs to step in sooner to offer support, waiting for nearly 2 years, has meant that my son is now a lot more poorly. It feels like so many missed opportunities to help him, still waiting for medication appointments, this would be helpful now and we have no idea how much longer we will have to wait”. Another parent suggested, “A phased transition to allow for delayed processing”.

As with the other open text responses in the survey, good communication and listening to the young person’s needs was repeatedly cited as being important:

- “Seamless, and fair waiting list transitions. Friendly and reassuring staff, more services catering to young people.”
- “Clear and open communication at all stages. So far I have phoned numerous times over recent weeks and everything is still pending. Waiting times are unknown, I do not know if we can opt for 'right to choose' and speed up the waiting process.”
- “My child was left with a big gap when transferring. We were told that CAMHS didn’t know what they could do for her. However they were happy to continue to up the dosage of medication without any therapy work being completed. There has been no improvement for my daughter since coming into service at the age of 11 years.”
- “The pediatrician passing information on to the adult doctor and the treatment and care being seamless, not having to fight for medication that has been given for 15 years and then having been seen once, never seen again despite being on restricted medication. My child has seen an adult doctor once in three years and is on controlled medication, how is that right?”
- “A phased transition to allow for delayed processing.”

5.1.11 Other comments and observations

Respondents to the survey were asked to share any final comments or observations about any of the issues covered in the survey or in relation to healthcare.

It appears that the final comments in this survey were largely made by people who had bad experiences and may reflect energy and motivation already used in completing the survey.

Not being listened to

Some of those comments describe failures to listen, and a lack of respect towards children, young people and their families.

“When my son was seriously ill with a burst appendix, he was told by a reception member he should go home and see his gp on Monday as he had already been in to a&e the day before and had managed with the pain. He was told he didn't need triaging as he'd been in prior, and nothing had changed! His girlfriend tried explaining he was much worse and he needed some medical intervention as she checked symptoms online on the nhs app. This was met with a smirk, to be told that just because they have a phone doesn't make them a doctor! Then they said you youngsters always think you know everything, and they were told to leave, or security would throw them out! He was rushed to hospital 20 mins later in an ambulance to have an emergency appendectomy and partial bowel resection as he had burst his appendix days before, and it had infected his bowel. If the receptionist had triaged him, it would have saved distress and an ambulance and staff which all costs money! Playing God was how my son described it and said "if you or dad had taken me it wouldn't have happened and that's a fact.”

Another parent spoke about their daughter who had to wait years to be taken seriously about her “horrific periods”. If a person is only 15 or 16 this is a long part of their life.

For children and young people with neurodiversity there is a lack of understanding about their condition. One parent was told by a paediatrician “your ASD sons, 'don't look autistic... Who told you they were?' ”. Another parent asked that “All professionals should have a good understanding of autism and mental health issues and should not dismiss children’s pain because they are autistic and/or have mental health issues”

Waiting lists

Parents/carers reported very long waiting lists for all specialists but for mental health, neurodiversity and CAMHS they reported that these are “exceptionally long”, running into years, with accounts given of children ageing off the waiting list without ever having received a service. Many others have paid for private treatment and assessments given the concern that they felt for their children’s distress and risks associated with self-harm, eating disorders and depression. Even if you got to the top of the waiting list there was still a sense of despair that the help would be what was needed:

“Just that the service is failing children. Parents are having to fight and pay to help their children. Money, we don’t have. Waiting lists are too long and even then there is no guarantee of help”. This feeling was borne out by other accounts of inconsistent support, paperwork being lost, constant delays and cancellations of booked appointments and children telling their story as they move from one service to another.

"I have needed to access mental health support a few times and never felt able to continue with choosing an NHS route. I have gone private each time - I do not believe this is ok. My child's mental health is so important that I would do whatever I can, but I should not have to pay thousands in private care when I pay my taxes for access to the NHS."

There is a strong feeling amongst parents that CAMHS needs reform with one suggesting that LLR ICB should, "Outsource your mental health department to someone that can do the job".

Sadly, one person made this direct appeal: "Can you speed up getting her to see a psychiatrist as she really struggles with her depression and anxiety right now?"

Services are not able to cope with Mental health crises and one respondent observed that: "Mental health crisis help seems to be the police NOT the NHS which is a very scary situation for a vulnerable young person"

Some parents/carers had a strong sense of failure and breakdown in the services they had tried to access. "I absolutely dread my children being poorly and myself, as you never know whether you're going to be one of the lucky ones or be left to sort it out yourself. No one cares, no one works together, and the services are leaking money everywhere."

They talked about staff shortages, reduced accessibility, staff who were too stretched to behave with empathy and a fear, even amongst those who had had relatively minor encounters, that if you ever truly needed help it would not be there. "So far, we've been lucky. We've not needed mental health services. Across the last couple of years: we've been able to be seen regularly by an NHS dentist; the ambulance arrived swiftly when called; the high-dependency care worked; medications have been available to fulfil repeat prescriptions... However, sadly, I no longer trust that the NHS will be there to give an adequate and timely response every time we need it."

5.2 Key Findings

- The most commonly cited concern among parents/carers regarding their child's health was in relation to mental health (see Figure 28). The results are striking insofar as they replicate the most reported concern among CYP who also reported mental health as the health issue that matters most. (See Figure 7).

- There was a very clear consensus that parents/carers knew what health services to use for physical health conditions with 88.1% (n=566) of parents/carers agreeing or strongly agreeing that they would know what health services to use should their child become ill. (See Figure 29). This differs markedly about knowledge of which mental health services to use, where those agreeing or strongly agreeing fell to 50.5% (n=325). (See Figure 30). The data therefore indicates a pronounced difference in the knowledge and confidence of parents/carers in accessing physical versus mental health provision. The results parallel the views of CYP where 78.8% (n=1,399) agreed or strongly agreed that they knew which health services to access while 59.7% (n=983) said they would know how to contact mental health services. (See Figures 9 and 24).
- The results are strongly indicative that parents/carers perceive that healthcare professionals treat their children with care, with 68.6% (n=418) agreeing or strongly agreeing with this idea. (See Figure 33). This aligns with the results from the CYP survey where 74.4% (n=1,344) indicated that they are treated with care and concern (Figure 12).
- Note however that parents/carers were less likely to indicate that staff listen to their child (at 58.4%(n=360)). This differs somewhat from the findings from CYP 68.1% (n=1,231) of whom said that they felt listened to (Figure 11). Of some concern, around a fifth of parents/carers (21.8%, n=128) did not feel like healthcare staff listened to their child. (See Figure 32). Of interest, the same proportion of parents/carers did not feel that they were listened to (21%, n=128). (See Figure 34).
- The results indicate that parents/carers were generally positive about the health service that they had last used for their child (59.7%, n=364 good or excellent) thereby giving a positive endorsement of NHS services for children. (See Figure 35). The results are interesting insofar as young people were more likely than parents/carers to give a positive assessment of health services – 73.7% (n=1,335) rating them as good or excellent (Figure 13).
- It is clearly evident from the survey results that the NHS is not perceived to perform effectively with regard to timely access to onward referrals with nearly two thirds (63.3%, n=285) of parents/carers indicating dissatisfaction (of whom 44.7%, n=201 strongly disagreed). See Figure 36. Young people were less likely to give a negative assessment of the speed of getting an onward referral appointment, with a quarter (25.7%) disagreeing or strongly disagreeing. (See Figure 15).

- Moreover parents/carers indicated that the quality of transfer was poor with over half of respondents (55.2%) indicating that the service transferred to did not have details of their child's condition. (See Figure 37). The findings therefore indicate that the transfer of patients between NHS services is an area of concern and warrants further attention to understand how this can be done better for young patients. Again, there is a slight contrast with views of CYP here with one quarter (24.9%, n=334) disagreeing or strongly disagreeing that the service had their details. (Figure 15).
- The results tend to suggest that more can be done to improve the information that is shared with CYP following a health intervention. The results at Figure 40 demonstrate that over a quarter of parents/carers (28%, n=157) stated that their child knew what was going to happen to their care. Almost as many (25.2%, n=141) stated that they did not know. This lack of information continues with regard to staff giving advice to children on how to look after themselves. Nearly a quarter (23%, n=130) of parents/carers stated that their child was not given advice. See Figure 41. The picture that emerges therefore is one where patients appear to be leaving NHS care without the full information that they need in relation to their complaint. The results are again worse than those given by CYP where 17.3% (n=290) said that they didn't know what was going to happen next with their care (Figure 20) and 12.1% (n=202) indicated that they had not been given advice (Figure 21).
- With regards to discrimination, the results between parents/carers again differ from those of young people. 22% (n=122) of parents (section 5.1.8) indicated that their child had faced discrimination or a barrier compared to 9.8% (n=163) of CYP (Section 4.1.9). Note however the difference in the qualitative data that was then provided. Whilst parents largely reported issues regarding lack of awareness of the needs of their neurodiverse child, young people tended to report outright discrimination (racism, sexism, transphobia).
- While the survey highlights some shortcomings in relation to aspects of care (such as that highlighted immediately above) the overall assessment of parents/carers in the NHS is positive with just over half (52.2%, n=287) rating healthcare as excellent or good. (See Figure 42). This is similar to the results from CYP where 69.5% (n=1,135) reported healthcare as excellent or good. (Figure 23).

6 Voices of health and care professionals

This section sets out the findings from the survey of health professionals.

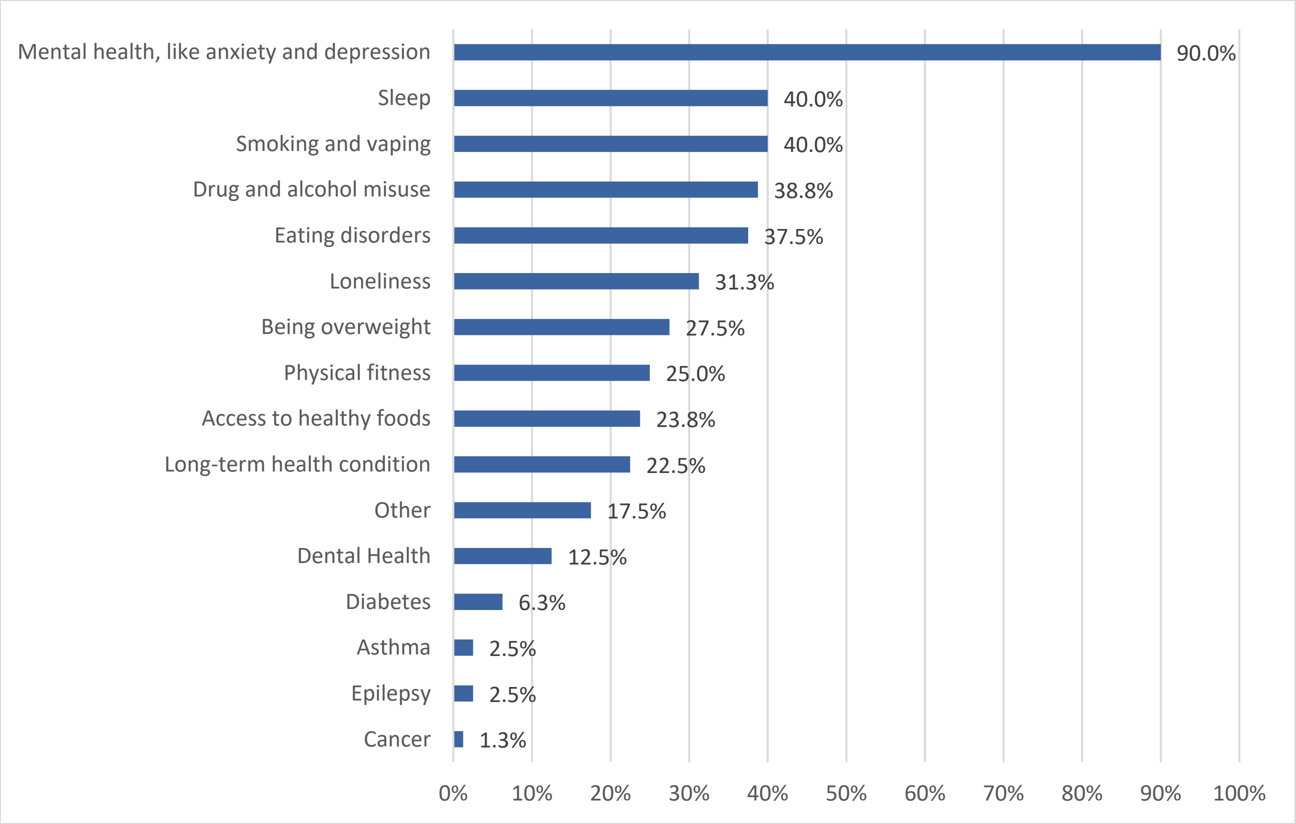
81 professionals responded to the survey.

6.1 Findings

6.1.1 Health priorities

Health and care professionals were asked to indicate which aspects of young peoples' health and wellbeing they felt need addressing most urgently. The results are set out at Figure 43.

Figure 43: What aspects of young peoples' health and wellbeing need addressing urgently



(Valid Total = 80. Note people were able to tick more than one option).

Condition	Number
Mental health	72
Sleep	32
Smoking and vaping	32
Drug and alcohol misuse	31
Eating disorders	30
Loneliness	25
Being overweight	22
Physical fitness	20
Access to healthy foods	19
Long-term health conditions	18
Other	14
Dental health	10
Diabetes	5
Epilepsy	2
Asthma	2
Cancer	1

Mental health was the most commonly given aspect of young people's health that professionals felt needed addressing, as cited by 9 out of 10 respondents (90%, n=72). Sleep and smoking and vaping were the next most commonly cited health issues with 40% (n=32) respectively.

17.7% (n=14) of professionals cited an "Other" option. All of the responses are set out verbatim below:

- "Healthy eating and drinking, sleep patterns and behaviours, emotional regulation and resilience."
- "Sickle cell, Thalassaemia."
- "Functional disorders in children and young people."
- "Parental support and education especially regarding parental responsibilities and our expectations of them."
- "Violence."
- "Body image."
- "Trauma."
- "Identifying young carers for support."
- "We feel like PMLD young adults are generally not given much thought or professionals do not know what to do with them. For example we had a parent take her 20 year old daughter to the

hospital as she was screaming and self-harming. The hospital ran some tests said there was nothing wrong and in no pain and sent her home. Mum asked what she should do as daughter clearly very distressed and they advised pain relief (even though they did test to rule this out) and again sent mum away when clearly they needed support."

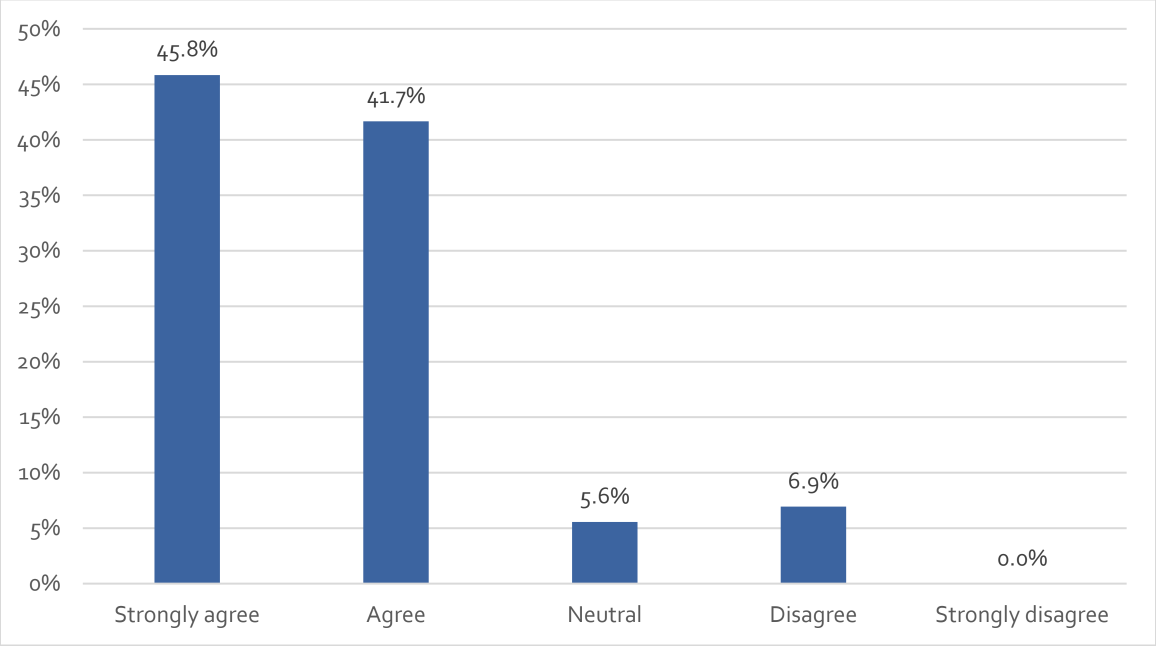
- "Isolation from peers and school life, impact on ordinary development, derailing outcomes and exacerbating mental health issues."
- "Neurodiverse conditions, Sensory Processing disorders."
- "Resilience building."
- "Neurodivergent conditions such as Autism and ADHD."

6.1.2 Confidence engaging children and young people

Respondents were asked to respond to the statement: Thinking about the last time you provided health services to a young person, to what extent do you agree with the statement: "I felt confident talking to the young person about all aspects of their care and treatment"?

The responses are set out below.

Figure 44: I felt confident talking to the young person about all aspects of their care and treatment



(Valid total = 72)

Assessment	Number
Strongly agree	33
Agree	30
Neither agree nor disagree	4
Disagree	5
Strongly disagree	0

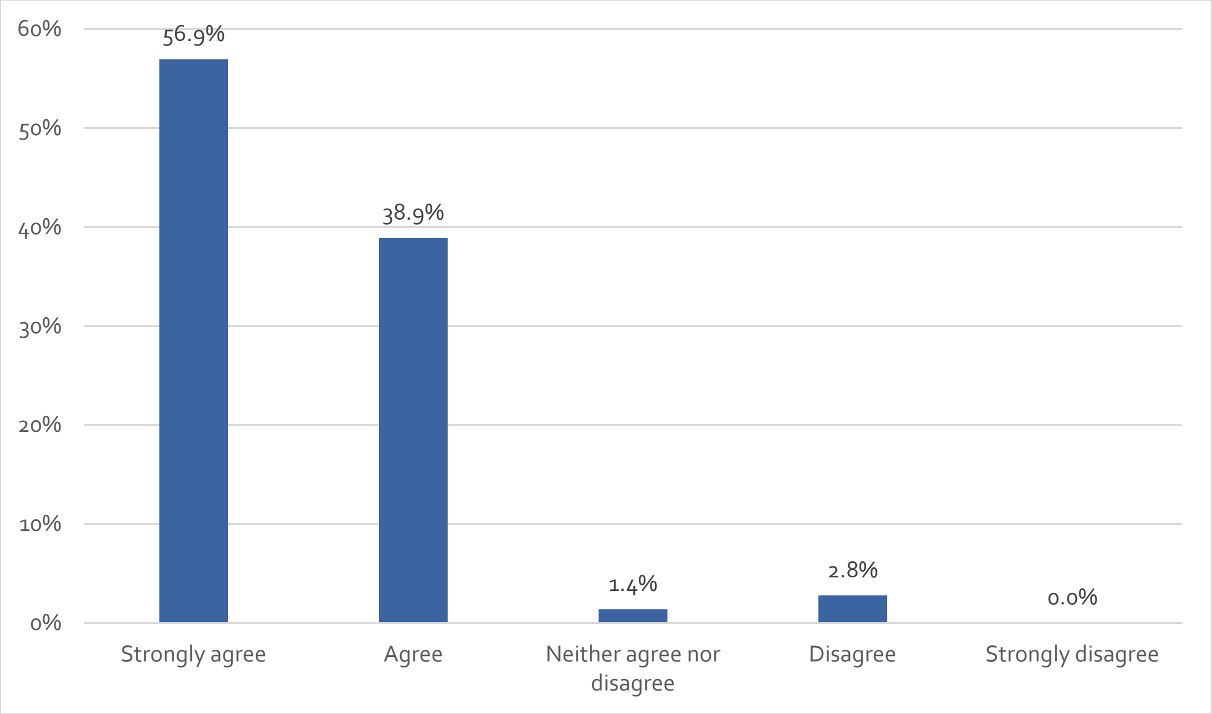
There was a clear consensus among professionals with 87.5% (n=63) of respondents stating that they agreed or strongly agreed with the statement. None strongly disagreed.

6.1.3 Young people involved in decisions about their care.

Professionals were asked to respond to the statement: Thinking about the last time you provided a health service to a young person, to what extent do you agree with the statement: "I felt confident in involving the young person in decisions about their care"?

The results are set out at Figure 45.

Figure 45: I felt confident in involving the young person in decisions about their care



(Valid total = 72)

Assessment	Number
Strongly agree	41
Agree	28
Neither agree nor disagree	1
Disagree	2
Strongly disagree	0

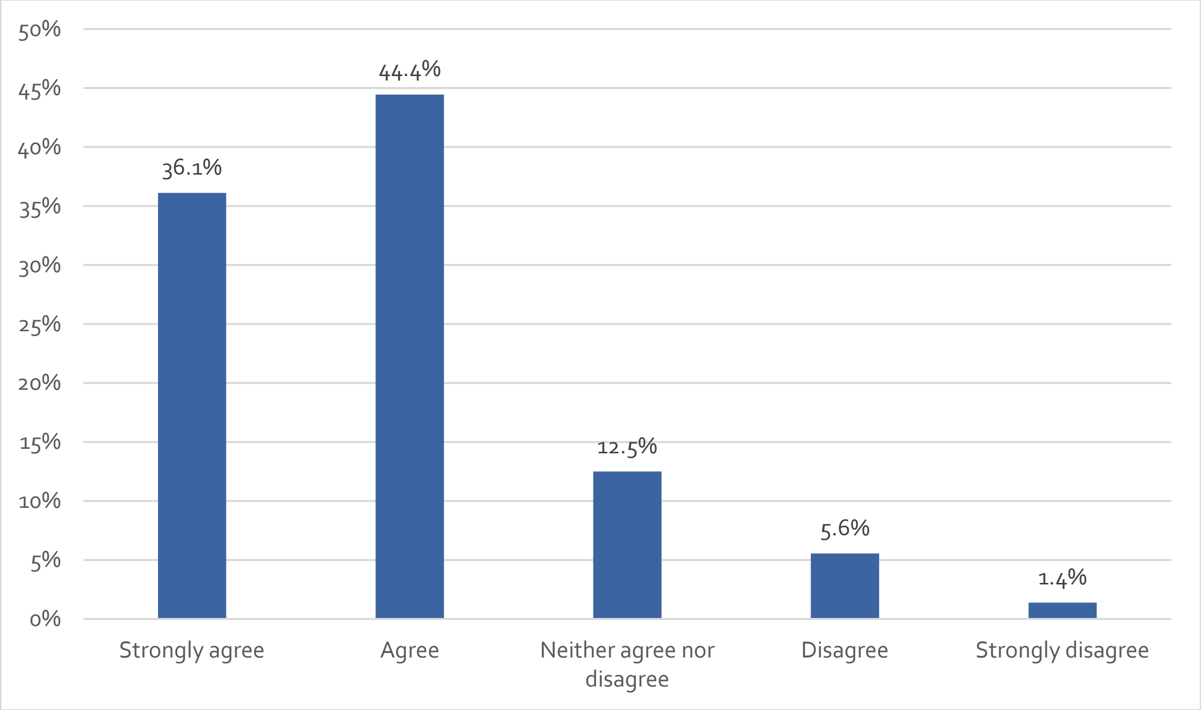
There was again a strong consensus among professionals with 95.8% (n=69) stating that they agreed or strongly agreed with the statement. None strongly disagreed.

6.1.4 Confidence in making decisions

Respondents were asked to respond to the question: Thinking about the last time you provided health services to a young person, to what extent do you agree with the statement: "I felt confident in making decisions about their treatment and care including onward referrals"?

See Figure 46 below for the results.

Figure 46: I felt confident in making decisions about their treatment and care including onward referrals



(Valid total = 72)

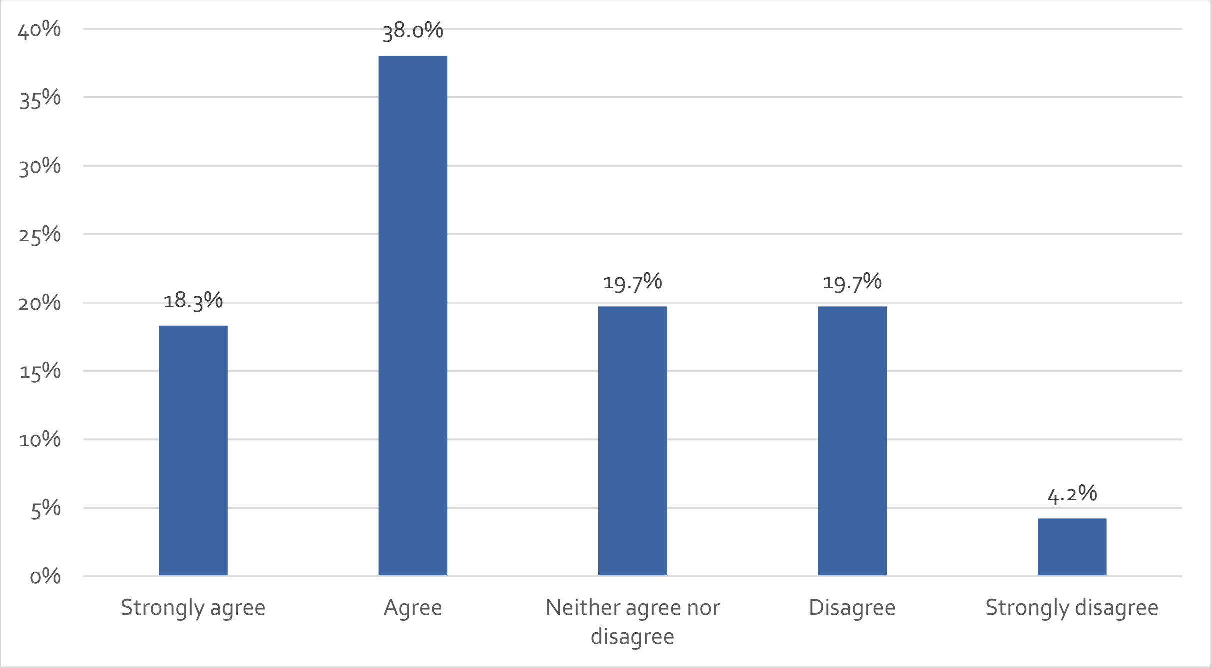
Assessment	Number
Strongly agree	26
Agree	32
Neither agree nor disagree	9
Disagree	4
Strongly disagree	1

Once again there was a very strong consensus among health and care professionals with 80.6% (n=58) reporting agreeing or strongly agreeing with the statement (albeit that those who agreed were greater than those who strongly agreed). 6.9% (n=5) disagreed or strongly disagreed.

6.1.5 Referring into other services

Respondents were asked to respond to the statement: Thinking about the last time you provided health services to a young person, to what extent do you agree with the statement: "I felt confident and was able to easily provide a referral into another service"?

Figure 47: I felt confident and was able to easily provide a referral into another service



(Valid total = 71)

Assessment	Number
Strongly agree	13
Agree	27
Neither agree nor disagree	14
Disagree	14
Strongly disagree	3

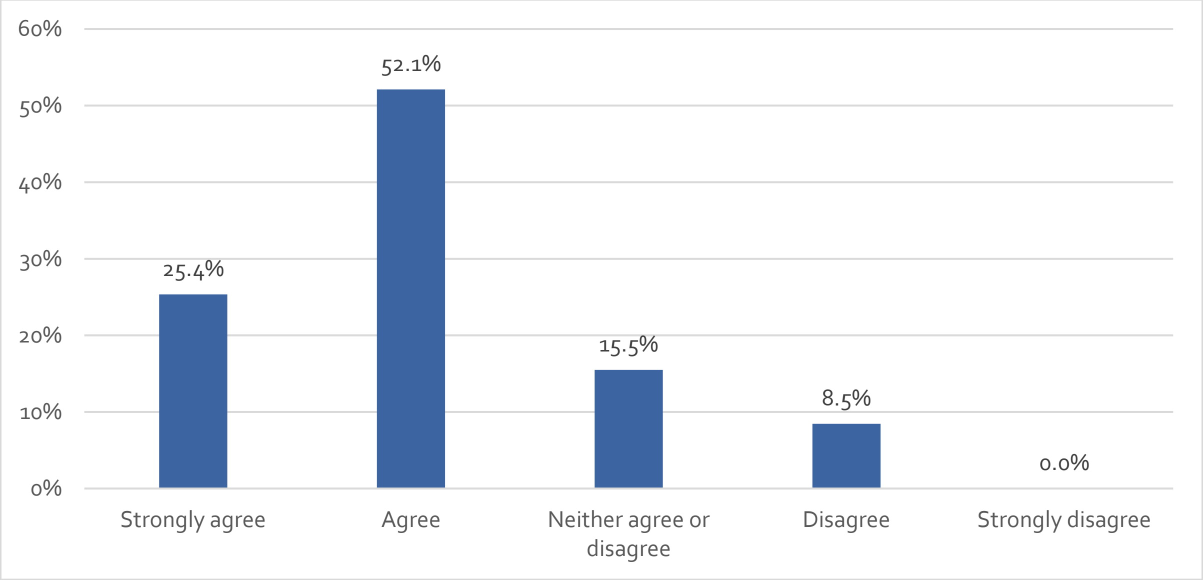
Just over half of respondents (56.3%, n=40) indicated that they agreed or strongly agreed with the statement while a little under a quarter (23.9%, n=17) disagreed or strongly disagreed.

6.1.6 Providing young people with advice

Respondents were asked to respond to the statement: Thinking about the last time you provided health services to a young person, to what extent do you agree with the statement: "I felt confident in providing the young person with advice on how to look after themselves after they left treatment"?

The results are set out at Figure 48.

Figure 48: I felt confident in providing the young person with advice on how to look after themselves after they left treatment



(Valid total = 72)

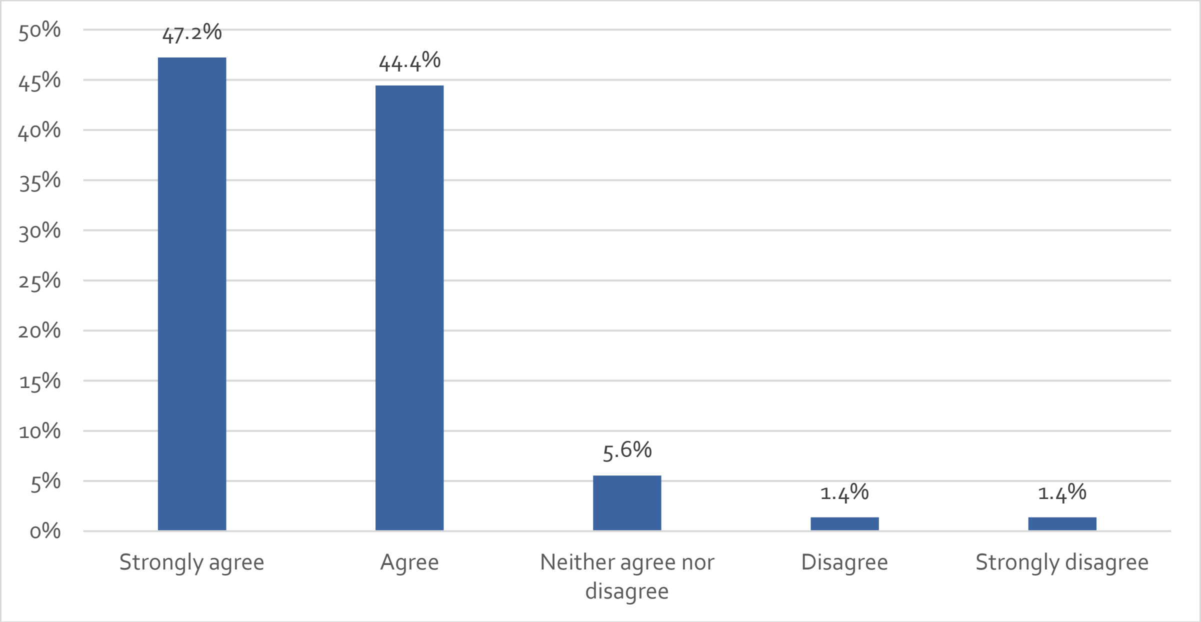
Assessment	Number
Strongly agree	18
Agree	37
Neither agree nor disagree	11
Disagree	6
Strongly disagree	0

The majority of professionals indicated that they were confident in providing advice to young people with over three quarters (77.5%, n=55) agreeing or strongly agreeing with the statement.

6.1.7 Working with family members

Those completing the survey were asked: Thinking about the last time you provided health services to a young person, to what extent do you agree with the statement: "I felt confident in building a relationship and communicating with the child's family member(s)"?

Figure 49: I felt confident in building a relationship and communicating with the child's family member(s)



(Valid total = 72)

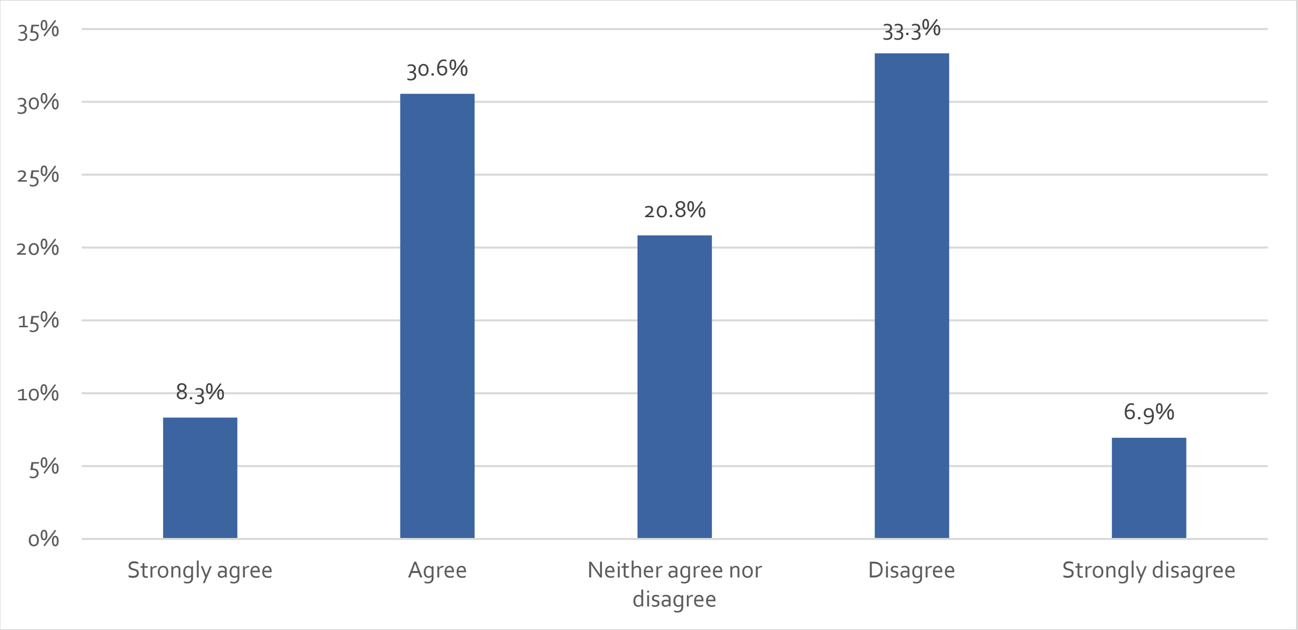
Assessment	Number
Strongly agree	34
Agree	32
Neither agree nor disagree	4
Disagree	1
Strongly disagree	1

There was a very clear consensus among professionals that they felt confident in building relationships and communicating with family members with 91.7% (n=66) of respondents agreeing or strongly agreeing with the statement.

6.1.8 Support for health and care professionals

Professionals were invited to respond to the statement: To what extent do you agree with the statement: "I have everything I need as a professional to help me in my role in supporting young people"? See Figure 50.

Figure 50: I have everything I need as a professional to help me in my role in supporting young people



(Valid total = 72)

Assessment	Number
Strongly agree	6
Agree	22
Neither agree nor disagree	15
Disagree	24
Strongly disagree	5

40.2% (n=29) of health and care professionals did not feel that they had what they needed to help them support young people while 38.9% (n=28) agreed or strongly agreed. A fifth (20.8%, n=15) neither agreed or disagreed.

Respondents were asked to explore their response to the statement in more detail. The key themes that were identified are set out below along with illustrative quotes.

Mental health

- "Access to the appropriate mental health services is limited and some of my young people just need someone to listen to them/counselling through difficult times. This not readily available."
- There is not enough psychological support for young people - school nurses do not provide enough services and need to be around more for drop in sessions. Young people need help to recognise when they have difficulties rather than waiting for them to say they want help."
- More resources needed specifically in mental health services, low level input for managing anxiety and low mood, managing emotions and navigating life as a teen /young adult. Emotional resilience overall needs improving."
- "I am not a mental health nurse - many of the young people I manage are struggling with school, friendships, social media, feelings of loneliness, self harming/feeling suicidal. There is very little support for young people's mental health and lengthy waiting lists. They need someone to talk to in a safe environment - sending to ED to see crisis team is often met with aggression or young people walk out. We have 2 psychologists in team, they have waiting lists of up to 6 months for our vulnerable patients-this seems unacceptable."

Collaboration and professional support

- "We work in partnership with agencies and professionals as part of our own supervision as well as supporting the needs of young people to ensure they are given the best advice and information for the care they require."
- "I am supported by doctors, psychologist, we have a good team."

- "I have support from the nurses and my manager."
- "In my role, I feel well supported by managers and have the equipment I need to deliver sessions in school. I have received lots of training to develop my skills and knowledge too."
- "I feel I have great links to specialists to seek advice and provide the support young people need."

Issue around onward referrals

- "Because there are different services available for different aspects of health and it is not always easy to pinpoint the exact service needed. Often when making calls/referral you get passed on with a different number several times which is frustrating."
- "The mental health services are not easily accessible for young children. I'm always unsure how to refer or what service will help the children appropriately."
- "Difficult getting some YP support with onwards referrals due to other teams criteria e.g. CAMHS."
- "Ability to onward refer and get swift support & action from the right services is something out of my control . But very frustrating for the child & family."
- "Referrals to services for diagnosis of ADHD, autism or any neurodivergent diagnosis is extremely difficult at present. This creates stress & anxiety for people of any age and their carers."
- "I am unable to refer to hospital services, and have to refer back to GP and ask them to refer on to these services."

Resources

- "General lack of resources and staffing within the NHS - no computer or desk space to work from, poor staffing & lack of time to talk to young people properly."
- "I don't think we have the in hospital resources or facilities to support some of the things these people need; especially the 16+ age group."
- "There are services that young person need to receive help from but I cannot provide this in a timely fashion due to long waiting list or lack of provision to refer. This is especially frustrating when there is no medical intervention I can offer to help and outside my work remit to help."
- "Most often parents bring their children because NHS services are not available."
- "Because my role, within an adult community learning disability service, is highly dependent on fully-functioning and coordinated support services for young adults receiving care, whether in their family home or accommodation supported by a registered provider. That coordinated

support is very difficult to get when social care services are so poorly funded, resulting in sub-optimal service provision from voluntary sector or private companies."

- "Lack of resources required for sessions in service, difficulties with staff recruitment means feeling overwhelmed and overburdened with extra work, therefore unable to provide 100% to CYP."

Lack of collaboration between services

"Sometimes there is a lack of understanding between different services about their roles and remit. This can cause divisions between different organisations, and even feelings of animosity. There is often a sense of 'passing the buck' with no services wanted to talk hold and coordinate the care of a young person. There seems to be no real guidance, plans or processes for that care coordination, for example if a young person has complex mental and physical health problems, and also difficulties related to their home life and education. It often feels like this role lands with CAMHS - who are not equipped, do not have the expertise of resources to coordinate such a variety of services."

- "I can support them but feel there is very little support from other services."

6.1.9 Discrimination

Respondents were asked whether they had witnessed any discrimination or barriers to CYP accessing healthcare. Nearly half (48.6%, n=35) of health and care professionals stated that they had witnessed discrimination or barriers, 37.5% (n=27) had not, and 13.8% (n=10) were unsure.

Discrimination

Respondents were asked to explore their responses with regards to the discrimination of CYP. The responses are set out below verbatim.

- "If we do witness anything, we are confident in our ability to follow protocol and reporting processes as well as ensuring the young people are not compromised in the provision of care they receive by following through with services to ensure there are no gaps and they are not further impacted or traumatised from any discrimination or barriers in healthcare."
- Working in CYP mental health, CYP from minority ethnic communities are vastly under represented in our patient population. Although attempts have been made nationally to increase awareness of common mental health problems, this has not reached the most isolated and hard to reach communities. It can sometimes feel like initiatives to improve access to services are almost lip service, so that organisations can tick a box to say they are acting on

inequalities, when actually minority communities can still struggle to access, or not wish to engage with these initiatives. In terms of the LGBTQ+ community I feel the barriers are related to lack of understanding, and reluctance to learn in staff members. I have experienced overt homophobia by a colleague, even though this was directed at me, within an office setting, it led me to be extremely concerned about how this attitude us reflected in the staff members work with CYP and their families."

- "There is clear unconscious bias and some conscious bias in the healthcare system, young people that frequently attend services can be labelled as "difficult" etc. Language barriers, cultural barriers all have impact on how some health care providers treat patients."
- "BAME cultures not fully represented in the service users accessing MH services. From experience, likely due to cultural belief systems from families not identifying/prioritising YP's mental health."
- "Protected characteristic groups are discriminated against in many ways - access to healthcare, timely referral, access to treatment."

Barriers

The question also addressed barriers experienced by young people. There was no single key barrier raised and so an illustrative selection of barriers that were identified are set out below.

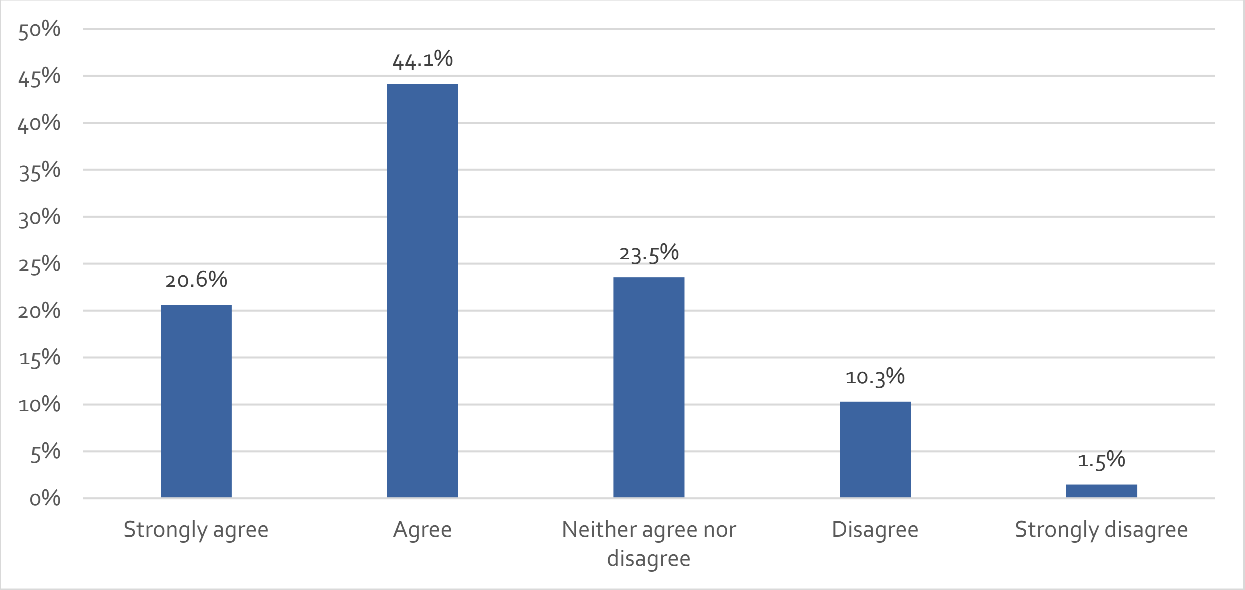
- "Young people often find it difficult to take the lead in their own care if parents have been managing their long term health condition throughout their lives."
- "Language barriers are the biggest difficulty and having access to the right interpreter."
- "Young people feel discouraged from accessing healthcare as they feel they don't matter and will just get put on a waiting list."
- "Lack of trauma formed approach for young. People who are victims or perpetrators of violence."
- "I don't think there are any actual active barriers to CYP accessing healthcare but I do think there are potential perceived barriers which we could manage better. Many of these are societal/ socioeconomic or cultural."
- "Access to services can be a postcode issue, who and how a referral is made can impact if it is accepted, parent engagement may mean child is not given full opportunity to access the correct support that is available for them. Lots and lots of issues and barriers."
- "We've now reached a point where young people have to have attempted suicide before they are even assessed."

- "Barriers: long waiting lists which means there is a lack of continuity for young people. Sometimes, young people feel spoken at rather than too if professionals address their parents more than them."
- "Young people not knowing where to go for support, schools should have more on offer for children and young people.

6.1.10 Working with other organisations

Respondents were asked to respond to the statement: To what extent do you agree with the statement: "I have a positive working relationship with other organisations who also engage, provide service or work with young people"?

Figure 51: I have a positive working relationship with other organisations who also engage, provide service or work with young people



(Valid total = 68)

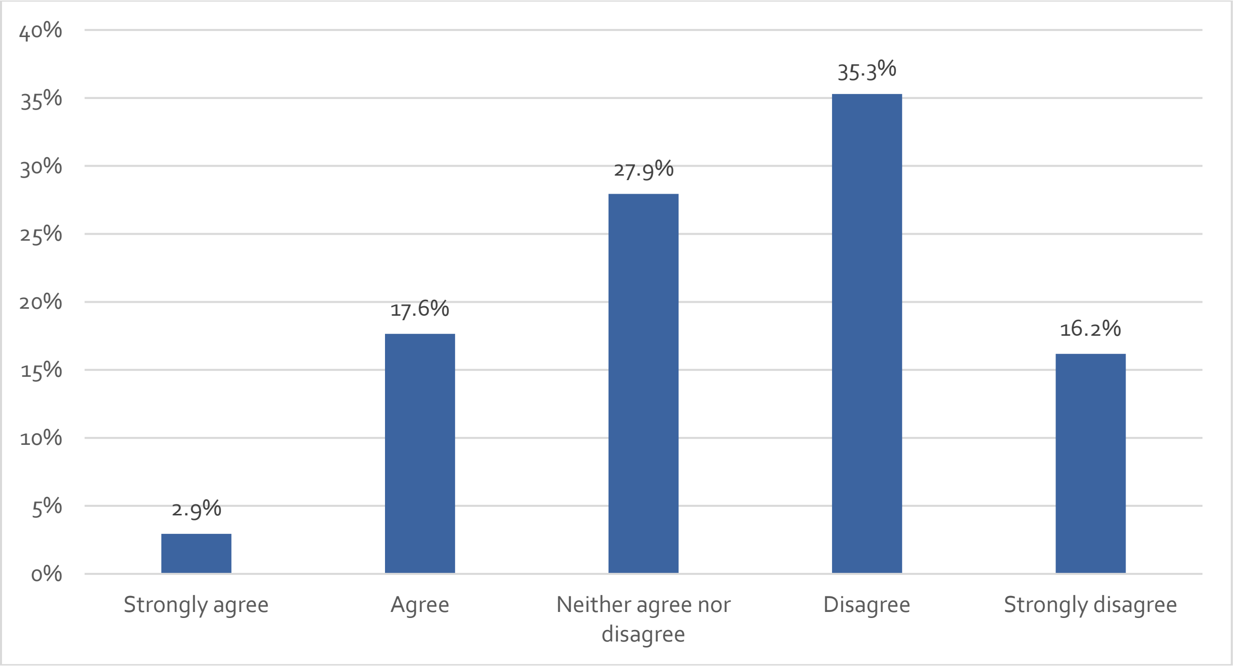
Assessment	Number
Strongly agree	14
Agree	30
Neither agree nor disagree	16
Disagree	7
Strongly disagree	1

Nearly two thirds (64.7%, n=44) of professionals reported a positive working relationship with other organisations, agreeing or strongly disagreeing with the statement. Almost a quarter (23.5%, n=16) neither agreed or disagreed.

6.1.11 Integration of health provision

The survey explored whether health and care professionals thought that services for CYP are integrated across health and care. The results are set out below.

Figure 52: Services for young people are integrated across the health and care system



(Valid total = 68)

Assessment	Number
Strongly agree	2
Agree	12
Neither agree nor disagree	19
Disagree	24
Strongly disagree	11

The results clearly show that health professionals do not think that services for young people are integrated with over half (51.5%, n=35) disagreeing or strongly disagreeing. Over a quarter (27.9%, n=19) neither agreed or disagreed.

6.1.12 Thoughts and observations about providing services to children and young people

The survey allowed respondents the opportunity to make any other observations about providing services to CYP. Fifteen respondents provided additional information. There were no consistent themes in the data and so a selection of quotes are provided below:

- “Yes services are integrated, but if the agency is unfamiliar with a 'softer holistic approach' they are likely not to refer or signpost, therefore, from our experience in working with partner agencies, it is important to know how other services that are not conventional are helpful and in fact help remove barriers and stigma that is perceived in society.”
- “A lot of services are under pressure, I appreciate that. There is a lot of disjointed working with service providers claiming it is not their job/role without trying to provide a solution or an answer for this child at the centre.”
- “Access to services outside of their 'disease' related treatments is limited.”
- “I don’t think we are as yet properly set up for the care of young adults with chronic conditions; 'transition' is only a part of it, our facilities, especially inpatients, are lacking unless they have cancer and that is unjust.”
- “All services that young person are not within same institution and this affects the input young person needs - like access to CAMHS if not for acute medical need.”
- “We need to advocate for our patients.”
- “We do not have access to each others’ record keeping systems therefore information missed as not able to find it.”
- “When I started out as a psychotherapist 18 years ago accessing services was easier, although the quality of those services was generally poor. Now access is almost impossible without at least a 1 year wait. Lower level issues are solidifying and causing lasting damage when they could be treated easily and quickly at outset.”
- “There needs to be more communication & working together with all teams & families. More communication & better information for families.”
- “Health and social care not always in alignment with child's needs.”
- “Health and social care is very disjointed, always difficulty in obtaining funding for certain aspects of child's care which leads to delayed discharge and maybe insufficient support in community for families. Families of children with complex healthcare needs have insufficient

help to assist them in the community especially as these children are living longer and require more care."

- "Services are not integrated, it can be very difficult to get hold of CAMHS staff-patients will be allocated a named CAMHS worker, I am rarely updated about what support the young person needs, services are working independently of each other. Several of my patients have not attended school - some for over 2 years, I have struggled to get hold of welfare officers, named social workers, services do not update health care professionals."
- "County offer differs to City Postcode lottery."

6.1.13 Mental health

Respondents were asked whether they feel confident in supporting young people to transition to adult mental health services or services available in the community.

Among those who reported that this issue was applicable to their role 47.3% (n=26) of respondents stated that they were not confident, 30.9% (n=17) stated that they were confident, and 21.8% (n=12) were "unsure".

Professionals were invited to share their experiences of supporting the transition. The responses generally related to a number of key themes:

- Differences between adult and young people's mental health access criteria,
- The impact of transition arrangements on CYP and their family,
- Lack of clarity about transition arrangements,
- The absence of transition arrangements.

Illustrative quotes for these themes are set out below.

Differences between adult and young people's mental health access criteria

The most commonly cited issue was the difference between adult and young people's services in terms of the criteria adopted and the nature of the service offer:

- "Majority of CYP with mental health difficulties accessing secondary services do not meet the criteria for adult services. It can be very difficult to help CYP and their families understand the remit of adult services, and how it is very different to child services. This is often met with anger and frustration from CYP and families, which feels misdirected. It can be hard to help CYP and their families understand and accept that there are other services than secondary MH care which may be best placed to support them."

- "A lot of patients who need to be transitioned are often missed and feel they have been dropped by children's services as they do not meet the adult services criteria."
- "The thresholds for YP and adults is very different with mental health and more support needed for 18-25 year olds."
- "I have worked in both child care and supported parents going through to adult services. I now work in adult care as a manager and have ongoing involvement in how transitions work. Again the transition criteria is very strict and requires a very high level of dependency and some of our service users I would have thought be 100% health are not due to the criteria which means they suffer as a result."
- "I feel referring to adult mental health services is an easy process, however it is noted that adult services have difficulties matching the offer children have received, noting children often requiring transition have had multiple services involved at the same time, often seeing patients every other day, where as adult services highlight this is not possible from their service and is considered this approach to have hindered the development of resilience in young people and causes reliance on service/revolving door."
- "Hard - having to cut down appointments so they get used to the new expectation of adults, and also the change in validation and care, feels like they get way more tough love in adults which is a change from the more softer approach in CAMHS."
- "I've been able to support and refer young people to adult services but have found mixed messaging on eligibility due on the exact age of transition. This created duplicity, confusion and made me appear unprofessional."

Impact on young people and their family

A number of respondents focused on what they perceived to be the impact of current transition arrangements on CYP and their families:

- "It's hard for the service user and their families."
- "Very poor, young people & families are exposed to lack of funding, no capacity , no support conversations often."
- "Young people can find the transition from a lot of support under CAMHS to adult services a challenge."

- "It's a really difficult process and it can be really hard seeing the effect of this upon the young person."

Lack of clarity about transition arrangements

Some respondents felt that current transition arrangements are not clear:

- "Lack of knowledge of where to refer and long waiting lists."
- "Confusion about how to access services - grey area - no one takes accountability."
- "I have varied experience of supporting transition - opportunities to discuss a young person and have an integrated plan of support can be good - or can be very poor. It is not a consistent picture."
- "Cumbersome and often frustrating."

The absence of transition arrangements

Some respondents felt that there was largely an absence of transition processes:

- "That the transition process is non-existent and relies on the young person starting their journey again as an adult via their GP."
- "In Primary care we are often left to see these cohort due to no other services available to support them when they are in crisis."
- "In my experience, transitions are often very sudden, and young people and young adults are often left without services for their mental health particularly when they reach 18 - unless they are care leavers."
- "The transition of young people between services is failing before it has begun."
- "There is no transition they just get moved from one waiting list to another or drop off the system entirely."

Learning disability

One respondent explored issues with regard to young people with learning disabilities, noting that transition here are also problematic:

- "I have supported transitions from children's to adult services within the Learning Disability community and not specifically in Mental Health. A lot more emphasis needs to be placed on ensuring supportive transitions for this cohort, as their families and carers often feel as though they have been 'pushed off a cliff'. The problems with transferring Education Health and Care

Plans from children’s to adult services just don't seem to be being addressed, with the 'education' aspects taking precedence and very little handover happening particularly in terms of 'care', which often isn't even documented in the plan. I have worked with a number of clients whose EHCP has been discontinued by the Special Education Service/local authority when an education provider feels they are no longer benefitting from the provision or is unable to continue offering them a place, whilst the person still has ongoing health and care needs. The provision of health services, such as Speech and Language Therapy, between children and adult services is so different that it is not feasible to continue to provide the same level of input which is documented in their EHCP (which often has not been being provided as recommended anyway due to lack of resources).”

6.2 Key findings

- The most cited health need among CYP that professionals indicated needs addressing is mental health (see Figure 43). This therefore constitutes a highly consistent message given that it was most cited also by CYP and parents/carers. Of some interest the results from the professionals parallel those of parents/carers with both groups indicating that the second most important area to be addressed is sleep.
- The results from health and care professionals very clearly indicate that they feel confident talking to CYP (87.5% (n=63) of respondents - see Figure 44). This finding, while a positive endorsement of NHS staff, is somewhat at odds with the views of CYP. Note that 68% (n=1,231) of CYP reported that they felt listened to (Figure 11). Note also a little over half (58.4%, n=354) of parents/carers felt that their child had been listened to by health staff (Figure 32). This also differs from the picture given by health professionals where 91.7% (n=66) felt able to communicate with family members. (Figure 49).
- There also appears to be somewhat of a disconnect between health and care professionals and young people in relation to the involvement of CYP. While 95.8% (n=69) of professionals endorse the idea that they are confident in involving young people in their care (see Figure 45) this drops to 79.3% (n=1,353) of CYP (of whom the majority – 55.5% (n=947) - indicated that they were involved in decisions about their care “a little”). (See Figure 16).
- There appears to be something of a disconnect between the views of health and care professionals regarding giving advice, and the views of parents/carers and CYP. While over three quarters (77.5%, n=55) of professionals indicated that they were confident in providing advice (see Figure 48) only about a third (32.4%, n=181) of parents and just over a half of CYP (52.6%,

n=880) indicated that they child had been given advice by a health professional. (See Figure 41 and Figure 21)

- Just over half (56.3%, n=40) of professionals indicate that they are easily able to refer CYP into another service (see Figure 47). From a parent/carer perspective though the picture shifts somewhat: the majority (63.3%, n=285) of parents/carers did not think that their child got an appointment quickly and only around a fifth (21.4%, n=95) stated that the service referred on to had details of their child's condition. See Figure 37. The results therefore show that, while professionals are confident in making referrals, the process of this is not perceived as smooth and easy by parents/carers. 25.8% (n=462) of CYP did not think they were able to access onward appointments quickly and 24.9% (n=249) felt that they had to tell their story again. (See Figures 14 and 15).
- The results from the professionals indicate that healthcare staff do not feel that they had the help or support that they need to carry out their role effectively, with 40.2% (n=29) indicating that this is the case. (See Figure 50).
- While the data regarding perception of discrimination and barriers is somewhat concerning (48.6%, n=35) of professionals stated that they had witnessed discrimination or barriers – see Section 6.1.9) the qualitative data accompanying the results tends to indicate that the issue is more to do with barriers, rather than high levels of discrimination existing. However, it remains the case that a number of respondents identified issues around discrimination in the delivery of healthcare to CYP.

7 Conclusions

A number of conclusions, drawn from the data in this report, are set out below.

7.1 Overall assessment of health services

CYP, overall, have a positive view of healthcare and health services. A large majority (73.7%, n=1,335) reported that the last health service that they had used was good or excellent (Figure 13) and a majority (69.4%, n=1,135) of young people rated their experience of healthcare overall as good or excellent (Figure 23). The views of parents/carers were also positive with just over half (59.7%, n=364) reporting that the last health service their child has used was good or excellent (Figure 35) and over half (52.2% n=287) giving an overall positive assessment (Figure 42).

While young people raised a number of issues of concern for them (explored below) it is evident therefore that, on the whole, young people have a positive view about health services and have had positive experiences in their interactions with healthcare.

We note though the different rates of satisfaction between parents/carers and their children. There is nothing in the data that would help to explain the difference between the views of young people and their parents/carers but it is clear from the research that parents/carers are less likely to be satisfied with health services than their children.

1. **Key finding: The majority of young people have a positive view of health services and report having had a positive experience in their last encounter.**
2. **Key finding: Parents and carers are generally less satisfied with healthcare for children than young people.**

7.2 Health concerns of children and young people

Mental health

A clear finding from the surveys of CYP, parents/carers and professionals is the concern regarding mental health which was the most commonly cited health issue reported across all groups (60.8% (n=1,103) of CYP, 92.1% (n=605) of parents and 90% (n=72) of professionals). (Figures 7, 28 and 43 respectively). Mental health also featured strongly as an issue in the participatory activities and was the most commonly raised topic. (See Section 3.2.1).

It was evident from young people that they do not feel that mental health is treated on a par with physical health and is not prioritised. Common motifs in relation to views on mental health include that it is not taken as seriously as physical health, that there is widespread under-diagnosis among young people and that there are insufficient services. Some young people explicitly drew parallels between physical and mental health services, noting the lack of support in the latter compared to the former.

While care should be taken in reporting based on a very limited number of statements, it is the case that more than one young person consulted reported not being engaged by mental health services having self-harmed or having reported thoughts of suicide. There was a sense therefore that even young people in explicit crisis were not able to access support for their mental health.

Sleep

Somewhat strikingly, both young people and their parents/carers identified sleep as the health issue that was most important to them after mental health. (45% (n=848) of young people and 43.7% (n=288) of parents/carers – see Figures 7 and 28). Note that sleep therefore ranks above all other conditions that might have been thought of to have been of a more pressing concern. The findings were further endorsed by professionals who also identified this as the second most important issue (39.5% (n=32) - Figure 43).

3. **Key Finding: CYP indicate that mental health is the health issue that matters most to them but do not feel that there are the right range of services in place to respond to their mental health needs and that more needs to be done to help young people with their mental health.**
4. **Key Finding: The key health issue of concern among parents/carers regarding their children is also mental health.**
5. **Key finding: Both young people and parents/carers identified sleep as the next most important issue to them.**

7.3 Knowing how to access healthcare services

The results with regard to young people's knowledge of how to access healthcare services are positive with a large majority (78.8%, n=1,399) reporting that they would know what to do should they become unwell. (Figure 9). The majority (59.7%, n=983) of young people also knew how to access mental health services. (Figure 24). Note that parents/carers were also clear that they would know how to access health services for their child (88.1%, n=566). (Figure 29). While half (50.5%, n=325) of parents/carers knew how to access mental health services for their child (Figure 30), the rate differs markedly for those for physical health services.

The majority (59.9%, n=1,118) of young people noted that the first thing that they would do if they had a health concern would be to talk to a parent/carer. Note that only 6.1% (n=114) would contact their GP. (See Figure 8). The results therefore very clearly illustrate the critical role that parents/carers play in young people's access to health services and that, to engage young people in healthcare, awareness raising must target both young people and those that care for them.

The results also show that nearly a quarter of young people would go online for information about health. This therefore emphasises the need to provide young people with information about the right sites to go to for information, to ensure that what they access is clear, accurate, timely and, ideally, points them towards locally available services.

The results indicate that there is scope to improve knowledge regarding how to access mental health services so that awareness is on a par with physical health services. This is all the more important given the heavy emphasis placed by young people on their mental health and getting the right support for this. (See Section 6.2.).

6. **Key finding: Most young people know how to access health services should they need them but are most likely to turn to parents/carers in the first instance. This therefore highlights the need to engage effectively with both young people *and* their parents/carers.**

7.4 Health services used

The most commonly used health services were dentists (74%, n=1,363) of CY) and GPs (72.9%, n=1,344). See Figure 10.

The results indicate a notably high use of emergency services with nearly a quarter of young people reporting having used A&E in the last 12 months.

While there is no data available that indicates why this level of usage is so high, it is possible that use of A&E is being driven by difficulties in accessing GP services (described below) and those young people who reported giving up on trying to get a GP appointment. This conclusion is however purely speculative. Note though that only 0.6% of young people stated that, if they were unwell, they would go to A&E first (Figure 8). This therefore tends to support this conclusion insofar as it indicates that young people are looking for support for their health elsewhere before turning to A&E.

7. **Key finding: Over half of young people had seen their GP in the last twelve months. A fifth had attended A&E.**

7.5 Waiting times and access

While young people's overall assessment of health services tended to be positive (see 6.1 above) , they raised a number of negative issues regarding health services. The most commonly cited of these was in relation to waiting times and access which was evidenced in both the surveys and the participatory activities.

A very strong theme through the participatory work was the difficulty in getting GP appointments which was widely reported as being difficult and time consuming. A number of young people reported failing to get appointments with their GP and some (worryingly) subsequently gave up trying.

Waits were also reported in relation to secondary care with frequent reports of waiting times of several months. Some young people reported waiting times of over a year, and some even of several years.

It is important to caveat these findings inasmuch as that long waiting times was not a universal feature of young people's comments and, in some cases young people reported quick access to healthcare including GP appointments the same day, and rapid access to hospital services.

The overall impression however is that young people have experienced long waits to access healthcare and find making GP appointments slow and difficult.

8. **Key finding: The most common complaint made by young people in relation to health services was long waiting times for both primary and secondary healthcare services. Young people also reported that they found it difficult to get appointments with their GP.**

7.6 Being listened to

A very strong theme emerging from the consultation was the need for young people to be listened to, to have their health concerns taken seriously, and not to have their worries dismissed (particularly on account of their age). Comments in the survey and from the participatory activities indicate young people are highly aware of their health needs, know when their health has deteriorated or is giving them cause for concern, and therefore when they need to access professional support. Given this, one of the most common reasons given for a positive interaction with health was that they were listened to and taken seriously. (See Section 3.1.4). Conversely, a commonly given reason for a negative assessment of healthcare was that they were ignored, dismissed or that healthcare workers did not take the time to listen to them.

Given the importance of being listened to, the results from the survey provide a positive picture with 68.1% of young people saying that they felt listened to. These results align with the views of parents/carers where around a fifth (21.8%, n=132) also indicated that their child was not listened to. (Figure 32).

These results should be read in conjunction with the findings from the professionals' survey whereby 87.5% (n=63) of respondents indicated that they feel confident talking to young people. (Figure 44). There is therefore a slight disconnect between the overwhelming majority of professionals, who report that they feel able to talk to young people, and what young people and their parents/carers are saying. We therefore surmise that there is a slight sample bias at play. Those professionals who responded to the survey regarding children's healthcare may be those who are more likely to engage effectively with young people. Or put simply, professionals who don't feel confident talking to young people didn't answer the survey.

9. **Key finding: Young people place significant importance on being listened by healthcare practitioners and this is integral to their assessment of the quality of healthcare.**

7.7 Caring and compassionate staff

The results from the survey make it very clear that being treated with kindness, compassion and in caring manner are of significant importance to young people. This was the most commonly given reason why a young person would rate their interaction with healthcare positively, and (where staff were uncaring) a key reason why they would give a negative assessment. (See Section 3.1.4).

The results from young people indicate that health services are treating them with care with just under three-quarters (74.4%, n=1,344) of CYP indicating that they were treated with care and concern. (Figure 12). (Note that the rate among parents/carers was however slightly lower at 68.6%, n=418 - Figure 33).

10. **Key finding: Being treated with care and compassion is a key factor in how young people judge the quality of healthcare.**

7.8 Next steps and advice

Given the importance of communication for young people (see 6.6 above) it is interesting to note that the survey indicates that not all young people were clear about what would happen next with their treatment. While just under a third (31.1%, n=550) of young people report knowing next steps, the most common response was that they "sort of" knew (39%, n=653). Nearly one in five (17.3%, n=290) did not know. (All data Figure 20). Parents/carers shared this view with just over a quarter (28%, n=157) reporting that their child knew what would happen next. (Figure 40).

Again there is a slight disconnect between the views of CYP and parents/carers and those of professionals, 95.8% of the latter felt confident in involving children in decisions about their care. (Figure 45, n=69). This would appear to provide further evidence of the sample bias that was noted above (see 6.6).

Note also that not all young people were provided with advice following treatment. While a little over half (52.6%, n=880) were given advice, over a quarter (26.9%, n=451) "sort of" were given advice and 12% 9n=202 were given no advice. (All data Figure 21). Of some interest, parents/carers were less likely to indicate that their child had been given advice (32.4%, n=181 - Figure 41).

The results from professionals are interesting to note at this point with 77.5% (n=55) of healthcare workers who responded to the survey stating that they felt confident in giving advice to CYP. (Figure 48). Once again, this would tend to suggest that the views of professionals who responded to the survey may not be representative of the views of healthcare workers more widely.

The results would therefore tend to suggest that there is scope to improve communication with young people about next steps in their treatment and how they can manage their own health.

11. **Key finding: A sizeable minority of young people leave treatment not knowing what the next steps in their treatment are.**
12. **Key finding: A small minority of young people leave treatment having been given no further advice.**

7.9 Onward referrals

The data from the survey tends to suggest that the issue of waiting times extends to onward referrals, with only a quarter (25.6%, n=457) of young people indicating that they got an onward appointment for diagnosis and treatment quickly. (Figure 14). Parents/carers were less likely to indicate that their child got an onward appointment quickly (20.9%, n=94 agreeing or strongly agreeing – Figure 36).

It is useful to contextualise these findings with the results from the survey of professionals which indicate that a fifth (20.5%) of respondents felt that services for young people are integrated. The majority (51.5%, n=35) did not think that services were integrated. (See Figure 52).

There appears to be an issue with the quality of the referral/handover process with only around a third (35.7%, n=479) of young people stating that the service they were referred on to had details of their condition. (Figure 15). Parents/carers shared this view about the quality of transfer, with 21.4% (n=95) indicating that the service had details of their child's condition. (Figure 37).

13. **Key finding: Young people and their parents disagreed that onward referrals to other health services were quick.**
14. **Key finding: Young people and their parents/carers disagreed that services that they were referred on to had the details of their condition.**

7.10 Support for professionals

The results from the survey of professionals show that under half (38.9%, n=28) felt that they had everything that they need as a professional to help them in their role in supporting young people. (See Figure 50).

The results are interesting insofar as, if our assertion that some degree of sample bias is true, then the data indicates that the majority of professionals who feel most comfortable working with young people (that is, professionals who responded to the survey) do not feel fully equipped and resourced to help them. This conclusion is of course conjectural given that it is based on our views of the sample of professionals who responded. Regardless of this however, it remains the case that the majority of professionals do not feel that they have everything they need to work effectively with their young patients.

The comments provided by professionals usefully illustrate what is preventing them from providing the help that they would like. The responses indicate that the main issues are: a lack of mental health resources, improvements to referrals, more resources and better collaboration between different health partners. (See Section 5.1.8).

15. Key finding: The majority of professionals do not feel that they have everything they need to help them in their role in supporting young people.

8 Appendix

8.1 Full breakdown of ethnicity from CYP survey

Table 10: What is your ethnicity?

Ethnicity	Count	Percentage
Bangladeshi	13	0.8%
Chinese	344	22.4%
Indian	106	6.9%
Pakistani	68	4.4%
Any other Asian background	17	1.1%
African background	31	2.0%
Caribbean	21	1.4%
Any other Black background	20	1.3%
Asian and White	47	3.1%
Black African and White	8	0.5%
Black Caribbean and White	21	1.4%
Any other Mixed or multiple background	26	1.7%
British, English, Northern Irish, Scottish, Welsh	704	45.8%
Irish	1	0.1%
Gypsy/ Traveller	9	0.6%
Roma	0	0.0%
Any other White background	24	1.6%

Ethnicity	Count	Percentage
Arab	15	1.0%
Polish	10	0.7%
Somali	4	0.3%
Prefer not to say	22	1.4%
Any other ethnicity	27	1.8%
(blank)	346	
Total	1,884	1,538

8.2 Full breakdown of ethnicity from Parent survey

Table 11: What is your ethnicity?

Ethnicity	Number	Percentage
Asian or Asian British - Bangladeshi	2	0.4%
Asian or Asian British - Indian	24	4.6%
Asian or Asian British - Pakistani	4	0.8%
Any other Asian background	0	0.0%
Chinese	2	0.4%
Black or Black British - African	4	0.8%
Black or Black British - Caribbean	2	0.4%
Any other Black background	0	0.0%
Mixed - Asian and White	3	0.6%
Mixed - Black African and White	3	0.6%
Mixed - Black Caribbean and White	3	0.6%
Any other Mixed or multiple background	3	0.6%

Ethnicity	Number	Percentage
White - British, English, Northern Irish, Scottish, Welsh	434	82.7%
White - Irish	5	1.0%
White - Gypsy/Irish Traveller	1	0.2%
White - Roma	1	0.2%
Any other White background	10	1.9%
Arab	0	0.0%
19. Polish	2	0.4%
Somali	1	0.2%
Any other ethnicity	1	0.2%
I would prefer not to say	20	3.8%
Blank	286	
Total	811	525

8.2 Limitations in geographic data analysis

As survey respondents were only asked to provide a partial postcode, the conclusions we can draw from this data are limited for two main reasons.

1. **Data Quality**

Since the question allowed free text responses, the input varied widely in format and accuracy. Many responses needed correcting, and some could not be used at all due to inconsistencies. This made it difficult to reliably analyse the geographical distribution of responses.

2. **Ambiguity of Partial Postcode**

Many partial postcodes cover multiple local authority areas. For example, LE2 2 has an almost equal number of postcodes in both Leicester City and Leicestershire County, making it impossible to determine whether a respondent lived in the city or the county. Similarly, LE15 spans across Harborough and Melton.

When analysing the data, we only recorded a local authority area/district for postcodes with a confidently determinable location. This limitation predominantly impacted postcodes on the border between two geographic areas, particularly Leicester City as it is centrally located in Leicestershire. While a 24.4% response rate for Leicester City suggests potential underrepresentation, we were unable to determine a definitive location for 170 valid postcode responses, so the actual number of respondents living in Leicester City may be higher than reported. Conversely, the number of respondents in Leicestershire County may be overestimated, as we did not consider postcode data from neighbouring counties (Nottinghamshire, Lincolnshire, Northamptonshire, Warwickshire, Staffordshire, and Derbyshire).

Table 12: Summary of geographical analysis from children and young people survey

	Number of respondents
Did not provide a postcode	797
Provided an invalid postcode	50
Provided a postcode that doesn't fall within LLR	18
Provided a valid postcode that we could use to categorise by geography	849
Provided a valid partial postcode, but it covers more than one local authority area	170
Total respondents	**1884**

City	207	24.4%
County	598	70.4%
Rutland	44	5.2%
Total number of responses we can confidently categorise by local authority area	**849**	

Blaby	39
Charnwood	56
Harborough	106
Hinckley & Bosworth	60
Melton	36
North West Leicestershire	26
Oadby & Wigston	174
Provided a valid partial postcode in County, but it covers more than one district area	101
Total County	**598**

Table 13: Summary of the postcode responses from the children and young people survey

First part of postcode	Number of respondents
CV13	4
DE11	2
DE12	1
DE74	1
LE1	16
LE10	45
LE11	21
LE12	17
LE13	31
LE14	10
LE15	96
LE16	17
LE17	3
LE18	57
LE19	14
LE2	303
LE3	37
LE4	40
LE5	85
LE6	3
LE65	3
LE67	38
LE7	87
LE8	45
LE9	41
NG13	2
NG33	1
PE9	2
Did not provide a valid postcode	862
Grand Total	**1884**

Table 14: Summary of geographical analysis from the parents and carers survey

	Number of respondents
Did not provide a postcode	202
Provided an invalid postcode	3
Provided a postcode that doesn't fall within LLR	2
Provided a valid postcode that we could use to categorise by geography	400
Provided a valid partial postcode, but it covers more than one local authority area	52
Total respondents	**659**

City	70	17.5%
County	306	76.5%
Rutland	24	6.0%
Total number of responses we can confidently categorise by local authority area	**400**	

Blaby	37
Charnwood	62
Harborough	50
Hinckley & Bosworth	38
Melton	17
North West Leicestershire	30
Oadby & Wigston	11
Provided a valid partial postcode in County, but it covers more than one district area	61
Total County	**306**

Table 15: Summary of postcode responses from the parents and carers survey

First part of postcode	Number of respondents
CV13	9
CV9	1
DE12	10
DE74	2
LE1	1
LE10	16
LE11	21
LE12	20
LE13	12
LE14	13
LE15	38
LE16	13
LE17	18
LE18	6
LE19	14
LE2	45
LE3	36
LE4	40
LE5	12
LE6	7
LE65	7
LE67	23
LE7	23
LE8	22
LE9	37
NG13	2
NG32	1
PE9	3
Did not provide	207
Grand Total	**659**

LEICESTER CITY HEALTH AND WELLBEING BOARD
DATE

Subject:	Mental Health Support for C&YP in the City
Presented to the Health and Wellbeing Board by:	Geraldine Burdett CYP MH Transformation Manager ICB LLR
Author:	Geraldine Burdett CYP MH Transformation Manager ICB LLR

Does the report concern any of the below groups?			
Severe Mental Illness	Learning Disability	Homelessness	Care Experience Children and Young People
☐	☐	☐	☐x

EXECUTIVE SUMMARY:
Historically when people think of MH and emotional wellbeing services for C&YP they think of LPT's Child and Adolescent Mental Health Services (CAMHS). However, there is a whole host of services available for C&YP with mental health and emotional wellbeing needs within the city. These are comprised not just of NHS but also VCSE and LA services. They range from preventative and early intervention to specialised services. This PowerPoint will provide a brief overview of the services that are commissioned by the ICB and their impact in supporting C&YP's MH and emotional wellbeing needs.

RECOMMENDATIONS:

The Health and Wellbeing Board is requested to: Receive the information.

Appendix H

Leicester City Council

Leicester City Health and Wellbeing Board
6 March 2024

Subject:	Update from the Leicester Integrated Health and Care Group
Presented to the Health and Wellbeing Board by:	Georgia Humby, Integrated Board Lead Officer
Author:	Georgia Humby

EXECUTIVE SUMMARY:

The Leicester Integrated Health and Care Group has been established to support the Health and Wellbeing Board in providing leadership, direction, delivery and assurance in fulfilling its aim to ‘Achieve better health, wellbeing and social care outcomes for Leicester’s population and a better quality of care for children, young people and adults using health and social services’.

The Group meets monthly and has regular partner reporting frameworks to drive forward the work of the Board in supporting the implementation of Leicester’s Joint Health and Wellbeing Strategy, as well as any other identified workstreams requested by the Board. The summary below provides an overview of the work from the last quarter to ensure a close partnership between the Group and the Board.

Discussions have continued around urgent and emergency care at UHL to ensure people are able to access to right care at the right place and the right time, and good practice and innovation across Leicester South PCN has been shared. The Group also discussed the readiness for the adult social care CQC assessment process.

Delivery Plan updates have been reported to the Group with discussions in the last quarter focussed on hypertension, healthy weight and mental health and wellbeing related to social inclusion and supportive networks – plans can be found below.

The Group have established a BCF subgroup with membership from across the system for planning and management. The subgroup will report into the Group and make recommendations to the Health & Wellbeing Board for allocating the Fund at Place level as per its responsibilities set out within the terms of reference.

A VCSE task and finish group has also been created to engage with organisations and strengthen community involvement in decision making.

Planning for integrated neighbourhood teams is underway and a workshop will take place across the system to develop discussions for the City.

The lead officer will continue to provide strategic oversight on projects and actions aligned to the Groups work and liaise with the Health and Wellbeing Board programme manager to ensure the Board receives regular updates and action any necessary workstreams.

Delivery Plan updates:

Date 17 12 2024

Title of workstream: Hypertension prevention and case finding
Objective: *To increase detection of hypertension in Leicester through primary and secondary preventative measures and optimisation of treatment.*

- Meds op design group
- City Place monthly meetings
- Long terms conditions partnership board

Reporting Project	Project KPIs and Targets	Update	Next steps	PLUS Groups - SMI - LD - Homelessness - Care experience young people	Risks and mitigations	RAG for period (please include an explanation for rating)
Advanced Pharmacy Meds op design group	• Increase proportion of blood pressure service consultations that are ABPM to 10% • Grow total annual blood pressure check service	Currently reviewing in LLR ICB best place for oversight. Better understanding of data available to ICB now in place Additional system targets from NSE region in place and being exceeded.	East Midlands Primary Care Team work on low provision of ABPMs to report. Consider appropriate actions around low ABPM performers Appointment booking pilot to go live.	None	BP checks inappropriately targeted drives low quality perception of service. EMPCT quality work to mitigate. Low GP practice engagement in referrals – trial new approaches with new in post pharmacy / PCN engagement leads.	Amber Overall growth strong, ABPM struggling

	consultations by 15% from 2024 baseline.	Pilot of appointments booking platform for community pharmacy imminent. October data: 8136 (219% annual growth) BP checks in LLR in total – 297 (3.6%) ABPM.				
NHS Health Checks Meds op design group	• N screened • N diagnosed within 12 months of check date • N receiving health check as part of QRISK score >10% recorded	• 24-25 Q1= 2802/24-25 Q2= 2670 • Not able to provide this data until April/May 2025 as we only get this	Q1 & Q2 NHS Health Checks NHS Health Check delivery has remained consistent over the last 2 year period, uptake for those receiving an NHS Health Check currently sits at around 40-50% of overall eligible population. The last two quarters for 2024-25 are slightly down from last year, although still in line with anticipated figures/forecast in respect of budget allocation	This will be somewhat dependant on current eligible population cohort for NHS Health Check offer.	Ongoing difficulties with ensuring new NHS Health Check contracts are drawn up and sent out to GP practices, the intended completion date for the new contracts to be sent out and signed was initially set for 1st April 2025. However, this is becoming more of an emerging issue due to	Green- overall performance of NHS Health Check programme is performing strongly and line with anticipated target

			data annually (although it will include 24/25 data for all 4 quarters). - 24-25 Q1= 352/24-25 Q2= 224	for this service. In addition, current NHS Health Check uptake rate for Leicester is notably higher than the current national average figure which sits at around 28%. Revised and developed new Data Processing and Data Sharing Agreements for the provision of data we receive through SystmOne and via LHIS. These have been developed to ensure better data quality is captured through the delivery of the HC programme. As a result, this will look to provide better intelligence and insight when looking to analyse NHS Health Check data, so that further service improvement and design can be implemented accordingly. In addition, allowing us to better monitor the impact and effectiveness the programme is able to provide for those individuals receiving their		PSR guidance and process with how the direct award process is awarded for these contracts. We are continuing to have regular and ongoing discussions with procurement colleagues to establish next steps and looking to get further steer on how to progress with these contracts.	figures for 2024/25. NHS Health Check - Data | Fingertips | Department of Health and Social Care

			check e.g. those being referred into lifestyle services and diagnosed/added to condition specific registers i.e. Hypertension.			
Support case finding and optimisation of Hypertension City Place monthly meetings Long terms conditions partnership board	• % of the expected number hypertension patients detected (80% by 2029) • % of patients optimised to NICE recommendations by 2025	Task and finish group currently in development to address health inequalities in hypertension case-finding, comprising stakeholders from public health (including communities representation), PCNs, ICB, Community Pharmacy and UHL. Scope will be to identify a priority group (or	- Initial meeting of group to be arranged. - Data to identify appropriate communities/geographical areas to target intervention. - KPIs to be agreed. - Intervention options to be discussed and appropriate intervention to be agreed.	TBC pending data insight to identify priority groups with whom to target intervention.	Key notable risks: 1. No designated resource attached to this work – intervention options have been developed to maximise on existing capacity/resources. 2. Requires ‘buy in’ from all key stakeholders – lack of this from any single area could limit reach and effectiveness of project. - Good T&F group representation	Green – on track in terms of setting up T&F group. All other elements still TBC.

		groups) experiencing greater hypertension-related health inequalities and deliver a targeted intervention to increase uptake of blood pressure screening.			across all required areas. 3. Possible impact on NHS Health checks (less people attending as a result of additional BP testing interventions) - Signposting to NHS HC to be embedded within intervention pathway. 4. Participation from target audience is essential. - Engagement with target audience ahead of development of intervention to support co-design/co-production. - Stakeholders include CWC	

					representation. Full risk log to be reviewed as a standing agenda item at T&F group.	

Case study/ qualitative examples of progress:

Project	Example

Point for escalation relating to any of the projects:

Bibliography of Projects

Project	Description
Advanced Pharmacy	Most pharmacies in Leicester are signed up to the NHSE hypertension case-finding programme. This involved blood pressure checks.
NHS Health Checks	The programme is a preventative check to assess overall health status for those aged 40-74 years and don't have a pre-existing medical condition, one of the key areas the NHS Health Check measures for is hypertension and risk of cardiovascular disease (QRISK score).
Support case finding and optimisation of Hypertension	i) Place based targeted work to support practices to identify pts , and link to neighbourhood plans (Community Health and Wellbeing plans) ii) a communication plans to support medication adherence (iii) using business intelligence analysis to understand the detection and optimisation gaps. iv) T&F group work to focus on reducing health inequalities in hypertension detection.

Date 21st January 2025

Title of workstream: Healthy weight
Objective: *To create a system that enables at least 40% of our adult population and at least 70% of the Year 6 population to live at a healthy weight by 2034.*
Governance arrangements:

Reporting Project (*governance*)	**Project KPIs and Targets**	**Update**	**Next steps**	**PLUS Groups** - SMI - LD - Homelessness - Care experience young people	**Risks and mitigations**	**RAG for period**
Pilot brief intervention training – Understanding barriers to healthy weight and raising the conversation of healthy living. Lead officer: Amy Hathway.	80 staff trained from a variety of workforces annually. Change in confidence, knowledge and awareness of assets/signposting locally pre and post training.	Officer within LNDS who is leading work is currently working notice period and will be in post in Feb 2025 when work will commence.	Ask colleagues to share information regarding existing training that could positively feed into the development of this package and ensure that relevant signposting routes are embedded.		Delays due to recruitment – mitigated through informing reporting avenues of delays.	Amber – recruitment delay

Reporting Project (*governance*)	Project KPIs and Targets	Update	Next steps	PLUS Groups - SMI - LD - Homelessness - Care experience young people	Risks and mitigations	RAG for period
Establishing local opportunity to improving healthy weight in pre, during and post-pregnancy Lead reporting officer: Amy Hathway Lead operational officer: Annie Kennedy.	Number of midwives and pre/post-natal workforces trained in raising conversation of weight during pregnancy and change in confidence, knowledge and awareness post training Page views for healthy lifestyle sections of Health for Under 5s website 8 Healthy Lifestyle Advisors within Live Well trained in Pre and Post Physical Activity course to support pregnant women accessing service. Explore opportunities for referrals of pregnant women with long term conditions to be made in to Live Well service.	This training is going to be developed by colleague who will commence employment in March 2025. Places on courses for Live Well advisors and 2 sports staff have been paid for. Completion dates for training to be confirmed with colleagues. Conversations regarding the referral of pregnant women with LTCs has commenced, including how to ensure that the classes are visibly accessible on the	Previous sessions delivered with midwives by Leicestershire County Council will be reviewed. Once officer is in post they will attend the Healthy Pregnancy, Birth and Babies group to garner support and ideas for how to promote the training and deliver it effectively with midwives and pre/during and post-natal workforces. Group to support identification of how to raise profile of importance of healthy weight within the agenda of maternity services and ensure that		Low engagement of workforces – identification of suitable colleagues to support uptake and prioritisation of course.	Amber – training development not commencing til March due to recruitment

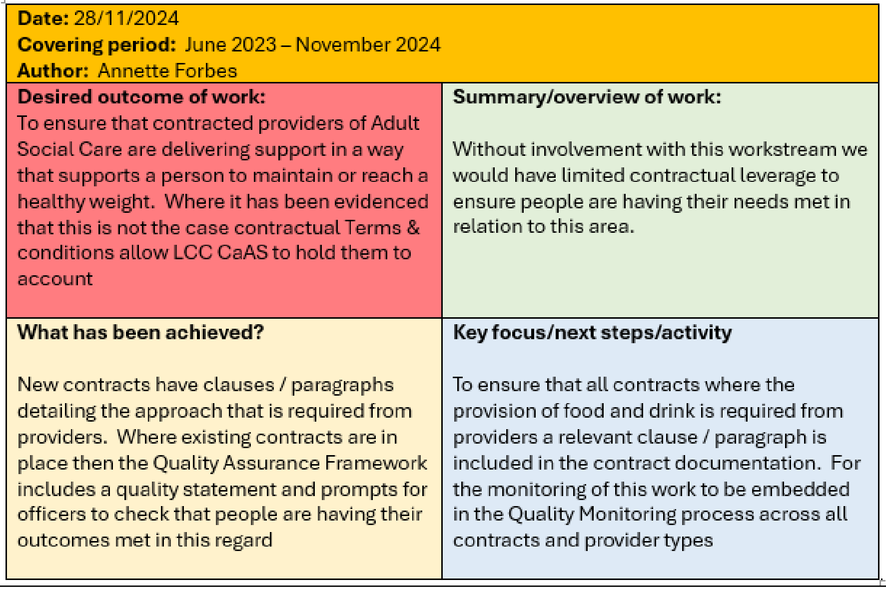
Reporting Project (*governance*)	Project KPIs and Targets	Update	Next steps	PLUS Groups - SMI - LD - Homelessness - Care experience young people	Risks and mitigations	RAG for period
	Number of mums attending Live Well Walk More mums walks. Review leisure centre opportunities to promote themselves as breastfeeding friendly. Antenatal physical activity classes at Aylestone Leisure Centre (March 2024	timetable. Links to midwifery/obstetrics for referrals will be explored. Live Well walks have paused for the winter. A plan for their delivery is being pulled together currently for the 2025 year, alongside how we can align with events and activities occurring to increase footfall. Each walk will be themed, and will be focused around families, not just mums. Work with leisure centres is commencing and a	midwifes are released to attend the training sessions once delivered. Trainers to complete courses and conversations to occur with Service Manager regarding referrals into the service for pregnant women with LTCs. Live Well walks materials to be created and issued to colleagues to promote throughout their networks.			

Reporting Project (*governance*)	Project KPIs and Targets	Update	Next steps	PLUS Groups - SMI - LD - Homelessness - Care experience young people	Risks and mitigations	RAG for period
		meeting is booked for January 2025 at Aylestone Leisure Centre to review what changes are required to make it breast feeding / infant feeding friendly.				
Increase number of schools doing The Daily Mile To be monitored through the Childrens Healthy Weight working group (Chaired by Chirag Ruda) Lead reporting officer: Claire Mellon / Inspire Together	Support 15 schools to start/re-engage in participation of the Daily Mile or alternative daily activity	Initial meeting with Inspire Together who are school sports partnership and were key partner previously. Undertook baseline survey. Identified current schools taking part and those who previously	Inspire Together feedback on which schools they will approach and which Programme Officer in Public Health will approach. Set up Children’s subgroup	Aim is to be inclusive of majority children – can walk, run or wheel	Engagement of schools – mitigations multiple sides of approach and benefits.	Green

Reporting Project (*governance*)	Project KPIs and Targets	Update	Next steps	PLUS Groups - SMI - LD - Homelessness - Care experience young people	Risks and mitigations	RAG for period
Lead operational officer: Rhiannon Pritchard		participated.				
Social care (LD) focused work Social care working group. Lead officer: Amy Hathway (with appropriate reps from LNDS/LPT and Social Care)	Front line adult social care staff trained in raising conversation of weight change in confidence, knowledge and awareness post training. Easy read information issued to all providers. Contracts reviewed to embed healthy living more prominently	This training is going to be developed and delivered by colleague who will commence employment in March 2025. Easy read information is currently in draft format awaiting final approval (last	Pull together insight from training needs analysis with social care to inform training ahead of officer coming in to post. Once training is in development, support ASC colleagues to identify priority workforces and decide suitable ways to provide the	Easy read information and pack of resources created by colleagues in LPT will be for people with LD.	Delays due to officer not being in post – inform colleagues interested in training about this.	Amber – recruitment delay

Reporting Project (*governance*)	Project KPIs and Targets	Update	Next steps	PLUS Groups - SMI - LD - Homelessness - Care experience young people	Risks and mitigations	RAG for period
		update received December 2024). Conversations regarding contracts occur within the social care working group. Colleagues have continued conversations outside of the working group. (See case study below).	training, ensuring language used is reflective of language used within social care. Support dissemination of easy read information to providers. Ensure that a contract review timeline is regularly discussed within the social care working group.			

Case study/ qualitative examples of progress:

Project	Example
Social Care (LD) focused work	

Date: 28/11/2024
Covering period: June 2023 – November 2024
Author: Annette Forbes

Desired outcome of work:	**Summary/overview of work:**
To ensure that contracted providers of Adult Social Care are delivering support in a way that supports a person to maintain or reach a healthy weight. Where it has been evidenced that this is not the case contractual Terms & conditions allow LCC CaAS to hold them to account	Without involvement with this workstream we would have limited contractual leverage to ensure people are having their needs met in relation to this area.
What has been achieved?	**Key focus/next steps/activity**
New contracts have clauses / paragraphs detailing the approach that is required from providers. Where existing contracts are in place then the Quality Assurance Framework includes a quality statement and prompts for officers to check that people are having their outcomes met in this regard	To ensure that all contracts where the provision of food and drink is required from providers a relevant clause / paragraph is included in the contract documentation. For the monitoring of this work to be embedded in the Quality Monitoring process across all contracts and provider types

<u>**Point for escalation relating to any of the projects:**</u>

- **Once developed, support and advocate for attendance of pilot training for workforces working with pre, during and post pregnancy, social care and multi-agency training.**

Bibliography of Projects

Project	Description
Pilot brief intervention training – Understanding barriers to healthy weight and raising the conversation of healthy living	Multi agency training will be offered on a quarterly basis for professionals working with any adults and families. This training will be open to a variety of workforces including teachers, VCS organisations, sports coaches, housing officers etc. This will build on the Healthy Conversation Skills offer and can be promoted through a variety of network. HWB Partners: Promote training to staff when contacted
Establishing local opportunity to improving healthy weight in pre, during and post-pregnancy	A Health Needs Assessment is due to be completed by January 2025 to inform the promotion of healthy lifestyles more effectively within pre, during and post pregnancy. This work spans across a variety of avenues but aims to explore how we can use our existing services more effectively to promote healthy weight. Opportunities within midwifery, health visiting and physical buildings are being explored to promote movement and positive nutrition choices pre, during and post-pregnancy, empower women to understand how to maintain a healthy weight, and ensure that workforces are confident in raising the conversation compassionately. HWB Partners: UHL: support midwifery staff to undertake training and undertake signposting included in that training: promote Health for Under 5s website information, refer to Live Well LPT/VCS/sports: Ensure signposting at contacts to support mothers: promote Health for Under 5s website information, refer to Live Well
Increase number of schools doing The Daily Mile	A recent survey (Nov 24, 52 responses) has shown us that now 14 schools are participating in the Daily Mile with a further 8 doing classroom/facilitated activity. HWB partners including public health nurses, sports clubs, VCS: promote the Daily Mile through contact with school senior leadership.
Social care (LD) focused work	A focus on how to improve health and wellbeing messages throughout social care including for working age people with LD. This includes reviewing procurement opportunities to embed healthy living into provider contracts, creating resources to inform practitioners and providing training. HWB partners: LPT/LCC Review contracts to support working age adults with LD for opportunities for good nutrition and physical activity.

Date 18 02 2025

Title of workstream: Mental health and wellbeing related to social inclusion, and supportive networks
Objective: *Improving the mental health of our local population by promoting and facilitating community-based offers that support inclusion, connectedness and wellbeing*

Governance arrangements:

- Leicestershire Partnership NHS Trust
- Early Intervention & Prevention Board (Adult Social Care, Leicester City Council)
- Community Public Health Steering Group
- Leading Better Lives Steering Group (LCC)
- Mental Health Partnership Board
- Leicester City Council – Public Health
- LLR Mental Health Collaborative

Reporting Project (*governance*)	Project KPIs and Targets	Update	Next steps	PLUS Groups - SMI - LD - Homelessness - Care experienced young people	Risks and mitigations	RAG for period
Neighbourhood Mental Health Cafés *LLR Mental Health Collaborative*	Case studies demonstrating impact. Quality review of individual cafes.	Monthly data and case studies collated. Reviews of individual cafes ongoing.	Complete review of cafes by November.	n/a	Risk that individual cafes do not embed – mitigated through support from neighbourhood leads in LPT.	🟩

Mental Health Wellbeing & Recovery Support Service *Early Intervention & Prevention Board (Adult Social Care, Leicester City Council)*	Undertake a quality review with a focus on impact of the service and how this offer fits within the wider mental health system.	Review ongoing in conjunction with County and Rutland.	Complete review of service.	n/a	Risk of non-collaboration with other services across the system Mitigation: monitoring and review asks for information on collaboration.	🟩
Bringing People Together Programme *Community Public Health Steering Group*	Let’s Get Together (LGT) • Maintain regular walks from the community locations • Warm Welcome to take place in all community locations Let’s Get Digital • Enrol 240 people per term on the course	• Walks are well attended approx. 90 people a month attend • All libraries are offering Warm Welcome in 24/25 • 33 VCSE organisations have received grants to open their spaces to people as a warm welcome space and/or provide health related support and wellbeing	• Working with walk providers to maximise reach and resources • Increase links with VCSE organisations	• LGT activities are accessible, free and open to all. Possibility of targeted walks. • Increasing inclusivity by empowering organisations • Identifying and supporting people	LGT operates from community buildings, mainly libraries, if sites reduce hours/close this will have an impact on LGT and Warm Welcome programmes. Let’s Get Digital is externally funded until March 2026	🟩

	- Maintain 60% of successful attendees accessing follow on courses Let’s Get Growing (Contracted) - Increase number of community food growing plots at allotment sites - Support educational settings to access food growing	- 327 people successfully completed the course (Apr ‘23- June ’24) - 60% of people continued digital learning after these sessions accessing another course - An additional module ‘Let’s Get from A to B’ is due to start shortly. People will have support with finding information, planning journeys, using google maps and booking tickets online - Green Gym	to offer LGD at their sites - Encourage community groups to take up community plots - Continue to support school-based initiatives	who are not digitally literate. - Increasing accessibility by working with VCSE providing courses in familiar locations - Work with VCSE organisations to support more people from plus groups to access activities	after which time the programme is at risk unless an alternative source is found. Let’s Get from A to B is funded separately	🟩

		moving from Rolleston Primary School to Eyres Monsell Community Centre (making it accessible for more people). • The Leicester and Rutland TCV project has been assisting Let’s Get Growing by using Leicester community food growing sites to host corporate volunteering team days. • Besides entry level courses TCV have provided a number of intermediate level courses and workshops tailored towards				🟩

		gardeners with existing experience, to allow community groups and individuals to develop their skills further in a supportive environment				🟩
Leading Better Lives *Leading Better Lives Steering Group (LCC)*	Metrics to be developed in co-production as part of the project	Task groups have been established for each of the four projects	Establish parameters of individual projects.	Capacity issues which had am impact upon the progression of the project have eased and a way forward has been agreed.		🟩

Prevention Concordat for Better Mental Health *Mental Health Partnership Board*	Partnership Board receives reports to address health inequalities Mental health in all policies, such as access to green space, transport, leisure, arts, and culture					🟩
Joy app rollout *LLR Mental Health Collaborative*	Quality Review of the impact of Joy including data, case studies and partner testimonies.	Work ongoing with social prescribers to collate data, case studies and testimonies.	Kavita has added Joy to the agenda of Leicester City Learning Disability Partnership Board is on Monday 28th April. Easy Read poster Joy onboarding session with Andy Humpherson and public health team (9th January) Joy steering group meeting is 26th February. (Andy Humpherson in attendance)	n/a		🟩

Mental Health Friendly Places *Leicester City Council - Public Health*	Case studies demonstrating impact Survey collating feedback from the Mental Health Friendly places to measure positive impact	41 organisations signed up in the city (29 for the city, and 12 covering city and county) 296 people trained in MH first aid aware 28 MH first aiders Survey from October 2024 72% of people surveyed report an increase in confidence about having conversations about mental wellbeing, showing that Mental Health Friendly Places is encouraging meaningful conversations about mental wellbeing among staff and people supported by VSCE organisations. 61% of services have found out about	Present outcome to a future Mental Health Partnership Board. Develop more Mental Health Friendly Clubs by working with the local Football Association Develop a business offer for Mental Health Friendly Places, to include bespoke training to fit with ways of working e.g. lunch and learn. Targeting support for small businesses, e.g. barbers, hairdressers Continue to offer bespoke training on men’s mental health	n/a	Organisational capacity to enable training requires flexible offers	🟩

		additional support for people with mental health difficulties in local communities. All people who have had training from Mental Health Friendly Places have found it helpful. This suggests they had learned new information, increased confidence, stayed up to date with appropriate language, and received helpful tips and tools for discussing mental health Mental Health Friendly Places have also helped to shape the training based on the needs of their own organisation. 5 Mental Health Friendly Clubs are trained across LLR (1 in Leicester).				🟩

		Pilot ongoing with FA around ‘Mental Health Friendly Clubs’ to train committee members and welfare leads of 5 clubs.				🟩
Getting Help in Neighbourhoods Projects *LLR Mental Health Collaborative*	Quarterly case study theming takes place to demonstrate the impacts and outcomes of the GHiN projects.	Quarterly reports and associated data are collected and collated. Review of individual GHiN organisations takes place in July / August, and actions identified from reviews are entered onto the GHiN scheme action log and regularly monitored, updated or closed.	The GHiN scheme is currently receiving and reviewing individual project briefs from the organisations taking part in the next round of grant wards, this is for the FY 25/26. Once all documents have been reviewed they will be sent to the ICB contracts team for draft contracts to be issued.	N/A	At present no risks identified.	🟩

<u>Case study/ qualitative examples of progress:</u>

Project	Example
Mental Health Friendly Places	**Saffron Acres:** “We have a small but dedicated staff team, who come from a variety of backgrounds and with different experiences. As a charity, it can sometimes be a little harder to find opportunities for funded training that is relevant to our job roles, and this is where the MHFP experience has really shined. Not only has the training enabled our team to gain uniform understandings so we are all on the same page, it has allowed us to become more confident when we are engaging people that visit us and access our services. It has been directly relevant in the mental health projects we run, but helps support all our other projects we engage people in.”
Aunty Sue	PDF Aunty Sue Case Study.pdf
Network Event Belgrave	PDF Case Study Network Event Belg

Point for escalation relating to any of the projects:

Bibliography of Projects

Project	Description

Neighbourhood Mental Health Cafés	Drop-in sessions delivered by voluntary sector providers and located in areas with highest levels of mental health need where people can get mental health support and advice – no appointment needed.
Mental Health Wellbeing & Recovery Support Service	Preventative mental health service enabling people to improve and maintain their mental health & wellbeing, or recover from mental illness, through better use of community assets & resources.
Bringing People Together Programme	Free activity sessions at community centres and libraries encouraging people to learn new skills, get more active and get together with others. Projects include: • Let's Get Together (LGT) • Let's Get Growing (LGG) • Let's Get Digital (LGD) • Let's Get Walking LGW) • Let's Get Creative (LGC) • Warm Welcome
Leading Better Lives	Developing a coproduced council-wide approach to prevention and community wellbeing.
Prevention Concordat for Better Mental Health	Underpinned by a prevention-focused approach to improve mental health, which in turn contributes to a fairer and more equitable society.

Joy app rollout	Roll out of the Joy social prescribing app which promotes activities and support and allows people and professionals to make referrals
Mental Health Friendly Places	Encouraging local businesses & community organisations to take up training offer & accreditation to equip them with skills and knowledge to support people with mental health
Getting Help in Neighbourhoods Projects	Grant-funded projects allowing voluntary sector organisations to expand or enhance their existing offer in order to support mental health & wellbeing through activities and support.

RECOMMENDATIONS:

The Health and Wellbeing Board is requested to:

- Note the update
- Raise any issues or concerns as a result of this
- Highlight any work it wishes to be explored by Leicester Integrated Health & Care Group